

**EXPLORING BARRIERS
REFUGEES AND REFUGEE CLAIMANTS
EXPERIENCED ACCESSING REPRODUCTIVE
HEALTH CARE SERVICES IN TORONTO**

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Abstract

A qualitative feminist study was conducted to explore the access barriers to three reproductive health care services: prenatal care, postnatal care, and screening for cervical cancer, experienced by women refugee claimants in Toronto, Ontario, Canada. The study was informed by social constructionist epistemology and antiracist and intersectional perspectives, and focused on the social, political, economic, and historical contexts of the participants' lives and their experiences with migration and the Canadian health care system. Sixteen women refugee claimants and 6 service providers were interviewed individually. The study explored how the systems, structures, and policies of Canadian society shaped refugee claimants' women's use of these services, or lack thereof, and shaped their everyday life experiences. The research findings indicated that the study participants' immigration status, lack of health coverage, living arrangements, absence of service provider support, degree of health care knowledge, discrimination, and having suffered pain, discomfort, or trauma in the past impacted their use or lack of use of prenatal care, postnatal care, and cancer screening services. An intersectional analysis revealed that the gendered and racialized immigration and integration policies, and neoliberal ideologies and practices intersected to locate the participants in racialized and disadvantaged situations as the *other* wherein access to these services became challenging.

Women refugee claimants' access to these and other reproductive healthcare services needs to be understood beyond the attempts to know their cultural health beliefs and practices, and beyond the neoliberal ideas of self-care, individual responsibility, and culturally sensitive care. Equitable access to healthcare cannot be ensured without resisting these women's

racialized position as the *other* while addressing the social, political, historical, and structural inequities in Canadian society. To ensure barrier-free, full health care coverage to women refugee claimants, as well as other refugee claimants and immigrants, social inequities need to be addressed coupled with instituting broader structural changes federally and provincially in policies, funding, procedures, and practices.

Dedication

To my beloved husband, David, for his endless encouragement, empathy, care, and sacrifice.

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List of Acronyms

BOC	Basis of Claim
BRRA	Balanced Refugee Reform Act
CASW	Canadian Association of Social Workers
CBSA	Canada Border Service Agency
CPNP	Canada Prenatal Nutrition Program
CHC	Community Health Centre
DCO	Designated Countries of Origin
ESL	English as a Second Language
FRFC	Fast Removal of Foreign Criminals Act
FGM	Female Genital Mutilation
HPPA	Health Protection and Promotion Act
HPV	Human Papilloma Virus
IRCC	Immigration, Refugees and Citizenship Canada
IRB	Immigration Refugee Board
IFHP	Interim Federal Health Program
MOHLTC	Ontario Ministry of Health and Long-term Care
Non-DCO	Non-designated Countries of Origin
OHIP	Ontario Health Insurance Program
OAU	Organization of the African Unity
PRRA	Pre-Risk Assessment
PCISA	Protecting Canada's Immigration System Act
RAD	Refugee Appeal Division
RPD	Refugee Protection Division
RPCD	Refugee Protection Claim Document
SCCA	Strengthening Canadian Citizenship Act
PHAC	Public Health Agency of Canada
TTC	Toronto Transit Commission
UNHCR	United Nations High Commissioner for Refugees
UNRWA	United Nations Relief and Works Agency for Palestinian Refugees
US	United States
WHO	World Health Organization

CHAPTER 1

INTRODUCTION

For the past 6 years, from 2012 to 2018, my research interest was focused on women refugee claimants in Toronto, Ontario, Canada. In the research study I embarked on in 2016–2017, I explored the access barriers to three reproductive health care services: prenatal care, postnatal care, and screening for cervical cancer, experienced by women refugee claimants living in Toronto. I investigated and explored the barriers this group of women faced in seeking these three reproductive health care services. The results of my research are presented in the seven chapters in this dissertation, which I summarize in the following section.

However, before moving on, I would like us to recognize that although the number of participants in my research study was small, numbering 16 refugee claimants, these women were and are representative of the enormous global crisis facing all developed and developing nations, with millions of displaced people seeking safe refuge that offers them possibilities for better lives in what are most often distant countries and unfamiliar cultures.

Organization and Summary of My Dissertation

In this chapter, Chapter 1, I present two perspectives on refugees and refugee claimants from 2013 to 2016: The first perspective is a global one, as provided by the United Nations High Commission for Refugees (UNHCR, 2015, 2016), which provide the statistics for millions of displaced people and the countries in which they sought asylum. The second perspective is a Canadian one. Here I explain the underpinnings of Canada's current role as a

nation that accepts a limited number of refugees on a yearly basis and the paths available to refugees for acceptance into Canada. I then explain my research problem statement, purpose, and the broader questions that guided this study. I also describe the rationale of my study, the definition of refugee and refugee claimants, and the changes in Canada's refugee system as of 2010.

Chapter 2 describes the theoretical approaches informed by feminist antiracist, postcolonial theoretical, and intersectional perspectives that informed my study. These approaches helped me to shape the research questions, design the study, and analyze the results.

In Chapter 3, I review the relevant literature and first identify the major gaps in it. Then I delve deeply into the literature on racism and discrimination, language and communication, cultural barriers, removing barriers, and enhancing access to pre- and postnatal care and cervical cancer screening. I also examine the literature written on the Federal, provincial, and municipal governments' guidelines for the provision of pre-and postnatal care, and cervical cancer screening.

In Chapter 4, I outline the methodology and research method I used in my study. I begin with a discussion of the philosophical underpinning of ontological and epistemological issues around knowledge production. Next is an illustration of the research design and procedure I followed in generating and analyzing the data. In reporting and representing my participants' voices, I also unpack the ethical dilemmas I encountered with reflexive accounts of my own location with this research.

Chapter 5 documents my research findings from the participants' narratives and my analysis. I demonstrate the varied levels of women refugee claimants' participation in prenatal care, postnatal care, and cervical cancer screening.

In Chapter 6, I provide a discussion of my research findings. I locate and discuss the intersecting factors that shaped my participants' varying levels of use, or lack thereof of these reproductive services under investigation.

In Chapter 7, the final chapter of my dissertation, I elaborate on the key findings that came out of my research findings. I link these results to my research questions and the findings in the earlier chapters. I consider the broader theoretical, methodological, and practical implications of my study, acknowledge its limitations, and offer ideas for future research. Lastly, I identify implications for social workers working with refugee claimants. At the end of this chapter, I recommend broader structural changes federally and provincially in policies, funding, procedures, and practices in order to improve the provision of equitable access to prenatal care, postnatal care, and cervical cancer screening as well as other health care services for refugee claimants.

Global Perspective on Refugees and Refugee Claimants

The UNHCR statistics I present for this study focused on 2013 to 2016, the period during which I conducted my research. However, at the time of writing this dissertation (June 2018), refugee numbers worldwide have continued to increase. Going beyond the 2016 numbers accounted for in my research, I provide the current information released this month from the UNHCR (2017b): At the end of 2017, the worldwide total of refugees was 68.5

million, an increase of 2.9 million over the 2016 total of 65.6 million. These refugees have been forcibly displaced as a result of persecution, conflict, violence, or human rights violations (UNHCR, 2016). See Table 1 for a comparison of the numbers of people displaced each year from 2013 to 2016.

Table 1

Global Totals of Forcibly Displaced People From 2013–2016 (UNHCR, 2016)

Year	Total (in millions)	Refugees (in millions)	Asylum- Seekers (in millions)	Internally Displaced People (in millions)	Additional Information
2016	65.6	22.5	2.8	40.3	The small increase from 2015 to 2016 was 0.3 million refugees, representing a slowdown in displacement, for the first time in several years, despite the annual total being at a record high.
2015	65.3	21.3	3.2	40.8	The increase from 2014 to 2015 was 5.8 million refugees.
2014	59.5	19.5	1.8	38.2	Every day in 2014, an average of 42,500 people became refugees, asylum seekers, or internally displaced. The increase from 2013 to 2014 was 8.3 million refugees.

2013	51.2	16.7	1.2	33.3	The 2013 level of displacement was the highest on record.
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Note. As explained by the UNHCR (2016), the smaller increase in 2016 compared to the increase in 2015 was due to several factors: (a) refugees returning home, (b) data reconciliation, (c) deregistration, and (d) departures for resettlement.

The increase in the number of refugees from 2013 to 2016 was driven mainly by the conflict in Syria. However, other conflicts contributed such as those in Iraq and Yemen, as well as in sub-Saharan Africa including Burundi, the Central African Republic, the Democratic Republic of the Congo, South Sudan, and Sudan (UNHCR, 2013, 2014, 2015, 2016).

The UNHCR (2016) further reported that developing countries continued to share a disproportionately large responsibility for hosting refugees, despite the growing numbers of people being forcibly displaced worldwide. See Table 2 for the numbers of refugees hosted in 2015–2016 in the six largest developing nations.

Table 2

Developing Nations: Hosting Totals in 2015–2016 (UNHCR, 2015, 2016)

Host Country (descending order)	2015 Total (in millions)	2016 Total (in millions)	Primary Countries of Origin & Reasons for Increase or Decrease
Turkey	2.5	2.9	Syria: 330,000, Iraq: 30,400, Afghanistan: 7,000, Somalia: 2,200
Pakistan	1.6	1.4	Afghanistan: 1.6 million & 1.4 million Decrease due to Afghans returning home
Lebanon	1.1	1.0	Syria: 1.0 million, Iraq: 6,500 Decrease due to (a) data reconciliation, (b) deregistration, and (c) departures for resettlement

Host Country (descending order)	2015 Total (in millions)	2016 Total (in millions)	Primary Countries of Origin & Reasons for Increase or Decrease
The Islamic Republic of Iran	979,400	979,400	No additional information was provided in the report.
Uganda	477,200	940,800	South Sudan: 68% of total in 2016 = 639,744; also, Democratic Republic of Congo, Burundi, Somalia, Rwanda
Jordan	664,100	685,200	Syria: 648,800, Iraq: 33,100, Sudan: 2,200 (these numbers, which add up to the 2015 total, are the ones provided in the report)

In stark contrast to the millions of refugees hosted by the six largest developing nations identified in Table 2 are the dramatically lower numbers hosted by the six wealthiest countries in the world. According to Oxfam International (2016), the six wealthiest countries, that is the United States of America (United States), China, Japan, Britain, Germany, and France, representing more than half of the global economy, hosted 8.88% of refugees and asylum seekers¹ out of the world’s total in 2016. Breaking down this 8.88% country by country, as stated by the UNHCR (2016), the total number of refugees hosted in 2015–2016 are shown in Table 3.

¹ The terms “asylum seeker” and “asylum claim” are most often used internationally and are equivalent to the term “refugee claimant,” which is the standard term used in Canada.

Table 3***Wealthiest Nations: Hosting Totals in 2015–2016 (UNHCR, 2016)***

Host Country (descending order)	2014 Total Received	2015 Total Received	2016 Total Received	Primary Countries of Origin & Other Information
Germany	173,100	441,900	722,400	In 2016, Syria accounted for one-third of all applications. Others were from Afghanistan, Iraq, the Islamic Republic of Iran, Eritrea, Albania, and Pakistan.
United States	121,200	172,700	262,000	In 2016, 52% of applicants were from Mexico and Central America. Salvadorian applicants accounted for 18,900 in 2015 and doubling to 33,600 in 2016. In 2016, others were from Guatemala (25,700), China (19,900), Honduras (19,500), and the Bolivarian Republic of Venezuela (18,300).
Italy	—	83,200	123,000	Nigeria: 27,100, Pakistan: 13,700, Gambia: 8,900, Senegal: 7,600, Eritrea: 7,400
China	—	—	—	Numbers not provided
Japan	—	—	—	Numbers not provided
Britain (postulated)	—	—	“substantial number”	The number of asylum claims received in 2016 had declined compared to 2015.
France (postulated)	—	—	—	Asylum claims had greatly changed in 2014 and 2015. In 2016, new claims were from Albania, Sudan, Afghanistan, Syria, Haiti, and the Democratic Republic of the Congo.

The forced migration of people across regional and international boundaries is an important and highly complex global problem that gives rise to many dire consequences. The situations that lead to forced migration include political instability, ethnic conflict, war, and human rights violations, all of which contribute to social disruption and a lack of basic health care and social infrastructure (Jatau, 2011). The long-term implications of this global disruption impacts refugees' access to health care services in all host countries. For example, here in Canada, as I discuss in the following chapters, barriers such as immigration status, lack of health coverage, living arrangements, absence of service provider support, degree of health care knowledge, discrimination, and having suffered pain, discomfort, or trauma in the past impede women refugee claimants' access to prenatal care, postnatal care, and cervical cancer screening. To address these barriers, as I will discuss, broad policy changes within the federal and provincial governments are required to address the inequities in immigration policy, health care procedures, and health care practices.

Before moving on to my discussion of Canada's hosting of refugees, I close this section with a final thought. The UNHCR statistics I presented reflect the period of time during which I was conducting my research. However, at the time of finalizing my writing of this dissertation (June 2018), there continues to be an increase in refugee numbers worldwide. Unfortunately, given the times in which we live, this displacement of lives, resulting in ever-increasing numbers of refugees (as evident in the UNHCR statistics from 2013 to 2016, and including the recently released number for the end of 2017), shows no signs of ending.

Canadian Perspective on Refugees and Refugee Claimants

Canada's 1976 Immigration Act affirmed Canada's commitment to the resettlement of refugees and provided federal guidelines for the establishment of a system for refugee claimants to enter the country (Lacroix, 2004). These guidelines have changed since the passage of the 1976 Immigration Act with additional federal bills adopted into law between 2010 and the present and continues to change based on the political will of the government in power. I delve more deeply into these bills and their changes in Chapter 6.

Currently, there are two routes of entry available to refugees. One is through Canada's resettlement program, and the other is through application as a refugee claimant. Looking at the resettlement program, as reported by Puzic (2017), in 2016 Canada resettled 46,700 refugees through its resettlement program, more than twice the 20,046 resettled in 2015. This was the largest number of refugees admitted through the resettlement program in a year since the implementation of the 1976 Immigration Act, according to the UNHCR (2017a). Refugees in the Canadian resettlement program are sponsored, either by the Canadian government or by private groups, and were automatically granted permanent residency when they arrived in Canada (Government of Canada, 2017c). Puzic (2017) further pointed out that in 2016 the top five countries of origin of refugees resettled in Canada through the program came from: Syria (33,266), Eritrea (3,934), Iraq (1,650), [The Democratic Republic of the] Congo (1,644), and Afghanistan (1,354).

Turning our attention to refugee claimants, the Government of Canada (2018b) stated that unlike sponsored refugees, refugee claimants seek protection upon or after arrival in

Canada. It is the responsibility of the Immigration and Refugee Board (IRB), which is Canada's largest independent administrative tribunal, to make decisions on immigration and refugee matters in accordance with the law (IRB, 2018a). Claims for refugee protection made within Canada are deemed eligible for referral to the IRB either by a Canada Border Service Agency (CBSA) immigration officer or an Immigration, Refugee and Citizenship Canada (IRCC) Immigration Centre. After referral to the IRB, refugee claimants wait to be notified of their hearing date with the IRB.

Over the course of a year, claims made by refugees to the IRB fall into one of six designated categories: received, accepted, rejected, abandoned, withdrawn, and pending. According to the IRB (2017b), the number of claims made in 2015 and 2016 are shown in Table 4.

Table 4
Status of Claims by Category Made to the IRB in 2015 and 2016

Status of Claims	2015	2016
Received	16,592	23,350
Accepted	8,596	9,972
Rejected	4,119	4,821
Abandoned	212	286
Withdrawn	532	682
Pending	9,999	17,537

Note. The 2016 pending figure of 17,537 represents the cumulative total of all claims referred on or after December 15, 2012, which had not been finalized (IRB, 2017b).

The IRB (2017b) further pointed out that in 2016 the top five countries of origin of refugee claimants were from: Nigeria (1,543), China (1,323), Pakistan (1,159), Turkey (1,103), and Iraq (1,059), and in 2015, the five main countries of origin for refugee claimants were from: China (1,722), Hungary (985), Pakistan (947), Nigeria (849), and Colombia (711).

These numbers indicate an increase in refugee resettlement in Canada which can be attributed to the Liberals' campaign commitment in 2015 to accept 25,000 refugees from Syria by the end of 2015 (Friesen, 2015). When the Liberals took power in the fall of 2015, the new minister of the IRCC revealed that in 2016 Canada will welcome between 29,000 and 44,000 Syrian refugees for a total of 35,000 to 50,000 (Friesen, 2015). Although these numbers indicated that there was going to be an increase in refugee resettlement in Canada in 2016, the Liberal government's priority was to increase the resettlement of government sponsored refugees and privately sponsored refugees, not refugee claimants. According to Osterberg (2016), the Canadian government has made it increasingly difficult for refugee claimants to get to Canada to make a claim through interdiction measures that included:

1. Visa requirements for countries with worst human rights violations
2. Carrier sanctions (fines on airlines if they bring passengers without proper documents)
3. The safe third country agreement, which means that most refugee claimants cannot make a claim at the US-Canada border

However, in spite of the safe third country agreement, since 2016 Canada has witnessed the largest influx of refugees from the US crossing the border to Canada because of US President Trump's anti-refugee and anti-Muslim measures (Cochrane & Laventure, 2017).

According to the IRCC (2017), in 2016; among resettled refugees admitted to Canada, 27% of principal applicants were female and 73% were male; however, 59% of spouses and dependant children were female and 41% were male. Additionally, of refugee claimants who were granted protected persons status, 46% of principal applicants were female and 54% were male.

For 2015, according to the IRCC (2016), 52% of resettled refugees were male and 48% were female. Further, 56% of asylum claims made in Canada were made by males and 44% were made by females. The proportion of males appears higher compared to females for both resettled refugees and refugee claimants because men more often come first as the principal applicant and bring their families later.

Problem Statement

Existing literature on refugees in Canada and other countries with similar health care systems, such as Britain and Australia, demonstrate that women refugees and refugee claimants experience barriers when attempting to access reproductive health care services (Amankwah, Ngwakongwi, & Quan, 2009; Ascoly, Halsema, & Keysers, 2001; Carolan & Cassar, 2010; Chalmers & Hashi, 2000; Dunn et al., 2017; Higginbottom, Morgan, et al., 2015). This literature indicates that the barriers that women refugees and refugee claimants face are due to racism and discrimination, culture, language, and communication (Amin &

Brigham, 2010; Ascoly et al., 2001; Austin, Ahmad, McNally, & Stewart, 2002; Chalmers & Hashi, 2000; Reitmanova & Gustafson, 2008; Woloshin, Schwartz, Katz, & Welch, 1997).

However, these studies rarely take into account the broader political, economic, historical, and social contexts within which these women are attempting to access reproductive health services. For example, the effects of immigration policies, health care cutbacks, and the guidelines governing the provision of care on women refugees' and refugee claimants' access to reproductive health care services have not been studied. Most studies on refugee and immigrant women's access to reproductive health care services, especially cervical cancer screening, have focused on cultural barriers, that is, they are based on the assumption that these women's cultural understanding of cervical cancer is the most important reason for their under-participation in cancer screening. If culture is viewed as the main problem, then attention is deflected from racism and discrimination and other systemic factors that impede access to reproductive health care services. The existing literature also fails to capture the unique gendered and racialized experiences of women refugees and refugee claimants and how these affect access to reproductive health care services. Resettled refugees,² however, do have more support than refugee claimants. For example, before arrival to Canada resettled refugees are eligible for Interim Federal Health Program (IFHP) coverage for pre-departure medical services. This coverage includes the following services: (a) immigration medical exams and follow-up treatment of health conditions that would

² Resettled refugees are refugees who have been selected overseas by the Canadian government. They enter Canada as either (a) government assisted refugees, (b) privately sponsored refugees, or (c) blended visa office refugees.

make an individual inadmissible to Canada, (b) vaccination, (c) outbreak management and control, and (d) any medical support needed for safe travel (Government of Canada, 2018b). On arrival in Canada IFHP coverage continues until the refugee becomes eligible for provincial or territorial health insurance (Government of Canada, 2018a). Refugee claimants do not receive Canadian government support prior to their arrival in Canada. However, they become eligible for IFHP after it has been determined that they may make a claim for refugee status. First, they attend an eligibility interview with an immigration officer to assess whether or not their claim is eligible for referral to the Refugee Protection Division (RPD) of the IRB (Government of Canada, 2017f). This process can take 30 to 45 days or longer, and refugee claimants are without health coverage during this waiting period.

Understanding health disparities, according to Weber and Parra-Medina's (2003) insightful argument, requires that we examine the broader social, cultural, economic, and political processes that control or influence the nature and extent of these disparities. Critical feminist health researchers have used antiracist and postcolonial theories to examine the deeper and broader structural forces, such as gender discrimination, racial and class exploitation, colonization, poverty, and globalization, that determine the health of marginalized people (Anderson, 2000). An antiracist perspective, and especially the intersectionality paradigm that best captures the experiences of racialized and marginalized people within larger interlocking political economic, historical, and sociocultural contexts, is a useful tool for exploring the experiences of refugees and refugee claimants. This perspective has been missing, particularly in research into access to pre- and postnatal care and cervical cancer screening of women refugees and refugee claimants. To address this gap,

my research used critical feminist and antiracist theory to explore women refugees' and refugee claimants' access to and experiences with the Canadian health care system with respect to pre- and postnatal care and cervical cancer screening services.

Another significant gap in this area is that very few studies have explored the ways in which race, class, age, and gender relations intersect with migration status to shape women refugees' and refugee claimants' experiences with pre- and postnatal care and cervical cancer screening. An intersectional framework was necessary to explore the broader context of women refugees' and refugee claimants' health, and particularly to uncover the complex interrelationships between the larger structures and these women's subjective experiences of use or lack of use of pre- and postnatal care and cervical cancer screening services. The lens of intersectionality was also needed to uncover how the historical as well as the current policies, institutionalized practices, and structural inequities in Canada interact with each other to marginalize these women in both discursive and material ways, and how this affects their health and access to pre- and postnatal care and cervical cancer screening services.

Research Purpose and Questions

This study is premised on the hypothesis, based on my experience with refugees and refugee claimants and on an extensive literature review, that refugees and refugee claimants in Toronto face barriers that impede their access to health care services. The ultimate goal of this study is to understand specifically the barriers that women refugees and refugee claimants experience when attempting to access reproductive health care services, such as prenatal care, postnatal care, and screening for cervical cancer (by means of the Pap test)

within the broader social, political, economic and historical contexts in which they find themselves. I am interested in gaining insight into how these women experience access to reproductive health care services in Toronto taking into account their gendered, racialized, and classed identities. In other words, my research aim was to find the links between the barriers to reproductive health care services faced by women refugees and refugee claimants and their structural positions in Toronto as shaped by the broader, interlocking system and policies related to race, class, gender, immigration status. The examination of barriers to reproductive health care experienced by the women refugees and refugee claimants in this study will be useful in gaining an understanding of their experiences accessing medical appointments or group programs related to pre- and postnatal care as well as cervical cancer screening services.

The following four key questions guided the research:

1. How do women refugees and refugee claimants engage with pre- and postnatal care and cervical cancer screening?
2. What factors influence these women's use or lack of use of pre- and postnatal care and cervical cancer screening services?
3. What are these women's experiences with the health care system in general, and how does this relate to their different identities based on race, gender, class, and immigration status?
4. How do the broader systems, structures, and policies of Canadian society influence the participation of women refugees and refugee claimants in pre- and postnatal care and cervical cancer screening?

Rationale

This study is significant to health care providers, educators, and policymakers because it seeks to illuminate how women refugees' and refugee claimants' gendered, racialized, and classed experiences intersect to situate them in a marginalized position from which it becomes difficult to access reproductive health care services. Reproductive health care is critical to all women, yet little research that explores the topic of women refugees' and refugee claimants' ability to access adequate reproductive health care services, particularly in Canada, has been done.

My research interest has been shaped by both my academic endeavours in a Canadian university and my personal experience as a frontline social worker in a Community Health Centre that provides health care services to racialized immigrant and refugee women in downtown Toronto. The research builds upon my graduate studies course work, during which I read and wrote about how race, gender, and class biases intersect with other social inequalities to create barriers for women refugees and refugee claimants attempting to access health care services. As my interest in this topic grew, I came to realize that there is a paucity of research on reproductive health care access and women refugees and refugee claimants. Further, as a former frontline social worker in a health care setting, I have had first-hand experience supporting women refugees and refugee claimants who are having difficulty accessing reproductive health care services. This experience in conjunction with my studies allows me to critically reflect on the multiple intersections of gender, race, class, culture, and other systems of inequality as interlocking systems of oppression that shape women refugees' and refugee claimants' access to reproductive health care services (Weber & Parra-Medina,

2003). From this critical reflection and the literature on this topic it is clear that ongoing dialogue and research to inform health care providers, educators, and policymakers of the factors, such as discriminatory practices and policies, that impede some marginalized groups' access to health care is needed. The lack of effective and timely health care during pregnancy experienced by this group could, for example, result in a larger, extended burden on the health care system. Long-term, even permanent, health issues could develop in women refugees and refugee claimants and their children because they have been denied appropriate health care during resettlement (Carolan & Cassar, 2010).

This study contributes to refugee and social work scholarship. It will broaden service providers', educators', and policymakers' knowledge and awareness of the reproductive health needs of women refugees and refugee claimants. This, in turn, could enhance the knowledge of health care providers, educators, and policymakers and lead to the development of research, policy, and practices that create more efficient and accessible health care services for refugee women and reduce the effects of systemic factors that give rise to health care inequities.

Who Is a Refugee?

According to the 1951 United Nations Convention, which focused on the displacement of people as a result of World War II, "a refugee is someone who is unable or unwilling to return to his or her country of origin because of a well-founded fear of persecution for reasons of race, religion, nationality, membership in a particular social group, or political opinion" (UNHCR, 2010, p. 3). This convention was amended by the 1967

Protocol to accommodate the flow of refugees from different regions of the world (UNHCR, 2010). The 1967 Protocol expanded the legal definition of “refugee,” eliminating temporal and geographical limitations, while adopting a universal, cause-related definition (Gunning, 1989). Two years after the signing of the 1967 Protocol, it was clear that a broader definition of “refugee” was needed for the continent of Africa. In 1969, the Organization of the African Unity (OAU) extended the definition of what constitutes a refugee based on refugee problems in Africa (Gunning, 1989). It became clear the 1967 Protocol was not adequate for Africans fleeing war and war-like conditions related to the liberation process. The intent of the OAU was to “Africanize” the international definition of “refugee,” given in the 1967 Protocol, by recognizing the causes of forced migration that were prevalent in Africa (Gunning, 1989).

Canada is a signatory to both the 1951 United Nations Convention and the 1967 Protocol relating to the status of refugees. In Canada, refugee claimants are individuals who have made asylum claims in Canada at a port of entry, at a Canada Border Services Agency (CBSA) inland office, or at an IRCC inland office (Government of Canada, 2018a). A refugee claimant receives Canada’s protection if he or she is found to be a Convention refugee as defined by the United Nations 1951 Geneva Convention relating to the status of refugees and its 1967 Protocol, or to be a person in danger of torture as defined in the United Nations Convention Against Torture (Canadian Council for Refugees, 2010).

Changes in Canada's Refugee System in the 21st Century

The past few years have been characterized by different approaches to migration by different governments. At the time of this writing in June 2018, the Liberal government is still making changes to policies brought in by the former Conservative government. The changes brought about by the Conservative government came in the form of passing a number of bills, such as the *Balanced Refugee Reform Act* (BRRA) in 2010, Bill C-31, the *Protecting Canada's Immigration System Act* (PCISA) in 2012, the *Fast Removal of Foreign Criminals Act* (FRFC) in 2013, and the *Strengthening Canadian Citizenship Act* (SCCA) in 2014 (Osterberg, 2016). The procedures governing persons seeking refugee protection were extensively reformed with the enactment of Bill C-31 in June 2012 (House of Commons of Canada, 2012). These enhanced restrictions imposed by Bill C-31 and the process of refugee determination by the IRCC and the IRB dropped the number of successful claims, beginning in 2013 (Schwartz, 2015). In 2013, the IRB accepted 7,817 refugee claims and rejected 9,897; 849 were abandoned by refugee claimants themselves, and 2,071 were withdrawn by refugee claimants. However, in 2014, the number of accepted refugee claims increased to 9,869, with 7,756 rejected, 864 abandoned, and 1,471 claims withdrawn (Schwartz, 2015).

Refugee claimants whose claims have been rejected by the IRB may choose to stay in Canada and appeal the board's decision to the Refugee Appeal Division (RAD) or apply for a pre-removal risk assessment (PRRA). Unfortunately, changes in the *Immigration and Refugee Act* as of June 2012 restrict failed claimants' access to the RAD and PRRA. The bill included the establishment of the "Designated Countries of Origin" (DCO) list, that is, a list of states designated at the discretion of the minister to be *safe* and therefore less likely to

produce refugees (Government of Canada, 2017b). However, a country might be *safe* for some residents and yet be unsafe for others, particularly those seeking protection from persecution based on gender, sexual orientation, non-heteronormative gender identity, or ethnicity (Will, 2015).

The aim of the DCO policy was to deter abuse of the refugee system by people coming from countries considered to be safe (Government of Canada, 2016a). Refugees, for instance, from DCOs, designated foreign nationals, claimants who came to Canada via a safe third country, and claimants whose refugee claims have been found to be manifestly unfounded or have no credible basis were denied the right to appeal to the RAD (Government of Canada, 2016a). Additionally, most failed claimants were ineligible for a PRRA for 1 year following a negative decision by the IRB or a negative PRRA decision; claimants from DCOs are banned from refile for 3 years (Government of Canada, 2016a). However, refugees in the above categories could be given a PRRA in the event of sudden changes in conditions in their country. The criteria used to determine eligibility for a PRRA are set by the IRCC minister (Government of Canada, 2016a).

In 2012, the DCO legislation significantly reduced timelines for refugee claimants from DCOs and non-DCOs to prove their claims by implementing the requirement that they submit their initial Basis of Claim (BOC) information form outlining claim details within 15 days. Similarly, the wait time for an IRB hearing was reduced to 45 days for claimants from DCOs and 60 days for claimants from non-DCOs (Government of Canada, 2013). Before 2012, refugee claimants had waited approximately 18 months for their hearing with the IRB (Canadian Council for Refugees, 2012b). These drastically shorter timelines limited refugee

claimants' ability to access resources such as legal assistance, gather evidence to prove their claims, and arrange for translation services to help them to prepare and submit their claim, compromising their ability to establish their case (Canadian Council for Refugees, 2012a). It is further postulated that the shorter timelines for asylum seekers adds to their stress at a time when they are going through a period of multiple loss and hardship (uprooting, family separation), uncertainty about the future, and isolation due to their lack of familiarity with the host country (PRAIDA, 2012). However, the shorter timelines to process claims resulted in an increased backlog, and the IRB has found itself unable to meet the new timelines (Keung, 2018). Keung (2018) observed that in January 2018 the IRB implemented a new scheduling system to process claims in the order in which they are received. However, exceptions could be made for priority claims, such as those involving unaccompanied minors and vulnerable persons, as well as straightforward cases from one of the eight selected countries with a high acceptance rate.

Refugee claimants from DCO countries were also restricted in their access to other resources such as preventive health care due to cuts to the IFHP (Robertson, 2012). For example, refugee claimants from DCOs were only eligible for health coverage sufficient to prevent or treat diseases that pose a risk to public safety. Non-DCO refugee claimants received generous coverage for primary health care and supplemental benefits (Barnes, 2012; Marwah, 2014). Restricting services covered by the IFHP created disparities in access to health care services and made the refugee population even more vulnerable (Robertson, 2012). The IFHP cuts had significant implications for refugee women and health care providers. For instance, some obstetricians refused to treat pregnant refugees due to the

financial uncertainties resulting from the changes to IFHP. As a result, some pregnant refugee claimants delayed seeking care or turned to emergency departments for conditions that could have been effectively treated through primary care (Barnes, 2012; Marwah, 2014). Denying health care to the refugee population is against the medical providers' codes of ethics, hence the new guidelines for eligibility for the IFHP created confusion. For example, the boundary between conditions that were non-urgent and those that were urgent, or life threatening was not clear. Without clear guidelines, health providers and institutions were forced to make ethically questionable decisions. Advocates for health care for refugees, including health care providers, expressed their concerns that these punitive health care cuts that restricted access to preventive routine care by refugees could threaten Canadian public health and safety because communicable diseases might not be diagnosed and treated in a timely fashion (Karstens-Smith, 2012; Wales, 2010). I argue that the IFHP cuts were used by the Conservative government's neo-liberal market ideology as a tool to enforce immigration policy to control the number of "bogus" refugees coming to Canada to abuse the country's health care system (Harris & Zuberi, 2014). It was also expected that the cuts would save taxpayers \$100 million over 5 years (*The Globe and Mail*, 2014).

With the election of Justin Trudeau's Liberal government in October 2015, positive changes were made to Canada's refugee policy. The courts also played a role. The Federal Court ruled that the "safe" country policy was discriminatory because it denied an appeal process to refugee claimants from the designated countries that was available to all other refugee applicants. The Liberal government supported the Federal Court ruling to drop the Conservative law, a law that breached the charter by marginalizing refugees from DCO

countries, which are considered safe and non-refugee producing (CBCnews, 2016a). The IRB, through its Refugee Protection Division (RPD), further informed failed refugee claimants from DCOs whose decisions were issued on or after July 23, 2015, and who were barred from appealing to RAD, that they could now file an appeal to the RAD. In addition, failed refugee claimants from DCOs who received RPD decisions prior to the Federal Court decision, but who were still within the timeline to file an appeal also received notice that they had a right to appeal (Government of Canada, 2017f). However, according to the IRB (2018a) the RPD is experiencing a high number of appeals because of the refugee determination system that came into force in 2012. Therefore, the RAD is no longer able to meet its 90-day timeline for making decisions on appeals. As reported by the Government of Canada (2016b) and Keung (2016), restrictions to the right to appeal for failed claimants are still in place for those who:

1. are subject to an exception to the Safe Third Country Agreement
2. are designated foreign nationals
3. have claims with no credible basis as decided by the IRB
4. have claims referred to the IRB before the new system came into force and re-hearings of those claims because of review by the Federal Court
5. are individuals who arrive as part of a designated irregular arrival
6. are individual who withdrew or abandoned their refugee claims
7. have claims rejected because of an order of surrender under the Extradition Act
8. have claims that have been deemed to be manifestly unfounded as decided by the IRB

9. have had decisions on their PRRA application. However, all failed claimants have a right to ask the Federal Court to review a negative decision.

There have been no significant changes to the rules governing a PRRA application for failed refugee claimants. For example, if a refugee claimant previously applied for a PRRA and the application was rejected, abandoned, or withdrawn, that claimant is not eligible to apply for a PRRA again until 12 months have passed. Moreover, failed refugee claimants from DCOs cannot apply for a PRRA until at least 36 months have passed since their original refugee claim or PRRA application was rejected, abandoned, or withdrawn. Refugees are exempted from the 1-year ban in the event of sudden changes in their country of origin's conditions (Government of Canada, 2016d). Ineligibility to apply for a PRRA is still in place for failed claimants who came to Canada from a safe third country, have been found to be a Convention refugee in another country, are protected refugees in Canada, or are subject to extradition because they are suspected or convicted criminals in another country (Government of Canada, 2016d).

On February 18, 2016, the Liberal government restored the IFHP to what it was before the Conservative government's cuts (CBCnews, 2016b). Refugees from any country of origin can receive health coverage through the IFHP, and as of April 1, 2017, they will receive coverage similar to what provinces and territories provide to Canadians on social assistance (CBCnews, 2016b). However, in spite of these changes some refugees' access to health care services is still limited. For example, refugee claimants who have withdrawn their claim, claimants who are considered by the IRB to have abandoned their claim, those who are ineligible to apply for a PRRA, and refugees who are ineligible to be referred to the IRB

are not covered for health care (Government of Canada, 2018b). Because of these changes, as well as lack of awareness of coverage and other factors, it is common for women refugee claimants—and particularly pregnant refugee claimants within these categories—because they have no health insurance—to underutilize pre- and postnatal care and cervical cancer screening services.

CHAPTER 2

THEORETICAL FRAMEWORKS

Introduction

In this chapter I present and discuss the three theoretical approaches that informed my study: feminist antiracist, postcolonial, and intersectionality. In the first section, I locate women refugees and refugee claimants in women's health research and provide the definition of reproductive health. In the second section, I describe the theoretical frameworks for this study. I consider work that used antiracist theory and that focused on refugees, immigrants, and other visible ethnic minority women who have experienced health inequities and inequitable access to health care. I also examine feminist antiracist theoretical frameworks and postcolonial theoretical perspectives in relation to immigrant women's health research. Integrated into the discussion is a review of intersectionality theory, with a focus on how interactions among the systems of gender, race, and class shaped women refugees' and refugee claimants' experiences of health inequities. These frameworks make up the theoretical context used in this research.

Women's Health Research and Women Refugees and Refugee Claimants

Despite the general view that Canada's universal health care system is equally accessible to everyone living in Canada, two populations, women refugees and refugee claimants, do not find this to be so (Gateri & Richards, 2017³; McKeary & Newbold, 2010;

³ This article was published in the *Journal of Refugee Review* and contains portions of Chapters 2 and 3 of this dissertation.

Pollock et al., 2012). Egan and Gardner (2004) pointed out that several studies have found that refugees, immigrants, and racialized Canadian women have health care needs as great as or greater than other women in Canada, yet they utilize health care services at a significantly lower rate than other women. As Anderson and Reimer-Kirkham (1998) insisted, the marginalization of some groups within the Canadian mosaic needs to be examined in order to uncover the reasons for women refugees' and refugee claimants' underutilization of the country's health care services. Varcoe et al. (2007) observed that considerable social and health inequities persist for all women, and particularly for women disadvantaged by multiple forms of oppression. Refugees and visible minority women often face barriers of racism, and sometimes language and cultural barriers, when trying to access health care (Anderson, 2000; Anderson, Blue, & Lau, 1991; Anderson & Reimer-Kirkham, 1998). While there is much recognition that socioeconomic inequities disproportionately affect women refugees' and immigrant racial minority women on health and access to health care services, Vissandjee et al. (2007) pointed out that women's experiences of migration were essentially invisible in health and migration research throughout the 1960s and 1970s. However, recently, scholars have been attempting to focus on migration, especially gendered experiences of migration, as an important contributor to health inequities among women. Vissandjee, Apale, and Wieringa (2009) insisted "that more extensive research is needed to clarify the health effects of migration especially how the relationship between migration and

health may be strongly influenced by the diverse experiences previous to, during, and after migration” (p. 190).

Feminist health researchers emphasize the importance of examining and understanding women’s health within the larger social, economic, cultural, and political contexts of their lives. As Ruzek, Olesen, and Clarke (1997) claimed, feminist models of health research place women at the center of analysis and emphasize that gender as well as other social roles and rules affect women’s health. However, they confessed that such models have not always adequately addressed the health issues of women whose life circumstances vary by race, class, or a variety of other factors, such as location, immigration status, and identities. Thus, they called for research that takes into account the complexities and differences in women’s health in a *multicultural society* in order to adequately address their inequitable access to health care, the challenges they face when accessing other resources, and providing working and living conditions that promote good health. Similarly, Varcoe et al. (2007) pointed out that a critical analysis of women’s health should not be limited to gender alone, “but rather should contextualize women in their diverse social and economic circumstances and understand gender as inseparable from other forms of social difference such as race, ethnicity, culture, class, sexual orientation, gender identity and ability” (p. 3). On the other hand, Narayan (1998) pointed out that attempts in feminist scholarship to avoid gender essentialism, or generalizing about *all women*, are often replaced by essentialist generalizations about cultural differences between Western and non-Western cultures, which reinforces colonialist assumptions and stereotypes about *non-Western culture* as historical and homogenous, that is, undifferentiated by class, ethnicity, language or geographical

location. For example, some health providers maintain a stereotypical representation of refugees and other minority immigrant groups as cultural *others*. Darroch and Giles (2012) and Shahjahan (2005) argued that such representations of racialized groups reinforce hierarchical social structures that see “the Western elite” as superior to the Southern. As a result, ethnic minority women are often constructed in health care, as well as in research and in immigration, as the cultural other in Canada and viewed as a *burden* on state funded services (Razack, 1998; Thobani, 1999).

Refugee and immigrant women’s health care, especially cervical cancer screening practices, are often viewed through a culturalist lens; that is, culture is viewed as the central focus and the core analytic tool of the research. Such an approach reinforces cultural stereotypes and homogenizes these women’s experiences. It also ignores the processes of immigration, settlement, integration, and racialization and hides the racism and other systemic barriers found in Canadian society and the health care system. A culturalist framework, as Jiwani (2006) argued, pathologizes immigrant women of color. Against the backdrop of systemic and everyday racism, a focus on culture quickly becomes a comparison between a *backward, traditional, and oppressive* cultural system and the modern, progressive, and egalitarian culture of the West. Such a focus again leads to a culturally insensitive approach that further reifies stereotypic representations of ethnic groups.

The antiracist literature on refugee and other immigrant women’s lives and experiences indicates that various socioeconomic, political, and structural processes place refugee women, identified as the other, into unequal and complex positions from which to access health care, including pre- and postnatal care and cervical cancer screening. But

research on refugee women's participation in cervical cancer screening, for example, largely remains focused on cultural and language barriers, and still seems to lack the antiracist and critical perspective that could explicate health care practices in broader political, economic, historical, and social contexts. Furthermore, efforts to integrate the gendered experience of migration with women refugees' and refugee claimants' access into health care are still absent in the research on this population's use of pre- and postnatal care and cervical cancer screening. Further research is required to explore whether and to what extent women refugees and refugee claimants underutilize health care services, such as pre- and postnatal care and cervical cancer screening, because of systemic and structural barriers in and outside of the health care system rather than because of cultural differences in beliefs about health and appropriate medical care.

Reproductive Health

The World Health Organization (WHO) defines reproductive health as, the condition in which the reproductive process is accomplished in a state of complete physical, mental and social well-being; it is not the mere absence of disease or disorder of the reproductive process. Reproductive health implies that people have the ability to have a responsible, satisfying, and safe sex life. It further implies that people have the capability to reproduce and the freedom to decide if, when, and how often to do so. It also means that men and women have the right to be informed about and have access to safe, effective, affordable, and acceptable methods of birth control. It finally means the right to have access to health care services that best facilitate a safe pregnancy and childbirth resulting in a healthy infant. (2004, p. 4)

As a researcher, I use this definition because it describes the ideal of reproductive health accepted by international agencies, however I acknowledge that it does not capture

reproductive health as it is understood in different communities. It is derived from the dominant understanding of health and does not take into account other cultures' understandings of health. It also neglects the intersecting historical, sociopolitical, and economic conditions that influence reproductive health. In other words, this definition captures the standard that my research demonstrates must be inclusive of diversity in order to permit access to adequate health care in Canada.

Theoretical Frameworks

Critical Feminist and Antiracist Theories

Critical feminist and antiracist perspectives help us understand how women's health and illnesses are embedded within complex layers of contexts, especially how socioeconomic and structural inequities determine the health and health care experiences of marginalized and racialized women and men (Anderson, 1996). Anderson (1996) further asserted that a critical feminist approach critiques the traditional biomedical model of health and the neoliberal approach to health care, and challenges culturalist explanations of illnesses, health practices, and health inequities. Such an approach works to contextualize health and health care within complex material, political, ideological, and historical conditions. Delgado and Stefancic (2001) pointed out that antiracist theories focus on knowledge of ethnic minorities and their communities of origin with respect to race and race relations. In health research, Ahmad (1993) pointed that these theories pay attention to how racism and power hierarchies operate in health care institutions, and they challenge Western biomedicine's use of culturalistic and individualistic issues to explain inequitable health conditions and health

disparities among populations. In my dissertation research, antiracist theories will be a useful tool to scrutinize the ways in which race and racism directly and indirectly affect women refugees' and refugee claimants' access to pre- and postnatal care and cervical cancer screening. According to Ponc (2007), critical and antiracist scholars also take a social justice approach to health care that advocates for the reduction of the social inequities that are at the root of health care inequities and for the creation of health and social policies and economic structures that foster quality health care for all members of society regardless of their social standing.

Antiracist scholars Ahmad (1993) and Jiwani (2001) have offered important critiques of Western biomedicine as a racialized and patriarchal system of dominance. As Jiwani (2001) has pointed out, Western biomedicine tends to regard a person as a “constellation of symptoms to be categorized, managed and processed” (p. 15) and tends to reproduce the hierarchical relations between patients and health care providers, relations that render refugee women and refugee claimants in particular as powerless victims. Ahmad (1993) insisted that the biomedical model of research and practice diverts attention from the production of ill health to its distribution among individuals and perpetuates the ideology of victim blaming by relating health problems to individual lifestyles. As a result, Ahmad (1993) argued, biomedicine “depoliticizes and individualizes ill health, treats the afflicted in isolation from social, economic, and citizenship context and thus legitimates structural inequities and supports the status quo” (p. 12). The biomedical approach promotes the ideology of liberal individualism through its attempts to identify behavioral or genetic risk factors for illness and its assumption that individuals are responsible for their health, and subsequent condemnation

of those unable to meet their health needs (Anderson, 1996; Fiske & Browne, 2006). Rather than highlighting the health behavior and lifestyle or cultural health practices of individuals within certain racialized groups, feminist antiracist health scholars (for example, Dossa, 2004; Dyck & Dossa, 2007; Jiwani, 2006) have shifted the focus to race and gender and have studied the impacts of these socially constructed power relations and structural factors on the health of immigrant minority women.

Many critical feminist and antiracist health researchers have also used postcolonial theories to examine immigrant minorities' and other racialized women's health issues (for example, Anderson, 2000; Browne, Smye, & Varcoe, 2007; Culley, 2006; Guruge & Khanlou, 2004; Reimer-Kirkham, 2003). Anderson (2000) argued that postcolonial feminist theory is an inclusive and comprehensive framework "that gives voices to racialized women who have been silenced" (p. 145) while providing an analytic lens for exploring how women's lives and health have been positioned and shaped by politics and history.

Postcolonial analysis in the realm of women's health, as Browne et al. (2007) noted, brings increased attention to the colonizing, racializing, and neocolonial practices that continue to construct race and culture as categories in which to locate non-European women as the essentialized, often inferior, and subordinate *other*. Such theoretical perspectives bring to the fore the "socio-historical positioning, culture, race and racialization as intersecting factors shaping the health and social status of women" (Brown et al., 2007, p. 134). This approach also helps us understand how racialization, intersecting with other social categories, such as class and gender, perpetuates inequity in society and how the inequities of race, class, and

gender relations create difficulties with health care access for women refugees and refugee claimants (Tang & Brown, 2008).

Thus, critical feminist perspectives enriched by antiracist and postcolonial scholarships can help us understand health care practices within wider political, socioeconomic, and historical contexts, particularly the way in which the historical and current positioning and racializing of women refugees and refugee claimants in Canada influence their health care access. Anderson (2000) further argued that research into how globalization and health care reform affect the health and health care access of women of color and the poor must focus on gender, racialization, and health, and especially on how gender and race intersect to put racialized women at a disadvantage.

Intersectionality and Women's Health

Some critical and antiracist feminist scholars (such as Brah & Phoenix, 2004; Collins, 1999) have argued that the seeds of intersectionality were sown in the antiracist movement during the 1800s. These scholars' analysis of the legendary speech of Sojourner Truth uses the lens of intersectionality to show how the ever-powerful question *Ain't I a Woman?* she asked in the mid-19th century challenged the essentialization and universalization of the category *woman*. Hesse-Biber and Yaiser (2004) drew attention to the fact that "feminist scholarship frequently failed to analyze the important *interrelationships* or *intersectionality* among the categories of race, class, gender, sexuality, and nationality within specific historic locations leaving the experiences of the others outside the history and social processes in which they live their daily lives" (p. 106). Social relations and oppression based on gender

was often the central focus, and while the issue of difference was acknowledged, there was still a lack of recognition of differences as being socially constructed and connected (Hesse-Biber & Yaiser, 2004).

Intersectionality, a relatively new approach in feminist analysis, began to gain much attention and popularity in the 1990s. It attempted to examine how gender, race, class, and citizenship mutually construct one another rather than examining them as distinctive social hierarchies (Collins, 2000). Black feminist critiques (for example, Collins, 1999; Crenshaw, 1989; hooks 1981; and others) provided important theoretical tools for critical inquiry into the intersection of race, gender, and class in the lives of Black women as well as other women of colour who share the experiences of racism, capitalism, and patriarchal oppression in a White, male-dominated society. The intersectional approach thus developed from the vantage point of Black women and other women of colour and took into account the multiplicity of experiences among women, and the local or internal differences within groups or communities. Black feminist critiques made it clear that prioritizing one aspect of oppression to the exclusion of others leads to a failure to address the totality as well as multiplicity of oppression and experience. The synthesis of race, gender, class, and sexuality through the lens of intersectionality can avoid inappropriate essentializing of women's experiences and, by so doing, can provide a better understanding of the diversity, subjectivity, and agency of women of colour.

Collins (1999) has further stressed that the Black feminist attention paid to the interlocking nature of oppression is significant for two reasons: first, it shifts the entire focus of investigation from explicating elements of race or gender or class oppression to

determining what the links are among these systems. Second, it does not prioritize one form of oppression over others and then deal with the remaining as supportive variables within that context.

In this research, for example, the experiences of women refugees and refugee claimants with reproductive health care services are captured by considering the interlocking nature of oppressive systems and the intersections of race, class, gender, and other social inequities in their lives. Hankivsky and Christoffersen (2008) posited that intersectionality strives to explain and interpret multiple and intersecting systems of oppression and privilege. For instance, women refugees and refugee claimants experience barriers when accessing reproductive health care services differently based on their countries of origin, race, age, immigration status, and social class. The practice of intersectionality seeks to disrupt linear thinking that prioritizes any one category of social identity over others. Instead, Hankivsky and Christoffersen (2008) asserted that it provides an understanding of what is created and experienced at the intersection of two or more axes of oppression (for example, race, ethnicity, class, and gender) on the basis that it is precisely at the intersection that a completely new status is formed that is more than simply the sum of its individual parts.

The scholarship on the intersectionality of race, class, gender, and sexuality emphasizes that these notions are social constructs, which Weber and Parra-Medina (2003) insisted cannot be understood outside the contexts of the real lives of real people. Weber and Parra-Medina (2003) also pointed out that macro social structural trends are often represented analytically as sets of “lifeless statistics about different populations” (p. 129), which says little about how they impact people’s lives. They further argue that race, class, gender, and

sexuality are not reducible to immutable personality traits or physical characteristics. Instead, they are social constructions that often give power in some arenas while restricting opportunities in others. We cannot argue that we are all oppressed or that our oppressions can simply be added up and ranked to identify the most oppressed group or the most victimized individuals. Weber and Parra-Medina (2003) further pointed out that there is “no simple mathematical relationship that can capture the complexity of the interrelationships of these systems” (p. 131). However, antiracist theories argue that the severity of the issues is not the same for everybody. There is a greater intensity of oppression for bodies that are impacted by racial identity.

In my opinion, a key aspect of intersectional analysis is the unpacking of the important linkages among the broad structures, trends, and events and the ways that people in different social locations live their lives and resist oppressive forces. Intersectional theory pays attention to the simultaneous operation of race, gender, class and sexuality along the dimensions of race, gender, class, and sexuality. Such simultaneity indicates that we can be dominant (privileged) and subordinate (oppressed) at the same time. Weber and Parra-Medina (2003) were keen to note that recognition of the history of subordination as well as the examination of the actions, motivations, and resistance of a subordinate group can help us to comprehend the human agency, resilience, creativity, and strength of members of oppressed groups.

The intersectionality approach in health research, informed by critical feminist theories, centers research on the lives of multiply oppressed groups, particularly women of color, and sees activism for social justice in health for all people as part of the knowledge

production process. According to Weber and Parra-Medina (2003), the intersectionality approach is driven by the goals of equitable access to health care, which attempts to identify, analyze, and address the health disparities created by broader economic and political structures and social relations of power. Intersectionality and health scholarship rely on a broader conception of health, situates health in communities and families (not simply in individual bodies), and emphasizes power relationships (not just distribution of resources) as central to social inequities and health disparities. Intersectionality calls for health research that simultaneously addresses the intersections of race and ethnicity with gender, class, age, and sexuality, and their impacts on women's health (Weber & Parra-Medina, 2003). Such analyses of women's health "contextualize women in their diverse social and economic circumstances and understands gender as inseparable from other forms of social differences such as race, ethnicity, culture, class, sexual orientation, gender identity, and ability" (Varcoe et al., 2007, p. 9). Schulz and Mullings (2006) pointed out that intersectionality helps us to understand the complex phenomena (social relationships and dynamics) underlying health, and to apprehend the ways that they can be modified to reduce disparities in health. Weber and Parra-Medina (2003) also argued that an intersectional approach is needed for understanding and eliminating disparities in health and health care. They noted that there is a rising awareness within traditional health disparities research of the need for new approaches, such as intersectionality, to address the problem of ongoing health disparities. Hankivsky and Christoffersen (2008) further noted that many of the complexities and much of the richness of intersectionality and health scholarship are increasingly emphasized in mainstream or traditional health disparities research and intervention. Yet, as Weber and Parra-Medina

(2003) argued, since these models are not primarily designed to explicate and challenge the systemic processes that constitute social inequality, and since they do not emerge from the perspective and experiences of multiply oppressed communities, the simple modification of the traditional models is unlikely to significantly change our understanding of health disparities.

Conclusion and Rationale for the Theoretical Frameworks

Antiracist approaches to health research advocate that certain political and culturalist constructions of knowledge about ethnic communities that essentialize and overemphasize culture while ignoring the structural and systemic barriers to health equity must consider the larger structural, social, and political processes that produce disparities in health. The approaches also acknowledge the interactions between race, gender, and class that render individuals and groups vulnerable to extreme injustice and suffering. The dominant strategies, guided by the neoliberal ideology, that try to address health inequities by providing culturally sensitive care for particular marginalized groups, are neither adequate nor effective. Such approaches, as Varcoe (2002) powerfully argued, must be replaced with strategies that address fundamental social inequities and organize and provide services in ways that take into account the inequities women experience and the impact of those inequities on women's lives and communities. However, despite several studies that use critical feminist antiracist and postcolonial approaches to explore issues of racism, poverty, immigration, and gender as these affect women refugees' and other groups of immigrant women's health, health care practices and policies remain largely unchanged. Vissandjee,

Thurston, Apale, and Nahar (2007) “insisted that “Canadian health care policies and services have failed to take an integrated approach to the needs and interests of women experiencing migration” (p. 222). Therefore, health research that explores how race, class, age, and gender relations intersect with immigration and settlement experiences to shape women refugees’ and refugee claimants’ health and health care experiences seems timely, especially in pre- and postnatal care and cervical cancer screening. As mentioned at the beginning of this chapter, antiracist theory and antiracist feminist theory have been used by several feminist antiracist health scholars in studying many different aspects of immigrant women’s health, including chronic diseases and mental health. The existing literature indicates that critical perspectives have been insufficiently employed in research into access to pre- and postnatal care, and cervical cancer screening among women refugees and refugee claimants. Therefore, I realized that research informed by a feminist antiracist, postcolonial, and intersectionality scholarship would mean that looking into women refugees’ and refugee claimants’ access to and experiences with pre- and postnatal care and cervical cancer screening services within the broader political, economic, historical, and social contexts of their lives would allow a special focus on these women’s diverse experiences of migration, integration, and racialization in Canada and would fill a major gap in the field of health care research.

CHAPTER 3

A REVIEW OF THE LITERATURE

Introduction

The following literature review identifies gaps in the published studies that were relevant to the research topic of this dissertation. Following this section is a review of the literature written on racism and discrimination, language and communication, cultural barriers, removing barriers, and enhancing access to pre- and postnatal care and cervical cancer screening. Lastly, I examine the literature written on the Federal, provincial, and municipal governments' guidelines for the provision of pre-and postnatal care, and cervical cancer screening.

Gaps in the Literature Reviewed

The existing literature fails to capture the historical context that affects women refugees' and refugee claimants' access to reproductive health care. For instance, as Jakubowski (1997) argued, despite Canada's reputation as a harmonious multicultural society, Canadian society contends with a legacy of discriminatory policies, including the direct or indirect exclusion of refugees and immigrants originating from certain countries and a history of repression of Indigenous people. Spitzer (2004) noted that this historical context contributes to racist and discriminatory policies and practices in the Canadian health care system, which are exacerbated by unequal power relations between the predominantly European Canadian health care providers and the large population of non-European women refugees and refugee claimants in need of reproductive health care services. Studies by

postcolonial feminist scholars, such as Anderson and Reimer-Kirkham (1998) and Brown et al. (2007), on immigrant and Indigenous women suggest that the history of colonization and systemic racism in Canada shapes these women's access to health care services. These scholars emphasized the importance of examining how the organization of the Canadian health care system affects these women's health and access to health care. They argued that there is a need for further research from a critical feminist perspective to reveal the historical, gendered, and sociopolitical context of discriminatory policies and practices in the health care system.

Limited studies have examined how language barriers are reinforced by women refugee and refugee claimants' gender roles and racialized experiences. Merry, Gagnon, Kalim, and Bouris (2011), Reitmanova and Gustafson (2008), and Stapleton et al. (2013) have noted that the lack of access to child care for refugee women with children can prevent them from participating in English as a Second Language (ESL) classes. In my opinion, there is a general lack of access to affordable child care for all families regardless of their immigration status and income level. However, Merry et al. (2011), Reitmanova and Gustafson (2008), and Stapleton et al. (2013) noted that refugee and immigrant women who do not speak English are expected to meet the demands of family responsibilities, which act as barriers to their participation in these classes where they could increase their English proficiency and thus would have easier access to reproductive health care information and services. Further research is required to critically explore how gender, race, class, colonization, and discourse intersect to shape these women's access to reproductive health care.

Studies of women refugees' and refugee claimants' access to cervical cancer screening have also failed to examine racial discrimination and the complexities and intersectionalities of various structural and broader socioeconomic processes that shape this group's participation in cervical cancer screening. A few studies have examined migration as a predictor of a low rate of cervical cancer screening, but these studies look at migration in isolation without considering other issues associated with migration that inhibit women's access to cervical cancer screening. Culture is viewed as a barrier to cervical cancer screening in most of the studies reviewed, but culture is overemphasized when it is abstracted from the broader social, economic, historical, political, and structural factors. As Razack (1994) argued, culture abstracted is viewed as fixed in a "timeless and unchangeable vacuum outside of patriarchy, sexism, racism, imperialism and colonialism" (p. 896). It is my opinion that the absence of literature on the gendered experiences of refugee women, everyday racism, and discriminatory and racialized practices within health care and other institutions in Canada that deter their access to cervical cancer screening services demonstrates the prevalence of the view that culture is the only barrier. Furthermore, Razack (1998) pointed that the absence of the notion of racialization, and the centeredness of the term *culture* within the literature and the discourse around women refugees' failure to participate in cancer screening perpetuate the *culturalization of racism*, a process whereby the notion of cultural inferiority, established on the assumption of sociocultural and technological inadequacy or *backwardness*, appropriates racism and sexism. Within such discourse, culture is viewed as the sole barrier; there is no consideration of the other variables affecting women refugees' and refugee claimants' access. As a result, Reimer-Kirkham (2003) noted these women are

viewed as a *challenge*, creating special problems for the provision of health care. White Western culture is constructed as the standard against which the needs and health-seeking practices of the other are understood and judged.

Another culturalist approach is to investigate whether the lack of knowledge about Pap smear testing among refugees and other ethnic minority immigrant women is related to their lack of acculturation (Gupta, Kumar, & Stewart, 2002; MacDonald & Kennedy, 2007). The concept of acculturation imagines Canadian culture as universal in measuring other cultures. Not only does this reflect an assimilationist approach to understanding women's access to health care, but it also underestimates the structural and systemic barriers that women refugees and refugee claimants experience when attempting to access health care services in Canada. Further research that recognizes the sociopolitical and historical disadvantages that reinforce discrimination and inequities is required to determine whether refugees underutilize reproductive health care services because of systemic and structural barriers both in and outside the health care system, rather than their culture alone. The result of the availability of such studies for social workers is that they would be in a better position to advocate for equitable policies, practices, and services to serve all populations, including women refugees and refugee claimants.

Pre- and Postnatal Care: Racism and Discrimination

The literature reviewed from Canada and other Western countries with similar health care systems about women refugees and refugee claimants indicate that these groups of women often present late in their pregnancies without having had prenatal care and without

giving a full medical history (Ascoly, Halsema, & Keysers, 2001; Bulman & McCourt, 2002; Carolan & Cassar, 2010; Kennedy & Murphy-Lawless, 2003), which is linked to poor maternal and neonatal outcomes. Scholars, such as Anderson and Reimer-Kirkham (1998) and Anderson et al. (1991), have asserted that the social structure and hegemonic nature of the Canadian health care system have contributed to poor maternal outcomes. Several studies have suggested that refugee women avoid reproductive health care services because of prior experiences of disrespect, prejudice, and racial stereotyping by service providers (Bulman & McCourt, 2002; Davies & Bath, 2001; McLeish, 2002).

Similar sentiments were echoed in a study of refugee and asylum-seeking women in Ireland who were pregnant or had recently given birth. The women reported inadequate communication by the hospital staff, which they perceived as a form of racism. It was also found that ethnocentrism in the form of inappropriate ideas about or a lack of awareness of refugee women's understanding of reproductive health care was prevalent among health care providers (Kennedy & Murphy-Lawless, 2003). Darroch and Giles (2012) and Spivak (1990) pointed out that failure to recognize non-Western ways of knowing and practices in reproductive health care that differ from the Western medical model indicates an assumption of positional superiority on the part of providers and constructs non-Western people as others. Whether instances of discrimination and racism are *real* or *perceived*, negative experiences can deter individuals from seeking health care and often contribute to feelings of isolation and despair (Beiser, Noh, Hou, Kaspar, & Rummens, 2001; Johnson et al., 2004; Magoon, 2005).

Johnson et al. (2004) found that despite the commonly held view that Canada's health care system is equitable and non-discriminatory, racism is enacted within the institutions and organization of the health care system and is embedded in its structures and practices. Studies in Canada and Britain on Muslim women who had experienced female genital mutilation (FGM) found that they were dissatisfied with health care providers. Chalmers and Hashi (2000), for example, studied the birth experiences in Ontario of Somali women refugees and immigrants who had experienced FGM. The women reported verbal expressions of shock and an attitude of disgust on the part of health care providers. In some instances, colleagues were invited by providers to look at the women's private parts without first seeking their permission, which was perceived as both a lack of respect for the woman and a lack of respect for her privacy. Studies conducted in the UK also found that refugee women often associate mainstream maternity services with a lack of sympathy, racism, and racial stereotyping, which discourages their participation in pre- and postnatal services (Bulman & McCourt, 2002; McLeish, 2002). Bulman and McCourt's (2002) study of the childbirth experiences of Somali women found that they experienced stereotyping and racism by health care providers during delivery. Other researchers have found that women who had been subjected to FGM expected the health care providers to discuss this with them before delivery but found that providers lacked knowledge on the subject (McLeish, 2002; Vangen et al., 2004; Wiklund, Aden, Hogberg, Wikmun, & Dahlgren, 2009). Similarly, Reitmanova and Gustafson (2008) explored discrimination against immigrant Muslim women accessing maternity care in St. John's, Newfoundland. The women in the study reported being subjected to remarks that were insulting, insensitive, stereotypical, and embarrassing when

they asked providers to respect their religious or cultural beliefs and needs, for example, their preference for female providers or their need to remain clothed. Although Gateri and Richards (2017) noted that some women refugees and refugee claimants subscribe to Western medical models for pre- and postnatal care, they might still prefer female health care providers. That respecting this preference is not considered reasonable accommodation by many health care providers is an example of racism and discriminatory practices in health care services that create barriers for women refugees and refugee claimants.

Discriminatory practices and disrespectful treatment of women refugees and refugee claimants because they have experienced FGM or because of their religious beliefs is a violation of section 17 of the Canadian Medical Association Code of Ethics, which states that “health care professionals are ethically bound not to discriminate in providing medical services against any patient on such grounds as race, gender, marital status, religion, age, medical disability, sexual orientation or socioeconomic status” (Canadian Medical Association, 2004). This Code of Ethics is designed to safeguard refugees and other marginalized populations against discriminatory treatment by health care providers. Studies reviewed indicate that this goal has not been completely realized; this may be attributable to the neoliberal cutbacks in health care spending that has resulted in an increase of health care providers’ workload. However, in Canada clinical guidelines for the care of women and adolescents affected by FGM have been written and put into practice (Perron, Senikas, Burnett, & Davis, 2013).

Other studies reported a lack of knowledge about pre-and postnatal services among women refugees and refugee claimants. For example, Carolan and Cassar (2010) explored

the experiences of pregnant African women refugees receiving antenatal care in Melbourne, Australia, and found that the women struggled to understand prenatal care services due to a lack of understanding of the need for this care. Refugee women from countries without a preventive care or health care infrastructure may have had prior pregnancies with good outcomes with minimal or no prenatal care. Women, for example, deliver babies at home or in refugee camps, usually attended by other women, family members, and occasionally a midwife or doctor (Carolan & Cassar, 2010). Some studies showed that women refugees and immigrants were sometimes not informed about the availability of prenatal and postnatal classes, their purpose, or the support offered to attend them (Ascoly et al., 2001; Reitmanova & Gustafson, 2008). Reitmanova and Gustafson's (2008) study found that some immigrant women were not told about these classes or did not attend the classes because they were unable to arrange care for their other children. Some refused to participate in these classes because the classes were open to both men and women. Attending classes with men can cause observant Muslim women great discomfort because it contravenes their religious beliefs. Others (Boerleider, Wieggers, Mannien, Francke, & Deville, 2013; Grewal, Bhagat, & Balneaves, 2008) have found that some women did not see prenatal classes as necessary because they had already experienced birth prior to migrating or had previous child care experience taking care of the children of their female relatives. They also reported that they were too tired after work and lacked childcare. These studies recommend that interventions and policies be developed to improve pre- and postnatal care for women refugees and refugee claimants.

Systemic Discrimination

A few studies have explored the racism embedded in the broader practices, structures, and policies related to immigration and health care that shape women refugees' and refugee claimants' access to reproductive health care services. However, it is important to acknowledge that some health care providers may not personally discriminate against women refugees and refugee claimants, but function as part of a system that constructs discriminatory barriers to care. For instance, a study conducted by (Spitzer, 2004) in Canada with South Asian and Vietnamese women documented racist views among nursing staff, including complaints about *peculiar body odors* and concerns about *inadequate mother-infant bonding* among some ethnocultural groups arising from dealing with individuals who did not fit their preconceptions of how a patient in the Canadian health care system ought to present herself. This study also exposed broader systemic and institutional factors shaping practitioners' attitudes and behaviors. For example, health care reform and cutbacks, stemming from Canada's public services' adaptation to neoliberal market forces, have resulted in increased workloads and staff and supply shortages, which in turn have given rise to a tendency in nurses to ignore patients assumed to be problematic and costlier in terms of time and energy. Patients who were visible minorities were seen as problematic due to linguistic and cultural barriers (Spitzer, 2004). Thus, health care restructuring may have particularly adverse effects on women refugees and refugee claimants, especially those who face language and communication barriers and are without the support of extended family. This results in increased marginalization and racialization of refugees as the other.

Similar studies examining barriers to health care access experienced by refugees in Canada have found that some health care providers are unwilling to accept refugees as patients even when they are accepting new patients (McKeary & Newbold, 2010; Merry et al., 2011). This population is perceived to be challenging due to complex health needs, linguistic barriers, and complicated insurance coverage that can delay payment for services delivered (McKeary & Newbold, 2010). McKeary and Newbold (2010) further noted that the Interim Federal Health Program (IFHP) health care coverage for refugees is difficult to negotiate and many general practitioners turn patients away because they do not wish to deal with the bureaucracy, payment delays, pre-approval process for some procedures, and lower financial compensation. This can be seen as institutionally reinforced discrimination, as health care providers are deterred from serving patients who may incur extra costs in terms of time and labor.

Some women refugees tend to present very late in their pregnancy for prenatal care due to fears arising from their uncertain immigration status and legal restrictions affecting their access to health care; this is particularly the case for failed asylum seekers as they lack health insurance coverage (Ascoly et al., 2001; Gaudion et al., 2006). Recent studies (Khanlou et al., 2017; Wilson-Mitchel & Rummens, 2013) have found that many asylum-seeking women receive less than adequate prenatal care or no prenatal care at all because they did not have health insurance. However, in 2016 the Liberal government restored IFHP coverage to all refugee groups (Government of Canada, 2016c). As mentioned earlier in this chapter, Canada has a publicly funded universal health care system that is expected to provide equal access to services to Canadians and immigrants; however, women refugees and

refugee claimants are covered through a different system, the IFHP (Government of Canada, 2018a). IFHP coverage for refugee claimants continues until they become eligible for provincial or territorial health insurance or leave Canada (Government of Canada, 2016b). IFHP coverage is terminated when an individual refugee claim is determined to be abandoned by the Immigration and Refugee Board (IRB) and withdrawn for a hearing. This happens when a refugee claimant fails to complete the required paperwork related to their claim. Failure to do so, or withdrawing a claim, results in the individual losing their status as a refugee claimant. In addition, those with claims that have been determined ineligible and are not eligible to apply for a Pre-Removal Risk Assessment (PRRA), are also considered ineligible for IFHP coverage (Government of Canada, 2018a).

Because of these barriers, as well as a lack of awareness of the availability of coverage and other factors, it is common for refugee women, and particularly refugee claimants, to underutilize pre- and postnatal care because they have no health insurance. Ascoly et al.'s (2001) study with women refugees in the Netherlands found that when medical complications that could be easily dealt with early in pregnancy are left untreated, more serious complications requiring increased levels of medical intervention and treatment can arise.

These acts of discrimination that deny refugees access to health care services others this population by separating them from us (Canadians; Olsen, El-Bialy, Mckelvie, Rauman, & Brunger, 2016). Through this process of *othering*, refugees are presented as taking advantage of Canada's generous and overburdened health care system (Olsen et al., 2016). Grove and Zwi (2006) argued that restricting this population's access to health care services

does not benefit the Canadian government or Canadians. Refugees not receiving appropriate and timely health care may indeed place the wider community at risk over time. Moreover, Wales (2010) pointed out that many refugees require immediate medical care upon arrival to Canada. This is not surprising given that they often come from war-torn countries and have lived in refugee camps where they had little access to treatment for chronic illness, and many may, as a result of this and other experiences, have suffered sexual abuse, hazardous and unsanitary living conditions, and undiagnosed health conditions.

Cervical Cancer Screening

The screening for cervical cancer usually involves the use of the Papanicolaou or *Pap smear* test, in which a nurse or physician removes cells from the woman's cervix to look for abnormal cell growth (National Aboriginal Health Organization, 2009). The Pap smear test lowers the incidence and provides early detection of cervical cancer and is expected to be available to all women living in Canada (Gupta et al., 2002; Pottie et al., 2011). In the existing literature, studies on cervical cancer screening among women refugees and refugee claimants are based on epidemiological data. These studies have completely ignored the complex perspectives and realities of women refugees and refugee claimants in Canada, realities shaped by their racialized and gendered experiences that deter their access to cervical cancer screening services. The literature suggests that cervical cancer in women refugees and refugee claimants is less likely to be detected early, as it can be in the general female population, because these women tend not to be screened due to the barriers they face accessing care (Amankwah et al., 2009; Oelke & Vollman, 2007; Pottie et al., 2011). Studies

have found that some women refugees and refugee claimants from developing countries where there are limited preventive services and no systematic cervical cancer screening programs have low rates of screening because of their lack of knowledge and understanding of the procedure and its benefits (Amankwah et al., 2009; McDonald & Kennedy, 2007). For these women, participating in a screening in the absence of symptoms is not a part of their health practice.

Ogilvie, Shaw, Lusk, Zazulak, and Kaczorowski (2004) found that, in Canada, women with low socioeconomic status, visible minority and immigrant women were overrepresented among those with cervical cancer and had higher rates of non-attendance for Pap smear screening and colposcopy services for follow-up of abnormal Pap smears. Others (Goel, 1994; Grunfeld, 1997; Lofters, Moineddin, Hwang, & Glazier, 2010) have suggested that low screening rates and never having been screened for cervical cancer are more prevalent among immigrant women, particularly older women living in the lowest-income neighborhoods. Similarly, Lofters, Moineddin, Hwang, and Glazier's (2011) study in Canada showed that factors affecting health, such as low income, not being in the 35–49 age group, not being enrolled with a medical practice, and having a male family doctor from the same region as the woman are associated with lower rates of cervical cancer screening among immigrants from all regions of the world. These studies suggest that these variables tend to negatively affect screening rates among women refugees and refugee claimants regardless of their culture or ethnicity.

Several studies have suggested that lower rates of Pap smear screening among refugee and immigrant women is correlated with educational status and lack of knowledge

about cervical cancer screening (Hislop et al., 2004; Lesjak et al., 1997; Maxwell et al., 2001). Hislop et al. (2004) found that higher education and having a female doctor increased the likelihood of cervical screening among Chinese immigrant women. Some studies have found a markedly lower use of Pap smear testing among recent immigrants, especially immigrants from Asian backgrounds (Lofters et al., 2010; McDonald & Kennedy, 2007; Woltman & Newbold, 2007). Lofters et al. (2010) observed that even where there is universal health insurance, rates of cervical cancer screening were significantly lower among women who were recent immigrants. On the other hand, Gupta et al.'s (2002) study with South Asian immigrant women in Canada found that a low level of acculturation, rather than simply a shorter length of residence, was a more significant characteristic of women who underutilized and demonstrated less knowledge of Pap smear testing. McDonald and Kennedy (2007) found that for most immigrant women, participation in screening increases the longer they live in Canada, except for women of Asian descent who have lower levels of participation in cervical cancer screening. This finding held even for those who arrived as children and second-generation Asian Canadians. Although such survey data cannot actually identify the casual factors behind low Pap smear testing rates exhibited by immigrant and ethnic minority women, these authors assumed that social or cultural factors, rather than access barriers, are involved because second-generation immigrant women of Asian descent and immigrants who arrived as children were less likely to encounter other access barriers (e.g., lack of English skills or lack of familiarity with the health care system). Similarly, ethnicity, such as South Asian, Chinese, and other Asian, was found by Woltman and Newbold (2007) to be a factor in the difference in women's use of cervical cancer screening.

I argue that a culturalist explanation such as this of the barriers to cancer screening faced by refugee and ethnic minority immigrant women fails to take into account the broader contexts of their lives, such as the racial discrimination in health care, social factors, education, economic status, immigration and settlement issues, and other challenges faced by non-White women.

Language and Communication

Pre- and postnatal care and cervical cancer screening

This discussion is a critical analysis of the literature on language, communication, and information barriers that discourage women refugees' and refugee claimants' use of reproductive health care services for pre- and postnatal care and cervical cancer screening. The literature in Canada and other countries recognizes that women refugees' and refugee claimants' lack of proficiency in the new country's dominant languages, such as English and French in Canada, is a crucial roadblock to reproductive health care (Ascoly et al., 2001; Bulman & McCourt, 2002; Carolan & Cassar, 2010; Merry et al., 2011; Woloshin et al., 1997). Studies by other researchers (for example, Grunfeld, 1997; Stapleton et al., 2013; Woloshin et al., 1997) have demonstrated a relationship between language barriers and access to reproductive care. For example, Woloshin et al.'s (1997) study, based on a sample of 22,448 women aged 18–74 years who completed the 1990 Ontario Health Survey, found that refugee and immigrant women who do not speak English at home are less likely to access cervical cancer screening services than women who speak English at home because of communication barriers. Other studies (Ascoly et al., 2001; Lofters et al., 2011) have found that refugee and immigrant women who do not speak a dominant language of the new

country do not know of the existence of pre- and postnatal classes or preventive services, such as the Pap smear for cancer screening, due to language barriers.

The lack of English-language skills also prevents refugee women from accessing reproductive health information through media, popular literature, pamphlets, and libraries (Anderson et al., 1991). Ironically, refugee women are often othered through stereotyping by health care professionals as non-compliant or unmotivated because they fail to understand simple information, show up late, or fail to attend appointments due to language barriers (Johnson et al., 2004). Both Anderson (1996) and Fiske and Browne (2006) have asserted that the expectation of the biomedical approach is that individuals should take responsibility for their health. However, because of language barriers, women refugees and refugee claimants experience difficulties accessing health care, and when they do they have communication barriers with health care providers. Ascoly et al. (2001) postulated that the ability to communicate is not only important for scheduling appointments and gaining access to services, but it is also critical for women refugees and health care providers to be able to communicate effectively about medical diagnoses and treatment.

Studies by McLeish (2002) and Wiklund et al. (2000) found that some refugee women may be unfamiliar with some aspects of Canadian health care services and the examinations that are part of reproductive health care in the West. As a result, procedures and tests involved may appear to be invasive and frightening, particularly to women who have been sexually abused or have experienced FGM. Good communication is imperative in the care of these women.

Other studies (Bulman & McCourt, 2002; Merry et al., 2011) have emphasized the importance of providing formal interpreting services to women refugees and refugee claimants in Canada who do not speak English or French and are seeking reproductive health care to enhance their understanding of screening and medical diagnoses. Communication is further hindered by a lack of interpreters and of appropriate interpretation (Bulman & McCourt, 2002; McKeary & Newbold, 2010). In Canada, health care reforms and neoliberal cutbacks have reduced budgets for language interpretation with the result that sometimes the cost must be borne by the individual client (McKeary & Newbold, 2010; Newbold, Cho, & McKeary, 2013). Further, refugee women and racialized patients with language barriers are often regarded as problematic, costly, and demanding because of the costs of interpretation in both time and money (Higginbottom, Safipour, et al., 2015; Spitzer, 2004). However, Ascoly et al. (2001) and Bulman and McCourt (2002) insisted interpretation is required. When it is not available from the health care provider, refugee women who cannot afford to pay for an interpreter may use family members or friends as interpreters for their reproductive health care appointment. Although informal interpreters can be useful for conveying demographic information, their interpretation of medical information might not always be accurate, and the presence of a friend or family member might make it difficult for women to discuss significant areas of their reproductive health care, such as options for pain relief in labor, management of issues arising from FGM, sexual health, sexual abuse, and domestic violence.

Although a lack of interpreters and inappropriate interpretation hinders communication, two studies (Higginbottom, Safipour, et al., 2015; Kale & Syed, 2010) have identified other concerns about interpreters that deter refugee women from accessing

reproductive health care service. Higginbottom, Safipour, et al. (2015) and Kale and Syed (2010) each found that the use of interpreters from a similar ethnic group as the client is often associated with a breach of confidentiality, particularly when the interpreter and client know each other. Sharing sensitive information such as sexual history or symptoms of pregnancy and labor can be difficult, and the use of an interpreter from the patient's community might jeopardize confidentiality between the woman and her health care provider. Similarly, Bhatia and Wallace's (2007) study found that refugee women did not trust that professional interpreters would maintain confidentiality, particularly in situations where there was inter-communal violence in their country of origin and the interpreter did not share their loyalties. Another factor contributing to miscommunication between refugee women and interpreters, reported by Binder, Borne, Johnsdotter, and Essen (2012) Higginbottom, Safipour, et al. (2015) is linguistic differences between them. These studies found that sometimes people with different sociocultural backgrounds interpret words, concepts, and their consequences differently based on differences in their understandings of health, well-being, and service provision. Differences in care-seeking and health behaviors can be attributed to different understandings of health, sickness, lifestyles, and bodies. Meddings and Haith-Cooper (2008) asserted that health care providers working with women refugees and refugee claimants would benefit from being aware of these differences, learning how to communicate medical concepts and procedures without relying on technical and medical terminology, and by being cognizant of possible differences in interpretations and attributions to minimize misunderstandings.

Cultural Barriers

Pre- and postnatal care and cervical cancer screening

Several studies on women refugees and refugee claimants have revealed that certain culturally based norms, beliefs, and values tend to hinder their access to reproductive health care services (Amin & Brigham, 2010; Carolan & Cassar, 2010; Higginbotton et al., 2013; Stapleton et al., 2013). Studies by Carolan and Cassar (2010) and Higginbotton et al. (2013) suggest that women who have grown up in a different sociocultural context with different medical traditions usually face many challenges in a new context, for example, misunderstanding of and resistance to health care practices. For example, Carolan and Cassar's (2010) study conducted with pregnant African refugee women and immigrants receiving care in Australia indicated that these women perceived pregnancy as a normal event in a woman's life, not as an illness. Most struggled to understand the need to participate in early prenatal care during their pregnancies. Such cultural beliefs discourage women refugees from attending prenatal care; however, Moffitt (2004) asserted that the Western medical model practiced in the health system in Canada medicalizes pregnancy and birth. Samerski (2007) pointed out that in the Western medical model once a woman's pregnancy is confirmed, she is expected to submit to routine medical care to manage her well-being, her body, and the development of the fetus. The routine medical care renders pregnancy as a perilous journey that the pregnant woman is expected to overcome, which does not consider how other cultures understand pregnancy. As a result, women refugees and refugee claimants sometimes fail to attend prenatal care early in their pregnancy, which may

lead to them being viewed as non-compliant and a potential risk to themselves and the growing fetus.

Literature that speaks to beliefs about childbearing practices indicates that these beliefs are very diverse among women from different sociocultural backgrounds. In several studies (Carolan & Cassar, 2010; Chalmers & Hashi, 2000; Higginbottom et al., 2013; Stapleton et al., 2013), it has been found that some women refugees and immigrants, perhaps based on their social class, who give birth in Western countries are uncomfortable with the practices of the highly medicalized Western maternity care, such as the induction of labor and caesarean section, or the devaluation of their traditional beliefs. Women participating in the studies conducted by Carolan and Cassar (2010), Higginbottom et al. (2013), and Stapleton et al. (2013) reported that they believed that labor is initiated by the baby when it is ready to be born, and that pain medication interrupts the natural birthing process. Another study exploring the beliefs of African refugee women found that they believed that pain medication would slow down delivery and cause the baby to be sleepy and drunk (Murray, Windsor, & Parker, 2010). These women often resisted caesarean sections because they believed that labor should take its natural course. As Darroach and Giles (2012) and Moffitt (2004) noted the failure to recognize beliefs and practices in maternity care that are different from the biomedical way of knowing is based on a universalist stance. From this point of view, when different ways of knowing are examined and measured using the discourse of the dominant group, the conclusions reached are taken to be universal truths. Moffitt (2004) argued that promulgation of this view enhances the power of the dominant group over others and inequalities persist through privileging the dominant group's views.

Studies conducted by Chalmers and Hashi (2000), Stapleton et al. (2013), and Vangen et al. (2004), for example, demonstrate that unnecessary caesarean sections have been performed on women refugees and refugee claimants who had undergone FGM without reasons being given to the women. Vangen et al.'s (2004) study found out often caesarean sections are performed because the health care provider does not know how to perform a defibulation⁴ to properly care for a woman who has undergone FGM. Cultural norms, beliefs, misperceptions, and limited knowledge have been found in these studies to be barriers to women's access to reproductive health care services. However, speaking from my experience as a former service provider, a focus on cultural barriers, while important, tends to overlook structural factors, such as racism, and factors arising from the model under which the health care system operates, which also influences the health care-seeking patterns of women refugees and other marginalized immigrants.

Studies on cervical cancer screening among women refugees and refugee claimants in Canada suggested that some minority women have culturally informed fatalist beliefs about cancer, and they lack the knowledge to make an informed decision about whether to engage in cervical cancer screening, when to seek medical advice, and which treatment to accept (Amin & Brigham, 2010; Maxwell et al., 2001). Other studies described strong beliefs among immigrant women from South Asia that cancer is a stigmatizing, painful, and untreatable disease (Choudhry, 1998). Such beliefs deter them from participating in cancer screening (Bottorff, Balneaves, Sent, Grewal, & Browne, 2001). Similarly, Thomas, Saleem,

⁴ Defibulation is a reconstructive surgery to reverse type III female genital mutilation (FGM).

and Abraham's (2005) study on barriers to the effective uptake of cervical screening knowledge among Black women in Britain found that this group of women associate cancer with death, so prefer not to talk about it, because talking about death is taboo. It is also evident that the participants in this study lacked knowledge about cervical cancer screening services and about the Pap test. This study stressed that cancer screening must be sensitive to the religious and cultural needs of ethnic minority women in order to increase their participation.

Some studies have found that health care-related barriers, such as not having a female family doctor from the same country of origin, are independently associated with lower rates of screening for immigrant women from all regions, regardless of their cultural or ethnic origin (Lofters et al., 2011). The lack of sufficient numbers of women in the medical profession has been cited as a barrier to reproductive health care access, including cancer screening, by women who prefer to be examined by a female physician (Amankwah et al., 2009; Amin & Brigham, 2010; Lofters et al., 2011; Stapleton et al., 2013). Ahmad, Gupta, Rawlins, and Stewart (2002) pointed out that several studies on women's preventive behaviors, such as participating in cervical cancer screening, have demonstrated that women's lower compliance and/or satisfaction with the recommended medical services is associated with the fact that the physician available to them is male. Other studies (Amin & Brigham, 2010; Oelke & Vollman, 2007) have found that health care provider issues, such as a physician's gender and lack of trust and confidentiality, along with other factors such as lack of knowledge about the importance of prevention and the influence of family and community, affected women refugees' and refugee claimants' access to cervical cancer

screening. However, Bryant, Browne, Barton, and Zumbo (2002) and Pollock et al. (2012) found that having a family physician has been found to be the primary predictor of regular participation in cervical cancer screening among refugees, ethnic minority, immigrant, and Aboriginal women to the point that it is likely that it overcomes many of the factors associated with low participation, including socioeconomic factors. This was also confirmed in Oelke and Vollman's (2007) study in Canada with Sikh South Asian immigrant women. The women in this study reported that their physicians had not informed them about the Pap test and its importance. Considering the literature on women refugees' and refugee claimants' inadequate participation in pre- and postnatal care and cervical cancer screening, this seems to be an important health problem for this group in Canada that requires further research that can point the way to better practices and policies.

Removing Barriers to Enhance Pre- and Postnatal Care and Cervical Cancer Screening

Most studies that focus on women refugees' and refugee claimants' low levels of utilization of pre- and postnatal services and cervical cancer screening recommend culturally sensitive care and health literacy in order to increase these women's participation (Amankwah et al., 2009; Bulman & McCourt, 2002; Carolan & Cassar, 2010; Chalmers & Hashi, 2000; McDonald & Kennedy, 2007; McLeish, 2002). Amankwah et al. (2009) and McDonald and Kennedy (2007), for example, recommended culturally sensitive and linguistically appropriate Pap test intervention programs involving members of the refugee and immigrant communities and the training of health care providers to improve participation of these women in cervical cancer screening. Similarly, Carolan and Cassar (2010), Chalmers

and Hashi (2000), and McLeish (2002) recommended the provision of culturally sensitive prenatal care and maternity care practices that demonstrate support and respect for women refugees and refugee claimants to facilitate a greater understanding of these populations and improve the provision of services.

Culturally sensitive or cross-cultural care training is intended to help service providers recognize how the client's culture and their own culture affect their relationships with the client (College of Nurses of Ontario, 2009). Browne and Varcoe (2006) stated that this training was informed by the ideals of multiculturalism, which were founded on the liberal principles of tolerance, respect, and appreciation of other cultures. McConagy (2000, p. 41, as cited in Browne & Varcoe, 2006, p. 160) argued "that tolerance and intolerance binary masks the more significant underlying binary of the tolerating majority and tolerated minority, which is a power-laden division that lies at the heart of Canadian multiculturalism." In a health care setting, these liberal calls for tolerance, respect, and appreciation of other cultures could mask the racialized assumptions embedded in such discourse (Browne & Varcoe, 2006).

Similarly, the discourse of culturally sensitive care tends to focus on the cultural or ethnic identity of the individual and ignores inequities in Canadian society grounded in race, gender, class, age, and ability. The structural and material differences between populations are reduced within the multicultural paradigm to the issue of cultural diversity. Bannerji (2000) insisted that through the discourse of community and cultural diversity inscribed in the official formulations and implementation of multiculturalism, notions of cultures and life practices of ethnic minority women are created and circulated within institutions and among

providers of education, health, and other social services in an effort to deal with diversity and to grapple with the challenges of providing cross-cultural services. Razack (1994) also pointed out that service providers from the dominant group try to ensure cross-cultural service delivery by raising awareness about differences in behavior and cultural cues that identify a person's cultural identity. However, despite these efforts to raise awareness, in practice service providers are rarely aware of the significant lack of knowledge about the effects of racism and neocolonialism on the racialized women they serve, such as women refugees and refugee claimants. Culturally sensitive care is informed by simplistic notions of culture and community that are engraved in the multicultural policy that constructs women refugees and refugee claimants as a homogenous group. However, refugees as a group are diverse with respect to ethnicity, language, sexual orientation, race, and political experience. These issues in relation to the conceptualization of culture are not intended to discredit the notion of cultural sensitivity or cross-cultural care training. Rather my arguments are intended to draw attention to the problems in adopting the narrow definition of culture embedded in cultural sensitivity models, and how this narrow understanding can perpetuate stereotypes about ethnocultural groups.

Studies of language barriers advocate for the dissemination of information about health care services in the languages of refugee and immigrant women and in a culturally appropriate manner (Ascoly et al., 2001; Carolan & Cassar, 2010; Gupta et al., 2002; Stapleton et al., 2013). Although disseminating information in different languages is important for improving the accessibility of health care services, in the context of official bilingualism, this also fosters the othering of refugees. Bilingualism has established English

and French as the official languages in Canada, which, in effect, relegates all other languages, those spoken by minorities, to unofficial or *cultural other* status, hence they fall under the umbrella of multiculturalism (Bannerji, 2000). Therefore, health care information, such as Pap testing, pre- and postnatal services, must be provided in ethno-specific languages to reach these populations.

A few studies have recommended changes in the health care system to remove structural barriers instead of the institution of culturally sensitive care. Lofters et al. (2011) suggested that efforts be made to ensure refugees and immigrant women are connected with the health care system soon after arrival by being provided with a primary care physician. They also suggested that settlement agencies could play a substantial role towards this goal. A centrally organized Pap smear screening system that sends periodic invitations to remind women to be screened instead of the current system of opportunistic screening, as Lofters et al. (2011) advised, could increase screening rates among under-users. In relation to the shortage of female physicians, who are preferred by many women refugees and refugee claimants, these authors suggested that some primary care models might benefit from having female nurses, physician assistants, or nurse practitioners available to provide cervical cancer screening. This point was also reiterated by Bottorff et al. (2001), as they thought the use of clinics staffed by nurse practitioners could be more effective in providing preventive health care and screening to women in ethnic minority groups.

Bottorff et al. (2001) also maintained that while the establishment of special Pap test clinics for ethnocultural groups has the potential to increase the participation of minority women in cervical cancer screening, changes in health policy and structures of health

services are required to fully implement women-centered health care. Clinical interactions that are respectful of the equality, uniqueness, and dignity of all women should be the goal of health care providers. Such care and service extend beyond cultural sensitivity. Bottorff et al. (2001) and Lofters et al. (2011) affirmed the important role nurses can play in mobilizing and maintaining collaborations with physician as well as women, an essential factor to the continuing success of community-based programs.

The literature reviewed reflects that women refugees and refugee claimants experience a number of barriers with access to pre- and postnatal care and cervical cancer screening and that interventions are required at multiple levels to create equitable and health-enhancing policies and structures. In other words, simply understanding women refugees' and refugee claimants' beliefs and being sensitive to these women's cultural understanding will not suffice without attention to structural, political, historical, and gendered constraints that have the potential to marginalize and disadvantage this group's access to health care services. Including these analyses in a broad and comprehensive plan of change will help to ensure equitable health care for all women.

Frameworks in Relation to the Guidelines for the Provision of Care

Reproductive health care needs of refugee women of childbearing age are an important example of the gendered needs of this population. Being a refugee, despite all the differences among refugees, coupled with undergoing the various stages of the asylum-seeking process, has a profound effect on women's reproductive health (Ascoly et al., 2001). The guidelines that govern the provision of reproductive health care to Canadians, including

refugees, are issued by various government bodies and professional associations. In this section I discuss the federal, provincial, municipal, and midwifery guidelines that govern reproductive health.

Federal government: Health Canada

Health Canada is the federal department responsible for helping Canadians maintain and improve their health while respecting individual choices and circumstances. Health Canada's goal is for Canadians to be among the healthiest people in the world (Government of Canada, 2014). To achieve this goal, Health Canada (Government of Canada, 2014):

- Relies on high-quality scientific research as the basis of their work.
- Conducts ongoing consultations with Canadians to determine how best to meet their long-term health care needs.
- Communicates information about disease prevention to protect Canadians from avoidable risks.
- Encourages Canadians to take an active role in their health by, for example, increasing their level of physical activity and eating well.

Health Canada works collaboratively with provincial and territorial governments to develop health policy, enforce health regulations, promote disease prevention, and enhance healthy living for all Canadians. Health Canada is also mandated to ensure that health services are available to First Nations and Inuit communities. And it works closely with other federal departments, agencies, and health stakeholders to achieve the goal of Canada being one of the healthiest countries in the world (Government of Canada, 2014; Oxman-Martinez et al., 2005).

Health Canada's basic mandate is to implement the Canada Health Act (Minister of Justice, 2017a), the federal law determining cash contributions to the provinces from the federal government and the criteria and conditions governing provincially insured and extended health care services. The five principles of the Act that guide the delivery of health care are "public administration, comprehensiveness, universality, portability, accessibility" (Minister of Justice, 2017a, p. 5). These principles are the foundations of health care delivery in Canada. Resources for health care are allocated based on negotiations between the federal and provincial governments. However, the definition of insured health services excludes services to persons covered by another act of Parliament, such as refugee claimants (Health Canada, 2015). Refugees and refugee claimants are covered by the IFHP (Government of Canada, 2017a).

The exclusion of refugees from coverage under the Canada Health Act 2014–2015 (Health Canada, 2015) is a result of the intersection of federal and provincial government policies. Federal health policies frame eligibility for coverage in the provinces as well as standards of access and equity while immigration policies determine a person's right to enter and reside in Canada and the conditions associated with these rights, such as access to health care. Although the provinces have some discretion when interpreting and administering the Canada Health Act 2014–2015 (Health Canada, 2015), the Act stipulates that only residents of a province who are legally entitled to remain in Canada are eligible for public health insurance, which does not include refugees (Oxman-Martinez et al., 2005). In some provinces, the Act has been interpreted to mean that public insurance is to be extended to immigrants of varying statuses who have been legally accepted in Canada through the

immigration process. These immigrants include permanent residents, sponsored family members and resettled refugees (who arrive as permanent residents), long-term temporary workers, and live-in caregivers. Excluded entirely from public health insurance are certain categories of temporary workers, refugee claimants (although they are covered by IFHP), foreign students, visitors, and undocumented migrants (Oxman-Martinez et al., 2005). This exclusion limits the ability of members of these groups to obtain appropriate health care when necessary.

Refugee women and girls are often in need of immediate health care services when they arrive in Canada because they have often been subjected to violence and sexual abuse (Kurth, Jaeger, Zemp, Tschudin, & Bischoff, 2010). Their health is further threatened by precarious living conditions and the absence of immediate or ongoing reproductive health services in refugee camps (UNHCR, 2015). Therefore, women refugees and refugee claimants need comprehensive and timely health care, including reproductive health care, upon arrival in Canada.

Provincial government: Ontario Ministry of Health and Long-Term Care

The Ministry of Health and Long-Term Care (MOHLTC) provides overall direction and leadership for the health care system in Ontario, focusing on planning and maintaining ongoing resources to bring value to the health system (Ontario Ministry of Health and Long-Term Care, n.d.a).

Screening for cervical cancer

The Ontario Cervical Cancer Screening Program is run by Cancer Care Ontario, an agency of the MOHLTC that is responsible for coordinating and overseeing cancer services in Ontario (Cancer Care Ontario, 2017a). The agency is also responsible for updating the screening guidelines for cervical cancer. The guidelines state that cervical cancer screening should begin at 21 years of age for women who are or have been sexually active. It is also recommended that screening be done every three years. It may be discontinued at age 70, if test results have been consistently negative over the previous 10 years (Cancer Care Ontario, 2017b). The Canadian Task Force on Preventive Health Care (2013) recommends that women aged 70 and over who have not been adequately screened in the past should continue screening until three negative test results have been obtained.

The guidelines also recommend screening for women with special circumstances, for example, pregnant women. A Pap test should be done either during a prenatal or postnatal visit if the woman is due for screening. Women who have sex with women should follow the same cervical screening regimen as women who have sex with men. Women who have received the human papilloma virus (HPV) vaccine should continue with screening. Women who have undergone a subtotal hysterectomy and transgender men who have retained their cervix should continue screening. Women who are immunocompromised, for example, women who are currently taking long-term immunosuppressants or those who are HIV positive, should receive annual cervical screening (Cancer Care Ontario, 2017b). Screening is not recommended for women under 21 years of age, as younger women have a lower risk of developing and dying from cervical cancer (Cancer Care Ontario, 2017b).

Although the overall objective of these guidelines is to educate women about cervical cancer screening to reduce morbidity related to cervical cancer, these guidelines are generally only available in Canada's two official languages, English and French. Refugee women who cannot read either language are unable to access this information. Given the multitude of languages spoken in Canada, it is surprising that such important information is not available in languages other than English and French. Further, refugee women and refugee claimants who do not have a primary health care provider or who do not have knowledge about cervical cancer may be less likely to access the website to read the guidelines and adopt the recommended practices. Therefore, refugee women and refugee claimants usually have to rely on advice given to them by a health care provider.

Midwifery

The MOHLTC's Community and Health Promotion Branch is responsible for administering and funding the Ontario Midwifery Program (Office of the Provincial Auditor, n.d.). In 2012–2013, Ontario expanded access to midwifery care by hiring 80 new midwives (Office of the Provincial Auditor, n.d.). The province also amended the Midwifery Act in September 1, 2011, expanding the scope of midwifery practice in Ontario. Midwives are now able to (a) diagnose conditions related to pregnancy, labor, delivery, and the early postpartum period; (b) test paternal blood for diseases related to pregnancy and the health of the baby; (c) take blood samples; (d) put an instrument, hand, or finger beyond the anal verge during pregnancy, labor, and the postpartum period; and (e) intubate beyond the larynx of the newborn (College of Midwives of Ontario, 2012). In 2014, the MOHLTC, in partnership with the College of Midwives, established two birth centers in Ontario: one in Ottawa and the

other in Toronto. The birth centers are midwife-led and were designed in collaboration with midwives. They provide a comfortable, home-like setting in which to give birth (Toronto Birth Centre, n.d.).

Some features of the midwifery model of care clearly distinguish it from the typical medical management of pregnancy and birth. The philosophy of midwifery care in Ontario, as described by the College of Midwives of Ontario (2013), contains a number of propositions intended to guide midwifery care. One of these, which explicitly differentiates midwifery from the medical model, is “Midwives regard the interests of the woman and the fetus as compatible. They focus their care on the mother to obtain the best outcome for the woman and her newborn” (College of Midwives of Ontario, 2013, p. 1). This is clearly an approach distinct from the medical model, which separates the mother and the fetus when considering risk (Wagner, 1994), and places the interests of the fetus ahead of those of the mother (Weir, 2006). Viewing mother and infant as having compatible interests allows midwives to value the health and well-being of the mother, recognizing that this in turn will promote the well-being of the fetus/infant.

The three fundamental principles on which the Ontario model of midwifery is based are continuity of care, informed choice, and choice of birth place (Ontario Midwives, n.d.). The Ontario Midwives also maintained that with respect to informed choice, the midwife recognizes the role of the woman in decision-making by facilitating a collaborative process of informed decision-making during which the midwife provides relevant information in a collaborative and non-authoritarian manner. The midwife also makes sure the client fully understands all the relevant information prior to making a decision. With respect to

continuity of care: midwives provide care to a woman throughout her pregnancy, labor, birth, and postpartum period. To accomplish this, midwives are on call 24 hours a day, seven days a week to ensure that the birthing woman has the same midwife at the birth that she has seen throughout her pregnancy. Choice of birth place means that the practice supports a woman's right to choose where to give birth, whether in a hospital, home, or birth center, supported by her midwife. MacDonald (2006) pointed out that the midwifery model of care in Ontario is also built on the philosophy that birth is a profound event in a woman's life, not just a physiological process. Further, Moon, Breiktkreuz, Ellis, and Hanson (1999) suggested that this holistic view of birth translates into a model of practice that puts women in control of their birth experiences.

However, the midwifery model of care, despite being empowering and transformative in supporting women to take control of their birth experience, can also be disempowering. Women refugees and refugee claimants, particularly those without health coverage, may choose midwifery care and a home birth in part because of a need for affordable care, rather than because they want to take control of their birth and experience a normal or less medicalized birth. According to Johnson (2008), midwifery care and home birth in Canada is a choice available to privileged women. Gagnon (2002) and Guruge et al. (2009) argued that making informed choices around childbirth, especially choices that challenge dominant views about pregnancy, birth, and women's bodies, requires language, computer literacy, and access to other resources that inform a woman's decision about what kind of care she wants. Refugees who are not fluent English speakers may be unable to make fully informed choices around midwifery care. Burton and Bennett's (2013) study found that sometimes midwives

use professional interpreters when providing care to non-English-speaking women; however, due to budget constraints, this is not always possible. Nestel (2002) and Kornelsen (2003) explained that there is also a lack of culturally competent midwives to provide care to refugee women. There are not enough foreign-trained immigrant women from different ethnic groups in the midwifery profession, which limits the availability of midwife care to refugee women and other immigrants who are not fluent in English, particularly those who prefer to receive care from providers who share their ethnicity and language (Kornelsen, 2003). Informed choices will not be possible unless resources are devoted to removing language and cultural barriers between midwives and their clients.

However, it should not be assumed that diversity of ethnicity and language among practitioners providing reproductive health care guarantees health care equity. Access to reproductive health care and the systemic barriers to health care for refugees and other marginalized populations are also affected by the standardized Western medical model in which the needs of those who are marginalized are often silenced. Midwives also work within this hegemonic framework, so are required to practice according to these standards. Still, such a model privileges the use of midwifery care, an alternative that refugee women might not find appealing or might not be aware is available to them.

Home birth in the midwifery model is also viewed as an emancipatory choice for the opportunity it provides for women to labor and give birth with minimal intervention (Bourgeault, 2006; MacDonald & Bourgeault, 2009). However, this perspective, which is situated in the history of the North American alternative birth and home birth movements, may not be shared by refugee women. Based on my experience as a health care provider, for

example, refugee women from countries where colonial powers have eliminated midwifery care to impose Western biomedical birthing centers in hospitals may be uncomfortable with the idea of a planned home birth with a midwife. WHO (2017) and van Eijk et al. (2006) observed that in many countries where reproductive health is not adequately resourced, home births are attended by untrained personnel making them substantially less safe than hospital births. As Burton and Bennett (2013) observed, refugee women from these countries may see home births as second-class care or even as a denial of reproductive health care services. From this perspective, home births may be viewed as oppressive and hospital births as safer and therefore preferable. Thus, midwifery and midwife care in the global South has different meanings than in the West, depending on the particular historical context. However, there have been efforts to promote midwifery care through educational materials to inform refugee women and refugee claimants about this option, so that they can possibly help them make informed choices.

Furthermore, women from marginalized groups, such as refugees, may not consider home to be the most comfortable or safest place to give birth (James, 1993). For example, many newcomers share accommodation with other family members, acquaintances, or friends (Statistics Canada, 2005), and birth in crowded and public conditions can be uncomfortable or awkward. Refugee women living in these conditions may not want to give birth at home and may consider medicalized birthing in a hospital to be safer and more private. However, the establishment of midwife-led birthing centers in Ontario may make a midwife a more attractive alternative for refugee women.

The choice of midwifery care for some marginalized groups, for example, some refugee women, can be seen as reinforcing disempowerment and exclusion. However, the availability of midwifery care provides Canadian women the opportunity to have prenatal, postnatal, and maternity care structured by a model that is woman-and-family focused, one that offers a choice between birthing in a hospital, a birthing center, or at home, and has proven to be as safe as birthing in a hospital under the care of a physician.

Municipal government: Toronto Public Health

Toronto Public Health is guided by the *Ontario Public Health Standards* (OPHS) (Ministry of Health and Long-Term Care, 2018), which specify the mandatory health programs and services provided by the board of health. They are published by the Ontario MOHLTC under the authority of the *Health Protection and Promotion Act* (HPPA)” (Ministry of Health and Long-Term Care, 2018). The OPHS outline the expectations for the boards of health, which are responsible for providing public health programs and services that contribute to the physical, mental, and emotional health and well-being of all Ontarians (Ministry of Health and Long-Term Care, 2018). The boards of health are also “responsible for the assessment, planning, delivery, management and evaluation of a variety of public health programs and services that address multiple health needs, as well as the context in which these needs occur” (Ministry of Health and Long-Term Care, 2018, p. 3).

The goal of the reproductive health standards is to enable women and families to achieve optimal preconception health, for mothers to enjoy healthy pregnancies and healthy babies, and for parents to be prepared for parenting (Ministry of Health and Long-Term Care, 2018). To meet these standards, Toronto Public Health works with primary care providers

and community partners to deliver programs and services. Although refugee health is the responsibility of the federal government, all residents of Ontario, regardless of their migration status, are eligible for public health services at no cost. For instance, as stated by (Keung, 2013) in February 2013, Toronto City Council implemented a policy that allows all migrants and refugees access to city services regardless of their immigration status. However, the delivery of these programs and services is shaped by the hegemonic view of health care that maintains paternalistic practices embedded in biomedical discourse, which reinforces neocolonialism in the health care provided to refugee women and other marginalized populations (Browne & Smye, 2002). In the delivery of reproductive health services, there is increasing attention paid to risks to the fetus posed by women's bodies and behaviors during all phases of the pregnancy.

Preconception health

Preconception health is defined as the health of the female body before and between pregnancies (Toronto Public Health, n.d.f). The focus is on the health of the female body prior to conception in an effort to decrease potential risks to the development of the fetus should conception occur (Ontario Ministry of Health Promotion, 2010). "The goal of the preconception visit and education is to identify medical and social risk behaviors that may put the mother or the fetus at risk" (Frey & Files, 2006, p. S73). For example, Toronto Public Health provides information on its websites, in its educational materials, and during its counseling services in its clinics about preconception health. Some of the areas covered are healthy eating, keeping active, alcohol and drug moderation, practicing safe sex, and birth control (Toronto Public Health, n.d.f). Certainly, attending to women's needs is important,

however, conceptualizing women's bodies as posing a risk to a potential fetus further entrenches the idea that women's bodies are vessels for others and contributes to their medicalization (Lupton, 1999). Frey and Files (2006) argued that focusing on individual risk behaviors and their relation to the development of the fetus does not take into account the broader social determinants of health. Refugee women, for example, experience barriers accessing health care services arising from such factors as a lack of knowledge about preconception health, language and communication difficulties, and racial discrimination in health care settings (Pollock et al., 2012), factors that are not determined by an individual's behaviors.

The identification of reproductive health risk factors in preconception health is a significant aspect of preparing women for healthy pregnancies. These risk factors can, however, be interpreted as lifestyle or personal choices by health care professionals and women themselves (Fraser & Gordon, 1994) when removed from the complex intersecting historical, sociopolitical, and economic conditions that influence health status and access to health care (Browne & Fiske, 2001). For example, factors that contribute to poor health among refugee women, such as the significant time they spend transiting through camps where they may suffer from poor nutrition, lack of exercise, and lack of access to basic health care (Fowler, 1998), could increase their risk of poor preconception health. Although these intersecting factors profoundly influence reproductive health, they tend to remain invisible in decontextualized discussions of risk.

Prenatal and group programs

When a woman confirms a pregnancy, public health nurses provide a referral to prenatal health care providers, for example, a family doctor, midwife, or nurse practitioner (Toronto Public Health, n.d.c). Toronto Public Health also provides information on its website and through its educational materials about the need for early and regular prenatal care from a health care provider, selecting a prenatal health care provider, and the types of prenatal health care providers available. There is also information about what women should discuss with their health care provider during their first prenatal medical appointment (Toronto Public Health, n.d.c). During this medical appointment, women's bodies continue to be framed in terms of the discourse of risk. The risks to be contained or managed involve risks to the mother's own health, but also risks to the fetus that she carries (Lupton, 1999).

Toronto Public Health provides free individual and group-based prenatal programs to support pregnant women in Toronto. These programs are facilitated by a public health nurse and/or a registered dietitian (Toronto Public Health, n.d.c) and are conducted online and in person. Toronto Public Health (n.d.e) offers these services in programs such as, Canada Prenatal Nutrition, Healthiest Babies Possible, Teen Prenatal Program, and Healthy Babies Healthy Children Program. These programs are delivered in settings such as public health units, hospitals, schools, community centres, public libraries, and faith-based locations (Best Start Resource Centre, 2014). The topics addressed include healthy pregnancies, nutrition during pregnancy, breastfeeding, labor and birth, and parenting. The programs provide experts in prenatal education, child development, and parenting to answer questions participants may have (Toronto Public Health, n.d.d). Based on my experience working with

prenatal clients, online prenatal education may attract young women and their partners who want to learn at their own pace and at times that suit them. It also allows them to participate in prenatal education in a comfortable and non-judgmental environment. Moreover, women experiencing a problematic pregnancy may find traditional sources of information and support inadequate, and online support could provide them with the information and support they need (Lowe, John, Griffiths, Thorogood, & Locock, 2009). As Evans et al. (2012) found, women with high-risk pregnancies can use online Internet support to learn about other women's experiences and feel validated in their feeling towards their own pregnancies.

However, my experience working with refugee women confirms that online delivery of prenatal programs is not appropriate for some refugee women. For example, some refugee women may not be aware of this service or have access to a computer. They may not be aware of free computer services, such as the Toronto Public Libraries services. The program is also delivered only in English or French, which excludes refugee women who cannot speak, read, or write in either of these languages. Furthermore, the topics addressed in online prenatal education programs in Toronto are rooted in a Western understanding of pregnancy, which does not incorporate other cultures. Higginbottom et al. (2014) argued that women who identify with other cultures, such as refugee women, may need prenatal nutritional information that incorporates their traditional beliefs, practices, and attitudes towards pregnancy. Higginbottom et al. (2014) suggested that service providers working with ethnocultural communities may consider the intersection of cultural food practices during pregnancy and biomedical information in order to improve their recommendations when providing dietary advice. In my experience as a service provider in a community health

centre, I learned that in some cultures there are food taboos about what pregnant women can and cannot eat. Therefore, it is critical for this information to be incorporated into prenatal nutrition.

Toronto Public Health provides a prenatal nutrition program, which is part of the Canada Prenatal Nutrition Program (CPNP), a national program funded in part by the Public Health Agency of Canada (PHAC). Toronto Public Health is one of the partner agencies (Toronto Public Health, n.d.a). The CPNP is provided to pregnant women living in Toronto and facing challenging life situations, such as a lack of adequate nutrition during pregnancy or being a new immigrant to Canada. Women who have delivered premature or low-birth-weight babies and are experiencing difficulties accessing health care are also eligible for this program (Toronto Public Health, n.d.a). This free program provides weekly prenatal groups with education and individual support from a public health nurse and registered dietitian working in collaboration with community partners (Toronto Public Health, n.d.a). The topics addressed include having a healthy pregnancy, healthy eating during pregnancy, basic labor and birth, breastfeeding, and becoming a parent (Toronto Public Health, n.d.a). The program might also provide interpreters, healthy snacks, food certificates, prenatal vitamins, child care, and money for public transportation.

Although the program focuses on the needs of vulnerable pregnant women, some refugee women may not benefit. Studies by Ascoly et al. (2001) and Reitmanova and Gustafson (2008) found out that sometimes refugee women and immigrant women do not receive sufficient information about prenatal and postnatal classes, their purpose, or the support offered. Furthermore, as Higginbottom et al. (2013) observed some women refugees

and refugee claimants' cultural beliefs, religions, and customs, such as pregnancy and fasting among Muslim women, that influence nutrition and food practices during and after pregnancy are not among the topics addressed. Some women are unavailable to take advantage of these programs because their economic situation requires them to work long hours. Browne and Fiske (2001) and Rankin and Kappy (1993) argued that when structural needs are ignored by health care providers, women often avoid prenatal care until it is critically necessary. Therefore, it is imperative for health care providers to ensure that this group of women is informed about prenatal classes and that these women understand their benefits. The classes should also incorporate different cultural and religious needs during pregnancy. Prenatal classes are important for all women because they can reduce the anxiety women might be feeling about labor and delivery, and they can help new parents adapt more easily to life with a newborn.

Postnatal programs

Toronto Public Health also provides information about postpartum depression and anxiety. This information includes the reassurance that depression and anxiety can happen to anyone, descriptions of other anxiety disorders that might be experienced after the birth of a baby, things that one can do to feel better faster, how partners and caregivers can help, and what resources are available for support (Toronto Public Health, n.d.c). There is an online video series created by Toronto Public Health showcasing women and their partners who have experienced postpartum depression and anxiety. The series includes videos that focus on identification and awareness, the road to recovery, and partner support. Women and couples can also chat on line with a public health nurse or dietitian about their postnatal

needs (Toronto Public Health, n.d.c). The benefits of online support for women experiencing postpartum depression are immediate access and a lack of geographical or transportation barriers. The anonymous nature of online support makes participants feel safe, particularly those dealing with health-related stigmatization. It also creates an environment for open discussion of topics that might be embarrassing or difficult to talk about in other fora (Evans et al., 2012).

These programs are well intended, but refugee women may not benefit from them. For instance, O'Mahony, Donnelly, Bouchal, and Este (2013) asserted that many refugee women are unfamiliar with the term postpartum depression and that they might describe and report postpartum depression in ways that are not understood by Western health care providers. Furthermore, O'Mahony and Donnelly (2010b) insisted that refugee women also experience barriers that stem from language difficulties and from a lack of knowledge about how and where to access services. Dennis and Chung-Lee (2006) and Morrow and Chappell (1999) found that refugee women might also face cultural barriers, which include fear, stigma, and a lack of validation of depressive symptoms, within their families and/or ethnic communities. Mental illness, for example, is heavily stigmatized in many cultures. In some cultures, as O'Mahony and Donnelly (2010b) observed, there is the perception that it is inappropriate to seek help outside the family for depressive symptoms. Postpartum depression is not viewed as a real problem in some communities, therefore seeking help for it is not considered appropriate. Studies by Rodrigues, Patel, Jaswal, and de Souza (2003) and Whitton, Warner, and Appley (1996) have shown that shame, stigma, and fear of mental illness are strong predictors of whether refugee women will seek help or not. For example,

Li and Browne (2000) found that informal social support within Asian families is highly regarded and most Asian immigrants would rather seek help for mental health problems from family members and friends than from health care providers.

Anderson and Reimer-Kirkham (1998) and Spitzer (2004) argued that cultural barriers are not the only barriers that affect refugee women's health care-seeking behaviors. Like other women, refugee women's gender role requires them to be responsible for domestic work, rearing children, attending to family needs, and working outside the home. This role limits these women's ability to access mental health services. The multiple and changing roles of refugee and immigrant women situate them in a vulnerable, high-risk position. As O'Mahony and Donnelly (2010a) explained, the shifting of gender roles and underlying power relations within the family, for example, when a woman is working and also expected to be responsible for domestic work at home, greatly influences refugee women's access to mental health services. Spitzer (2005) also found that health service utilization is influenced by gender roles that intersect with socioeconomic level, immigration status, cultural and historical marginalization, and the strains of domestic and paid work. These conditions result in an unfair health burden being borne by women, in particular marginalized women whose access to health care is limited. This intersection has been neglected in the development of policies and procedures intended to enhance the delivery of postnatal care to refugee populations and other marginalized women.

Public health nurses and registered dietitians provide parents with telephone support and counseling on child development, parenting, and raising children (Toronto Public Health, n.d.c). Toronto Public Health provides free parenting programs to families that live in the

City of Toronto in a variety of locations such as, elementary schools, CHC, and Toronto public libraries (Toronto Public Health, n.d.d). These programs consist of weekly sessions over the course of 6 to 14 weeks, facilitated by public health nurses. Some programs are offered in languages other than French or English (Toronto Public Health, n.d.c). The aim of these programs is to help parents recognize why children behave in particular ways and promote changes in relationships within the family (Toronto Public Health, n.d.d). Some of the topics addressed include adjusting to parenthood, behavioral changes, parenting stress, and handling children with difficult behaviors (Toronto Public Health, n.d.a). These parenting programs appear to be an effective means of supporting parents to promote positive parenting to improve their children's social and emotional development, for example, Ulfsdotter, Enebrink, and Lindberg's (2014) study found that women, and particularly women refugees and refugee claimants, learn from health care providers about the expectations for raising and disciplining their children. However, other cultures' parenting practices are not discussed in these programs. The result is as Villenas (2001) asserted, cultural differences in parenting have been racialized. Some mainstream providers strictly follow the public health guidelines in these parenting classes, which seem to advocate for the First World/Third World binary that is associated with colonial constructs (e.g., backwardness versus advanced practices) and linked to race and class. I argue that parenting classes for racialized women can be viewed as colonial education for racial others. As Villenas (2001) argued, colonial education includes the policing or the surveillance, disciplining, and control of racialized bodies. In my opinion, this policing of mothers' bodies is not just racial, it also creates gendered others, Black and Brown refugee women and

refugee claimants. These women are the recipients of colonialism, racism, and sexism aimed at assimilating the parenting of their children within First World practices. Although health care providers delivering these programs are well-meaning, this kind of racism is difficult to confront, particularly in the context of the relationship established in the delivery of health care to marginalized populations. However, these programs can be expanded to include different topics such as the parenting approaches of other cultures represented in Canada's refugee and immigrant communities.

Cervical cancer screening

Toronto Public Health works with community partners to promote cervical cancer screening within populations that are not regularly screened. Public health nurses provide consultation, education, resources, and links to screening services (Toronto Public Health, n.d.b). This information is meant to educate all women in Toronto about the significance of cervical cancer screening. However, Esses and Medianu (2012) pointed out that accessing online and printed health information can be challenging for refugee women with limited English- or French-language skills. Furthermore, in my experience some educational resources, such as brochures and pamphlets, provided by the public health nurses are not tailored to refugee women and refugee claimants' needs. For example, they do not address these women's cultural beliefs and misconceptions about cervical cancer screening, which are highly diverse. Additionally, as noted by Hislop et al. (2004), Lejak et al. (1997), and Maxwell et al. (2001), refugee women and refugee claimants' may not be motivated to find this information because of the barriers they face in accessing reproductive health care, such as lack of knowledge and understanding of the importance of screening. However, online and

printed cervical cancer health information does help Canadian women understand the need for cervical cancer screening for the prevention of cancer and the reduction of mortality from cervical cancer.

The review of the current literature found that women refugees and refugee claimants experience many barriers to pre- and postnatal care and cervical cancer screening, and that interventions are required at several levels to create equitable and health-enhancing policies and structures. In other words, simply understanding the complexity of women refugees' and refugee claimants' beliefs and being sensitive to these women's cultural understanding will not suffice. Addressing structural changes also requires paying attention to the social determinants of health inequities that take into account social, economic, political, and cultural realities, as well as behavioral and biological factors (Raphael, 2016) to ensure equitable access to health care for all women.

CHAPTER 4

METHODOLOGY AND RESEARCH METHODS

Introduction

Methodologies are coherent sets of ideas comprising the philosophy, methods, and data that underlie the research process and the production of knowledge (McCall, 2005).

Methodology is the “plan of action, a process or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcome” (Crotty, 1998, p. 3). It includes the logic or theoretical framework that shapes and supports the selection of data sources, data-generating methods, and analysis and interpretation of that data (Crotty, 1998; Harding, 1987; Mason, 1996). Methodology guides the research design, processes, and decisions taken regarding how to go about generating data based on particular epistemological, ontological, and theoretical perspectives. Thus, the choice of methodology should support the implementation of methods of acquiring data and producing knowledge best suited to the particular research questions and analysis and interpretation of research data.

My research aimed to explore the barriers to reproductive health care services, such as prenatal care, postnatal care, and screening for cervical cancer (by means of the Pap test), experienced by women refugees and refugee claimants in Toronto. Although I had received approval from the York University Research Ethics Board to interview two groups of women—refugees and refugee claimants—I interviewed only one group—refugee claimants—because this was the group I was put in touch with by the service providers who supported me in the recruitment of my participants. The loss of having refugee women in my research meant that I

had limited ability to learn how this group experience access to these reproductive health care services. Devers and Frankel (2000) suggested that the criteria for selecting who to interview may change throughout the research process as more knowledge of the setting and subjects is obtained.

In my interviews, I was interested in learning about the contexts of the research participants' everyday lives, which are shaped by the complex intersections of such dynamics as race, age, gender, class, immigration status, language, and length of stay in Canada. The research questions guided the inquiry into how these dynamics and broader social relations, structures, and processes shaped these women's experiences with the health care system, in particular their access to prenatal and postnatal care and cervical cancer screening services. To explore the research questions, I undertook qualitative feminist research informed by a non-positivist, social constructionist epistemology and critical feminist and antiracist theory using an intersectionality theoretical framework. Data collection took the form of in-depth interviews enriched by some techniques of ethnographic and collaborative interviewing processes.

Paradigms of Women's Health Research

Ramazanoglu and Holland (2002) insisted that a feminist methodology cannot be independent of the ontology, epistemology, politics, ethics, subjectivity, and social location of the researcher. Epistemological issues are not only interconnected with methodology and choice of methods for research, but, as Harding (1987) argued, they also have important implications for the application of a theoretical structure in a particular area of knowledge. Crotty (1998) further noted the importance of ontology, which, along with epistemology, informs the theoretical

perspective used to justify methodological choices. My theoretical framework was shaped by my ontological and epistemological perspectives, explained below. My choice of research questions was influenced by the gaps or limitations in the existing literature on women refugees' and refugee claimants' access to prenatal care, postnatal care, and cervical cancer screening services.

Ontological perspective refers to how one's views of the world are constituted (Crotty, 1998), and includes beliefs and assumptions about the nature of the social and natural world (Ramazanoglu & Holland, 2002). It is a philosophical understanding of the nature of reality, what constitutes reality, and where and how it exists. Epistemologies are theories of knowledge that make basic claims about the nature of knowledge and about who can know, how we know, and what counts as evidence for our knowledge claims (Harding, 1987). As Crotty (1998) put it: "It is a way of understanding and explaining how we know what we know" (p. 3). Guba and Lincoln (1998) further explained that epistemology examines whether knowledge is an accumulation of objective facts about the world or something we agree upon that changes over time, and what distinguishes knowledge from opinion or belief. Different epistemologies structure the methods for conducting research and for understanding the subject area, in this case marginalized and racialized communities in society at large, differently (Hunter, 2002). Ontology along with epistemology informs the theoretical perspectives used to justify the choice of the methodology employed in a study.

In the designing and analysis of my research, I used a critical feminist and intersectionality lens to view and understand racialized women's access to health care as shaped by the interlocking systems of gender, race, age, class, language, and immigration status. As

Mason (2002) pointed out, different ontological positions are expressed in different conceptualizations of social entities or realities. Different philosophical paradigms for the social sciences (positivist, interpretivist, feminist, realist, ethnomethodologist, postmodernist, and so on) express different versions of the nature and essence of social things, beings, and realities. Mason suggests that qualitative research methodology is about the social realities such as social processes, interpretations, social relations, social practices, experiences and understanding. Therefore, researchers need to understand the implications of adopting a particular ontology.

Women's accounts of their lived experiences provide important entry points to understanding their social realities. By trying to understand the broader social structures, processes, and relations that shape women refugee claimants' experiences through in-depth interviews, I was confirming Mason's (2002) position that "it is useful and possible to frame intellectual puzzles about the social world, and that these can be answered or addressed through empirical research rather than simply through abstract theorizing" (p. 22). Mason further suggested that it is important for empirical researchers to know where they stand, what they can do, and what they know, because their answers will influence what they judge to be good research practice.

As Miles and Huberman (1994) have pointed out, realism has come to mean many things, and is often confused with objectivism. But as Crotty (1998) also pointed out, realism does not necessarily correspond to objectivism, which not only posits the existence of an objective world/reality but also views this reality to be independent from subjective reality. Contrary to objectivism, Ramazanoglu and Holland (2002) maintained that knowledge of social life is

produced in particular social, historical, political, and intellectual conditions and situations. My methodology is consistent with Ramazanoglu and Holland's ontological position of historical realism, which views society as shaped by gender, ethnicity, social, political, cultural, and economic factors, and attempts to understand the reality of any given time and context by taking these factors into account. This ontological position is also compatible with qualitative research methodologies and critical feminist antiracist theories and epistemologies (Crotty, 1998).

Because historical realism views the social and physical world as a series of structures created through the interaction between objects and human consciousness, this ontological position is connected with social constructionism (Guba & Lincoln, 1998). Social constructionist epistemology maintains that there is no objective reality to be discovered and that meanings are attributed to objects as a result of our subjective engagement with the objective/physical world (Crotty, 1998). For example, my participants' knowledge about access to reproductive health care services is socially constructed through their engagement with the "real world," that is, health care services. This is consistent with the idea that reality is socially constructed (Crotty, 1998).

Social constructionists do not believe in the objectivity of knowledge, but rather believe that reality is subject to multiple interpretations (Crotty, 1998). "Realism in ontology and social constructionism in epistemology turn out to be quite compatible. This is an example of how ontological issues and epistemological issues arise together" (Crotty, 1998, p. 11). Social constructionism is also congruent with critical feminist perspectives that view gender along with

race, class, and other relations of power as socially constructed categories, and view biomedicine and health as social constructions as well (Weber & Parra-Medina, 2003).

Situating Knowledge Production

Feminist scholars, such as Haraway (1988), Harding (2004), and Bhavani (2004), have argued that conventional “objectivity” needs to be replaced or transformed into “feminist objectivity,” which simply means “situated knowledge.” The main tenet of this kind of objectivity is, as Hesse-Biber and Yaiser (2004) explained, “the nature of truth is that it is partial, situated, subjective, power imbued, and rational” (p. 13). Feminist research obligates the researcher to disclose her/his positions, history, influences, beliefs, and morals at every step of the research process. “Rather than taking a value neutral, detached and objective position, feminist researchers usually start from their own personal experiences” (Reinharz, 1992, p. 260) and critically situate themselves within the research process and production of knowledge. For example, the current research topic has been shaped by my past work experiences as a social worker in a community health centre that provides health care and social services to racialized women refugees and refugee claimants as well as immigrants.

Despite the disagreements among feminists over the features of feminist research, such as research trends to share certain political and ethical concerns, particularly that of social change, there is a common ethical concern for “morality of social investigation” (Ramazanoglu & Holland, 2002, p. 3) and a commitment to political activism and social justice (Hesse-Biber & Yaiser, 2004). For Harding and Norberg (2005), a good social research project is socially engaged and ethically and politically accountable for its social consequences, which meets the

feminist goal of producing knowledge that can promote the development of more democratic social relations. Thus, feminist researchers take responsibility for the practical and ethical implications of their decisions about knowledge production and aim to produce knowledge that has potential to be used for social transformation. As a Black, immigrant woman and a feminist scholar, my research has been inspired not only by the lack of literature on women refugees' and refugee claimants' use of prenatal care, postnatal care, and cervical cancer screening services, but also by an ethical and political commitment to social justice and more equitable and just health care policies and practices.

Collins (1986) has argued that Black women's and other marginalized groups' status of *outsiders within* White-dominated academia and mainstream sociology provides them with a unique standpoint for producing distinctive analyses and understandings of the intersection of race, class and gender in their lives. Twine (2000) has argued for the merits of *racial matching* as a methodological tool for addressing the absence of race analysis in mainstream White feminist discourse. My own location as a former service provider and a racialized feminist in Western academia and my insider status in the racialized refugee community therefore provide me with certain epistemological and methodological advantages in the quest to understand these women's perspectives and experiences and produce reliable knowledge about them. As Reinharz (1992) insisted, according to the "epistemology of insiderness, being an 'insider' enables a researcher to understand the experiences of a community in a way that would not be possible for an 'outsider'" (p. 260).

However, I did not always feel like an insider to the refugee community. Given my understanding of the socially constructed and fluid nature of identity, and of the mutability and artificiality of the insider/outsider dichotomy described by Naples (2004), I knew that my insider status within the refugee community would not always hold. Naples (2004) provided numerous examples of the multiple and fluid state of fieldwork identities for feminist ethnographers, and in-depth accounts of how their insider/outsider identities are re-negotiated throughout the fieldwork period. I had realized that my status as an insider or outsider with respect to the refugee community would depend on the social location of the research participants and how they identify themselves and me in terms of certain racial, ethnic, class, and other dynamics of social identity. I found that while I shared insider status with my research participants similar to other Black scholars conducting research in communities with which they have shared racial membership, that status was not enough to preclude other challenges. For instance, given my multiple social locations as a feminist researcher, Black African woman, former service provider, low-income, able-bodied, and heterosexual woman, I might have been considered an outsider by many women within the refugee community. My multiple locations not only determined my insider/outsider position in different contexts, but also shaped power relations within the research process. I also found that my African identity and service provider experience were both advantages and disadvantages in that they held different meanings for different women, based on their knowledge about reproductive health and their bodies.

As an insider to the refugee community, I might have missed certain issues that would be more visible to outsiders. Sometimes research participants feel safer when there is distance

between themselves and a researcher who is not from their community. Instead of claiming the knowledge produced through my research is the universal, complete and ultimate truth about the experiences of refugee claimants in Toronto, I acknowledge that the product of my research is incomplete, partial, and located within the relationship established through the insider/outsider boundaries during the research process. In summary, advantages as well as disadvantages emerged from the fluid and contested nature of my insider/outsider status.

Research Design and Procedure

Equity and justice in health care can be achieved through the integration of the voices and perspectives of my participants into relevant policy making. With this assumption in mind, my research attempted to understand the lived experiences and make audible the voices of my participants—women refugee claimants—who lived in the city of Toronto. I designed a qualitative study to situate my participants' experiences with health care access in the context of their everyday lives as shaped by their immigration status and the processes of relocation and settlement.

Social constructionism, one of the epistemological foundations of qualitative research, acknowledges and highlights the active engagement of researchers in creating knowledge within their sociocultural and historical contexts. It also dismisses the idea that knowledge is a political or neutral. As such, it is a particularly compelling philosophical framework for critical feminist qualitative researchers (Morrow & Hankivsky, 2007).

Guba and Lincoln (1998) observed that feminists and critical theorists predominantly use qualitative methodology with a goal to critique, transform, and emancipate. Although policy

makers tend to favor research findings of quantitative studies involving large samples, Bauer (2014) and Goodkind and Deacon (2004) have noted that quantitative methods often fail to capture the unique and gendered experiences of marginalized women, and that there is a particular need for more qualitative research into the health care experiences of women such as my participants who are from non-European cultures. In the health context, qualitative research provides rich and detailed descriptions about how people experience health and illness within the broader contexts of their lives (Morrow & Hankivsky, 2007), and gives insights into the agency of people seeking health care, particularly people from less privileged groups (Segel, Demos, & Kronenfeld, 2003). Therefore, I found feminist qualitative research informed by social constructionist epistemology to be a good fit with my research goals and also consistent with my ontological and theoretical views.

Data Sources

One source of data for this study is The Ontario Ministry of Health and Long-Term Care guidelines for the provision of reproductive health care to Canadians, including refugees, and a review and analysis of the Interim Federal Health Program (IFHP) that provides health care to refugees and refugee claimants. This was useful for understanding the basic parameters of the provision of reproductive health care in general and comparing that to the health care available to women refugee claimants.

The second data source is in-depth interviews, audio-recorded, conducted with individual women refugee claimants and service providers. My field notes, written after finishing each interview, provide situational or contextual information particularly about participants' class or

socioeconomic conditions, everyday life context, lifestyles, and life constraints. I tried to take notes during the interviews, especially at the beginning, but found it made it difficult for me to focus on the conversation. As a result, I did not take notes during the interviews unless necessary, rather I wrote my reflexive reports after the interviews. The notes included my reflections on the interview process and insights about the interview relationships, non-verbal communication, the context of interviews, and early analyses of the interviews. The notes enhanced the data quality and helped me to contextualize the women's voices and experiences and perform analyses in greater depth.

Recruitment

I started recruitment for the study with service providers because of my familiarity with them as an insider—as a former service provider myself—and because I hoped that they would help with the recruitment of women refugees and refugee claimants. In many cases this was proven true. As a former service provider, I was easily accepted in two community health centres and several settlement services that provide services to the refugee populations. As a Black African immigrant woman, I was able to attract the interest, attention, and trust of many women refugee claimants from Africa and the Caribbean. I was welcomed by many women and I never encountered any discomfort having conversations with them about their experiences with prenatal and postnatal care and cervical cancer screening processes, topics which are quite invasive. As an immigrant woman, I could share with the women my experiences of health care access and other struggles. My heterosexual, married background and experiences as a mother helped me to build rapport with many women. But I was unable to include in the study women of

different sexual orientations because of my outsider status although the recruitment flyer included women of different sexual orientations. All the women were presently or previously involved in a heterosexual marital relationship.

I was unable to recruit service providers to participate in a focus group interview at the community health centre I had collaborated with for data collection. Although I had thought that my research topic would appeal to many service providers and they would readily agree to participate in a focus group, I could not get the service providers at the community health centre I had collaborated with to participate as the busyness they all encountered did not permit them the time to participate in such a focus group. Therefore, I applied to the Research Ethics Board at York University for permission, which I received, to amend my research to allow me to do individual interviews with service providers. The challenges I faced in the recruitment of service providers clearly means that being an insider does not always guarantee easier recruitment of research participants.

Data Collection

In total, 22 participants were interviewed individually: 16 women refugee claimants and 6 service providers. Several interviews were done in the presence of children. In one case, there were three children present, a 3-year-old and 1-year-old twins. When I walked into the apartment the twins were getting up from a nap. In the midst of the interview they started crying for their mother. I stopped the interview while she took care of them. In other interviews which I conducted on a weekend, I interviewed 6 women who had young children born in Canada.

When the question of immigration status came up in an interview, I sensed some hesitation with some of my participants when they were asked about their immigration status. One woman did not disclose her immigration status during the interview. I phoned her later and asked if she was willing to answer some questions she did not answer during the interview. When I asked about her immigration status, she said she is uncomfortable sharing her immigration status with people she does not know, or she is not familiar with. After I explained that the information would be kept confidential, she revealed that her refugee claim had not been accepted by the IRB during her hearing, but she was appealing.

My initial research plan was to conduct in-depth interviews with (a) women refugees, (b) women refugee claimants, and (c) focus group interviews with service providers (see Appendix A, Recruitment Flyer for Women Refugees and Women Refugee Claimants, and Appendix B, First Service Providers' Recruitment Flyer: Focus Group). But as Mason (1996) points out, qualitative research is characteristically exploratory, fluid, data driven, and context sensitive. Flexibility and the sequential nature of research design are important features of qualitative research. Over the course of several meetings and email communications asking service providers in a community health center to participate in the focus group interview, I realized they were not interested, so I opted for individual interviews. Because the research project had already been granted ethical approval by York University Research Ethics Board (see Appendix C, York University Ethics Approval: December 5, 2016, and Appendix D, York University Ethics Amendment Approval: May 1, 2017). Before the onset of data collection, further amendments were proposed and approved by the York University Research Ethics Board to incorporate into

the interview protocol (see Appendix E, Second Service Providers' Recruitment Flyer: One-Hour Individual Interview After Amendment Approval).

The triangulation of data sources, which are the interviews with women refugee claimants and service providers added to the study rigor and trustworthiness. In fact, comparisons between service provider interviews and those of my participants added richness and depth to the data. This also helped me to see data gaps and make necessary changes in research design or sampling techniques in order to enrich the data. From a methodological perspective, the data collected from the service providers and my participants seemed ontologically consistent due to their similarity and the complementary assumptions about the nature of social entities made by the women and the service providers. From an epistemological point of view, interviews with my participants brought the voices of women disadvantaged by their social locations and class into the study. Spivak (1998) and Anderson (2000) suggested the need to give voices to those who have been silenced, and especially racialized women who are excluded in mainstream health research. I recruited research participants from two community health centers, and two shelters that provide housing to refugees and refugee claimants.

Method of Data Collection

Sampling and Procedure

Qualitative research is about depth, context, and process rather than quantity. Therefore, snowball sampling in combination with purposive sampling was used in the research to recruit service providers and a heterogeneous and diverse group of women refugee claimants who had some common experiences. I started with purposive sampling by identifying service providers

working in community health centers that provide health care services to women refugees and refugee claimants in the city of Toronto. I also contacted service providers working in settlement services for refugees and immigrants. After identifying appropriate service providers, I sent each a letter requesting their assistance with the recruitment of study participants (see Appendix F, Letter to Service Providers).

I followed this with several meetings with service providers in two community health centres and three shelters that provide housing and settlement services to refugees and the homeless population to start recruitment in January 2017. At the first meetings, I presented the study and explained the criteria for selecting the study participants. I also requested their assistance in recruiting the study participants based on the criteria: (a) women refugees and refugee claimants of childbearing age, that is, between 21 and 45 years of age; (b) residents of Toronto; (c) pregnant or not pregnant; (d) of all marital statuses; and (e) able to speak and understand English. It was hoped that these criteria would help to develop a deeper understanding of the intersection of race, gender and culture with other dynamics of social and immigration processes while resisting the homogenization of my study participants. I gave the service providers flyers to hand out to women who might be interested in participating in the study and to post on the bulletin board in common spaces in the health centres and the shelters. I also asked them to provide me with contact information of interested women who gave permission for this.

The first two meetings that took place in January were not successful as I did not receive referrals of potential research participants. I contacted the same service providers I had met in

January and asked to meet again in February 2017 to review the recruitment strategies. During this meeting, I was advised to provide interested participants with an honorarium for participating in the study. I was also asked to present the study in two resident meetings in one shelter that provides housing to refugees and refugee claimants. As a result, I made changes in the flyer and included an honorarium of a \$25 grocery gift card and two TTC (Toronto Transit Commission) tokens (i.e., subway tokens) to be provided to the research participants. These changes generated interest in the study; in a few weeks, I received phone calls from service providers regarding women refugee claimants interested in participating.

Starting with the recruitment of service providers was significant because they have established relationships with their clients (women refugee claimants). I also think this was an appropriate path by which to reach out to my research participants because it helped them to view me as someone who they could trust. Disclosing personal information, particularly immigration status, requires being able to trust that confidentiality will be maintained.

Posters were also posted in public places such as community centres and churches in order to reach out to women who were not connected with community health centres or using settlement services. The flyers asked interested women refugees and refugee claimants to contact the researcher by phone or email. Additionally, snowball-sampling techniques were used to recruit participants. This process is congruent with the third-party recruitment process as participants were not asked for the contact information of other potential participants, instead they were asked to spread the word about the study to their contacts and provide potential subjects with flyers with the researcher's contact information.

Study Participants: Women Refugee Claimants

Sixteen women refugee claimants were recruited. The first 3 participants were referred by a service provider working in a settlement agency. Later these 3 women referred friends to participate in the study. There were no responses from the posters posted in public places; the majority of the participants were recruited through the snowball method. All the interviews took place March to July 2017 (see Appendix G, Interview Questions for Women Refugee Claimants).

When I was contacted by a potential participant, I conducted pre-screening interviews on the phone to ensure her eligibility to participate in the study. For example, when the first 3 women I eventually interviewed contacted me regarding their interest. I confirmed they met the criteria for the study through pre-screening interviews. I arranged for the interview appointments with each one based on her availability. I met with each one of them individually for the interview and began by completing the consent form. I found completing the consent form the same day was helpful because I was able to explain the content to each participant to ensure they understood the implications of their participation in the study. All my refugee claimant study participants completed the demographic information in the interview guide followed by the other questions. The interviews took from 1.0 hour to 2.5 hours. After completing each interview, I had a 30-minute break to write my reflective notes before the next interview.

Four interviews were conducted with refugee claimants who had lived in Canada between 2 to 6 months. These participants were referred by service providers from the two shelters I had approached for help with recruitment. I had an informal conversation on the phone before the

interviews with the service provider regarding their eligibility to participate in the study. I then contacted them by phone for pre-screening interviews. I conducted all four interviews at the park that was close to the shelter on two different days because the women stated they were not comfortable at the shelter because of lack of privacy. When I asked the demographic question about the length of stay in Canada, I learned that they had lived in Canada for a few months. I decided to continue with the interview because we had already agreed that they would be participating. As I was conducting the interviews, 2 participants' responses to the questions were very brief. For example, in response to some questions the response was a "no" or "I do not know" without further elaboration. When probed they stated that it was difficult to obtain health care services because they did not have their acknowledgment letter from IRB where they can identify as refugees. Service providers also mentioned that it was challenging for refugees without an acknowledgement letter or identity document to access health care services. However, all the women had been referred to community health centers and were waiting for their first appointment with a health care provider. After completing the interviews, I reflected on whether to keep or cancel the two interviews since the information they provided was very brief. I consulted with my supervisor, who advised me that I could either follow up with the women for a second interview in the fall of 2017 or cancel the interviews and replace them with two new interviews. I decided to keep the interviews since they added richness to the data that I collected. These interviews are good examples of the barriers refugee claimants experienced in health care access while waiting for IRB determination for their claims. I contacted the participants in the summer of 2017 and asked about their availability for a second interview in the fall. They stated they would not be available since they were moving out of the shelter in the summer. I followed

up with the service providers and requested for assistance to recruit 2 more participants to add more richness to the data that I had collected.

The demographic characteristics of the refugee claimant participants are shown in Table 5: (a) ages, (b) socioeconomic status, (c) country of origin, (d) education, (e) immigration status, (f) living arrangement, (g) length of stay in Canada, and (h) number of children.

Table 5***Demographic Characteristics of the Study's Women Refugee Participants***

Participant's study number	Age group	Socio economic status	Country of origin	Education	Immigration status	Living arrangement	Length of stay in Canada (months)	Children Total # # Abroad # Canadian-born
R1	26–30	Social assistance	Nigeria	Post secondary	Appealing	Refugee shelter	7–12	Total: 1 Abroad: 0 Canadian: 1
R2	26–30	Social assistance	Nigeria	Post secondary	Refugee claimant	Refugee shelter	13–18	Total: 1 Abroad: 0 Canadian: 1
R3	26–30	Social assistance	Nigeria	High school	Refugee claimant	Refugee shelter	7–12	Total: 3 Abroad: 1 Canadian: 2
R4	36–40	Social assistance	Nigeria	High school	Refugee claimant	Refugee shelter	7–12	Total: 1 Abroad: 1 Canadian: 0
R5	31–35	Social assistance	Uganda	Post secondary	Refugee claimant	Refugee shelter	7–12	Total: 2 Abroad: 2 Canadian: 0

Participant's study number	Age group	Socio economic status	Country of origin	Education	Immigration status	Living arrangement	Length of stay in Canada (months)	Children Total # # Abroad # Canadian-born
R6	31–35	Social assistance	Cameroon	Elementary school	Appealing	Refugee shelter	19–24	Total: 3 Abroad: 2 Canadian: 1
R7	21–25	Social assistance	St. Vincent	High school	Appealing	Refugee shelter	25 +	Total: 1 Abroad: 0 Canadian: 1
R8	26–30	Social assistance	Uganda	Post secondary	Refugee claimant	Refugee shelter	0–6	Total: 0 Abroad: 0 Canadian: 0
R9	21–25	Social assistance	Nigeria	High school	Refugee claimant	Refugee shelter	7–12	Total: 1 Abroad: 0 Canadian: 1
R10	36–40	Social assistance	Nigeria	Post secondary	Refugee claimant	Homeless shelter	0–6	Total: 0 Abroad: 0 Canadian: 0
R11	26–30	No income	Nigeria	High school	Refugee claimant	Homeless shelter	0–6	Total: 0 Abroad: 0 Canadian: 0

Participant's study number	Age group	Socio economic status	Country of origin	Education	Immigration status	Living arrangement	Length of stay in Canada (months)	Children Total # # Abroad # Canadian-born
R12	26–30	No income	Nigeria	Post secondary	Refugee claimant	Homeless shelter	0–6	Total: 0 Abroad: 0 Canadian: 0
R13	41–45	\$35,000 (husband's income)	Antigua	Post secondary	Appealing	Lived in the community	19–24	Total: 4 Abroad: 3 Canadian: 1
R14	51–55	Social assistance	Zambia	High school	Refugee claimant	Homeless shelter	25 +	Total: 4 Abroad: 4 Canadian: 0
R15	41–45	Social assistance	Nigeria	Post secondary	Refugee claimant	Refugee shelter	13–18	Total: 3 Abroad: 3 Canadian: 0
R16	31–35	Dependent on partner's income	Nigeria	High school	Appealing	Lived in the community	25 +	Total: 2 Abroad: 1 Canadian: 1

To elaborate on the information in Table 5, I discuss each of the demographic characteristics in the order in which they are presented in the table.

Age group

Six of the women were between 26 and 30 years of age, which is considered the reproductive age for most women (Liu & Case, 2011). Two women were under 25 years of age, which is sometimes viewed as an early age for childbearing. One participant was between 51 and 55 years of age, although the study recruitment flyer asked for women refugees or refugee claimants between 21 and 45 years old. I decided to include this older participant because Pap-smear screening (cervical cancer screening) begins at 21 years of age and continues to age 70 for women who are or have been sexually active (Cancer Care Ontario, 2017b), and she was in this age category. Her contribution in the interview enriched the data because of her experiences with cervical cancer screening services in her country of origin and in Canada.

Socioeconomic status

Twelve women were receiving social assistance or financial support from Ontario Works. Although a separate question was not asked, 3 women on social assistance stated their income was just enough to meet their basic needs. Another 4 participants reported their income was not enough to meet basic needs. For example, 1 woman with young children living in a refugee shelter transitional housing said, “I can say the money I am getting is not enough to buy food and diapers.” Two women were depending on their spouses’ income; however, 1 stated she did not know her spouse’s annual income. Two other participants

reported zero income because they were newly arrived refugee claimants and they had not completed filing their claims.

Although the women did not assign themselves to any class, I assumed that all the women were living in the lowest income class based on their income. This is not surprising, considering that many of these women had recently arrived in Canada, they were processing their refugee claims, and therefore they were not eligible to work. Most of the women had arrived in Canada with children without their partners or husbands, with the exception of 2 women whose husbands had joined them a few months after their arrival in Canada. Some of these women might encounter challenges working outside their home and raising young children alone.

Country of origin

The majority of the women in the sample (10) were from Nigeria, which is reflective of the country of origin with the highest number of African refugee claimants in Canada (IRB, 2017b). Two were from Uganda, 1 from Cameroon, 1 from St. Vincent, and 1 from Antigua, and 1 from Zambia. Although women from Nigeria were over-represented in my study sample, the data analysis does not reflect the experiences of the diversity of African women refugee claimants. However, it is possible the voices of Nigerian women might have influenced my analysis.

Education

There was a good mix of education levels in the sample. There were 8 women with postsecondary education: 5 were from Nigeria, 2 from Uganda, and 1 from Antigua. The

other 8 women did not have post-secondary education; however, 7 of them had completed high school, and 1 had completed elementary school. All the women had completed their education in their countries of origin. At the time of the interview, the woman with elementary education was attending the adult high school to complete the Canadian high school diploma. These women's level of education and fluency in English made it easier for them to participate in the interviews and have their voices included in this study. Women disadvantaged by limitations in English are generally excluded from mainstream health research. Marshall and While (1994) pointed out that participants with significant English language difficulties have been traditionally excluded from research studies due to language barriers. Therefore, it is important that future research on this topic include women refugee claimants with limited English. They could make a unique contribution to research, since their needs, views, and perceptions are likely to be different from others given the language barrier.

Immigration status

At the time of the interviews 11 women study participants were still processing their refugee claims. The other 5 women had been turned down in their refugee claims hearings with the IRB and were appealing. The women were also asked to self-identify. Interestingly, 15 women identified as refugee claimants, and 1 woman (R13) identified herself as a “woman of color.”

Living arrangement

Ten women lived in a refugee shelter, 4 women lived in a homeless shelter, and two women lived in the community. Three of the women living in the homeless shelters had no children, and 1 of the women had four children, all living abroad.

Length of stay in Canada

Almost a third of the women (5) had been in Canada for 7 to 12 months, while 4 had only been in Canada for 0 to 6 months. Only 3 of participants had been in Canada over 25 months. The women's length of stay in Canada affected their contribution in the interviews. For example, women who had been in Canada longer contributed more because of their greater experience with the Canadian health care system. Women with the shortest stay lacked experience with the health care system.

Children

Eight of the women in the study had Canadian-born children between 6 months and 2 years old; 1 of these women was pregnant with her second child. Four women reported they did not have any children. Four women had children back in their countries of origin living with their spouse and/or relatives. The recruitment message asked for women refugees and refugee claimants to participate in the current study to share their experiences accessing prenatal and postnatal care and cervical cancer screening. The women who had Canadian-born children had participated in both prenatal and postnatal care and cervical cancer screening. The pregnant woman shared her experiences by answering questions related to prenatal care and cervical cancer screening. The women, who did not have Canadian-born

children, participated in the study by answering questions related to cervical cancer screening in Canada.

Study Participants: Service Providers

The service providers interviewed were selected because they had front-line professional experience working with women refugees and refugee claimants. Once they confirmed their participation, I sent the consent form and the demographic interview guide and asked them to read and sign the consent form before the interview (see Appendix H, Interview Questions for Service Providers). I also asked them to provide the personal and demographic information asked for in the interview guide. The service providers who participated in the study were: 2 nurses, 3 social workers, and 1 administrative assistant for the prenatal and postnatal group in a community health centre. All the providers were female. They had between 2 and 18 years of professional experience working with refugee populations. Two spoke a second language and the others spoke only English. Table 6 shows the demographic characteristics of the service providers.

Table 6

Demographic Characteristics of the Study’s Service Providers

Number of Interviews	Professional Background	Number of Years of Experience	Type of Organization
1	SP1: Nurse	8	Community Health Center
1	SP2: Nurse	7	Community Health Center
1	SP3: Social Worker	18	Settlement Agency
1	SP4: Social Worker	2	Settlement Agency

Number of Interviews	Professional Background	Number of Years of Experience	Type of Organization
1	SP5: Administrative Assistant	5	Community Health Center
1	SP6: Social Worker	6	Community Health Center

All the service providers shared their personal experiences and valuable insights about women refugee claimants’ experiences with the Canadian health care system. As an immigrant and former service provider, I occasionally shared my personal experience with the participants, which I believe enriched the quality of data. In all cases, the participant and I (the researcher) dialogued and negotiated to co-construct the data.

In-Depth Interviews

In-depth interviewing is a widely used qualitative research method. Feminist in-depth interviewing especially recognizes the interactive nature of the researcher–respondent relationship (Oakley, 1981). Unlike mainstream interviews, feminists usually try to establish a subjective relationship rather than an “objective” or distant relationship with their interviewees. In other words, feminist interviews are guided by the feminist ethics of commitment and egalitarianism, which is in contrast with the scientific ethic of detachment and role differentiation between researcher and subject (Reinharz, 1992). Fontana and Frey (2005) described the in-depth interview as an active and emergent process that produces a negotiated text in which the meaning is created at the intersection of the interactions between the interviewer and the interviewee and is shaped by the context in which the interview takes place. Thus feminists, especially those influenced by social constructionism, not only

recognize research participants as subjective beings with agency, but also take into account how the power relations between researcher and participants stemming from their different social locations shape the production, analysis, and interpretation of the interview transcripts.

I used a feminist in-depth interviewing method enriched by some techniques of ethnographic and collaborative interviewing processes. As Sherman (2001) succinctly pointed out, the usefulness of ethnographic interviewing is that it facilitates the gathering of rich, detailed data directly from participants in the social world under study with recognition of the complexity of human experience. Sherman (2001) noted that feminist scholars view “ethnographic interviewing as a *conversation* [my italics], and as such many of them focus on the *talk* [my italics] going on in the interview and how it is shaped by both parties” (p. 374). The researcher and interviewee engage in a *talk* to locate a collaborative basis on which to develop their question-and-response sequence and the construction of meaning. Mutual exchange and dialogue instead of interrogation are at the heart of the collaborative approach to interviewing (Ellis & Berger, 2003). Through the use of this interview technique, the researcher attempts to close the hierarchical gap between herself and the respondent as much as possible (Oakley, 1981). Collaborative interviewing is mostly used to generate stories for narrative analysis. Ellis and Berger (2003) wrote, “The respondents become narrators who improvise stories in response to the questions, probes and personal stories of the interviewers” (p. 160). Sherman (2001) insisted that interview projects based on single short interviews do not constitute ethnographic interviewing. Although I was seeking neither an ethnography nor a collaborative narrative, I tried to follow the conversational and collaborative techniques and styles of interviewing. I did not want to just collect information

from women and service providers, but I tried to encourage them to tell their stories, which often involved sharing my own experiences, especially of migration and health care issues, such as pregnancy and childbirth.

The interview was designed with semi-structured and mostly open-ended questions for generating ideas and understanding women refugees' and refugee claimants' social reality from their own words and from service providers' perspectives. Interview questions were developed under three broad themes related to prenatal and postnatal care and cervical cancer screening: health care access, use or lack of use of these services, and immigration. All the research participants were asked the same questions although they were not always asked in the same order or with the same emphasis. In other words, the focus of the interview varied according to the participants' interests, period in their lives, and professional backgrounds. For example, women with young children born in Canada or pregnant women had a lot to say about their prenatal and postnatal care, and cervical cancer screening, whereas women who did not have Canadian-born children only answered questions related to cervical cancer screening. The health care providers I interviewed were very well informed about the lives of the study participants. They provided detailed information in response to the questions for all three themes. This flexibility and open-endedness, is an important aspect of feminist ethnographic interviewing, and was useful for me to address and also allowed me to capture, the diverse experiences and social realities of the study participants.

Feminist researchers try to avoid harm and exploitation of the research participants by building trust and empathy through identification or self-disclosure. My African ethnicity and cultural orientation, personal experience of working with women refugee claimants in health

care settings, parenting and family backgrounds were helpful for building rapport and gaining trust with participants. All the interviews were conducted at a place of the participant's choice. I was always welcomed by service providers and the women at the shelter, transitional housing, and community health centers where I conducted most of the interviews. This was convenient for me because I needed space to sit, put the audio recorder, and write my notes. I think this also helped to downplay my power as the researcher. I always addressed the women and the service providers by their first name and greeted them with due respect. This helped me to establish myself as an insider.

Although some women seemed to open up their hearts and share their experiences, stories and opinions, others seemed to be more reserved and cautious in expressing themselves. Some women seemed to be rather quiet, afraid or shy and provided simple or brief answers, such as “yes” or “no,” and sometimes just nodded. In some cases, women who had not established a relationship with the Canadian health care system appeared reserved and often did not have much information to contribute during the interview. In other words, while some women were telling their stories in their own voices, some were merely answering my questions. In the latter case, the interviews felt like an interrogation rather than a collaborative process. Thus, the quality of the conversation was affected by the women's different personalities, experience with the Canadian health care system, storytelling, and different levels of trust and comfort with my personality and social location.

The service provider interviews provided detailed information according to their professional background and experiences working with women refugee claimants. For example, service providers in the medical professions focused on the medical care they

provide to this group of women. Whereas service providers working in settlement areas were more focused on providing health care information, immigration, social support, and other resources that support these women in their settlement process. Although the majority of interviews were conducted in person, two interviews with service providers were conducted on the phone late in the evening due to time constraints. As suggested by Sturges and Hanrahan (2004), telephone interviewing may provide an “opportunity to obtain data from potential participants who are difficult to access in person” (p. 109). Although my intention was to conduct face-to-face, collaborative interviews with all the research participants, I had to be flexible to accommodate these 2 service providers.

Ethical Considerations

Feminist researchers are concerned not only with ontological and epistemological positions but also the ethical implications of a research project. A feminist ethical framework is one of the distinguishing features of feminist research wherein the well-being of participants is an ethical priority to which needs of the researchers, their institutions, and profession must be subordinated (Kirsch, 1999). Participants are never to be forced in any direct or indirect ways and are required to give informed consent to their involvement in research. Therefore, a consent form for all the research participants was prepared in English language outlining the purpose and procedures of the research in hand (see Appendix I, Informed Consent Letter for Service Providers: Focus Group, Appendix J: Second Informed Consent Letter for Service Providers: Individual Interviews, and Appendix K, Informed Consent Letter for Women Refugee Claimants). Participants were offered the option to

refuse to participate or answer any specific questions during the interview, or to withdraw at any time with no consequences. The form was attached to the flyer provided to the recruiting agencies so that it would be available for clients and service providers to look at and read at the agency bulletin board or in common spaces where it was posted. Often, I left copies of the recruitment flyer with women already interviewed to distribute to their friends.

Otherwise, the objectives and procedures, especially the required time and options, were explained over the phone before the face-to-face or phone interview with the participants. All the service providers also asked for the interview question guide before the interview. I emailed it to them and explained the interview protocol. Before starting the interview, I made sure participants understood and signed the consent form. I reviewed the information in the form verbally with all the study participants. The conversation was audio taped with participants' permission; 4 women refused to be taped. Women who refused to be taped were given the choice to ask me to stop taking notes at any point in the conversation if they felt the need. I also checked if the women had any questions about any aspect of the research. A few women apparently used a pseudonym to sign the consent form.

To ensure confidentiality and protection of identity, all the participants were assigned an alpha-numeric identifier (R1 for the first interview with women refugee claimant and SP1 for service provider first interview). All other identifying information was removed from the written reports. Descriptive and demographic data such as age, education, or income were included in reports when they were deemed relevant and important to the presentation of data, or necessary for contextualizing certain findings within the participants' socioeconomic group. Special care was given to leave out those details that might cause a particular

participant to be identified within the refugee and service provider communities where people tend to know each other well. Information about specific life circumstances that might allow the women refugee claimants to be identified by service providers were not revealed either. Confidentiality was further maintained through careful handling of data. All interviews were transcribed by the researcher. Additionally, hard copies of data were stored in a locked cabinet by the researcher. Electronic copies were saved in a personal computer protected with a password only accessible to the researcher.

Participants were also asked if they wanted to see their interview transcripts. Most women were not interested while a few suggested they should be contacted when the final report is written. The service providers requested a formal presentation of the research report upon completion. Participants (women refugee claimants) received a \$25 gift card and two TTC (Toronto Transit Commission) tokens (i.e., subway tokens) for travel in appreciation of their time and assistance with the study. The anticipated risks of taking part in this study were minimal, but included distress arising from talking about the refugee process and settlement challenges or access to prenatal and postnatal care and cervical cancer screening. Two women started crying during the interview while talking about their refugee hearing, but at the same time appreciated being able to share their experiences and feelings. They also made some strong recommendations to improve the health care system for women refugee claimants and wanted their voices to be heard by the Canadian government and policy makers. Most of the women who did not have any knowledge and information about cancer screening appreciated the opportunity to learn about the issue through the interview process. I had some pamphlets from community health centres that provided health care services for all

women, including refugees and immigrant women, who needed and wanted to learn more about reproductive health or health care services, and I distributed them to my refugee claimant participants.

Data Analysis

Data analysis refers to the process through which data might be turned into evidence that can be used to support conclusions or arguments, and explanations or interpretations (Mason, 1996). As data cannot just make sense by themselves they need to be organized, analyzed and interpreted in light of the research questions as well as the theoretical and methodological perspectives. Information gathered through in-depth interview questions formulated to answer the research questions constituted the basic data for the project at hand. Data analysis was continuous, flexible, and often concurrent with data collection. The analysis began with the reframing of research questions as well as the interview layout, selection of methodological and theoretical approaches (i.e., before the data collection) and continued through collection, transcription, reorganization, and representation of data. While the pre-data collection process influenced the nature of data collected, early analysis of the data facilitated “generating strategies for collecting new, often better, data” to fill in the gaps (Miles & Huberman 1994, p. 50).

Coding or sorting, combining and differentiating data among different but interrelated categories is not just a technical task, but also constitutes an important part of the analysis. As Mason (1996) put it, “cataloguing and indexing systems are not analytically neutral” (p. 148). She also suggested that codes should be loose and flexible groupings rather than

concrete, uniform, and static categories. The coding categories in the present study were initially constructed in the light of the research questions and the interview guides and in relation to pertinent literature and overall theoretical and methodological perspectives. But they were mainly drawn inductively from the data and then revised and grounded in the data through iterant and reflexive readings. Reflexive reading is reading through or beyond the data to make inferences, not only from what the text actually contains but its implications and what is not literally present in the text (Mason, 1996). This reflexive reading demanded my paying attention to contextual information and the participants' implicit norms or rules or discourses by which they are influenced. Such reading also involves thinking about the process of data production, locating the researcher as part of the data generated, and exploring the roles and perspectives of the researcher in the process of interpretation of data. The researcher is inevitably and inextricably implicated in the data generation, categorization, and interpretation process. Although many qualitative researchers, as Sipe and Ghiso (2004) noted, obscure their own involvement in the creation of conceptual categories, Sipe and Ghiso insisted, "we don't discover conceptual categories in our data; we build them" (p. 474). These authors suggested that we must be clear that category building involves our subjectivities and therefore reflexive explanations are demanded throughout the process of coding and analysis of data.

A preliminary list of codes was constructed while the interviews were being transcribed. Then the interview scripts, demographic profiles of the participants, and my reflexive field notes were entered for coding into NVivo11 software for analyzing qualitative data. Because of the small sample size in my study, I chose to present this data in MS Word

tables rather than in NVivo charts. The NVivo software is a helpful tool for organizing and categorizing data and managing the coded segments so they could be easily retrieved, compared, and contrasted for analysis. This also facilitated moving back and forth between the research questions, theoretical approaches, and the different kinds of data so that coding categories and coded segments of data could be revised, reorganized, and reinterpreted through this interactive process (Mason, 2002). The initial categories were mostly descriptive of the women's experiences of access to prenatal and postnatal care and cervical cancer screening. But a deeper level of analysis demanded more interpretation of data, and accordingly, reorganizing, polishing and linking of the codes and coded data segments to reveal patterns, themes, and explanatory links (Miles & Huberman, 1994). In generating the themes, consideration was given to both similarities and differences among the participants' experiences, both refugees and service providers. Some of the codes and coded data had more theoretical resonances as they were linked with theories and literature that helped explain the ways the multiple and intersecting systems and structures shape women refugee claimants' access, understanding, and use of prenatal and postnatal care and cervical cancer screening in the Canadian healthcare system.

Intersectionality theory along with feminist antiracist critiques of women's health and health inequities provided the needed lens for viewing the intersections of gender, race, class, age, immigration status and other structures of inequity in the everyday lives of women refugee claimants. The intersectionality lens was helpful for linking the women's accounts of subjective experiences to the larger discourses and systemic processes in Canada, such as the social, economic, historical, and political processes in which their experiences were

embedded (Bannerji, 2004; Man, 2002). As suggested by Cuadraz and Uttal (1999), in order to analyze the intersectionality of both the social structures (macro processes) and individual experiences (micro level) of race, class, gender, and immigration status, the data or participants' narratives needed to be read to identify:

- **Individual locations:** how the individuals understand their experiences and explain their situations.
- **Social locations:** how histories of race, class, and gender stratification (and other structural forms of domination) have shaped contemporary social locations for the social group the individual represents.

Cuadraz and Uttal (1999) pointed out that from the perspective of the intersections of race, class and gender, to simply present the voices of those studied is not enough. The voices and individual accounts must be contextually located in history, place, and structured social locations, and further synthesized with knowledge from historical and structural analyses. Historical information, findings from previous studies, and theoretical statements about social categories and power relations can be helpful in analyzing the data. Furthermore, as Bishwakarma, Hunt, and Zajicek (2007, p. 9, as cited in Hankivsky & Cormier, 2009, p. 32) remarked, intersectionality as a method of analysis attempts to deal with “the way the specific acts and policies address the inequities experienced by various groups.” Thus, the participants' experiences were linked to or situated within historical as well as current contexts of the Interim Federal Health Program (IFHP) and Canadian guidelines that govern the provision of reproductive health care to Canadians, including refugees, to understand the effects on women refugee claimants' access to prenatal and postnatal care, and cervical

cancer screening services. Such an approach was useful for addressing how the broader systems and structures shape women refugee claimants' access to and experiences with prenatal and postnatal care and cervical cancer screening services in Canada.

Representing the Voices of Women Refugee Claimants

Critical feminist researchers have extensively debated on whether and how to make truth claims about a reality that is viewed as a social construction (Fonow & Cook, 2005). While historical realism holds the view that knowledge of social reality is produced in particular social, historical, political, and intellectual conditions, social constructionism believes in multiple interpretations or the validity of more than one perspective or argument about realities. As my research design has been shaped by the ontological and epistemological positions of historical realism and social constructionism, and by a subjective rather than objective point of view, I acknowledge that the findings of the current research are incomplete, partial, and situated within the research relationships and processes. However, feminist methodology involves explaining and justifying the design and techniques used in feminist research; therefore, feminist researchers need to stand behind their use of particular methods and techniques in order to claim credibility or rigor for the data produced and interpreted through the research. This is also important because qualitative research is in many ways a marginalized methodological discourse, and researchers cannot escape addressing their position in relation to quantitative and positivist methodologies and traditions (Edwards & Ribbens, 1998). Sandelowski (1993), for example, posited that rigor or credibility in qualitative research:

is less a matter of claiming to be right based on rules assumed to be sufficiently abstract and universal for every project, it is a matter of having practiced good science or logic relying on contextually ground linguistic and interpretive practices. (p. 2)

It does not reflect the subjective or objective stance of the researcher, rather it indicates the soundness or accuracy of the data or research findings themselves.

Reflexivity, the practice of exposing the researcher's positionality and the part played by the researcher in constructing the data, is a common feminist approach to negotiations over certain knowledge claims (Dyck & McLaren, 2004; Ramazanoglu & Holland, 2002). Reflexive research practice involves critically situating oneself as a researcher within the process of knowledge production through disclosing the subject's positions, histories, influence, beliefs, and morals, and being self-critical, thoughtful, and sensitive in all interactions with participants and in representing their lives. It also means that instead of hiding the moments of discomfort and dilemmas in our research, feminist researchers should disclose these dilemmas through sharing and exchanging information and experiences about how they make decisions, and about what they have learned during the research process (Kirsch, 1999). I have adhered to this feminist practice by documenting reflexive accounts of my social locations with a special focus on my varying degrees of insider/outsider status in the refugees' community, and also through revealing my personal, intellectual, and political interests in the research topic. I have also reported the methodological challenges and dilemmas I faced in doing the research and the strategies adopted to overcome or address those as well as the limitations of the study. Furthermore, Sandelowski (1986) has suggested that *achieving auditability* is an important strategy for achieving rigor or confirmability of

qualitative research. This simply means “describing and justifying what was actually done and why” (Sandelowski, 1986, p. 34) so that any reader can follow the progression of events and the logic behind those events in the study. In this research, auditability was ensured through incorporating and demonstrating in the research report how I became interested in the subject matter of the study, how I viewed the matters studied, the specific purpose of the study, how the participants came to be included in the study, and how they were approached, the impact the participants and I had on each other, how the data were collected, how the data were reduced or transformed for analysis, interpretation, and presentation. I followed many of the approaches offered by Sandelowski.

However, I shared the concern raised by Kirsch (1999), “can researchers understand and represent the experiences of others without misrepresenting, misappropriating, or distorting their realities?” (p. 10) because I maintained the sole power of representation by being primarily in charge of mapping the research design and analyses as well as writing my thesis. My analyses have been shaped by my personal and social locations, the research objectives and questions, my experience working with women refugee claimants as well as relevant theories and literature. But I have endeavored to bring the women’s and service providers’ experiences to the centre of analysis and to ground the analyses on their diverse perspectives and voices. I have also tried to present the diverse perspectives, experiences, and voices of the research participants by maximizing the use of examples, quotations, and excerpts from their narratives in the thesis. I made efforts to include all the participants’ voices, but some are quoted more frequently than others. The voices of those who articulated their experiences most compellingly have been overly represented. Instead of presenting

verbatim quotes of the women's voices, interview excerpts were edited for clarity, coherence, and grammatical correctness where necessary. This was not to speak on behalf of the participants, but in consideration of the effects of research on women refugee claimants, public discourse, and policy makers (Kirsch, 1999), and particularly to resist the dominant perception of the study participants as ignorant or weak in spoken English. Also, to avoid essentializing and homogenizing the research participants' experiences in the study, I sought to identify differences in their experiences as well as to understand whether and how those experiences were influenced by diverse social locations. But at the same time, it was necessary to emphasize the shared experience of women refugee claimants of being the "other" while simultaneously recognizing their varied levels of agency and resistance.

Frith and Kitzinger (1998) insisted that qualitative data, or "talk-in-interaction," (p. 301) is constructed in relation with other researchers as well as other participants in a group, and therefore, any claims about the meaning of what participants say should be made carefully with a recognition of the specific social interactive context in which data are produced. Frith and Kitzinger also cautioned that no data is produced in a neutral and disinterested way by research participants, rather participants pay attention and adjust to the questions, concerns, assumptions, interpretations, and judgements of others in producing their talk. In recognition of this, I have taken special care throughout the analyses, interpretation, and presentation to contextualize individual interview data in the interaction with the researcher. When citing examples of women's experiences and perspectives, I tried to include as much relevant contextual information as possible.

In the case of analysis and interpretation of research data, feminist researchers, such as Kirsch (1999), suggested collaboration with participants, particularly to avoid myriad ethical problems ranging from disagreement over meaning of data to conflicts in interest, values, and ideology. Kirsch believed that interviewees should be invited to co-interpret data. While obtaining validation from participants themselves through collaboration and member check is an important strategy to gain credibility for qualitative data and interpretation, the present study attempted but received very limited success with this strategy. This strategy can be especially challenging when participants have precarious immigration status, and do not have the time and interest or feminist or critical consciousness to participate in the process of data analysis. When I finished transcribing the interviews, I contacted all the women who participated in the study and asked if they would like to get a copy of their transcript and an opportunity to provide corrections or other feedback. After 1 participant responded, I emailed a copy of her transcript to her. She read the transcript and provided her input. I also emailed transcripts to service providers and asked them to provide their input. I did not receive any service providers' input. None of the participants were asked to collaborate on the analysis of data, or to provide any input or feedback on interpretation of the data because it did not seem feasible given the time and other constraints.

The accuracy or soundness of the interpretation is dependent on the validity or credibility of the data. While all the data were co-constructed through the interactions and negotiation between the participants and me (the researcher), this data generation process was further layered and challenged by some women refugee claimants' short stay in Canada, and their unfamiliarity with the Canadian health care system. I was able to compensate for

these interviews by interviewing more women who were familiar with the Canadian health care system.

CHAPTER 5

WOMEN REFUGEE CLAIMANTS' PARTICIPATION IN REPRODUCTIVE HEALTH CARE

Introduction

The information discussed in this chapter is drawn from the interviews conducted with the study participants. The main purpose of this chapter is to present the participants' narratives, accounts, and stories as these relate to the broad research questions informing the study.

1. How do women refugee claimants engage with pre- and postnatal care and cervical cancer screening?
2. What factors influence these women's use of pre- and postnatal care and cervical cancer screening services?
3. What are these women's experiences with the health care system in general? And how are these experiences informed by their race, gender, class, and immigration status?

This chapter also engenders a discussion on the intersection of influences that appear to have shaped the women's use of these reproductive health care services. The women's varied levels of participation in these reproductive health care services indicated that several interconnected influences and complex, interwoven issues facilitated or hindered their use of pre- and postnatal care and cervical cancer screening. I go into more detail about this in the Discussion section of this chapter. The sections that follow include the themes from the data results: (a) support and access to services, (b) lack of health coverage, (c) immigration status,

(d) living arrangements, (e) discrimination, (f) lack of health knowledge and understanding of pre- and postnatal care and cervical cancer screening, and (g) pain, discomfort, and trauma. I begin answering the first research question in the next section, “Support and Access to Services;” the second question discussion starts on page 132 of this chapter. The third question is answered in the discussion section of Chapter 6.

Support and Access to Services

Support in the form of referral to refugee shelters facilitated refugee claimants’ engagement in pre- and postnatal care and cervical cancer screening. Seven out of the 16 women in the study engaged in pre- and postnatal care and cervical cancer screening because of being referred by immigration officers and other service providers to refugee shelters upon arrival in Canada. Women living in shelters mandated to provide services, for example, housing and settlement to the refugee populations, were more likely to use pre- and postnatal care and cervical cancer screening services than women living in community-based homeless shelters or in the community. During the interviews, I observed that residents of refugee shelters were provided with a wide range of services to support them in their initial settlement in Canada. The two shelters from which I recruited the study participants collaborated with refugee clinics and community health centers that provide health care services to refugees. SP3, who worked in a refugee shelter, remarked: “We have a partnership with the refugee clinic that is based in a hospital in downtown Toronto. A doctor or a nurse practitioner comes 3 days a week to the shelter in-house clinic. It is easily accessible to all our clients living in the shelter.”

Having a clinic in the shelter not only provided for the women's health care needs, it also alleviated other barriers that these women might experience that can ultimately hinder access to health care services. For example, SP4 stated that: "When women access the in-house clinic we are able to break other barriers, such as transportation and having health care providers who understand their migration issues and many other issues." The staff in the shelter facilitated women's access to the in-house clinic by conducting a needs assessment. It is during this appointment that a new client could talk about her pregnancy. Then service providers take the opportunity to tell her about the services available in the shelter and provide a pamphlet with this information. Right at the beginning the women are made aware of the services available to them. If necessary, an appointment is scheduled on the client's behalf with appropriate health care providers in the shelter clinic. Women are also provided with cervical cancer screening information and other services as well as routine care.

Upon moving out of the refugee shelter, women are provided with follow-up support by social workers. This includes access to all the services at the shelter clinic and registration for their babies for 2 years. Those without IFHP or other health coverage are referred to community health centres (CHCs), which provide health care services to "uninsured" patients. In the health care sector, the term "uninsured" refers to anyone ineligible (temporarily or permanently) for provincial or federal health coverage, plus anyone ineligible for health care (Villegas, 2013). Community health centres provide free multidisciplinary services, such as medical care, counseling, diabetes care, and health education, to all Ontario residents without asking about whether or not they have health coverage (Wilson-Mitchell & Rummens, 2013). Some participants described finding out about CHCs through word of

mouth from friends, family members, and service providers. Service providers in CHCs also conduct outreach in the community by participating in health fairs, which are opportunities to educate the community about the services available in CHCs. Clients may also be referred to access care outside the CHC, such as prenatal care with obstetricians or midwives. SP6, who worked in a CHC, mentioned that, “We have shared care with obstetrician and gynecologists with our partner hospitals where we refer clients for follow-up.”

Service providers also encourage women to participate in pre- and postnatal classes, facilitated by health care providers and therapists, which provide information related to their reproductive health needs. For example, service providers, such as public health nurses and community health workers, are invited by the nurse in charge of pre- and postnatal care to provide education about the Canadian health care system and sexual health. Health care providers also recommend that clients take a Pap smear test (screening for cervical cancer) and they set time for this procedure within their schedule. SP2, who works in a CHC, shared: “Pap test is a regular procedure that we all stay on top of, both our nurses and doctors, in terms of scheduling clients in and calling them for their appointments after 3 years.” Many of the study participants who accessed CHCs appeared satisfied with the services and the staff. R16 remarked, “The health care system has been very good to me, to the extent that the CHC paid for a taxi cab to take me to the hospital when I was having contractions at 5 months of my pregnancy.”

However, the services and support provided in refugee shelters are not available to women refugee claimants living in homeless shelters. One participant living in a homeless shelter said: “Some of our friends living in refugee shelters receive more support than we do.

They have access to the shelter clinic and doctors. They also receive TTC tokens for transportation to medical and other appointments outside the shelter.” She and other participants living in homeless shelters felt their needs were not met.

What Factors Influenced Participants’ Use of Pre- and Postnatal Care and Cervical Cancer Screening Services?

The women’s use of pre- and postnatal care and cervical cancer screening services seemed to be influenced by multiple intersecting factors including: (a) whether they had health care coverage, (b) what their living arrangement was, (c) recommendations made by their health care providers, (d) the degree of their health care knowledge, (e) whether or not they had experienced discrimination and language barriers, and (f) whether or not they had suffered any pain, discomfort, or trauma.

For 6 of my refugee claimant participants who did not have the Pap test, the reasons included: (a) they had never been informed about it, (b) it had never been recommended by any of their health care providers, (c) they had a low degree of health care knowledge, (d) they had experienced pain and discomfort related to the procedure, or trauma such as FGM or sexual assault prior to migrating to Canada, or (e) they did not have a primary health care provider to do the test. However, pregnant women without health care coverage did have access to midwifery care, CHCs, and hospitals. One of the most important influences in their access to these health care services was where they lived, that is, refugee shelters or community-based homeless shelters, and, further, the support they received from service providers and friends. For women who had a relationship with a health care provider, that

provider's recommendations also appeared to influence their participation in cervical cancer screening.

Intersecting Influences on Women's Participation in Pre- and Postnatal Care and Cervical Cancer Screening

To answer the second and third questions, several intersecting factors that seemed to shape women refugee claimants' participation in pre- and postnatal care and cervical cancer screening are discussed in the following sections. The participants' narratives showed how complex and entangled the diverse and multiple intersections of the factors shaping their participation in pre- and postnatal care and cervical cancer screening were. These are considered as separate influences for the sake of organization and presentation of the data although the intersections of these issues seemed to present challenges beyond their sum.

Lack of health coverage, immigration status, and living arrangements

Participants who experienced barriers or did not use pre- and postnatal care and cervical cancer screening at all were newly arrived refugee claimants, those who lived in the community, those who lived in community-based homeless shelters, and failed refugee claimants. Despite Canada's claim to provide universal health coverage (Gateri & Richards, 2017; McKeary & Newbold, 2010; Pollock et al., 2012). These authors create an impression that health coverage is available to *all* residents in Canada, when universal health care is only for permanent residents and Canadian citizens.

Refugee claimants' health coverage determines the kind of services these women received from health care providers and hospitals. For example, newly arrived refugee

claimants had difficulty accessing health services because they did not have health care coverage. Refugee claimants request protection by making a refugee claim upon arrival in Canada. To complete this claim, they are required to complete all the application forms, gather relevant documents, and then take this paperwork in person to an IRCC office. Then they attend an eligibility interview with an immigration officer to assess whether or not a refugee claim is eligible for referral to the Refugee Protection Division (RPD) of the Immigration and Refugee Board (Government of Canada, 2017f). This process can take 30 to 45 days or longer, and refugee claimants are without health coverage during this waiting period. As shared by one refugee claimant participant: “We have not gone for our claim hearing then we don’t have status and the refugee identity (ID). We can’t go to the hospital. We have submitted everything; we are waiting for the immigration IRB hearing. It is very serious when you don’t have status if your health condition gets worse.”

It is difficult for newly arrived refugee claimants to access health care while they are waiting to process their claims. Studies in Canada and other countries (Ascoly et al., 2001; Khanlou et al., 2017; McKeary & Newbold, 2010; Merry et al., 2011) indicated that refugee claimants experience barriers with access to health care services due to lack of health coverage. However, refugee claimants living in refugee shelters are referred to CHCs that collaborate with these shelters to provide health care services to their residents. Sometimes CHCs do not have the capacity to meet the increasing health needs of the refugee population, particularly pregnant women. In this situation, CHC health care providers refer pregnant women without health coverage to midwifery services. For instance, R1, a refugee claimant, reported:

I arrived in Canada 8 months pregnant. I was referred to a refugee shelter by immigration officers at the airport. The staff at the shelter booked me to see the in-house doctor, who then referred me for follow-up in a CHC. I was seen at the CHC for 2 weeks and then transferred to the midwifery clinic since I didn't have health coverage. I continued to see the midwife throughout my pregnancy until delivery. The midwife paid all my blood work and ultrasound.

Because midwifery care accommodates pregnant refugee claimants without health coverage, many of these women choose midwifery care because of a need for affordable care, rather than because they want to take control of their birth and experience a normal or less medicalized birth. When I probed R1 on how she made the choice to be cared for by a midwife and deliver at the midwifery birth center, she responded: "I was told by health care providers during my appointments that if I deliver at the hospital I will be billed. I was afraid, for I didn't have money to pay the hospital bills." The emancipatory choice of midwifery care that allows women to give birth with minimal intervention (Bourgeault, 2006; MacDonald & Bourgeault, 2009) was not shared by R1. Her choice of midwifery services was based on her finances, which precluded her being able to receive prenatal care by family physicians or nurse practitioners and deliver in a hospital.

CHCs provide primary health care to refugees without cost; however, services such as prescription medications are not covered by CHCs. In this situation, service providers advocate on behalf of their clients for medication to be prescribed through the CHC. Once the client's IFHP is in place, the CHC is reimbursed. In cases where clients needed emergency services, service providers advocate on their behalf by calling the hospital and negotiating for their emergency visit bill to be covered once the IFHP is issued. Sometimes,

these negotiations fail, and clients are billed for their hospital visits even when service providers have advocated on their behalf. This may disproportionately affect pregnant refugee women who are more likely to need immediate health care services upon arrival in Canada.

Refugee claimants without health coverage are required to pay for health care services when they access hospitals and other services that CHCs do not cover based on a CHCs' budget. For example, pregnant refugee claimants are expected to pay for their hospital stay during delivery. Fees can range from \$1,100 to \$2,500 per night. Two participants, for example, who had been hospitalized when they were pregnant without health care coverage, said that they were asked to sign some papers related to the payment of their fees. When they were discharged from the hospital, bills were mailed to them. Because it can be very costly for this group to access certain care, some pregnant women delay getting the care that they need because of the financial burden involved. For example, 12 of my participants received social assistance from the Ontario government as their sole source of financial support. Service providers working in a CHC shared:

Some women refugees and refugee claimants we serve tend to present late for pregnancy care. We see women coming for care in their third trimester or just about to give birth. This is very difficult for us to get all the blood work and tests done before delivery. It is also difficult to find an obstetrician-gynecologist to see them and hospitals where they will deliver.

Several studies (Ascoly et al., 2001; Gaudion et al., 2006) have also noted that this group of women tends to present late for prenatal care due to their uncertain migration status.

Others (Jarvis et al., 2011) have postulated that presenting late for prenatal care can result in serious health consequences for both the women and their babies. Late presentation means missed screening opportunities, including genetic and ultrasound screening, and missed postnatal group programs for health promotion. R13, for example, described her health condition and delivery without prenatal care:

When I arrived in Canada I lived in the community. I was pregnant and did not access prenatal care. I thought I couldn't because I did not have health care coverage. I went to a program provided by Public Health in the community because I was not feeling well, and I was 34 weeks pregnant. I spoke to the nurse about my condition and she advised me to go to a walk-in clinic. The doctor told me my blood pressure was high, and I should go to the hospital emergency. When I arrived at the hospital, I received diligent care although I had to sign so many papers because I didn't have health coverage. The health care providers were very helpful. They tried to lower my blood pressure, but the solution was to deliver my baby through a C-section.

R13's baby was born at 34 weeks, which is less than a full-term pregnancy. Studies in Canada (Khanlou, Haque, Skinner, Mantini, & Landy, 2017; Wilson-Mitchel & Rummens, 2013) have found that many asylum-seeking women receive less than adequate prenatal care or no prenatal care at all because they do not have health insurance. Inadequate prenatal care can increase the risk of preterm delivery and low birth weight, both of which are factors for neonatal morbidity and mortality (Jarvis et al., 2011).

As discussed earlier, refugee claimants are often referred to midwifery care, which will accommodate late presentations if the women do not have complications with their health or pregnancy. There are also some programs based in hospitals for high-risk

pregnancies that will treat refugee claimants with late presentations without charge because of their risk of complications. Although it can be challenging to coordinate care for refugee claimants, CHC service providers will connect them with their partner health care services so that they are billed at Ontario Health Insurance Plan (OHIP) rates as opposed to the higher rates charged to visitors to the country. This reduces the financial burden on women refugee claimants without health coverage.

Both service providers and refugee participants reported that even when refugee claimants have IFHP health coverage they are not fully covered for their medical services. The Government of Canada (2017d) noted that IFHP provides coverage for services such as medical appointments with health care providers, diagnostic tests, prescription drugs, assistive devices, and medical supplies and equipment. This coverage does not, however, cover the prenatal and postnatal supplements that some refugee claimants may require. Considering that some women arrive in Canada pregnant having had minimal or no prenatal care and inadequate nutrition because of war or internal conflict, they may need these supplements to support their health and that of the growing fetus.

While women refugee claimants living in shelters dedicated to serving this population receive health care support, this is not the case for refugee claimants living in the community or in homeless shelters. Six participants, 1 living in the community and 5 in community-based homeless shelters, were not aware at the time of their arrival in Canada that they could access health care services such as pre- and postnatal care and cervical cancer screening services, as they did not have the support that refugee shelter service providers offered to

women who lived in refugee shelters. Some of the participants acknowledged that they did not access the health care services they needed because they were not aware they could.

My study participants' narratives indicate that women refugee claimants without health coverage and living in the shelters that serve this population were more likely to use pre- and postnatal care and cervical cancer screening than women living in the community or in community-based homeless shelters. Women who were living in the community or in community-based homeless shelters were not given information about accessing public health services and hassle-free clinics that provide health care services to all Ontario residents without questioning whether or not they have health coverage. The refugee claims of 5 of my participants had been denied, 4 lived in refugee shelters, and 1 lived in the community. Although they were appealing their claims, they appeared to be afraid to access health care services because of their immigration status. However, 2 of these participants whose claims had been denied accessed emergency services at the hospitals because of their pregnancies.

Discrimination

When participants were asked if they had experienced unpleasantness or challenges with access to health care or with health care providers, 12 out of 22 participants, 8 women refugee claimants and 4 service providers replied they had experienced or supported friends or clients who had experienced instances of discrimination accessing health care services. The reported incidents were broadly categorized as: staff acting as gatekeepers, refusal of care, IFHP confusion, and language and communication barriers.

Staff as gatekeepers

The current study found that incidents of discrimination are sometimes exacerbated by the administrative staff who act as gatekeepers to the system. Participants who had accessed emergency services at a hospital when pregnant described being asked for their health coverage up front even though they were unwell. They felt that the hospital administrative staff discriminated against them based on their health coverage or ability to pay. Staff were more concerned about whether they had health coverage or were able to make payment than their health. The initial screening question posed by the staff, “Can I have your health card?” determined whether they could see a doctor. Participants felt that the screening process could endanger the life of a pregnant woman or her baby because it delays access to urgent health care services.

Participants also noted other forms of discriminatory treatment by administrative staff. R13, for example, spoke about the discriminatory actions she had experienced accessing care. She stated:

I go to a CHC and sometimes the shouting from the front reception staff is embarrassing. I am constantly asked, “Can I have your health card?” Sometimes, they are very rude, they ask this question at the reception area, and people waiting can hear them shouting at me. It is embarrassing and especially when you have children.

She felt that these incidents also made her children uncomfortable. She further said that she moved here to make a better life for herself and her family, and although she did not have health coverage, she did not deserve to be discriminated against. However, she mentioned

that other health care providers were very accommodating and respectful of her needs. She accessed the services and programs at the CHC, for example counseling and health care, without incident.

Refusal of care

Women who had IFHP or did not have any coverage were dismissed, neglected, and had trouble accessing care. R1 noted:

I have noticed when we refugee women visit the hospital when we are not well, or our babies [are not well], the health care providers dismiss our concerns as if they're not normal. It is as if they wait for our conditions to get worse for treatment to be provided.

When I asked R1 if she had been dismissed by the hospital or by health care providers, she said this had not happened to her; however, her friend, who was also a refugee claimant, was dismissed by a health care provider at the hospital when her baby was sick. My participant had been with her friend when this happened. She shared the incident:

When we arrived at the hospital the nurse assessed the baby and asked my friend to go home and observe the baby for a few days. If he doesn't get well, she should bring him back. My friend was very worried since her baby had been sick for 4 days and she was noticing he was getting worse. She started crying and explained to the nurse her baby's health condition was getting worse. When the healthcare providers saw she was crying, the baby was attended immediately by a nurse and the doctor, and the IV was administered because he was dehydrated.

She thought the initial dismissal occurred because health care providers and/or hospitals do not want to deal with refugees' health coverage.

Service providers working in CHCs reflected on their refugee clients' experiences of discrimination accessing services outside the centres. SP6 said that some refugee claimants had been denied care or neglected because they did not have OHIP. She also felt there was a lack of proper communication between the hospital administrative staff (specifically the uninsured patients' liaison) and CHCs even though CHCs provide letters to all their uninsured and refugee claimant patients to facilitate access to services outside the centre. She articulated other service providers' frustrations: "Even with the letter they have been sent away or pressured to leave the hospital because they did not have OHIP or payment." Sometimes, clients who had unpaid bills were told they could not receive services at the hospital until the bills were paid. But once the social workers were involved, they advocated for clients to sign a payment plan to receive services.

Interestingly, two service providers working in CHCs agreed with SP6, arguing that access to health care for refugee claimants and refugees can be difficult and sometimes confusing. They noted other forms of discrimination against pregnant refugee claimants at the hospital during labor. For example, they stated that there have been occasions when financial staff walked into the labor ward and prevented a client giving birth from receiving the care that she needed because of an unpaid bill. Service provider participants also expressed concern that hospitals were sending clients' bills to collection agencies right away instead of contacting the CHC or other provider to work out a payment plan with the client. Discriminatory actions towards refugee claimants because of their health coverage was

viewed by the service providers in the study as a major obstacle to health care access outside the CHCs, which sometimes compromised the women's health.

IFHP confusion

With respect to IFHP, service provider participants argued that there have been so many changes to the program, that hospitals may be confused about what should be charged to whom. Sometimes refugee claimants with health coverage have been billed by hospitals when they should not have been. R4, a pregnant refugee claimant, was asked to pay for services despite her having health coverage. She explained, "The staff did not understand my refugee health coverage; they insisted I should pay for blood work." She was embarrassed when she was asked for payment because she was in a line with other people who could overhear the conversation. The service providers felt that this confusion may have been caused by some health care providers' lack of understanding of refugee health coverage (IFHP) and the billing process. Because of recent changes to the IFHP, health care providers are often uncertain of what is covered and how to complete paperwork related to IFHP billing. Some healthcare providers are not familiar with IFHP and may refuse to accept these women as their patients. Ruiz-Casares, Cleveland, Oulhote, Dunkley-Hickin, and Rousseau (2016) suggested that the recent reforms with the IFHP might have increased confusion among health care providers and hospital administration staff in navigating the revised IFHP program. This confusion may have led to one or more of the following; (a) refusal of services to refugee claimants with valid IFHP coverage, (b) staff requesting payment for services which are covered, or (c) health care providers being discouraged from providing services. As my participants reported, these situations deterred them from seeking care. Other studies

by McKeary and Newbold (2010) and Merry et al. (2011) acknowledged systemic discrimination with some health care providers who might be willing to provide care to refugee claimants but chose not to because of systemic barriers with the IFHP, which is fraught with many difficulties such as payment delays and lower compensation, and service providers may be unwilling to accept refugees as patients.

Language and communication barriers

Language and communication, and accents were seen as potential sources of discriminatory behavior on the part of health care providers. R3, mother of three children, a 3-year-old and 1-year-old twins, reported being treated in an unfriendly manner by a pediatrician who was seeing her children. She felt the doctor did not care about her and the children. She stated, “She walks in, gives the children immunization, and she doesn’t say hello or ask me how I am feeling.” She thought the doctor was unfriendly to her because she is Black, and because she had difficulty with her accent. She suspected the doctor’s behaviors were “somehow racist,” although she never said this directly to her. R3 was thinking of transferring care to the in-house doctor at the shelter where she lived because the doctor works in the CHC where she accessed care. She was happy with the care at the CHC and the support she received from service providers there. Despite the unpleasant experience with the pediatrician, she acknowledged that most of the health care providers she dealt with were competent and caring.

Several studies (Ascoly et al., 2001; Bulman & McCourt, 2002; Carolan & Cassar, 2010; Merry et al., 2011; Woloshin et al, 1997) have demonstrated a relationship between language barriers and women refugees’ and refugee claimants’ lack of access to reproductive

health care services. Although language was not a barrier for participants in this study since they all spoke English, the service providers reported that language was a barrier to some clients who did not speak English and that this compromised the care they received. They explained that they provide interpretation services to clients during their medical appointments to facilitate communication with health care providers. However, some clients decline this service because they are afraid of discussing their health needs in presence of someone who is not a health care provider. SP6, a service provider, expressed her concern that women who do not speak English and access health care services without an interpreter have been discriminated against. She said, “When they don’t speak English, without interpretation, it is a way for them to be taken advantage of, pushed to the side, not taken seriously, and their needs are not met by health care providers.” Despite the women’s negative experiences with access to health care services, the CHC service providers reported that they have valuable resources for addressing refugees’ and refugee claimants’ health care needs.

Lack of Health Knowledge and Understanding of Pre- and Postnatal Care and Cervical Cancer Screening

Data from the study reflects a complex relationship between women refugee claimants’ understanding of pre- and postnatal care and cervical cancer screening, and their utilization of these services. The participant’s level of knowledge and understanding of pre- and postnatal care and cervical cancer screening depended on a number of intersecting factors beyond their migration status and living arrangements. Their lack of understanding of the Canadian health care system, lack of health care coverage, country of origin, past

experience, resources available to them, relationship with their health care providers, and length of time in Canada also played a role.

Pre- and Postnatal Care

Most of the women were not knowledgeable about the Canadian health system or how to navigate with their health coverage (IFHP) or without health care coverage. Yet, they were expected to navigate a patchwork of unfamiliar health services to obtain the care that they needed. One of the service providers remarked:

Women refugees and refugee claimants we see here are not very knowledgeable about everything related to their health care and the Canadian health care system. For example, diagnostic tests that are required during pregnancy, medical appointments, and how the payment works if they do not have IFHP.

Women who were pregnant for the first time and presented late for prenatal care did not understand the care they needed. This group of women depended on health care providers for guidance. Sometimes, women who had had children prior to coming to Canada seemed knowledgeable about the medical services they needed to maintain health while pregnant and after delivery. But they did not understand the level of care required by Canadian prenatal screening guidelines. Some of the women, for example, said that when they were pregnant in their countries of origin, they did not seek prenatal care until they had been pregnant for 6 months. Carolan and Cassar's (2010) study with women refugees and immigrants in Australia confirmed that some women struggle to understand the need to participate in early prenatal care during their pregnancies, particularly women from countries with inadequate

preventive health care who may have had successful pregnancies and deliveries with minimal or no prenatal care.

Canadian health care providers informed them of the need for medical care early in their pregnancy for their well-being and that of the growing fetus. They were also informed about pre- and postnatal group programs that were available to them during their first appointment with a service provider. SP5, a service provider in a CHC, explained:

When the women come for their medical appointments they are informed about pre- and postnatal care. For example, when the doctor finds out they are pregnant they inform them about prenatal classes. It is the same thing when a client comes with a newborn baby.

Although women were not obligated to attend pre- and postnatal classes, some of the participants attended these classes even though they had not known about them prior to coming to Canada. R2, who was a mother for the first time, expressed this sentiment:

The presentation in both classes were very helpful. The public health nurse helped us to understand what to expect during delivery. I enjoyed the discussions about taking care of self and the baby, sleep patterns, and self-care. Since this is my first baby and I did not know anything regarding taking care of the baby and myself.

Women in the study without health coverage and not living in a refugee shelter were not aware that they could access prenatal care. For example, R13, who had three older children, delivered her child without prenatal care with a health care provider; however, she attended prenatal group classes in her neighborhood that were provided by public health. R13 explained, “When I was pregnant, I did not have prenatal care, I thought I couldn’t because I

didn't have a health card." She also acknowledged that the program she attended was very helpful and that she received support from staff. R13 was not the only one without health coverage who was not aware of the availability of prenatal care. Some participants who arrived in Canada during their third trimester of pregnancy did not receive adequate prenatal care with a health provider and did not attend prenatal classes because they were not aware of these services. Service providers had to make a quick referral for follow-up with the obstetrician-gynecologist and the hospital for their delivery.

Cervical Cancer Screening

Ten women in the study lacked knowledge about preventive health care unless educated by their health care providers or other resources. Several studies (Hislop et al., 2004; Lesjak et al., 1997; Maxwell et al., 2001) have suggested that lower rates of Pap smear test among immigrant and refugee women are associated with lack of knowledge about cervical cancer screening. However, some participants' previous experience with a family member's or friend's death from cervical cancer, as well as having had the test in their country of origin before migrating, contributed to their knowledge base. For 9 participants, a lack of knowledge and understanding about cervical cancer screening seemed to be related to a lack of awareness of screening. For example, SP5 mentioned:

I have noticed most women coming into our facility are not aware of cervical cancer because what is out there is breast cancer awareness. As far as cervical cancer is concerned most of our women get to learn about it when they arrive here.

R6, a young woman, learned about cervical cancer in Canada. She admitted: “It was my first time to learn about the test. In my country, I did not know or hear about Pap smear test for cervical cancer screening.” In general, many women associate cancer with death. SP6, a service provider in a CHC, stated: “Sometimes when they hear ‘cancer’ they see death. Then it is for me to educate them, so that they understand the advantages of screening for cervical cancer.”

Although a lack of knowledge and understanding about the Pap test was related to a lack of awareness of cancer screening, some women in the study had learned about and used cancer screening prior to migrating to Canada. For example, R14, a 53-year-old woman from Zambia, knew about cervical cancer screening before coming to Canada. R14 said:

Cervical cancer is not new to me. I have lost a friend, an aunt and another aunt is dying because of cervical cancer. I am always reading and watching programs related to cervical cancer. There are so many women in my country suffering from cervical cancer; therefore, it is important for women to get checked. I did the test back home and two in Canada.

Thus, the incidence of cervical cancer among family or friends or a country’s health care infrastructure seemed to be an important influence on women’s knowledge and understanding of cervical cancer screening. As shared by R5, “In my country, cervical cancer screening is offered free in most government hospitals.”

Some participants without prior knowledge or understanding of cervical cancer screening were found to have used the services because their health care providers had recommended it and educated them about the test during medical appointments. As R3

shared: “I have a family doctor in a CHC, my first appointment she asked me if I have had a Pap test. I said no, first she explained to me about the test, then she did the test.” R3 was not the only one; 4 other women reported that a health care provider had recommended that they have a Pap smear during their prenatal or postnatal appointments. These women were comfortable with the test because the health care provider was female. In general, refugee and immigrant women’s preference for a female health care provider, especially for a Pap test, has been well documented (Ahmad et al., 2002; Hislop et al., 2004). This was true for my participants, who were not influenced by the race or ethnic background of a health care provider, but by the provider’s gender and recommendations.

The service providers shed more light on some women’s preference to be examined by a female health care provider for cervical cancer screening. For example, SP3, a service provider in a CHC, said: “Three women who lacked knowledge about Pap smear and had not been examined shared that if they have to get it done they need a female doctor or nurse to do the test. It is still part of their cultural thing they don’t want a male doctor.”

However, 2 women in the study, length of time in Canada, living arrangements, and lack of a primary health care provider affected their level of knowledge about cervical cancer screening services. The following excerpts from my field notes shed some light on two interviews conducted with women refugee claimants who were unfamiliar with the Canadian health care system. The two women were living in a community-based shelter. Their length of time in Canada was under 6 months. They both shared that they didn’t have a primary health care provider, and therefore they had not had a Pap test to screen for cervical cancer. They also said that their friends living in a shelter dedicated to refugees had easy access to

primary health care providers. Other studies (Bryant, Browne, Barton, & Zumbo, 2002; Pollock et al., 2012) have found that the lack of a family physician is a primary barrier to regular participation in cervical cancer screening among refugee, ethnic minority, and immigrant women. I also learned from the interviews that settlement agencies dedicated to supporting refugees ensure that this population is connected with the health care system soon after arrival by referring them to a primary health care provider and providing money for transportation if needed. Health care providers' education and recommendation for pre- and postnatal care and cervical cancer screening helped women navigate the Canadian health care system for their health care needs. For some of the women, whether they had health care coverage or not, having a proactive and caring health care provider facilitated their use of these services and to some extent their knowledge of these services.

Pain, Discomfort, and Trauma

Little is known about women refugee claimants' experiences with cervical screening and how these experiences affect their use of this service. I asked the women in the study about their experiences with the Pap test procedure. The service providers were also asked about the challenges these women experience with respect to cervical cancer screening. The question did not elicit an elaborate response from the women. Most of the women provided very brief answers such as "it was good" or "it's okay." Five women, however, talked about feeling uncomfortable and the process being a bit painful. R5 said, "It was uncomfortable and painful." Despite this, she said she knew it was good for her health. Two women said the procedure was painful and they couldn't do it. For example, R7 said: "I didn't have the Pap

test. It was painful because my cervix was tight, the doctor tried to insert the equipment and it couldn't get in." However, like R5, she recognized that this is a useful test and she said she is willing to get it done another time because of the potential health benefits.

Health care providers acknowledge that the Pap test can be uncomfortable and painful for women, particularly the first time. Older women as well can experience pain during a Pap smear because of changes in their bodies. Women who have experienced trauma, such as sexual assault, domestic violence, or FGM, tend to avoid the Pap smear because of these traumatic experiences. As SP2, a nurse explained: "Women who have experienced sexual assault do not want to see anything invasive in their vagina. While FGM causes pain because the procedure narrows the vaginal canal. We try to be very careful and complete the procedure quickly." Thus, despite the discomfort and pain experienced by some women, some study participants believed the Pap test was important and that they needed the test for the benefit of their health. A number of participants endorsed the services provided by midwives, nurse practitioners, and community health centres. They felt that these providers use a holistic approach and a sensitivity to trauma in addressing the needs of refugee women. As many refugees are exposed to physical and emotional trauma prior to coming to Canada, they appreciate service providers who can take this into account.

Understanding the Complex Barriers of Women Refugee Claimants' Participation in Pre- and Postnatal Care and Cervical Cancer Screening

One of the main objectives of my research was to gain insight into how the women refugee claimants in the current sample engage in pre- and postnatal care and cervical cancer screening. Among the women who participated in this study, 12 out of 16 participants

accessed pre- and postnatal and cervical cancer screening services. Seven of these women lived in refugee shelters, 3 in a homeless shelter, and 2 in the community. Newly arrived refugee claimants without health care coverage and those not living in a refugee shelter were among those not accessing these services. However, another research objective was to explore the influences that shaped these women's level of participation in pre- and postnatal care and cervical cancer screening. Several intersecting determinants were identified to have facilitated and or constrained the women refugee claimants' participation in these reproductive health services. As previously discussed, among the intersecting determinants were: (a) support and access to services, (b) health care coverage, (c) living arrangements, (d) health care providers' recommendations, (e) degree of health care knowledge, (f) discrimination, and (h) having suffered pain, discomfort, or trauma in the past. Similar determinants exist that influence barriers to accessing different kinds of reproductive health care services.

As my study revealed, one of the major influences affecting the women's participation in pre-and postnatal care and cervical cancer screening services was the support they received from service providers. Access to this support was related to health care coverage, immigration status, living arrangements, and health knowledge and understanding. Participants who lived in refugee shelters received adequate support from service providers compared to women living in community-based shelters or in the community. This support included settlement and housing, health information, and referral to health care services. However, as pointed out earlier, these women were not given the information about how our public health system works.

Twelve out of 22 study participants, 8 women refugee claimants and 4 service providers, acknowledged experiences of discrimination when accessing health care services. Studies by several scholars (Bulman & McCourt, 2002; Chalmers & Hashi, 2000, Davies & Bath, 2001; McLeish, 2002; Reitmanova & Gustafson, 2008) drew similar conclusions, stating that refugee women experience discrimination when accessing health care services which contributed to their underutilization of these services. Likewise, my study participants reported personal and systemic discrimination encountered while accessing health care services. Instances of discrimination in this study intersected with factors such as staff acting as gatekeepers, refusal of care (due to IFHP health coverage, lack of health coverage, and/or immigration status), language barriers, and confusion about IFHP coverage. At the level of provider/patient interaction, discrimination can lead to misuse of interventions, underdiagnoses, and the underutilization of treatment and services. Some participants may avoid accessing health care even in an emergency.

A number of studies have reported limited or minimal knowledge about Pap smear screening and pre- and postnatal care among refugees and immigrant women, and this lack of knowledge has been associated with lack of use of these health care services (Ascoly et al., 2001; Carolan & Cassar, 2010; Hislop et al., 2004; Lesjak et al., 1997; Maxwell et al., 2001; Reitmanova & Gustafson, 2008). However, data from my study demonstrates that the knowledge factor intersects in complex ways with various other factors, such as health care coverage, understanding of the Canadian health care system, health care provider/service provider support, country of origin, past experience, resources available to them, and length of time in Canada in influencing women's actual utilization of pre- and postnatal care and

cervical cancer screening. The 2 women who had never had a Pap smear or pre- and postnatal care had recently arrived, lived in a community-based shelter and did not have health care coverage. Thus, the participants' length of time in Canada, living arrangements, and health care coverage impacted their access to these reproductive health care services. Shorter time in Canada and lack of cervical cancer screening is consistent with the results of studies that found a markedly lower use of Pap smear testing among recent immigrant women, especially among those of Asian backgrounds (Lofters et al., 2010; McDonald & Kennedy, 2007; Woltman & Newbold, 2007). However, 2 women's knowledge about cervical cancer screening was related to their experience with a family member or friend's death as a result of cervical cancer and their country's health care system.

Studies in Canada and other countries have found that refugee women with uncertain immigration status lack health care coverage (Ascoly et al., 2001; Gaudion et al., 2006). These women presented late for care because of fears arising from their uncertain immigration status and legal restrictions affecting their access to health care. This is consistent with the data in this study: women who did not have health coverage, were not living in a refugee shelter, arrived in Canada in their third trimester, and were not knowledgeable about prenatal care and the Canadian health care system presented late to health care providers or at the hospital emergency for care.

While some women had accessed pre-and postnatal care and cervical cancer screening as a result of recommendations by service providers, others did not because they lacked health care coverage, were not living in a refugee shelter, and were not aware they could access these services. Yet some women were using these services, often without clear

knowledge, because their health care providers or other service providers had recommended them, and because they, like some non-users, believed in the importance of the services for their health and their babies. Some participants who had not received recommendations for Pap smear screening from health care providers expressed willingness to use the service for cervical cancer screening. The perceived importance of the health care provider's recommendation appeared to be one of the major influences on study participants' use as well as lack of use of pre- and postnatal care and cervical cancer screening in this study. Several studies on pre- and postnatal care and cervical cancer screening among refugees and immigrant women (Ascoly et al., 2001; Oelke & Vollman 2007; Reitmanova & Gustafson, 2008) also noted that women's participation in pre- and postnatal care and Pap smear screening relied on physicians' recommendations. In the context of my study, education or recommendations given by a health care provider seemed to be an important factor in utilization.

There was no major cultural health belief among this study's participants that seemed to have exclusively facilitated or hindered women's use of pre- natal and postnatal care and cervical cancer screening; rather some women expressed different understandings of prenatal care that were related to their previous experience in their country of origin's health care system. Carolan and Cassar's (2010) study with women refugees and immigrants in Australia confirmed that some women struggle to understand the need to participate in early prenatal care during their pregnancies, particularly women from countries with inadequate preventive health care. Some may have had successful pregnancies and deliveries with minimal or no prenatal care. However, similar experiences among women in this study did not impact their

participation in prenatal care. Some studies (Choudhry, 1998; Thomas et al., 2005) noted strong beliefs among Asian and Black women that cancer is a stigmatizing, painful, untreatable, and fatal disease. Bottorff et al. (2001) observed that such beliefs deter the women from participating in cervical cancer screening. But these beliefs or attitudes were not observed among the participants in the research for this study. However, 5 women shared their feelings of discomfort and concerns that cervical cancer screening is painful although most women thought going through the procedure was necessary for the sake of maintaining good health. This is congruent with a study that reported that some South Asian immigrant women thought that the Pap test was beneficial as a way to “keep healthy” (Bottorff et al., 2001). It was also reported by service providers in this study that some women with previous experiences of FGM, sexual assaults, and domestic violence in particular find Pap smear screening uncomfortable and painful.

Women refugee claimants in my study accepted Western biomedical model practices particularly when they had been educated about them in their interactions with health care or other service providers. All the women, irrespective of their use or lack of use, believed in the benefits and importance of pre- and postnatal care and cervical cancer screening. But they also believed that health care providers should provide education in community centres and shelters where most refugees live upon arrival in Canada. Thus, beliefs about and attitudes toward pre- and postnatal care and cervical cancer screening did not necessarily diverge between users and non-users. Even though one service provider in the study mentioned that some women associated cancer with death, nevertheless, they reiterated the responsibility of

care providers to discuss and explain the purpose and procedure of cervical cancer screening test with them.

There are many studies that indicated that refugee and immigrant women's preference for and comfort with female health care providers for cervical cancer screening (Amin & Brigham, 2010; Amankwah et al., 2009; Bottorff et al., 2001; Lofters et al., 2011; Oelke & Vollman, 2007). My study noted similar trends, even for women who had not had a Pap smear for cervical cancer screening. Some participants who lacked knowledge and had not used cervical cancer screening emphasized their preference for a female health care provider for Pap smear screening. Although the findings of Lofters et al. (2011) suggested that refugee and immigrant women prefer having a health care provider who shares their language or ethnicity, this was not raised in the study, as all the participants were fluent in English. Lofters et al. (2011) noted that having doctors of the same ethnicity is associated with lower rates of cervical cancer screening among South Asian and other ethnic minority women. Therefore, the health care provider's gender appeared to be more important, regardless of their language or ethnic background.

To conclude, the women's utilization of pre- and postnatal care and cervical cancer screening was not simply a matter of their individual attitudes or cultural health beliefs, which are neither static nor homogenous. There were no unique cultural health beliefs or practices that seemed to have shaped women's participation in pre- and postnatal care and cervical cancer screening. Two women did not use the services because of other issues, such as immigration status, lack of health coverage, living arrangements, and lack of service provider support. Women who were using the services were quite diverse with respect to

their immigration status, living arrangements, and health care coverage. But generally, those who were living in shelters mandated to provide services to the refugee populations were able to access these services without health coverage because of support provided to them in these facilities. Many of the users were also connected to CHCs that provide health care and settlement services to refugees. They received important health care services, information, education, and advice from health care and other service providers which supported their access to health care and settlement services. The diverse context of immigration status, health care coverage, living arrangements, and resources shaped the participants' knowledge, perception, and attitudes about the need for pre- and postnatal care and cervical cancer screening. Given the diversity and complexities of women refugee claimants' lives during the refugee claim process, refugee claimants should not be discriminated against or refused access to health care services because of their immigration status or lack of health care coverage.

CHAPTER 6

THE IMPACT OF IMMIGRATION AND HEALTH CARE POLICIES ON WOMEN'S HEALTH AND ACCESS TO HEALTH CARE

Chapter 5 presented the data collected from the interviews with the study participants. The present chapter addresses the last research question: How do the broader systems, structures, and policies of Canadian society influence the participation of women refugee claimants in pre- and postnatal care and cervical cancer screening? Women's personal experiences shed light on the broader racializing processes and the systemic barriers in immigration policy, the Canadian health care system, and other institutions. Despite the diversity of the participants, there were certain commonalities among their experiences, and those commonalities were shaped by the systemic and structural problems within these institutions.

This chapter also examines how the social locations of refugee claimants have been created by race, class, and gender stratification policies in Canada. It also explores how the current immigration and health policies and the larger sociopolitical and discursive contexts continue to shape these women's access to and experiences with the health care system, specifically with pre- and postnatal care and cervical cancer screening services, as well as their ability to make choices and take the necessary actions to improve or maintain their health. Rather than describing the general experiences of all the participants, this chapter focuses on analytical and inferential themes reflecting racializing processes and broader systemic issues that organize the everyday life experiences and affect the health of women refugee claimants and other ethnic minority women in Canada.

Feminist theorist Wendell (1996) argued that when we view people as the other, “we group them together as the objects of our experiences instead of regarding them as subjects of experiences with whom we might identify” (p. 60). Wendell also pointed out that we see the other “primarily as symbolic of something else, usually but not always, something we reject and fear and project on to them” (1996, p. 60). According to Wendell’s arguments, the notion of the other signifies an unequal social relation between dominant and subordinate groups so that those who are the other are not only different, but also inferior in the eyes of the dominant group, taken to be at the centre of the universe, the norm, ideal, or “paradigm of humanity” (1996, p. 61). Using the lens of intersectionality, this chapter presents an antiracist analysis of how the broader systems, structures, and policies affect refugee claimants’ status and position as the other in Canada and shape their access to and experience with the health care system, in particular pre- and postnatal care and cervical cancer screening services. It links the research findings presented in earlier chapters with the theories and literature pertinent to the historical as well as current position of women refugee claimants as shaped by Canadian immigration policies, health policies, and neoliberal ideologies. The ways in which current health care restructuring is informed by the neoliberal discourses and policies that govern clinical practices and affect women refugee claimants’ participation in pre- and postnatal care and cervical cancer screening will be discussed.

As discussed in Chapter 2, the concept of intersectionality is based on the view that gender, race, class, and other systems of oppression co-construct each other and therefore these dimensions of social life cannot be understood in isolation from one another. The intersectionality framework provides important tools for critically examining the

intersections of race, gender, class, and immigrant status in the lives of women refugee claimants, as well as linking the women's subjective experiences with the larger social, economic, and political processes and discourses governing a society. Cuadraz and Uttal (1999) pointed out that in order to do an intersectional analysis, individual experiences of race, class, and gender should be examined and understood within the broader context of social location. This involves exploring "how social structures shape and inform the processes by which individuals as members of historically defined groups negotiate and interpret their social location" (Cuadraz & Uttal, 1999, p. 179). Cuadraz and Uttal (1999) also suggested that empirical data from in-depth interviews should be placed by the researcher within the context of the historical experiences of the groups represented in the study as well as the material conditions contemporaneously organizing their individual lives. Thus, the lens of intersectionality can help us view the diverse experiences of women refugee claimants as determined by their dynamic social locations (of race, class, immigration status, and so on), and at the same time explore how individual experiences are shaped by their historical and structural position as the other.

Refugees Claimants as the Other and Immigration and Refugee Policy

The development of Canada as a nation state and the persistence and advancement of capitalism in the country are closely linked with its history of colonization and immigration. Canada as a state was founded through colonization, which involved the subjection and capitalist exploitation of native people. With the colonization of the First Nations and the

early settlement of Europeans on Indigenous lands, immigration policies were an important tool for building the Canadian nation (Agnew, 2009; Thobani, 2007; Zaman, 2006).

Canada's 1976 Immigration Act instituted, for the first time, a refugee determination process for inland claims. Prior to this, inland claimants made their application on paper and had no right to an oral hearing. In 1987, the 1976 Act was changed with the institution of Bill C-55, creating the IRB (Lacroix, 2004). Since then refugee claimants have a right to an oral hearing by the IRB and are entitled to legal representation. The current refugee inland determination process has been designed to make refugee claimants the other through its screening to determine the eligibility of their claims. Under the present Immigration and Refugee Protection Act, inland claimants are required to complete and submit all the documents and information supporting their claim in person to the IRCC office in any major city in Canada (Government of Canada, 2017c; Minister of Justice, 2017b). When the eligibility screening interview is scheduled, which can take 30 to 45 days or longer, the claimant meets with an IRCC officer to determine if their claim is eligible for referral to the IRB (Government of Canada, 2017e; Minister of Justice, 2017b). During this screening process, refugee claimants do not have health coverage. Five participants in my study were in the midst of this and consequently did not have access to health care. The lack of health coverage often results in refugee claimants feeling like others, people excluded from Canadian society, which, in fact, they are and will be until the IRB has determined if they will be accepted into Canada.

The time it takes for a refugee claimant's status to be established disproportionately affects women refugee claimants who arrive in Canada pregnant and in need of immediate

prenatal care. Twelve of the 16 women refugee claimants in my study who were waiting for their cases to be determined accessed community health centres without having to pay for the services they received. In contrast, when 2 participants had emergency hospitalization because of their pregnancies they received the services they needed. However, because of their lack of health coverage, they were billed by the hospitals. Two women in my study delayed seeking prenatal care for fear of not being able to pay. Although Toronto Public Health provides prenatal care without charge and/or asking for residency, in my experience women refugee claimants are not aware of this service. However, 1 resourceful participant, R13, accessed this service later in her pregnancy. Many refugee claimants are very poor, and without the financial support of their spouse, paying for hospital care can be extremely difficult if not impossible. From my experience, my point of view is that this economic barrier to accessing health care services may shape a refugee claimant's perception of the Canadian health care system. I think this perception may cause a reluctance or resistance on their part to using health care services in the future, which might have a negative effect on their overall health. Service providers working in CHCs in my study noted that some women refugee claimants present late for prenatal care due to their immigration status and lack of health coverage, making it difficult for service providers to arrange for adequate care. These same circumstances for this group of women were noted in studies by Ascoly et al. (2001) and Gaudion et al. (2006). The consequence of this, as Johnson et al. (2004) pointed out, is that this group of women may be viewed as non-compliant with their medical care.

According to the Minister of Justice (2017b), after the eligibility interview the officer determines whether a claim is eligible to be referred to the IRB for hearing. If it is, the officer

then confirms the date on which the claimant is to appear at the IRB to make the case for refugee protection. The claimant also receives a Refugee Protection Claim Document (RPCD) confirming that a claim has been referred to the IRB, and IFHP coverage for health care is provided unless the claim is suspended or rejected (Government of Canada, 2017c). If the IRB decision is positive, the claimant applies for permanent residency, and initiates the process of family reunification if the claimant's family members are not already in Canada. If the decision is negative s/he may apply for an appeal to the IRB or apply for a PRRA if eligible. Five study participants who were denied in their refugee hearings with the IRB were also appealing their claims. These participants stated that they were afraid to access health care services because of their immigration status, thinking that because they were appealing they were not entitled to health care. From a governmental perspective, this fear is unfounded because under the current Liberal government changes to IFHP, refugee claimants in Canada are fully entitled to coverage during the appeal process with the IRB (Government of Canada, 2018b). Unfortunately, my participants were not aware of this change.

My study findings noted that women refugee claimants experience discrimination. Twelve out of 22 participants, 8 women refugee claimants and 4 service providers reported they had themselves experienced or supported friends or clients who had experienced instances of discrimination accessing health care services. Participants reported instances such as staff acting as gatekeepers of the system by asking women refugee claimants for their health coverage up front even when they were unwell. They felt discriminated against based on the type of health coverage they had (IFHP) or ability to pay for services if they did not have coverage. Other instances of discrimination reported were refusal of care to women

refugee claimants with IFHP or without any coverage. Service providers reported that there had been confusion with the recent changes within the IFHP, which may lead to one or more of the following; (a) refusal of services to refugee claimants with valid IFHP coverage, (b) staff requesting payment for services which were covered, or (c) health care providers being discouraged from providing any services to refugee claimants. These acts of discrimination that denied women refugee claimants access to health care services othered the participants and deterred them from seeking care at all. Similar patterns of discrimination against refugee claimants have also been discussed by other scholars (Bulman & McCourt, 2002; Chalmers & Hashi, 2000; Davies & Bath, 2001; McKeary & Newbold (2010); McLeish, 2002; Spitzer, 2004) in their studies with women refugee claimants.

Although Canada's Immigration Act recognizes gender-related persecution against women as a violation of their human rights (Razack, 1995), the refugee determination process frequently reproduces gender hierarchies which other women refugee claimants. For example, women refugee claimants presenting claims based on gender persecution to the IRB may find it difficult to fully make their case because of the shame and negative sanctions around transgressive behavior that can make women extremely reluctant to discuss rape and other forms of sexual violence in front of male IRB members and/or interpreters who may be known in the community (Boyd, 1999). Women refugee claimants who are unable to tell their story to the IRB members during their hearing to establish the credibility of their claim are usually denied refugee status. Five participants in my study shared that they were not successful in their hearings with the IRB; however, they did not elaborate on the reasons for their rejection. Razack (1995) argued that women's claims are most likely to succeed when

they present themselves as victims of dysfunctional, exceptionally patriarchal cultures and states. Therefore, the “successful applicant must be cast as the cultural other” (Razack, 1995, p. 50). It is through this colonial frame that women’s claims of gender-based persecution become visible in the West.

Even when women refugee claimants are accorded refugee status and have a high level of education and solid work experience, they may experience difficulties with settlement, particularly in the labor market. For example, the women might experience challenges to participation in the labor market because of childcare responsibilities. A number of the women refugee claimants in my study had young children for whom they had sole responsibility. Women refugee claimants might take longer than men to settle, particularly when they do not have the support of their spouse or extended family members, because finding employment that will allow one to also meet childcare responsibilities can be challenging.

In summary, the racist, gendered, and capitalist selection process of refugees inherent in Canadian Immigration and Refugee policies becomes visible through the overt and covert injustices and systemic inequities. The biases and inequities in these policies also become evident in the way refugees are viewed and constructed as the other. Anderson and Reimer Kirkham (1998) point out that through the explicit and/or implicit race, gender, and class biases of Canada’s present immigration and refugee policies, refugee women are constructed by the state as the other. Therefore, Canada’s Immigration and Refugee policy is an important determinant of the unequal status of women refugee claimants, and the provisions in this policy complement the other forms of gender and racial inequality in Canadian society

that contribute to the multiple disadvantages of refugees and immigrant women. Therefore, race, class, and gender inequities continue to shape the identities and social locations of women refugee claimants in Canadian society and set up the ideological discursive and material conditions within which these women access, experience, and deal with the country's health care system, including pre-and postnatal care and cervical cancer screening.

Canada Health Act and Women Refugee Claimants' Access to Health Care

The Canada Health Act ensures that the Canadian provinces and territories provide health care to Canadian citizens and permanent residents (Health Canada, 2015). The accessibility of health care is an important determinant of women's health and one of the fundamentals of the Canada Health Act. Access to health care is a complex concept and it has been understood and defined in the health services literature differently at different times and in different contexts (Jacobs & Visano, 2015). It usually encompasses geographical, organizational, and financial aspects as well as effectiveness and outcome of health services. However, health care coverage for refugees is not included in the Canada Health Act, the legislation governing publicly funded health insurance, which provides access to Canada's universal health care services for Canadians. As discussed in Chapter 3, the Act excludes persons covered by another Act of Parliament, which is the case with refugee claimants. Although refugee claimants are covered by the IFHP (Government of Canada, 2018b), they only become eligible for provincial health coverage when they are given permanent resident status.

The exclusion of refugees from coverage under the Act (Health Canada, 2015) is a result of the intersection of federal and provincial government policies. Federal health policies frame eligibility for coverage in the provinces as well as standards of access and equity while immigration policies determine a person's right to enter and reside in Canada and the conditions associated with these rights, such as access to health care. Data in my study indicate that some women's immigration status affects their access to health care services. This is particularly the case with newly arrived refugee claimants who lack health coverage while their refugee claims are being processed.

Health research that focuses on barriers to pre- and postnatal care and cervical cancer screening for women refugees and refugee claimants tend to emphasize cultural beliefs, understanding, and the lack of English proficiency, which provides only a partial picture of the women's access to these health services (Amin & Brigham, 2010; Ascoly et al., 2001; Carolan & Cassar, 2010; Choudhry, 1998; Grunfeld, 1997; Merry et al., 2011; Woloshin et al., 1997). Furthermore, this literature tends not to focus on the exclusion of refugee claimants due to the lack of health insurance coverage. There is also the ignorance of the experiences of women refugee claimants who actually use these services and are affected by the quality and effectiveness of the care they receive because of their immigration status and lack of health care coverage. Access barriers to pre- and postnatal care and cervical cancer screening that are ingrained in the Canadian health care system are still largely ignored in the literature. However, there are a number of researchers studying refugee claimants and uninsured immigrants in Canada, for example, Caulford and D'Andrade (2012), Kulie, Rousseau, Munoz, Nadeau, and Ouimet (2007), Wilson-Mitchell and Rummens (2013), and

Jarvis et al. (2011). My participants talked about seven intersecting determinants that constrained women refugee claimants' access to pre- and postnatal care and cervical cancer screening:

1. immigration status
2. lack of health coverage
3. living arrangements
4. lack of service provider support
5. degree of health care knowledge
6. discrimination
7. having suffered pain, discomfort, or trauma in the past

These access barriers are beyond these women's individual health beliefs and behaviors, understanding, and the lack of English proficiency. They can only be discerned when one looks at their overall experiences with the Canadian health care system.

The Canada Health Act does not define *reasonable access* to universal health care for all residents of Canada. Many immigrants, including refugee claimants, face special challenges or barriers to accessing health care in Canada due to lack of knowledge about existing services provided by provincial governments, such as cervical cancer screening, midwifery care, and public health, because of their lack of familiarity with Canadian health care systems and practices. Data from my study showed that most of the women refugee claimants are not knowledgeable about matters related to their health care and the Canadian health care system. For example, R6 a young woman was not aware about cervical cancer screening until she came to Canada. However, 4 women who had had children prior to

coming to Canada seemed knowledgeable about the medical services they needed to maintain health while pregnant and after delivery, although they did not understand the level of care required by Canadian prenatal screening guidelines. Further, 2 women seemed to have learned about cervical cancer screening prior to migrating to Canada.

The prevalence of cervical cancer among friends and family members and having had the test in their country of origin before migrating, contributed to their knowledge base. R5 also shared that she was familiar with cervical cancer and had done the procedure in her country since it is offered free in government hospitals. Health care provider recommendations was also a vital factor for women learning about cervical cancer screening. Five women without prior knowledge or understanding of cervical cancer screening were found to have used the services because their health care providers had recommended them and had educated my participants about the test during medical appointments. Four women who had been recommended for a Pap smear during their prenatal or postnatal appointments with a health provider were very pleased with the service. R3 for example mentioned: “I have a family doctor in a CHC; [at]my first appointment she asked me if I have had a Pap test. I said no. First, she explained to me about the test, then she did the test.” These women were comfortable with the test because the health care provider was female. Studies by Ahmad, Gupta, Rawlins, and Stewart (2002) and Hislop et al. (2004) discuss refugee and immigrant women’s preference for a female health care provider, especially for a Pap test.

Language and cultural barriers also make the services inaccessible for many refugees who come from non-European or non-Western countries and do not speak English or French, the two official languages in Canada. A number of studies have pointed out that the common

barriers that this group of women experience with access to pre- and postnatal care and cervical cancer screening include language difficulties and cultural beliefs (for example, Amankwah et al., 2009; Amin & Brigham, 2010; Ascoly et al., 2001; Choudhry, 1998; Grunfeld, 1997; Maxwell et al., 2001; Merry et al., 2011; Stapleton, Murphy, Correa-Velez, Steel, & Kildea, 2013; Woloshin et al., 1997). Although all the participants in my study spoke English, non-English accents can also give rise to discriminatory behavior on the part of health care providers. For example, 1 participant in my study articulated her experiences of discrimination by a health care provider and reported that she thought the service provider had difficulty understanding her because of her English/African accent. As an African immigrant myself, I think I can speak on behalf of fellow Africans when I say that, for most of us, our upbringings in Africa did not expose us to the culture of subtle racism and prejudice that exists in Western European countries and North America. Although my participants did not tell me about their recognizing this kind of subtle racism in their experiences here in Canada, I have come to this point of view because of a combination of my doctoral studies and professional experience, both of which now enable me to have a broader overview of immigration policies and access to health care.

Studies by Amin and Brigham (2010), Amankwah et al. (2009), Lofters et al. (2011), McKeary and Newbold (2010), Merry et al. (2011), Spitzer (2004), and Stapleton et al. (2013) have looked at the factors that affect women refugees' and immigrants' underutilization of pre-and postnatal care and cervical cancer screening and suggested that structural issues within the health care system, such as systemic discrimination and the lack of adequate numbers of females in the medical professions, besides the cultural values, and

health beliefs, that restrict these women's use of these reproductive health care services. My study notes similar structural issues, such as systemic discrimination within the Canadian health care system, that women refugee claimants encounter in accessing pre- and postnatal care and cervical cancer screening. Participants' personal experiences with the Canadian health care system varied with their immigration status, but also reflected some of these systemic problems. Most women, irrespective of their immigration status or lack of health care coverage, were appreciative of the health care services in Canada. They embraced the Canadian universal health care system, which they compared favorably to the one in their countries of origin, because most of the services are free; moreover, some health care providers are caring and treat the women with respect. However, a number of women in my study commented on the long wait times in the hospitals before a health care provider could see them. R2, for example, stated: "I was booked for delivery at 7:00 am, when I called the hospital I was told the bed was not available. I arrived at the hospital by 1:00 pm and waited until 7:00 pm when a bed was available." She also said that she waited so long for the epidural that when the doctor who was scheduled to administer it arrived, she was about to deliver her baby. So, she did not receive the epidural. All the participants affected by long wait times thought they had to wait longer because there were so many patients at the hospitals and not enough doctors and nurses. Some newly arrived women refugee claimants among the participants did not have much exposure to or experiences with hospital or other health care services. This could have been because they were not pregnant, did not have children, lived in a community-based shelter, or did not have a primary health care provider. Over all, the participants' experiences and perspectives provided an important understanding

of the broader Canadian health care system and the systemic barriers inherent in it. This is the backdrop against which my participants access to and experiences with pre- and postnatal and cervical cancer screening services were critically misunderstood.

Neoliberal Ideologies and Health Care Reforms

Neoliberal discourse of equality of opportunity assumes individuals are autonomous and free to access social and financial resources or services and able to take responsibility for their own well-being (Ponic, 2007). Liberal egalitarianism, when applied as a professional standard of equality and fairness in health care, can encourage health care providers to uphold the value of equality by *treating everyone the same* regardless of their social location (Tang & Browne, 2008). In my opinion, this approach of *treating everyone the same is* unjust for refugee claimants *because they are not the same as everyone else*. As discussed in Chapter 5, refugee claimants are not entitled to health care under the IFHP until they are eligible for a hearing with the IRB. Their immigration status and lack of health or IFHP coverage means that they are in a unique category that requires treatment that takes this into account. As stated by Ponic (2007) and Tang and Browne (2008), these structural inequities and power relations deeply embedded in the neoliberal discourse of equality are generally ignored to the extent that those who do not fit into the system are seen as personal failures and are often accused of taking advantage of Canadian universal health care.

Socioeconomic and health policies in Canada since the late 1980s have been dominated by the ideology of neoliberalism, which promotes an economic system free of government regulations or restrictions and seeks to dismantle the publicly funded services

intended to establish equity and social justice in a welfare state (Anderson, 2000). This has resulted in a diminishing social welfare system and erosion of the social safety net, increasing the gap between the rich and poor. The resultant decline in public health services has worsened the health status of marginalized Canadians (Anderson, 2000; Ponc, 2007). Neoliberal ideology has also shaped health care reforms, a global phenomenon and a consequence of globalization, which aim to control health care costs through massive restructuring of health care services (Anderson, 2000). Health care reforms may have different effects on women refugee claimants than on the general population. As Vissanjee et al. (2007) pointed out, health care reform is one of the important contextual and environmental factors that has changed the living conditions of immigrant women and resulted in increased demands on community organizations and on the women, themselves, who are most often the informal or unpaid caretakers of ill, disabled, or elderly relatives. The focus on cost containment of public health services and early discharge planning translate into “fairly extensive healthcare services in the home upon discharge from the hospital” as noted by Anderson (2000, p. 223) and lack of access to homecare or support with other activities of daily living. Three women in my study, for example, complained about early discharge from hospitals and what they perceived as abandonment by the nurses, especially after delivery. R3, for example, who is a mother of three, recalled her experience: “My twin boys were born premature through a C-section. I was surprised because I was discharged from the hospital after a few days, but I continued to visit them because they were in the incubator for 2 months.” R3 lived in a refugee shelter, had a 3-year-old child to take care of, and visited her newborns at the hospital every day. R1 felt abandoned and stated, “I felt

abandoned by the nurses at the hospital because when my baby was born she was not given a bath.” This participant also felt abandoned because she did not receive prenatal care from the hospital obstetrician/gynecologist because she did not have IFHP health care coverage. However, when the midwife who had referred her to the hospital came to visit the following day she bathed the baby. Shortened length of stay in the hospital is standard treatment for all patients in the Canadian health care system (Sword, Watt, & Krueger, 2006). Spitzer (2004) noted that this standard treatment of patients in the Canadian health system is embedded within middle-class Euro-Canadian values that focus on self-reliance and self-care and the presumption that all Canadians have the support and financial ability to cope. However, women refugee claimants and other women with first generation migration status, lack this extensive support network and the financial ability to cope with a standard such as a short hospital stay (Sword et al., 2006).

Spitzer’s (2004) study further found that the impact of health care reform in hospital obstetrics wards has placed a greater burden on minority women because of time constraints and hospital policies that limit their access to nursing care and information. From my experience minority women and particularly refugee claimants compared to established native-born Canadian women need more time and support in hospital obstetrics wards. Tang (1999) also pointed out that when the health care provider is already struggling to manage a tight schedule, spending time with patients or finding and using an interpreter can be frustrating and burdensome. Furthermore, racism can influence the attitude of some health care providers towards policies designed to make health care more accessible to refugee claimants. Thus, health restructuring may have particularly adverse effects on women

refugee claimants, especially for those without health care coverage, support of family members, and when they experience language and communication barriers. This can result in increased marginalization and racialization of women refugee claimants.

The reorganization of the health care system, driven by the discourse of scarcity and efficiency, to make it more cost-effective, has direct implications for the everyday organization and delivery of health care services (Anderson, 2000; Tang, 1999). Anderson, Tang, and Blue (2007) stressed the importance of examining the broader societal contexts that organize and shape the culture of health care rather than focusing on health care providers as individuals, because health is delivered in social and ideological contexts. Tang and Browne (2008) also pointed out that the micro-politics of health care delivery cannot be separated from the sociopolitical and historical contexts within which they occur. Decisions about reducing resource allocations in health care are not value-neutral; rather they reflect the dominant notions that the majority culture holds about health and health care (Tang, 1999). As pointed out by Tang and Browne (2008), the practice of *treating everyone the same* ingrained in health care services, including racialized and Aboriginal patients, reflects a predominant egalitarian discourse in Canadian health care. Such a discourse fails to address the structural inequities and unequal power relations that shape social locations, life opportunities, and the everyday experiences of women refugee claimants and members of other minority groups. This ideology and the practice of *treating everyone the same* is not adequate to serve people experiencing racial discrimination, lack of health coverage, uncertain immigration status, and other inequities prevalent in health care and other institutions, rendering them as the other in Canada.

Liberal Individualism and Self-Care

Individualism is central in liberalism which advocates the idea that citizens are autonomous, rational, and self-interested actors capable of making their own choices and exercising their rights and potential, irrespective of their economic, political, historical, and racial/ethnic backgrounds (Anderson, 1996; Ponio, 2007; Tang & Browne, 2008; Varcoe et al., 2007). This approach results in the construction of health as an individual issue decontextualized from broader socioeconomic policies, systemic inequities and historical processes that craft the differential life opportunities, priorities, and unequal access to resources and health care for different groups of people. It also assumes that individuals have the economic capability to purchase the support services that are not provided by the government through health care. As Varcoe et al. (2007) also pointed out, “these ideologies run counter to understanding the complexity of women’s lives, their interrelationship with others and their environments, and the impact of those interrelationships” (p. 21). Neoliberal approaches to health and wellness identify behavioral or genetic medical risk factor and place responsibilities for health and illness on the shoulders of individuals. In turn, individuals who personalize their health and wellness, having adopted this neoliberal approach, are reluctant to form social support networks to support each other’s health needs. Such approaches fail to adequately recognize and redress broader social determinants of health and public policies pertaining to immigration status, economic opportunities and poverty, housing, and service provision. These social determinants of health extend to a lack of access to health care services, which shape the health of women refugee claimants and other immigrant communities. They also determine the extent to which a “person possesses the physical,

social and personal aspirations [to] satisfy needs, and cope with the environment” (Raphael, 2016, p. 3). Moreover, neoliberal messages of individual responsibilities for one’s health constructs health as an individual rather than a social and public policy issue. They also label those who cannot meet their health needs as “discredited citizens” (Fiske & Browne, 2006, p. 106), that is, the other for their failure to make healthy choices or to thrive in Canada’s egalitarian environment.

Personal responsibility is a predominant theme in the neoliberal state discourse of health promotion. The target of such health promotion strategies is to enable individuals to take greater control of his or her life by mobilizing resources (Anderson, 1996). This concept of “self-care” or taking decisions and actions about one’s own health is an example of the expectation that women refugee claimants educate themselves about pre- and postnatal care and cervical cancer screening by reading the online guidelines, pamphlets and brochures and to make decisions to access these services. Such concepts emphasize and value self-reliance and individual responsibility, which are underpinned by the liberal assumption that individuals have equal opportunity and equal access to resources (Anderson, 1996; Tang, 1999). However, these concepts tend to ignore the structural constraints that may hinder a person’s ability to access health care services to maintain health and manage illness. For instance, in my study several intersecting determinant constrained women refugee claimants from accessing pre- and postnatal and cervical cancer screening. These included health care coverage, living arrangements, health care providers’ recommendations, degree of health care knowledge, discrimination, and language barriers and having suffered pain, discomfort, or trauma in the past. Such determinants are rarely addressed as the focus is on the processes

by which individuals can be enabled to assume greater responsibility for their health. SP6, a social worker, offered insights into how health care providers and the health care system could support women refugee claimants in taking on responsibility for their health, and particularly cervical cancer screening:

I think it is important to remind women about regular visits to their family doctor because the doctor might suggest or remind them if they have not done their Pap test. Although the Public Health keeps records when you do a Pap test and after 3 years when it is time for your next test they send a reminder in the mail. But people move, and it can be difficult to receive this reminder. Sometimes they may lose track, and the doctor reminders are significant to keep on track with the Pap smear tests.

Reminding women to make regular visits to their family doctors would be ideal, particularly for women refugee claimants who are new to Canada and have minimal information about the health care system. However, in an era of constrained budgets, doctors and other health care providers might not have the time and resources to contact patients to remind them to make appointments for cervical cancer screening and other medical services. Health care providers are also pressured to attend to more patients in less time using fewer resources. Because of this, in order to ensure participation in reproductive health care services for women refugee claimants, changes are needed to improve the IFHP bureaucracy.

CHAPTER 7

DISCUSSIONS, IMPLICATIONS, AND CONCLUSIONS

This study sought to understand the barriers that women refugees and refugee claimants experienced with access to reproductive health care services, such as prenatal care, postnatal care, and screening for cervical cancer (by means of the Pap test), within the larger context of their lives and their overall experiences with the Canadian health care system. My initial goal in this study was to interview these two groups of women—refugees and refugee claimants. However, I interviewed only one group—refugee claimants. The reason for this was that the service providers who supported me in my recruitment efforts, and through whom I was put in touch with potential participants, were themselves working only with refugee claimants at the time I was establishing my participant group. The loss of having refugee women in my research meant that I was not able to learn how this group experienced access to these reproductive health care services. In addition, this research strived to uncover how the use of these services, or lack thereof, by refugee claimants is affected by the broader systems, structures, and policies that shape the everyday life experiences of these women. Data generated through in-depth interviews were organized, analyzed, and interpreted using the research questions with the help of antiracist and intersectionality theoretical perspectives. In this final chapter, I discuss the main findings and arguments of the study in relation to the research objectives and questions. This work, however, had some limitations, which will be pointed out here. I then reflect on the implications for social workers working with refugee claimants in health care settings and the possibilities for future research in this

area. The chapter ends with some recommendations for improving access to pre- and postnatal care and cervical cancer screening, as well as other health care services, in Canada.

Reviewing the Key Findings and Analysis

This section revisits the research findings based on the analysis of the data in relation to the questions that guided the study. The first research question was: How do women refugees and women refugee claimants engage with pre- and postnatal care and cervical cancer screening? As previously mentioned, I had to amend my first question to: How do women refugee claimants engage with pre- and postnatal care and cervical cancer screening? The second question was: What factors influence these women's use of pre- and postnatal care and cervical cancer screening services? Another related question was: What are these women's experiences with the health care system in general, and how does this relate to their different identities based on race, gender, class, and immigration status? The findings related to these questions were reported in Chapter 5.

Although the majority of the women were using pre- and postnatal care and cervical cancer screening services, 9 of them experienced barriers accessing these services. The women who had experienced barriers were newly arrived refugee claimants, those who lived in the community, those who lived in community-based homeless shelters, and failed refugee claimants. The newly arrived refugee claimants in my study experienced difficulties with access to health care services because they did not have health coverage. Women who lived in the community and in community-based homeless shelters were not aware at the time of their arrival in Canada that they could access these health care services. Furthermore, the

women whose refugee claims were denied were afraid to access health services because of their immigration status. These women also reported at the time of their interviews that they were appealing their claims. Despite their lack of health care coverage and immigration status, and short length of stay in Canada, women who were living in shelters mandated to provide services to refugees were provided with a wide range of supports, such as settlement, health information, and referrals to health care providers.

Women refugee claimants living in mandated shelters had easier access to these services than women living in community-based shelters and in the community. In mandated shelters they had in-house clinics and staff referrals to CHCs. For 2 of my study participants who were living in a refugee shelter their access to health care service outside the shelter had been shaped by their experiences of personal and systemic discrimination in the hospital. These instances of discrimination intersected with factors such as administrative staff acting as gatekeepers, refusal of care (due to IFHP health coverage, lack of health coverage, and/or immigration status), confusion about IFHP coverage on the part of staff, and language barriers, which made it difficult for the participants to access health services. On the other hand, many of the women who were using these services, including the women living in refugee shelters, community-based shelters, and in the community, demonstrated a lack of understanding and knowledge of pre- and postnatal care and cervical cancer screening services, especially participants who had recently arrived in Canada. Thus, women's level of knowledge and understanding of pre- and postnatal care and cervical cancer screening services intersected with a number of factors, such as lack of understanding of the Canadian

health care system, lack of health care coverage, country of origin, past experience, resources available to them, relationship with their health care providers, and length of time in Canada.

Seven women had not had the Pap test for cervical cancer screening for some or all of the following reasons: they had never been informed about it, it had never been recommended by any of their health care providers, they had a low degree of health care knowledge, they had experienced pain and discomfort related to the procedure, or trauma such as FGM or sexual assault prior to migrating to Canada, or they did not have a primary health care provider to do the test. Receiving a recommendation to have the test from a health care provider played a very important role. In the case of most of the users of cervical cancer screening, health care providers recommended, initiated, and managed the administration of a Pap test while most of the non-users had not had this test recommended to them by their health care provider. Most of the women reported that the gender of their health care provider was more important than their language or ethnic background, and that they had a strong preference for a female provider.

As I discussed in Chapter 6, there were intersecting factors that shaped the women's use of pre- and postnatal care and cervical cancer screening services, several of which seemed to have structural or systemic resonance:

1. immigration status
2. lack of health coverage
3. health care policies
4. health care providers' practices based on neoliberal ideologies and health care reforms

5. socioeconomics
6. gender

These findings answered my final research question: How do the broader systems, structures, and policies of Canadian society influence the participation of women refugees and refugee claimants in pre- and postnatal care and cervical cancer screening? This question was addressed in Chapter 6 and led to deeper insights into how women refugee claimants' access to health care, including pre- and postnatal care and cervical cancer screening, was linked with their experiences of migration through the process of claiming refugee status in a gendered, racialized and classed immigration system.

I undertook an intersectional analysis in order to uncover the larger and interlocking political, socioeconomic, and health care policies, processes, and discourses by which these women's use of pre- and postnatal care and cervical cancer screening might be influenced. I examined the current construction and positioning of women refugee claimants as the *other*, particularly through Canadian immigration and health care policies and neoliberal ideologies. I also analyzed how neoliberal discourse and policies govern social and health care structuring and practices as these affect women refugee claimants' participations not only in pre- and postnatal care and cervical cancer screening services but also in the Canadian health care system in general. The women in the study reported experiencing discrimination accessing health care. But the historical and current positioning of these women as the other, both in immigration and health policies and at the margin of Canada's White-centered national imagery, shapes their future socioeconomic status, opportunities, and priorities as well as their access to quality health care services. Although the research participants did not

discuss their economic status, data from this study indicated that they were living in lower socioeconomic circumstances, which posed a challenge to the successful integration of these women and their families into Canadian society. From my experience, lower socioeconomic status could lead them to put their families first before their health care needs, which might overshadow their potential use of preventive health care, such as pre- and postnatal care and cervical cancer screening.

Through situating the experiences of women refugee claimants in this study within the antiracist literature and critiques of the Canadian immigration and health care policies and neoliberal ideologies, it became apparent that both historical and current policies, institutionalized practices, and structural inequities in Canada interact with each other to marginalize these women in both discursive and material ways to shape their health and access to health care. Within the neoliberal environment, Canadians, including refugee claimants, are expected to be self-reliant and to assume more responsibility for their health. In the case of pre- and postnatal care and cervical cancer screening, women refugee claimants are expected to educate themselves by reading the Toronto Public Health websites, brochures, and pamphlets. There is also the expectation that they will be self-motivated to participate in pre- and postnatal classes and to ask health care providers for regular Pap smears. However, some women refugee claimants in this study expected that health care providers would inform or educate them on health issues and support them in navigating the health care system in order to access the services that they needed for prevention and treatment.

Women refugee claimants who may be unable to comply with the indiscriminate and standardized neoliberal message of self-care due to structural and systemic barriers are viewed as the other. Furthermore, such women are left on their own without information and support with respect to the services available to them. In the health care system, these women are viewed as a burden or providers attempt to manage their *otherness* through providing *culturally sensitive care*. The women's perspective and experiences reported in this study reflect the need for health care providers and social workers to conceptualize health care access in light of the broader social, economic, historical, and political contexts of their lives rather than only in terms of their particular cultural beliefs, practices, and health behaviors. I argue that uncritical notions of culture and cultural barriers tend to provide only a partial picture of women's access to pre- and postnatal care and cervical cancer screening, and other health care services, and ignore the access barriers rooted within women's immigration, health care coverage, and integration processes. I further argue that health research that tries to measure the level of women refugee claimants' acculturation, or attempts to understand simply the cultural barriers to pre- and postnatal care and cervical cancer screening, and the attempt to educate women refugee claimants about these services through health literacy programs and clinical practices of culturally sensitive care all fail to take into account the struggles of racialized women refugee claimants with Canadian institutions including health care. I also argue that all these processes reinforce women refugee claimants' historical as well as current racialization, marginalization and construction as the *other*, which negatively affects their health and access to health care in general, and pre- and postnatal care and cervical cancer screening services in particular.

Health care providers' practices related to women refugee claimants and access to pre- and postnatal care and cervical cancer screening need to be understood within the broader structures and power relations. In the ideological, sociopolitical, and fiscal atmosphere in which the health care system operates, health care providers are pressured to provide care and treatment to patients using as little as possible of the system's resources. This is not conducive to comprehensive care that is responsive to the issues of gender discrimination, racialization and socioeconomic marginalization of women refugee claimants and other ethnic minority immigrant women. Furthermore, through the discourse of culturally sensitive care, ethnic minority health care providers and other service providers are essentialized and othered as cultural *experts*, only fit to serve minority populations.

Study Limitations and Directions for Future Research

Before highlighting some of the implications of my study, I acknowledge some of the limitations and challenges of my work that might be addressed in future research. I did not interview refugee women in my research, which meant that I was not able to learn how this group experienced access to these reproductive health care services. However, the small sample of research participants (i.e., refugee claimants) I was able to interview was quite diverse in terms of the participants' ages, education, length of stay in Canada, immigration status, living arrangements, and number of children. There were also commonalities, as all were Black women, 2 were from the Caribbean, 14 were from Africa (2 from Uganda, 1 from Cameroon, 1 from Zambia, and the other 10 women were from Nigeria). The significant number of Nigerians in my sample can be explained by the IRB's (2017b) statistics on

refugee claimants for 2016 and 2015. At the time I was collecting data in 2017, the rate of Nigerian refugee claimants in Canada had significantly increased, almost doubling from 2015. According to the IRB (2017b), in 2016 the number of Nigerian refugee claimants was 1,543 compared to 849 in 2015. This fact may have affected the participation numbers of my sample. This over-representation of African women does not reflect the experiences of all refugee claimants or all African women, but rather those who participated in this study. It was also harder to locate women who were not accessing services in community health centres or settlement agencies. Overall, the purposive and snowball techniques were more effective sampling approaches.

I anticipated including a diverse sample of English-speaking women, and consequently, did not include participants who did not speak English due to a lack of funds to pay interpreters to help in the interviewing and transcribing stages. I have discussed this in more detail in Chapter 6. To assist me with recruitment of my study participants, I contacted several community health centres, shelters, and settlement agencies that provided services for refugee populations. They posted my flyer, which was written in English, on their bulletin boards, and although I did receive a number of responses, I received fewer responses than I had hoped for. I suspect, the information on my flyer, which was limited to pre- and postnatal women, may have played a part in reducing the overall number of responses I received. In addition, because the word “cancer” was on my flyer, this may have scared some women who might otherwise have been interested in participating. As 2 service providers working in a community health centre told me, for some women when they hear “cancer,” they see death. All the women identified as heterosexual. Future research could integrate women of

other sexual orientations, non-English speaking women, women from a wider array of countries of origin, and women of different migration statuses in Canada.

There were also other barriers to the participation of women refugee claimants. For example, I noticed some women were afraid to answer the question about their immigration status and were unwilling to sign the consent form. When I noticed this fear, I explained to the participants that their participation in my study was not related to their immigration process. The newly arrived refugee claimants, particularly the women who were living in the homeless shelters, had limited knowledge about the immigration and health care system; because of this, these women volunteered less information in their interviews than did other women. Some women feared being audio taped, and in those cases I took written notes of our conversations. However, it is possible that women who were more confident and had more knowledge about the immigration and health care system were more likely to participate in the interviews, which later influenced the analysis.

Looking at pre- and postnatal care and cervical cancer screening together posed certain challenges, such as increased complexity in analyses and comparison of data, particularly given the small sample size and limited data on women who had only recently arrived in Canada. Because my sample size was small, I was unable to generalize about the experiences of these women in their use of, or lack of use of, these reproductive health care services. A larger sample size would have naturally led to a deeper comparison of the complex relationships at work and would have enriched this discussion.

Although I had planned on involving my participants in the analysis of the data and invite feedback from them, because of time constraints, I was not able to do this. While I was solely in charge of all aspects of the research from designing the study to analyzing the data and writing the report, future research could involve collaboration with research participants and/or other stakeholders such as health care providers (physicians, nurses, social workers, community health workers).

Implications and Recommendations

As a feminist researcher, I started this research from a non-positivist perspective, not to test specific hypotheses, but to bridge the data gap with alternative and new knowledge about women refugee claimants and access to pre-and postnatal care and cervical cancer screening services. My location as a Black African immigrant woman, feminist scholar, and former service provider immensely influenced the knowledge produced through this research. Instead of claiming the knowledge and research findings to be universal, complete and true representations of the experiences of all women refugee claimants in Canada, I rather acknowledge that the research product is incomplete, partial, and located within the relationship established between the participants and me. It is also influenced by insider/outsider boundaries that shaped the research process. I have only constructed and presented a partial truth or one of the many possible truths about women refugee claimants and access to pre- and postnatal care and cervical cancer screening services in Toronto, Canada. Moreover, the findings of any qualitative research have limited scope for generalization because the goal of such research is rather to provide context-specific, detailed

information about the experiences of and phenomena affecting a relatively small sample. Although the current research findings were drawn from a small sample of women refugee claimants of diverse demographic backgrounds, the conclusions or arguments based on the participants' narratives support meaningful explanations or interpretations of women's experiences. The current research findings also show congruence with many statistical and large-scale empirical findings with respect to ethnic minority immigrant women and refugees and their access to health care services. Therefore, there are certain significant and important theoretical as well as practical implications of the current research findings for future research, social work practices, and health care and other related policies.

Theoretical Implications

One of the theoretical objectives of the study was to challenge the cultural essentialism and narrow theorization of culture noted to be prominent in the literature on women refugees' and immigrant women's access to pre- and postnatal care and cervical cancer screening services. The problematic conceptualization of culture found in the literature fails to grasp culture as complex power relation grounded in diverse social, economic, historical, and political contexts (Browne & Varcoe, 2006). As already pointed out, through an overemphasis on women refugees' cultural beliefs, knowledge, and understanding with respect to these reproductive health care services and a lack of focus on the challenges of migration and racialization that shape their access to health care, the existing literature have constructed them as the cultural other. The current study's emphasis on the challenges of migration, health care coverage, living arrangements, systemic

discrimination, and institutional and structural barriers to health care services faced by women refugee claimants helped to avoid inappropriate essentializing of the women's culture and, at the same time, gain a better understanding of their diversity and subjectivity.

The women's narratives in the current study revealed no homogenous cultural beliefs among women refugee claimants that determine these women's knowledge, understanding, and practices of pre- and postnatal care and cervical cancer screening; rather systemic and structural barriers seemed to have had the greatest effect on their use or lack thereof of pre- and postnatal care and cervical cancer screening. Lack of recognition of the need for pre- and postnatal care and cervical cancer screening among women refugee claimants is commonly cited in the literature as a major factor influencing their lack of use of pre- and postnatal care and cervical cancer screening; but the current study noted that women did not ignore these services due to cultural beliefs, but rather due to the challenges of migration, lack of health care coverage, and lack of recommendations and support from health care providers.

Women's understanding, use or lack of use of pre- and postnatal care and cervical cancer screening services were shaped by many intersecting systemic issues and structural processes, such as support and access to services, health care coverage, living arrangement, health care providers' recommendations, degree of health care knowledge, discrimination, and having suffered pain, discomfort, or trauma in the past. These findings offer a more complex understanding of the issues and challenge the essentialist theoretical assumptions that women refugee claimants' culture is homogenous or static.

By bringing to the forefront the gendered and racialized processes of migration in Canada, the study aimed to understand how these processes affect women refugee claimants'

access to quality health care, including pre- and postnatal care and cervical cancer screening. Findings of this study provide support for Vissandjee et al.'s (2007) finding that women's migration experiences are a significant health determinant that tends to shape the effects of other generally acknowledged social determinants of women's health. This study's focus on women's migration experiences showed that the challenges women refugee claimants face in Canada not only affect their overall health but also shape their access to health care services, including pre- and postnatal care and cervical cancer screening. The women refugee claimants in my study encountered more than cultural barriers in accessing these reproductive health care services, which underlines the importance of theorizing and understanding the factors that affect these women's access to pre- and postnatal and cervical cancer screening beyond their personal understandings, cultural beliefs, and practices around health, pre- and postnatal care and cervical cancer screening. Because of my study's unique approach to understanding the broader context of women refugee claimants' everyday lives and their general experiences with primary health care in Canada, the structural and systemic barriers that particularly impact women's participation in pre- and postnatal care and cervical cancer screening were uncovered and revealed. This implies that women's personal health issues cannot be separated or understood in isolation from the larger social, political, historical, material, and discursive contexts of their lives.

My research therefore signifies the importance of examining women refugee claimants' and other ethnic minority, racialized women's access to pre- and postnatal care and cervical cancer screening services and other health care services with the lens of intersectionality. An intersectional approach reveals the historical, socioeconomic, and

political processes that create structural and systemic barriers to resources and services. All these implications indicate that there is a need to reject the construction of knowledge about certain groups or ethnic communities that essentializes culture and ignores the structural and systematic barriers to health care. This further demonstrates the limitations of the concept of culturally sensitive care, a neoliberal approach to managing the health needs of multicultural populations, in addressing the health inequities and inequitable access to health care experienced by women refugee claimants and other marginalized women in Canada. Moreover, the neoliberal concepts of self-care, individual responsibility, and choice seem to have very little significance for women refugee claimants with limited understanding of the Canadian health system, difficulties with access to organized health care, lack of service provider support, and lack of English language skills. Overgeneralizations and stereotypical assumptions about women refugee claimants' cultural beliefs and health needs must be avoided. Women refugee claimants, like any other community, are diverse despite their shared immigration status.

Practical Implications and Recommendations

As Reinharz (1992) pointed out, “feminist research is connected to social changes and social policy questions” (p. 251) either through making intellectual contributions or policy recommendations for social, structural, and material changes in social services and health care practices or through challenging oppressive ideologies and discourses. The current research shifts the understanding from *women refugee claimants' culture* to the intersections of the broader structures and interlocking systems that produce health inequities and

inequitable access to health care. I used antiracist and intersectionality frameworks as well as a social justice approach to construct new knowledge that can be used to change policy and health care practices to improve women refugee claimants' and other racialized immigrant women's health and access to care, especially pre- and postnatal and cervical cancer screening services. The intersectional analysis of the current data implies that strategies to promote health equity must consider the larger structural, social, and political processes that produce health inequities. Focusing on women's health behaviors and cultural health practices as barriers to women's access to pre- and postnatal care and cervical cancer screening services draws attention away from the other intersecting factors that produce ill health. A fuller understanding requires focusing on the broader structural and systematic barriers to health care. The critical and complex analysis of the current study should be useful to researchers, policy makers, social workers, and health care providers working with refugees, and working to develop future research, policies and practices to improve the quality and accessibility of pre- and postnatal care and cervical cancer screening and other health care services in general for the refugee population and other racialized or marginalized women. I finally suggest some recommendations to transform the interconnected areas of research, policies, and practices in such a way as to make pre- and postnatal care and cervical cancer screening as well as the general health care services more accessible for everyone in Canada irrespective of their gender, race/ethnicity, class, immigration status, or language skills.

Developing Economic and Social Policies That Support Health

Equitable and just health care is health care without the structural and systemic barriers that prevent access to the basic necessities of life including health care. This is in opposition to the neoliberal ideology that dictates that everyone be treated the same despite the immense socioeconomic inequalities among populations. Many determinants of health lie outside the health care system. For example, reducing inequities among income groups is an important goal for the reduction of health inequities between different groups (Mikkonen & Raphael, 2010). The erosion of Canada's welfare system and the rise of neoliberal economy approach that emphasizes economic globalization and the role of markets in organizing and allocating resources are the root causes of increased income and wealth inequalities in the country (Anderson, 2000; Mikkonen & Rapheal, 2010, Ponic, 2007). In particular, general health inequities can be addressed through the reduction of poverty and underemployment among refugees and immigrant populations. This in turn can be accomplished through the elimination of gender discrimination and racialized practices, such as recognizing education and professional skills earned outside Canada. Improving access to community support, social services, and childcare could also enhance women refugee claimants' and other racialized immigrant women's health and access to pre- and postnatal care and cancer screening as well as other health care services.

Health education that depends on reading public health websites, brochures, and pamphlets excludes women without formal education, or who lack skills in English or French. Therefore, these women need to be educated on health issues through different means, as stated by participants. For example, education in the form of workshops related to

cervical cancer screening could be provided to women refugee claimants and immigrants to Canada. These education workshops could be conducted in shelters and community health centres that serve these groups. In my experience as a former service provider, community health centres provide free multidisciplinary health services and health education to all Ontario residents without asking about their immigration status or health coverage. Some participants suggested that to enhance women's participation in these educational workshops, they could be integrated with other programs in the shelters. Further, health care providers, such as public health nurses, could be invited to deliver the workshops and to talk to women one-on-one about cervical cancer screening.

Health awareness can be raised through community outreach conducted where this population live, for example refugee shelters, women's shelters and ethno-specific communities. For example, funding for an outreach bus with diverse health care providers would reach women refugee claimants and other marginalized women in the community. Women without primary health care providers could easily access pre- and postnatal care and cervical cancer screening on the bus. The government could also advertise through media outlets (e.g., television, radio, social media) and in shelters, in languages represented by larger groups of refugees' or immigrants in Canada, that health care services are available. For example, public health clinics and hassle-free clinics provide services to Ontario residents without health coverage, yet most refugees do not know about these services. However, women refugee claimants who may be overwhelmed by the demands of a stressful refugee process, settlement, and socioeconomic integration in a new country with limited support from the state may have a limited ability to take in health care information. Some

women refugee claimants might need to be educated in English so that they gain the agency and ability to understand, and to freely explain their problems to and ask questions of their health to a health care provider. These women cannot be empowered simply by being showered with health information without improving their literacy skills and finding a secure source of income. Improved access to English language training, employment with better pay and benefits, and appropriate health information will likely result in women refugee claimants' empowerment as well as long-term positive health outcomes and better access to preventive care such as pre- and postnatal care and cervical cancer screening.

Improving Services and Health Care Practices

Women refugee claimants' access to pre- and postnatal care and cervical cancer screening in this study is related to their access to general health care and especially to the quality of primary care that they received. Therefore, improving the general access to primary care, especially to primary health care providers, could improve women's access to pre- and postnatal care and cervical cancer screening. Participants in this study unanimously suggested the need to open clinics in refugee shelters to make health care services accessible to women refugee claimants and to provide information about pre- and postnatal care and cervical cancer screening in different languages. Primary health care providers should also inform or educate women, especially newly arrived women refugee claimants, about the importance of these services and initiate the regular Pap smear. Having access to primary health care can also be a significant source of support for women refugee claimants who have limited knowledge about reproductive health care and other health care services in Canada.

Participants in this study also suggested that there is a need to recognize refugee claimants' health care coverage, coverage by IFHP, in the health care system. This could be met by providing education to health care providers and administrative staff who work in hospitals and CHCs about the refugee determination process, and the length of time refugee claims take to be approved by the IRB, and therefore the time it takes for a refugee to become eligible to apply for provincial health care coverage. This education could help the administrative staff and health care providers to understand the immigration system and develop compassion and sensitivity to the needs of women refugee claimants. This may enhance women refugee claimants' access to appropriate care and minimize the stress of financial burden on refugee claimants who are currently without coverage and sometimes required to pay for health care services. Additionally, training on trauma-informed approaches for health care providers and other service providers who serve refugees is needed. This training could help them to understand refugees' traumatic histories, and to build trust and rapport by creating space for these women to share their stories and find ways to cope with their needs.

Service providers working in CHCs who participated in my study stated that there is a need for appropriate language assistance programs in hospitals to help refugees and new immigrants who do not speak English to access services at the hospitals. These groups experience difficulty navigating the health care system because of language barriers. The service providers also suggested the need for hospitals and CHCs to develop partnerships to coordinate their patients' care that are not based on the patient's catchment area or hospital, or the CHC in which they are accessing services. Rather these partnerships could be based on

the health issues that need to be addressed. This would make it easier for health care providers to connect women to other health services they need. The service providers further suggested that access to health care in Canada needs to be available to all residents, regardless of the status of their refugee claim. It costs the health care system more when sicker people access hospital emergency services. When primary care is provided in the community it lessens the cost to our health care system.

The service providers also suggested that there is a need to advocate for more funding for female-centered health care services, particularly for marginalized groups such as refugee claimants and other racialized women. Hiring more female health care providers, as most women prefer female doctors or nurses, would also improve access. For instance, nurses who work in community health settings with refugees, immigrants and other racialized ethnic minorities could educate women refugee claimants about the importance of pre- and postnatal care and cervical cancer screening. Women may feel more comfortable with community nurses who reflect diverse races and languages and are in a position to build long-term, positive, trusting, and less hierarchical patient-provider relationships. Lastly, in order to ensure good quality services, health care and other services providers need to be sensitive not only to the cultural issues but also to the diverse age, generations, education backgrounds of various women refugee claimants at various stages of immigration, empowerment, and settlement or socioeconomic integration in Canada.

Implications for Social Workers Working With Refugee Claimants in Health Care

Social work interventions with women refugee claimants intended to increase their use of pre- and postnatal care and cervical cancer screening need as Danso (2009) pointed out to integrate an antiracist sociopolitical stance, which would direct the worker to assess how personal and structural processes can affect these women's access to health care services. Danso further suggested that by considering clients' histories and structural issues, the worker would be better informed about the circumstances surrounding the immigration processes that affect refugees. They would also have a clearer understanding of the structural and other factors that limit refugee claimants' access to reproductive health care services. A sociopolitical approach to the interventions would demonstrate that refugee claimants' health care access is related to the larger and interlocking political, socioeconomic and health care discourse through which these women's use of pre- and postnatal care and cervical cancer screening might be influenced.

As Danso (2009) postulated using the antiracist sociopolitical tools for critical assessment would help the worker to identify the forms of marginalization that women refugee claimants are subjected to because of their migration status, race, gender, and class. Moreover, Healy (2005) pointed out that the approach draws the worker's attention to critical analyses of the prevailing ideologies, such as the neoliberal immigration and health policies that shape refugees' access to health care services. For instance, the worker might consider how the language of neoliberal economics shapes health care procedures and health care providers' assessment of and provision of health care services to refugees. In this regard, the

worker could reflect on the salience of discrimination in the way mainstream society views refugee claimants and access to health care in Canada. In my study, 8 refugee claimants reported that they themselves had experienced or had supported a friend who experienced discrimination when accessing health care services because of their race, immigration status, IFHP coverage, or lack of any coverage, while the structural inequities embedded in neoliberal discourse, as pointed out by Tang and Browne (2008), such as treating everyone the same regardless of their circumstances, are ignored.

Furthermore, a critical assessment of women refugee claimants' experiences of discrimination within the health care system would provide the worker with a better perspective on the contradictions in Canada's health care and immigration policies. For instance, the Canada Health Act, the legislation governing publicly funded health insurance, provides access to Canada's universal health care services for Canadians, however, the act excludes persons covered by another act of Parliament such as refugee claimants. While refugee claimants are covered by the IFHP (Government of Canada, 2017b), the exclusion of refugees from coverage under the Canada Health Act (Health Canada, 2015) is a result of the contradiction between health care and immigration policies. For example, federal health policies frame eligibility for coverage by the provinces as well as standards of access and equity while immigration policies determine a person's right to enter and reside in Canada and the conditions associated with these rights, such as access to health care. This contradiction casts doubt on the assertion that Canada is committed to supporting refugee claimants. While Canada claims that it is a welcoming and diverse country open to refugee claimants, the facilitation of this population's access to health care services is complicated,

which results in women refugee claimants' underutilization of pre- and postnatal care and cervical cancer screening services.

A sociopolitical approach to the antiracist analysis could inform social workers that the inexorable experiences of women refugee claimants with access to health care services stems from a racist ideology. This ideology is reflected in the historical and current discriminatory biases within immigration and refugee policy in Canada that views refugees as the other. As pointed out by Danso (2009), the exclusion of vulnerable groups such as refugees from the Canada Health Act is discriminatory and inconsistent with the democratic principals of justice, equality, and fairness that Canada espouses and prides itself on. Most refugee claimants who come to Canada are fleeing war, conflict, torture, and/or persecution in their countries, circumstances in which health care was likely unavailable. Beiser (2005) argued that because Canada is a signatory to the 1951 United Nations Convention on the Status of Refugees, and accepts refugees and asylum seekers, it is responsible for protecting refugees and asylum seekers' rights, including their right to health care. However, as the convention is non-binding, the provision of comprehensive health care to refugees is not mandatory.

Applying antiracist principles could also provide social workers with the tools to support women refugee claimants facing personal, institutional, and/or structural obstacles to accessing pre- and postnatal care and cervical cancer screening. Cambridge and Williams (2004) indicated that at the interpersonal level, the social worker could encourage women refugee claimants to share their needs, then based on these needs the worker could provide whatever information about asylum applications, legal status, and resource options they need.

This could be accomplished through various means, such as workshops, informal gatherings, and pamphlets. As Thompson (1998) and Mullaly (2002) observed, the worker could also support an awareness-raising process to inform women refugee claimants how structural and institutional injustices shape their access to health care services. The worker could also promote women refugee claimants' involvement in decision making about access to pre- and postnatal care and cervical cancer screening.

At the institutional level, social workers could work towards fundamental transformation of procedures and services to make them more just and the access to health care services more equitable (Healy, 2005; Payne, 2014). Also, the worker could promote and advocate for institutional changes in the delivery of health care and programs in ways that embrace anti-racism to ensure that women refugee claimants have access to health care as needed.

To address the structural barriers created by immigration and health care policies and neoliberal ideologies, social workers need to engage with other stakeholders to advocate for changes in these policies; for example, refugee claimants' health coverage could be integrated into the Canada Health Act. Social workers and other advocacy groups, such as the Canadian Association of Social Workers (CASW) and Canadian Doctors for Refugee Care, could also lobby for reducing the influence of neoliberal ideologies in health care policies in order to facilitate women refugee claimants' use of pre- and postnatal care and cervical cancer screening. This could include advocacy to develop antiracist policies, procedures, and programs in health care services to combat the racism and oppression that makes refugee claimants' access to health care services difficult. These policies, programs, and procedures

could incorporate best practices to address the intersections of racism, immigration, sexism, and socioeconomic status. Women refugee claimants and other marginalized women could be engaged in the development of these policies, programs, and procedures to incorporate best practices to address these intersections.

Conclusion

This study set out to explore, using a feminist qualitative research methodology, women refugee claimants' access to and use of pre- and postnatal care and cervical cancer screening in Toronto, Canada. The participants' narratives showed that their varied levels of participation in pre- and postnatal care and cervical cancer screening were shaped by several interconnected influences, such as social and structural circumstances. Although some of the women expressed a lack of knowledge and understanding of pre- and postnatal care and cervical cancer screening which, in conjunction with other entangled issues, hindered their participation in these reproductive health care services, the women's narratives did not reflect any cultural beliefs that seemed to determine whether or not they participated in pre- and postnatal care and cervical cancer screening. One of the most important influences on their participation in these reproductive health care services, however, appeared to be the support they received from service providers. Access to this support appeared to be related to their living arrangements. Women who lived in refugee shelters received adequate support from service providers while women living in community-based shelters or in the community generally did not. The data collected for this study showed that women refugee claimants

encountered more than cultural and language barriers in accessing pre- and postnatal care and cervical cancer screening services.

My research attempted to situate women refugee claimants' participation in pre- and postnatal care and cervical cancer screening within the broader context of their migration experiences in order to explore to what extent these women underutilize these reproductive health care service due to systemic and structural barriers in and outside of the health care system, rather than due to cultural beliefs and practices. In general, my study's data showed that lack of health coverage intensified the effects of the intersecting forms of inequities and the social determinates of health in Canada, such as gender, class and poverty, racialization, and discrimination, and adversely affects women's health and access to health care services, such as pre- and postnatal care and cervical cancer screening. Women's immigration status, living arrangements, degree of health care knowledge, language barriers, and past experiences of pain, discomfort, or trauma were the common barriers to socioeconomic integration and equitable access to health care services for women refugee claimants, and especially for newly arrived women. The responsibilities of childrearing, most often in the absence of extended family support, could also challenge the women participants' settlement and integration and have a negative effect on women's health and access to health care. These structural barriers directly or indirectly influenced the women refugee claimants' access to and participation in pre- and postnatal care and cervical cancer screening in Canada. Thus, women refugee claimants' common challenges arising from the gendered and racialized processes of migration, settlement, and socioeconomic integration, along with the structural barriers within the health care system, shaped their marginalized and vulnerable

positionalities, which in turn affected their access to pre- and postnatal care and cervical cancer screening services.

This study also aimed to explore how women refugee claimants' migration and settlement experiences in Canada are shaped by the racialized and gendered immigration and integration policies, and neoliberal ideologies and practices, and how these broader forces influence women's access to pre- and postnatal care, cervical cancer screening, and other health care services. An intersectional examination of the broader discourses, policies, and processes that create and sustain the social inequities for refugees and govern health care and the clinical practices of health care providers revealed that race, class, and immigration status intersect with gender in diverse and complex ways in the material and everyday lives of women refugee claimants to situate them into a racialized and disadvantaged situation as the other. Accessing health care, especially pre- and postnatal care and cervical cancer screening services, from such a position seems to pose significant challenges for many women refugee claimants, especially newly arrived refugees, and women with limited English language skills. On the other hand, through the Canadian immigration and refugee policies, women refugee claimants are constructed as the other at the edge of Canada's White-centered, national imagery. Further the neoliberal notion of *treating everyone the same* overlooks the struggles of racialized women refugee claimants, and the challenges they face in the refugee process. It also overlooks their particular needs for health care, particularly prenatal care for those who arrive in Canada pregnant. The policies and systemic barriers that hinder racialized women refugee claimants' economic and social integration in Canada, and create these women as the other, will, in the long run, negatively affect their physical and mental

health. Thus, the intersectional analysis in this research indicates that the problem of women refugee claimants' inadequate access to pre- and postnatal care and cervical cancer screening cannot be separated from the larger social, political, historical, material, and discursive contexts of their lives.

To conclude, improving access to health care services is complicated and involves more than ensuring universal or *free* financial access and providing services in a culturally sensitive manner. Women refugee claimants' access to pre- and postnatal care, cervical cancer screening, and other health care services needs to be understood outside the limiting ideas of providing services according to women's health beliefs, behaviors and cultural practices. Instead, the broader contexts of their everyday lives as shaped by the intersecting relations of power (race, gender, class, and immigration status among others) must be taken into account. The cultural sensitivity approach to health care delivery cannot, by itself, ensure better access for racialized women who face structural and systemic barriers to health care services and socioeconomic integration in Canada; broader policy changes are required to address social inequities. In my study, the women refugee claimants described varied experiences of migration, settlement, and access to health care, indicating that these women are a diverse group facing various intersecting barriers and challenges both inside and outside the Canadian health care system.

Therefore, any monolithic attempt to improve ethnic minority women's health status or access to services by trying to understand their cultural practices will likely be unsuccessful. Long-term and multi-layered strategies need to focus on broader policies and forces beyond cultural issues, beyond indiscriminate neoliberal approaches to self-reliance,

and beyond improving health literacy through brochures. Strategies able to address the diverse needs and health practices of women refugee claimants need to be developed. Structural changes need to be made at different political levels and in different organizational and institutional practices, such as reducing the hospital fees for emergency visits and treatment of refugee claimants without IFHP. The bureaucracy that provides IFHP to new refugee claimants could be improved by shortening the eligibility interview for referral to the IRB for hearing, since it is during this waiting period that refugee claimants are without health coverage. To facilitate the implementation of these changes the federal and provincial governments need to work together to facilitate funding and delivery of health care services to new refugee claimants. Obtaining input from women refugee claimants and settlement workers who work with these populations can assist in influencing the development and design of policy, its implementation, and associated funding and programming.

This study contributes to refugee and social work literature and scholarship, and can broaden service providers', educators', and policymakers' knowledge and awareness of the reproductive health needs of women refugee claimants. In concluding this dissertation, it is my hope that this will lead to the development of research, policy, and practices that will reduce the effects of systemic factors that give rise to health care inequities in order to create more efficient and accessible health care services for women refugee claimants.

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APPENDICES

Appendix A:

Recruitment Flyer for Women Refugees and Women Refugee Claimants

I am a doctoral student in York University's Social Work Program, and I am conducting a study titled, **“Exploring Barriers Refugees and Refugee Claimants Experience Accessing Reproductive Health Care Services in Toronto.”**

The main purpose of the research is to explore women refugees' and refugee claimants' access barriers to reproductive health care services, specifically prenatal and postnatal care and cervical cancer screening (by Pap test).



- **If you are:**
- a woman refugee or refugee claimant
- between 21 and 45 years of age
- able to speak English
- and a resident of Toronto

And you are willing to be interviewed for an hour or so about your experiences with access to health care services, **I would like to speak with you! Two TTC tokens will be provided to those who will be interviewed.**

My name is Helen Gateri and I can be reached at [telephone number] or by email at [email address].

This research has been reviewed and approved for compliance to research ethics protocols by the **Human Participants Review Subcommittee (HPRC)** of York University.

**Appendix B:
First Service Providers' Recruitment Flyer:
Focus Group**

I am a doctoral student in York University, Social Work Program. My doctoral research is titled “**Exploring Barriers Refugees and Refugee Claimants Experience Accessing Reproductive Health Care Services in Toronto.**” I am looking for **service providers** working with women refugees and refugee claimants in community health centres or settlement services to participate in my research.

The main purpose of the research is to explore women refugees' and refugee claimants' access to reproductive health care services, such as pre- and postnatal care and cervical cancer screening.

Who should participate?

- social workers
- family doctors
- nurses
- psychologist
- midwives
- health promoters
- Any staff involved with this population

If you would be willing to participate in a ninety-minute focus group to discuss the barriers women refugee and refugee claimants experience when attempting to access reproductive health care services, **I would like to speak with you!**

I can be reached at [telephone number] or by email at [email address].

If you agree to participate in this research, you will receive an informed consent form advising you of your rights and of the measures that will be taken to preserve confidentiality. Please be advised that the research has been reviewed and approved for compliance to research ethics protocols by the **Human Participants Review Subcommittee (HPRC) of York University**. Be assured that the information you provide will remain confidential and that your identity will be protected.

If you know someone else who fits the criteria above and might be interested, please feel free to pass this information on.

Thank you for your time and consideration,

Helen Gateri

Ph.D. Candidate
York University

**Appendix C:
York University Ethics Approval:
December 5, 2016**



Certificate #:	STU 2016 - 151
Approval Period:	12/05/16-12/05/17

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ETHICS APPROVAL

To: **Helen Gateri**
Graduate Student of Social Work, Faculty of Liberal Arts & Professional Studies

From: Alison M. Collins-Mrakas, Sr. Manager and Policy Advisor, Research Ethics
(on behalf of Denise Henriques, Chair, Human Participants Review Committee)

Date: Monday, December 05, 2016

Title: **Exploring Barriers Refugees and Refugee Claimants Experience
Accessing Reproductive Health Care Services in Toronto**

Risk Level: Minimal Risk More than Minimal Risk

Level of Review: Delegated Review Full Committee Review

I am writing to inform you that this research project, "**Exploring Barriers Refugees and Refugee Claimants Experience Accessing Reproductive Health Care Services in Toronto**" has received ethics review and approval by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines.

Note that approval is granted for one year. Ongoing research – research that extends beyond one year – must be renewed prior to the expiry date.

Any changes to the approved protocol must be reviewed and approved through the amendment process by submission of an amendment application to the HPRC prior to its implementation.

Any adverse or unanticipated events in the research should be reported to the Office of Research ethics (ore@yorku.ca) as soon as possible.

For further information on researcher responsibilities as it pertains to this approved research ethics protocol, please refer to the attached document, "**RESEARCH ETHICS: PROCEDURES to ENSURE ONGOING COMPLIANCE**".

Should you have any questions, please feel free to contact me at: [telephone] or via email at: [email address].

Yours sincerely,

Alison M. Collins-Mrakas M.Sc., LLM
Sr. Manager and Policy Advisor,
Office of Research Ethics

RESEARCH ETHICS: PROCEDURES to ENSURE ONGOING COMPLIANCE

Upon receipt of an ethics approval certificate, researchers are reminded that they are required to ensure that the following measures are undertaken so as to ensure on-going compliance with Senate and TCPS ethics guidelines:

1. **RENEWALS:** Research Ethics Approval certificates are subject to annual renewal. **It is the responsibility of researchers to ensure the timely submission of renewals.**
 - a. As a courtesy, researchers will be reminded by ORE, in advance of certificate expiry, that the certificate must be renewed. Please note, however, it is the expectation that researchers will submit a renewal application prior to the expiration of ethics certificate(s).
 - b. **Failure to renew an ethics approval certificate** (or to notify ORE that no further research involving human participants will be undertaken) **may result in suspension of research cost fund and access to research funds may be suspended/ withheld.**
2. **AMENDMENTS:** Amendments must be reviewed and approved **PRIOR** to undertaking/making the proposed amendments to an approved ethics protocol;
3. **END OF PROJECT:** ORE must be notified when a project is complete;
4. **ADVERSE EVENTS:** Adverse events must be reported to ORE as soon as possible;
5. **POST APPROVAL MONITORING:**
 - a. More than minimal risk research may be subject to post approval monitoring as per TCPS guidelines;
 - b. A spot sample of minimal risk research may similarly be subject to Post Approval Monitoring as per TCPS guidelines.

FORMS: As per the above, the following forms relating to on-going research ethics compliance are available on the Research website:

- a. Renewal
- b. Amendment
- c. End of Project
- d. Adverse Event

**Appendix D:
York University Ethics Amendment Approval:
May 1, 2017**



Certificate #:	STU 2016 - 151
Initial Approval:	12/05/16-12/05/17
Amendments:	Amendment approved: 05/01/17
Renewals:	
Current Approval Period:	12/05/16-12/05/17

OFFICE OF
RESEARCH
ETHICS (ORE)
5th Floor, Kaneff
Tower

4700 Keele St.
Toronto ON
Canada M3J 1P3
Tel 416 736 5914
Fax 416 736-5512
www.research.yorku.ca

ETHICS AMENDMENT APPROVAL

To: Helen Gateri - Graduate Student
School of Social Work
Faculty of Liberal Arts & Professional Studies

From: Alison M. Collins-Mrakas, Sr. Manager and Policy Advisor, Research Ethics
(on behalf of Denise Henriques, Chair, Human Participants Review Committee)

Date: Monday, May 01, 2017

Title: Exploring Barriers Refugees and Refugee Claimants Experience Accessing
Reproductive Health Care Services in Toronto

Risk Level: Minimal Risk More than Minimal Risk

Level of Review: Delegated Review Full Committee Review

With respect to your research project entitled, “**Exploring Barriers Refugees and Refugee Claimants Experience Accessing Reproductive Health Care Services in Toronto**”, the committee notes that, as there are no substantive changes to either the methodology employed or the risks to participants in and/or any other aspect of the research project, a renewal of approval re the proposed amendment(s) to the above project is granted.

Any further changes to the approved protocol must be reviewed and approved through the amendment process by submission of an amendment application to the HPRC prior to its implementation.

Ongoing research – research that extends beyond one year – must be renewed prior to the expiry date.

Any adverse or unanticipated events in the research should be reported to the Office of Research ethics (ore@yorku.ca) as soon as possible.

For further information on researcher responsibilities as it pertains to this approved research ethics protocol, please refer to the attached document, “**RESEARCH ETHICS: PROCEDURES to ENSURE ONGOING COMPLIANCE**”.

Should you have any questions, please feel free to contact me at: [telephone] or via email at: [email address].

Yours sincerely,

Alison M. Collins-Mrakas M.Sc., LL.M.
Sr. Manager and Policy Advisor,
Office of Research Ethics

RESEARCH ETHICS: PROCEDURES to ENSURE ONGOING COMPLIANCE

Upon receipt of an ethics approval certificate, researchers are reminded that they are required to ensure that the following measures are undertaken so as to ensure on-going compliance with Senate and TCPS ethics guidelines:

1. **RENEWALS:** Research Ethics Approval certificates are subject to annual renewal. **It is the responsibility of researchers to ensure the timely submission of renewals.**
 - a. As a courtesy, researchers will be reminded by ORE, in advance of certificate expiry, that the certificate must be renewed. Please note, however, it is the expectation that researchers will submit a renewal application prior to the expiration of ethics certificate(s).
 - b. **Failure to renew an ethics approval certificate** (or to notify ORE that no further research involving human participants will be undertaken) **may result in suspension of research cost fund and access to research funds may be suspended/withheld.**
2. **AMENDMENTS:** Amendments must be reviewed and approved **PRIOR** to undertaking/making the proposed amendments to an approved ethics protocol;
3. **END OF PROJECT:** ORE must be notified when a project is complete;
4. **ADVERSE EVENTS:** Adverse events must be reported to ORE as soon as possible;
5. **POST APPROVAL MONITORING:**
 - a. More than minimal risk research may be subject to post approval monitoring as per TCPS guidelines;
 - b. A spot sample of minimal risk research may similarly be subject to Post Approval Monitoring as per TCPS guidelines.

FORMS: As per the above, the following forms relating to on-going research ethics compliance are available on the Research website:

- a. Renewal
- b. Amendment
- c. End of Project
- d. Adverse Event

**Appendix E:
Second Service Providers' Recruitment Flyer:
One Hour Individual Interview
After Ethics Amendment**

I am a doctoral student in York University, Social Work Program. My doctoral research is titled “**Exploring Barriers Refugees and Refugee Claimants Experience Accessing Reproductive Health Care Services in Toronto.**” I am looking for **service providers** working with women refugees and refugee claimants in health care services or settlement services to participate in my research.

The main purpose of the research is to explore women refugees' and refugee claimants' access to reproductive health care services, such as pre- and postnatal care and cervical cancer screening.

Who should participate?

- social workers
- family doctors
- nurses
- psychologist
- midwives
- health promoters
- Any staff involved with this population

If you would be willing to participate in a one hour individual interview to discuss the barriers women refugee and refugee claimants experience when attempting to access reproductive health care services, **I would like to speak with you!**

I can be reached by email at [email address].

If you agree to participate in this research, you will receive an informed consent form advising you of your rights and of the measures that will be taken to preserve confidentiality. Please be advised that the research has been reviewed and approved for compliance to research ethics protocols by the **Human Participants Review Subcommittee (HPRC) of York University**. Be assured that the information you provide will remain confidential and that your identity will be protected.

If you know someone else who fits the criteria above and might be interested, please feel free to pass this information on.

Thank you for your time and consideration,

Helen Gateri

Ph.D. Candidate
York University

Appendix F: Letter to Service Providers

Date:

Dear Madam/Sir,

I am a doctoral student at York University, School of Social Work, under the supervision of Dr. Nick Mulé [telephone number]; [email address]. I am writing to ask for your assistance with recruiting participants for my dissertation research (a requirement of my doctoral degree). Your organization has been selected because you provide services to women refugees and refugee claimants.

The title of my study is “Exploring Barriers Refugees and Refugee Claimants Experience Accessing Reproductive Health Care Services in Toronto.” This study has been approved by the Ethics Review Board of York University. The study aims to understand the barriers that women refugees and refugee claimants experience when attempting to access reproductive health care services, such as prenatal care, postnatal care, and screening for cervical cancer. The participants will be asked some broad open-ended questions about their experiences with the Canadian health care system, particularly about pre- and postnatal care and screening for cervical cancer. Based on the experiences and perspectives of these women some policy recommendations will be generated aimed at making access to these services more equitable.

I am asking for your help in making women refugees and refugee claimants aware of the study. I need your permission to post an advertisement at your agency asking interested women refugees and refugee claimants to participate in my study. Attached, please find copies of the advertisement and the participant consent form that explains the purpose and procedures of the study. If you are willing to support this work and think your clients might like to participate, please distribute the advertisement by hand or email to the women refugees and refugee claimants you serve. Or you could provide me with the contact information of interested parties.

You or your agency will not be held responsible for the study or any problems arising from the study. You will be provided with copies of the final dissertation and/or any publications resulting from the research if you wish. Research findings could also be shared through oral presentations or any relevant program organized by your agency.

If you are willing to assist with the research project, please provide me with a letter of permission (email or otherwise) to contact your clients. Further, if I could use your facilities to conduct interviews with study participants that would be greatly appreciated.

If you have further questions I would be happy to meet with you to discuss the aims and procedures of the research project.

I look forward to your response.

Yours sincerely,

Helen Gateri

Ph.D. Candidate
York University

**Appendix G:
Interview Questions for Women Refugee Claimants**

1. Personal and demographic information

- a. How do you identify yourself? (Please circle all that apply)
Refugee/ refugee claimant/immigrant/woman of colour/other...
- b. Age
- c. (i) Country of birth
(ii) Last country of residence prior to arriving in Canada
(iii) Other
- d. Length of stay in Canada
- e. Immigration status
- f. Education/highest level of schooling
- g. Yearly family income or economic status
 - (i) We do not have enough money for basic necessities
 - (ii) We have enough money for basic necessities but no extras
 - (iii) We have enough money to buy extra things beyond necessities, at least on some occasions

2. Experiences with and access to health care system

Pre- and Postnatal Care

- a. After moving to Canada, how did you first find out about the Canadian health care system, for example, doctors, nurses, health care services, clinic, midwifery care, and hospitals?
- b. Where do you usually go to seek treatment for pre- and postnatal care or any other health needs?

- c. What are the problems/challenges you usually face seeking pre- and postnatal care or any other health care service?
- d. What is your most pleasant or unpleasant experience with your health care provider or the Canadian health care system?
- e. What changes would you recommend to the health care system in general and in particular pre- and postnatal care to make it more accessible to you or to provide better care for you?

Cervical Cancer Screening

- a. Tell me a little bit about your medical care? Do you have a family doctor? Has your doctor or health care professional recommended that you have a Pap smear test (screening for cervical cancer) or referred you to another health care provider to do the test?
- b. If you have not had a Pap smear test, could you tell me why?
(Doctor's gender, fear of screening, distrust, alternative practices, lack of knowledge?)
- c. If you have had a Pap test, could you tell me what the experience was like?
(Equipment, staff, support, test result?)
- d. Is there anything that concerns you about having a Pap smear test?
(Location, transportation, childcare, etc.?)
- e. What is your understanding of this test and of cancer screening?
- f. What changes would you recommend to the manner in which cervical cancer screening education is introduced (or not introduced) to women refugee and refugee claimants population?
- g. Is there anything else you would like to share with me? Do you have any questions for me?

**Appendix H:
Interview Questions for Service Providers**

1. Personal and demographic information

- a. How do you identify yourself?
- b. Professional background/education
RN _____
NP _____
Physician _____
Social Worker _____
Other _____
- c. Years of experience working with refugees, refugee claimants, and women _____
What percentage of your clients are women refugees _____?
What percentage of your clients are refugee claimants _____?

2. Pre- and Postnatal Care

- a. How do women refugees and refugee claimants in need of pre- and postnatal care find out about your services and/or the Canadian health care system?
- b. How knowledgeable are these women about the services they need?
For example, pre-natal and postnatal care with service providers or group programs?
- c. What reproductive health care services and general services are available to them?
- d. What are the problems/challenges they experience seeking pre- and postnatal care or other health care services?
- e. Are there any challenges you have experienced/experience providing pre-and postnatal reproductive care or working with women refugees and refugee claimants?

- e. What would you recommend be changed about the Canadian health care system in general and pre- and postnatal care in particular to make it more accessible to women refugees and refugee claimants or to provide better care to these women?

Cervical Cancer Screening

- a. Can you tell me about the women refugees and refugee claimants you serve in your organization? Do you help them to find a family doctor or do they have family doctors in your agency? Do you know if the doctors generally recommend that they have the Pap smear test (screening for cervical cancer) or refer them to other health care providers to have this test?
- b. Are these women knowledgeable about the services they need? For example, do health care providers let them know that it is recommended that a woman have a Pap test every 3 years?
- c. What health education resources are available to them?
- d. As a service provider or health care provider could you describe some of the challenges women refugees and refugee claimants experience with respect to cervical cancer screening?
- e. Can you tell me what aspect of Pap smear screening you think may be problematic for women refugees and refugee claimants, and for health care providers working with these women? Are there different problems/issues for women of different ages or different migration categories? Are there problems with equipment? Is there time to teach about screening?
- f. Are there any challenges you have experienced/experience providing reproductive health care or working with women refugees and refugee claimants?
- g. What are some recommendations you would make for other health care providers or services providers and policy makers to make cervical cancer screening more accessible to women refugees and refugee claimants?
- h. Is there is anything else you would like to add or any question you would like to ask?

**Appendix I:
Informed Consent Letter for Service Providers:
Focus Group**

Date:

Study Name: “Exploring Barriers Refugees and Refugee Claimants Experience Accessing Reproductive Health Care Services in Toronto.”

Researcher: My name is Helen Gateri. I am a doctoral student at York University, School of Social Work. My faculty supervisor is Dr. Nick Mulé. I am doing this research as part of the requirements for my PhD degree. I would like to meet with service providers working with women refugees and refugee claimants in a focus group setting to discuss reproductive health care services access barriers experienced by these women. If you are interested in participating, please contact me by email at [email address].

Purpose of the Research: The purpose of the study is to investigate: 1). How women refugees and refugee claimants engage with pre- and postnatal care and cervical cancer screening, and prevention. 2). What shapes these women’s use or lack of use of pre- and postnatal care and cervical cancer screening services? 3). What are these women’s experiences with the health care system in general, in particular pre- and postnatal care and cancer screening services? Are these experiences related to their refugee status? 4). How do the broader system, structures, and policies in Canada shape women refugees’ and refugee claimants’ participation in and access to pre- and postnatal care and cervical cancer screening services?

What you will be asked to do in the research: If you agree to participate in this study, you will take part in a focus group with other service providers and the researcher. The focus group will take about 90 minutes and will be held at a community health centre or settlement agency. The discussion will be guided by a series of open-ended questions. It will begin with questions about how each participant identifies him or herself in terms of ethnicity, education background and years of experience. Then there will be a discussion of the barriers women refugees and refugee claimants experience with access to pre- and postnatal care and cervical cancer screening. How knowledgeable are the women you serve about what is available and what they need?

Risks or Discomfort: Risks or discomfort related to this study are primarily related to sharing your personal experiences in the context of a focus group. Additional risks may include those associated with expressing a different perspective than that of co-workers, and particularly those in a greater position of power. You do not need to answer any questions that make you uncomfortable. Please be advised that you can stop participating in the focus group at any time. You are also welcome to contact me after the focus group if you want any

part of your remarks to be removed from the transcript or you want to withdraw from the study.

Benefits of the research and benefit to you: There are no direct benefits to participants as a result of participating in this study. However, you may enjoy the opportunity to share your experiences and be part of an ongoing effort to make health care services accessible to all refugees in Canada.

Voluntary Participation: Participation in this study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer will not affect your relationship with the researchers, York University, or any other group associated with this project either now, or in future.

Withdrawal from the study: You can stop participating in the study at any time, for any reason. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researchers, York University, or any other group associated with this project either now or in the future. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

Confidentiality: All information shared during the focus group will be held in confidence and unless you specifically indicate your consent, your name will not appear in any report or publication of the research. The collected data, consisting of handwritten notes and transcripts of the focus groups discussion will be safely stored in a locked cabinet. All the recordings will be kept in the researcher's personal computer protected by a password. The focus group transcripts and data will be destroyed 3 years after graduation. Confidentiality of participants will be fully maintained, to the extent allowed by law.

Questions about the Study: If you have questions about the research or about your role in the study, please feel free to contact Dr. Nick Mulé either by [telephone number] or by email [email address]. This research has been reviewed and approved by the **Human Participants Review Sub-Committee; York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines.** If you have any questions about this process or about your rights as a participant in the study, you may contact the senior manager and policy advisor for the Office of Research Ethics, 5th Floor, York Research Tower, York University, telephone: 416-736-5914 or email: ore@yorku.ca

Legal Rights and Signatures:

I, _____, consent to participate in the study entitled **“Exploring Barriers Refugees and Refugee Claimants Experience Accessing Reproductive Health Care Services in Toronto”** conducted by Helen Gateri. I understand the nature of the study and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature _____ **Date** _____
Participant

Signature _____ **Date** _____
Helen Gateri (Principle Investigator)

Appendix J:
Second Informed Consent Letter for Service Providers:
Individual Interviews

Date:

Study Name: “Exploring Barriers Refugees and Refugee Claimants Experience Accessing Reproductive Health Care Services in Toronto.”

Researcher: My name is Helen Gateri. I am a doctoral student at York University, School of Social Work. My faculty supervisor is Dr. Nick Mulé. I am doing this research as part of the requirements for my PhD degree. I would like to interview service providers working with women refugees and refugee claimants about reproductive health care services access barriers experienced by these women. If you are interested in participating, please contact me by email at [email address].

Purpose of the Research: The purpose of the study is to investigate: 1). How women refugees and refugee claimants engage with pre-and postnatal care and cervical cancer screening, and prevention. 2). What shapes these women’s use or lack of use of pre- and postnatal care and cervical cancer screening services? 3). What are these women’s experiences with the health care system in general, in particular pre- and postnatal care and cancer screening services? Are these experiences related to their refugee status? 4). How do the broader system, structures, and policies in Canada shape women refugees’ and refugee claimants’ participation in and access to pre- and postnatal care and cervical cancer screening services?

What you will be asked to do in the research: If you agree to participate in this study, you will take part in a confidential interview with the researcher. Interviews should take about one hour and take place at a time and location that is convenient for you and the researcher. The interview will be guided by a series of open-ended questions. It will begin with questions about you identify in terms of ethnicity, education background and years of experience. Then there will be questions about the barriers women refugees and refugee claimants experience with access to pre- and postnatal care and cervical cancer screening. How knowledgeable are the women you serve about what is available and what they need?

Risks or Discomfort: Risks or discomfort related to this study are primarily related to sharing your personal experiences in the context of a focus group. You do not need to answer any questions that make you uncomfortable. Please be advised that you can stop participating in the interview at any time. You are also welcome to contact me after the interview if you want any part of your remarks to be removed from the transcript or you want to withdraw from the study.

Benefits of the research and benefit to you: There are no direct benefits to participants as a result of participating in this study. However, you may enjoy the opportunity to share your

experiences and be part of an ongoing effort to make health care services accessible to all refugees in Canada.

Voluntary Participation: Participation in this study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer will not affect your relationship with the researchers, York University, or any other group associated with this project either now, or in future.

Withdrawal from the study: You can stop participating in the study at any time, for any reason. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researcher, York University, or any other group associated with this project either now or in the future. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

Confidentiality: All information shared during the interview will be held in confidence and unless you specifically indicate your consent, your name will not appear in any report or publication of the research. The collected data, consisting of handwritten notes and transcripts of the audio recordings, will be safely stored in a locked cabinet. All the recordings will be kept in the researcher’s personal computer protected by a password. The focus group transcripts and data will be destroyed 3 years after graduation. Confidentiality of participants will be fully maintained, to the extent allowed by law.

Questions about the Study: If you have questions about the research or about your role in the study, please feel free to contact Dr. Nick Mulé either by [telephone number] or by email [email address]. This research has been reviewed and approved by the **Human Participants Review Sub-Committee; York University’s Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines.** If you have any questions about this process or about your rights as a participant in the study, you may contact the senior manager and policy advisor for the Office of Research Ethics, 5th Floor, York Research Tower, York University, telephone: 416-736-5914 or email: ore@yorku.ca

Legal Rights and Signatures:

I, _____, consent to participate in the study entitled “**Exploring Barriers Refugees and Refugee Claimants Experience Accessing Reproductive Health Care Services in Toronto**” conducted by Helen Gateri. I understand the nature of the study and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature _____ **Date** _____
Participant

Signature _____ **Date** _____
Helen Gateri (Principle Investigator)

Appendix K: Informed Consent Letter for Women Refugee Claimants

Date:

Study Name: “Exploring Barriers Refugees and Refugee Claimants Experience Accessing Reproductive Health Care Services in Toronto.”

Researcher: My name is Helen Gateri. I am a doctoral student at York University, School of Social Work. My faculty supervisor is Dr. Nick Mulé. I am doing this research as part of the requirements for my PhD degree. I would like to interview women refugees and refugee claimants about barriers they experience accessing reproductive health care services. If you are interested in participating, please contact me by email at [email address]

Purpose of the Research: The purpose of the study is to investigate: 1). How women refugees and refugee claimants engage with pre- and postnatal care and cervical cancer screening and prevention. 2). What shapes these women’s use or lack of use of pre- and postnatal care and cervical cancer screening services? 3). What are these women’s experiences with the health care system in general, in particular with pre- and postnatal care and cancer screening? Are these experiences related to their refugee status? 4). How do the broader system, structures, and policies in Canada shape women refugees’ and refugee claimants’ participation in and access to pre- and postnatal care and cervical cancer screening services?

What you will be asked to do in the research: If you agree to participate in this study, you will take part in a confidential interview with the researcher. Interviews should take about one hour and take place at a time and location that is convenient for you. During the interview you will be asked general questions about your age, migration status, education level, and so on. You will also be asked about what your experiences with and access to pre- and postnatal care and cervical cancer screening. With your permission, the interview will be audio-recorded. If you do not agree to an audio-recording of your interview, the researcher will take detailed handwritten notes on the information you provide.

Risks or Discomfort: Risks or discomfort related to this study are primarily related to sharing your personal experiences during the interview. You do not need to answer any questions that make you uncomfortable. Please be advised that you can stop participating in the interview at any time. You are also welcome to contact me after the interview if you change your mind about participating and you want any part of the interview removed from the record or to withdraw from the study.

Benefits of the research and benefit to you: There are no direct benefits to participants as a result of participating in this study. However, you may enjoy the opportunity to share your

story and be part of an ongoing effort to make health care services more readily available to refugees in Canada.

Voluntary Participation: Participation in this study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer will not affect your relationship with York University or any other group associated with this project either now or in future.

Withdrawal from the study: You can stop participating in the study at any time, for any reason, if you decide to do so. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researchers, York University, or any other group associated with this project. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

Confidentiality: All information shared with the researcher will be held in confidence, if you specifically indicate your consent, your name will not appear in any report or publication of the research. The collected data, consisting of handwritten notes and transcripts of the audio recordings, will be safely stored in a locked cabinet. All the recordings will be kept in the researcher's personal computer protected by a password. The interview transcripts and data will be destroyed 3 years after graduation. Confidentiality of participants and all the study findings will be fully maintained to the extent allowed by law.

Questions about the Study: If you have questions about the research or about your role in the study, please feel free to contact Dr. Nick Mulé either by [telephone number] or by email [email address]. This research has been reviewed and approved by **Human Participants Review Sub-Committee; York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines.** If you have any questions about this process or about your rights as a participant in the study, please contact the senior manager and policy advisor for the Office of Research Ethics, 5th Floor, York Research Tower, York University, telephone: 416-736-5914 or by email: ore@yorku.ca.

Legal Rights and Signatures:

I, _____, consent to participate in the study entitled "**Exploring Barriers Refugees and Refugee Claimants Experience Accessing Reproductive Health Care Services in Toronto,**" conducted by Helen Gateri. I understand the nature of the study and that I am not waiving any of my legal rights by signing this form. My choice of having my interview audio-recorded or not recorded is indicated by the check mark I have placed in one of the two circles, and my signature below indicates my consent to participate.

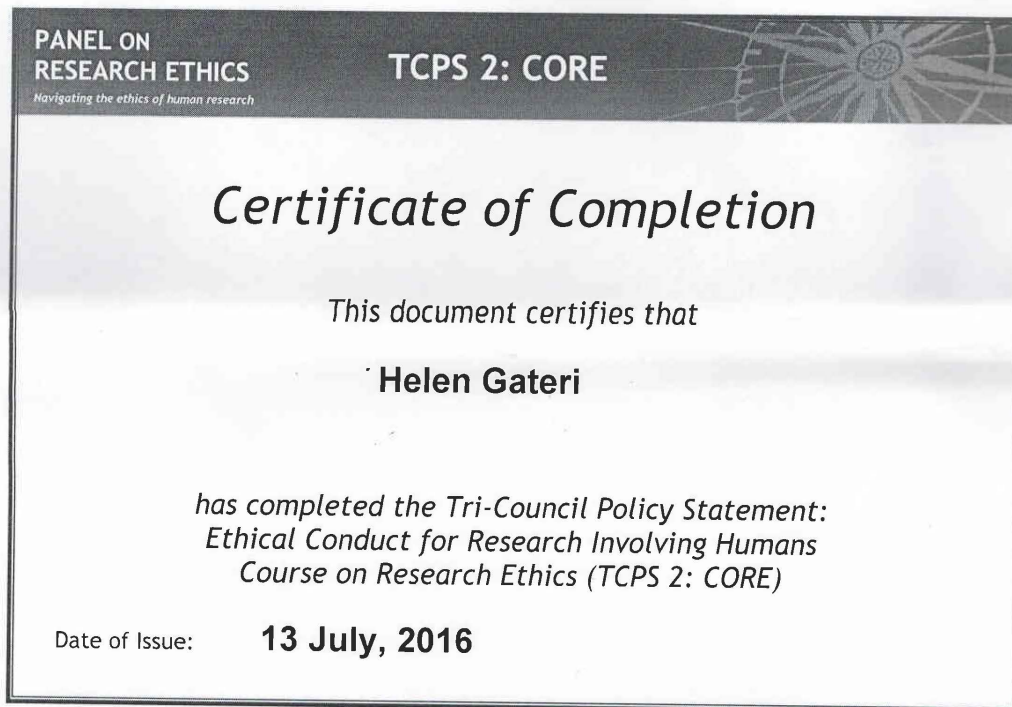
- I agree to have my interview audio-recorded.

- I do not agree to have my interview audio-recorded. I prefer to have the researcher make handwritten notes of the information I provide in the interview.

Signature _____ **Date** _____
Participant

Signature _____ **Date** _____
Helen Gateri (Principle Investigator)

**Appendix L:
Certificate of Completion
Tri-Council Policy Statement:
Ethical Conduct for Research Involving Humans
Course on Research Ethics**



Appendix M: Form TD1: Thesis/Dissertation Research Submission

Form TD1: Thesis/Dissertation Research Submission

(Please print clearly or type)

Students must complete the top portion of this form and deliver it along with copies of completed appropriate documents (as indicated below) to their program office.



Student Helen Waigumo Gateri ID# _____

Program Social Work Degree PhD Date 2016

Title of Research Proposal Exploring Barriers Refugees and Refugee Claimants Experience Accessing Reproductive Health Care Services in Toronto

Type of research	Documents to submit
Please check one:	Program will forward the following to the Office of the Dean, Graduate Studies, 230 York Lanes
<input type="checkbox"/> No human participants →	<input type="checkbox"/> TD1 form <input type="checkbox"/> Proposal <input type="checkbox"/> TD 4 form (if involves animals or biohazards) + HPRC Approval Certificate
<input checked="" type="checkbox"/> Human participants, minimum risk, with written consent →	<input checked="" type="checkbox"/> TD1 form <input checked="" type="checkbox"/> Proposal <input checked="" type="checkbox"/> TD2 form (original + 1 copy) <input checked="" type="checkbox"/> Informed consent documents (written or verbal script) (original + 1 copy) <input checked="" type="checkbox"/> TD3 form <input checked="" type="checkbox"/> TCPS Tutorial Certificate dated within last 2 years
<input type="checkbox"/> Human participants, minimum risk, with verbal consent	
<input type="checkbox"/> Human participants, funded by faculty research grant →	<input type="checkbox"/> TD1 form <input type="checkbox"/> TD4 form + HPRC Approval Certificate <input type="checkbox"/> Proposal <input type="checkbox"/> TCPS Tutorial Certificate dated within last 2 years
<input type="checkbox"/> High risk or funded →	<input type="checkbox"/> TD1 form <input type="checkbox"/> Proposal <input type="checkbox"/> Completed appropriate HPRC package plus 6 copies (submit to FGS for forwarding to HPRC) <input type="checkbox"/> TCPS Tutorial Certificate dated within last 2 years

TD1 = Thesis/Dissertation Research Submission Form

TD2 = York University Graduate Student Human Participants Research Protocol Form

TD3 = Informed Consent Document Checklist

TD4 = Statement of Relationship between Proposal and an Existing HPRC Approved Project

Graduate Program Director Recommendation:

I recommend to the Faculty of Graduate Studies approval of the proposal for the above student. The Supervisory Committee has reviewed the Research Proposal and has recommended it be submitted for approval.

Supervisory Committee <small>(Please print/type) (If additional members are on the committee, please attach listing)</small>	Member of York Graduate Program in <small>(list program relevant to this supervision; See FGS Appointment list www.yorku.ca/grads/fmr.htm)</small>	Date	Supervisory Committee Approval <small>(Please sign or attach e-mail indicating approval of proposal)</small>
Supervisor: Nick Mule	Social Work		
Member: Susan McGrath	Social Work		
Member: Michaela Hynie	Psychology		
Member:			

A TCPS tutorial certificate dated within the past 2 years must be attached.

Graduate Program Director Signature

Date

Associate Dean, FGS Signature

Date

TD1 Form Effective February 2008

Appendix N:
Form TD2: York University Graduate Student
Human Participants Research Protocol:
Original & Second Copy

YORK UNIVERSITY GRADUATE STUDENT HUMAN PARTICIPANTS RESEARCH PROTOCOL		
Student Name: Helen Waigumo Gateri	Date: June 20, 2016	
E-mail: _____	Phone Number: _____	
Program: Social Work	Degree: PhD	
Check one: <input type="checkbox"/> Thesis <input checked="" type="checkbox"/> Dissertation <input type="checkbox"/> Major Research Paper <input type="checkbox"/> Course		
Title: Exploring Barriers Refugees and Refugee Claimants Experience Accessing Reproductive Health Care Services in Toronto		
Name of Supervisor (Thesis, Dissertation or MRP) or Course Director:		

PART A - GENERAL INFORMATION

1. Is the research you are conducting funded?

No Yes

The definition of "funded" does not include funding in the form of student OGS scholarships, SSHRC fellowships, NSERC scholarships, or CIHR studentships. These awards are intended to support students through their studies and do not require reports from students on the specific research activities conducted. The definition of "funded" does apply to grants awarded for specific research projects, whether those projects be the student's own research projects or research being conducted as part of a faculty member's funded research project. Typically, for funded research, granting agencies require reports of the research conducted.

2. Is this a revised version of a protocol previously submitted to FGS (and/or HPRC)?

No Yes If yes, please explain.

PLEASE DO NOT SUBMIT YOUR PROPOSAL TO THE HPRC OFFICE

For Thesis or Dissertation this protocol must be submitted to the Office of the Dean, Graduate Studies accompanied by *Thesis/Dissertation Proposal Submission Form (i.e. TD1)* and your thesis/dissertation proposal.

In cases requiring preliminary research, this protocol must be submitted to the Office of the Dean, Graduate Studies accompanied by *Thesis/Dissertation Proposal Submission Form (i.e. TD1)* and your research proposal. Please indicate on the TD1 form that your research is a pilot study, or preliminary research.

PART B: RESEARCH INFORMATION

1. Are the risks to participants more than minimum risk*?

No Yes

*The Human Participants Research Committee uses the definition of minimal risk as outlined in the SSHRC/NSERC/CIHR *Tri-Council Policy Statement "Ethical Conduct for Research Involving Humans"* (August 1998): "If potential subjects can reasonably be expected to regard the probability and magnitude of possible harms implied by participation in the research to be no greater than those encountered by the subject in those aspects of his or her everyday life that relate to the research then the research can be regarded as within the range of minimal risk" (p. 1.5). An expanded version of this definition is available from the Office of Research Ethics (5th Floor, York Research Tower) upon request.

2. Project Description and Rationale:

In layperson's terms, please provide a general and very brief description of the research and rationale (e.g., hypotheses, goals and objectives etc.)

This study is premised on the hypothesis based on my experience with refugees and refugee claimants' and on the extensive literature review, that refugees and refugee claimants' face barriers in Toronto that impede their access to health care services. The goal of the study is to understand the barriers that women refugees and refugee claimants' experience when accessing reproductive health care services. Such as prenatal care, postnatal care, and screening for cervical cancer (by means of the Pap test) within the broader social, political, economic and historical context.

The proposed study objective are:

- a). To explore and depict the complex and multiple intersecting influences on women refugees and refugee claimants' access to reproductive health care services from their diverse life contexts in Toronto.
- b). To gain an insight on how these women experience access to reproductive health care services in Toronto taking into account their gendered, racialized, and classed identities.

This study is significant to service providers, educators and policymakers for the following reasons:

- a). To gain the perspectives of women refugees and refugee claimants' regarding how their gendered, racialized, and classed experiences intersect to situate them in marginalized positions from which it becomes difficult to access reproductive health services would be important in an increasingly diverse Canadian communities where the state is accepting many refugees in the country and are receiving health care services.
- b). In my previous experience as a frontline social worker in a Community Health Centre that provides health care services to racialized immigrant and refugee women in downtown Toronto, service providers grapple with issues and concerns of gender, race, class and other social inequalities that create barriers for women refugees and refugee claimants' access to reproductive health care services. These issues require ongoing dialogue and research to inform health care providers, educators and policymakers on the structural inequities that impede some marginalized groups access to health care services.

3. Participants:

- a. State who the participants will be (e.g. experimental subjects, interviewees, community members to be observed, etc.). Please provide details about the research subjects that are relevant to your particular research (number, age, sex, students, children, businesspeople, government employees, etc). Also discuss the relationship of the researchers to the prospective subjects (e.g. teacher, parent, advisor, stranger, etc.):

Research participants:

- a). 15 to 20 participants
- b). women refugees and refugee claimants' of childbearing age, between 21 and 45 years of age
- c). service providers working with women refugees and refugee claimants', for example, social workers, psychologists, nurses, family doctors and others.

I have no relationship with the prospective subjects.

- b. How will the participants be recruited (e.g., snowball technique, random sampling, previously known to the interviewer, telephone solicitation, etc)?

Participant recruitment:

- a). Purposive sampling
- b). Snowball sampling

c. Will you be offering inducements to participate (e.g., money, gift certificates, academic credit, etc.)?

No Yes (If yes, please elaborate)

d. What exactly will be required of the participants (e.g., answer a formal questionnaire, respond to interview questions, engage in a free-ranging discussion, undergo any medical procedures, etc.)? If applicable, please attach any research instruments (e.g., sample interview questions, questionnaires, etc).

Requirement of the participants:

- a). consent to participate in the study in a confidential interview with the researcher
- b). interviews will take around one hour at a location of the participant's choice and convenience.
- c). the interviews will consist of answering open-ended questions.

4. Risks and Benefits:

a. What are the risks to the participants?

Participants may be asked questions related to sharing their personal experiences that may be uncomfortable. To minimize the risks for participants, they will be advised of their rights to refuse answering questions if they are uncomfortable.

b. What are the benefits to the participants?

There are no direct benefits to participants as a result of participating in this study. However, the intent of the study is to provide an opportunity to participants to share their experiences and be part of an ongoing effort to make health care services available to refugees in Canada.

Part C: This section pertains to issues around informed consent. Before completing, please read "Important Statement Regarding Informed Consent" attached to the end of this form.

1. Will you provide a full explanation of the research to the participants prior to their participation?

Yes No (If NO, please elaborate)

2. Is substitute consent involved (e.g., for children, youths under 16, incompetent adults)?

Yes No

3. Is deception involved?

Yes No (If YES, please elaborate below. Please comment on debriefing, if applicable.)

4. Will individuals remain anonymous?

Please note that it is expected that participants remain anonymous unless they have given their prior written consent.)

Yes No (If NO, please elaborate below.)

5. Will the data be kept confidential?

Please note that it is expected that the data will be kept confidential unless the participants have given their permission otherwise. Please also note that if you advise participants that the data will be confidential, you should state that confidentiality will be ensured, within the limits of the law.)

Yes No (If NO, please elaborate below).

6. How will data be securely stored and for how long?

The collected data in form of handwritten notes, transcripts and audio tape will be safely stored in a locked cabinet. All the recordings in form of digital files will be kept in the researcher's personal laptop computer protected by log-in name and password. The interview transcripts will be destroyed after data is published in various forms.

7. Please also indicate for how long the data will be securely stored and what will happen to the data after the retention period, that is, will it be destroyed or archived (if archived, indicate where)

The collected data will be securely stored for 3 years, as I intend to publish my thesis in various forms. After publication is complete, data will be destroyed.

8. How will informed consent be obtained? (Check one)

Written Informed Consent Document (Please attach draft version)

* Letter (please attach draft version)

* Oral Informed Consent Document (Permissible only in extenuating circumstances, where written communication is not feasible; draft script of oral informed consent must be provided)

*If informed consent is being obtained by letter or verbally, please provide a rationale regarding why an informed consent form is not being used.

Appendix B provides a checklist for the content of the Informed Consent Document.

9. If you have previously received approval for a research ethics protocol, please attach documentation, as appropriate.

STUDENT DECLARATION

I hereby certify that all information on this form and all statements in the attached documentation are correct and complete. I understand that all human participants in the research must have signed a written consent form or have provided oral consent for their participation in the research. I understand that should there be any change in the research methodology or any increased anticipated risks to human participants, I will advise the Faculty of Graduate Studies; if these changes are not minor, my research proposal may be required to undergo a further ethics review. I understand that any misrepresentation in the proposal or attached documentation may lead to a charge of breach of academic honesty. I also understand that I must retain Consent Forms for two years following the completion of the research.

Student's Signature

Date

SUPERVISOR DECLARATION

I hereby certify that all information on this form and all statements in the attached documentation are correct and complete. I have advised the student that, as specified in Item 6 above and in attached documentation, all human participants in the research must have signed a written consent form or have provided oral consent for their participation in the research. I have advised the student that the Faculty of Graduate Studies will be advised of any changes in research methodology or any increased anticipated risks to human participants and that a further ethics review may be required as a result of such changes. I have advised the student that Consent Forms must be retained for two years following the completion of the research.

A TCPS tutorial certificate dated within the past 2 years is attached

Signature of supervisor (of Thesis, Dissertation, or MRP)
or Course Director

Date

Important Statement Regarding Informed Consent

- A. The HPRC has adopted the position that all human participants (e.g., interviewees, research subjects, community members, etc) have the right to be informed of:
- the nature of the research (hypotheses, goals and objectives, etc.);
 - the research methodology to be used (e.g., medical procedures, questionnaires, participant observation, etc.);
 - any risks or benefits;
 - their right not to participate, not to answer any questions, and/or to terminate participation at anytime without prejudice (e.g., without academic penalty, withdrawal of remuneration, etc.)
 - their right to anonymity and confidentiality;
 - any other issues of which the participants should be aware that are relevant to specific protocols and research projects.
- B. The HPRC recognizes that the manner the researcher uses to obtain the informed consent varies according to the nature of the research, status of the participants, and culturally-specific norms. Although the HPRC requires that the principles of informed consent (outlined in A. above) be met, it is very flexible in how this consent is obtained. The HPRC will accept any of the three methods outlined below:
1. Informed consent form: The traditional informed consent form is the standard for research involving human participants. This would detail the principles outlined in A. above, and require the participants' signatures.
 2. Letter: Where the traditional informed consent form is not appropriate (e.g., interviews with artists or government officials, mass mailed questionnaires, etc.), the researcher may wish to seek permission through a letter inviting them to participate. This letter must nonetheless incorporate the principles of informed consent outlined in A. above.
 3. Verbal statement: In some instances, where written communication is not feasible (children, illiterate adults, certain communities), researchers can relay the principles outlined in A. above verbally.

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http://www.yorku.ca/grads/current_students/ethics.html

The Office of the Dean, Graduate Studies has also developed the *Informed Consent Document Checklist for Graduate Students* to assist in the preparation of appropriate informed consent documentation.

- C. The HPRC recognizes that researchers completing this protocol may not be at the stage of their research where they are able to provide this information. Nonetheless, the HPRC requires that a "best effort" draft be attached to this protocol. **PROTOCOLS THAT DO NOT ATTACH THIS INFORMATION WILL BE RETURNED.**

November 2009

Human Participants Research Protocol
Effective: November, 2009

Form TD2: Second Copy

YORK UNIVERSITY GRADUATE STUDENT HUMAN PARTICIPANTS RESEARCH PROTOCOL				
Student Name:	Helen Waigumo Gateri	Date:	June 20, 2016	
E-mail:	_____	Phone Number:	_____	
Program:	Social Work	Degree:	PhD	
Check one:	<input type="checkbox"/> Thesis	<input checked="" type="checkbox"/> Dissertation	<input type="checkbox"/> Major Research Paper	<input type="checkbox"/> Course
Title:	Exploring Barriers Refugees and Refugee Claimants Experience Accessing Reproductive Health Care Services in Toronto			
Name of Supervisor (Thesis, Dissertation or MRP) or Course Director:				

PART A - GENERAL INFORMATION

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No Yes

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In cases requiring preliminary research, this protocol must be submitted to the Office of the Dean, Graduate Studies accompanied by *Thesis/Dissertation Proposal Submission Form (i.e. TD1)* and your research proposal. Please indicate on the TD1 form that your research is a pilot study, or preliminary research.

Human Participants Research Protocol
Effective: November, 2009

PART B: RESEARCH INFORMATION

1. Are the risks to participants more than minimum risk*?

No Yes

*The Human Participants Research Committee uses the definition of minimal risk as outlined in the SSHRC/NSERC/CIHR *Tri-Council Policy Statement "Ethical Conduct for Research Involving Humans"* (August 1998): "If potential subjects can reasonably be expected to regard the probability and magnitude of possible harms implied by participation in the research to be no greater than those encountered by the subject in those aspects of his or her everyday life that relate to the research then the research can be regarded as within the range of minimal risk" (p. 1.5). An expanded version of this definition is available from the Office of Research Ethics (5th Floor, York Research Tower) upon request.

2. Project Description and Rationale:

In layperson's terms, please provide a general and very brief description of the research and rationale (e.g., hypotheses, goals and objectives etc.)

This study is premised on the hypothesis based on my experience with refugees and refugee claimants' and on the extensive literature review, that refugees and refugee claimants' face barriers in Toronto that impede their access to health care services. The goal of the study is to understand the barriers that women refugees and refugee claimants' experience when accessing reproductive health care services. Such as prenatal care, postnatal care, and screening for cervical cancer (by means of the Pap test) within the broader social, political, economic and historical context.

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3. Participants:

- a. State who the participants will be (e.g. experimental subjects, interviewees, community members to be observed, etc.). Please provide details about the research subjects that are relevant to your particular research (number, age, sex, students, children, businesspeople, government employees, etc). Also discuss the relationship of the researchers to the prospective subjects (e.g. teacher, parent, advisor, stranger, etc.):

Research participants:

- a). 15 to 20 participants
- b). women refugees and refugee claimants' of childbearing age, between 21 and 45 years of age
- c). service providers working with women refugees and refugee claimants', for example, social workers, psychologists, nurses, family doctors and others.

I have no relationship with the prospective subjects.

- b. How will the participants be recruited (e.g., snowball technique, random sampling, previously known to the interviewer, telephone solicitation, etc)?

Participant recruitment:

- a). Purposive sampling
- b). Snowball sampling

c. Will you be offering inducements to participate (e.g., money, gift certificates, academic credit, etc.)?

No Yes (If yes, please elaborate)

d. What exactly will be required of the participants (e.g., answer a formal questionnaire, respond to interview questions, engage in a free-ranging discussion, undergo any medical procedures, etc.)? If applicable, please attach any research instruments (e.g., sample interview questions, questionnaires, etc).

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Part C: This section pertains to issues around informed consent. Before completing, please read "Important Statement Regarding Informed Consent" attached to the end of this form.

1. Will you provide a full explanation of the research to the participants prior to their participation?

Yes No (If NO, please elaborate)

2. Is substitute consent involved (e.g., for children, youths under 16, incompetent adults)?

Yes No

3. Is deception involved?

Yes No (If YES, please elaborate below. Please comment on debriefing, if applicable.)

4. Will individuals remain anonymous?

Please note that it is expected that participants remain anonymous unless they have given their prior written consent.)

Yes No (If NO, please elaborate below.)

5. Will the data be kept confidential?

Please note that it is expected that the data will be kept confidential unless the participants have given their permission otherwise. Please also note that if you advise participants that the data will be confidential, you should state that confidentiality will be ensured, within the limits of the law.)

Yes No (If NO, please elaborate below).

6. How will data be securely stored and for how long?

The collected data in form of handwritten notes, transcripts and audio tape will be safely stored in a locked cabinet. All the recordings in form of digital files will be kept in the researcher's personal laptop computer protected by log-in name and password. The interview transcripts will be destroyed after data is published in various forms.

7. Please also indicate for how long the data will be securely stored and what will happen to the data after the retention period, that is, will it be destroyed or archived (if archived, indicate where)

The collected data will be securely stored for 3 years, as I intend to publish my thesis in various forms. After publication is complete, data will be destroyed.

8. How will informed consent be obtained? (Check one)

Written Informed Consent Document (Please attach draft version)

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Appendix B provides a checklist for the content of the Informed Consent Document.

9. If you have previously received approval for a research ethics protocol, please attach documentation, as appropriate.

STUDENT DECLARATION

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Student's Signature

Date

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A TCPS tutorial certificate dated within the past 2 years is attached

Signature of supervisor (of Thesis, Dissertation, or MRP)
or Course Director

Date

Important Statement Regarding Informed Consent

- A. The HPRC has adopted the position that all human participants (e.g., interviewees, research subjects, community members, etc) have the right to be informed of:
- the nature of the research (hypotheses, goals and objectives, etc.);
 - the research methodology to be used (e.g., medical procedures, questionnaires, participant observation, etc.);
 - any risks or benefits;
 - their right not to participate, not to answer any questions, and/or to terminate participation at anytime without prejudice (e.g., without academic penalty, withdrawal of remuneration, etc.)
 - their right to anonymity and confidentiality;
 - any other issues of which the participants should be aware that are relevant to specific protocols and research projects.

- B. The HPRC recognizes that the manner the researcher uses to obtain the informed consent varies according to the nature of the research, status of the participants, and culturally-specific norms. Although the HPRC requires that the principles of informed consent (outlined in A. above) be met, it is very flexible in how this consent is obtained. The HPRC will accept any of the three methods outlined below:

1. Informed consent form: The traditional informed consent form is the standard for research involving human participants. This would detail the principles outlined in A. above, and require the participants' signatures.
2. Letter: Where the traditional informed consent form is not appropriate (e.g., interviews with artists or government officials, mass mailed questionnaires, etc.), the researcher may wish to seek permission through a letter inviting them to participate. This letter must nonetheless incorporate the principles of informed consent outlined in A. above.
3. Verbal statement: In some instances, where written communication is not feasible (children, illiterate adults, certain communities), researchers can relay the principles outlined in A. above verbally.

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- C. The HPRC recognizes that researchers completing this protocol may not be at the stage of their research where they are able to provide this information. Nonetheless, the HPRC requires that a "best effort" draft be attached to this protocol. PROTOCOLS THAT DO NOT ATTACH THIS INFORMATION WILL BE RETURNED.

November 2009

Human Participants Research Protocol
Effective: November, 2009

**Appendix O:
Form TD3: Informed Consent Document Checklist for Researchers:
Original & Second Copy**

APPENDIX B
FORM TD3
INFORMED CONSENT DOCUMENT CHECKLIST FOR RESEARCHERS

YES	NO	N/A	DESCRIPTION
<input checked="" type="radio"/>	<input type="radio"/>	----	Have you included a brief description of the purpose/rationale of the study?
<input checked="" type="radio"/>	<input type="radio"/>	----	Have you included a brief description of the study design?
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	If the research involves a questionnaire or a survey, have you provided the questionnaire or survey? Or supplied sample questions?
<input checked="" type="radio"/>	<input type="radio"/>	----	Have you indicated the time commitment required of participants?
<input checked="" type="radio"/>	<input type="radio"/>	----	Have you indicated whether and what incentives are offered to participants and why?
<input checked="" type="radio"/>	<input type="radio"/>	----	Have you included a brief description of risks/benefits and mitigation methods?
<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	If the study involves any type of physiological assessment or procedure (such as those studies undertaken by Kinesiology and/or psychology researchers), have you provided the following information in the Informed Consent Document?: i. Information about the expertise of the researchers conducting the study (i.e., if it involves giving an injection, that the researcher is competent to do so) ii. Notification to participants of any measures that are being taken to safeguard their person iii. Notification to participants of any potential risks and/or impacts to their person due to their participation iv. Information for participants on any anticipated circumstances arising from their participation in the study v. Notification to participants of any benefits vi. Contact information for participants regarding resources available to them should any concerns arise at a later date
<input checked="" type="radio"/>	<input type="radio"/>	----	Have you described the methods by which confidentiality and anonymity will be attained and maintained?
<input checked="" type="radio"/>	<input type="radio"/>	----	Have you included statements of the following (as applicable)?: i. Participants have the right not to answer questions ii. Participants have the right to withdraw at any time iii. Should a participant withdraw from the study, all data generated as a consequence of their participation shall be destroyed iv. Participants shall address any ethical concerns regarding the research to the Manager of Research Ethics v. How the research will be presented or reported
<input checked="" type="radio"/>	<input type="radio"/>	----	Have you described the storage method, length of retention and disposal method of all data gathered during the study?
<input checked="" type="radio"/>	<input type="radio"/>	----	Have you included a statement indicating that the research has been reviewed and approved for compliance to research ethics protocols by the Human Participants Review Subcommittee (HPRC) of York University?
<input checked="" type="radio"/>	<input type="radio"/>	----	Have you provided contact information for participants should they have questions (a contact phone number for <i>your Graduate Program Office</i> and contact information for the <i>Manager, Office of Research Ethics, York University, 309 York Lanes, phone 416-736-5914</i>)
<input checked="" type="radio"/>	<input type="radio"/>	----	Have you provided contact information for yourself as the Principal Investigator (your name, your campus address, your status--i.e., Graduate Student)
<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	If the study involves the use of a minor, have you included: i. A separate information letter to the parents of the minor ii. A separate parental permission letter which is to be attached to the minor's letter of "assent" iii. A line for the Parent or Guardian to indicate their relationship to the minor iv. A signature line for the parent/guardian of the minor.
<input checked="" type="radio"/>	<input type="radio"/>	----	Have you included a signature line and a date line for participants?
<input checked="" type="radio"/>	<input type="radio"/>	----	Have you included a signature and a date line for yourself as Principal Investigator?

Form TD3: Second Copy

APPENDIX B FORM TD3

INFORMED CONSENT DOCUMENT CHECKLIST FOR RESEARCHERS

YES	NO	N/A	DESCRIPTION
<input checked="" type="radio"/>	<input type="radio"/>	----	Have you included a brief description of the purpose/rationale of the study?
<input checked="" type="radio"/>	<input type="radio"/>	----	Have you included a brief description of the study design?
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	If the research involves a questionnaire or a survey, have you provided the questionnaire or survey? Or supplied sample questions?
<input checked="" type="radio"/>	<input type="radio"/>	----	Have you indicated the time commitment required of participants?
<input checked="" type="radio"/>	<input type="radio"/>	----	Have you indicated whether and what incentives are offered to participants and why?
<input checked="" type="radio"/>	<input type="radio"/>	----	Have you included a brief description of risks/benefits and mitigation methods?
<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	If the study involves any type of physiological assessment or procedure (such as those studies undertaken by Kinesiology and/or psychology researchers), have you provided the following information in the Informed Consent Document?: i. Information about the expertise of the researchers conducting the study (i.e., if it involves giving an injection, that the researcher is competent to do so) ii. Notification to participants of any measures that are being taken to safeguard their person iii. Notification to participants of any potential risks and/or impacts to their person due to their participation iv. Information for participants on any anticipated circumstances arising from their participation in the study v. Notification to participants of any benefits vi. Contact information for participants regarding resources available to them should any concerns arise at a later date
<input checked="" type="radio"/>	<input type="radio"/>	----	Have you described the methods by which confidentiality and anonymity will be attained and maintained?
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<input checked="" type="radio"/>	<input type="radio"/>	----	Have you provided contact information for yourself as the Principal Investigator (your name, your campus address, your status--i.e., Graduate Student)
<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	If the study involves the use of a minor, have you included: i. A separate information letter to the parents of the minor ii. A separate parental permission letter which is to be attached to the minor's letter of "assent" iii. A line for the Parent or Guardian to indicate their relationship to the minor iv. A signature line for the parent/guardian of the minor.
<input checked="" type="radio"/>	<input type="radio"/>	----	Have you included a signature line and a date line for participants?
<input checked="" type="radio"/>	<input type="radio"/>	----	Have you included a signature and a date line for yourself as Principal Investigator?

Appendix P: Statement of Relationship Between Proposal and Existing Approved Research/Facilities

**graduate
studies**



Office of the Dean
York University

230 York Lanes – 4700 Keele Street
Toronto, ON, Canada M3J 1P3

Tel: (416) 736-5521
gradstudies.yorku.ca/

TD4 Form

Statement of Relationship between Proposal and Existing Approved Research/Facilities

Student Information		
Name: Helen Waigumo Gateri		
Program: Social Work		
Proposal Title: Exploring Barriers Refugees and Refugee Claimants Experience Accessing Reproductive Health Care Services in Toronto		
Research Information		
Please check appropriate box:		
<input checked="" type="checkbox"/> Research Involving Human Participants		
The above proposal is a subset of a larger project (see title below) for which I am a principal investigator. The full project has existing approval (attached) from the York University Human Participants Review Committee (HPRC). All the procedures, the methods for participant recruitment and methods for obtain informed consent within this proposal were included in the HPRC application of the full project and have not changed. The informed consent form has not changed.		
<input type="checkbox"/> Research Involving Animals		
The above proposal is a subset of a larger project (see title below) for which I am a principal investigator. The full project has existing approval (attached) from the York University Animal Care Committee (ACC). All the procedures for animal care and use within this proposal were included in the Animal Use and Care Protocol application of the full project and have not changed.		
<input type="checkbox"/> Research Involving Biohazards		
The above proposal is a subset of a larger project (see title below) for which I am a principal investigator. The full project has existing approval (attached) from the York University Advisory Committee on Biological Safety (ACBS). All the procedures relating to the use of biological hazards within this proposal were included in the Biosafety Certificate (Research) application to the full project and have not changed.		
Project Title: Exploring Barriers Refugees and Refugee Claimants Experience Accessing Reproductive Health Care Services in Toronto		
Supervisor's Name: Nick Mule	Supervisor's Signature:	Date: (mm/dd/yyyy) 07/13/2016