THE HEALTH OF REFUGEES IN WINNIPEG

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Executive Summary

Immigration to Manitoba is increasing and is intended to reach 10,000 immigrants a year by 2006. Research highlights sexual and reproductive health, mental health and communicable diseases as areas of health concern for many immigrants, especially the refugee sub-set. Despite these health concerns, research in Manitoba also indicates that immigrants and refugees do not generally utilize physician and hospital services to the same degree as other Manitobans. Due to the combination of these factors, the health concerns and health determinant challenges of immigrants, specifically the refugee sub-set, have become of greater concern to service providers and policy planners.

In this project 71 key informants were interviewed in order to determine what services and referral networks exist in the Winnipeg Health Region that address the health needs and health determinants of refugees living in Winnipeg, and to identify potential gaps in these services or referral networks.

In Winnipeg, it was found that many services are working to address the health of refugees, as well as other immigrants, and referral networks between these services are complex. In exploring potential gaps, themes were identified in the responses of key informants (who for the most part discussed the situation of refugees as well as other immigrants).

The health determinants of culture, employment, income, health services, physical environments and social supports networks were highlighted as being of key importance for immigrants and refugees. Key health concerns of immigrants and refugees, according to informants, included sexual and reproductive health, oral health, nutrition, mental health and mental illness, communicable diseases as well as immediate health issues upon arrival.

Informants also discussed how immigrants and refugees experience cultural, educational, informational, and language barriers that impede their presentation to the health or social system for care when they are in need. Barriers experienced within the health encounter by immigrants and refugees involved language barriers, the length of encounter and practitioners' cultural responsiveness.

Interview respondents also discussed the effectiveness of the broader immigrant and refugee serving system. They cited the need for effective service delivery and organizational culture, the importance of partnerships and system navigation, the key role of community-based cultural groups, as well as the capacity of the system.

Acknowledgements

I am very grateful to the people who made this project possible. The people that I interviewed were wonderful resources who shared openly their views and experiences. I also appreciate those people who helped me learn about the process of immigration as well as health care and social services eligibility for immigrants and refugees. I would like to thank Citizenship and Immigration Canada who provided me with detailed information on the immigration of refugees to Winnipeg.

I am grateful to my supervisors at the Winnipeg Regional Health Authority, Jeanette Edwards and Sharon Macdonald, for their guidance and facilitation of my learning.

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Introduction

This document reports on a project that was conducted to determine the capacity of services in the Winnipeg Health Region (WHR) to address the health of refugees living in Winnipeg. Working from a population health perspective, the project did not only focus on direct health services but also on those that address the determinants of health. The project was delimitated to the WHR and had a specific focus on refugees. Refugees were chosen due to recent increases in the number of refugees coming to Winnipeg and because of their greater health needs.

The purpose of the project was threefold. Building on the 2004 Winnipeg Regional Health Authority (WRHA) Community Health Assessment, a profile of past, current and future refugees living in Winnipeg was first constructed in order to give context to the results. Next key informant interviews were conducted in order to determine what services and referral networks exist in the WHR that address the health needs and health determinants of refugees living in Winnipeg, and finally the project highlighted gaps in these services or referral networks.

This report includes sections on background, methodology, and major findings. The background section includes an overview of immigration categories and describes eligibility for health and social services according to these categories. A profile of past and current immigration to Manitoba, highlighting refugees, follows and includes predicted trends for the future. A brief overview of relevant literature is also included as background information. The methodology section outlines the process that was undertaken to interview sixty-six key informants who represented twenty-nine organizations and five key informants who were involved in their community receiving health care and who had been a refugees before coming to Canada. Major findings from the analysis of existing health services and referral networks as well as potential gaps are then discussed.

Background

Immigration categories and their corresponding health and social services eligibility are provided as background information. Subsequently, a brief literature review highlights on what is known about the health and health care of refugees, as a subset of immigrants in Winnipeg. The profile of refugees in Winnipeg is also included in this section, satisfying one of the purposes of the project as well as providing a foundation for evidence based planning regarding the immigrant and refugee population. The increasing immigration of refugees, as well as other immigrants, to Winnipeg make this topic relevant to the planning of health and social services.

What Is A Refugee And What Services Are They Eligible For?

The term refugee is often used to describe both refugee claimants (also known as asylum seekers) as well as permanent residents who immigrated to Canada under the refugee class. Refugee claimants are people who have arrived in Canada seeking protection and whose claim will be assessed in Canada (see Appendix A for details of the refugee claim process) (2). A person who has immigrated under the refugee class has already had their claims accepted abroad and has been determined to be a Convention refugee or a "person in need of protection". This group of people is also known as immigrants because they are permanent residents upon arrival.

Convention refugees are people who are outside of their country of nationality or habitual residence and who are unable or unwilling to return to that country because of a well-founded fear of persecution for reasons of race, religion, political opinion, nationality or membership in a particular social group (1).

People in need of protection are people whose removal to their country of nationality would subject them to the possibility of torture, as defined by the Convention against Torture, or the risk of cruel and unusual treatment or punishment, or a risk to their lives (1).

In many cases service providers will not know the immigration category of the person they are working with and in many cases there is no need. There are, however, certain differences in service eligibility depending on the immigration category of a person with the largest differences being for refugee claimants. The following tables outline the characteristics of different categories of immigrants as well as examples of health benefit and social services eligibility for each category. Some rarer immigration situations, including refugee appellants and people with Ministerial permits, are not included in these tables.

Permanent residents of all classes are eligible for Manitoba Health benefits upon arrival, as are persons whose refugee claim has been successful (Table 1). Refugee claimants, who are waiting for their claim to be assessed, are only eligible for Manitoba Health benefits if they have a valid one-year work permit, which is the same for temporary residents. In order to provide coverage to those refugee claimants who do not have work permits there is the Interim Federal Health Program, which covers essential services. The Interim Federal Health Program also gives limited benefits to permanent residents under

the refugee class for one year after arrival and covers dental, visual, pharmaceutical, and like care in addition to the provincial health insurance coverage they receive. Please see Appendix B for more information on the IFH program.

Social services have different eligibility criteria, only some of which are related to immigration status (Table 2). "Eligible", in Table 2, therefore is used to indicate that a person in the specific immigration category is eligible for the social service if they meet the other criteria not related to immigration. These additional criteria can be found through contacting the programs or exploring their websites (Appendix C). Many social services are available in Manitoba, therefore Table 2 is not an exhaustive list.

Table 1: Examples of Health Benefit Eligibility by Immigration Status

	Permanent Resident			Refugee Claimant/Asylum Seeker	Convention refugee or protected person determined in Canada	Visitor/Temporary Resident
	Family Class	**Economic Class**	**Refugee Class**			
Characteristics*	Foreign nationals sponsored by close relatives or family members in Canada.	People selected for their skills and ability to contribute to Canada's economy, including skilled workers, business persons and provincial nominees.	Convention refugees or persons in similar circumstances selected at a visa office abroad	People who have arrived in Canada seeking protection and whose claim will be assessed in Canada	People in Canada whom the Immigration and Refugee Board (IRB) has accepted as Convention refugees or persons in need of protection	People visiting, studying or working temporarily in Canada
Planned departure from home country	Yes, planned and prepared to leave		May not have planned or prepared to leave			Varies
Immigration Status in Canada	Permanent Resident status upon arrival			No status in Canada, allowed to remain temporarily pending decision of Immigration and Refugee Board	Eligible to apply for Permanent Resident status	Temporary Resident
Manitoba Health Insurance Eligibility	Eligible immediately upon arrival			Eligible if have work permit that is valid for 1 full year. Dependents of this person eligible if they have any immigration document that confirms their right to be in Canada for at least six months.	Eligible once declared a Convention refugee or person in need of protection.	Eligible if have work permit that is valid for 1 full year. Dependents of this person eligible if they have any immigration document that confirms their right to be in Canada for at least six months.
Interim Federal Health Program Eligibility	Not Eligible		Eligible for one year for limited IFH coverage, services not covered by Manitoba Health Insurance.	Eligible while refugee claimant in renewable 1- year terms. If covered by Manitoba Health Insurance then only eligible for limited IFH coverage.	Not Eligible	Not Eligible

***From "You asked about ... immigration and citizenship" by Citizenship and Immigration Canada, Minister of Public Works and Government Services Canada, 2002**

Table 2: Examples of Social Services Eligibility by Immigration Status

NOTE:

1. **"Eligible" indicates that a person in the specific immigration category is eligible for the social service if they meet the other criteria not related to immigration (see Appendix C for listing of websites that provide non-immigration criteria and were source of program descriptions).**
2. **Eligibility does not guarantee service.**

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		Permanent Resident			Refugee Claimant/ Asylum Seeker	Convention refugee or protected person determined in Canada	Visitor/ Temporary Resident
	Program Description	**Family Class**	**Economic Class**	**Refugee Class**			
Characteristics*		Foreign nationals sponsored by close relatives or family members in Canada.	People selected for their skills and ability to contribute to Canada's economy, including skilled workers, business persons and provincial nominees.	Convention refugees or persons in similar circumstances selected at a visa office abroad.	People who have arrived in Canada seeking protection and whose claim will be assessed in Canada.	People in Canada whom the Immigration and Refugee Board (IRB) has accepted as Convention refugees or persons in need of protection.	People visiting Canada or working temporarily in Canada.
Immigration Status in Canada		Permanent Resident status upon arrival			No status in Canada, allowed to remain temporarily pending decision of Immigration and Refugee Board	Eligible to apply for Permanent Resident status	Temporary Resident
55 PLUS	Income supplement for lower-income Manitobans who are 55 years of age and over.	Eligible			Eligible if have valid Manitoba Health Registration Number, requiring work permit that is valid for 1 full year.	Eligible	Eligible if have valid Manitoba Health Registration Number, requiring work permit that is valid for 1 full year.
Canada Child Tax Benefit (CCTB)	Non-taxable amount paid monthly to help eligible families with the cost of raising children under the age of 18.	Eligible			Not Eligible	Eligible	Eligible if have lived in Canada throughout previous 18 months, have a valid permit in the 19th month.

Table 2: Examples of Social Services Eligibility by Immigration Status (page 2)

		Permanent Resident			Refugee Claimant/ Asylum Seeker	Convention refugee or protected person determined in Canada	Visitor/ Temporary Resident
	Program Description	**Family Class**	**Economic Class**	**Refugee Class**			
Child Related Income Support Program (CRISP)	Assists lower-income families with the cost of raising their children.	Eligible			Not Eligible because not eligible for Canada Child Tax Benefit	Eligible	Eligible if have valid Manitoba Health Registration Number, requiring work permit that is valid for 1 full year, and receiving the Canada Child Tax Benefit, requiring that have lived in Canada throughout previous 18 months and have a valid permit in the 19th month.
Children's Special Services	Provides supports and services to families parenting children with disabilities.	Eligible					
Complementary Assistance Program (CAP)	Provides grant assistance to housing co-operatives, to lower housing charges for income-tested occupants.	Eligible after period of sponsorship ends or citizenship is obtained, whichever comes first.	Eligible	Eligible after period of sponsorship ends or citizenship is obtained, whichever comes first.	Not Eligible	Not Eligible	Not Eligible

Table 2: Examples of Social Services Eligibility by Immigration Status (page 3)

		Permanent Resident			Refugee Claimant/ Asylum Seeker	Convention refugee or protected person determined in Canada	Visitor/ Temporary Resident
	Program Description	**Family Class**	**Economic Class**	**Refugee Class**			
Employment and Income Assistance Program	Provincial program of last resort for people who need help to meet basic personal and family needs. Wherever possible, the program is aimed at helping people find a job or get back to work.	Eligible after period of sponsorship ends. Eligible during sponsorship period if sponsor unable or unwilling to honour sponsorship undertaking; legal action can be taken against defaulting sponsor.	Eligible	Eligible after period of sponsorship ends. Eligible during sponsorship period if sponsor unable or unwilling to honour sponsorship undertaking; legal action can be taken against defaulting sponsor.	Eligible, except for health benefits that are covered by the Interim Federal Heath Program.	Eligible	Not Eligible
Healthy Baby Prenatal Benefit	A monthly cheque during pregnancy is available to income-eligible women to help with eating well.	Eligible			Eligible if have valid Manitoba Health Registration Number, requiring work permit that is valid for 1 full year, and Social Insurance Number.	Eligible if have Social Insurance Number.	Eligible if have valid Manitoba Health Registration Number, requiring work permit that is valid for 1 full year, and Social Insurance Number.
Manitoba Child Care Subsidies	Provides subsidies for child care fees.	Eligible			Eligible if have Social Insurance Number.	Eligible if have Social Insurance Number.	Eligible if have Social Insurance Number.
Manitoba Housing Authority - Public Housing	Affordable and subsidized accommodation for people who are living on low or moderate incomes.	Eligible			Not Eligible	Not Eligible	Not Eligible

Table 2: Examples of Social Services Eligibility by Immigration Status (page 4)

		Permanent Resident			Refugee Claimant/ Asylum Seeker	Convention refugee or protected person determined in Canada	Visitor/ Temporary Resident
	Program Description	**Family Class**	**Economic Class**	**Refugee Class**			
Old Age Security	Pension is given to people 65 and over.	Eligible			Not Eligible	Not Eligible	Not Eligible
Rent Supplement Program	Assists low and moderate-income households to obtain affordable, adequate and suitable housing in the private rental sector and in private non-profit or not-for-profit co-operative housing projects.	Eligible after period of sponsorship ends or citizenship is obtained, whichever comes first.	Eligible	Eligible after period of sponsorship ends or citizenship is obtained, whichever comes first.	Not Eligible	Not Eligible	Not Eligible
Shelter Allowance For Elderly Renters (SAFER)	Financial assistance for persons aged 55 and over who rent their living accommodation in the private marketplace and who are required to spend a large portion of their income on rent.	Eligible after period of sponsorship ends or citizenship is obtained, whichever comes first.	Eligible	Eligible after period of sponsorship ends or citizenship is obtained, whichever comes first.	Not Eligible	Not Eligible	Not Eligible
Shelter Allowance For Family Renters (SAFFR)	Financial assistance for families who rent their living accommodations in the private marketplace and spend a large portion of their income on rent.	Eligible after period of sponsorship ends or citizenship is obtained, whichever comes first.	Eligible	Eligible after period of sponsorship ends or citizenship is obtained, whichever comes first.	Not Eligible	Not Eligible	Not Eligible

Table 2: Examples of Social Services Eligibility by Immigration Status (page 5)

		Permanent Resident			Refugee Claimant/ Asylum Seeker	Convention refugee or protected person determined in Canada	Visitor/ Temporary Resident
	Program Description	**Family Class**	**Economic Class**	**Refugee Class**			
Social Insurance Number (SIN)	Nine-digit number used in the administration of various Canadian government programs. Required to work in Canada or to receive government benefits.	Eligible			Eligible for temporary SIN if have work permit/employment authorization or study permit/student authorization and contract of employment. Eligible for these permits if 1) found eligible to have claim referred to Immigration and Refugee Board (IRB), 2) had and passed refugee medical examination, 3) submitted personal information form to IRB.	Eligible for temporary SIN if have work permit/employment authorization or study permit/student authorization and contract of employment.	Eligible for temporary SIN if have work permit/employment authorization OR study permit/student authorization and contract of employment OR a visitor record indicating eligibility to for work in Canada OR a diplomatic identity card and a letter of permission of employment.
Supported Living	Person-centered services are provided to eligible adults with a mental disability to meet the unique need of each individual.	Eligible after period of sponsorship ends. If during sponsorship period and sponsor is unable or unwilling to honour sponsorship undertaking then case considered.	Eligible	Eligible after period of sponsorship ends. If during sponsorship period and sponsor is unable or unwilling to honour sponsorship undertaking then case considered.	Eligible	Eligible	Not Eligible

Table 2: Examples of Social Services Eligibility by Immigration Status (page 6)

		Permanent Resident			Refugee Claimant/ Asylum Seeker	Convention refugee or protected person determined in Canada	Visitor/ Temporary Resident
	Program Description	**Family Class**	**Economic Class**	**Refugee Class**			
Vocational Rehabilitation Program	Assists eligible adults with a disability to pursue and secure gainful employment, by providing a range of vocational training, education and support services.	Eligible			Not Eligible	Not Eligible	Not Eligible

***From "You asked about ... immigration and citizenship" by Citizenship and Immigration Canada, Minister of Public Works and Government Services Canada, 2002**

16-May-05

Brief Review Of Literature Relevant To The Health And Health Care Of Immigrants And Refugees In Winnipeg

The following review of literature is not exhaustive but rather highlights the key messages of literature that is specific to the health and health care of refugees, as a subset of immigrants, in Winnipeg.

The Winnipeg Regional Health Authority (WRHA) 2004 Community Health Assessment Report describes how the areas of mental health and communicable disease are the most significant health concerns for the immigrant and refugee population in Canada (3). Although some health concerns may be common to refugees as well as other immigrants, research has documented that the medical concerns of refugees are different than those of other immigrants in that refugees experience "infectious diseases because of poor living conditions, traumatic injuries, malnutrition, and psychiatric disorders" (4). Literature also highlights sexual and reproductive health, in addition to mental health and communicable diseases, as additional areas of health concern for refugees (5). In general, refugees also experience more mental health challenges than other immigrants; finding it more stressful to adapt to a new society (4) as well as suffering more from post-traumatic stress disorders and somatisation (3).

Despite significant health concerns, immigrants and refugees have low health service utilization rates. A pilot study has examined the health service utilization rates of newcomers to Manitoba through linking the Citizenship and Immigration immigrant landing file to Manitoba's provincial health records (6). The study found that recent immigrants to Manitoba utilized physician and hospitals services less than other Manitobans, except for infectious diseases and pregnancy (6). When comparing recent immigrants, refugees and family class permanent residents, as well as newcomers with no education, visited physicians more often than other recent immigrants, but all less than other Manitobans (6).

The apparent discrepancy between health needs and utilization rates may be due to barriers to accessing health and social services. The WRHA 2004 Community Health Assessment Report highlights the potential of cultural and language barriers to influence access to needed services, as well as a lack of knowledge about navigating the system (3). In the study "An Analysis of Barriers Facing Immigrant Women And Their Families In Accessing Health and Social Services", prepared for The Immigrant Women's Association of Manitoba (IWAM), a variety of access barriers are identified at the level of the consumer, implementing agencies, and at a higher policy level (7).

Many of the consumer level barriers to access found in the IWAM study were related to the women being disadvantaged with regards to the twelve determinants of health (Appendix D) (7). The WRHA 2004 Community Health Assessment Report discusses how language, culture, age, gender, socio-economics and social support are determinants of health that may be of particular importance to immigrants and refugees (3). Other Manitoba research cautions against using the Determinants of Health Model emphasized in North America when discussing immigrant and refugee health (4). This study found

that refugees from one ethno-cultural community emphasized the social roots of health and illness (4).

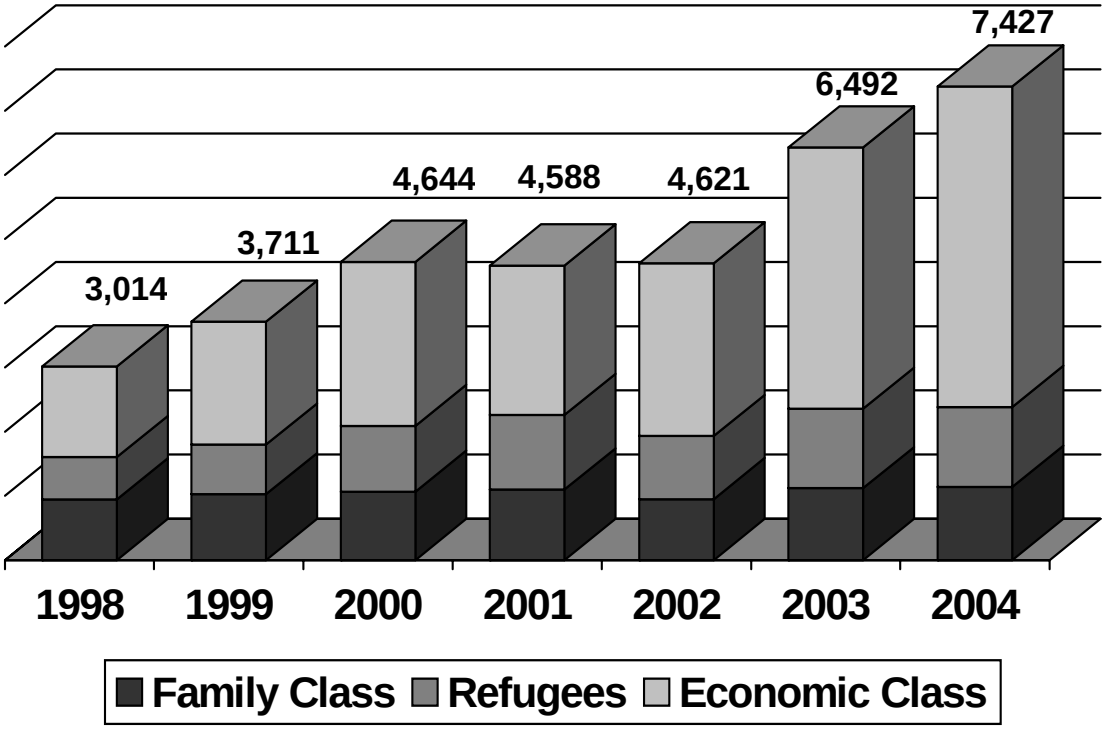
Profile And Trends Of Refugee Population In The Context Of Immigration To Manitoba

The majority of this subsection is based on data from Citizenship and Immigration Canada (8). The data includes all family members of families that had Winnipeg as their immigration destination. Throughout this subsection, 2004 data only includes the months of January through November inclusive (with the exception of Graph 1).

Immigration Levels: Immigrants

Between 1998-2002, approximately 4000 people immigrated to Manitoba annually, with the majority (75-80%) settling in the Winnipeg Health Region (3). In 2002, the Government of Manitoba set the goal of increasing this number to 10,000 immigrants annually by 2006 (3). The largest increases are expected to be in provincial nominees, who are part of the economic class of permanent residents, and in persons under the refugee class (9). Evidence of the rising trend in immigration to Manitoba can be seen in Graph 1.

Graph 1: Manitoba Immigration 1998 to 2004[1]

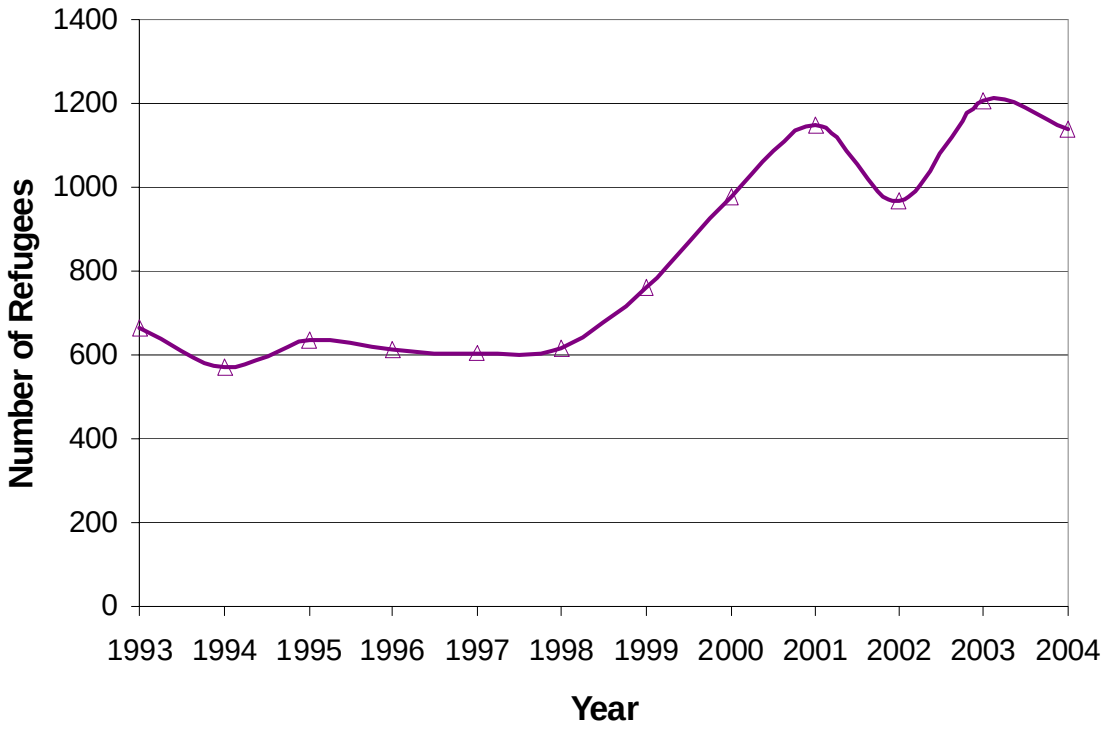


[1] Source of Graph: Manitoba Labour & Immigration with data from Citizenship and Immigration Canada.

Immigration Levels: Refugees

In 2003, approximately one fifth (19%) of the immigrants to Manitoba were considered refugees, having immigrated under the refugee class or having made a refugee claim (10). The number of refugees to Manitoba began to increase around 1999, as can be seen in Graph 2, with the average between 1993-1998 being 647 and between 2000-2003 being 1099 (8). In 1993 through 2004 Winnipeg has received between 90 and 99 % of the refugees to Manitoba (8).

Graph 2: Refugees to Winnipeg 1993-2004



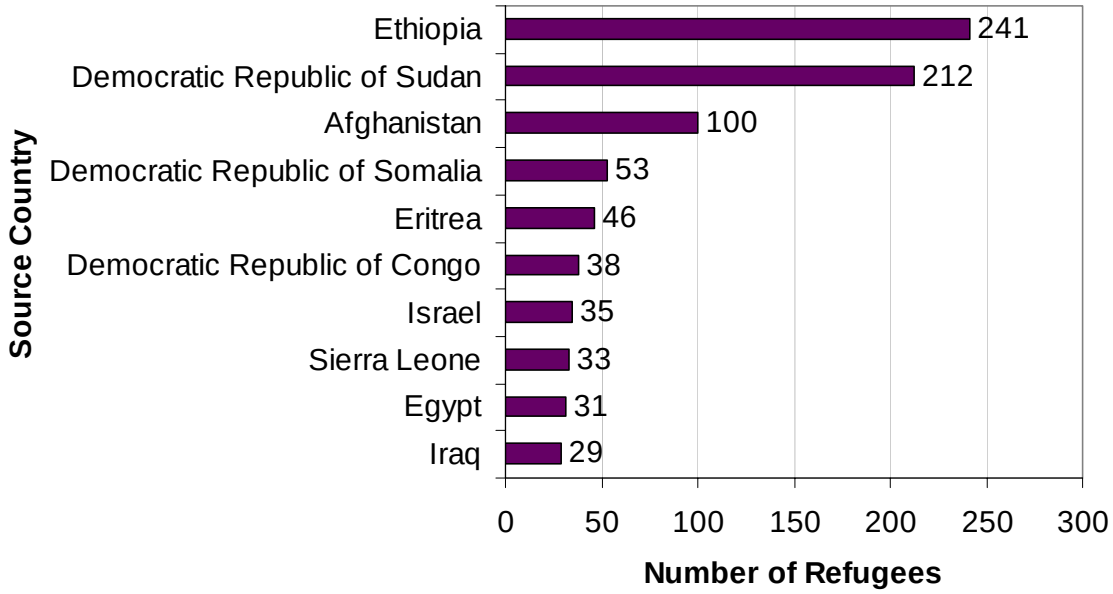
Source Countries

The refugees that come to Winnipeg are a diverse group. Evidence of this can be seen in their variety of source countries. Current refugee newcomers, who arrived in Winnipeg from January to November 2004, came from 56 different countries (8). The major source countries are included in Graph 3 with the top sources to Winnipeg during this time period being Ethiopia, the Democratic Republic of Sudan, and Afghanistan (8).

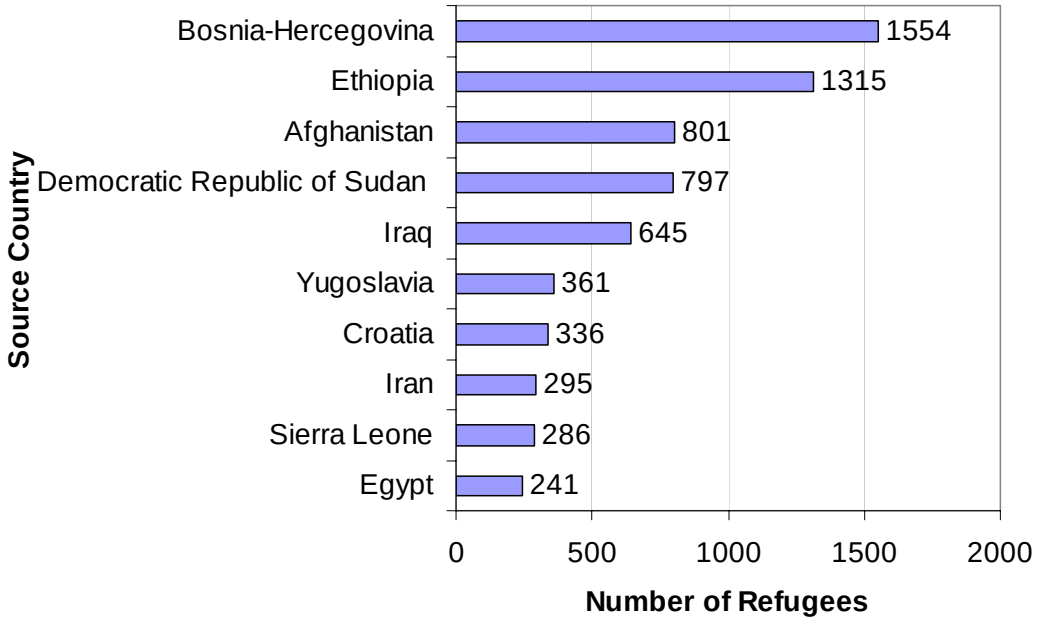
It is important for evidence based planning to be aware, not only of the profile of recent refugees, but also those that have come previously as some challenges are not only newcomer issues but are also concerns for those people who immigrated to Canada many years ago. Graph 4 shows the major source countries of refugees who settled in the Winnipeg Health Region over the past 10 years (1993 –2004) (8). The top sources were the former Yugoslavia (including Bosnia-Hercegovina, Yugoslavia and Croatia),

Ethiopia, Afghanistan, the Democratic Republic of Sudan and Iraq (8). Although people are still coming in 2004 to Winnipeg as refugees from many of these countries there are no longer a large number of refugees from the former Yugoslavia.

Graph 3: Source Country of Refugees to Winnipeg from Jan-Nov 2004



Graph 4: Source Country of Refugees to Winnipeg from 1993-2004



Gender and Age

Of those refugees who came to Winnipeg in the past decade 46% were female (8). The age distribution was similar for males and females (8). The refugee population upon arrival is relatively young, with a third of refugees being children or youth and only 5 % being over the age of 45 (8). The average (1993-2004) proportion of refugees to Winnipeg in each age category can be found in Table 3 below (8).

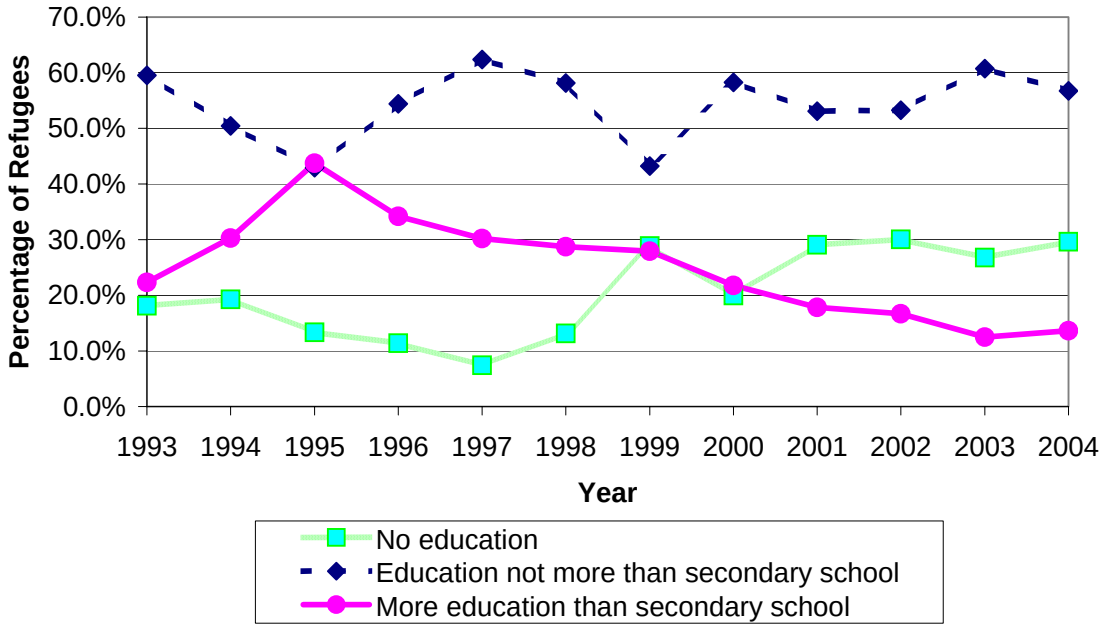
Table 3: Age Distribution of Refugees to Winnipeg from 1993-2004

Age range	Child (0 to 11)	Youth (12 to 17)	18-25	26-35	36-45	46-55	56-65	66+
1993-2004 Average (%)	23	11	19	28	14	4	1	0.5

Education Level Upon Arrival

Although formal education does not necessarily equate to the level of skills a person has, the level of education that newcomers have upon arriving in Canada does affect their ability to learn English and adapt to their new life. Recently the proportion of refugees who have come to Winnipeg with no education has increased (Graph 5) to approximately 29% (2001-2004 average) (8). Over the past ten years, on average 20% of refugees to Winnipeg have come with no education and another 55% have come

Graph 5: Education Level Upon Arrival of Refugees to Winnipeg 1993-2004



with some education but not more than secondary school (8). The proportion of refugees with secondary school or less cannot be explained solely by age distribution. A quarter of refugees to Winnipeg, on average over the past ten years, have come with more education than secondary school (college, university, or trade schools), however, the proportion of refugees with more education than secondary school has been decreasing in recent years as the percentage of persons without any education has increased (Graph 5) (8). These changes in the education level of the refugee population that is arriving in Winnipeg are relevant to program planning because of educational barriers.

Methodology

Purpose

The purpose of this project was to determine:

1) The profile of past, current and future refugees living in Winnipeg in order to determine trends.
2) What services and referral networks exist in the Winnipeg Health Region that address the health needs and health determinants of refugees living in Winnipeg.
3) The current and projected gaps in health services and referral networks in the Winnipeg Health Region that address the health needs and health determinants of refugees living in Winnipeg.

Project Preparation

The Western Regional Training Centre field placement intern needed to become familiar with the background issues relevant to the health of refugees in Winnipeg in order to design the methodology of study and to prepare for its implementation. Accordingly, the intern was exposed to the Winnipeg Regional Health Authority's decision making structure and processes. The intern also observed the process of refugee settlement and had discussions with representatives from Winnipeg's refugee settlement agency, Manitoba Labour & Immigration, Citizenship and Immigration Canada (CIC) as well as Winnipeg Regional Health Authority (WRHA) staff members. Information regarding immigration categories and their corresponding health and social services eligibility were also sought in these discussions, as well as discussions with the Insured Benefits Branch of Manitoba Health and staff of various social services. Eligibility information was sought because it had been mentioned in initial discussions with WRHA staff as necessary background information for service providers.

Project Design

Refugee Profile

Data Source

Data from the WRHA 2004 Community Health Assessment Report and from Manitoba Labour & Immigration publications provided information on overall immigration to Manitoba (3;10). CIC provided information on refugees destined to Winnipeg from 1993 to November 2004 inclusive. Information included the number of refugees from each source country, age group, gender, and education level, as well as annual refugee immigration levels (8).

Analysis of Refugee Profile

The detailed CIC data was summarized into tables and charts that highlighted the overall trends in the data. Averages over the time period (1993-2004) were calculated where applicable.

Key Informant Interviews

Rationale

Key informant interviews were conducted with service providers, refugee sponsors and refugees in order to determine what services and referral networks exist in the Winnipeg Health Region that address the health needs and health determinants of refugees living in Winnipeg as well as to identify any potential gaps in these services and referral networks. Due to a focus on extant services and referral networks, the majority of informants were service providers, however, refugees and refugee sponsors were also interviewed to confirm that gaps relevant from their perspectives were identified.

Sampling

A purposive sampling methodology was employed in which interviewees were chosen because they were information-rich cases from which knowledge could be gained about the research questions.

Service Provider Informants

Service provider informants were recommended by previous organizations and matched the purposive sampling criteria. Initial contacts included the major refugee settlement organization of Winnipeg and staff members at the WRHA. Informants were asked about their referral networks and asked "Who else should I be talking to about this project to help me understand how the health care system in Winnipeg currently responds to the health needs of refugees?". Organizations or programs that were mentioned in the responses to both of these types of questions were added to the potential informant list. Potential informants were then compared to the purposive sampling criteria which limited informants to representatives of community care health service organizations or refugee serving organizations (see definitions below). If the organization/program matched the criteria then its director, or specific contact that was given in the referring interview, was contacted and asked about having an individual or group from their organization/program interviewed. This point of contact was also an opportunity to confirm that the organization/program did work with refugees.

Community care health service organizations provide direct health services to refugees. Fee-for-service clinics were not included in this category unless the clinic specifically targeted refugees. Acute care settings were not included in this category.

Refugee Serving Organizations provide services to refugees. They may be formally or informally involved in the process of refugees receiving health services but did not provide the services.

Refugee Sponsor Informants

The project was described to representatives of groups that regularly privately sponsor refugees at two of their regular meetings. The representatives were then asked to give their name and contact information if they were interested in participating in the project. Refugee sponsors were then contacted to set up an interview for the project. These groups were most often faith based groups.

Refugee Informants

A complete survey of refugees or ethno-cultural organizations could not be conducted within the limitations of this project. Instead refugees who were involved with their ethno-cultural community receiving health care were interviewed. Through these interviews it could be determined whether the gaps in services and referral networks relevant to refugee informants were captured in the more numerous interviews with service providers.

In order to get the hypothetically most diverse perspectives, refugee informants were sought from different source countries, with different lengths of time living in Canada. It was important to interview people who had arrived recently as well many years ago because health related issues of immigrants and refugees are not only newcomer issues. Informants were sought from source countries that had a substantial population in Winnipeg. In order to eliminate the bias of an interpreter, and for convenience, only refugees that could communicate in English orally were sought. Literacy was not however a requirement.

A health care organization that had volunteers from various ethno-cultural communities contacted potential refugee informants that met the abovementioned criteria. If the refugee consented then they were contacted to set up an interview for the project.

Interview Protocol

Informed consent for the interview was done orally because although spoken English was a requirement of the interviewees, literacy was not. Interviews were semi-structured and included both open and closed questions (see Appendix E for interview guides). Interviews lasted half and hour to two hours in length depending on the size of the group and the scheduling restrictions of the respondents. They were, in general, held at the work site of the respondents.

Analysis of Key Informant Interviews

The information from the key informant interviews was used to describe the services and referral networks that exist in the Winnipeg Health Region, which address the health needs and health determinants of refugees living in Winnipeg, as well as to identify any potential gaps in these services and referral networks. The major focus of the informants' organizations/programs were categorized according to the determinants of health. Within

the health services determinant, which made up the majority of service provider interviewees, sub-categories were also created based on the type of health service. Organizations/programs that were part of interviewees' referral networks were also categorized according to their major type of activity. Once the organizations/programs were categorized the networking between them was examined.

All interviewees were asked what they felt aided refugees in living healthy lives in Winnipeg or made it more challenging, as well as what aspects of Winnipeg's health care system were working well or not working well for refugees. The answers to these open-ended questions were transcribed and then grouped into themes. In many cases interviewees spoke to the experience of both immigrants and refugees but if they had opinions specific to refugees, this specification was documented.

Limitations

Purposive Sampling Criteria

The purposive sampling criteria limited key informants to representatives from community care health service organizations, refugee serving organizations, groups that sponsor refugees, as well as a limited number of refugees that are involved in their ethno-cultural community receiving health care. Acute health care sites, the majority of fee-for-service clinics, ethno-cultural community leaders, etc. did not meet these criteria. This delimitation was necessary and appropriate for the scope of this project.

Time Constraints

Even with the delimitations of the purposive sampling criteria, there were organizations which matched the criteria that could not be interviewed due to time constraints.

Key Informant Interviews

Through gathering information via key informant interviews, it is knowledge of an informant's perspective that is ascertained. For example, the documented referral networks were based on the informants' perspectives, rather than observing each encounter and documenting the referrals that occur. Since the analysis highlights trends and key themes this limitation in the interview methodology is acceptable.

Findings

Key Informants

In total 71 key informants were interviewed; five refugees, two refugee sponsors and sixty-four service providers, as can be seen in Table 4 below.

Table 4: Number of Interviewed Key Informants by Type

Type of Key Informant	Number of Organizations/ Programs	Total Number of Informants
Refugees	N/A	5
Refugee Sponsors	2	2
Service Providers	27	64

Interviewed Refugee Informants

Five of the project's informants were refugees. Their source countries were varied and included Afghanistan, Chile, Ethiopia, Iran, and Vietnam. The interviewed refugees had lived in Canada for variable lengths of time, having arrived between 1975 and 2002. All knew a group of people in Winnipeg who were from their home country. Fulfilling the requirements of the sampling criteria, all of the refugee informants also were involved with people from their home country receiving health care. The informants helped people from their home country by acting as interpreters, taking people to hospitals or clinics, helping people make appointments, as well as sharing information such as the meaning of medical results, what rights people have in Canada, where doctors are that speak their language, and what organizations exist.

All of the interviewed refugees felt that when people from their country first arrived in Canada, the majority could not speak English well enough to speak to a doctor or nurse. Although informants expressed that English proficiency had increased for some people from their country, many of the informants felt that there were still people from their country that lacked the language capabilities to converse with a doctor or nurse. The number of doctors in Winnipeg that spoke any of the languages of the informants' home countries varied between none and ten, according to the refugee informants.

All of the refugee informants were female because none of the health care organization volunteers who consented to being interviewed were male. This factor could potentially bias the results.

Interviewed Refugee Sponsor Informants

Representatives from two different faith-based organizations that sponsor refugees were interviewed (Appendix F). The informants illustrated how some organizations that

sponsor refugees do so as part of a national network and others do not. The two informants represented organizations that provide settlement supports to refugees in many ways including: meeting refugees at the airport, providing financial support, finding an apartment/house and furniture, helping refugees get a medical card and required forms at Citizenship and Immigration Canada, aiding in finding employment or schooling, helping contact health professionals, as well as providing a social support network.

Interviewed Service Provider Informants

Service provider informants were representatives from community care health service organizations or refugee serving organizations. Sixty-four service provider informants were interviewed from twenty-seven different organizations/programs (Appendix F). Due to the population health perspective of this project the major focus of the informants' organizations/programs were categorized according to the determinants of health (Appendix D). Within the health services determinant, which made up the majority of service provider informants, sub-categories were also created based on the type of health service. Table 5 (below) outlines the number of organizations/programs in each health determinant category.

Table 5: Number of Organizations/Programs by Major Focus

Major focus of organization/program	Number of organizations/ programs interviewed
Employment & Working Conditions	**2**
Health Services	**19**
general	2
community development	1
dental	1
disability	1
mental health	5
primary health	6
sexual and reproductive health	2
women's health	1
Settlement	**3**
Social Support Network - services	**3**

The majority of service provider informants were representatives from organizations that focused on heath services (19), with the bulk focusing on primary health or mental health. Two organizations/programs predominantly focused on the health determinant of employment and working conditions. Three organizations/programs provided services that addressed the health determinant of 'social support network', however, these services differed from other social support networks of refugees, such as faith-based or ethno-cultural organizations. The three interviewed organizations/programs that provided

settlement supports were given a separate category because their work addresses a multitude of health determinants.

In addition to the type of services provided, service provider informants were asked about other aspects of their organizations/programs. Almost all of the organizations/programs whose representatives were interviewed were reachable by bus and could be accessed by people with mobility challenges. The majority, but not entirety, of the interviewed organizations/programs were located in Downtown Winnipeg. There was, however, variety in the scope of geographic eligibility with organizations/programs serving specific catchment areas, Winnipeg, or Manitoba.

For approximately half of the organizations/programs, non-geographic eligibility criteria included factors related to immigration status. All organizations/programs that did not include immigration criteria were health service organizations that serve refugees but do not limit their programs by these criteria.

The organizations/programs of the informants provided services through staff or volunteers in 45 different languages. Only seven of these languages (excluding English and French), however, were documented as available at five or more organizations/programs.[2] The majority of languages spoken by recent refugee newcomers were not languages identified as being available at many organizations/programs. When clients could not speak a language available at the organizations/programs the most common responses included: asking the client to bring a family member or friend to interpret, using an interpreter from within the organization (possibly within another program), and acquiring an interpreter from another organization.

Referral Networks

The referral patterns of service provider and refugee sponsor informants were examined in order to describe the referral networks that exist in the Winnipeg Health Region that address the health needs and health determinants of refugees living in Winnipeg. The major focus of the interviewed organizations/programs as well as organizations that informants refer to were categorized according to the determinants of health. Although there were referral connections between interviewed organizations/programs, there were also many organizations that were part of informants' referral networks that were not interviewed because they did not meet the purposive sampling criteria or due to time limitations. Additional health determinants focused on by non-interviewed organizations that were part of the informants' referral networks included healthy child development, education, acute health services, income and social status, personal health practices and housing as part of the physical environment.

Due to the nature of key informant interviews and their inherent limitations, which were described in the methodology section, only general trends in the referral networks are

[2] The seven languages are Spanish, Vietnamese, Tagalog, Portuguese, Arabic, Laotian, and Punjabi.

described. The referral networks were complex and most organizations made referrals to as well as received referrals from various organizations. Key findings upon further examining the referral networks included that health organizations were referring to a wide variety of organizations except for acute health services, which were documented as referring to many types of health services but not to organizations that addressed other determinants of refugees' health. Social support networks of immigrants and refugees, such as their churches or ethno-cultural organizations, as well as settlement services appeared to be referring to mental health services but not to many sexual and reproductive health services. Oral health has appeared to be of concern for refugees yet referrals to dental services were only documented from other dental services and not from a wide variety of organizations.

Themes Identified By Key Informants

In order to identify potential gaps in services and referral networks informants were also asked about what they felt aided refugees in living healthy lives in Winnipeg or made it more challenging, as well as what aspects of Winnipeg's health care system were working well or not working well for refugees. The answers to these open-ended questions were transcribed and then grouped into themes.

This subsection describes key informants' main messages regarding the identified themes. In many cases informants' answers to the open-ended questions spoke to the experience of both immigrants and refugees. In cases where refugees were specifically discussed it was documented. Five major themes were identified in the interviews and are listed below. In the descriptions of each theme that follows, sub-categories are also identified. Opinions expressed are not, unless stated, those of all informants but rather were mentioned in some of the interviews.

Major Themes Identified in Interviews

1. Health determinants
2. Barriers to presentation of need
3. Key health concerns
4. Barriers within health encounter
5. Effectiveness of immigrant and refugee serving system

Health Determinants

The Determinants of Health Model outlines twelve key determinants of health (Appendix D). Research has found that refugees from some ethno-cultural communities place a greater emphasis on the social roots of health and illness than the North American Determinants of Health Model (4). Informants did, however, emphasize the importance of the six determinants of health that are described in this sub-section.

Culture

Cultural Adaptation

Many interviewees discussed the importance of cultural adaptation to living a healthy and successful life in Canada. Cultural adaptation was discussed as learning about Canadian cultural norms as well as practical aspects of life in Canada in order to reduce cultural barriers. The focus of these comments were not on changing the culture of newcomers but instead assisting with

> One refugee informant noted that although they were very educated when they came to Canada they did not know what the transfer on a bus was, how to do laundry here or how to use the phone to call home.

familiarizing them with Canadian culture so that they could better understand and thrive in their new milieu.

Facilitation of cultural adaptation, through orientation and settlement programs, was seen as necessary to successful adaptation and was, according to informants, not currently happening enough. A mixture of support from people within the ethno-cultural community of the immigrant or refugee as well as from other Canadians, was seen by informants as ideal. Supports for newcomers were also discussed as having a role in reducing informational barriers through teaching newcomers about what health and social services are available, what services are free and which ones have associated costs, as well as to what services they are entitled.

The adaptation process was emphasized as being challenging and stressful due to the complexity of immediate needs that the immigrant or refugee faces as well as the differences between Canada and their country of origin. Not all immigrants and refugees expect the challenges of adaptation and are additionally stressed by their expectations being unfulfilled. Although speaking English was cited as making adaptation easier, the challenges were not exclusively language based. Informants also discussed how a person's background influences how easy it is for them to adapt to life in Canada, including whether they are a refugee and whether they have been affected by war.

Adapting to life in Canada can strain immigrant and refugee families. Informants discussed how traditional gender relations and roles can be challenged through living in Canada, placing stress on relationships. Many interviewees also discussed how immigrants and refugees can find parenting difficult in the Canadian context due to differences in parenting norms and laws. Raising an infant can be challenging for newcomers and support from a public health nurse in combination with an interpreter, if necessary, was praised. According to informants, differences in parenting norms and laws leave some immigrant and refugee parents not knowing how to effectively discipline their children in the Canadian context. Informants also described how interactions between immigrant and refugee parents and youth can be strained by the youth often being caught between the culture of their family and that of their peers. Concerns regarding the involvement of immigrant and refugee youth in gangs and/or networks of drug users were raised as well by a number of informants.

Discrimination

Regarding the health determinant of culture, interviewees highlighted how discrimination is a factor that inhibits the health of immigrants and refugees and adds to their isolation. Informants felt that Canadian society is still racist but that it is more systemic than overt. There was the perception that some Canadians thought immigrants and refugees were stupid and that they were taking jobs away from Canadians. Sensitivity training and a focus on the similarities between cultures were seen as important steps in reducing discrimination.

Employment and Income

Employment

Employment was viewed by respondents as a key determinant of the health of immigrants and refugees and although employment of any type was important, meaningful work in the person's field of expertise was seen as crucial to overall health. Finding a job or prerequisite training is therefore often the first priority for immigrants and refugees upon arrival. According to informants, it is challenging for immigrants and refugees to find jobs and when they find employment, they are often underemployed. Informants were concerned that the combination of these factors can lead to immigrants and refugees being frustrated, lacking money, working many shifts or different jobs, not saying if they are hurt during employment, and/or taking any available job. Cited barriers to employment included language proficiency/accent, lack of Canadian connections/experience, as well as being uncomfortable with the need to 'sell yourself' or brag. Organizations exist whose purpose is to help immigrants and refugees overcome these barriers and find suitable employment.

Informants discussed how the stress incurred by being under- or un-employed is generally greater for people who were professionals in their home country. Foreign trained professionals face many barriers to having their credentials recognized and being able to practice in Canada. They are required to pass Canadian professional exams which have high associated costs, require a high level of English, and pose questions in ways that other cultures may not be familiar with. Interviewees also described how some immigrants and refugees are required to repeat their degrees entirely, not being eligible for the exams, because they lack appropriate documentation. For some immigrants and refugees, exams and further education are not feasible, especially for those who need to immediately support their families. It was also mentioned how having a professional background may, however, hinder immigrants and refugees from getting other 'survival jobs' because they are over-qualified, despite the fact that their qualifications are not recognized in Canada.

Increasing the recognition of foreign-trained professionals' credentials was seen by many interviewees as being beneficial not only to the individual but also for the immigrant and refugee serving system. The recognition of foreign-trained doctors was most often discussed and informants felt that increasing the number of practicing foreign-trained doctors would allow immigrants and refugees to go to doctors from their home countries, thereby addressing language barriers and providing culturally responsive service. Informants also discussed the general need to increase the representation of immigrants and refugees in decision-making as well as staff positions within the health system.

Income

Informants discussed how many immigrants and refugees have limited income and are living in poverty and therefore have health risks similar to other low-income persons. Refugees are given financial support from government or private sponsors for one or two years at the social assistance rate. Some interviewees felt that this financial support should be provided for more years in order to help refugees 'get back on their feet' while

others felt that the amount should be greater so that they could 'get ahead'. It was noted that at present levels the financial support does not meet the provincial standard for persons living with HIV, a health concern for some newcomers. Another interviewee felt that refugees should not be given 'hand outs' because it would lead to their dependence on financial support. It was also highlighted that financial challenges are not limited to immigrants who come as refugees.

It was recommended that settlement services include guidance regarding financial management in the Canadian context due to the complexity of immigrants, and refugees, financial situation. Many immigrants and refugees are also using their income to pay off transportation loans and to support relatives or friends in their source country. Supports such as Employment and Income Assistance (EIA) and Pharmacare exist yet interviewees stated that many immigrants and refugees do not want to use them because they feel it is shameful and that 'they are cheaters'. Staff of some community health centers are nevertheless involved in advocating for EIA for some of their immigrant and refugee clients who are in need.

Health Services

Access to Health Services

Access to health services was seen by informants as an integral component to ensuring the health of immigrants and refugees. The health care system was praised, especially by interviewees that were refugees, for its free medical and hospital care which took, as a respondent described it, the "greedy element" out of care and fostered a positive patient-provider relationship. Non-financial barriers to medical and hospital care for some immigrants and refugees included long waits for care as well as the lack of clinics and community health centers taking new patients. The challenge of finding a family doctor, experienced by many Canadians, was perceived by informants to be greater for immigrants and refugees due to the need for language and gender compatibility. Immigrants and refugees also experience financial barriers in accessing non-insured services including pharmaceuticals, counseling, physical therapy and occupational therapy. Although the Pharmacare plan exists, informants described how the deductible can be prohibitive for some immigrants and refugees, as with many persons of low-income.

> One informant stated how health care is much better here than in their home country where at one point no doctor would see them because they had been beaten up and the doctors were afraid of retaliation if they helped.

Interim Federal Health Program

The Interim Federal Health (IFH) Program covers essential health services to refugee claimants who are not covered by Manitoba Health[3] and provides limited benefits to permanent residents under the refugee class for one year after their arrival (Appendix B). According to an interviewee from a refugee serving organization, the majority of local

[3] Refugee claimants are eligible for Manitoba Health benefits if they have a valid one-year work permit.

doctors and dentists turn away clients with IFH coverage or bill them directly. Hospitals normally accept IFH coverage but certain refugee claimants have had challenges with acceptance at hospitals as well. Some community health centers will serve patients who do not have health coverage and these locations will accept refugee claimants but may not bill the IFH program. The length of time it takes to bill was stated as the main reason that IFH is not accepted by some health services. The restricted coverage of the IFH was also cited as a challenge to providing care. Alternatively, a representative from a health care organization stated that billing IFH was not a problem and an interviewed refugee said that they had no problems with receiving care covered by the IFH.

Refugee claimants require a medical exam as part of their claim process and a limited number of physicians are designated to perform this exam. According to an informant, only one of the designated physicians bills directly to IFH and does not bill the patient. As part of the claim for refugee status, persons may also require medical or psychological reports (i.e. in order to prove torture) that are time consuming and not billable to anyone, which makes it difficult to find professionals to do these assessments.

Physical Environments

Finding housing, an important component of a person's physical environment, is one of the first concerns for immigrants and refugees when they arrive in Canada. The need for safe housing was emphasized by informants as key to the health of immigrants and refugees and their housing needs were considered huge. A lack of affordable housing and long waits for subsidized housing were cited by interviewees as barriers that are faced by many with housing needs (and not only immigrants and refugees). In addition to housing, area of residence is an important aspect of a person's physical environment that affects their health. Interviewees felt that many immigrants and refugees live in housing and/or areas that are unsafe. Informants told stories of immigrants and refugees sobbing to go back to their home country because of their living conditions here in Canada. Some informants felt that safe housing and a safe area of residence were especially important for refugees who had come from traumatic situations so that they would be able to adjust and heal.

Social Support Networks

Loneliness and social isolation were viewed by interviewees as huge issues for some immigrants and refugees that impedes their health. Mentioned contributors to social isolation included cultural misunderstandings, the climate, language barriers, transportation barriers, lack of knowledge of resources, and gender inequality leading to the expectation that women will stay at home. Within some ethno-cultural communities, infection with HIV or having a disability were also cited as reasons why people would be isolated or shunned.

Immigrant and refugee serving organizations, as well as community-based cultural groups, run special events and have mentoring programs in order to increase the social support networks of immigrants and refugees. In some ethno-cultural communities,

newcomers have a social network upon arrival but informants noted that coming from the same part of world does not necessarily mean people are going to get along. It was also pointed out by interviewees that having a strong social network within an ethno-cultural community can contribute to isolation from Canadian culture and that a connection to both is ideal.

Barriers to Presentation of Need

Immigrants and refugees experience barriers that impede their presentation to the health or social system for care when they are in need. Barriers to presentation of need can result in needed care, including preventative care, not being received. This can contribute to greater health problems over time. Cultural, educational, informational, and language barriers to presentation of need were discussed by informants. Although these barriers are discussed as separate sub-sections of this section, many of them overlap and reinforce each other in the lives of immigrants and refugees.

Cultural Barriers to Presentation of Need

Many different cultural barriers were discussed by informants that they felt inhibited immigrants and refugees from seeking care when it was required. The cited cultural barriers to presentation of need were as follows:

- **Gender relations**: In some cultures, informants described how men make the decisions for women so a woman will not seek care without the permission or accompaniment of her husband. One interviewee gave the example of a woman who had gone into labour when their husband was not home and they did not seek care. Gender compatibility with a family doctor is also a requirement of some cultures that was highlighted by informants.

- **Ethnicity**: The ethnicity of the name of a health care provider that a patient is referred to can deter an immigrant or refugee from seeking care from this person due to events that occurred in their source country.

- **Understanding of Appointments**: Informants discussed how immigrant and refugee cultures can have different concepts of time leading to some immigrants and refugees not understanding the importance of timeliness in the Canadian appointment process and potentially missing appointments.

- **Fear**: Immigrants and refugees may not trust the health or social services systems, according to interviewees, and may fear being deported if they are sick. They may also be afraid of unknown symptoms and ignore them rather than seek care, an incidence where educational and cultural barriers are both active.

- **Pride**: Informants felt that many immigrants and refugees are very proud and do not want to admit that something is wrong or to accept assistance and so they will not seek care. Both Employment and Income Assistance as well as Pharmacare

were mentioned as programs that some immigrants and refugees may not want to participate in because they see them as "hand outs".

- **Stigmas:** In some cultures, certain diseases or conditions are taboo and therefore are not talked about, leading to the affected individual not seeking care. Informants described how persons with disabilities are stigmatized in some immigrant and refugee cultures so families will hide the person with disabilities and therefore they will not seek care. Some immigrant and refugee cultures also stigmatize people who have HIV or a mental health condition.

> One interviewee related how an immigrant client that they had now provided care to, had been in need of a wheelchair for 15 years and had been crawling around inside their house without leaving it for this time period.

- **Perception of Health:** Some informants believed that for a number of refugees, a state of health that they perceived as normal because of their life experiences would not be considered normal by Canadian standards. As one interviewee stated, for some refugees "when they are alive they are healthy" and it may not be part of their understanding that physical or emotional pain is not normal and can be treated.

- **Perception of Health Services:** Certain health and social services, according to informants, that are available in Canada are not available or not part of the culture in other countries so immigrants and refugees will not use them here. Other services are available in other countries but are perceived differently. The example was given of how in some of the source countries of immigrants and refugees only the dying go to the hospital, thereby discouraging the use of hospitals for other types of care. Mental health professionals were cited as another type of health service that for some cultures would only be used in extreme cases.

Educational Barriers to Presentation of Need

Educational barriers include the general lack of knowledge about personal health and symptoms of diseases of some, but definitely not all, immigrants and refugees.

> A service provider described how when educating about the symptoms of cervical cancer to a group of immigrants and refugees, one woman panicked. Upon going to the hospital the woman required emergency care.

Informants described how educational barriers can lead to immigrants and refugees not recognizing that they have a medical problem that needs care. Without an understanding of preventative health procedures common in Canada (yearly check-ups, immunizations for children, PAP smears, etc.) informants felt that this type of care would not be sought. In addition to being a barrier to immigrants and refugees presenting their health needs to the health care system, informants felt that a lack of familiarity with common injury and disease prevention practices increases immigrants and refugees health risks.

Informational Barriers to Presentation of Need

Informational barriers were cited by the majority of interviewees as limiting immigrants and refugees from presenting their needs to services. It was felt by many informants that immigrants and refugees need to have a greater understanding of what health and social services are available, what services are free and which ones have associated costs, as well as to what services they are entitled. Health Links – Info Santé[4] was cited by informants as a great service that has the potential to address informational barriers, however, interviewees felt that many immigrants and refugees are not aware of this service. Language barriers to accessing Health Links – Info Santé were also highlighted by informants and are described in the following sub-section. Active outreach to immigrants and refugees was seen as necessary by some informants in order to increase the knowledge of available services.

Language Barriers to Presentation of Need

Language barriers compound the effects of other barriers and act on their own to inhibit those immigrants and refugees who experience them from accessing services. As mentioned Health Links – Info Santé is a service that addresses informational barriers and it can provide interpretation in many languages. Informants felt, however, that people who do not speak English or French can not navigate the phone line in order to ask for these other languages. Interviewees also felt that a reduced understanding of the ambient environment due to language barriers would make navigating the system and accessing health services difficult. Language barriers also contribute to educational barriers because educational pamphlets are only useful if the immigrant or refugee is literate in the language of the pamphlet. Not all immigrants and refugees are literate in their own language even if the information has been translated.

Key Health Concerns

Interviewees often discussed what they viewed to be the key health concerns of immigrants and refugees. These concerns are reviewed in this section.

Health Issues

Immediate health issues experienced by immigrants and refugees upon arrival as well as communicable diseases, such as HIV/AIDS and parasitic infections, were highlighted by informants as relevant health issues.

Immediate Health Issues Upon Arrival

Interview respondents discussed how newcomers may arrive with urgent or emergent health needs, contributed to by potentially not having medical care for many years. Newcomers may arrive pregnant with potential complications of nutritional deficiencies or that the pregnancy is the result of rape. Emphasis was accordingly placed on the need for newcomers to receive a complete health assessment that takes into account factors not

[4] Health Links – Info Santé provides health related information and referral assistance to callers, using a phone line staffed 24 hours a day, 7 days a week by specially skilled Registered Nurses.

normally seen in Canada (i.e. torture, starvation, specific communicable diseases). Assessment of this type was not felt to be widely happening at present. A short summary for medical practitioners, which newcomers can carry with them, has been recently prepared by the WRHA to begin addressing these types of concerns (Appendix G).

Communicable Diseases

Multiple health care organizations reported seeing a recent increase in the number of immigrants and refugees seeking care for the communicable disease HIV/AIDS. Immigrants and refugees may have a high prevalence of HIV/AIDS because many of their source countries have high levels of HIV/AIDS but informants also felt that immigrants and refugees are contracting the virus in Canada. Newcomers may be at a greater risk of contracting HIV in Canada due to misconceptions of some immigrants and refugees that HIV is not present in Canada. An additional factor cited by informants is that young male immigrants and refugees are targeted by sex trade workers in some areas of the city, increasing their risk of being infected with sexually transmitted infections, including HIV.

HIV/AIDS is extremely stigmatized in most immigrant and refugee communities and can lead to social isolation for those who are infected. Accordingly, confidentiality in HIV/AIDS care for immigrants and refugees is of great importance. Informants discussed how many refugees do not want to share their HIV status with their refugee settlement councilor, creating challenges in a system where currently settlement councilors often interpret at medical appointments. Interviewees also mentioned how immigrants and refugees do not always feel comfortable at clinics that focus on HIV/AIDS care because others could surmise that they are HIV-positive. Many also feel uncomfortable around the other clients. [5]

Informants described how access to specialized HIV/AIDS care is limited. Interviewees felt that organizations currently providing HIV care lacked cross-cultural experience. In order to address these concerns and provide immigrants and refugees with various venues for HIV/AIDS care, partnerships are being developed.

Although HIV/AIDS was the communicable disease most often mentioned by informants, parasitic infections were also discussed. Certain informants questioned whether health practitioners had sufficient knowledge to address health concerns regarding parasitic diseases that are common in the source countries of some immigrants and refugees.

Mental Health and Mental Illness

Almost all informants discussed how many immigrants and refugees experience poor mental health and some mental illness, with depression highlighted as a major concern. Mental health stressors experienced by immigrants and refugees, which were mentioned by informants, included experiences in their home country (especially for refugees), the immigration experience, as well as the challenges of adapting to life in Canada. Mental illness in immigrants and refugees will, according to informants, often occur after they

[5] Clients may include GLBTTQ* (Gay, Lesbian, Bisexual, Transgender, Two-Spirited, Queer and Questioning) people, Aboriginal people, people who live on the street as well as intravenous drug users.

have settled into life in Canada and can be decades later with varied events noted as triggering mental health issues through their connection with past traumatic incidents. The mental health issues of immigrants and refugees were also perceived by informants to contribute to insomnia, somatisation, isolation, threatened and completed suicides, other physical ailments, as well as domestic violence. Domestic violence was seen by some informants as being a huge issue within immigrant and refugee families. Both a lack of available services, especially for men, and cultural factors were cited as contributing to help in addressing domestic violence often not being sought.

It was felt by most interviewees that the mental health support needs of immigrants and refugees, especially those from war-affected countries, were not being met. Financial barriers exist to accessing many mental health supports and low-cost options were cited as having long waits. Even if services could be accessed, select informants felt that many current doctors and mental health professionals are not able recognize trauma and Post Traumatic Stress Disorder or that they do not know how to address these concerns. Additionally, informants discussed how mental health and mental illness can be challenging to address in a cross-cultural context and they were disappointed by the general lack of professionals who understood the cultural background of immigrant and refugee clients.

As mentioned earlier, the stigma that many cultures place on mental illness may impede immigrants and refugees from presenting their needs to the health system or accepting help for mental health conditions. Consequently informants believed that more successful programs would facilitate healing without labeling the individuals as having mental health challenges or talking directly about mental health. Moving towards the prevention of mental health concerns was generally seen as a positive step that could be taken through helping newcomers adjust to life in Canada and deal with the stressors in their lives.

Nutrition

Nutrition was identified as being of key importance to immigrants and refugees staying healthy. Informants believed that barriers to good nutrition for immigrants and refugees included those experienced by other low-income persons. Informants discussed how these barriers include the costs of fresh fruits, vegetables and meats compared to chips and ‘junk food’. Food security issues were also raised.

Depending on their country of origin, immigrants and refugees can also face the challenge that foods in Canada are very different than those in their home country. Informants noted how it is advantageous that some ethnic foods are available in Winnipeg. Interview respondents mentioned how for some newcomers it may be appropriate for them to consult with a nutritionist to shift their diet to foods available in Canada, address malnutrition and/or shift eating habits away from only one meal a day. It was also deemed important for immigrants and refugees to understand the Canadian food system including how to grocery shop, the difference between no-names and brand name products, as well as the locations of and process of accessing food banks.

Informants were concerned that the shift in diet that immigrants and refugees make, combined with changes in activity level and increased stress, leads to an increased risk of obesity, diabetes and dental health concerns.

Oral Health

Oral health was mentioned by only a few respondents but was emphasized as being a key area of need for some immigrants and refugees and as being a recognized health concern among ethno-cultural community leaders. The main barriers to care were financial and although low-cost dental care programs in the city were praised, their long wait lists were also considered an impediment. Due to the lack of dental care in some source countries, the dental needs of many refugees were considered by a knowledgeable interviewee, to be similar to those of "remote on-reserve Aboriginal persons". Informants felt that it was important for immigrants and refugees to be knowledgeable of oral health practices, especially for children.

Sexual and Reproductive Health

Several informants discussed the lack of sexual and reproductive health knowledge of many immigrants and refugees. Both the lack of newcomers' knowledge upon arrival and the paucity of education regarding such issues were of concern to interviewees. Immigrants and refugees were thought to need more information regarding age of consent laws, what constitutes sexual harassment, pregnancy prevention, and safer sex. Specific concern was raised by informants regarding the vulnerability of immigrant and refugee youth who they felt are at greater risk of unplanned pregnancies and sexually transmitted infections due to their lack of knowledge.

Interviewees considered sexual and reproductive health to not be discussed enough during the settlement process. Barriers to discussing sexual and reproductive health experienced by persons providing settlement support included that they are often from a similar cultural background and sexuality is a very sensitive issue in many cultures and in some, discussing it is taboo. Informants felt that immigrants and refugees, as well as those who provide settlement support, would be more comfortable if health care providers educated immigrants and refugees about sexual and reproductive health issues. Some of the barriers experienced by persons providing settlement support were also considered relevant for health care providers. For example, when male family members attend appointments with females, which is often the case, discussion of sexual and reproductive health issues with the women may be impeded. Since informants stated that pregnancy prevention is often seen as "women's business", these barriers mean that it may not be discussed with immigrants and refugees.

> A refugee informant told a woman that if a condom was worn during sex that she would not get pregnant. The woman, however, wore the condom on her finger and became pregnant.

An additional complication for persons providing sexual and reproductive health education to immigrants and refugees is that newcomers may not have a basic understanding of their body or disease processes. Without explaining the basics of sexual and reproductive health, education may not be relevant.

An important preventative health practice for women are PAP tests, which are routine in Canada but may not be common to all immigrants and refugees. In order to promote PAP tests among immigrant and refugee woman, PAP day in Winnipeg has been targeted to this population and according to interviewees it was successful in reaching this group.

Female genital circumcision (FGC) was highlighted by select informants as presenting a challenging situation for health care providers. Although FGC is against the law in Canada, providers mentioned that they are seeing more clients recently who have had FGC. FGC is mentioned here because it is topic that is relevant to the sexual and reproductive health of women from some cultures. A full discussion is not feasible due to the limitations of this project.

Barriers Within Health Encounter

Interviewees discussed barriers, described in this section, that they believed immigrants and refugees experience during the health encounter. Informants highlighted how these barriers often do not act alone but complement each other within the health encounter.

Language Barriers Within the Health Encounter

As was previously discussed, language barriers impede immigrants and refugees from presenting their needs to the health system. Language barriers were also highlighted by almost every interviewee as being a barrier of great concern within the health encounter that ultimately affects the overall health of immigrants and refugees. Informants believed that language barriers within the encounter led to confidentiality being breached, informed consent not occurring and misunderstandings happening between the health practitioner and patient. Informants emphasized the importance of immigrants and refugees learning English in order to reduce language barriers but discussed how some had lived in Canada for many years and never learnt English, highlighting how language barriers do not only affect recent newcomers.

Services in the language of the immigrant or refugee were seen as ideal but not necessarily feasible. Currently services were thought to be lacking in the languages of many immigrants and refugees. Increasing the number of health care professionals who speak other languages and the number of practicing professionals from various ethno-cultural communities were mentioned by informants as steps towards providing same language services.

Interpretation was seen by interviewees as a viable option, in lieu of same language services, if the interpreters were trained, neutral and preferably staff members. Informants emphasized how currently interpreters include strangers who work in the building, settlement councilors, volunteer interpreters from different organizations, as well as family or friends of the patient. Many interview respondents were outraged by the use of clients' children, who generally learn English faster than their parents, as interpreters. Concerns regarding confidentiality and loss of privacy arose with all of the

abovementioned types of interpreters, especially because of the relatively small population of people who speak some languages in Winnipeg. Informants were also concerned that some interpreters may put their "own spin" on the situation, affecting informed consent and communication.

Overall respondents felt there was a lack of availability and use of trained interpreters in all health care settings. Informants felt that without interpretation or service provision in the language of the immigrant or refugee the client may not understand the health care provider. The potential for miscommunication was thought to remain present for people with some English proficiency and may be compounded by some immigrants and refugees not feeling comfortable asking for clarification.

> An informant related how a newcomer had received medication that the doctor said they should take three times a day for ten days but not understanding the newcomer took the medication all at once.

Length of Encounter

The short length of typical health care encounters, and the limit on the number of concerns that one can present, was cited as a barrier to effective health encounters. Although this barrier was mentioned by only a few respondents, they emphasized its importance, especially for newcomers. Interviewees felt that newcomers, who may not have received medical care in years, have too many complex health issues to be able to address them in these short visits. Additionally, language barriers and the use of interpretation necessitate longer health encounters. One interviewee cited how some refugees are seeing health care professionals more than 10 times in a month and that they felt it would be more effective to have longer visits less often.

Short health encounters that are "rushed", according to interviewees, intimidate some immigrants and refugees who may lack assertiveness. Informants expressed that these short encounters also do not allow practitioners to probe immigrant and refugee clients who may not be forthcoming with sharing information. Informants felt that in combination these factors lead to relevant health concerns not being recognized.

Practitioners' Cultural Responsiveness

In addition to language barriers almost all interviewees cited the need for practitioners to be culturally responsive in order to effectively address issues with immigrants and refugees. Cultural awareness, cultural sensitivity and cultural competency were other terms that were also used by various informants. Although interview respondents felt that some practitioners were culturally responsive they felt that systemically there was a need for more cultural responsive practitioners.

The changes informants believed were needed included but extended beyond practitioners having a knowledge of other cultures and their perceptions of health. Informants discussed the need for all practitioners to treat immigrants and refugees with respect, including not stereotyping or acting paternalistic. If practitioners increased their

cultural responsiveness, informants believed that practitioners would be able to reduce the effects of cultural, educational and language barriers.

Informants described multiple ways to increase the number of culturally responsive practitioners. Cross-cultural training for practitioners as well as increasing the number of practitioners from different cultures were discussed as promising options.

Effectiveness of Immigrant and Refugee Serving System

The immigrant and refugee serving system is made up of a variety of organizations, including health service organizations, which serve immigrants and refugees. In order to be effective, informants felt that the system needed to meet the health needs of immigrants and refugees, reduce barriers to presentation of need and those within the health encounter as well as address key health determinants. In previous sections of this report, the importance of these factors has been highlighted along with issue specific recommendations from informants. Additionally, interviewees discussed the important contribution of various characteristics of the larger immigrant and refugee serving system and its component organizations to achieving these goals.

Service Delivery and Organizational Culture

In order to effectively and appropriately address the health of immigrants and refugees, interview respondents discussed the importance of changes to service delivery and organizational culture. Active outreach and follow-up were emphasized as key to reducing barriers to presentation of need. Many representatives from organizations stated that they found the best way to access the immigrant and refugee communities was to have volunteer or paid outreach workers from communities who were able to share knowledge with their own cultural groups. Accommodating immigrants and refugees who may not be familiar with common procedures in the Canadian health and social services systems was also seen as necessary. The potential of addressing health concerns, where possible, in an informal setting was also mentioned. Informants furthermore discussed how systemically there was a need for organizational culture to facilitate effective interactions between practitioners and immigrants and refugees.

Partnerships

Different types of organizations need to work together towards immigrant and refugee health. Interview respondents mentioned exciting partnerships that currently exist but also expressed that greater partnering is needed. Informants discussed specifically the need for more partnerships between health services organizations and immigrant and refugee serving organizations as well as with immigration departments. Through such partnerships, it was believed that health services organizations would be better prepared for newcomers and would learn how to better serve immigrants and refugees in general. Another anticipated benefit of greater partnering was that immigrants and refugees would get referred earlier to needed health care. Some informants expanded on their vision of partnerships and stated that an integrated plan was needed between all players in the

immigrant and refugee serving system so that newcomers would have access to all the services they required and avoid duplication.

Community-Based Cultural Groups

The key role that community-based cultural groups, also referred to as ethno-cultural organizations, play in ensuring the health of immigrants and refugees was emphasized by informants. Community-based cultural groups help newcomers adapt to life in Canada and provide a social support network, addressing two earlier reported key health determinants. The potential of community-based cultural groups to transfer knowledge to immigrants and refugees and to champion certain ideas or practices was also discussed by interview respondents. Specifically, the capacity of group leaders to pull a community together and catalyze change was cited. For these reasons, interviewees stressed the importance of partnerships between community-based cultural groups and the organizations that serve immigrants and refugees. Partnerships were considered especially important for the success of primary prevention programs.

System Navigation

Informants described how many immigrants and refugees have challenges navigating the health and social services systems due to cultural, educational, informational and language barriers that were previously discussed. Due to these barriers, interviewees felt that many immigrants and refugees are "falling through the cracks" and not getting the care and/or support that they require. For those immigrants and refugees who could not navigate the system on their own it was recommended that a facilitator be available to help with system navigation. This person was described by various informants as a buddy, a peer facilitator, a point person as well as a system navigator, indicating the variety of conceptualizations of this key role. Although some refugees have settlement councilors that aid in system navigation, it was discussed by select informants how refugees may not be comfortable with their settlement councilor knowing their health situation, therefore limiting the role of the settlement councilor in health system navigation. For those interviewees who advocated for an integrated immigrant and refugee serving system, the role of a system navigator was central.

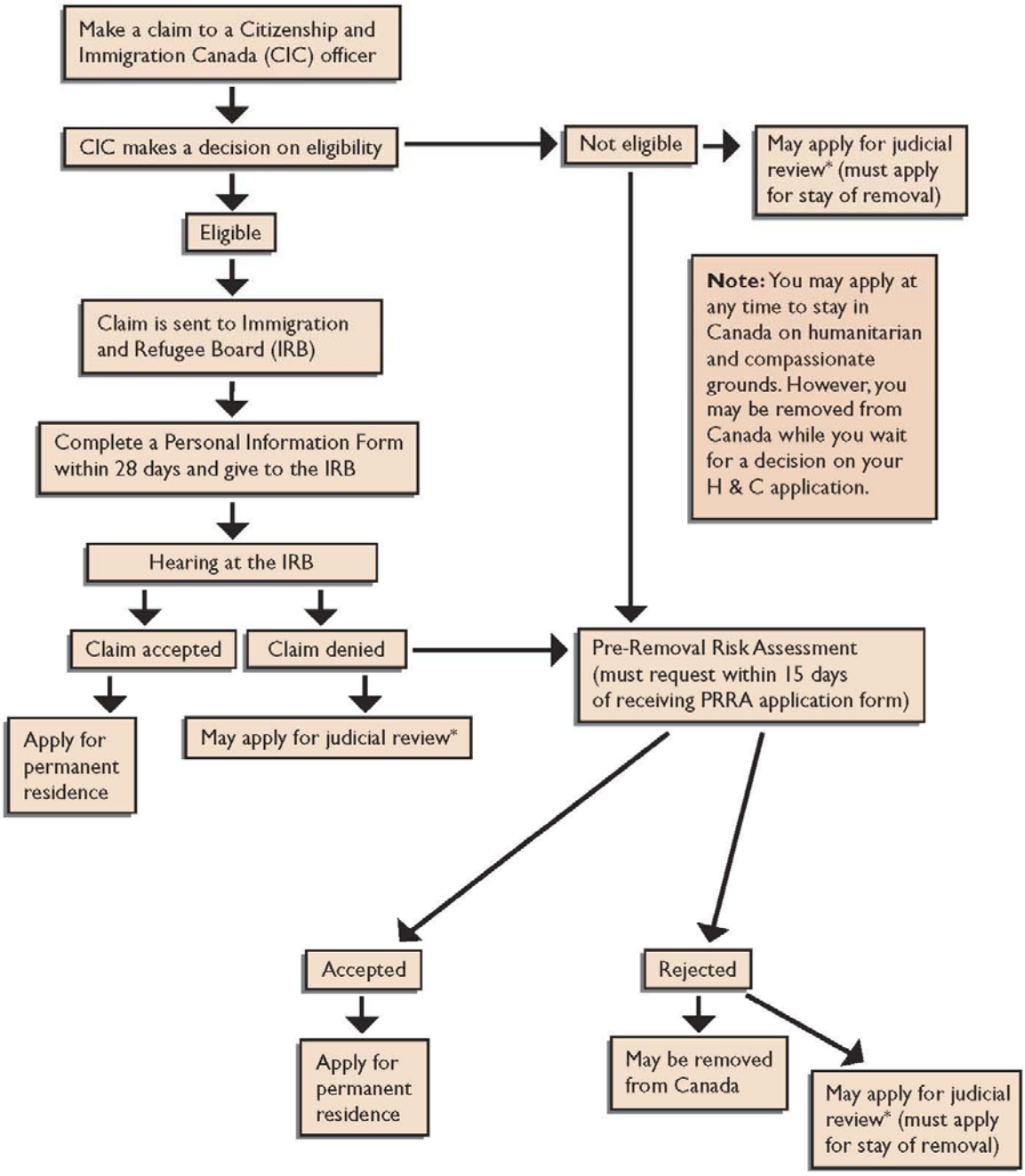
Capacity

Many representatives from various organizations mentioned how they feel their capacity is being stretched by the increasing immigration to Winnipeg. Some informants stated that their organizations are no longer able to accommodate the flow of newcomers. As noted in the discussion regarding immigration levels, the number of immigrants to Manitoba is set to rise above current levels (approximately 6,500 per year) to 10,000 a year. A number of informants lamented the lack of capacity to provide services to immigrants and refugees but stated that rising immigration has not been accompanied by increased resources. Informants discussed how experienced, smaller organizations that have focused specifically on immigrants and refugees can not meet the growing demands and other organizations that have not usually worked with this population are now seeing more immigrant and refugee clients. A positive impact of this stretch in capacity appears to be that organizations are having an increased interest in the needs of immigrants and

refugees, are forming new partnerships and are learning more about how to provide appropriate and effective service to immigrants and refugees.

Appendices

Appendix A: Overview Of The Refugee Claim Process



*Must apply to Federal Court of Canada within 15 days of receiving written decision.

This flow chart was taken from the fact sheet Starting a Refugee Claim, published by the Legal Services Society in British Columbia in May 2004.

Appendix B: Interim Federal Health Program

The Interim Federal Health (IFH) Program is a federal program that provides temporary medical coverage for certain newcomers to Canada. Citizenship and Immigration Canada gives a photograph-bearing document to eligible persons.

Refugee Claimants (persons who arrive in Canada and claim refugee status) are eligible for the IFH Program. This program covers essential services only, for the treatment and prevention of serious medical and dental conditions; contraception, prenatal and obstetrical care; as well as essential medications only that are CPS prescription drugs. Other forms of care are covered with prior approval.

Persons who immigrate to Canada under the refugee class are eligible for the dental, visual, pharmaceutical, and like care of the IFH in addition to the provincial health insurance coverage they receive. The IFH limited benefits coverage for immigrants under the refugee class lasts for one year after arrival.

An outline of those services covered by the IFH follows. For further information and forms please consult their website at http://www.fasadmin.com/ and find the IFH program under the Client Info heading. The "Information Handbook for Health Care Providers" can be found on this site under the "IFH English Manual" link. This handbook, a key resource for utilizing the IFH, provides details on eligibility documents as well as the billing form that must be submitted. It can be accessed directly at http://www.fasadmin.com/images/pdf/{0E492845-ABE1-4CA9-9019-98808A15FB7E}_IFH%20Manual.pdf.

Information from Citizenship and Immigration Canada Regarding:
Interim Federal Health Program (IFH) Information for Health Professionals

Services covered without Citizenship and Immigration Canada (CIC) approval

- Essential health services only for the treatment and prevention of serious medical conditions.
- Essential health services only for the treatment and prevention of serious dental conditions (see dental regulations).
- Contraception, prenatal and obstetrical care.
- Essential CPS prescription medications (or life supporting over-the-counter drugs such as insulin or nitro). Must be lowest cost alternatives. Only drugs featured on the IFH medication list found at "www.fasadmin.com" are covered without prior approval.
- Professional fees as per applicable provincial health care plan. Fee codes (where applicable) must be supplied. Invoices must be submitted within six months of service.
- The Immigration Medical Examination is performed by an authorized Designated Medical Practitioner – reimbursed only for IFH eligible individuals who cannot afford the costs.

Services covered with CIC approval only

- Complete physical examination/ counselling services by a general practitioner.
- Ambulance/medical transport (unless emergency).
- Diagnostic services (surgical, laboratory, or x-ray) when no significant medical short-term complications are foreseen.
- Certain high cost medications (e.g. Imitrex, Accutane, Interferon and Lamisil).
- Allergy testing/desensitization.
- Plastic surgery for esthetic purposes.
- Elective surgery (e.g. hernia repair, joint replacements).
- High cost procedures (e.g. organ transplantations).
- Office-based psychotherapy by a psychiatrist after the initial consultation.
- Psychotherapy by psychologists/general practitioners.
- Physiotherapy.
- Prosthetic or mechanical devices including hearing devices.
- Eyewear. Visual acuity tests needed for all patients.

Last Updated: 2004-12-13
Source: Citizenship and Immigration Canada website at
http://www.cic.gc.ca/english/applications/guides/5568EA.html#wp200756

Requests for prior approval must be submitted by mail or fax to:

Medical Director, IFH/CIC

219 Laurier Ave. West, 3rd Floor FAX: 1-800-362-7456
Ottawa, Ontario K1A 1L1

Services not covered under the IFH Program

- Routine medical/eye exams.
- Infertility investigations and treatment.
- Routine circumcision of the newborn.
- Chiropractic care.
- Alternative/complementary medicine.
- Most over-the-counter medications even when written on a doctor's prescription.

Invoices to be sent by the health care providers only to:

FAS Benefit Administrators Ltd

9707- 110 Street, 9th floor
Edmonton, Alberta T5K 3T4

Fax: 780 452 5388

Email : info@fasadmin.com

FAS Customer Service: 1-800-770-2998 between 7:00 a.m. and 5:00 p.m. MST

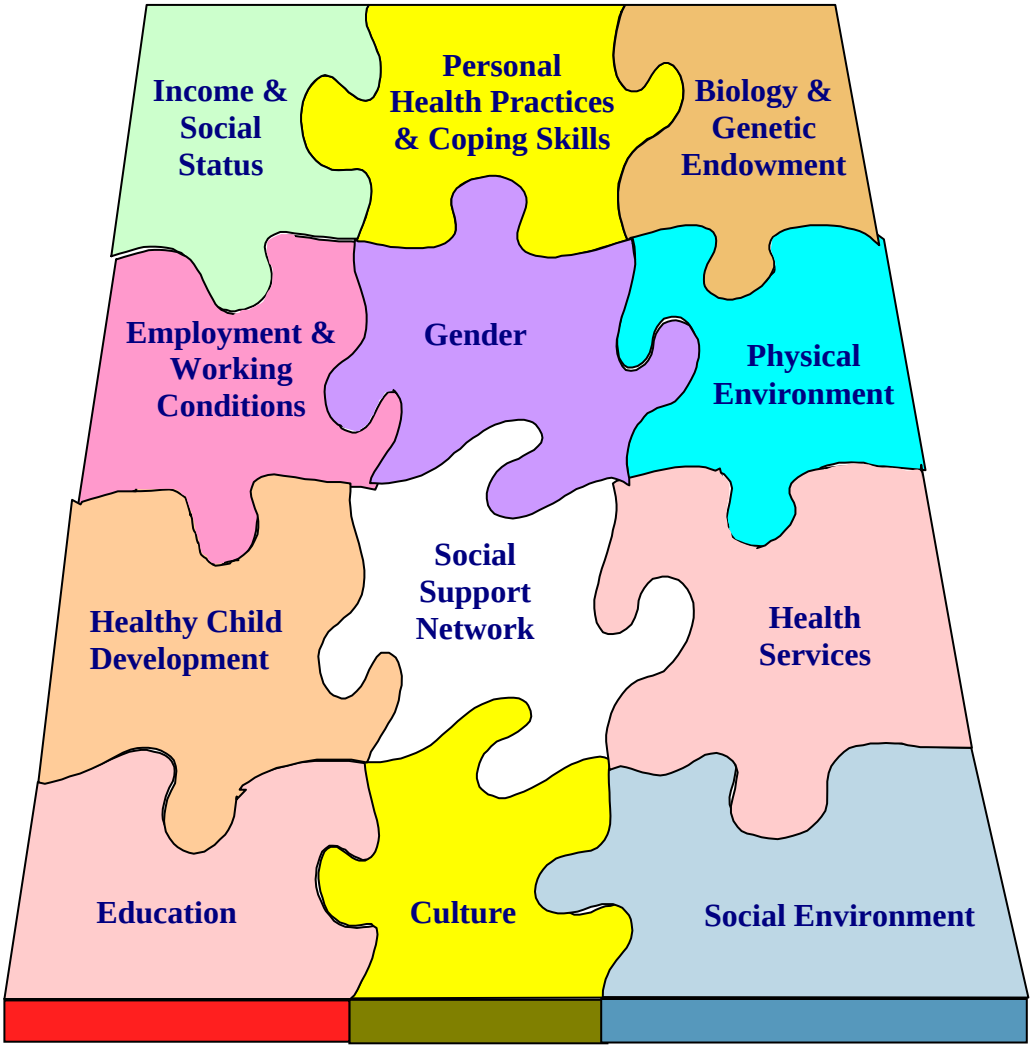
Note: If FAS does not already possess patient's eligibility, you must send a copy of the eligibility document. The health provider can check this by telephone at 1-800-770-2998.

Last Updated: 2004-12-13
Source: Citizenship and Immigration Canada website at
http://www.cic.gc.ca/english/applications/guides/5568EA.html#wp200756

Appendix C: Social Services Program Websites

Program	Website
55 PLUS	http://www.gov.mb.ca/fs/assistance/55plus.html
Canada Child Tax Benefit (CCTB)	http://www.cra-arc.gc.ca/E/pub/tg/t4114/t4114-e.html#P57_1861
Child Related Income Support Program (CRISP)	http://www.gov.mb.ca/fs/assistance/crisp.html
Children's Special Services	http://www.gov.mb.ca/fs/pwd/css.html
Complementary Assistance Program (CAP)	http://www.gov.mb.ca/fs/housing/cap.html
Employment and Income Assistance Program	http://www.gov.mb.ca/fs/assistance/eia.html
Healthy Baby Prenatal Benefit	http://www.gov.mb.ca/healthychild/programs/healthybaby/index.html
Manitoba Child Care Subsidies	https://direct.gov.mb.ca/cdchtml/html/internet/en/about.html#subsidies
Manitoba Housing Authority - Public Housing	http://www.gov.mb.ca/fs/housing/mha.html#eligibility
Old Age Security	http://www.sdc.gc.ca/en/isp/oas/oastoc.shtml
Rent Supplement Program	http://www.gov.mb.ca/fs/housing/rentsuppl.html
Shelter Allowance For Elderly Renters (SAFER)	http://www.gov.mb.ca/fs/housing/safer.html
Shelter Allowance For Family Renters (SAFFR)	http://www.gov.mb.ca/fs/housing/saffr.html
Social Insurance Number (SIN)	http://www.sdc.gc.ca/asp/gateway.asp?hr=en/cs/sin/100.shtml&hs=sxn AND http://www.sdc.gc.ca/asp/gateway.asp?hr=/en/cs/sin/print_03_06_30.shtml&hs=sxn
Supported Living	http://www.gov.mb.ca/fs/pwd/supported_living.html
Vocational Rehabilitation Program	http://www.gov.mb.ca/fs/pwd/voc_rehab.html

Appendix D: Determinants Of Health Model



Source: Strategies for Population Health Investing in the Health of Canadians, 1994.

Appendix E: Interview Guides

Interview Guide for Representatives from Health Service Provider and/or Refugee Serving Organizations

Date: *[DD/MM/YYYY]* __ __/__ __/ __ __ __ __

Informant Information: *[if applicable, ask for card]*

NO.	NAME	TITLE	PHONE NUMBER
1	_____	_____	(____)_____
2	_____	_____	(____)_____
3	_____	_____	(____)_____
4	_____	_____	(____)_____

Address of informant(s): *[If multiple addresses document all with corresponding informant number]* _____

_____

Organizational Characteristics:

Name of organization: *[may have legal and common, record both]*

_____

_____

Scope of interviewee(s) role:

Provincial_____ Regional (city) _____ CA _____ Site _____

Program within area checked above: _____

Name of program *[if applicable]*: _____

If not provincial or regional in scope then what Community Area located in:

_____

Where do people have to be geographically located to be eligible for your services?

_____

What are the characteristics of people eligible for your services?

_____

_____

Site Characteristics: *[Only for site specific representative(s)]*

Name of site: _____

Address: _____

_____

Hours of service: hours _____ to _____ on day(s) _____
hours _____ to _____ on day(s) _____
hours _____ to _____ on day(s) _____

What bus routes are you on? _____ Don't know _____

Can people with mobility challenges (cannot use stairs) fully access your services?
Y N

Service Information:

What services do you *[the organization, site, or program they are representing]* provide? [If not evident] How are you *[the organization, site, or program they are representing*] involved in the process of refugees receiving health care?

_____

_____

_____

_____

_____

_____

_____

_____

In general what are the waiting times for these services? _____

_____

How many people provide these services *[in your organization, site, or program]*?

_____

How do people access your services?

_____

_____

Language Information:

What languages are your services directly provided in? [persons providing service speaking in language]

_____

_____

If a client cannot communicate in these languages, how do you handle this?

_____

_____

_____

If use interpretation services:

Who provides these services?

[In-house *Y* *N]*
[Language bank *Y* *N]*

Others not mentioned above: _____

_____

What training do these interpreters have? _____

_____

Can you provide interpretation for the languages of all your clients? Y N

What languages can you get interpretation for? _____

_____

Referral Information:

What organizations **do you refer clients to** the most often?

_____

_____

_____

_____

_____

_____

_____

What organizations **refer clients to you** most often?

_____

_____

_____

_____

_____

_____

_____

Refugee Health and Health Care:

[This section should act as an interview guide with exact question wording varying based on informant.]

In your opinion what helps/contributes to /supports refugees living healthy lives in Winnipeg?

You may feel that you have already answered this partly but what makes it difficult for refugees to live healthy lives in Winnipeg (other than these things that have been mentioned not happening)?

In addition to what has already been mentioned what aspects of the response of the Winnipeg health care system to the needs of refugees is working well or not working well?

If factors are mentioned that are generally considered issues for all Canadians (ex. Not being able to find a doctor) then ask “Is this more of a concern for refugees than it would be for other Manitobans?”

Of these issues/factors are some only important for more recent newcomers to Canada or are they also an issue for persons who came to Canada as refugees 20 years ago?

Contacts:

Who else should I be talking to about this project to help me understand how the health care system in Winnipeg currently responds to the health needs of refugees? Why would they be useful to talk to? *[if an organization is mentioned ask "Who do you normally deal with there? What is there role in the organization?"]*

Would you like an opportunity to verify my notes from our discussion?

Notes/Comments:

Interview Guide for Representatives from Groups that Sponsor Refugees

Date: *[DD/MM/YYYY]* __ __/__ __/ __ __ __ __

Informant Information: *[if applicable, ask for card]*

No. Name Title Phone number

1 _____ _____ (____)_____

2 _____ _____ (____)_____

Address of informant(s): *[If multiple addresses document all with corresponding informant number]* _____

_____

Organizational Characteristics:

Name of organization: *[may have legal and common, record both]*

_____

_____

Are you religiously affiliated: Y N

Name of site: *[if applicable]* _____

_____

Address of site: *[if applicable]* _____

_____

How many persons from your organization are involved in the sponsorship of refugees? How many persons are involved in your organization in total? *[try and get idea of proportion]*

_____

_____

Sponsorship Information:

How often do you sponsor refugees?_____

How do you arrange for sponsorship? What other organizations are involved in the process of your group sponsoring refugees?

How is it decided where the refugees you sponsor are coming from?

Where have the refugees you have sponsored come from?

How many refugees do you sponsor in a year?

Settlement Information:

How does your group help refugees settle into life in Winnipeg?

How is your group involved in the process of refugees receiving health care?

What proportion of the help you provide to refugees would be related to health care?

Language Information:

What languages can persons in your group who sponsor refugees speak?

_____

_____

If a refugee cannot communicate in these languages, how do you handle this?

_____

_____

_____

If use interpretation services:

Who provides these services?

[In-house *Y* *N]*
[Language bank *Y* *N]*

Others not mentioned above: _____

_____

What training do these interpreters have? _____

_____

Can you provide interpretation for the languages of all your clients? Y N

What languages can you get interpretation for? _____

_____

Referral Information:

What organizations **do you refer refugees to** the most often?

What organizations **refer refugees to you** most often?

Refugee Health and Health Care:

[This section should act as an interview guide with exact question wording varying based on informant.]

In your opinion what helps/contributes to /supports refugees living healthy lives in Winnipeg?

You may feel that you have already answered this partly but what makes it difficult for refugees to live healthy lives in Winnipeg (other than these things that have been mentioned not happening)?

In addition to what has already been mentioned what aspects of the response of the Winnipeg health care system to the needs of refugees is working well or not working well?

If factors are mentioned that are generally considered issues for all Canadians (ex. Not being able to find a doctor) then ask "Is this more of a concern for refugees than it would be for other Manitobans?"

Of these issues/factors are some only important for more recent newcomers to Canada or are they also an issue for persons who came to Canada as refugees 20 years ago?

Contacts:

Who else should I be talking to about this project to help me understand how the health care system in Winnipeg currently responds to the health needs of refugees? Why would they be useful to talk to? *[if an organization is mentioned ask "Who do you normally deal with there? What is there role in the organization?"]*

Would you like an opportunity to verify my notes from our discussion?

Notes/Comments:

Interview Guide for Refugees

Date: *[DD/MM/YYYY]* __ __/__ __/ __ __ __ __

Informant Information:

No. Name Phone number *[do not have to give]*

1 _____ (____)_____

2 _____ (____)_____

Address of informant(s): *[do not have to give] [If multiple addresses document all with corresponding informant number]*

_____

_____

Home Country:

Where did you live before Canada? *[confirm, should know based on selection process] [use this answer throughout interview where asks for country of origin]*

_____

_____

When did you move to Canada? *[MM/YYYY]* __ __/ __ __ __ __

Do you know a group of people who are also from *[country of origin]*?

_____

_____

Did you all move to Canada around the same time? Y N

Comment:_____

_____

_____

Languages

What languages were spoken in *[country of origin]*? Which ones do you speak?

_____

_____

When people from your country first arrived in Canada, could they speak English or French well enough to communicate with a doctor or nurse?

_____

_____

What about now? _____

_____

Here in Winnipeg can people from *[country of origin]* go to a doctor that speaks [language]? *{Could ask about other languages mentioned}*

_____

_____

What kinds of services can you get in [language]? *{probe: are there corner stores where people speak [language]}*

_____

_____

Health and Health Care

Have you helped people from your country get health care in Winnipeg? Y N

How have you helped them?

_____

_____

_____

_____

What types of health services have you or people you know from *[country of origin]* had contact with?

_____

_____

_____

_____

_____

_____

[The following should act as an interview guide with exact question wording varying based on informant.]

In your opinion what was good about these contacts with [services mentioned above]?

In your opinion what was bad about these contacts with [services mentioned above]?

In your opinion what helps/contributes to /supports persons who come to Canada as refugees living healthy lives in Winnipeg?

You may feel that you have already answered this partly but what makes it difficult for refugees to live healthy lives in Winnipeg (other than these things that have been mentioned not happening)?

If factors are mentioned that are generally considered issues for all Canadians (ex. Not being able to find a doctor) then ask “Is this more of a concern for refugees than it would be for other Manitobans?”

Of these issues/factors are some only important for more recent newcomers to Canada or are they also an issue for persons who came to Canada as refugees 20 years ago?

Personal Characteristics:

Gender F M

Would you like an opportunity to look at my notes from our discussion when they are in an excel file?

_____

_____

Notes/Comments:

_____

_____

_____

Appendix F: Interviewed Key Informants

Note: Where informants names are shared, permission has been given.

Interviewed Service Provider Informants

Organization	Program (if applicable)	Interviewee	Interviewee Title	Major Focus of Organization/Program
Centre Youville Centre (St. Vital Site)		Sophia Ali	Community Development Officer	Health Services - Primary Health
Employment Solutions for Immigrant Youth		Fatima Soares	Coordinator	Employment & Working Conditions
Health Links - Info Sante		Barbara Featherstone	Professional Advisor	Health Services
Health Service Provider		Anonymous		Health Services - Primary Health
Immigrant Women's Association of Manitoba		Monica Singh	Board President	Social Support Network - Services
Jewish Child and Family Service		Emily Shane	Executive Director	Social Support Network - Services
Klinic Community Health Centre		Lori Johnson	Executive Director	Health Services - Primary Health
MATC Mental Health Services for Children, Youth, & Families		Petra Roberts	Mental Health Clinician	Health Services - Mental Health
MFL Occupational Health Centre		Carol Loveridge Neri Dimacali	Executive Director Health Educator	Health Services

Multicultural Family Centre A Unit of The Salvation Army, Manitoba& Northwest Ontario Division		Glen Norton	Director	Social Support Network - Services
		Ivan Seunarine	Manager of New Canadian Programs	
Mount Carmel Clinic	Cross Cultural Counselling Program (CCCP)	Jaime Carrasco	Social Worker, Team Leader of Cross Cultural Counselling Program	Health Services - Mental Health
Mount Carmel Clinic	Dental Department	Ronda Pfeiffer	Dental therapist	Health Services - Dental
		Maria Cabral	Dental receptionist	
Mount Carmel Clinic	Primary Health	Linda Abraham	Director of Primary Health	Health Services - Primary Health
		Paul Sawchuk	Medical Director	
Newcomers Employment and Education Development Services (NEEDS) Inc.		Margaret von Lau	Executive Director	Health Services - Mental Health
Nine Circles Community Health Centre		Liz Lagartera-Manning	Advocate	Health Services - Sexual and Reproductive Health
Nor'West Co-op Community Health Centre	Immigrant Women's Counselling Services	Kim Storeshaw	Director of Family Violence Services	Health Services - Mental Health
Peace Village Medical Clinic		Aziz Sibaii	Clinic Manager	Health Services - Primary Health
Refugee Serving Organization		Anonymous		Settlement

Sexuality Education Resource Centre (Winnipeg Site)		Linda Plenart	Sexuality & Reproductive Health Facilitator	Health Services - Sexual and Reproductive Health
		Anna Ling	Multicultural Health Resource Coordinator	
		Martha Chicas	Multicultural Sexuality & Reproductive Health Facilitator	
		Paula Migliardi	Research and Program Evaluation	
Society for Manitobans with Disabilities Services	Ethno-Cultural Program	Jennifer Perron	Director Community Education & Training Services	Health Services - Disability
Success Skills Centre		Monika Feist	Director	Employment & Working Conditions
		Rany Jeyaratnam	Labour Market Specialist	
Welcome Place (Manitoba Interfaith Immigration Council Inc.)	In-Canada Protection Department	Janis Nickel	Refugee Claimant Advocate	Settlement
Welcome Place (Manitoba Interfaith Immigration Council Inc.)	Settlement Department	20 people		Settlement
Winnipeg Regional Health Authority	Cross-Cultural Mental Health Program within Community Mental Health Program	Laura Coogan	Cross-Cultural Mental Health Specialist	Health Services - Mental Health

Winnipeg Regional Health Authority	Vince Sansregret	Community Facilitator River East	Health Services - Community Development
Winnipeg Regional Health Authority (Health Action Centre)	Ray Pichora		Health Services - Primary Health
Women's Health Clinic	11 people		Health Services - Women's Health

Interviewed Refugee Sponsor Informants

Organization	**Program (if applicable)**	**Interviewee**	**Interviewee Title**
United Church of Canada		Heather Bird	Sponsorship Agreement Holder Representative for Manitoba
Calvary Temple		Pastor James Okot	Pastor of African Congregation

Appendix G: Health Concerns For Newcomers To Canada

Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg

Please bring this letter with you and share it with your doctor

Dear Physician:

HEALTH CONCERNS FOR NEWCOMERS TO CANADA

Certain health concerns are more common in new immigrants to Canada arriving from developing countries, especially refugees. Although immigrants have been "screened" by Canadian immigration medical authorities, and considering the many cultural/language barriers that may exist adding to the challenge of obtaining informed consent, there are certain health issues and screening investigations that should be considered after arrival in Canada including:

1) Complete Blood Count and Differential (including eosinophil count)
   - Useful for detecting nutritional problems such as iron, folate, and vitamin B12 deficiencies.
   - Also useful for detecting eosinophilia suggesting the presence of asymptomatic tissue helminthic (worm) infections (such as schistosomiasis, strongyloidiasis, leishmaniasis, and others).

2) Hepatitis A (antibody), hepatitis B (surface antigen and antibody) and hepatitis C (antibody) serology
   - The prevalence of HBV and HCV is very high in many developing countries.
   - Detection of HBV or HCV in any immigrant warrants timely investigation of close contacts, free HBV immunization of any susceptible close contacts, and free hepatitis A (HAV) immunization of HAV susceptible individuals with evidence of chronic liver disease.

3) Stool for ova and parasites
   - Over 50% of refugees from subSaharan Africa have asymptomatic carriage of intestinal parasites, some of which require prompt treatment.
   - Any immigrant with eosinophilia should have three stool examinations for ova and parasites (using stool containers with preservative). Some authorities recommend performing "routine" stool examinations for ova and parasites in all refugees.

4) Pap smear
   - Cervical cancer risk is very high in women who have immigrated to Canada.
   - All women immigrants to Canada should be offered a Pap smear (informed consent may be difficult to obtain in some cultural groups).

5) Routine immunization status
   - All immigrants (especially refugees) should be considered under-immunized requiring primary immunization series as per the Canadian Immunization Guide (http://www.phac-aspc.gc.ca/publicat/cig-gci/index.html) and Manitoba Health immunization schedules (http://www.gov.mb.ca/health/publichealth/cdc/schedule.html).

6) Sexually Transmitted Infections (STI) work-up
   - Immigrants who are at risk for STIs, or whose partners are at risk, require a full STI work-up including genital swabs (or urine in males) for chlamydia and gonorrhea, Pap smear (as mentioned above), syphilis serology, and HIV serology.
   - Chronic low abdomino-pelvic pain in women must be considered pelvic inflammatory disease until proven otherwise.

In addition, clinicians should be aware of particular clinical presentations in recent immigrants:

1) Febrile illness with chills within the first 6-12 months of arrival in Canada
   - Must be considered malaria until proven otherwise.
   - Is a potential medical emergency requiring STAT malaria blood smears.

2) Cough lasting more than 3 weeks with or without weight loss or night sweats, within the first 5 years of arrival in Canada
   - Must be considered tuberculosis until proven otherwise.
   - Requires chest radiography and sputum or gastric aspirate examination for acid-fast bacilli.

3) Mental health issues
   - Post-traumatic stress disorder must be considered (but not over-diagnosed) in all refugees who are unable to make cross-cultural adjustments beyond 9 to 12 months after arrival in Canada.

Resources for more information or consultation:

- Infectious Diseases (HSC 787-2071; SBGH 237-2053)
- Tropical Medicine (WRHA Travel Health and Tropical Medicine Clinic 940-8747)
- Tuberculosis Clinic (HSC 787-2384)
- Viral Hepatitis Investigative Unit (HSC 787-3630)
- Community Support Services for refugees (Welcome Place 977-1000)
- Public Health/Mental Health/Family Services (see table below):

Community Area	Address	Phone number
St. James-Assiniboia	2015 Portage Ave	940-2040
Assiniboine South	3401 Roblin Blvd	940-1950
Fort Garry	3-139 Tuxedo Blvd	940-2015
St. Vital	6-845 Dakota St.	940-2045
St. Boniface	240-614 Des Meurons	940-2035
Transcona	1615 Regent Ave	940-2055
River East	975 Henderson Hwy	938-5000
Seven Oaks	1021 Court Ave	940-5050
Inkster	61 Tyndall Ave	940-2020
Point Douglas	601 Aikins St	940-2025
Downtown	490 Hargrave St	940-2274
	425 Elgin Ave	940-3160
River Heights	385 River Ave	940-2000

Pierre Plourde, WRHA Medical Officer of Health, February 2005

Également offert en français

Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg

Veuillez apporter cette lettre avec vous et la faire voir à votre médecin.

Docteur,

PROBLÈMES DE SANTÉ CONCERNANT LES NOUVEAUX ARRIVANTS AU CANADA

Les nouveaux immigrants au Canada qui arrivent de pays en voie de développement, surtout s'il s'agit de réfugiés, sont plus fréquemment confrontés à certains problèmes de santé. Bien que les autorités médicales d'Immigration Canada aient procédé à un certain dépistage, et compte tenu qu'un nombre d'obstacles possibles sur les plans de la culture et de la langue augmentent la difficulté d'obtenir un consentement éclairé, d'autres problèmes de santé et analyses de dépistage devraient retenir votre attention après leur arrivée au Canada :

1) Formule sanguine et formule leucocytaire du sang (y compris taux des polynucléaires éosinophiles) :
   - Permettent de détecter les déficiences nutritionnelles telles que les déficiences en fer, acide folique et vitamine B12.
   - Permettent également de détecter les polynucléaires éosinophiles suggérant la présence d'une infection helminthique (ver) asymptomatique (comme la schistosomiase, la strongyloidose, la leishmaniase, et d'autres du même genre).

2) Sérologie de l'hépatite A (anticorps), l'hépatite B (antigène de surface et anticorps) et l'hépatite C (anticorps) :
   - L'hépatite B et l'hépatite C sont très fréquents dans les pays en voie de développement.
   - Des analyses de détection de l'hépatite B et de l'hépatite C chez les immigrants nous permettent de réagir rapidement pour ce qui est de la recherche des contacts intimes, de la vaccination gratuite contre l'hépatite B de tous les contacts intimes, et de la vaccination gratuite contre l'hépatite A des personnes susceptibles d'être infectées, avec signes évidents de maladie chronique du foie.

3) Analyse des selles en vue de détecter les parasites et les œufs :
   - Plus de 50 % des réfugiés de l'Afrique sub-saharienne sont des porteurs asymptomatiques de parasites intestinaux, dont certains doivent être traités sans délais.
   - Tout immigrant qui présente une éosinophilie doit subir trois analyses des selles en vue de détecter la présence de parasites et d'oeufs (en déposant les prélèvements dans un contenant avec agent de conservation). Certains spécialistes recommandent de procéder à cet examen de façon systématique chez tous les réfugiés.

4) Test de Pap
   - Le risque du cancer du col est très élevé chez les femmes qui ont immigré au Canada.
   - Toutes les femmes ayant immigré au Canada doivent subir un test de Pap. (Il peut être difficile d'obtenir un consentement éclairé chez certains groupes culturels.)

5) Vaccination systématique
   - Tous les immigrants (en particulier les réfugiés) doivent être considérés comme insuffisamment vaccinés et doivent recevoir les séries de vaccins jugés essentiels selon le Guide canadien d'immunisation (http://www.phac-aspc.gc.ca/publicat/cig-gci/index.html) et les calendriers de vaccination de Santé Manitoba (http://www.gov.mb.ca/health/publichealth/cdc/schedule.html).

6) Investigation des infections sexuellement transmises (IST)

- Les immigrants qui sont soumis à un risque élevé d'IST, ou dont le partenaire est soumis à un risque élevé, doivent subir une investigation complète des IST, y compris un frottis des organes génitaux (ou un échantillon d'urine chez l'homme), en vue du dépistage de la chlamydia et de la gonorrhée; un test de Pap (tel que mentionné ci-dessus), et une sérologie pour la détection de la syphilis et du VIH.
- Une douleur abdominale basse ou pelvienne chez la femme doit être considérée comme une infection pelvienne jusqu'à preuve du contraire.

En outre, les médecins doivent savoir que les nouveaux immigrants peuvent présenter des tableaux cliniques particuliers :

1) Accès de fièvre et frissons durant les 6 à 12 premiers mois de leur arrivée au Canada

- Doit être considéré comme la malaria jusqu'à preuve du contraire.
- Est une urgence médicale potentielle nécessitant un frottis sanguin immédiat (STAT) pour le dépistage de la malaria.

2) Toux pendant plus de 3 semaines avec ou sans perte de poids ou sueurs nocturnes durant les 5 premières années de leur arrivée au Canada

- Doit être considérée comme de la tuberculose jusqu'à preuve du contraire.
- On doit procéder à une radiographie thoracique, une analyse des expectorations et du liquide d'aspiration gastrique pour le dépistage du bacille acidorésistant.

3) Problèmes de santé mentale

- Il faut songer au syndrome de stress post-traumatique (mais sans sauter trop vite aux conclusions) chez tous les réfugiés incapables de s'adapter à une nouvelle culture après 9 à 12 mois de leur arrivée au Canada.

Ressources pour de plus amples renseignements ou pour consultation :

- Maladies infectieuses (Centre des sciences de la santé, 787-2071; HGSB, 237-2053)
- Médecine tropicale (ORSW, Clinique santé-voyage et services de médecine tropicale, 940-8747)
- Clinique de lutte contre la tuberculose (Centre des sciences de la santé, 787-2384)
- Service de dépistage de l'hépatite virale (Centre des sciences de la santé, 787-3630)
- Services de soutien communautaire pour les réfugiés (Welcome Place, 977-1000)
- Santé publique/santé mentale/services à la famille (voir tableau ci-dessous) :

Zone communautaire	Adresse	Numéro de téléphone
St. James-Assiniboia	2015, avenue Portage	940-2040
Assiniboine Sud	3401, boulevard Roblin	940-1950
Fort Garry	139, boulevard Tuxedo, pièce 3	940-2015
Saint-Vital	845, rue Dakota, pièce 6	940-2045
Saint-Boniface	614, rue Des Meurons, pièce 240	940-2035
Transcona	1615, avenue Regent	940-2055
River East	975, chemin Henderson	938-5000
Seven Oaks	1021, avenue Court	940-5050
Inkster	61, avenue Tyndall	940-2020
Point Douglas	601, rue Aikins	940-2025
Centre-ville	490, rue Hargrave	940-2274
	425, avenue Elgin	940-3160
River Heights	385 avenue River	940-2000

Pierre Plourde, médecin hygiéniste de l'ORSW, février 2005

Also available in English

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