

# HEALTH ISSUES AND NEEDS OF UNSPONSORED REFUGEE WOMEN IN CANADA: A QUALITATIVE STUDY

by

Vindya Attanayake  
B.A. in Sociology, University of Peradeniya, 2000

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF  
THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SCIENCE

POPULATION AND PUBLIC HEALTH

In the  
Faculty of Health Sciences

© Vindya Attanayake, 2010

SIMON FRASER UNIVERSITY

Spring 2010

All rights reserved. However, in accordance with the *Copyright Act of Canada*, this work may be reproduced, without authorization, under the conditions for *Fair Dealing*. Therefore, limited reproduction of this work for the purposes of private study, research, criticism, review and news reporting is likely to be in accordance with the law, particularly if cited appropriately.

# APPROVAL

**Name:** Vindya Attanayake  
**Degree:** Master of Science in Population and Public Health  
**Title of Thesis:** Health Issues and Needs of Un-sponsored Refugee Women in Canada: A Qualitative Study

**Examining Committee:**

**Chair:** **Dr. Susan Erikson**  
Assistant Professor Faculty of Health Sciences

**Dr. Rochelle Tucker**  
Senior Supervisor  
Assistant Professor Faculty of Health Sciences

**Dr. Marina Morrow**  
Supervisor  
Assistant Professor Faculty of Health Sciences

**Dr. Nicole Berry**  
External Examiner  
Assistant Professor Faculty of Health Sciences

**Date Defended/Approved:** March 31, 2010



SIMON FRASER UNIVERSITY  
LIBRARY

## Declaration of Partial Copyright Licence

The author, whose copyright is declared on the title page of this work, has granted to Simon Fraser University the right to lend this thesis, project or extended essay to users of the Simon Fraser University Library, and to make partial or single copies only for such users or in response to a request from the library of any other university, or other educational institution, on its own behalf or for one of its users.

The author has further granted permission to Simon Fraser University to keep or make a digital copy for use in its circulating collection (currently available to the public at the "Institutional Repository" link of the SFU Library website <[www.lib.sfu.ca](http://www.lib.sfu.ca)> at: <<http://ir.lib.sfu.ca/handle/1892/112>>) and, without changing the content, to translate the thesis/project or extended essays, if technically possible, to any medium or format for the purpose of preservation of the digital work.

The author has further agreed that permission for multiple copying of this work for scholarly purposes may be granted by either the author or the Dean of Graduate Studies.

It is understood that copying or publication of this work for financial gain shall not be allowed without the author's written permission.

Permission for public performance, or limited permission for private scholarly use, of any multimedia materials forming part of this work, may have been granted by the author. This information may be found on the separately catalogued multimedia material and in the signed Partial Copyright Licence.

While licensing SFU to permit the above uses, the author retains copyright in the thesis, project or extended essays, including the right to change the work for subsequent purposes, including editing and publishing the work in whole or in part, and licensing other parties, as the author may desire.

The original Partial Copyright Licence attesting to these terms, and signed by this author, may be found in the original bound copy of this work, retained in the Simon Fraser University Archive.

Simon Fraser University Library  
Burnaby, BC, Canada

## STATEMENT OF ETHICS APPROVAL

The author, whose name appears on the title page of this work, has obtained, for the research described in this work, either:

(a) Human research ethics approval from the Simon Fraser University Office of Research Ethics,

or

(b) Advance approval of the animal care protocol from the University Animal Care Committee of Simon Fraser University;

or has conducted the research

(c) as a co-investigator, collaborator or research assistant in a research project approved in advance,

or

(d) as a member of a course approved in advance for minimal risk human research, by the Office of Research Ethics.

A copy of the approval letter has been filed at the Theses Office of the University Library at the time of submission of this thesis or project.

The original application for approval and letter of approval are filed with the relevant offices. Inquiries may be directed to those authorities.

Simon Fraser University Library  
Simon Fraser University  
Burnaby, BC, Canada

## **ABSTRACT**

Little is known about the unsponsored refugee women in Canada and about their health in particular. Through interviews with 11 unsponsored refugee women living in greater Vancouver area, this research project focuses on their health issues and needs. In order to better understand how their health is grounded in the varied historical and current contexts of their lives, through powerful narratives and stories of women, I document their own perspectives on health, the multiple factors that affect their health outcomes, and the pathways to care. I use qualitative methodology and a critical theoretical framework informed by intersectionality to study these aspects of health. Through intersectional analysis I illustrate how their experiences of health, health outcomes, determinants of health and pathways to care are shaped by intersecting circumstances of lived experiences, multiple identities and the larger social, political and economic processes and contexts within which they live.

**Keywords:** women's health; unsponsored refugee women; refugee claimant; asylum seeker; intersectionality; conceptualizations of health; health issues; pathways to care; determinants of health

## **ACKNOWLEDGEMENTS**

I am grateful to all the wonderful women who made this very study possible by giving their valuable time and sharing their powerful stories and life experiences. I express my heartfelt gratitude to my thesis supervisory committee: my senior supervisor Dr. Rochelle Tucker and my co-supervisor Dr. Marina Morrow for providing invaluable support, insights, feedback, guidance and encouragement throughout the research process. I would like to thank Dr. Nicole Berry for kindly devoting her time and providing much valuable advice. Special thanks go to Cecilia Tagle, Paul Mulangu, Byron Cruz, Mariana Martinez and Bayron Figueroa for their valuable assistance and insights. I thank my wonderful family for their continuous support and encouragement.

# TABLE OF CONTENTS

Approval.....	ii
Abstract.....	iii
Acknowledgements.....	iv
Table of Contents.....	v
List of Tables.....	vii
Glossary.....	viii
<b>Chapter One: Introduction.....</b>	<b>1</b>
Introduction to Research.....	1
Background and Rationale.....	4
Un-sponsored Refugee Women in Canada.....	7
Literature Review: Un-sponsored Refugee Women’s Health.....	10
Key Definitions.....	14
Conceptualizing “Refugee”.....	14
“Convention Refugee”.....	17
“Un-sponsored Refugee/Refugee Claimant/Asylum Seeker”.....	18
Conceptualizing “Health”.....	19
<b>Chapter Two: Methodology.....</b>	<b>24</b>
Research Question.....	24
Conceptual Framework.....	25
Setting.....	27
Data Collection.....	31
Key Informant Interviews.....	31
Interviews with Participants.....	32
Analysis.....	36
Positioning Self in Research/Reflexivity.....	38
Methodological Challenges.....	40
<b>Chapter Three: Women’s Conceptualizations of Health.....</b>	<b>42</b>
Introduction.....	42
The Realms.....	43
Women’s Representations of Health.....	46
Health as Mental and Emotional Wellbeing.....	46
Health Defined in Relation to Physical Wellbeing, Absence of Disease and Functional Capacity.....	54
Health Defined in Relation to Others’ Wellbeing.....	56
Health as Synonymous with ‘Life’ and ‘Good Living’.....	58
Health as Something to be Determined by Expert Opinion.....	60
Health as a Holistic Concept.....	61

<b>Chapter Four: Self Reported Health Issues</b> .....	<b>62</b>
Depression, Other ‘Issues in the Head’ and Their Causes .....	63
Sleep Disorders, Migraines and Headaches.....	74
Chronic Health Conditions.....	75
Other Health Concerns.....	77
<b>Chapter Five: Determinants of Health</b> .....	<b>80</b>
Liminality, Identity, Social Positioning and Labelling .....	80
Migration and Settlement Experiences .....	86
Institutional Discrimination, Maltreatment and Manipulation .....	90
Financial Instability, Income and Employment.....	95
Refugee Claims Process and Other Policies of Deterrence.....	103
Pre-migratory Circumstances, Violence and Gender .....	113
<b>Chapter Six: Pathways to Care</b> .....	<b>122</b>
Health Status and Health Maintenance .....	122
Changes in Health Status since Moving to Canada.....	126
Access to Medical Care: Access and ‘Access’.....	128
Interim Federal Health Program (IFHP).....	128
Other Issues with Access to Healthcare .....	134
<b>Chapter Seven: Discussion</b> .....	<b>143</b>
Women’s Conceptualizations of Health .....	145
Health Issues .....	150
Determinants of Health.....	152
Pathways to Care.....	154
<b>Conclusion and Future Directions</b> .....	<b>156</b>
<b>Reference List</b> .....	<b>158</b>
<b>Appendices</b> .....	<b>167</b>
Appendix 1: Interview Guide for Participants .....	167
Appendix 2: Interview Guide for Key Informants.....	170



## **LIST OF TABLES**

Table 1: Demographic Profile of Participants.....	30
---	----

## **GLOSSARY**

<b>Un-sponsored refugee.</b>	An individual in search of asylum due to fear of persecution in their own country. They are also referred to as asylum seekers and refugee claimants in Canada.
<b>Convention refugee</b>	An individual who meets the refugee definition of the 1951 Geneva Convention relating to the Status of Refugees.
<b>IRB</b>	Immigration and Refugee Board
<b>PRRA</b>	Pre-Removal Risk Assessment
<b>CIC</b>	Citizenship and Immigration Canada
<b>IFHP</b>	Interim Federal Health Program
<b>UNHCR</b>	United Nations High Commissioner for Refugees

# CHAPTER ONE: INTRODUCTION

## Introduction to Research

*When Fatima fled her country of origin, all she had on her mind was to go away, 'to escape the problems she had at home'. When she left home that day, she had little knowledge that she was on her way to Canada.*

*Fatima's husband Kareem was a taxi driver. They did not have many possessions but lived a happy life. Then one day Kareem was shot dead while at work. The 'soldiers' had killed him. They suspected he was helping the militia, 'the people from the bush' to fight against the government. After he was killed, Fatima feared for her life and for her children's.*

*It was only a matter of days before the 'soldiers' were at her door. They thought she was hiding guns in her house. They wanted to 'take her to the police station to ask questions'. She refused. Her defiance made them furious. That's when they started 'harassing her at home, kicking her, beating her badly, throwing her against the wall'. They 'threw her in to the military truck'. Then they took her to the police station and locked her up in jail. For five days she was questioned and tortured. When she was finally set free, her body was badly beaten and she had a broken leg. The soldiers threatened to come back to kill her. She went into hiding.*

*For many months afterwards she remained gravely ill. She was afraid that she would be captured again. When Fatima finally recovered her family and friends and 'the people in the mosque' helped her to leave the country. They provided her with a fake passport and found her a 'lady' to travel with. Fatima did not know where she was going. When they finally reached the end of their journey, the lady told her that she was in Vancouver, Canada. The lady checked her into a motel. Then she was gone.*

*Fatima felt abandoned. She didn't know where to find help. An 'African man' she met took her to his church. A woman she met at the church put her in touch with the immigration office. She went and claimed refugee status. Another organization found her a transition house. She didn't like living there one bit because the 'woman there was so stressful and strict'. She 'couldn't stand her any longer' so she finally left.*

*A few months after Fatima arrived in Canada, she decided to go to work. She had never worked in her life before. She found a job as a cleaner. On the way back from work she slipped and fell and broke her hip. She never went to work again.*

*Fortunately for Fatima, within a few months of her arrival, she was granted the protected person status in Canada. She feels relieved and happy and safe in Canada. Yet her troubles are far from over. What of the children she left behind? The 'youngest doesn't even remember her anymore'. She was only a toddler when Fatima left them. She cannot help but worry about them day and night. She had just received news that her sister had had to 'disappear' with the children to safety. The local immigration office had become suspicious of Fatima's whereabouts when her sister went to process her children's immigration applications to Canada. Her children are no longer safe. They no longer go to school. The last she heard of them, they were living in a crowded house with no food to eat. She sends them what she could, whenever she could. But being on welfare it's not always easy for her.*

*When Fatima left her country, she carried with her a bag of beads. She used to do beadwork back home. She left with the hope that she could perhaps, at least rely on her beads to survive if everything else failed. She continues to do beadwork and sells them whenever she gets the chance. Whatever she earns, she sends back to her sister to feed her children. She looks forward to the day she would see her children again, but when that would be only time could tell.*

Fatima and all other women in this study are unsponsored refugee women. They are women refugee claimants, or women in search of asylum in Canada. Although they account for a considerable proportion of the asylum seekers who make their way to Canada each year, little is known about these women in general, and about their health in particular. This study focuses on aspects of their health. More specifically, the core research question in this study is: *what are the health needs and issues of unsponsored refugee women in Canada?* In order to better answer this question, I explore how their health is grounded in the varied historical and current contexts of their lives through the following specific objectives. First, through powerful narratives and stories, I document women's own representations of health and health issues and needs. That is, I explore the 'meanings' of health, health issues and health needs as perceived by the women within the current and historical contexts of their life circumstances. Second, through the collective voices of the women's narratives, I attempt to shed light on the multiple interlocking factors that influence their health outcomes. Finally, I examine their pathways to care with a particular focus on barriers and facilitators to accessing healthcare.

I use qualitative methodology and a critical theoretical framework informed by intersectionality to study these aspects of health. The use of intersectional analysis reveals how a confluence of intersecting circumstances including diverse lived experiences, multiple identities defined by aspects such as race, class, social location, gender, immigrant identity and ethnicity, and the larger structural processes within which they live shape their unique experiences of health and health outcomes.

## Background and Rationale

Over the past few decades, significant strides have been made towards the advancement of women's health both in Canada and elsewhere. Particularly in Canada, along with its global leadership in the field of innovative healthcare as well as its commitment to provision of universal healthcare, Canadian women are seen to enjoy generally good health (Varcoe, Hankivsky & Morrow, 2007). The initiation of women's health movement in Canada, and subsequent calls particularly by feminist scholars and women's health advocates to promote health of women have further contributed to charting a course in women's health in Canada, and in bringing the women's health agenda to the forefront of policy and action<sup>1</sup> (Boscoe et al., 2004; Morrow, 2007; Hankivsky; 2007; Cohen; 1996; Canadian Women's Health Network, n.d.).

In spite of such progress however, health disparities for women in Canada continue to persist (Varcoe et al., 2007; Hankivsky, 2008; Spitzer; 2005). These disparities are seen to be particularly pronounced for certain sub-populations of women, for instance, those who are marginalized by multiple forms of oppression such as aboriginal, homeless and poor women, refugee and immigrant women and women in precarious circumstances such as the unsponsored refugee women in this study (Beiser & Stewart, 2005; Varcoe et al., 2007; Hankivsky, 2006; Mulvihill, Mailloux & Atkin, 2001; Gagnon et al., 2007). Scholars have

---

<sup>1</sup> For instance, the establishment of Women's Health Bureau by Health Canada (Health Canada Web site; Canadian Women's Health Network, n.d.) in 1993 and its multiple initiatives and projects since then such as; Women's Health Strategy (1999) which serves as a framework for action in the area of women's health; Women's Health Contribution Program (1996) to supports research and information in the area of women's health; Gender-based Analysis Policy (2000) ; Women's Health Indicators Project (2002)

increasingly suggested that at least part of these persistent disparities stem from the narrow frameworks within which women's health continue to be theorized and understood; the failure to adequately address the diversity of women's health in Canada; ongoing exclusion of specific health needs and issues of disadvantaged groups of women from policy, research and action; and failure to recognize women's own voices and perspectives of health within the multiple contexts of their lives (Amaratunga, 2001; Beiser et al., 2005; Hankivsky, 2006; Varcoe et al., 2007; Weber & Parra-Medina, 2003; Desmeules et al., 2003). Particularly as Canada moves towards more and more multiculturalism, recognizing that Canadian women's health needs and issues are diverse, and incorporating their diverse perspectives into the decision-making in women's health remains critical if we are to truly eliminate ongoing health disparities. To this end, many scholars point out the importance of integrating novel approaches that go beyond the traditional frameworks (i.e. gender and reproductive determinism) to understand women's health (Schulz & Mullings, 2006; Weber & Parra-Medina, 2003; Morrow & Hankivsky, 2007; Hankivsky, 2007; Hankivsky, Cormier, & de Merich, 2009). They also emphasize the importance of grounding women's health within the broader contexts of their lives and within the multiple identities and forms of oppression (such as race, class, ethnicity, immigrant status, social and geographic location, sex, gender, ability etc.) that intersect to create unique health outcomes for women (Schulz et al., 2006; Weber et al., 2003; Varcoe et al., 2007; Hankivsky et al., 2009; Guruge & Khanlou, 2004; Vissandjee et al., 2004; Ruzek, Oleson & Clarke, 1997). However, research that incorporates

diverse women's perspectives, particularly those of marginalized women, and new ways of inquiry such as emerging framework of intersectionality that contextualizes health within multiple and broader dimensions of their lives are still nascent (Hankivsky & Christoffersen, 2008).

This research builds on this emerging body of work, and examines the health issues and needs of unsponsored refugee women, a group of particularly disadvantaged women in Canada. There is clearly a paucity of studies focusing on specific health needs and issues of unsponsored refugee women in Canada. The existing literature suggests that unsponsored refugees in general and women in this group in particular are much more likely to experience poor health outcomes than other immigrant categories, particularly as a result of their precarious immigrant status, limited access to services and disadvantaged social position (Gagnon, 2004; Gagnon, Merry & Robinson, 2002; Gagnon et al., 2006; Yu, Ouellet & Warmington, 2007; Oxman-Martinez et al., 2005; Simich, Wu & Nerad, 2007). Through the use of an intersectional lens, this study explores their health within the multiple current and historical contexts of their lives, and illustrates how their health outcomes are determined by a confluence of factors such as interlocking systems of social, cultural, economic and political structures, lived experiences and intersecting identities.

While the purpose of this research is to shed light on the health issues and needs of unsponsored refugee women as described above, it also has crucial significance and relevance in other ways. First, it responds to a need for research that calls for the importance of bringing to the forefront the health of excluded



populations of women whose lives have not been adequately theorized. Second, it also responds to a need for research that calls for the importance of highlighting women's diverse voices and perspectives on health. Third, it contributes both theoretically and methodologically to the emerging body of empirical work in women's health research that uses broader frameworks for understanding women's health, particularly in relation to intersectionality. Fourth, given the dearth of research on unsponsored refugee women in general and their health in particular, this study adds valuable knowledge to the existing knowledge base on refugee claimant women and their health, as well as to that of women's health in Canada. Finally, this study could also help inform future directions in research, policy and decision-making with regard to unsponsored refugee women's health.

## **Unsponsored Refugee Women in Canada**

Every year, thousands of unsponsored refugees make their way to Canada in search of asylum. Women constitute a significant proportion of this population. In 2008, approximately 36, 800 asylum seekers were in Canada, of which nearly half (16, 300) were women (Citizenship and Immigration Canada, 2008). These are women who do not necessarily fit the strict criteria of 'Convention refugees' as laid out by the Geneva Convention Relating to the Status of Refugees (1951). They are neither selected overseas nor sponsored to come to Canada by anyone. Instead, they have made their way to Canada seeking asylum on their own, seeking justice, seeking freedom from multiple forms of persecutions in their countries of origin. In order to get to their 'safe

haven', they have taken their destiny in own hands, crossed multiple borders and endured arduous and perilous journeys.

For many State sponsored refugee women, arrival at their host country of asylum marks the end of a long journey. They are guaranteed safe asylum, and along with it a safety net is already in place to ensure that their basic needs are taken care of. They have guaranteed access to health care, housing, settlement assistance and other essential social welfare services and a conducive environment where they can finally begin to pick up the pieces and start afresh. Yet for many unsponsored refugees, like the women in this study, arriving at the country where they intend to seek asylum ironically heralds the beginning of another long journey; that is, a long rocky road to asylum.

Increasingly in today's world, amid a myriad of critical global concerns - such as the threat of global terrorism, heightened awareness of security and sovereignty of Nation States, expanding trans-boundary movement and human migration, and along with it, concerns of human smuggling – many Nation-States (including Canada) traditionally receptive to refugee claimant populations are now wary of allowing them within their national borders (Whittaker, 2006; Tazreiter, 2004; Freedman, 2007). As a result, they are met with increasing hostility, and a mounting range of bulwarks, such as restrictive immigration policies and stringent border protection measures are constantly put in place to stem the flow of these people (Silove, 2000; Whittaker, 2006; Freedman, 2007). Even while the Universal Declaration of Human Rights (1948, Article 14) distinctly spells out that “everyone has the right to seek and to enjoy in other

countries asylum from persecution”, sadly, for countless individuals like the women in this study, seeking asylum anywhere, let alone in a ‘country of their preference’, has become a near insurmountable endeavour amid these circumstances.

In Canada like elsewhere, unsponsored refugee women undergo a rigorous refugee determination process to sufficiently ‘prove their refugeeeness’ in order to be eligible for safe asylum. Yet for many of these women, ‘proving their refugeeeness’ is a daunting task given many of the reasons mentioned above. In addition, their precarious, ‘floating’ identity as unsponsored refugees renders them a low social status, and they are often regarded as low priority within the macro political, social and economic structures. As a result, they belong to one of the most marginalized segments in Canadian society, living in limbo without many rights, and being largely excluded from many of the societal privileges and resources available to other groups in society (Goldring, Berinstein & Bernhard, 2007; Yu et al., 2007; Wayland, 2006). Unlike State-sponsored refugee women, they lack adequate access to healthcare, housing, employment, settlement assistance and other essential social services (Goldring et al., 2007; Wayland, 2006).

By virtue of being unsponsored refugees, they are also viewed with a squinted eye by the larger society, and remain the target of a plethora of hostile and negative stereotypes. They are often essentialized as ‘bogus’, ‘unwanted’ and ‘undeserving’ refugees (Freedman, 2007). They are what media and others in society would like to portray as the ‘uninvited guests’ at our doorstep. The

extent of the negativity that surrounds unsponsored refugees is such that they remain largely othered, invisible and particularly vulnerable in numerous ways (Tazreiter, 2004; Freedman, 2007; Lacroix, 2004). Their voices are deeply silenced, and the true nature of events that compel them to take great risks on their lives as they search for asylum outside of their countries remains grossly eclipsed by these pervasive negative embodiments about them.

### **Literature Review: Unsponsored Refugee Women's Health**

Despite a growing volume of literature relating to research on women's health in Canada, it has not adequately deepened our understanding of specific health issues and needs of unsponsored refugee women, as evidenced by the paucity of studies in this area. My extensive literature review yielded only a handful of studies focusing on various aspects of health of unsponsored refugees in general, and barely any studies looking at the specific topic of health needs and concerns of refugee claimant women in Canada.

Among the few studies referring to unsponsored refugee women in Canada is a research by Gagnon et al. (2007). The quantitative study was carried out to determine whether women's postnatal health concerns were addressed by the Canadian health system differentially depending on migration status (refugee, refugee-claimant, immigrant, and Canadian-born) or city of residence. The most common unaddressed concerns among women (n=341) were reported as post-partum depression, pain and maternal blood pressure aberrations. However, no differences in unaddressed concerns by immigrant status was found among this group, although they differed by place of residence.

In another study relating to immigrant and refugee women's health in Canada, Battaglini et al. (1999) reports that unsponsored refugee women were much more likely to report a deterioration in health than other categories of immigrant and refugee women as a result of their specific circumstances. Unlike state-sponsored refugee women, unsponsored refugee women were less likely to have settlement assistance, access to health care and social support in the absence of federally funded reception programs for refugee claimants.

Rees's (2003) qualitative study with East Timorese asylum seeking women in Australia is particularly important as it sheds light on the impact of asylum seeker status on the overall wellbeing of the women, including physical, psychological, social, economic, and spiritual. She found their wellbeing to be "dangerously compromised" and "overwhelmingly effected" by their precarious immigrant status, and by the re-traumatizing effects of having to live with the constant threat of forced removal. The research highlights the necessity for speeding up the claims process, and the importance of recognizing the effects of torture and trauma on asylum seekers in policy, as well as the provision of access for asylum seekers to essential and gender specific supports and services.

Similar qualitative research conducted in Canada looking into the wellbeing of persons living with precarious status document findings similar to Rees's (Bernhard et al., 2007; Simich et al., 2007). Bernhard et al.'s (2007) study conducted in Toronto emphasizes the tremendous impact of the uncertain status of a person on the wellbeing of the entire family unit. It demonstrates how the

family's status particularly disadvantaged children where parents' status was often used to justify denying children's rights to which they are entitled by international, national, and provincial laws. The study questions the immigration policies and approaches that fail to recognize the implications of legal status for a person's social units and wellbeing. In the same vein, Simich et al.'s (2007) study, also carried out with irregular immigrants in Toronto explores important aspects relating to immigrant status and health security. The study findings highlight the impact of their status as it related to employment circumstances, lack of social support, diverse forms of stressors stemming from migratory circumstances and family separation on their overall health. Similar to Bernhard et al.'s findings (2007) this study also found that parents' status to be adversely affecting the wellbeing of the family unit, particularly that of children.

A fair amount of literature from different countries including Canada draws attention to the psychological and emotional wellbeing of unsponsored refugees as they relate to various dimensions of their lives. These include pre and post migratory circumstances; settlement issues; and diverse aspects of the asylum policies and processes (Silove et al., 1997; Laban et al., 2004; Steel et al., 1999; Mansouri et al., 2007; Keller et al., 2003; Tribe, 2002; Simich et al., 2007). For instance, in a comparative study Laban et al. (2004) examined the impact of long term asylum procedures on the prevalence of psychiatric disorders among Iraqi asylum seekers living in Netherlands for a period of time and among those who had just arrived in the Netherlands. They found that the psychiatric disorders such as anxiety, depression and somatoform disorders to be higher among those

who had been in the country for a long period, and conclude the prolonged asylum procedure to be the key risk factor for these psychological issues. Other studies have focused on various policies of deterrence such as mandatory detention and the re-traumatizing effects of these on the health of unsponsored refugees seeking asylum (Silove et al., 2000; Sultan et al., 2001).

In addition, an epidemiological study conducted by Thonneau et.al (1990) in Montreal, Canada during the period 1985-1986 provides a general health profile of asylum seekers in Quebec. Although the majority of the study participants reported satisfactory health status (n=1,994), various health problems were identified among them, including anaemia, nutritional deficiencies, stunting, syphilis, tuberculosis, parasitic infections, and inadequate vaccination. It also reports on the evidence of physical torture and highlights the need for better access to mental health services. Other studies conducted elsewhere on unsponsored refugees report similar disease profiles (Blackwell et al, 2002; Sinnerbrink, 1996). For instance, in a study of health needs assessment of asylum seekers in Britain (n=397; male=291; female=106) found high rates of gastro-intestinal issues, musculo-skeletal disorders, respiratory and emotional issues such as feeling tense and worried, sleep disorders and depression among the participants (Blackwell et al; 2002). The results of this study do not present an in-depth analysis of health issues and needs by gender, except for reproductive health related symptoms experienced by some women (27). The need for dental and mental health services was found to be a priority among this group.

Finally, available literature from Canada and elsewhere has also explored the link between precarious immigration status and access to healthcare (Oxman-Martinez et al., 2005; Simich et al., 2007; Caulford et al., 2006; Rousseau et al., 2008; Reeves, 2006; Gagnon, 2004). These document numerous personal and structural barriers to accessing healthcare for unsponsored refugees and other immigrant categories with precarious status, including language, socio-cultural barriers, policy barriers related to immigration and legal processes and administrative delays in processing claims.

While much of the literature discussed above does not specifically focus on aspects related to unsponsored refugee women's health per se, it nevertheless highlights valuable information to draw upon that are relevant to this population. This literature review is also testimony to the dearth of information on unsponsored refugee women and their health and underscores a critical gap in research in this regard.

## **Key Definitions**

### **Conceptualizing “Refugee”**

The Geneva Convention (1951), along with subsequent modifications made to it in 1967, defines a refugee as any person who,

owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, is unable or, owing to such fear is unwilling to return to that country (UNHCR website).



Beyond this [ostensibly] straightforward, institutional taxonomy however, the term 'refugee' is "loaded with political, economic and experiential overtones" (Ruff; 1998; p.5) that are subtle and powerful. These overtones "convey complex sets of values and judgments" (Zetter, 1991; p. 40) that produce stereotyping images and labels about refugees. These in turn tremendously impact the ways in which refugees are perceived and treated by the larger society.

To this end, some of the most far-flung characterizations of the refugee are as helpless "victims" incapable of exerting control over their own agency, incapable of making sound decisions for themselves, without an identity, without a past and without a heritage; (Malkki, 1996; Malkki, 1995a; Lacroix, 2000). In addition, they are also treated as "objects" needing external intervention; objects to be handled, healed and deciphered by experts. Their objectification is particularly pronounced within the trans-national political and bureaucratic structures where they become objects of control, management and intervention (Malkki, 1996; Zetter, 1991). Because they are primarily a product of the global refugee regime, they remain more or less the 'property' of the various players that make up this regime continually being passed on among these players. As Malkki points out, once they become objectified in this process, they cease to exist as "historical actors" and individuals with a "voice", so much so that they can be stripped of the authority to tell their own stories about their life circumstances. Through this process, they become, what Malkki calls "speechless emissaries".

That is, refugees suffer from a peculiar kind of speechlessness in the face of the national and international organizations whose object of care and control they are. Their accounts are disqualified almost a priori, while the languages of refugee relief, policy science, and "development" claim the production of authoritative narratives about the refugees. (1996; p. 386)

In addition, they are also constructed as an “epistemic object” or an object of study, and are seen as a portal to uncovering a whole new “terra incognia”, a strange and unfamiliar world that lies beyond the ordinary encounters of the ordinary citizen (Malkki, 1995a; Showcross, 1989 as cited in Malkki, 1995b;).

Finally, refugees are also constructed as a “problem” (Freedman, 2007); a multi-faceted “problem” of legal, social, economic, political, pathological, national and global dimensions. In fact, the very existence of the refugee regime rests on this premise. It specifically originated to handle the “refugee problem” (Loescher, 1992). The shared notion that refugees are a problem is perhaps most blatant today than ever before, in the face of heightened concerns of global terrorism, increased trans-national migration and fears for the sovereignty of nation states. All of these have set in motion a new wave of awareness of refugees as a particular problem of security, leading to subsequent solidifications of national borders and restrictive national and international immigration policies (Freedman, 2007). They make it increasingly difficult for refugees to find alternative safe havens, rendering them even more “speechless”; making them even more easier to discard them as “disposable people” (Mayotte, 1992) and ensnaring them in a vicious cycle of what Alund calls “victims of a new world order” (1995, p.311).

## **“Convention Refugee”**

“Convention refugee” refers a person who meets the refugee definition of the Refugee Convention mentioned above (UNHCR, 2006). An individual is recognized as a Convention refugee after having ascertained his/her eligibility according to the guidelines and inclusion criteria laid out by the Refugee Convention (UNHCR, 2006). Individuals deemed deserving to be Convention refugees are pre-selected overseas by consulates of host countries or the UNHCR, the central international bureaucratic apparatus mandated to lead, coordinate and manage the global refugee problems (Wayland, 2006; UNHCR, 2006). Once conferred the Convention refugee status, individuals are resettled in a safe other country.

In the case of Canada, most persons identified abroad as bona fide refugees are sponsored by the government to resettle in Canada, while some others are sponsored by private individuals, groups or various other organizations such as humanitarian organizations and faith-based communities (Citizenship and Immigration Canada, 2006). As resettling Convention refugees, they are granted permanent resident status in Canada, and receive a range of well equipped support services from the State during their initial period of resettlement. These include financial assistance, accommodation, clothing, food and other services such as community orientation, assistance with finding employment and language training programs (Wayland, 2006; Doyle, 2007). In addition, they are also assured uninterrupted access to healthcare. They are eligible for the provincial health coverage and receive this coverage within

approximately 3 months of arriving in Canada. During the wait period for this coverage, any immediate health needs are looked after through a federal health program known as the Interim Federal Health Program (IFHP), which covers emergency and essential medical care (Wayland, 2006; Citizenship and Immigration Canada, 2005).

### **“Un-sponsored Refugee/Refugee Claimant/Asylum Seeker”**

Un-sponsored refugees are also known as asylum seekers or refugee claimants and these terms are used interchangeably in this study. They are individuals in search of asylum in a country outside of their own. They are people forced out of their country due to fear of persecution based on race, religion, nationality, political opinion, membership in a particular social group and of cruel and unusual treatment. Unlike Convention refugees, refugee claimants are not sponsored by the State or any individual or organization. Instead, they enter Canada, whether by boat, airplane or on foot, and request for asylum for reasons mentioned above. They could request for asylum at the border or within the country (Wayland, 2006). Requests for asylum in Canada are assessed by the Immigration and Refugee Board (IRB). The individuals seeking asylum are classified as un-sponsored refugees until their request for asylum has been assessed. Once a claim for refugee status has been successfully assessed, s/he is granted ‘the protected person’ status. Those who fail are ordered to leave the country within a specific time period. Such persons could re-apply to stay in the country through a process known as Pre-Removal Risk Assessment (PRRA) (Canadian Red Cross, 2008) or could re-apply to remain in Canada on

humanitarian and compassionate grounds (Citizenship and Immigration Canada, 2006). While unsponsored refugees are able to apply for welfare or seek work they are not considered permanent residents. They also do not have access to the same health care as do the convention refugees and permanent residents. Once a person applies for asylum however, they are granted a temporary health care coverage through the IFHP

### **Conceptualizing “Health”**

“*Ayubowan*” is what you say when you meet and greet someone in Sri Lanka, in my own culture. It is an everyday thing, a casual salutation. A simplistic and literal translation of “*Ayubowan*” [pronounced *aa-yu-bō-wan*] would mean ‘may you have many years of life’. There is nothing explicit about ‘health’ jutting out in there, at least to the outsider. Yet everyone who has lived in Sri Lankan culture long enough ‘knows’ that it is more than a mere greeting. It is a blessing for health. And everyone ‘knows’ that what it ‘really means’ is ‘*may you live a long healthy life*’ or something proximate to that expression. In this emic sense it is possible then, to rationalize “*Ayubowan*” as an equivalent of good health. It is an understanding of ‘health’ that is drastically different from the understanding of ‘health’ in everyday Canadian life that may conjure up images of ‘daily exercise’, ‘organic foods’, ‘prescription drugs’, ‘healthy eating’, ‘the yoga class’ or the ‘annual check-ups’. “*Ayubowan*” as a metaphor for health is also a radical digression from ‘health’ as posited within the deep-seated parameters of pathology in modern bio-medicine.

How then, should we define 'health'? What do we really mean by 'health'? Despite millennia of discourses around health, it remains difficult to pin down what is precisely meant by 'health'. Health as a concept has been variously characterized as "fluid", "relative" (O'Sullivan et al., 2004, p. 30), "abstract", "elusive" (Rosenstock, 1966 as quoted in Spector, 2009, p. 50) and as one scholar describes, as a "receding mirage" (Dubois, 1961 as quoted in Larson, 1999).

From a distance, health appears to be a clear concept, but as we approach and attempt to define it, the substance disappears (Larson, 1999 p.123).

This is so because health is a prismatic concept that constitutes a spectrum of components and meanings (Larson, 1999). Definition of it primarily sits within the locus of a given time, place and people (Blaxter, 2004; Nettleton, 2006). For this reason, it is difficult to strive towards a single definition of 'health' that is truly universal. What there exists is a multitude of representations of health that varies in context and scope (Nettleton, 2006), defined along the continuum of somewhat rudimentary and reductionist images to the most encompassing and holistic depictions of 'health'.

For instance, within the narrow enclaves of Western biomedicine, which primarily exists to repair diseased bodies (Blaxter, 2004), health is essentialized as merely the 'absence of disease' in the body. Within this system health is understood against the gold standard of 'disease' which, in turn is conceived as an anomalous or deviant entity (Blaxter, 2004). Within this system, body itself is regarded as a passive biological organism, a potential site of 'deviance'. And

within this system, health is nothing more than a 'residuum' after filtering out the refuse. As Tripp-Reimer aptly sums up,

Primarily concerned with the appearance of conditions which interfere with biological functioning of the organism, medicine focuses on the identification and treatment of pathology. In this system, health becomes a residual category containing those individuals or states which manifest as normal. Health is considered present in the absence of pathological symptoms (1984, p. 102)

This conception of 'health' in modern biomedicine is inherently negative and reductionist (Blaxter, 2004; Nettleton, 2006). It precludes other dimensions of health that shape people's experiences of health (Nettleton, 2006). Even so, 'health as absence of disease' is one of the most ubiquitous conceptualizations of health (Larson, 1999) in modern society, because, "since medicine is one of society's major systems, it is obvious that it is these definitions which will be institutionalized and embodied in law and administration" (Blaxter, 2004, p. 10).

Since the advent of this sparse biomedical view of health however, much paradigmatic shift has occurred in thinking related to the nature of health (Larson, 1999). Critiques of biomedical model have since argued for a 'social model of health' that is both comprehensive and positive, and that takes account of the complex social, cultural, environmental, physical and metaphysical elements that shape experiences of health and illness in people's lives (Blaxter, 2004, Nettleton, 2006; Larson, 1999). The advancement of World Health Organization (WHO) definition of health in 1948, for instance, gained widespread acceptance as one such social model that connotes a more holistic and positive image of health. WHO defines health as "a state of complete physical, mental, and social

well being and not merely the absence of disease”. Although criticized for being ‘utopian’ and ‘abstract’ (Saylor, 2004; Larson, 1999; Tripp-Reimer, 1984), WHO definition is still acclaimed as a welcome move beyond the grim and limiting medical view of health.

Other, contemporary discourses around health call for yet more integrative approaches to understanding health. Sociological and anthropological paradigms in particular emphasize the ‘social constructive’ nature of health (Nettleton, 2006). They argue that people have their own ideas and interpretations about health (O’Sullivan et. al, 2004). As Nettleton (2006) illustrates, these lay representations of health are much more than “merely diluted versions of medical knowledge; rather they are shaped by people’s wider milieu, such as their structural location, cultural context, personal biography and social identity” (p. 34). In other words, beliefs about health are grounded in people’s social and historical contexts. They are informed by shifting ‘norms, values and social relations that influence people’s lives’ (Ruff, p. 13). Health is hence something that is experiential and subjective, and “definitions of health, and accepted ways of producing, maintaining and restoring of it are socially constructed” (O’Sullivan et al., 2004, p. 27).

Building on these evolving ideas of health, more recent dialogues on health show how health is shaped by the combined effects of multiple axes of intersecting identities and larger social, political and economic structures of society (Weber, 2006; Hankivsky, 2008). The emerging approach of intersectionality, for instance, illustrates how the underlying societal power



dynamics, macro structures and individual identities simultaneously converge to create unique experiences of health for different people in different social positions.

## CHAPTER TWO: METHODOLOGY

The intent of this research is to gain an in-depth understanding of the health issues and needs of unsponsored refugee women in Canada. The research process and protocol are guided by qualitative methodology for data collection, analysis and interpretation.

### Research Question

The core research question in this research is; *what are the health needs and issues of unsponsored refugee women in Canada?* With a view to answering the above question, I explore aspects of the health of unsponsored refugee women along the following key themes.

- ***Women's conceptualization of health, health issues and health needs:*** I explore the 'meaning' of health, as well as particular health issues and health needs as perceived by the women within the current and historical contexts of their life experiences.
- ***Life stories and determinants of health:*** Through the narratives of women's own life stories and lived experiences, I attempt to illuminate a myriad of determinants of health, including cultural, social, economic and political and psychological determinants of health that impact the health outcomes of these women.

- ***Pathways to care:*** Finally, through the collective voices of the women's narratives, I document the barriers and facilitators to accessing available health care services, and alternative coping mechanisms and pathways to care.

## **Conceptual Framework**

Disparities in health along various trajectories such as class, race, gender, socioeconomic status and ethnicity have existed for many centuries (Weber, 2006). While making some headway, the bulk of the approaches to eliminating and reducing these disparities to date remain largely stagnant, and these disparities continue to persist. An increasing body of critical scholarship, particularly stemming from critical feminist scholarship, pinpoints to the inherent weaknesses in the traditional approaches to addressing health disparities. On the one hand, these traditional approaches, largely dominated by biomedical paradigms often situate health disparities within the bodies of individuals (Weber & Parra-Medina, 2003; Weber, 2006). That is, they emphasize proximal or individual characteristics as causing health disparities, such as genetic make up, individual lifestyles and psychosocial issues (Weber et al., 2003). On the other hand, when the role of broader social categories is acknowledged as contributing to health outcomes experienced by individuals, these categories are often prioritized among others so that a particular singular category is seen as the main cause of health disparities. For instance, gender is often illustrated as the main cause of health outcomes among women. Such essentialization of certain categories results in overlooking other aspects that are equally important, such

as class, race, social and geographic location, immigrant status, sexual orientation, and that simultaneously contribute to health outcomes. As such, these approaches fail to recognize that individuals live their lives within broader social contexts where mutually constitutive, multiple identities influence their health outcomes (Ruzek et al. 1997; Weber et al., 2003). Given these weaknesses, emerging critical paradigms, particularly critical feminist scholarship have argued for novel ways of inquiry to addressing health disparities that move beyond the narrow and linear conventional approaches, such as intersectionality (Hankivsky, 2008).

Intersectionality emphasizes that multiple axes of social identity, such as class, race, gender, socio-economic status, geographic location, immigrant identity and sexuality simultaneously intersect to produce unique health outcomes for different individuals and groups (Hankivsky, 2008; Hankivsky 2007). These dimensions in turn get transformed into “hierarchies and get built into institutional structures” (Guruge, 2004, p. 33). These hierarchies are characterized as power structures and perpetuate and legitimize inequalities among groups, such as women (Guruge, 2004). Accordingly, in order to understand health outcomes, individual health experiences need to be located and viewed within the complex amalgam of macro social forces such as economic, political and cultural structures (Guruge, 2004; Varcoe et al., 2007; Weber et al., 2003). In other words, intersectional analyses takes into account the ‘system of ideological, political and economic power as they are shaped by

patterns of multiple identities such as race, class, gender, sexuality, nation, ethnicity and age and social justice' (Dill et al., 2007).

Grounded in feminist theory, Intersectionality is increasingly used to study aspects of “women’s health, and health disparities of race, ethnicity, gender and social class” as an alternative to positivist biomedical paradigms which often fail to consider the specific needs of marginalized communities (Weber et al., 2007; Schulz et al., 2006). One of the main strengths of the approach lies in its analysis which places a greater appreciation on the lived-experiences of hitherto marginalized, under-represented and disadvantaged groups in society, including women, specially women of color whose life have not been adequately theorized (Hankivsky, 2009). Thus, I consider the use of this approach as particularly appropriate in illuminating the health issues and needs of unsponsored refugee women who remain a disadvantaged segment in society. It gives an opportunity to explore how conflating dimensions of their multiple identities and specific social locations contribute to produce unique experiences of health.

## **Setting**

The research was conducted in Vancouver BC, which is one of the key destinations for refugee populations arriving in Canada. The interviews took place at a location and time proposed by the participants, such as at participants’ residences, within the premises of service organizations through which the participants were recruited, and on one occasion at a coffee bar in a shopping mall.

In total, eleven unsponsored refugee women participated in the study. All women were 19 years or above and had been living in Canada for a period of 5 years or less at the time of the research. All participants were either current refugee claimants at various stages of refugee claims process or those who had been accepted as protected persons after completing the claims process. Even though the ability to converse in English was not intended as a strict selection criterion initially, it was subsequently included following complexities surrounding interpreting and translation. An attempt was made to recruit participants from diverse ethnic and cultural backgrounds as indicated in the table below (table 1).

I employed a combination of purposive and snowball sampling techniques to select participants, where purposive sampling technique was the predominant method. My decision to use purposive sampling technique was in part prompted by the hard-to-reach nature of the study population, and in part by my desire to locate participants who could best elucidate the phenomenon under study.

Participants for the study were recruited through various community organizations serving immigrant and refugee populations in the Lower Mainland area. These organizations were located through referrals by diverse individuals, colleagues, other organizations and by a thorough search of online resources. After obtaining a list of prospective field sites, I contacted each organization with a description of my research and its purpose, and a request for recruitment of participants. Entry into the organizations that agreed to recruit participants was gained after obtaining a letter of permission from each organization stating their consent to recruiting women. All participating organizations were provided with a

copy of the letter of ethics approval for the study, the exact interview protocol used with the participants and the research proposal detailing the purpose of the study and use of information. In-person meetings with liaisons of each of the organizations then followed in order to discuss the recruitment process. Regular contact with all liaisons was maintained throughout the period their clients were being interviewed.

In all instances eligible women were first contacted by the respective organizations regarding the research. If a participant expressed interest in taking part in the study, I was then provided with their contact information, often a telephone number. I contacted each participant with an explanation of my study and an invitation to participate. If they were still interested, I arranged to meet them on a day and at a place of their own preference to conduct interviews. On two occasions eligible participants were introduced to me in person while I was making visits to the organizations where certain women were also present.

In addition to the unsponsored women, 7 key informants were interviewed. The group of key informants consisted of mental health counsellors, settlement workers, a health care worker, frontline workers in community organizations and a physician engaged in working with asylum seeking women. As well, my liaisons in participating organizations acted as important 'unofficial' key informants who provided valuable information during our often lengthy, informal conversations.

**Table 1: Demographic Profile of Participants**

Variable	Response	No. of participants
Age	20-29	3
	30-39	7
	>40	1
Marital Status	Single	4
	Separated	2
	Married	4
	widowed	1
Country of origin	Burundi	2
	Iraq	1
	Kazakhstan	1
	Mexico	4
	Nigeria	1
	Sri Lanka	1
	Zimbabwe	1
Children	Yes	8
	No	3
Level of education	< High school	1
	High school	2
	College	3
	University	5
Employed	Yes	6
	No	5
Type of work (if employed)	Service (i.e. kitchen helper, food server)	4
	Unskilled/domestic (i.e. cleaner)	2
Sources of income	Work	6
	Spouse's work	1
	Welfare	4
Hold a work permit	Yes	10
	No	1
Length of time in Canada	<18 months	1
	18 months-36 months	7
	37 months-3 years	3
Reasons for fleeing country of origin (All that apply)	War	2
	Better avenues	1
	Domestic violence	2
	Political persecution	2
	Persecution by individuals	5
	Threat to life and/or family members	8
	Physical/sexual/emotional abuse	5
	Fear of genital mutilation	1
	General political violence in country of origin	2
Means used to enter Canada	Work visa	1
	Visitor visa	1
	Tourist visa	6
	Forged documents	3
Claimed refugee status	Inland	10
	Port of entry	1
Immigrant status at the time of interviews	Refugee claimant	5
	Protected person	3
	Failed refugee claimant	3



## **Data Collection**

Face-to-face, semi-structured interviews formed the primary method of data collection. All interviews with participants were guided by an interview protocol (Appendix 1). The protocol was initially developed based on the literature review. However, minor modifications were made following input from the key informants and in consultation with supervisors. The questions in the interview guide were designed in line with the objectives of the study and were subtitled under the following: the community, the journey, settlement process, demographic details, health status and perceptions of health, determinants of health and life stories, health in the context of pre and post-migration, pathways to care, barriers to accessing care and alternative means of coping.

## **Key Informant Interviews**

The objectives of the key informant interviews were manifold. First, in the absence of substantive existing literature in the domain of the proposed topic, the key informant interviews played a significant role in helping me to gain a firm understanding of the research context. As individuals experienced in working with unsponsored refugee women for varying periods of time, they were able to profile the context in which I would conduct research, as well as provide a portrayal of the study population. Second, they were important in informing the various ethical considerations in conducting research with disadvantaged communities such as these women, and in guiding the research protocol. Third, they provided valuable information about their own experiences in providing

services to this category of women and about the inherent challenges and issues they encountered while providing services.

Four of the key informant interviews preceded the interviews with the participants. The rest were conducted at varying points during the data collection phase. I found the spacing of the key informant interviews to be an advantage. For instance, during the interviews with the women, a number of references to aspects of service provision were made (i.e. issues relating to claims process). These were aspects that I was not sufficiently knowledgeable about or understood to be of immense importance in defining the health of unsponsored refugee women at the start of the research. Nor were these aspects sufficiently brought up during the initial key informant discussions. Yet it was evident that these pieces were intrinsically connected to women's health and emerged as key determinants of their health. The interviews with subsequent key informants facilitated elucidation of many of these issues.

Even though a general list of questions was prepared for the key informants, these questions remained flexible in order to accommodate an array of view points that emanated from their respective vantage points and diverse experiences as service providers.

### **Interviews with Participants**

As mentioned earlier, interviews with the participants were conducted at a place and time convenient to the participant. 15 interviews were conducted in total, however only 11 were included in the analysis.

Four interviews were excluded from the analysis after considering the various issues they presented, such as methodological, language, and ethical. For instance, one interviewee insisted on having her mother present during the interview. As the interview progressed, it became apparent that she was seeking her mother's opinion on the questions I was asking, or sometimes the mother herself would answer the questions for her. As a result, since I felt that some of the interviewee's ideas and opinions may not be her own, it was decided to exclude this interview from analysis. Two interviews were excluded on the grounds of lack of clarity due to poor language. Although both participants were able to express themselves generally well in English, they both appeared to have trouble articulating their ideas clearly enough due to limited vocabulary, particularly when it came to explaining an issue at length. Sometimes the questions were misinterpreted and I felt that rich descriptions were not often captured. Finally, another interview was excluded after debating the ethical dilemmas it raised. This was a participant who was suffering from extreme PTSD and depression and possibly other severe forms of psychological issues of which I was not aware at the time. During the interview with her she revealed numerous memories of extreme forms of abuse, trauma and torture which at times appeared incoherent. She also revealed that she was under heavy medication for her present psychological conditions, and feared that revisiting these memories may trigger fresh emotional instability and cause her to relapse in her tough road to recovery. Immediately after the interview I contacted her social worker (who

introduced her to me) expressing my concern for her wellbeing. I decided it was best not to follow up on this interview for fear of causing any further damage.

Prior to the start of the interview, I explained in detail the purpose of the study and use of the information they provided, and both written and verbal consent to participate in the study was obtained. I also offered to arrange childcare if they so required although none did.

Two interviews were conducted with each participant, in two phases; interview I and interview II. The first phase involved a preliminary interview intended to obtain background information of the participant such as demographics, details of family, her country of origin, about her journey to Canada, and a cursory orientation to the topic of health. Additionally, this interview allowed me the opportunity to gain trust, and to build and establish a comfortable rapport with the women. This process facilitated my subsequent discussions relating to potentially sensitive issues with regard to their health and lived experiences. The duration of the first interview lasted approximately 45 minutes – 1 ½ hours.

The second phase of data collection consisted of a 1-1 1/2 hour interview with each participant, where a detailed discussion of specific aspects of health within the context of their lives, both past and present took place.

All interviews were conducted in-person, and all participants were offered an honorarium of 30\$ CAD per interview in appreciation of their time and participation. At the end of each interview I questioned women about any need for debriefing they may have in order to ensure their safety and wellbeing. This

remained a concern for me particularly after hearing women's recounts of life stories and recollections of the past that sometimes entailed intimate details of distress and suffering.

All interviews were audio-recorded with the permission of the participants. In order to safeguard the anonymity of the participants I also requested them to come up with a pseudonym of their choice to be used in the transcripts and in the write up of the study. Brief notes were taken throughout the interviews and field notes were maintained. The spacing between the first and the second interview allowed some time to transcribe the first interview which I was able to share with the participant during the second meeting. This allowed for clarification of details on some occasions. However, I often found many women to be not so keen about reading the transcript other than giving it cursory attention. On other occasions, getting the transcript ready for the second meeting was not always possible due to time constraints. In such cases I listened to the audio recording before the second interview to note down any information to be clarified or to identify important missing information which I presented to the women during my second visit. Two of the women expressed their inability to meet for a second interview which resulted in one-time meeting of approximately 3 hours covering both interviews. All women were conversant in English and no interpreters were employed during the interviews.

## **Analysis**

In order to prepare data for the analysis, interviews were transcribed verbatim. The transcribing process was carried out as soon as possible after each interview. Transcripts were read and re-read to familiarize myself with the data. I used the “open coding” method used in Grounded Theory approach as the first step of condensing data into initial analytic categories (Neuman, 2006; Strauss et. al; 1998). It is an inductive, open process where the researcher engages in exploring data with no presumptions of what concepts to be discovered (Boyatzis, 1998; Bilge, 2009). First, each transcript, all field notes and memos were coded line by line to develop preliminary themes emerging from the data. A codebook was maintained throughout the process of coding and analysis. The initial codes were then reviewed and examined, and were re-organized according to specific objectives of the study. Within each of the study questions, I then used “axial coding” to identify core concepts and themes for analysis (Neuman, 2006; Srauss et. al; 1998). During this process, I looked for links, patterns and relationships within themes, and re-organized these into broader categories or clusters of concepts and themes.

In the next level of analysis, I used intersectionality as a framework for analysis. More specifically, I engaged in multiple readings of the data within each of the clusters and themes I had developed in order to understand overlap between these sets. I frequently used visuals such as concept maps and colour codes to trace and identify how these broader sets of themes interacted and intersected with each other to create new concepts and thematic categories. I

then proceeded to map these new categories, locating them at different levels within the broader social structures and contexts to understand how they produced different dimensions at each level. To give a specific example, during the initial phases of coding and analysis it became evident that violence was a key concept that repeatedly emerged. Once I had identified this as a core theme, using concept mapping I tried to locate it hierarchically within the micro, meso and macro levels of social structure. I then examined how it intersected with other aspects at each of these levels to produce different facets of violence. For instance, I examined how at micro level violence as a concept intersected with specific lived experiences to create intensely personal and gendered experiences of violence, such as genital mutilation. I then attempted to understand how, genital mutilation while being personal at micro level was also produced and sustained simultaneously at higher levels of social structure; such as through traditions, stereotypical gender and cultural norms (meso level) and patriarchal societal values (macro level). I repeated this process in relation to each of the core concepts I had identified and under each study questions, and a final set of themes and concepts were selected for interpretation based on the common emergent patterns. Finally these themes were analyzed and interpretations were carried out. Quotes were extracted from the interviews to support the themes and the interpretation of data.

## **Positioning Self in Research/Reflexivity**

In conducting this research, I recognize that my own multiple, intersecting identities, my 'roots', and my social positioning in Canada, have all contributed to shaping the epistemological lens through which I have approached this research, and the manner in which I have carried out the research process. I was born and raised in Sri Lanka alongside a decades old ethnic conflict. However I must admit that I was never personally affected by the war itself because of my membership in the dominant ethnic group. Yet the occasional encounters with the displaced populations and refugees, and the constant stream of media reports and images of them left a permanent awareness of refugee issues in me, particularly with regard to women.

And then my immigration to Canada a few years ago caused profound shifts in my worldview especially as it concerned my own issues with identity, shifting social and geographic locations, my own stressors and struggles with adjusting to life in a new social system, as well as my own (sometimes dramatic) encounters with the Canadian healthcare system as a new immigrant. My new identity as an 'immigrant woman' and 'a woman of colour' in Canada have been particularly key in challenging me to reflect on my own assumptions about identity and issues beyond my comfort zone and in sensitizing me to this new community that I now form part of, the 'immigrant and refugee community', as well as the social positioning that I now occupy as 'a member of a minority group'. All these subjective aspects I acknowledge tinge, even if unintentional,



my choice of this research topic, and my approach to executing the research process.

I consider myself to be uniquely positioned, and privileged to study this topic by virtue of the 'border space' that I occupy in this social system. On the one hand, there are many elements that I share with these women as a result of my own multiple, interlocking identities and life circumstance; for example, as a mother, as a woman, as an immigrant woman, as a woman of colour and as a member of a minority group. All these have been tremendously beneficial in reaching and establishing trust with this otherwise hard-to-reach population. In this regard I consider it a humbling experience, an honour and a privilege to be accorded an 'insider' status (even if partial) by the women who had the courage to trust a stranger to divulge many intimate details of their lives. On the other hand, within my unique position as an immigrant scholar and researcher I have the privilege to interact and engage closely with the intellectual community of the dominant society. This 'outsider-within' location (Collins, 1986; 1998; 2000) affords me a unique advantage in approaching this research. However, I recognize and acknowledge the power differentials that each of these positions entail. By the same token, I am keenly aware of the biases that I bring in to this research process and the powerful representations that I make about these women. I have tried my best to minimize these by engaging in a continual process of self-reflexivity at each stage of the research process, and by allowing women's own voices to take precedence where possible, particularly through the use of their quotes. Even so, I am aware that the quotes that appear in this thesis

are my own choosing, the meanings that I make of them are filtered through my own epistemological lens, and the voice that narrates and interprets the end product is my own. This means that I occupy an asymmetrical position of power within this research process. However I hope that this does not negate my sincere efforts to bring to the foreground the important issues of a group of women who have hitherto been bypassed by mainstream policy, research, practices and decision making in health.

### **Methodological Challenges**

I encountered a number of methodological challenges in conducting my research. First, unsponsored refugee women being a hard-to-reach population, I encountered numerous challenges in finding and recruiting participants. Their precarious legal status coupled with their often distressing life experiences rendered them a state of 'invisibility' which in turn forced many women to remain covert. Any approach by strangers was often regarded with suspicion, fear, and as an invasion of their safe havens. Similarly, while I was glad to find that there were many organizations providing services to refugee claimant population in Vancouver, it took me an unprecedented amount of time, e-mails, phone calls and in-person meetings to get past the 'gate keeping'. Given the profile of their clients, many organizations were cautious about involving them in research, and I was turned down on numerous occasions. Gaining trust and establishing trusting relationships required concerted efforts not only with women themselves but also with the organizations protective of their clientele. My role as an unobtrusive, independent researcher had to be thus reiterated over and over again.

Second, a clear lack of available studies in the area to draw upon was a limitation in informing the pros and cons of the research process and appropriate methodological approaches. I found the data analysis using the intersectionality framework to be particularly challenging in the absence of clear methodological guidelines to be adopted in intersectional research. While the existing literature on intersectionality as a theoretical framework abounds, empirical studies that used intersectionality as an analytic tool with explicit methodological guidelines remain scant (Bilge; 2009). As a novice researcher, it would have been beneficial to have learnt from such studies and methodological approaches.

Third, the issue of language posed one of the biggest challenges. On the one hand, once I included being able to converse in English language as a strict criterion, the sample selection appeared overly restrictive. Given that many unsponsored women had a poor knowledge of English it was challenging to find participants who were able to communicate effectively in English. Further, even when I had found those who were 'conversant' in the language, I struggled with the dilemma as to how much English they really needed to know. For instance, in the very first interview, although I found the participant to be conversant, she had limited vocabulary. Her inability to explain issues in depth may have resulted in missing out on important information. On the other hand, not including English as a strict criterion posed many complexities relating to interpreters and translating. Given the constraints of conducting a Master's thesis, such as limited time and resources, this was not an option for me.

## **CHAPTER THREE: WOMEN'S CONCEPTUALIZATIONS OF HEALTH**

### **Introduction**

Each woman I interviewed had her own unique image of what health meant to her. Each woman also had her own criteria she deemed as important for constructing this image of health. Their conceptions of health appear to emerge from a coalescence of deep insights that they had gained during the course of their own lives, as well as through pervasive ideologies of health and illness produced and maintained by society and its institutions. In other words their conceptualizations of health convey a fusion of what Blaxter calls 'private' and 'public' accounts of health (2004, p.70).

'Private' accounts of health are narrative accounts of health, or those that are derived from much more personal and subjective experiences of health. 'Public' accounts of health on the other hand, consist of 'social representations' of health promulgated and maintained largely by social institutions, such as medicine (Blaxter, 2004). Because these institutions are powerful structural forces, they invariably shape the context in which people live and influence people's perceptions about health and illness (Calnan, 1987). The ideologies propagated by these structural establishments get often idolized and indoctrinated in society as 'real knowledge' particularly since they are 'legitimated by expert opinion' (Blaxter, 2004; Calnan, 1987). And subsequently, as people

take on these ideologies as credible sources of knowledge, their concepts of health and illness get inevitably filtered through medical models of health and illness, and their representations of health get colored by images and stereotypes derived from this public sphere of health (Calnan, 1987; Shaw, 2002).

Throughout their narratives women went back and forth to draw from both these ends to sculpt their image of health. In doing so, they created multiple meanings of health that are nuanced and complex. What follows is a discussion of the ways in which women sought to give meaning to the idea of 'health' as they drew on this dynamic interplay of 'public' and 'private' realms of experiences. In organizing this analysis, I first outline and explore these separate spheres in greater detail. I then move on to illustrate how they simultaneously contribute to create meanings of health for these women. Finally I attempt to delineate the key conceptions of health that emerged from the interviews with the participants.

### **The Realms**

From the beginning, women consistently referred to intensely personal experiences of health and illness of their own and of those who are dear to them in articulating what and how they thought about health. These personal experiences were situated in historical and current realities of women's lives and intersected with a multitude of other aspects of their life circumstances. They expressively enunciated and contextualized their ideas about health within these multiple realities and circumstances, particularly within those phases they saw as 'milestones' in their lives.

In framing their ideas about health within these key points in their lives, participants spontaneously talked, for instance; about those culminating events 'back home' that set the stage for their eventual 'flight'; about those 'burnt bridges' that gestured the lives they left behind; about their long and often difficult 'journey' to Canada that heralded the start of a new life; and about the subsequent settlement processes that called for a plethora of voluntary and involuntary adjustments on their part.

Each of these milestones carried with it its own unique baggage of sentiments for these women; fears, dilemmas, worries, frustrations, expectations, insecurities, feelings of emancipation, guilt, regret, let-downs and more. Each of these mileposts also necessitated negotiating new identities, shifting social and geographic locations, confronting diverse value conflicts, and grappling with the practicalities of multiple changes that were often unanticipated. Women talked at length about these passing stages of their lives, about the way they felt about these lived realities, about the challenges, the conflicts and the difficult choices they had to make along the way. By relating to these deeply personal realities set in different times and spaces, women gleaned vivid pictures of health. By relating to these realities they illustrated how their health, as well as their perspectives about health were shaped and re-shaped by the fluctuating events in their lives.

Similarly, women also 'borrowed' from those ubiquitous ideologies about health that are 'out there' in society in forging their own definitions of health. Their images of health were tinged with these ideas when they talked for instance about 'being in good health', which they articulated using a variety of expressions

and terms drawn from popular parlance around health. Their talk was replete with terms such as 'being fat' [body image], 'healthy eating', 'dieting', 'exercise', 'the gym', 'the yoga class' or the 'relaxation music' as they exemplified their notion of being in good health. Likewise, when women framed health in reference to 'absence of disease', their conversations often couched an array of idioms and expressions that are clearly compatible with medical lingo of health, such as; 'annual check-ups', the 'Pap-test', 'hypertension', 'diabetes' or 'medical diagnosis'.

Such 'public' ideas about health ebbed and flowed throughout their accounts of health and were often incorporated into their 'private' experiences. In articulating their ideas about health, women digressed, for example to tell varied stories of diseases and illnesses that they themselves had experienced at some point in their lives, or that had afflicted their loved ones. As they told these stories, they often conversed about how these diseases were diagnosed and treated, and went into stirring speculations about their specific etiologies. They tried to make sense of these diseases and illnesses in explicating their points about health, and as they did so, they presented accounts of health that contained interlocking ideas derived from both public and private realms; when women spoke about diagnosis of certain diseases, they almost always referred to expert opinion, but at times also relied upon self-diagnosis. Similarly when they talked about why and how these diseases came to be, they opined alluding to the public pool of floating medical ideologies as well as to their intimate personal experiences.

General ideas of health were much more conspicuous when women talked about health and being healthy within the context of their current lives. They now lived in a more westernized society, in which these ideas of health are often regarded as the standards of health.

## **Women's Representations of Health**

Although each woman had her own unique image of health, certain similarities ran throughout their narratives. Subtly nuanced conceptions of mental, emotional and physical ideas of wellbeing along with health defined in light of various functional capabilities ranked high among the recurring themes. In other words, an assemblage of both 'mentalistic' and 'physicalistic' dimensions of health, defined in varying degrees, made up these common threads. These themes are discussed in more detail in the following sections<sup>2</sup>.

### **Health as Mental and Emotional Wellbeing**

One of the most notable depictions of health that women garnered had to do with psychological and emotional notions of wellbeing. Almost all participants crystallized health within varying degrees of mental conditions, defining it in terms of 'happiness', absence of 'stress', 'worry' or 'fear', 'feeling good' and as a 'state of mind'.

---

<sup>2</sup> In order to facilitate the following analysis, I have categorized women's representations of health along themes. However it is important to remember that these categorizations are not intended to be strict classifications that can be neatly fitted into ideal types, nor are they intended to be mutually exclusive. On the contrary, they largely emerge as comprehensive definitions that overlap and encompass many dimensions, such as emotional, psychological, physical and spiritual.



Listening to these women's narratives, it was evident that both the dramatic events in their lives as well as the pace at which these events unravelled had profoundly impacted their emotional and psychological state of being. As women recounted the events in their lives at numerous occasions during the interviews, a constant stream of emotions appeared to enwrap their narratives. When women reminisced about the lives they left behind for instance, there was often an ambiance of sadness, grief and loss. This was particularly evident when women talked about the family members they were forced to leave behind - especially children - as they sought sanctuary in Canada alone. Many participants spoke of how much they missed their loved ones, how much they worried for their safety and wellbeing, how much they longed to be reunited with them, and the sense of guilt and regret they sometimes felt at having to leave them that way. As Edith, a mother of three, summed up her feelings about the children she had to leave behind;

"I miss them, I phone them, I call them everyday if I can, almost everyday I talk to them oh yeah it is so difficult, staying away from your children, I've never left those kids alone before, never. I feel so bad. The longest time that I would leave them was the time that I was going to work and coming back home"

Fatima, another mother separated from her four children expressed similar sentiments.

"It makes me feel good here but only that I'm so stressed out, whichever I have I'm not happy with it, because I miss my kids I can't see my kids and that's the only question, if I can have my kids life would be so good here, yeah so good"

Annette, a young woman who was left in charge of her two young siblings after her parents had been killed as a result of the ethnic strife in her country of origin also had to leave her siblings behind, and talked about how she felt about leaving them;

“It’s hard for me sometimes, they are still there, and they don’t have anyone, I mean ok my uncle is there but uh it’s not the same you see, I used to look after them (silence) I miss them, I miss them, I think about them all the time”

Not only did some women grieve the separation from loved ones, they also often grieved the loss of numerous other ‘things’ that were dear to them, such as their life’s possessions –the home they had once called their own; the pieces of furniture they had lovingly amassed over the years; the car they had owned - the job they had enjoyed doing; occasional cravings for those familiar foods back home; or the ‘good life’ they had lived before their troubles began. Some participants still grieved the loss of these ‘small luxuries’ as they struggled to settle in, in their new safe haven, living in crowded, shared-community houses or often run-down, cheap [yet over-priced] apartment or basement suites; living from hand-to-mouth on welfare or on survival jobs; contenting themselves with hand-me-down household items and other paraphernalia. Particularly for those women who considered themselves as having lived a comfortable life before, having to let go of these things that were important to them as they endeavored to adjust to their current realities was not easy. On multiple occasions during our meetings they nostalgically spoke of these ‘good times’ gone by, times and things that they could not just sever from their current lives. As Cecilia commented;

“Coming here, it was very difficult because in my country I have a big house, new cars and I had a very, very good life there, and it all stopped in one week, in one week we had to leave all that, and I told one friend to rent my house and she sold my appliances, my cars, and my furniture, everything I had you know, I feel very sad...”

By the same token, both Farah and Fatima recollected the ‘good lives’ they lived back home before their troubles began. They talked about the close knit families, the friendly, open neighbours and the circle of friends and communities they formed part of, all of which they missed, and all of which contrasted dramatically with their current realities as they lived lone, separate lives, mostly confined to their ‘cubicles’. As Farah commented;

“Yeah you know back there we are middle class, and like uh my husband was a university professor, and we had our relations with neighbours and the friends really close and we have uh, we lived good...now it’s hard for me because you know I’m a refugee now and when we left there you know we couldn’t take anything, like I have my house, over there, whom some people occupied with all my furniture and they are living there...and so everything we left there...”

Fatima expressed similar sentiments;

“I was a housewife, yeah, (silence) I got married, then the problem started there, my life wasn’t bad, it was a good life, (silence), I used to not to be so rich or what, but you know always home, in my community because they are friendly, even if you don’t have salt you can go to the neighbour and ask for salt and the neighbours can come and we share food, so we used to be poor but then we are happy, you get what I mean? But here it’s totally different. I live in my cubicle here and even I don’t talk to the next neighbour, yeah...just alone”

For many of these women, life also happened so fast and abruptly that it left them no time to think other than to make split-second decisions about their immediate future. As Cecilia recalled of her decision to flee to Canada;

“And within one week we came, left there, it was very quick and it was very difficult, very difficult...and in moments like this you think very fast, very fast you know you have no time to think so we took the decision to come here, to Canada, it was long ...”

Women talked about how difficult and confusing it felt to be suddenly jostled out of their familiar lives in this manner, and to be thrust into an unending sea of challenges that were complicated and unprecedented. As Anna commented about the immediate circumstances after her hasty decision to get away from her troubles, and spoke about how she felt at a loss not knowing what to do next as she landed in Vancouver.

“Umm at the beginning, how can I say...we were not thinking...some people prepare they, sometimes they give in at the airport and they know what they’re doing. I’ve listened to people they say oh you go to airport you do this you do that and they’ve got it all planned. We come here we didn’t know what to do... we just come, just to get away from it all as far as possible, and we didn’t know what to do. It was hard you know”

Having to juggle with a multitude of these challenges as they navigated through a labyrinth of transformations in life was emotionally draining for the women. And so they constantly ‘feared’, ‘worried’ or were ‘stressed out’ about things. For instance, they worried about their loved ones, they were stressed out about the refugee claims process, they feared for their uncertain future. In short, a myriad of accumulated stressors and uncertainties overshadowed their current lives. When women framed their ideas about health, their representations were

unmistakably textured with notions that derived from this emotional landscape. Indeed, as Anna expressively articulated, emotional and psychological wellbeing was the most important aspect in defining overall health. As she explained, one's emotional state of being is the source that predicts the nature of one's physical actions, and consequently the nature of one's physical wellbeing.

“Yeah, umm the ideal sense of it is mental health is the most important, physical health yes it is important, but mental health is the most important I think b'cause mentally you can do a lot more things than just physically, because mental health, it can make you feel really good and it can make you feel really bad, and if it makes you feel really bad then it's not gonna move yourself physically to do anything”.

Referring to her own life circumstances marked by a profuse of worries and uncertainties, she went on to explain how a healthy mind is key to ensuring a healthy body, and also emphasized on physical activity as a crucial component of 'perfect health'.

“So that's how it is I think and, umm and perfect health obviously, umm as I said for me it's all connected with mental, when you settle down...umm when settle down you don't have worries, you stop having worries, you stop having stomach pains, you stop having heart pains or any other you know... perfect health for me as well, I like to be physically active. I don't do it very much here but I used to do”

Nadia expressed a slightly nuanced idea of health as it related to emotional and psychological wellbeing when she identified health with 'a state of mind'. As she explained, it is one's state of mind, shaped by the nature of emotions and feelings that one holds within that 'really makes one healthy' more than other things, such as the food one eats.

“And you know, sometimes it’s your state of mind, yeah because sometimes when you always think about things if you think in life I can’t make it it’s like, making your immune system, this is what I think so, it’s like going down, you get depressed... like your emotions and your feelings and what’s inside of you that really make you healthy, sometimes it’s not really what you eat.. Sometimes you can eat, you can eat, and eat and eat but you’re still sick, you still feel sick you’re not healthy, so it’s just like the state of mind...”

In many cases this ‘state of mind’ corresponded closely to various forms of inner contentment, described using terms such as ‘being happy’, ‘feeling good’, ‘feeling relaxed’, ‘peace of mind’ or freedom from stress or worries. These positive emotions were continually identified as important elements to the idea of health by many of the interviewees. Sometimes women used these terms in the negative to portray their concept of health. It was evident from the interviews that the manner in which women used these concepts were greatly shaped by the unique experiences and circumstances of their lives, and therefore, they held nuanced meanings for the women. Nadia for instance, went on to illustrate how her recovery from depressive episodes has been key to her happiness, which, for her was synonymous with good health. In addition, as did some other participants, she also spoke of absence of stress and feeling good as important for being in good health.

“To have, be in good health is like happiness, to be happy, like oh, like, since I moved away depression from my life, if I’m like sad I can like put on my music, and start dancing or I can like start dancing in front of my daughter, and she would be like laughing, and then she would like dance with me so it’s like, being in good health is like being happy and feel relaxed, take your mind off any stress even if you have, normally you have one stress or the other...”

Like the above participant, Fatima characterized health primarily in terms of 'being happy', being 'free from stress', and functional capacity, but she also attributed lack of good health as resulting from lack of access to sufficient food to eat. To her, as she indicated throughout the interview, the concept of happiness and freedom from stress as it related to health was largely defined by the wellbeing and safety of the children that she left behind.

V: And in your opinion what is health, what does it mean to you?

Fatima: It means a lot... You have to be happy of course (long silence), but thank God I'm healthy that's the most important thing because I would like to see, see my kids again (clicks tongue, very long silence) and when you are not healthy of course you don't feel good

V: In what way?

Fatima: In all ways, if you are not healthy you cannot do things, I don't know how to explain this for sure but what I know is if you are not healthy you don't feel good you have to be stressed out every time, yeah, and what brings people not to be healthy is to be when you don't have enough food to eat when you are poor, yeah stuff like that

In sum, emotional and psychological wellbeing emerged as an important dimension in women's characterizations of health. Various forms of positive and negative mental states were identified by the participants as crucial contributors to their idea of emotional wellbeing. These included concepts such as 'happiness', 'feeling good' and 'feeling relaxed'. As well, stress and worries which had become such a familiar feeling in their daily lives, were continually referred to by women as a menace to their idea of health. In turn, freedom from stress and worries was seen as essential to being in good health.

## **Health Defined in Relation to Physical Wellbeing, Absence of Disease and Functional Capacity**

Being able to 'work', or carry out physical activities was another important dimension that constituted women's conceptualizations of health. Physical fitness, freedom from disease, regular exercise, and energy or physical stamina were identified by women as important elements that tied in closely with the idea of functional capabilities, and their concept of health. Throughout their interviews women frequently talked of how important it was for them to be 'physically fit', or be physically 'energetic', or be free from diseases or 'not to be sick', as they went about their daily chores. For instance, Irene conceptualized health primarily in relation to 'not being sick' and happiness, and for her, 'not being sick' was directly tied to the physical demands of her daily life. In this sense, health as defined in terms of absence of disease and happiness had a practical meaning to her.

"Health? I think it's when you are not sick, sick all the time, uh when you are happy you know...if I'm sick, who, uh is going to take my daughters to school? Who is going to cook and uh do it all here (pointing around the house), you know? So it is very important, uh and if you are sick, sick all the time, then may be you are not happy, you don't like to go outside, see people, so it is good when you are not sick"

In a similar manner, for Maria, being healthy signified 'being able to do things' or primarily as it related to functional capacity to work, and fulfilment of parental obligations. She recognized absence of disease and exercise as vital to facilitating physical functioning in order to engage in these tasks.



V: So what comes to your mind when I say health?

Maria: Mmm...(long silence), I don't know but...mmm...if you are sick you uh can't do anything, so you have to be healthy, do exercise, uh I don't know, uh that's what I think

V: Can you explain a bit more?

Maria: Uh for my work, for my kids I have to be healthy (silence)

In this light, health was also a principal form of 'tool' (Pierret, 1993) they carried, especially in relation to employment. Not having a lot of other resources to rely upon, 'having good health' or 'being in good health' was crucial to them particularly in ensuring financial stability, the mainstay of their lives. In this sense, health was a 'tool' that they could utilize to not only obtain, but also to retain employment. This was quite important given the limited choice and type of work available to the women; work that was as equally precarious as their social position; work that promised no form of added benefits; work that warranted no form of income or job security; work that demanded a high level of manual labor; work that was often deemed unsafe and unhealthy by public health standards; and work that ironically, drained much of their reserve of health. Yet work it was, and women needed to find and keep work, in order for them and their families to survive. And so, almost all participants recognized the critical significance of health as it related to work. There was a deep sense of urgency when Farah, who was the primary provider for herself and her ailing spouse, commented;

“...I ask God to keep my health uh, and to keep my work because I need health and I need work now yeah and that's it”

## **Health Defined in Relation to Others' Wellbeing**

In many women's view, the concept of health could not be wholly defined in relation to individual wellbeing alone. Familial ties and other social relationships were regarded as integral to their idea of health. For these women, the wellbeing, safety and the closeness of family members largely determined how they felt about their own health. In an abstract sense, women felt 'healthy' as long as they were close to their loved ones, and as long as they felt that their loved ones were alive and well. As Irene illustrated;

"You know also, when you are a mom it's not easy, when your son or your daughter have fever or something, you worry, so it is hard, but when they are happy you feel good, thank God my, uh my kids, they have no problems, no health problems, and my husband, we are all healthy, so it's good, it's good"

But for those women who were separated from family members as they sought sanctuary in Canada alone, it was the converse. They felt their health was sabotaged in a way as they continually worried about the safety and wellbeing of those they left behind, particularly when it concerned children. The thoughts of them always preoccupied women as they went about their daily lives. For instance Fatima consistently spoke about her worries and how 'stressed out' she felt about having to live separated from her children who were still living in her own country.

"I'm so stressed out...my kids, they are persons who are lost, they are suffering like nothing, and since I came here, last year I broke my leg, this year I've broken my leg so I don't know, now I'm protected here and everything is good, but I'm so worried about my kids"

She went on to explain how she was even unable to plan for her future without her kids around.

“I think if I get my kids here I can start to think about what to do with my life but now I’m so worried about my kids I don’t know how they are living, it’s a really bad situation for them”

Edith who had also been separated from her children as she took flight from danger in a hurry explained how ‘phoning her kids to see if they’re alive first thing in the morning’ was a part of her daily routine, and how she constantly worried and feared for her children’s safety and wellbeing;

“...no they [children] are not, no one is safe in that country, no one is safe there, it’s like everyday when you are sleeping, when I sleep and wake up in the morning the first thing, the first thing for me is to phone and see if they are alive, you know, it’s quite a difficult life, anything can happen any day, it’s not a safe place there...that’s how bad it is and my children are not safe, no one is safe there...I’m so worried about those kids”

For these women like Fatima and Edith, as mothers who experienced separation from their children, ‘keeping themselves healthy’ had a crucial life’s purpose, that is, to be alive and well to see their children some day;

“It’s [health is] *very* important because I would like to see my kids, and, so I try to keep myself healthy as much as possible so that I see my kids, so it’s very important for me...(silence) I’m so worried (sobs, long sigh, very long silence)”

Another important dimension of health emerged when some women contextualized health within their societal role as primary caretakers or in order to be able to ‘do for others’. Good health was seen as almost ‘imperative’ to be able to effectively fulfil their familial obligations. For example, Edith opined why it was unjust or ‘not good’ for children to have to live with ‘sick’ parents.

“...I think it’s not good for the kids also to be raised by a parent with a condition because they see it as ‘oh mommy is sick all the time’ and they are not happy because of what they are seeing about their mom, so I think that psychologically it will damage their lives and that’s what I think, children they just want to lead a happy normal life with a normal mom and a normal dad, so it is very important for a parent to be healthy for the sake of their children yeah”

### **Health as Synonymous with ‘Life’ and ‘Good Living’**

In its broadest sense, some women defined health as something synonymous with ‘life’ or ‘living’ itself. Health was seen as inextricably linked to life that these two elements could not be easily teased apart. For these women, health and life complemented each other. Or rather, ‘everything in life depended on health’. According to Farah;

“Good health, it means you live good, because everything depends on your health...”

In this light, health was seen as a valuable resource for living, if not the most valuable resource in the sustenance of life. Health was seen as a portal to achieving everything else in one’s life, both tangible and intangible things. In short, health was the key to living a life of fulfilment and harmony. The same participant effectively illustrated this idea by alluding to her spouse’s continuing battle with a kidney disorder. She explained how, despite having money and regular access to medical care, her spouse’s health could never be restored to what it was. In her view, without ‘good health’ life becomes incomplete, and health is an irreplaceable element essential for ‘living good’. In addition, she also defined health in reference to functional capabilities, particularly as it related to employment.

“...if you have good health you can work and you can enjoy your life, and you are not scared, and I feel health is more important than money, as I said, my husband, like back there we had money but his problem with the kidney, yeah may be money would help him to see doctors but the doctors cannot bring him the changes in his kidney, they make it better for him yes but they cannot change the whole health so health is more important than anything and, good health [is] if you can work good, and live good, so this is health”

For these women, health was deemed ‘the most important’ in a sense because, in Pierret’s (1993) words, it was ‘a principal form of wealth’ they possessed. In the case of these women, particularly within the context of their current lives, the social label they carried as ‘refugee claimants’ created much instability in their lives. It placed them at a number of disadvantaged positions in society that depleted them of many social and economic benefits regularly enjoyed by the rest of the society. By virtue of their social status, they also had limited or no access to the kind of safety nets the other members of society did, particularly during times of need. Given these circumstances, health was the one form of wealth readily available to them. It was so valuable that it was not something that women could afford to jeopardize in any way. For them, having this reserve of ‘wealth’ [in the form of health] was essential in order to cope with their daily lives that were replete with a myriad of constraints and stressors. Throughout their narratives, women emphasized the importance of ‘having health’ as they went about their daily lives. As Edith pointed out;

“It is very important yeah because when you have a condition it limits you in many ways, it limits you to do certain things right, it doesn’t feel good, you are

not happy, you cannot do everything , you are limited, you are not free, so I think the best way to live is in good health”

### **Health as Something to be Determined by Expert Opinion**

For certain women, health was seen as something that needed to be determined by a visit to the doctor’s office. For them, it made sense to have the doctor – the expert- define their health for them, because they were no experts and ‘couldn’t know what went on inside their bodies’. In this sense, the periodic reassurances of the physician that everything was in order with respect to the physiological body was important in ensuring that they were in ‘good health’.

Thaya voiced this idea drawing on an experience of an unsuspecting friend who was diagnosed with cancer on a visit to the doctor’s office;

“Yeah good health, this is very important you know, health is very important, sometimes we don’t know what happen in our body no?... my brother’s friend, two months ago he went to the doctor with a tummy pain, it’s very strong...then it’s cancer, then health is very important, I’m healthy now but don’t know what happens, so we have to go to doctor and check the body because I don’t know what happens there no?... every year I take the medical test, they test the blood and urine and here (pointing to her lower body) and everything, I did that last year”

For these women, keeping up with deliberate and routine ‘medical check-ups’ and laboratory work was a vital step in this process of ‘expert’ warranting and legitimization of health. After all, it was these tests and check-ups that briefed the doctor about the goings-on inside one’s body and enabled her/him to value one’s health.

In addition to above definitions, Edith framed being healthy in relation to having access to medical care and management of health conditions, and being sufficiently knowledgeable about health conditions. Her understanding of health within this perspective was directly drawn from her own past experiences of being denied proper access to healthcare, as well as her poor knowledge about the health issues as it related to better management and prevention of her chronic health conditions.

“Being healthy, I think it’s all about having access to medical health, getting the proper medication for whatever condition you are in, to manage your condition, getting the education about your condition, yeah because sometimes you can have a condition like in my case the diabetes, uh no one really taught me about diabetes, most of the things I started to research by myself but I didn’t get much in depth about it, they didn’t tell me...so I’m thinking now oh what I missed there was some education, so it is very important to get education, it really helps...”

### **Health as a Holistic Concept**

Finally, Sara articulated a much more inclusive notion of health, referring to its multi-dimensionality. She incorporated and reiterated many of the ideas of health presented by the women above, drawing attention to the fact that health was a lot more than a unitary concept that could be defined by a single element.

“Health? Umm uh it’s a good question. Umm I don’t know probably it is like uh, I mean it is important to be mentally or emotionally fine, or ok, of course healthy I mean like physically you do exercise and eat well and do all that stuff to be healthy but also by mentally, or emotionally, or just spiritually, I don’t know its, uh to me it’s all that”

## CHAPTER FOUR: SELF REPORTED HEALTH ISSUES

Women reported as experiencing a range of health issues and concerns in response to the question 'Can you talk to me about any health issues that you may be having?' The question was left open for the participants to frame in their own terms and expressions what they viewed to be 'health issues' that affected them. This question was later followed by a second question; 'Who thought you had this issue? You or someone else (i.e. doctor)? The follow up question was intended to clarify whether the decision that they had a particular health issue was based on their own self-diagnosis or on 'expert' opinion.

The answers that women generated in response to the latter question derived from both ends, that is from their own self-diagnosis and subjective decisions about what they considered to be 'health issues', as well as from standard clinical diagnoses and other professional opinions. The health concerns that women presented extended from somewhat minor and temporary illnesses such as colds and flu to more concerning issues of sleep disorders; varying degrees of 'depression' and other 'problems in the head' characterized by multiple forms of stress, worry and anxiety; various bodily aches and pains; 'weight problems'; 'women's problems' that related to menstrual cramps and other reproductive health concerns; migraines and headaches; bouts of fatigue; as well as chronic conditions that included high cholesterol, asthma, diabetes



and hypertension. Most women reported as experiencing more than one health concern at a given time period.

What follows is an analysis of health issues and concerns that were most frequently cited by the participants. As also illustrated in the following sections, women's talk around health issues was also almost always followed by speculations as to why and how these issues came to manifest in their lives.

### **Depression, Other 'Issues in the Head' and Their Causes**

Depression emerged as a recurrent health concern for the women and was consistently mentioned by more than half the interviewees. Women alluded to a multitude of somatic symptoms of depression including headaches, migraines, sleep disorders and feelings of exhaustion in describing their experiences of depression. As well, women diligently sought to situate these experiences within different events in their lives as well as in situations external to their lives [i.e. structural contexts] as they tried to make sense of their depression, and frequently delved into deep speculations as to what their root causes were. Interestingly, as evident from the following analysis, when women contextualized depression, they did so primarily against the backdrop of their more immediate migratory and post-migratory experiences, and seldom adverted to events that happened prior to their journey to Canada. Although women drew heavily from post-migratory circumstances to depict their experiences of depression, in doing so they were also able to highlight important intersecting dimensions of migratory and post-migratory scenarios that led to these experiences. These realities and circumstances included [but were not limited to]

settlement challenges including housing, employment and language issues; issues of negotiating identities; cultural and value conflicts; institutional detention; and most importantly, various aspects of the precarious refugee determination process.

Irene for instance recounted what her life had become since the onset of her depressive episodes ever since her first claim for asylum had been rejected a few months earlier. She attributed the origins of her depression directly to the grievances of her failed asylum process, a factor that is beyond her control. She developed depression because she 'kept thinking about things all day long' - about the frightening precariousness of her current reality as a rejected claimant and the bleak and uncertain future that awaited her and her family. She developed sleep disorders, and was no longer able to sleep well at night *because* she kept thinking about all these things. She heard incessant 'noise in her head' which had brought back migraines that she had suffered from in the past but that had long vanished. 'Her body didn't feel well' and she felt tired often, and so she could not spend as much time as she liked in the gym. Her symptoms had aggravated lately to the point that she had been put on medication not only for depression, but also for migraines and insomnia. Since the rejection of her claim for asylum, Irene and her family had launched a second claim through the process of PRRA, and were earnestly awaiting a decision. She found the waiting itself to be tormenting, possibly as she dreaded yet another rejection, all of these contributed to exacerbate her symptoms and further deteriorate her health.

Irene: Umm yes, now I have depression yeah, depression, you know...

V: I see (silence)

Irene: (silence) ...because all the time I keep thinking about all this, now I sleep a little bit, but in the last months I couldn't sleep, now I take medicine for depression, because you know it's not easy, I don't know if I can stay here, or go there, I don't know if they'd say yes or no, all the time I think, I think, and the doctor he says, oh you need to relax, but it's not easy you know with all this going on... (silence) yeah this depression is not easy...I went to the doctor, because I don't know why, because my body is not feeling well, because I don't sleep well, all day I'm tired...and then last week I had a bad headache, because for the last ten years I had this migraine and when I came here I didn't have it anymore, but now it's come back, I think it started six months ago, because it is noisy, noisy in my head all the time because I think all day long, about this problem, I don't know how long, we have to wait long time, and I'm very scared because I don't know what they'll say..."

Farah too 'felt' she had depression. But unlike in Irene's case, her depression was self-diagnosed, and she never sought medical care for her condition. She conjectured at length on a constellation of reasons that she felt was responsible for her depressing feelings, all of which she largely associated with various elements of 'the life that she was now living'. As she described these elements, she highlighted how a confluence of intersecting factors simultaneously contributed to her perceived depression. These factors included talking about her demoted social status; dwindling self-worth; her confusions and struggles with identity; financial struggles; family issues; immigration process etc.

For instance, she spoke of how she was 'not used to this life'. She talked about how her "refugeeness" was painfully taunting her and affecting her self

esteem, and of the ongoing dilemmas and battles she faced in negotiating her very identity; she couldn't tell 'who she was or what she was anymore'. She felt constantly vulnerable as she worried about her own health and her spouse's. She worried that she 'might fall sick' one day and what that would mean. She worried about her spouse, who was chronically ill with a serious kidney disease. It terrified her to think how she would face her future alone in her old age, with no family and friends by her side. Her family could not visit her as they liked, nor could she visit them, all because of issues above and beyond her control – she had no papers, and they would not give visas to her people easily – and all this made her feel crippled and imprisoned. Her financial instability was a source of great distress to her. She was now the only and primary breadwinner, because her spouse was too ill to work and because he was elderly, and even if he were not sick, he would probably only have a slim chance of finding work because of his age, for 'they only preferred young guys' in this country. And then there was the refugee claims process, long and sluggish and hazy, and the wait was 'killing her'. And as much as she tried to keep these thoughts at bay, all these things that she 'did not want to think about, that she did not want to face', they inundated her mind. She felt stressed and depressed, she felt tired, and she suffered from ever frequent and worsening headaches.

"You know sometimes I feel so stressed, uh depressed, and I know it's because of this life, so if I get depression I get it from this life, I am not used to this life, and, and like now I don't know, who I am or what I am, like I don't have papers, I don't have anything, you know when I was there, I really, I never thought one day I will be a refugee, because I feel to be refugee it's not easy for your prestige, for whatever you do, but

uh now I don't think this way, but sometimes I feel it...and I always have this migraine, I don't know if it is really from the stress, sometimes I say, no, I don't keep anything in mind, but I think it's something inside, you don't feel it, but there is things you don't want to face, so when I feel like my health is not good, I feel really bad, and so how I would face the life, just me and my husband and like there you know, the family will look after you, your kids, now I am separated from my family, like my son cannot come to visit me or to help me because you know with the people from my country here, now they don't give uh visa, and if I, like now I cannot travel, because I don't have papers, you just feel that you are in a prison, so all this situation, it's very hard (silence), and I felt really, uh this is too long to say either they accept us or not, one and a half years we are waiting and it's just killing you, killing you yeah (silence), and also you know, sometimes like uh if I don't work financially I'm not good, so my husband he didn't get work because he is sixty six, and he is, like I said he was a university professor, he cannot work any kind of work here, and you know here they prefer young guys, so all these things, difficulties, so these are which make me uh depressed, yeah, yeah, so this is my life. You see me one day I am happy, next day I am down, yeah (laugh)"

Two other participants in the study talked of depression within the context of their immediate migratory experiences. Nevertheless, depression was not an issue for both of them at the time of the interview. For both these women, it was a thing in the past, and had nothing to do with their current state of health. And similar to Farah, their depression was self-perceived, and had never been clinically diagnosed. For instance, Cecilia described her first experiences of being in Canada, and the numerous hardships she faced as she went about seeking help and 'figuring out' her way in a new country. She had no knowledge of the system, and had no knowledge of what to do or where to start. After entering Canada on tourist visa, Cecilia and her family spent many months as 'tourists'

before finally approaching the immigration with a request to claim refugee status. They only decided to do so after they had drained all the money they had brought with them, and had exhausted all of their options. With very little English and keenly aware of their wobbly legal status, Cecilia and her family were fearful of people, and of asking for help. She was so afraid that she and her family 'went into hiding' in their small apartment they had rented and lived in much social isolation. Even when they did manage to locate places [i.e. two service organizations, a church] where they thought they could find help, they were turned down, maltreated and badly exploited. She felt that all those issues she encountered during these first months triggered her depression.

V: So you said you had depression before? Can you tell me a bit more about it?

Cecilia: Umm yeah but that was when we came, not umm not now I don't have any depression now.

V: So can you explain to me, uh why do you think you got depression then?

Cecilia: Umm oh my God...[silence] because as I told you we were so scared, very scared, uh she told us [a service provider], we have to go to the immigration, she said it's illegal [for them to be in Canada without legal status], and we were so afraid to go to the immigration, we thought the immigration, they will tell us to go back to my country, and my kids they couldn't go to school for umm many months. We went to that Church but nobody help us, it was very hard, I was so scared, we were all here [pointing around the house], my kids they had no friends, they were just here all the time [in the house], I was so scared and I didn't open the windows even, oh my God it was hard, and I didn't speak nothing, no English, only my husband a little bit English, and we didn't know what to do, and that guy [a service provider], he was so rude, we went to him and he was so rude, so that's why, I think that's why I got it...but now I'm

good, I feel so good I don't have any [depression] problems now.

On a similar note, Maria narrated how various stressors and challenges she encountered during her tumultuous first year in Canada gave way to her experiences of depression. Although she was not clinically diagnosed, a service provider suggested that “may be she had depression” and directed her to another organization for counselling, which she received on a few occasions. She referred to a range of issues that she considered to be the spring-wells of her depression, and these were primarily related to the vicissitudes of settlement and adjustment to life in Canada. She described her and her family's difficulties as they struggled to reconcile their new life within an unfamiliar country and culture, her fear of strangers, as well as economic challenges; housing issues; issues in finding employment and those with language, all of which she considered contributed to her eventual depression.

V: So do you have any other health concerns?

Maria: Mmm...as I said just cholesterol in this moment...(silence)... but umm in the first year, I had a little problem because you are scared of other people and about thinking of my problems, I didn't take medicine, I only went for the psychological counselling, it's gone now, but umm the first year was very difficult because I had depression because it was a new country, different culture and wow, we were scared, because my child she only spoke a little English and we arrive in Canada and she said oh mom no, I don't want to go to school, it was very difficult for her, and for my husband and me, the rent was very expensive and the work permit was very slow, it's very different I don't know, when you change our money here to Canadian dollars it's very little and I didn't know the money just flew, and the renting, no kids in many places, no kids, ah how many people turned us down, and it was difficult to find a

job when we first came here because we don't have a work permit and the professionals international doctors, nurses it is very difficult, and my husband we both had good jobs, it was very difficult, and we got the work permit very late yeah

Anna on the other hand characterized her health concerns as those residing 'mainly in her head'. While she did not refer to depression directly, she did however talk about her experiences of stress, anxiety, panic attacks and sleep disorders which she felt stemmed primarily from the unsettled state of affairs of her current life. Similar to previous participants, Anna also expressed her worries and fears for her future and concerns about the immigration process as a major source of her agitations. She talked extensively about her impressions on access to psychological care and use of medications for her mental health, and explained why she thought (or rather, why her physician thought) it apt for her to continue medication for an extended period.

V: I see, so do you think you have any health concerns right now?

Anna: No, umm no not at the moment, just mainly just in my head...

V: What do you mean it's mainly in the head? Can you explain a bit more?

Anna: Yes, umm as I said before, nothing, nothing is settled, sometimes I feel like I wanna settle down but then you don't know what's gonna happen you know, that's why it's so stressful, and umm as I said, when you settle down obviously, you stop having worries and pains and all, and all this is taking so long, so long you know, I don't know if they're gonna say we can stay here or not, so nothing is settled you know, (silence)...

V: I see, and did the doctor say for how long you have to be on medication?

Anna: No but he knows from his experience because he deals with immigrants, closer the time gets to your hearing, more nervous



and uh worse it gets, and he said may be now kind of you relax a little bit because nothing's happening, when you receive the papers that when it's gonna be the date of your hearing you try to prepare with your lawyer you get more, take more stressful, and he said umm obviously even after your hearing's gone, maybe it's positive which is good celebration and you relax but people still suffer like post traumatic, umm post traumatic disorder so it takes some people for years, it depends on the abuse of umm, the level of abuse so and how settle here and how comfortable you find yourself within the community, because not everybody can settle in a new country, new people, new cultures...

Nadia brought out another important dimension of depression as she contextualized depression within her immediate immigration experiences of institutional detention. In doing so she highlighted numerous aspects of 'policies of deterrence' that are responsible for her depression. Throughout the two interviews, she flashbaked on numerous occasions to describe in great detail the fearful and bitter experiences she endured during her three weeks of detention in Canada as she arrived at the airport and declared her intention to claim refugee status. She divulged at length her impressions and feelings of those very first weeks of being in Canada, which to her was riddled with untold humiliations and degradations, and of the lasting traumatizing effects that the whole detention experience left on her. She spoke intensely about the insensitivity of the detention officers and 'sheriffs' in the way they handled her and their complete disregard for the difficult circumstances that she was in, particularly their indifference to the fact that she was then pregnant. She expressed her regret at being in Canada after she arrived, a 'nightmare' far removed from the safe haven she had envisioned it to be. She identified the

stigmatizing effects of her experiences of deterrence as the major source of the depression she subsequently developed.

### **Box One**

*When Nadia arrived at the air port, she had no papers, no passport, and no identification. She went to an immigration officer to explain herself. She was sent into mandatory detention. That was the beginning of a new episode of 'nightmare' for her. It was 'torture'. She had never been in a place like this in her life. She was in jail among 'criminals and drug addicts'. The guards were always on vigil with pointed guns. She had never had anyone point a gun at her before. It terrified her. When they brought her out of the cell, they always cuffed her hands and feet. When she tangled her feet and fell, no one helped her. When she needed to do her toileting, she had to do it before everyone in the cell. It was humiliating. They never gave her any extra food because she was pregnant. And she always went hungry. She was getting depressed. She didn't deserve this. She had second thoughts about being here. Who said it was a safe place here? She longed to go back. Whatever the torture that awaited her at home was better, and she could handle it, so she felt. All she could do now was pray. She prayed day and night. Then one day after attending a court session she was released. They said [the immigration] they were 'satisfied' with her. They only gave her a list of shelters. She didn't know where to begin. She walked around looking for help, still in her 'jail uniform'. When she approached people to ask for directions, they thought she was begging for money and quickly shoved past her. Then she finally found a shelter, and the people there finally connected her with service organizations. But it all didn't stop there. She developed fear of strangers. She was fearful of the police. She wanted to isolate herself completely. She began having bad dreams. Finally she went to the doctor, and he diagnosed her with clinical depression.*

Nadia was also the only participant to link her depression as also partially arising from her pre-migratory circumstances. She explained how she was fleeing her immediate family after having witnessed an equally traumatizing event; she had seen her own sister bleed to death having been forced into genital mutilation, and her sister was pregnant like Nadia. Now they were forcing her to do the same. She was terrified and was determined to save her life, and her unborn child's, and so she fled as far from home as she could. Now in

Vancouver she felt that her ordeal was far from over. She was constantly haunted by the thought that her family would have dispatched people to look for her, and to capture her and to bring her back home. She explained how she developed tremendous fear of strangers, especially of 'black people', whom she imagined were people from home on a mission of espionage against her. She went on to explain how all these accumulating stressors had given rise to her eventual depression;

“Even then I, I'm like really scared, because I felt like, oh, maybe I would see one of my family members on the street they might just like, grab me and take me back to my country [snaps her fingers loud] so I was so scared, [laugh], I was like, oh any black I see I would just like hide myself, oh maybe this person is from my country and maybe, my parents have told this person oh in case if you see my daughter just, just let us know you know, so I'm really scared, even because of what I have experienced when I came with the Sheriff and the police, if I see police like this I would be scared and even when I sleep, I can't even open my door like this [pointing to the door], the door is always locked behind me, I can't open my windows I'm like really scared because I don't want to like, oh, somebody like find me here and take me back to my country I was getting depressed you know, so I have to go to the, the doctor, he gave me some depression pills and I was on pills for more than a year even when I was pregnant (silence)”

And her ongoing battle in trying to 'suppress' the snippets of memories from the past that still came to haunt her occasionally.

“Like oh, Jesus, it was like, uh even when I watch movies I would like, maybe it's like a robber or someone in handcuffs I don't, I don't like really believe movies but it's like happening live you know, so it's like really depressing and scary, sometimes I sleep and I dream, oh, somebody's chasing me with handcuffs to like, handcuff my legs and my hands and oh I just wake up and I start screaming, so then it was like hell, hell

for me, I can't even sleep, for like two days I'm like trying to see who's coming after me, at night [laughs], but now, thank God now, it's ok, it's not like the feelings is not there, but it's still there, I try to like suppress the things like suppress, you have to like put those things away, put those things aside..."

## **Sleep Disorders, Migraines and Headaches**

Sleep disorders was another common health concern frequently cited by women. 'Bad dreams' or nightmares, interrupted sleep patterns [not being able to sleep through the night] and insomnia were among the more prevalent types of sleep disorders reported by women. As evident in many of the above interview excerpts, sleep disorders, while being a concern in itself for these women, often manifested themselves as a somatic expression of a larger issue, for example as a symptom of depression, or conflated with multiple issues such as ongoing fear, worry, anxiety etc. Similar reasons that brought about depression were also seen to be responsible for these sleep difficulties, such as worries about an uncertain future, lack of control over the refugee claims process (as in the case of Irene and Anna above), fear of strangers and being discovered by family and detention experiences (as in the case of Nadia). In addition, Farah, being the oldest participant and in her retirement age, expressed many fears for own health and her chronically ill spouse's. This perceived threat of ill health and worries about a future in isolation constantly plagued her and contributed much to her 'bad dreams' and sleep difficulties.

"...sometimes I think but not always, you know we are just me and my husband here and I am afraid of being sick, one of us, because I'm already tired, I need someone to, uh either my daughter or my son or my family so I need help with this I just don't want to think about may be one day we will be sick and

who will help us, so you see sometimes I cant sleep, like always I am uh dreaming when I'm, uh when I sleep at night I dream, either I am lost or I lost my shoes or so just even sometimes I, I just get scared of things and I scream when I'm sleeping”

Similarly, migraines and headaches emerged as another common health issue. And similar to sleep disorders they converged with a multitude of other issues. Those women who suffered from migraines/headaches also reported a worsening of their headaches since coming to Canada [see interview excerpts above].

V: So you said you have this migraine, and can you tell me a little bit about it and any other health concerns that you may have?

Farah: first when I came here really I get many times this migraine and I had it before, it's not just when I came here, but for like two or three months I didn't get it but I am going back like to have it, now I get it many times, whenever I have a little bit of headache I am just so afraid of it, yeah I don't know if it is from depression but I, I always feel tired, yeah, but mostly I am good, Yeah and like uh, this week I went to the doctor because I has this migraine so she gave me the pills and also like I always have the low blood iron, yeah, and I think may be because of that I, I am tired, even if I take medicine or vitamins yeah (silence) and my husband he has many health problems yeah he, he has uh one kidney and his kidney doesn't work good, he should face dialysis and we are just afraid of it yeah because, and I don't want to think about that

## **Chronic Health Conditions**

In addition to emotional health concerns, some women also reported various chronic health conditions in response to the question regarding health issues. These conditions included ongoing issues such as high cholesterol, hypertension, asthma, diabetes and menstrual irregularities. Many of these

conditions were seen to be generally more common among middle aged or older participants than among younger women, except in the case of Annette who was the youngest participant, who suffered from chronic asthma.

Annette: Health issues? Uh yes, I'm asthmatic, I have asthma, that's the only one yeah, I have that problem

V: I see (silence) so how long have you had this issue?

Annette: Umm for a long time, like, even when I was in my country, um when I was a kid I had it, yeah so I have it for a long time

Like Annette, all other women who experienced chronic conditions commented that these were protracting issues, that is, conditions that they had been suffering from over a long period of time, and not necessarily issues that mushroomed since their arrival in Canada. While women contextualized many of their mental health concerns within the aspects of their current lives and the larger socio-economic and political dynamics that shaped their current lives [as evident from previous discussions], these chronic conditions were not necessarily seen to be *caused* by any of these. Unlike depression, headaches or sleep disorders, women hardly ventured into lengthy speculations about why they were suffering from these, and in cases where they did talk about the causes, they usually rested with biology, family genetics or simply ignorance and offered explanations compatible with expert opinion. For instance, Maria attributed her elevated cholesterol level to family heredity;

V: So do you have any health concerns?

Maria: Yeah a little problem, because my cholesterol is very high, because my father my brother carry high cholesterol, very high, so I receive medicine for that

Edith who suffered from diabetes, hypertension and weight issues viewed her condition as partially caused by complications in previous childbirth. More importantly she regarded these to be arising from her general lack of knowledge about these conditions and preventative measures that would have averted her conditions in the first place.

“My main health issues are just diabetes and hypertension, yeah, those are the only problems that I have, about five years now, I think it started with my last pregnancy about six years...they really gave me a lot of education about those uh, those diseases, you know when I was there [in my country] and even before I got the diabetes I don't remember anything being said about diabetes there, to conscientize people about the diabetes to prevent it yeah...and my doctor helped me with losing weight, uh I was very big when I came here I'm still on the program of losing weight, I was very big”

All women who experienced chronic conditions also mentioned that they used regular medication to manage their conditions.

## **Other Health Concerns**

Although not common, some women also reported other issues, such as fatigue/tiredness, various bodily aches and pains (i.e. back pains, stomach pains, leg and hand aches), urinary and digestive concerns attributed to side effects of medication, and dental issues. One participant, Fatima, was also experiencing a broken leg at the time of the interviews as a result of a fall.

V: So can you explain to me any health problems you have?

Fatima: Just my leg (silence) yeah just my leg, as I told you I broke my leg three times, it's bad experience, but I'm ok, otherwise I'm ok

None of these were seen to be 'serious' concerns by the women however. Many of the experiences of fatigue and bodily aches and pains that women mentioned were deemed to be commonly resulting from factors such as multiple forms of ongoing stress in their lives, as well as hard work. For example Cecilia who works as a kitchen help in a busy restaurant described how her physically demanding work left her tired often.

"Mmm no, no, I'm good, I feel good, I went for the check up recently to the hospitals, may be three months ago, because I went to put this umm, inside, because I don't want to get pregnant, and they took from me uh pee and blood and they said everything is fine, so I feel good, so good (long hearty laugh) umm the only thing is that umm sometimes I feel so tired, and I have pain in my wrist and umm my back hurts and in my legs, because I have to work hard, yeah it's hard work and I finish totally tired, but I feel good yeah"

Similarly, Thaya described her multiple physical discomforts within the context of 'hard work' and side effects of medications she was receiving for her 'woman's problems' [menstrual issues].

Thaya            Sometimes if I work too hard I have a pain in this part of this hand (pointing to right wrist) and when I wake up in the morning my hand is a bit swollen and I can't move it and I have to massage, when I massage it is ok, otherwise I can't move the fingers ... about six months ago I had a tummy pain, and it's because, uh I had it when i get periods and then I have to stay in bed and I can't do any hard work... so I have to go to the doctor but when I take these tablets sometimes I get other problems

V:                What kind of problems?

Thaya:           Uh sometimes urine problems, constipation, and then I get pain in this side, the back side and so I have to go to the doctor every time...



While only one woman directly alluded to dental issues, this remained a recurrent theme especially in relation to family members, particularly when it concerned children's health. As Maria described her dental issues;

“I have a dental problem, before in my country I used to go to the dentist every six months for a clean up, here last year I went and I paid, only for myself I paid thousand dollars for myself to fill the cavities because it was bad, and cleaning...”

Irene, in explaining about her child's dental needs also commented on the high cost of dental care.

“My little daughter has a problem with orthodontics and it's very, very expensive here, very expensive, may be 6000 dollars, and I see the doctor she said may be 6000, so I don't know, and I only saw the doctor and he said to me may be six thousand dollars and I know it is very expensive”

In sum, women's self reports of health issues entailed a range of concerns spanning from minor illnesses to more serious ones. Depression emerged as an important health concern for the women. While some women were clinically diagnosed with depression, others concluded they had depression based on their own subjective assessments. Many of the physical ailments such as sleep disorders and migraines and headaches were presented as somatic expressions of depression. Most participants situated health issues within more recent events of their lives, particularly within the context of migratory and post-migratory experiences. Through their narratives women illustrated the causes of their health woes as emanating mostly from circumstances external to themselves, and contextualized these within the intersecting structural aspects of society.

## **CHAPTER FIVE: DETERMINANTS OF HEALTH**

Interviews with the participants elucidated a host of interlocking factors that impacted their health. Some of the more salient determinants of these included identity and social status; migration and settlement experiences; income and employment; institutional discrimination; refugee determination process and policies of deterrence; pre-migratory circumstances and gender-based violence. These themes are explored in more detail in the following sections.

### **Liminality, Identity, Social Positioning and Labelling**

Issues relating to identity, liminality, social status/positioning and labelling emerged as important determinants of these women's health. The legal taxonomy that women carried as "unsponsored refugees" particularly appeared to overshadow their current lives, and profoundly impacted the manner in which they perceived themselves; the way they thought the others perceived them; and the manner in which they related to the world around them based on these perceptions. It was an imposed label that they carried, unwillingly obtruded upon them by forces beyond their control; partly by legal, bureaucratic and immigration apparatus that constantly straddled their lives and partly by glaring negative social constructs that accompanied this label. And this label bothered them, and confused them and deeply affected them physically, emotionally and psychologically. It was not necessarily the tag itself that was disconcerting to them, but the mass of unspoken assumptions, judgments, and expectations that

this new identity couched within itself<sup>3</sup>. Talking to these women, it was evident that for many of them, to be an unsponsored refugee denoted a sense of degradation of social status, lowered self esteem, a sense of subordination, stigma, disempowerment and helplessness.

For instance, Farah as already mentioned in previous sections clearly articulated how this new identity caused her to doubt who she was. It raised unsettling dilemmas and questions about her 'self'. She spoke about her lowered sense of self worth, and degraded social position that it caused.

“... and like now I don't know, who I am or what I am, like I don't have papers, I don't have anything, you know when I was there, I really, I never thought one day I will be a refugee, because I feel to be refugee it's not easy for your uh prestige, uh for whatever you do, uh yeah, so but uh now I don't think this way, but sometimes I feel it...”

By the same token, Sarah commented on how the refugee claimant identity worked to obliterate or vaporize her as a person because it made her a 'nobody'. Not only that, it threw her into a limbo world of ambiguity and uncertainty, and greatly curtailed her aspirations, options and access to resources.

“Uh first of all because I'm not a refugee yet, I'm still a refugee claimant so I don't have any status right now, until I'm accepted, so it's just like I'm a claimant, so it's like it's practically the same because you have no status, you have no status in this country, so you have access to some things but

---

<sup>3</sup> For example, the public perception regarding refugee claimants remains inherently negative both in Canada and elsewhere. A plethora of negative stereotypes are constantly used to describe them. Constructed, popularized and sustained by various powerful societal forces (i.e. mass media, social and political structures, immigration policies) these stereotypes are systematically deployed to effectively ostracize them in society, and to exclude them from various societal benefits and privileges.

not to many other things right, so if I wanna buy a car or something, because I drive so I feel like I wanna buy a car or something but right now I don't know if I probably want to do it because I could probably go back to my country so some things that, that you are like in an uncertain situation, you don't know what's going on now right, so that's that's why I think that's the principle thing you have no status here you are like a nobody here"

Similarly Anna clearly highlighted the differential power relations that her new identity embodied. She described the slighting treatment that she often received from authoritarian service providers, which she associated partially to her identity as a 'refugee' that put her in a powerless, helpless, and subordinate position. She voiced her frustrations at having to negotiate with these people of power who appeared to deliberately thwart her efforts to accessing even the services that she was entitled to.

"And umm...the attitude is not very nice, they umm...they treat you as if, umm I know I'm a refugee because I have problems and I don't have much money to support myself right now, but they treat you as if I'm kind of, type of person, as if I'm a drug addict or (?) or a beggar. I'm not like that, yeah, I have my mind and everything at the moment I'm just very low because of this big move and everything else. They just treat you like...they don't care about you (fading voice, dismissive gesture with hand)"

Not only did this identity as refugee claimants directly impact the women as shown above, but it also intersected with other scenarios to create further disadvantage to the women. For instance, imbued in this identity is a dual state of legality-illegality (Menjivar, 2006). That is, on the one hand, "unsponsored refugee" is a legal taxonomy to the extent that it is legally conferred by the immigration system. It gives them the legal grounds to remain in the country until

their immigration case proves otherwise. On the other hand, unsponsored refugees are people who are in transition; people who are still *in the process* of legally proving their “refugeeness” to be able to fully conferred as legitimate refugees. In this sense, they also occupy a position of illegality, because they have not yet proven their refugeeness to be fully recognized as legitimate refugees. And because of this inherent duality in their identity they become people who are ‘in-between’ the ‘legal-illegal’ continuum, or people who are ‘neither here nor there’.

One of the debilitating consequences of being in this ‘in-between’ status (Menjivar calls this ‘liminal legality’) is that it creates a pervasive state of liminality<sup>4</sup> for those who become unsponsored refugees, like the women in this study. (For this reason, refugee claimant identity is frequently described as a ‘liminal identity’ by scholars). On one level (i.e. at individual level), this liminality is characterized by a prolonged state of temporariness which Bailey et al. (2002) calls a state of ‘permanent temporariness’, precariousness, unpredictability and chronic uncertainty. On another level, because they are represented as ‘liminal’ people, or people who are neither here nor there, they are often seen as low priority both within the immigration system and within the macro political, social and economic structure. And in turn, this idea of their liminality is subtly manipulated by various societal forces and individuals to justify why it is ok to exclude them from wider societal privileges; privileges such as education,

---

<sup>4</sup> Menjivar (2006) uses liminality to define ambiguity that surrounds their identity. The concept was originally developed by Turner (1967) to capture the ambiguous periods of *rites de passage* and conceptualized as a transitional intervening period between “two relatively fixed or stable conditions”.

adequate access to healthcare, housing, employment etc which delineate some of the most fundamental determinants of health.

In the case of the women in this study, liminality emerged as one of the central points of discussion along both the above trajectories (micro and macro), and was consistently referred to by almost all participants. These discussions elucidated fine examples of the ways in which the multi-dimensional aspects of their 'floating' or liminal identity interlocked to create unique, yet powerful health outcomes for women. For example, most women identified the precariousness that characterized their current lives as the main cause of some of the key emotional and psychological health concerns they experienced. It put their lives on a complete hold, leaving them to play an unending waiting game, unable to make any constructive decisions about their future, leaving them groping in the dark not knowing what awaited next. It was clear from women's discussions that this complete state of absurdity they lived everyday was a key source of fear, worry, stress, distress, anxiety and depression that women experienced (for more examples, see Irene, Farah in depression section). As Anna summed up;

“Thinking, always thinking what's gonna be, what's gonna be, and umm and if we knew that Canada's gonna accept us then you could relax, but uh umm the process, it takes so long, so nothing is settled, nothing, and that's why it's so hard, we, we wanna settle but we don't know what's gonna be, it's so stressful...”

In the same manner, their liminal identity worked as a serious deterrent as they related to others in society, particularly as they navigated through various bureaucratic and administrative systems, service organizations and numerous

other tiers in society. On the one hand, it appeared that women themselves felt reluctant to reach out and ask for help or seek out resources, even the ones that they were entitled to. This was primarily due to fear of hostility, rejection, deportation and any other activity that they felt may jeopardize their refugee claim.

On the other hand, many individuals or people in power (i.e. in service organizations) who came in contact with the women often played on their fears and vulnerabilities to take undue advantages of them and sometimes to prevent them from accessing some of the basic services such as housing, welfare, and even food banks. As one key informant commented;

“Uh there are people who take advantage of them, of refugee claimants, like for filling up one form, fifty dollars, sixty dollars, applying for claims so they take the advantage of them, not only this there are lawyers who take advantage of them, yeah so lots of people who take advantage from them...”

Similar ideas were echoed by other women in the study, such as Edith who was deprived from going to the food bank because she ‘had no papers’ while she stayed in a transitory house and Anna, who described her unwelcome experiences at the welfare office.

The confluencing factors discussed above, such as their immigrant identity, the liminality and the stereotyping attributes that embodied this identity caused to greatly ostracize these women in society. As such they occupied a subordinate socio-economic position forcing them to live on the edge, othered and mostly invisible.

## **Migration and Settlement Experiences**

It was apparent from the interviews with the women that their move to Canada entailed diverse experiences that gave rise to multiple forms of stress and distress for them. Unlike for other categories of immigrants and Convention refugees, for these women, being unsponsored refugees, the road to safe asylum has been nothing but a rocky road, portended by a mountain of bulwarks every step of the way. On the one hand, their reasons for fleeing their countries of origin, the constraining circumstances within which they decided to stake their lives to flee and the journey itself to Canada involved making choices on the part of the women that were difficult enough and often painful enough. On the other hand, as many of the women hoped, landing in their supposedly safe haven neither really put an end to their suffering that they were trying to escape, nor their treacherous journeys. Instead ironically, it heralded the beginning of another long road, a road to sanctuary marked by a profuse of unprecedented quagmires that caused fresh worries and stressors for them. Throughout the interviews, many women made references to the various stages of their immigration to Canada that subjected them to profound experiences which in turn, clearly impacted their health and wellbeing.

For instance, in Anna's words, the involuntary decision for many women to leave their countries meant 'burning many bridges behind'. It meant 'cutting off' the familiar world they knew, severing ties with the people and communities that they formed part of, leaving behind the hard earned livelihoods, abandoning the possessions that they cherished, and hardest of all, having to separate from their



closest family members. As already discussed in previous sections (i.e. see women's conceptualizations of health) these decisions engendered numerous forms of grief, regret, loss, guilt, fear, anxiety and distress for the women. Anna expressively summed up this point when asked to reflect on changes to her health since moving to Canada. She felt 'broken', particularly mentally, as she and her mother plunged into an unknown destiny far away from home, confused and unsettled only to await an uncertain future.

“...mentally because I'm so far away, broken, kind of burned all my bridges behind me and umm nothing settled, uh when you live in a country where you have your own place, you work you kind of, you know what's going on, but now I don't know what's going on, and that's why it's very stressful...and um, when we left nobody knows from my family where we are, not my friends nobody, yeah, but we, um it's like, we cut off the world you know, who we knew, very important people you know, kind of cut off, and we don't even know how long for we're gonna keep it like that...”

Similarly, the many dangers that threatened their lives or that of their loved ones back home often forced them to make instantaneous decisions to flee as a means of last resort; decisions that left them no time to think; decisions that were so unplanned to the point that sometimes some women did not even know where they were headed, or what to expect at the end of their journey. As Fatima, who had been subjected to severe torture commented, all she had on her mind at the time was to 'go away to escape the problems she had at home' in order to save her life. So she let a stranger accompany her to an unknown destination.

“I had to go somewhere, anywhere, to escape the problems I had at home, it was dangerous, they said they would kill me if they found me again, so I had to leave yeah...”

These impromptu decisions brought much chaos and confusion for the women. As Maria recalled of her decision to leave her country of origin;

“...in one week to change your life, to change your life like that it is very confusing, very, very confusing and you have so many ideas, so many things in your head and your head is not clear, your life just change in one week yeah, it is very fast, very difficult, and I was so confused, so, so confused, yeah about what is happening...”

Further, as they left in a haste, most women brought with them only a few possessions, such as a few clothes and a meagre sum of savings that was barely sufficient to sustain them in a new country. And as they appeared at the doorstep of Canada, they hardly had any knowledge of what steps to take next. Throughout the interviews many women talked about the numerous unprecedented challenges that they confronted as they went about feeling their way through an unfamiliar system. They talked, for instance; about the issues in locating resources, such as settlement services, housing, employment and welfare assistance; about the hostility and apathy of the service providers that made them feel powerless and subordinate; about the daunting effects of the precarious bureaucratic machinery upon which the fate of their future rested.

For instance, Nadia who was pregnant and had been in detention as she came to Canada powerfully articulated the dilemmas and challenges she faced at the crossroads of the life she had just left and the one that she was about to start. Although she was speaking for herself, her comments nevertheless reflects and sums up the hardships that many other women in this study experienced.

“Uh, it’s like ooh you are running away...like a big lion chasing you, you’ve gone to one place that you can’t go back so that the lion is about to devour you, and in front of you is the big ocean, I don’t want to like look back and see that lion because I can’t like watch myself like, this lion is going to eat me up so when I came here it’s like a very big ocean because this place is big, I don’t even know where to start from, and then back, I can’t look back, I’m already in the middle, so I just like tell myself, crossing this ocean, is a challenge, I have to go pass it, I know immediately after I stepped my legs in that water the lion is not going to come in that water...getting pregnant, you don’t know anybody, you don’t even know where to start from, the immigration, you are in detention, you don’t even know what, may be they will tell you oh go back home, like the people I met there like those drug addicts, it’s like I’m already in the ocean, I have to like go through these difficult, difficult times there so I was like, where do I start from? Even getting the lawyer then, oh my God, the first lawyer I called he said sorry I can’t, I can’t help you know stuff like that, they [immigration] just gave me a number and they just said, call this organization, they just said call, I don’t even know how to call, I don’t know anything, when I was released from the detention, I came out and I see this road, these roads are like big, like back home roads are not like wide and big and massive like this, and I was like where am I going I don’t know even after then my like there’s a form that you have to fill and send back to the immigration for you to continue your refugee process, I have not written anything I don’t even have a lawyer I don’t have web, and I have to submit it within fourteen days, and already I’ve spent, spent almost three weeks, I don’t even know where to find a shelter, I don’t even know where to get the work permit, work permit is even far away, I didn’t even want to think about that yet, so I know nothing, I’m pregnant and I don’t even have food to eat, oh Jesus...”

Similarly, Farah characterized her new life as a ‘really big challenge’ as she and her ailing spouse struggled to adjust to a life in isolation, away from friends and family. She illustrated her conflicts about having to accustom herself

to live in a community house which she 'never ever imagined she would have to do'.

"This is a new life, a really a big challenge, and it's uh different life, like now we are facing the life by ourselves I am fifty two but I never felt that I'd face my life by myself or just me and my husband, we had family around us and we had friends, but here it's just the two of us, we are facing it alone, so this is hard...(silence) and you know first when I came here to live I, we were living in a community house which I never, ever, lived before or imagined to live with people, so for three days I was crying, how do I live with people and I have to share the bathroom, and you have to share the kitchen and uh the bathroom and the living room, just you have your own bedroom, so this was so hard "

All these intersecting string of events, experiences and hardships invariably added to an accumulating pool of stressors taking a toll on women's health, both physically and emotionally as evidenced from previous discussions.

### **Institutional Discrimination, Maltreatment and Manipulation**

Being unsponsored refugees necessitated women to be in constant contact with a wide range of organizations and figures of authority. On one level, the relationships that women sustained with certain organizations and persons to a large extent were of mandatory nature. For instance, because of their legal status, it was essential for them to be in periodic contact with certain institutions and persons whether they desired it or not, such as the immigration system. On another level, the affiliations that women maintained with certain other organizations (i.e. the welfare office, frontline community organizations serving refugee claimants, faith-based community centres etc) although not imperative, arose primarily out of necessity. That is, their specific circumstances and needs,

such as financial instability, housing needs, lack of knowledge about the immigration process etc. did compel them to seek out people and places who they imagined could assist them in various ways.

At various points of the interviews, women highlighted various instances of personal experiences of discrimination and maltreatment by service providers. As well, they made references to numerous structural forms of discrimination they encountered, for instance in accessing services such as welfare, obtaining work permits, and systematic deskilling, all of which closely tied in with their precarious legal status.

In talking about service providers, many women consistently used terms such as 'rude', 'unhelpful', 'restrictive', 'stressful' and 'controlling' to characterize such people and often expressed apprehension, dissatisfaction, dismay and anger at the way they were handled. Women described, sometimes tearfully, how slighted and powerless and stigmatized they felt at the hands of these people in power, and their remarks point to lasting psychological and emotional scars they suffered as a result. For some women, encounters with certain officials were much more than mere unpleasantness that these experiences left them fearful and reluctant in seeking any further support and help. For example, Cecilia emotionally described the treatment she received from the first person she approached for help. He was 'rude', menacing, unsympathetic and dismissive. As she later explained, all this made her shy away from seeking out any further support and services. In addition, she also attributed the depression she developed later on partly to these stigmatizing experiences.

“I was thinking he will help me and he was totally rude, totally rude, he asked what are you doing here? and I said here I need a school for my kids, he said you don’t have any chance here in Vancouver, it is better you go back to your country and that’s it, totally rude that guy, I was crying I was trying to get some answers and he was not going to tell me, he threw one book at me like this (dramatizing) and he told me umm, here in Vancouver we don’t have a school for your kids, they’re for other people, but if you want you can find a school in here and I don’t give those information and if you want you can try here. And he said I think you need to go back to your country, and I didn’t know what to do, so I said thank you and I left”

Similarly, both Fatima and Edith drew attention to the discriminatory and inhumane conduct of the concierge of a transitory shelter they were forced to stay in until they found their own place to live. Edith for instance described the ‘predicament’ she suffered during her three week stay in a ‘welcome house’ [shelter]. The ‘girl’ there constantly picked on her, restricting her movement and freedom, playing on her fears and vulnerabilities, even depriving her of food and finally forcing her out of the shelter in the middle of the night.

“I tell you I had the time there [at the shelter], I even thought of going back to my country, because the girl who was looking after the shelter she would pick on me all the time that she wanted the immigration documents, she wanted the shelter fee, they would not give me food, she said I could not go to the food bank because I didn’t have the ID, I had a terrible time, everyday she would harass me... so one day I was walking and I just met this girl, then we just started talking and she gave me some groceries and stuff, that girl didn’t like it, she said, ay you are not allowed to go out, you are not allowed to get things from other people because that means you know people around here and I said no, I’m not in prison, that girl was so rude, yeah she was so rude yeah... and then one day I went to the church and when I came back she said I had to leave because I had friends and I can go and stay with my friends and shelters are meant for people who, who don’t have

anyone, and I said this is someone that I had just, just met, and how can I just go stay with her, and she said no, and that was around 10, 11 in the evening...”

She went on to passionately opine about these injustices that people in her situation should not have to put up with, characterizing the shelter as a ‘prison’ and the treatment people received there as ‘abuse’.

“I just thought she was not someone who could help people you know, people coming into that place they are not coming on holiday, they are people who come because they need help yeah, they have different situation and that treatment that she was giving to the people who were making it there you don’t feel, you don’t feel that you’ve been helped yeah, like myself I thought that place was a prison, because the main thing that she was complaining about me was because I was not supposed to go out of that place and I said no why, I can’t be in my room from this Sunday to Sunday you know, because she said if you go out the immigration will think you know someone I said the immigration doesn’t refuse me to know people I’m in a, I’m in a new country, I have to meet people, I have to know people I’m not in a prison, I ran away from prison there and now I have to be in prison here, why, and she was, hay you don’t have any immigration papers you don’t have, ah (clicks tongue) hell of a lot of stories yeah and then she asked me to leave yeah and I said ah ok, and that was eleven PM... when people are going there for help, that’s abuse, yeah, they shouldn’t put people like that there yeah”

Anna too highlighted a range of important aspects relating to varied forms of institutional discrimination particularly when she spoke of accessing welfare services. She alluded to how these people of power appeared to deliberately thwart people like her from accessing these services and resources, even those ones that they were entitled to. She expressed her frustrations at how the welfare officers often evaded providing information about services, how they complicated things by miscommunication, how they slighted and derided people like her, how

they made it all 'so unavailable' to people who sought help there, and in short, about how it was not in their best interest to serve people like her.

Anna: ...the receptionist, the lady, her attitude she was dressed in such a way like she's a punk, which I don't mind but it's not just the way she dressed it's the way she behaved with people like trying to pick on you, like I don't understand things... I had to go in one day three times to bank, back to welfare because of the lack of communication she said oh the bank they just do that, go. I come to the bank, I couldn't put my money in you know I go back to the office and she say oh you forgot to fill that in and stamp this they forgot to stamp this, so I had to go back...I don't know these things and if I knew I would have done it straight away, and then when you come back, umm, the attitude was as if she kind of had fun with that you know...umm the people I see who go to that office they are handicapped or with mental disability so they treat people like that, which is very bad not very nice at all, I was, umm not impressed at all. But, umm I know it's not in their interest to help people you know, and the welfare gives umm only so much you can, because I, I wanted to see the document or some brochure about what services they provide, they don't give you that.

V: Even if you ask?

Anna: Yes, they say oh there is nothing like that, that's what I faced, they said there is nothing like that, and then because when I lived with that family they give me one, and then I spoke to somebody and that man he said to me oh they never give you...they make it so unavailable, you know, for people to receive things.

Women also commented on instances of manipulation by service providers, who charged money for services that were meant to be free, such as charging for filling out forms and providing information about services. This was a point reiterated by many of the key informants as well. As Maria recalled;



“I went, uh before I found this place I went to this Spanish center but I didn’t like it because she always took money from me, if you, if you want to know this you need to give me money, if you want to fill this form you need to give me money she always took you know, tried to get money, I don’t like it because the people that are here, these people, they are here for many reasons probably for dangerous reasons and sometimes the language is so hard for us to understand and I don’t like that, she try to get money from these people and sometimes we don’t have money and we don’t know about other centers that we can go for tips or for help so I don’t like it...”

### **Financial Instability, Income and Employment**

It was clear from women’s discussions that the prolonged financial instability they experienced was a source of continuous stress and distress to women. In the course of the interviews, women made countless references to their financial woes particularly as they contextualized these within their financially handicapped current lives and the ‘good lives’ they lived in the past. Their discussions pointed to a host of intermixing factors that contributed to their deteriorating socioeconomic status and the overhanging sense of stress, low self esteem, helplessness and disempowerment they experienced as a result.

For instance as previously mentioned, many women noted bringing with them only a little bit of savings as they left their homes. Women talked about how the meager savings they brought they exhausted within weeks or months of arriving in Canada as they struggled to sustain themselves in the absence of any other social support. As Irene pointed out;

“I didn’t have big money, only for six months, five months it was enough and then I needed help, and we didn’t have a lot of options”

Amid these circumstances, for many women, the stress of the financial constraints rendered an immediate reality that they confronted since their move to Canada. As Maria commented elsewhere (i.e. see health issues section), “the money just flew” specially when it was converted to Canadian currency, and as she and her family grappled with the high cost of rent, food and hunt for jobs while they tried to settle in. She associated the depression that she developed during these initial phases of her life in Canada partially to the economic grievances she experienced at the time.

For many of the participants, this situation was exacerbated by other insinuating circumstances. For instance, women like Cecilia and Irene, although arrived in Canada with the intent of seeking asylum, decided to contact the immigration with an asylum claim only after all their savings had drained, by which time they had been in the country for many months. Even though they had both entered Canada on valid visas (tourist visa), they had refrained from approaching the immigration any sooner due to multiple reasons, such as their general lack of understanding about the immigration process; lack of access to information and assistance; reluctance to seek help due to prior experiences of thwarted attempts and hostility on the part of the service providers; and an overwhelming fear of the immigration apparatus itself (such as the fear of being deported). As Cecelia illustrated;

V:                You didn't ask for any help for seven months?

Cecelia:        No because I was so afraid to go to the immigration because my first fear it was that the immigration will say ok, you are here, you are illegal, go back to your country, I didn't want that,

I couldn't go back so for that reason I couldn't go to them, I was so afraid, and I was here like this around, I remember, about six, seven months...and I don't know, we didn't know that, the process and right now I know that if you are going to ask for help they give you the help, they don't tell you ah, go back, just like that but we didn't know that then so I stayed like this six, seven months here, like that, yeah

All this meant for them was to be stuck in an extended period of economic and legal limbo, being unable to obtain the necessary legal status or the documents that would allow them to earn a living in Canada. Bypassing the chances of being employed anytime soon meant that they were forced to look for other avenues of coping and surviving, similar to what Irene described;

"We had to look for help, and somebody said to go to the church, and we went to that church and the father of the church helped us with food, with clothes, because we didn't have money, and my husband he worked at the church as a volunteer, and he painted the gym at the church and the father helped us, sometimes he gave tickets for the bus and food and for two months he paid the rent because money was finished after five or six months, it was very difficult yeah, oh very stressful"

Even for those women who had entered the legal and immigration process of becoming refugee claimants faster, there were a number of structural and personal obstacles to obtaining employment opportunities. Although many of the women possessed high levels of skills and education (Table 2.1), their qualifications were rarely recognized. In addition, issues relating to childcare, language, identity and social positioning contributed to their financial grievances.

For example, although women were eligible to work in Canada as unsponsored refugees, they needed a work permit to do so. However, the

process of obtaining a work permit involved overcoming equally precarious and complicated administrative red tapes and procedures. All this was further confounded by long wait to receive the work permit that resulted in serious economic instability for many women, often characterized by frustration, stress and worry at having no avenues for income generation. As Edith described;

“Yeah when I came, I came in November and the work permit, I had to wait for so long, so long for my work permit you know, I had no money, very little money and it was so frustrating, I had a time yeah, you know when you can work, you know you can find some work but then you can’t because this thing was taking so long, and I had no money, it was terrible...I had to ask for welfare yeah what was I to do?”

Because of the unavailability of any income generating activities during the wait period for the work permit in turn forced many women to seek out welfare assistance. Almost all women mentioned having been on welfare at some point since their move to Canada, particularly as they waited for the work permit. Maria mentioned;

“I received support from the welfare, yeah, only for four or five months, it was a short term, may be five months, I needed to pay the rent, and we had no work, now it’s ok”

For many of them, having lived financially stable, ‘good lives’ in their own countries, and then having to live on social welfare denoted a sense of low self esteem and shame. Irene for instance felt it was ‘not nice’ to be on welfare.

“Only when we applied, I think only for three or four months, not any more because in my country I worked, my husband he likes to work, we don’t want to take welfare, no, it’s not good, and when he got the work permit he started working, I feel it’s not good to take welfare, it’s not nice you know, we had good jobs then, uh and now we can work”

Similarly Anna expressed similar sentiments following her continuing unhappy experiences with the welfare office.

“...I can't wait for my work permit, I don't need money from them you know [welfare], I just need a little support and un, until, because it's not up to me it's government again why it takes so long, long for them to process. I don't want their money, I know I can do some work and I can support myself, and because it takes very long obviously all the savings I had, not very much, they go. Here it's very expensive...”

Another key point of women's talk pertained to the type of work that was available to them even if they had obtained the work permit. At the time of the interviews many women worked as cleaners, restaurant kitchen helpers or waitresses, the type of work that were low-end, low-paid, unskilled, unstable and labour consuming survival jobs that offered no extended benefits. They talked about how they felt about having to do these types of work, as they contrasted these with their past lives and professions, and alluding to the spiral of downward social and economic mobility that engulfed them in their present lives. Women expressed similar sentiments as they did with feelings about being on welfare, pointing to issues of lowered self worth, loss of social status, disempowerment and shame. Farah tearfully described how hard it was for her 'inside', both culturally and personally, to come to terms with the type of work she was now doing ['cleaning tables'], something that is not 'suitable' for someone of her social standing or age particularly in her own culture. She felt ashamed and reluctant to tell even her family back home what her work was really like.

“Uhh, like it's not only you know it's like cleaning tables specially you know, serving yeah, and making salads sometimes, it's ok but really when I think about myself as

cleaning tables and like uh, sometimes I help with the dish room uh yeah it's not easy in this age and you know, I don't know about here but in our culture like, I cannot say in front of people, even my mom she doesn't know that I'm doing this kind of work, because there, it's different, like in my country you cannot, it's not suitable work for anybody, uh like as I told you we were living good, a good life, my husband was a university professor like we were middle class, and here, they say there's nothing wrong with the work, but I don't know, yeah so this is also, it's hard inside, yeah, yeah I say it's ok while I'm not doing anything wrong and I, they give me like money to live but inside, inside it's very hard, and you know uh almost I am in the end of my age, and then I work this kind of work, so it's not easy (sniffs, wiping tears)"

Similarly, Maria expressed her unhappiness as she compared her good life and work in her own country to her family's struggles to make ends meet as they sought refuge in Canada.

"Umm, I feel umm not very happy, because my work, and my house and my life in my country was very well and the first year here was very, very difficult here, the work, the change of work, we changed the language, he is a doctor there, and I am a nurse there, I worked for fifteen years as a nurse, he liked to make furniture as a hobby in my house, little things like coffee table and things, but here he is a carpenter now, I am a cleaner now, I work in the cleaning company, and I work in the afternoon everyday Monday to Friday from 4.30 to 12am, and my husband care for my kids, he return from work and then I go, it's hard"

Edith also described how 'depressing' and 'frustrated' she felt working as a housekeeper/cleaner in a hospital where she felt 'stuck', when she knew she was capable of doing better.

"I was working at this hospital, cleaning, uh housekeeping yeah and it was depressing me, I felt so stuck, you know when you know that you can do something better and you start comparing your life with then and what you are doing now it

really frustrates you and I was always frustrated and depressed and things like that, what am I doing so I started asking myself, no, no, no, no, do I really like this, or I'm just doing it, no, I have to do something I really like doing yeah so then that's when I started inquiring about college and stuff like that"

Women also described their physically demanding work as hard or tiring and spoke of various body aches and pains that they suffered, which they attributed primarily to their working conditions.

In addition throughout the interviews, they also continually referred to the inadequacy of their current income, as they tried to sustain themselves and their families. Particularly for those women who were lone providers with dependents to care for, such as children, siblings, spouses or parents, the situation created added stress. Women like Fatima and Edith both living on welfare, for instance, who both had children living in their own countries, commented how difficult it was for them to provide for themselves as well as their children. As Fatima explained;

"It's really hard, if the money [from welfare] is for my budget I can't send them money because it's very little and there's nowhere to beg that's what I have, but if things goes well and I get like, may be a friend to give like two hundred I just send it to them yeah...(silence) yeah I'm so stressed out"

Edith, whose children were living with her elderly mother with no income of her own also expressed how stressful she felt about not being able to provide sufficiently for her children.

"I was feeling so low about the money and the kids, I have to send some money for my kids, but where do I get the money and you are also struggling to, to stabilize yourself in a new country yeah, you have to send money home for those kids,

you know because when they tell, when they say they don't have food they don't have, they've nothing, here people they don't understand, when you tell them they've no food things are like that they don't understand...so it's very, very stressful, very stressful, when you are on welfare, so that's why I want to finish this course and get a proper job"

The instability of work available to women or their family members also added to their daily worries and stresses. For example, Irene did not work outside the home due to childcare issues, while her spouse, a construction worker provided for the family. However he worked only when work was available, which remained a source of pervasive stress for Irene and her family as she worried about their future. As she illustrated;

"Umm, it's its different, you know, sometimes, he works only one hour, sometimes ten hours, may be you know uh two days ago he didn't have work, so it's different, sometimes I'm so worried, because I don't work you know and we have the kids, so I worry how we can, uh you know do, uh manage and what will happen in the future, because it's little money and we don't know if we can stay here or not, so I think everyday, it's stressful..."

Because the women's income was inadequate or sometimes unstable, they often devised ways of coping with their daily financial insecurities, such as by pooling income, or piecing it with other occasional means of income. For instance, Fatima who was living on welfare also continued to do beadwork at home, selling it whenever or wherever she had the opportunity. She also resorted to living on bare minimum, restricting herself to a strict budget that she carefully planned for herself at the start of each month. Irene sometimes babysat neighbours' children and volunteered at community organizations where she occasionally received 'free stuff', such as a free meal, a bus ticket, used clothes,



or household items. Anna and her mother, who were both on welfare pooled their money together so that they could pay the rent and put food on the table.

Sometimes they attended the community food bank, and other religious organizations which also served free meals, apart from helping them to 'take their mind of everyday worries and chores'. However, as Anna explained, even attending the food bank was not always possible, because of the 'vicious cycle' that enwrapped her life.

“Uhh because this income is terrible, what we get now, people help with things sometimes but, and we go to food banks uhh and, when we have time but when sometimes I'm in college I cannot even go to food bank, because it's during that time that I'm in college, but if you, if I don't go to college but then government would stop paying money, so you see it's a vicious circle”

## **Refugee Claims Process and Other Policies of Deterrence**

In all of the interviews I conducted with the women, the topic of refugee determination process occupied a recurrent and central point of discussion. This was one crucial event that every participant, as refugee claimants, had to deal with, a sort of a 'rite of passage', and upon which the verdict of their future largely awaited. It was clear from women's remarks that this represented a daunting phase in their current lives, replete with countless challenges, complexities, stressors and uncertainties. Varying degrees of stress, anxiety, fear, depression, and other somatic symptoms that women attributed to this process is testimony to how much it affected their daily lives in general, and their health in particular. The lengthy wait times that stretched for months and sometimes years; the unpredictability that their future harboured; the complex particularities of the

process itself, such as the amount of the paperwork involved, tracking down lawyers, having to tell and retell their stories to various officers that evoked memories and events that they would rather bury in time and of course the issue of credibility of their claims; and numerous other draconian policies such as institutional detention and high rejection rates designed to keep the unsponsored refugees at bay all formed part of this thorny terrain which was their path to asylum. In the course of the interviews women commented on these issues at length, illustrating the profound ways in which they affected them emotionally, psychologically and physically.

In particular, the length of time the women had to wait for the court decision regarding their status, and the uncertainty that it all created regarding their future remained one of the biggest sources of stress and distress for the women. It typically took anywhere between a few months to years to get to their 'hearing', during which time their lives were 'put on hold', not being able to make any decisions about their future. It was evident from women's comments that their lives were marked by a low-lying persistent state of volatility, stress and anxiety as they went through this hazy phase. Many women characterized it as 'killing', 'stressful', 'worrisome' and as a 'knife above their heads'. As Farah explained;

"We have already been uh waiting now one and a half years, and really, as I said before it's so long, it's taking too long and it's just killing me, yeah killing me and yeah so I feel so stressed, if they just tell us when..."

Both Anna and Sara similarly voiced their frustrations, commenting on the unsettled state of their lives that left them unable to take any positive actions towards their future even if they wanted to. As Anna commented ‘you just have to take it as it comes’;

“Five months here, four four months here, it’s nearly four months, waiting and, and as the lawyer said to us it takes about a year, or may be longer and that’s why the waiting process is killing it’s so bad, you know always thinking you feel like you want to settle but you don’t know what’s gonna happen, obviously you want to hope for the better so you continue developing with uh working or studies or something, try to uhhh adapt to the country, but at the same time there is the worry in case Canada does not accept me, what do I do then you know, there’s always that thinking in the back of my mind (pointing to the side of her head) yeah so, I don’t know, it’s a big worry, you can do nothing, literally you have to take it and stay as it comes”

And Sara who referred to her aspirations;

“I would love to go to school and to meet new people and learn new things but right now it’s not my priority right, later on, probably just to get a course, something that helps me to get a better job or whatever, may be VCC, I’ve been reading and I know what to take and I know how much it is and how much it costs but that’s not my priority right now I have to take care of my status first of all and then start planning other things”

For those participants like Irene, Cecilia and Maria, whose initial claim for asylum had been rejected, and who were on an appeal process, the situation was seen to be even more exacerbated, creating even more stress and distress. Irene for instance, directly attributed her depression to the failure of her asylum process (i.e. health issues). She further commented on how scared and worried she and her family felt as they waited for the impending appeal decision;

V: So do you know when your next decision's going to be?

Irene: No, I don't know yet, I don't know when, I don't know why (silence), and always my daughter, she asks always when mom, when, because they are worried too. We are all worried, because they rejected it last time and I'm so scared, so scared. (silence) I say it's, it's not easy, may be if the government say, uh you can stay one year, if they say we will let you know in one year, ah then you relax, but you don't know, they don't say anything, so always, all day I think, think about the decision, what is it, and it's not easy, not easy, so stressful.

All this was in sharp contrast to the women whose claims had been accepted, such as Edith, Nadia and Fatima's, where they all expressed relief at having been granted protection. Nadia, who had also developed depression since coming to Canada, could 'feel her depression melting away' since the affirmative decision and talked about how she felt 'relaxed' and peaceful, and how she longed 'to do things' and move on with her life.

"After my hearing I was like, oh a little peace, my mind was a little bit relaxed and, I can like, feel the depression going away, melting away, I don't like, get too scared all the time, I like, go out, see people, so right now, after my hearing I do wanna do things, to go and get my communication 12 in English, and Biology and do some other things, go to a serious school and get a career..."

Not only the wait times and the ambiguous future that tied into it, but also the various elements of the process of claiming refugee status themselves were seen to have a tremendous grip on the women. Because they were unsponsored refugees, there was no overt system in place to step them through the process of refugee determination as there was for Convention refugees. Just as they had decided to initiate their own claim for asylum, they were expected to navigate the system on their own and to figure out what they needed to do, where they

needed to begin, who they needed to reach, all on their own. For many women, it turned out to be a complex, overbearing bureaucratic mass marked by confusion, antagonism and a myriad of hurdles, something that they did not quite expect. For instance, as many women explained and also illustrated in previous sections, accessing information about and resources to guide them through the immigration process, was one of the first challenges that they encountered. True that there was a handful of community organizations providing most of these services, such as helping with putting together their immigration case, finding lawyers, filling out forms etc, but only if they knew where to find these. Like the women themselves, many of these organizations and community centres existed on the margin, somewhat obscure and largely unknown to the public, making it difficult to locate them easily. As Anna further pointed out these challenges;

“Where to go? Where to go what to do because we had a little money on us because we knew obviously you know we were not gonna come and somebody was gonna put us in somewhere. We came, we had some money to pay for the hotel, we tried to find the cheapest possible going and, and then, the challenge was, you don’t know anybody, where to find the information, even in the papers you see and you can’t find it and you don’t even know which name it is, and so we stayed there and, uh the day goes so quickly you go out you try to find where to go what to do, I tried to find any umm...Russian speaking community or...any help for immigrants and you come back and oh! You need to pay again. So we paid again and next morning get up, running around just looking for something, talking to people what can we do and, how to find help and uh only a week and a half gone before we realized, and met that person at that organization who told us what to do, she explained how we can apply for refugee status, even she advised us to go to a lawyer, to represent the case, and from there we just find out where CIC office and all... it was very hard finding things you know and...I didn’t even know

where to look, which companies provide what kind of services and that's why..."

Sometimes, even if the women managed to reach these marginal resources, there were still obstacles to accessing them, such as language, perceived fear of the immigration and of deportation, and discriminatory practices of service providers described elsewhere (i.e. apathy, hostility and manipulation). For instance, Cecilia explained how her initial attempts at help-seeking with the immigration process was thwarted by a fear-mongering, unsympathetic service provider who insisted she went back to 'where she came from', that she had no business in Canada, and that the immigration would most certainly deport her. Although she was on a valid tourist visa, all this misinformation created much stress and fear for her and her family, who subsequently lived in fear, almost in hiding, evading the immigration for many months.

"I don't know, he speak Spanish, he asked what are you doing here? I said I have problems and he uh he laughed and he said you need to go back, to your country, uh where you come from, he said the immigration will catch us, we are illegal, and he said immigration will deport, deport us you know, it was not true, he said we have no business here, he was so, so rude, yeah so rude, and I was so scared to, to go to the immigration"

In addition, other issues such as tracking down lawyers, and gathering proof for their case caused numerous problems for some women. For instance, although there were organizations providing free legal services to unsponsored refugees, this information was not explicitly available to most women, similar to the case of frontline service organizations above. This sometimes meant having to find their own lawyers like what Farah and Anna did, and having to pay

exorbitant service fees. Farah explained that her unawareness of the availability of free legal services, coupled with her general fear of the immigration system (stemming from her experiences of seeing her ailing spouse in institutional detention, who applied for asylum before her) compelled her to hire a private lawyer. However, having to pay 'big money' every month was a great source of stress to her, particularly as her income was meagre.

V: So why did you hire a private lawyer? I mean there are places that provide free services?

Farah: You know, when my husband, I told you he applied by himself, but me, I said I cannot apply by myself, I was afraid, because of this (meaning after her husband's detention), and we found this lawyer, really I like her, but, and also, I didn't know about this free service then, and so I keep her

V: So do you have to pay every month? How do you manage?

Farah: Yeah, this is the thing, just for the lawyer I give, big money a month, very month I pay 500\$ to the lawyer, it's like uh first I paid her one thousand five hundred and then 500 a month, till the end of the case yeah...uh really if I have work I can manage the rent and the lawyer, but if I don't have work, it's hard, uh this is what worries me, sometimes I'm so afraid I won't have work, like, I told you in the summer I didn't have work

Anna commented on a similar note;

"we didn't try many lawyers because some people try and because this lady, she gave us the number so I called and the first appointment we had to pay, 'cos I didn't know about legal services either... and it was two hundred and thirty dollars, for the very first appointment, it's a lot of money and I thought oh my goodness (surprised voice), but I thought I'll give it a try and I said ok, and it was our money and we didn't go to that free place nothing, but then we changed later, it was too expensive"

Similarly, even when the women were able to find lawyers who provided free services, they were frequently turned down because the lawyers did not have the time to commit. As one key informant explained;

“and ah the legal issues, it’s hard enough to get the lawyer you know, sometimes the lawyers don’t have time or the people don’t feel comfortable with the lawyer’s assistant”

And Nadia commented;

“...even getting the lawyer then, oh my God, the first lawyer I called he said sorry I can’t, I can’t help you know stuff like that...”

Further, putting together proof for their case, and having to recount their stories to various individuals also created traumatizing effects for the women. For instance, because they were unsponsored refugees, the burden of proof fell entirely on the women themselves. That is, they needed to produce convincing evidence to prove their “refugeeness”, or why they needed protection. Producing such proof sometimes required contacting/providing information about people and places in their own countries; the very people and places that threatened their lives, and that they were trying to escape. This created numerous conflicts for women, where they were reluctant, and were fearful of being tracked down by their persecutors. Anna for instance, talked about her lawyer’s request to obtain witness statements from her friends and family. She talked about how she feared contacting them for these statements, which she felt could put their lives in danger by having to reveal her whereabouts.

“...because the lawyer, she asked if we could get as much witness statements enough, but we can’t even ask them, you know, all the witnesses who have seen what that person did to



my mom and for me, you know because they're scared themselves, very much, and obviously because they're gonna send letters to this address and then it's just a problem you know, obviously we don't want him to know where we are, that's why we decided to go as far away as possible, but they need all this...umm for protection, I don't know for me it's enough because it has been happening for so long but I don't know how IRB (Immigration and Refugee Board) will be looking at that, the lawyer says it's not a very easy case but I don't know"

Similarly, women felt reluctant to share their stories with many people. As Cecilia summed up;

" I'm here because I have problems, and I don't like to tell my problems to many people, I don't like it, I think I don't like to tell every one that I meet my problems, I never like that people know my life, it's hard oh my God"

And another key informant reiterated the re-traumatizing effects of having to tell and retell their stories;

"They need to fill the PIF to the lawyer, the personal information form, it's telling your story, telling your narrative in front of a lawyer, and of course to many others, at the hearing and so on, and you are out there, telling your story and that's hard for someone who has survived trauma you know, so they need to deal with that in a very articulate, trustworthy way, for that phase of refugee claims it's hard, it can get very traumatizing"

Irene, who was on an appeal process waiting for her next hearing date spoke about how nervous she felt about having to go through the whole process once again. Her fear was exacerbated by the fact that she had been rejected once and was not certain what the next decision was going to be.

"You know in the Hearing you are very nervous, because they ask many, many questions, different questions. Now I'm nervous a little bit again because you don't know what is the

answer, or the umm decision. I say, I say to my husband I'm nervous, he say, try not to worry but its not easy, it's not easy"

Apart from these, the issue of credibility of their claims for asylum posed problems for the participants. Even though they had their own valid reasons for seeking asylum, they encountered numerous issues with validating their reasons and stories, particularly within an increasingly restrictive immigration system and a larger socio-political structure that supported negative public stereotypes about unsponsored refugees as 'bogus' or untrustworthy. Maria expressed that;

"Uh trying to get refugee status, and they don't believe us, they don't believe us because um right now I've seen here many, any people who try to claim refugee status, sometimes the people lie, but some people who really, really need the refugee status, and because they think a lot of people lie they don't give us the refugee status, but my and my family we really, really need this protection, and they don't believe, we had to leave, because it was dangerous, but they don't believe us, it's so hard"

Infused with these complexities of refugee claims process itself were other prohibitive immigration policies and practices, such as mandatory detention that further made the road to sanctuary increasingly difficult for some women, and infringed upon their health and wellbeing. Nadia who had been subjected to detention described her detention experience as 'torture', 'too tormenting' and 'scary', all of which gave way to her subsequent depression.

"...the torture, let me say the torture that I went through that it was, and I was like oh this place is not safe and why did they say it's a safe place, they told me that oh this place is safe, so later, and with now like this detention, oh the sheriff putting handcuffs and all that I mean it's not safe it's scary, it's too tormenting, I've never seen like, uh handcuffs in my like you know, let alone putting it on my legs and my had like this, and

so then, at first like I didn't like this place and I said to myself oh I'm going back even if they have to like kill me at home, back home, I need to go back because I was like, this is too much"

As illustrated, all these intersecting dimensions of the refugee determination process and immigration policies were seen to profoundly impact women's health and wellbeing.

### **Pre-migratory Circumstances, Violence and Gender**

While many women did not explicitly contextualize their health within pre-migratory circumstances as frequently as they did referring to post-migratory events, it was evident from women's own stories and various comments they made during the interviews that this was indeed a key determinant of their health. On the one hand, pre-migratory circumstances as a determinant of health was particularly evident when they talked about 'burnt bridges', that is, about the people and places and things that they left behind. Particularly for women who were mothers, having to stay separated from their children as they sought asylum alone was a tremendous source of stress and distress.

On the other hand, as evidenced in the women's narratives, their reasons for running away, or the pre-migratory events that led up to their flight point to an overwhelming amount of physical and emotional violence and abuse which are unmistakably gendered in nature. These include physical and sexual abuse, genital mutilation, domestic violence, incarceration and political persecution directed at the women themselves or other members of their families. Through their narratives women clearly highlighted the multiple layers of power dynamics that simultaneously operated to subject them to multiple forms of violence at

different levels (i.e. at individual, communal and structural levels). For instance, Nadia's flight was triggered by intensely personal experiences of genital mutilation (i.e. having seen her sister bleed to death of the same while pregnant), an obvious case of gender-related violence. At the same time her circumstances were seen to be further intensified by the traditions, culture and issues of family honour that pressured her into it, because these were partly what valued the worth of a woman in that society. As she explained, it was a thing that 'every woman must go through' because it was the tradition and 'you couldn't stand against the tradition'.

"Uh and circumcision, FGM (female genital mutilation), uh and that is my tradition, it is what they do in my tradition, and *every female* must go through that process, even before, before you're pregnant, or, when you're pregnant or, even after ... so you can't like stand against the tradition of your people I would say"

And particularly in her case, her father was also the chief in the village, whose status was similar to that of a 'president in a small community'. His inability to make his own daughter toe the line when it came to the important traditions of his people brought disgrace to his family and stripped him of his power, giving her further reasons to flee.

"Like my dad, he's a chief, oh you know, he's like a president of a small community, so right now, he's no more a chief because as chief, he's been participating in it, encouraging it, you stand and say this girl must do it you know, they must do it, so when it comes to your own daughter it's like he allowed me to run away to escape the circumcision and he didn't, and so the people told him that he can't be chief anymore so he's like really crazy about me, because it's, it's like a disgrace to the family, like, to the community you know"

Similarly, both Thaya and Anna specifically cited domestic violence as their main reasons for fleeing. In Thaya's case similar to above, part of her marital woes stemmed from cultural traditions and practices that directly tied into aspects of gendered forms of power relations. For instance, she was continually taunted by her spouse on the grounds that she did not bring in sufficient dowry when she married him. Providing dowry in the form of material value to the groom is a traditional custom in her society that implicates compensation for taking on the responsibility of shouldering the added economic burden of a woman (Rajaraman, 1983). It also implicates the ownership and commodification of a woman (Ghansham, 2002), putting her in a subordinate position of power within the family unit and in society at large.

“He drinks, that's his problem, he drinks and then he argue with me and fight, sometimes he hits me and slaps me, too much trouble (laugh), yeah trouble, and also the problem, the dowry problem, sometimes he ask me why I did not bring dowry, but my brothers, all of them they were studying then, they were not working, so how can you give dowry, so it was trouble...”

Anna, whose mother had also been subjected to domestic violence, highlighted how the patriarchal values and lax societal attitude towards women abuse in her society left them helpless, and forced them to seek protection elsewhere. As she pointed out, domestic violence in her society was no more than a 'private' or a 'family matter', expected to be resolved within the bounds of the family unit.

“Like he decided that she was gonna be his woman, you know...their way of attitude to women is, ah I like this woman and she's mine and this is it, you know...so it's gone on for so many years, it's gone from mental abuse, to physical abuse,

and it's gone from, not just like that, its because he is a very rich man he's got connections in Government, and he threatened my mom a lot and myself... my mom she used to call the police and police wasn't very much helpful. And in my country they don't have protection for women, (clicks her tongue), yeah it's more of a private, umm family matter...and that's why we decided to go as far away as possible"

In a similar light, Sara drew attention to the 'crazy, corrupt, violent' and male-dominated societal structure of her native land that treated women like 'second class people'. She spoke of how tired she was of living in fear, 'because if you are a woman there you never knew what could happen to you', and her quest to find a safer, peaceful place to live where 'you are not robbed and mocked when you walk down the street', a place where you can 'breathe freely, have a life and have opportunities'.

"I mean all over the place it is the same there is like a little war there, drugs and delinquency, it's so corrupt, I mean if you're a woman oh, I don't feel good living there and you just expect sometime you are gonna be raped or something, it's scary, something worse could happen to me if I stay there any longer and that's why I don't want to that's why it feels so good here, I feel safe here...I mean you can breathe, you can go out in the street, that you are not robbed or mocked by somebody so that's all I want, I mean you can walk in the street here if it is twelve or one and nothing happens, but you cannot do that in the city there or if you are a woman, forget it, I mean you cannot do it, it's so risky you know, I mean they can rape you, I mean you take a taxi at night and you can be raped by the taxi, taxi driver yeah I mean there's a lot of kidnapping..."

Both Edith and Fatima also highlighted other dimensions of violence that prompted their flight. They had both been subjected to direct political persecution, characterized by severe forms of physical and emotional torture. Edith for instance, while making it clear that she did not want to 'go into too much

details', implicated the use of rape as a weapon of violence and power by her captors.

V: So you said you were injured, would you mind talking a little bit about it?

Edith: Yeah, uh I don't want to get into too much detail here, but uh yeah I was physically injured, but now I'm ok, when I came here I had a lot of bruises and scars and all (silence), uh when those people take you, specially women, they'll beat you up, and they'll do whatever they do, you understand what I'm saying?

V: Uh not sure, can you explain a bit?

Edith: They'll do whatever they want to do, uh, if you are a woman they will *never, never* leave you before they rape you, that's what they do, yeah, Uh that's what I'm saying, and that's how bad they are...uh as I said, I don't want to get into too much details but it was a very sort of uh, it's something that I'm trying to forget yeah, because it was so, so bad it was, yeah (silence)

The intensity of these nuanced experiences of violence was such that many women expressed unwillingness to revisit these events in intimate detail as Edith above.

In addition to the above, women's narratives illuminated other intersecting dimensions of gender as they related to violence, safety of family members and pre-migratory events that worked to put them in disempowered circumstances. This was particularly evident when it concerned decision-making processes with regard to their own interests and wellbeing and those of others. For instance, sometimes women were forced to flee not necessarily due to a direct threat to their own life, but because of a threat to the life and safety of family members, such as a spouse or children. It was evident from women's comments that in

such situations, they were fleeing unwillingly, having no other choice or say over the circumstances or the decision making process on behalf of themselves. In other words, it was seen that their deep attachments to the family unit, for instance as a mother, as a spouse, as a sister or as a daughter often compelled them to put the interests and wellbeing of the family unit above their own.

For example, this was the case with Maria, who had no direct threats to her own personal security. Yet the fact that her spouse was subject to persecution by an individual and the threats to her child's life (she was threatened with death as a form of retribution by their persecutor) left her no recourse but to follow through with her family's [more specifically, spouse's] decision to go away.

“They came and said they'd kill him, they said he killed his baby, and they said they would come and kill our daughter, my little kid for that, so because of that you know we moved very fast, we had to leave you know because we were scared for my family, so this is the problem, and these people found all information about my kids, when they go to school, what time and all you know, they said to my husband we know that your kids go to school with your wife at seven a clock everyday and they go to this school you know, and we know that the nanny pick up them up at this time and they said, you exchange your daughter for your life”

Few other women were fleeing under similar situations as Maria's. For instance, Anna was fleeing primarily for her mother's sake who was being subjected to domestic violence as discussed earlier. She was taking her mother 'as far away as she could' so that her mother felt safe. Irene and her family had 'no intention of leaving their country of origin at all', but for the fact that the threats to her husband's life was growing intense by the day. Likewise, Cecilia



had no choice but to accompany her family to Canada after her spouse's life was threatened by individuals. Nadia, whose flight was triggered by her intense fear of genital mutilation also had tremendous concerns for her unborn child's life, particularly having witnessed her pregnant sister's death under similar circumstances. As she illustrated;

"I came to Canada because (short laugh) my parents and my family members, they tried to force me into circumcision, so, I had to like run away (silent laugh) I had to save my life and my baby's, because then I was pregnant and in my tradition, you have to go through circumcision, because the belief is that before you get married, or before you have your baby you have to do it, I was so scared, my sister, when she was pregnant, they did it to her...yeah, and she died So I was like really scared about this thing when my dad told me that I can't have my baby, (silent laugh) without circumcision I had to save my baby"

Similarly Farah decided to come to Canada only after she learned that her spouse, who had come before her had been detained and was in severe depression as a result. As she explained, she just had to come to 'stay with him' because she 'couldn't just leave him' that way.

"While we were there waiting for the visa, uh a lot of professors were caught, so he said I don't think we should, go back to our country, so when he came here to Canada, he applied for refugee status, yeah, so first I didn't come with him and because when he applied for refugee he had like, tough time, you know, so it made him so stressed and so whenever I phoned him he was really bad and down and so he was like in depression, yeah so I had to come, I came after him, and then I also applied for refugee, to just to stay with him because I cannot leave him like that, yeah"

Sometimes, for some women, putting the family's interests before their own meant not necessarily accompanying their families, even if unwillingly, but

having to make the more difficult decision of fleeing alone, as did Fatima and Edith. Both these women, having experienced extreme forms of torture and having been subjected to direct political persecution had tremendous fears for the wellbeing of their immediate families, particularly children. They both went into hiding on their own, deliberately severing ties with their loved ones in order to ensure their [loved ones'] safety. As Fatima explained, she left alone to ensure the safety of her kids; but continued to fear for their lives as a result of circumstances that developed following her flight.

“Those people who tortured me, they said they would kill me if they found me again, so I just left, and my kids, I sent them to my sister, because it was not safe, but now I hear, uh, I sent a friend to the immigration to process their [kids'] applications to come to Canada, um, I think they have me in their list and stuff like that who they are looking for because I didn't leave home physically [left on forged documents], they asked him many questions and they arrested him, so my sister was scared, they were looking for them, and so she had to disappear with the kids, take them somewhere else, to get out of the place fast”

It was evident from women's decisions that all these involuntary decisions that they had to make on behalf of others came at a serious emotional and psychological cost to them. For women such as Fatima and Edith, having to stay separated from their children caused tremendous grief, and the constant worrying for their wellbeing and safety remained a great source of stress and distress, as evidenced from previous discussions. For those like Cecilia, Maria, Anna, Irene or Farah, having lived comfortable lives, having held professional jobs and being well educated, to be suddenly caught up in a spiral of dramatic downward mobility due to no fault of their own created much heartache as they

nostalgically talked about the things and people and places they lost and missed from their past (see previous discussions).

## CHAPTER SIX: PATHWAYS TO CARE

### Health Status and Health Maintenance

Almost all participants reported being in generally good health in spite of the various health issues and concerns that they experienced, discussed earlier. They recognized being in good health as crucially important to them for various reasons, but particularly in the context of daily practicalities, such as; being able to do the household chores; being able to retain employment; 'for the sake of family members' especially children, and also for fear of falling sick and having to cope with it all alone. As Irene pointed out;

“ Uh I don't know...(silence) uh health...but yeah it is very important, yeah very important because you know, if I'm sick, who, uh is going to take my daughters to school? Who is going to cook and uh do it all here (pointing around the house), you know? So it is very important, uh and if you are sick, sick all the time, then may be you are not happy, you don't like to go outside, see people, so it is good when you are not sick”

Likewise Maria explained;

“You know it is important [to be in good health], very important, for my work and my kids so yeah...”

Farah articulated the importance of good health for her in relation to work, particularly since she was the primary breadwinner of her family. In addition, she also emphasized its importance as a safeguard against her persistent fear of 'falling sick' in the future and her perceived vulnerability to social isolation, or

having to 'cope with it alone' in the absence of any social support such as family or friends, as a result.

"You know as I told you before, sometimes uh, this is what makes me, uh sometimes I feel so scared that we will be sick one day and there is no one by us, like back home we have family but here it's only me and my husband, and uh as I said he has many health issues, his kidney is not good, and uh so when I get this migraine, uh this headache I feel worried, like how am I going to work and uh if we are sick, my daughter, my son is not here, so how we are going to cope with it alone you know, so good health it is very important, if I have my work and my health that is the most important, yeah"

All these reasons were seen to motivate women to maintain their health on a regular basis. They mentioned a variety of means they used to sustain health which included engaging in regular exercise regimes, such as attending a gym or going for a walk; making healthy food choices; attending free yoga classes; meditation and relaxation activities (i.e. listening to relaxing music); going for regular medical check ups and engaging in spiritual and religious activities. As Irene mentioned physical activities such as jogging in the park, attending the gym and walking constituted key means to creating and sustaining good health for her.

"Yeah I go to the gym sometimes, uh I walk, walk with a friend, uh jog, you know, jog in the park with a friend sometimes, in that park it's just one block, and I walk in the mall (laughs), only window shop (laugh aloud), I go and do voluntary work, uh yeah"

Similarly, while Anna referred to physical activities, she also identified healthy food and taking care of mental wellbeing by way of meditation, turning to

nature, and engaging in yoga activities as vital pathways to maintaining overall health.

“Umm I do swimming sometimes, I do swimming and umm healthy food, I try to eat healthy, we’re vegetarians, and sometimes, I like walks so when we have the weekends free we, we usually go to some park or nature, I like nature or the seaside very nice, try to relax and umm what do you say, uh revitalize, try to get my energy back, and I just found this free yoga class, and try to do a bit of meditation, it was actually my psychologist who told me about meditation, so that’s how, umm some exercise and good food and relaxation yeah (laugh)”

In addition to exercise and food, a positive mental attitude, ‘letting go’ of the past events and feeling good and happy about oneself was mentioned as important pathways to self-care and good health by Nadia.

V: So what do you do to keep yourself healthy usually?

Nadia: Uhh I walk a lot, with my child yeah, because when I have my baby I was like big, I was about uh two hundred pounds, yeah, two hundred pounds but now, I eat healthy food like I eat fruits, I eat a lot of fruit, I don’t eat too much, I take a walk a lot, walk, walk, walk, walk, right now I’m about one forty two pounds (laughs) so between few months I lost that weight, but then even with depression I was like oh, just sit down even when I don’t eat I see myself very big and very fat, so many things on my head and then, but when I try to make myself happy I see myself looking good and all, I say to myself it’s good, feel good, just let it all go and not think much of it...

A similar idea was voiced by Farah when she stated ‘trying not to think much’ about the past as a means of sustaining health.

“Uh you know like, uh we go for walks, we eat like good food, even if it is simple but I cook by myself and we try not to think a lot (laugh)”

For some women like Cecilia, employment and household chores provided their daily dose of exercise, and any additional physical activities were not necessarily deemed as needed to maintain health.

“Oh my God, nothing (laugh), umm I try and eat good food, drink a lot of water, but I always do many things, like housework, and then I go to work, and in my workplace I have a lot of work, a lot of work yeah, so I finish totally tired, when I finish I feel pain in my wrist, my back, and my feet totally and I can't stand up, but it's uh fun, and you do a lot of exercise because I have to run upstairs and then I squat a lot so it's good for my body yeah”

In addition to above, regular medical check-ups were identified as an important step to being in good health by several participants. As Maria illustrated;

“I go do the test, you know the blood test, test medical every year, and it was ok, and the Pap test, I went two months ago and everything's ok”

Some women also emphasized the role of spirituality as an important coping strategy, particularly within the context of dealing with stress, depression, and worries that overshadowed their lives. Sometimes it was seen that women preferred spirituality as a more viable means of mitigating their emotional and physical agonies to other, mainstream forms of therapies, such as medication and counselling. For instance, Nadia described her decision to cease standard medication for depression because ‘it made no difference’, and resort to her faith to find a cure instead, which she felt was more effective.

“For me like taking medication after medication and the depression is still there because all this long I've been taking, and taking and taking and it's still there, so there was no point,

no difference, so I wanted to stop and when I go to Church I pray about it and like my Bible study group pray about it and all that so I just decided, let me just stop this thing, let me see, if there will be changes and really, I can sleep now”

In a similar light, Fatima, who expressed her dissatisfaction with counselling services (described below), thought that ‘drawing closer to God’ may be the only way to solve her problems.

“I cancelled [the counselling appointments], I told them if I feel like I’ll call you guys and, yeah, but I don’t like it, I just have to draw closer to God may be, He’ll solve my problems, but nobody can solve my problems”

Likewise, Irene commented on how it makes her feel relaxed and forget her problems when she ‘speak to Christ’

“Sometimes I speak to Christ, about my problems, and I stay more relaxed, when I go to the Church I’m more relaxed, helps me to forget my problems you know”

## **Changes in Health Status since Moving to Canada**

Women also reported varying degrees of changes in health status –both physical and mental- since their move to Canada. Many of these changes were attributed mainly to food, climate, and multiple forms of stresses that women experienced. They self-assessed these changes as ‘better’, worse, or sometimes as ‘the same’. For instance, Maria explained that her health has changed for the ‘better’ since coming to Canada. Although she found life here to be ‘a little stressful’, she concluded it was still better than the kind of stressors she lived with in her own country.



V: Do you think that your health has changed since coming to Canada?

Maria: Umm yes, I think it is better because there we lived with various stress, it is a big, crazy place to live we live in stress all the time and here, it is a little stressful but I don't think it is the same as there so it is very well here

Both Annette and Cecilia reported changes to their physical health.

Annette who was suffering from chronic asthma reported a worsening of her condition since moving to Canada, which she alluded primarily to changing seasons.

“Yes I think so, umm you see, I don't have a problem during the cold months and my asthma is ok, but during summer I'm always sick, yeah, because when it's too hot, I don't like it and it makes me feel sick all the time, and my asthma gets worse in summer usually, uh when I was in my country, it was hot all year round and then I was used to it, but when I came here it's different, the climate, it changes all the time, one time it's hot and then it's cold”

Cecilia, although considered her overall health to be the 'same', nevertheless had concerns for her body image. She felt she had gained weight since coming to Canada, which she assigned to changes in food choices.

“No I feel the same, the same mostly, but when I was in my country I was a skinny girl, but now I feel that I have too much weight, it all changed because when we came here, to get my own food we didn't know about the places, and so always, we ate hotdogs and hamburgers, and we didn't know what to eat because it is different, different food there and here in Canada, for that reason I get weight, yeah, and I couldn't lose weight after that”

In addition, Anna indicated that certain aspects of her health have changed. For instance she felt her mental health has deteriorated, while she saw

no particular changes in her physical health. She conjectured on the unsettled nature of her present life and the feeling of being 'at a loss' it all created as contributing to her declining emotional and psychological wellbeing.

“Umm, well mentally it's changed, yeah mentally, because I still feel not settled, still kind of very much at a loss, physically I don't feel much different because it's a very similar climate as there in my country so umm, yeah”

Finally Farah explained that her health felt better in certain respects but still felt stressed in others, particularly due to her current state of life that entailed personal struggles with identity, an overhanging fear of social isolation and financial instability.

“Uh from one side I feel it's better, I feel I am healthier, but from other side this is the problem with the, uh like I get tired I get stressed, I feel depressed but like I told you I had, uh when I was in my country I had uh blood pressure and I take medication for this, when I came here, because you know blood pressure is mostly from stress and even if we lived there good, we lived there with stress, uh you know political, yeah, so I feel my, from one side it is better, but from other side because of my situation now, we are alone here, uh I don't know who I am, my identity, I am not good financially, so I feel stressed, uh stressful but mostly I feel healthy yeah”

## **Access to Medical Care: Access and 'Access'**

### **Interim Federal Health Program (IFHP)**

Technically, in keeping with the recognition of their legal status, even if liminal, the Canadian government does assure access to medical care for unsponsored refugees. However for equally justifiable reasons that again relates to their legal status, they only have access to limited care, that is, only to essential and emergency medical care. Such care is administered by a federal

program known as the Interim Federal Health Coverage (IFHP). The IFHP was primarily introduced by the Canadian government in 1957 for humanitarian reasons. It allows asylum seekers, Convention refugees, and other eligible individuals to receive temporary coverage during their transitory period pending access to provincial health care (Citizenship and Immigration Canada, 2005). Eligibility for this program is determined by a demonstrated lack of funds to pay for healthcare, and if they are not covered by a private or public health plan. The coverage is provided for one year but can be renewed if needed.

IFHP benefits are limited to essential health services such as for the treatment and prevention of serious medical/dental conditions, essential prescription medications, contraception, prenatal and obstetrical care, and the Immigration Medical Examination. For anyone needing special medical care, such as the need for a complete physical examination, diagnostic services, ongoing psychiatric care, and psychotherapy/counselling, prior approval is required (Citizenship and Immigration Canada, 2005).

At the time of the interviews eight of the women were still eligible for IFHP, and therefore had access to the services provided under this program. The other three women, whose claims had been accepted, were covered by the provincial health program. The majority of participants (9) indicated that they were generally satisfied with the services provided under IFHP (However, two women expressed concern with access to certain types of care, discussed in the following sections). This is likely because none of the women reported themselves as experiencing very severe health issues that required extensive treatment options and

diagnoses that were outside the coverage of IFHP. In addition, all women, except one, were also in young-middle age range and reported as being in generally good health, in spite of the various health issues and concerns discussed previously.

Although this was the case, in depth interviews with the women as well as key informants pointed to some systemic deficiencies of the program that were associated with health outcomes for women. For instance, although IFHP technically comes into effect immediately upon making a refugee claim, it was seen that various administrative and processing delays in turn caused substantial delays (even up to a few weeks) for participants to receive the IFHP document. Having this piece of paper in hand was critically important as this was the only physical evidence indicating that they were indeed eligible for care, particularly for someone in need of immediate access to medical care. This was the case with one participant, Edith, who suffered from hypertension and severe diabetes as she arrived in Canada. She had finished the medication she had brought and had to wait for a prolonged period to receive the IFHP document during which time she had no access to medical care. She went on to explain the difficulties she encountered in trying to manage her condition and the 'dangerous precautions' she resorted to in her desperation.

"Uh for the first three weeks or so I didn't have any medication, uh I was waiting for my paper, I tell you I, at one point I did one of the most dangerous things, I was having this headache and I knew my blood pressure was high and I didn't have any tablets I didn't have nothing, and that headache went on for two days and I went to, uh a friend took me to this pharmacy to test my blood pressure and it was extremely high, extremely, extremely

high, and that friend, she had hypertension and she gave me a tablet, and we started sharing these tablets, but those tablets were meant for her not for me, but there was no choice because my blood pressure was too high and my headache was going on and on and she was afraid that I would get into a stroke or something so she started giving me the tablets until I got my own papers to go to the doctor, that's why I'm saying it's dangerous, good thing that didn't react, it was just risky taking risks"

Another issue with the IFHP was the haziness that surrounded the program itself. This primarily stemmed from the limited knowledge of participants as well as many of the service providers themselves about the program. For example during the interview Farah explained that her critically ill spouse who was also an unsponsored refugee was no longer covered by the program. His IFHP eligibility had expired after one year and had not been renewed while hers was. This meant that they were having to pay out of pocket for an insurance for his medical care which was expensive. When asked why, she could not explain why this was so, and commented that she had no knowledge of how this program operated and what her rights and privileges were. However she also felt that it was partially 'their fault' because they were 'too lazy with these things', and took no time to research these in detail.

Farah: At first, for two months they renewed it, and then they asked him to pay and for me just till the end of the year they renewed it, the medical insurance so I don't need to pay, but for him he is paying you know

V: So how much is he paying now?

Farah: For the medical insurance I think they sent him like he should pay two hundred fifty six

V: What medical insurance is that?

Farah: Uh I don't know, I'm really, we are with these things, we are so lazy,

V: Is that amount per month?

Farah: No he, uh would pay in three months, and like he pay fifty something, I think to the end of the year I don't know really exactly what kind of, he went to the woman who did this for him and she said this is a new, they give the refugee this for just one year, if they uh stop it at least to the end of our case, because uh we will be like Canadian and then ok, we can pay the insurance it's different but still now we are refugees, uh this is what for us we don't understand these, like first welfare, yeah we were at welfare but when I start work I stopped, we stopped, now we don't get

V: Is he getting any?

Farah: No, no, no, so these kind of things, just before we know about it and now we don't know, just before because we are not working uh so we know, now, is he, if they will pay him or not, because I am working so I don't know anything, there is things like, what is our rights, I think it is also our fault, our fault we don't research in the internet and see what's our right and all that, so this is what makes us uh, yeah

Similarly, it was seen that many of the key informants, who were frontline workers had different opinions and interpretations about the IFHP. For instance, while it was commonly agreed that the IFHP coverage was limited, one of the key informants explained that it in fact provided substantial coverage ['only if you knew how to use it properly'], but that the issue was that it was not user-friendly. In addition he pointed to other important issues inherent in the program; that is health care providers' unfamiliarity with the program and the complex administrative procedures that the program involved. These administrative issues involved filling out numerous forms, which took much time and effort, and many physicians were unwilling to spend their time on these activities. As a result of

these bureaucratic issues as well as health care providers' lack of knowledge of the program, many physicians declined to take on refugee claimants as their patients. In addition even the hospitals sometimes ended up charging refugee claimants for services even with a valid IFHP document due to this same issue of lack of substantial knowledge of the program.

John: It has a good coverage, but the problem, uh probably if someone knows how to use it, the problem is that X clinic [a clinic serving refugees and refugee claimants] they know how to use it, but, private doctors they don't know the IFH, like X clinic has been able to learn a lot as to how to use it, you can even use it for translations if you know how to use it, I was talking to someone at the X clinic and yeah its possible, if translation is needed for a specific procedure then they do it, but they don't know it very well, the private physicians are, uh some of them are ok with the IFH and some of them, specially in the Fraser Health Region, they are not familiar with, with that document.

V: So do they decline to take on patients because of that?

John: Yes they decline, because they don't know how to do it so they say oh we don't accept new patients,

V: Really?

John: Oh yeah, because they don't know or they don't want to take the time to search around what is the possibility, why because probably it is a little bit more paper work for the receptionist and the medical personnel and yeah, very often, and even the hospitals where they are supposed to be more familiar with that even they don't understand how to do it

V: So what happens in a situation like that?

John: Like in the hospital what happens is that they will see people anyway, but, later on even when the refugee shows the IFH later on they will get a receipt, thousands of dollars of receipt sometimes, then the client would come to me and say John I was in the hospital in March and see how much they are

charging me, three thousand, four thousand 5000, dollars then we have to call the financial officer at the hospital and explain to them that this is the situation, that this person has a valid IFH and then they will process the info

### **Other Issues with Access to Healthcare**

In addition to the above, various other issues were identified by the participants as barriers to accessing care. One of the most common issues that emerged related to language. Although some women felt that they were able to 'manage' it, they also expressed doubts about whether they were articulating their issues clearly enough so that the physician understood her issue well. As Thaya commented;

“The first time I go with my sister, but this time I went alone but I think I can manage it alone a little bit, but here the main thing is the language, every time, when I was in Germany too, every time I used to go alone to see my family doctor, and I can speak the German language, but here I can speak English but now very well but I think I can manage, I don't know if the doctor understands”

Because of this issue with the language many women often chose to let someone who could communicate in English accompany them to the physician's office. In most cases it turned out to be a family member such as the spouse, or even school aged children who acted as interpreters, as in the case of Maria.

V: So what other problems do you have when you go to the doctor?

Maria: Umm because the doctors who speak Spanish are very very few, yeah so it is a problem because our English is not very well and it is not the same when you explain in English and Spanish, in Spanish it is more comfortable to speak in Spanish



V: So if you go to a doctor who doesn't speak Spanish what do you do?

Maria: I try to explain little by little and my husband tries to explain and help me, so we do it together, so that is a problem, because for example in the Children's hospital, my daughter translated for me in English ah mom, doctor says this uh like that, so it's hard

However, taking along family members, friends or other individuals as interpreters to the doctors' office raised other concerns for the participants, such as issues with confidentiality (i.e. having to share personal information they did not want others to know), or having to explain intimate issues that made them uncomfortable. For instance, Thaya explained that her brother sometimes accompanied her to translate for her, but then she felt uncomfortable explaining certain issues through him, particularly when it came to explaining things such as 'ladies' problems'

V: So when you go to him do you speak English with him?

Thaya: Yes but sometimes my brother comes to interpret a little bit, but I can understand I can manage with my family doctor but sometimes it's hard so he comes but uh, and some problems I can't tell my brother to interpret to the doctor you know, because they are ladies' problems you know

George, a key informant, further underscored the conflicts surrounding the issues of confidentiality, use of interpreters and language. As he explained, particularly when it concerned appointments with specialists, many unsponsored refugees tended to shy away from showing up for appointments, primarily due to issues with language coupled with their unwillingness to be accompanied by interpreters from the same community for fear of having to disclose personal information in front of these other individuals.

“There’s a big, big percentage of people who would not go to their appointments with specialists because they are afraid they don’t understand and they don’t have anyone who can come with them...and some people, they don’t want an interpreter from the same tribe, or from the same community coming to translate you know, you don’t want anyone to know what’s going on, your personal problems, so there’s that confidentiality issue for them”

Sometimes the issues with the language and translators compelled women to limit themselves to accessing healthcare specifically in the few community health clinics which served refugee populations, which often had interpreters and physicians who could communicate in diverse languages. The majority of women in this study expressed that they preferred to go to these clinics, some even identifying certain physicians working in these community health clinics as their ‘family doctor’ (in response to the question: Do you have a family doctor?). As Irene explained;

Irene: It’s a doctor in the X clinic, she speak a little bit Spanish because it is better for me you know, because you know I don’t understand everything, and may be you can’t explain exactly, well, you know, what’s happening in my body, and may be she doesn’t understand, so it’s good, very nice doctor, she speak a little bit of Spanish

V: I see, so do you have a family doctor as well?

Irene: I think she is my family doctor too, because she treats my kids and my husband and she speaks Spanish so it’s good

Or sometimes women tried to seek out a physician, a ‘family doctor’ elsewhere who spoke their language, often with little success. They used a variety of means, such as calling up various medical clinics, or acquaintances or

friends' contacts to find such physicians, as did Sarah, who finally found her physician through a friend's contact.

“Our room mate gave us the contact of a doctor, a Latino doctor, so we go there because it is easier to talk to them and to explain what is going on with you, so it is easier to explain to them what your feeling are right”

However finding a family physician in general [let alone someone who spoke their own language] remained a difficult task for most women, both for reasons that related to IFHP issues such as the refusal from physicians to accept refugee claimants due to the numerous administrative procedures involved mentioned above (i.e. filling out forms, unfamiliarity), and the general difficulty in finding physicians who accepted new patients. Anna commented on her repeated unsuccessful attempts at locating a family doctor because the places she called were all 'full'.

“Yeah, to find a family doctor, the lack of them, ah I went on the Yellow Pages and phoned a lot of places, I couldn't, when you phone the place they say oh we're full, we're full, and I don't have one, and this is a very bad”

Sarah too commented on the difficulty in finding family practitioners in light of the particular issues surrounding the IFHP.

“...if you were not a resident or a citizen so right so it's like a little bit harder probably, so if you don't have your medical card and all that stuff because obviously you don't have like a status in the country right so that's why it can be like harder because not all the doctors accept your refugee paper for example..”

In addition the above, some participants also expressed dissatisfaction with health care providers in providing the kind of care and treatment that met

their expectations. For instance, some women felt that the physicians had too little time for them, that they were not listening or sensitive to their issues, or that they did not provide adequate medication for their conditions. As Irene illustrated;

“Uh one time I went to this clinic, may be six months ago, I had my headache, very strong and I went to this walk in clinic, and the doctor, he check only my eyes, and not pressure, and he says it's ok, everything's ok, maybe I stayed there only four minutes in the office, inside the doctor's office, but I stay outside maybe for one hour, and the doctor didn't give anything, no medicine, nothing I don't like it, I don't like it, they don't check, no they don't check you, so I don't like it... why they don't check, I don't understand why they say no everything's ok, everything's ok, and they give no medicine, but in my country they give lot of medicine, and you can talk, you have time”

Irene's points were echoed by some other women and certain key informants as well, where one of them characterized the doctor-patient relationships as indicative of a 'cultural gap'.

“They need some time to talk with the doctor, so that is a cultural gap, always they have complaints regarding ah the doctor is not listening to me”

Further, some women were on the opinion that certain care providers were not in a position to truly understand their issues in their entirety because they 'had not really been in their shoes'. This was particularly conspicuous when it concerned mental health and counselling services. It was evident that even when these services were readily available some women were not keen on accessing these services, as they felt 'it didn't help', or doubted the experts' ability to mitigate their sufferings. Fatima for instance explained that counselling 'didn't make any sense' to her because she did not like their approach, and that it

really 'did not help' in solving her problems, specially the 'pain she felt in her heart' about not having her children around, and that in fact, it 'added more to her pain';

V: So you said you feel stressed out? So do you go out and ask for help?

Fatima: But still it doesn't help, I know what I need (raised, strong voice) If I tell you I need my kids and you tell me how do you feel if you want, uh, it doesn't help you know, Do you feel you want to kill yourself, what, how can you ask you know how they call these people..., I used to have appointments with those people, people who are counselling me

V: ok, when?

Fatima: uh, by the time I came here, but me, compared to how I saw they are asking me it doesn't make any sense you know, I tell you I have pain because I can't see my kids and you are asking me do you feel like killing yourself? What's that? As if you are giving me idea of killing myself (raised voice, very passionate, (almost angry?) tone, lots of hand gestures)

V: I see, did they ask that?

Fatima: Yeah lots of times, I didn't take it, even they used to call me can you come for counselling, but yeah I don't like, because it doesn't help me, yeah

V: Did you go at all for counselling?

Fatima: Yeah I went like two times but I didn't like it, that's what I'm telling you.

V: What did...(overlap)

Fatima: It didn't make any sense to me, just you add more to the pain, it adds more, that's why

A similar idea was voiced by Farah, who commented that she was well aware of the reasons for her own depression, and expressed her doubts about

others being able to 'help her with that'. As she pointed out elsewhere, the reasons stemmed from the various aspects of the current state of her life, which lay in spheres beyond her control, in the social, political and economic structures, and she suggested that no amount of counselling could help her get past these issues that shaped her life's circumstances.

"I don't know, I don't know exactly, yeah just like visit and speak but uh, the problem, there are problems which, may be sometimes when we were talking just sit and talk about something it helps but to, like there are some problems it's not by counselling we can solve, if like I know why before I didn't really want to go for counselling, because I like said I know my problems, like I know I'm getting all this from this life, this depression, and I don't think they can help with that..."

Location of the care facilities, such as community health clinics and the proximity to these facilities were also identified by certain women and key informants as obstacles to accessing timely healthcare. As George, a key informant illustrated, much of the health services were concentrated within the Lower Mainland area while the refugee and immigrant populations resided in the outskirts. Amid these circumstances, the cost of travel, length of time, and other responsibilities such as childcare issues often hindered people from accessing these services.

"We are facing the situation that as I explained to you last time, 80% of refugees and the immigrants live in the Fraser health region and they are not doing enough for them, they live in Delta, Surrey, in New West, they live there and then uh they don't have a health care system that welcomes them, and all the services are here, here in Vancouver and they are having to travel all that way you know, and sometimes, uh it's expensive for them, and they have other issues with kids and all, and they don't want to spend time travelling"

By the same token Anna described the difficulties she and her mother encountered as they tried to access services in downtown, commenting on the high cost of transportation and the distance to service providers.

“We found this place in Surrey, it was cheap but because it was so far away where we lived and, and because we were paying for our transit, it is three seventy five and we had a lawyer downtown, and my mom, umm she was going to that psychologist in the X clinic you know, you have to, it’s a lot of money and at the beginning when you file information and everything it costs a lot of money we have to travel a lot”

The majority of women also pinpointed to the lengthy wait times as an obstacle to receiving efficient care, and their discussions echoed many of the public perceptions surrounding the issue. As Maria reflected on her experiences of sitting in an emergency room for long hours;

“One day I had to go to the hospital and we had to wait for two hours, and I went at 9.30 to the emergency and they called me at 11.30 I had to wait almost two hours and so many people were waiting there too”

Access to dental care, although not an issue for most women themselves, nevertheless emerged as a frequent topic of discussion particularly as it concerned family members, specially children. Dental issues were not covered by the IFHP, and women like Thaya commented on the exorbitant amount of money that she required for her children’s dental matters, which she could not afford, thus forcing her to forego aspects of her children’s health.

“With my kids I haven’t taken them to a clean up for one and a half years and my son has a problem and he has a little space between his teeth and I took him to the dentist and he said it is 6000 dollars, my son is only 13 years and the immigration can’t pay that money and I have no other help, so I’m not doing it,

I'm not doing it, and they want it in one payment and I don't have big money so I'm waiting so that's the problem"

Finally, Edith, who experienced specific issues with accessing healthcare during the time she waited for her IFHP document recognized it as a major issue, and recommended that this needs to be dealt with since 'there is no guarantee that people won't get sick' while they waited for the 'piece of paper'.

"I told you that when I came here I didn't have anything and I ended up getting medicine from my friend and everything because I didn't have that document, and I think you have to put in something before you go for any interview you put in something so that even when you collapse people can take you to hospital and you can get your medication because there's no guarantee that you are not gonna be sick because you don't have that piece of paper, so that's a major problem there"



## **CHAPTER SEVEN: DISCUSSION**

The last few decades have seen a growing interest in women's health research, both in Canada and elsewhere. Through the incorporation of various theoretical approaches, this growing body of research has contributed to theorizing, framing and deepening our understanding of the various aspects that shape women's health. In spite of these advances, health disparities for women still persist, and remain much more pronounced for women who are marginalized by multiple forms of oppression (Varcoe et. al., 2007), such as the unsponsored refugee women in this study. These persistent disparities call for innovative and critical ways of inquiry that go beyond the inherently limited, gender-centred, euro-centric conventional approaches to conceptualizing and theorizing women's health (ibid, Guruge, 2004). They require approaches that create space to explore multiple and layered social, economic and political dimensions and identities within which women's lives are contextualized.

Particularly in Canada, characterized by diverse communities, much of research on women's health to date has tended to bypass the diversity of Canadian women, as they occupy different social hierarchies defined by diverse identities, such as race, class, sexuality, gender, social positioning, geographic location, immigrant status, ethnicity and culture. Failure to acknowledge these differences as well as the way in which these differences interlock to create unique health experiences for women have resulted in homogenizing women's

health issues and needs, and undermined the fact that “women’s health needs are socially heterogeneous” (Varcoe et al., 2007, p.10). This tendency to homogenize women’s health does much injustice particularly to women in marginalized social locations, such as unsponsored refugees. Because they remain already disadvantaged and othered in society, their voices and health concerns get easily quelled and eschewed, thereby contributing to the perpetuating health disparities. Acknowledging and understanding the socially heterogeneous nature of such women’s health then becomes important if we are to make meaningful advances towards women’s health, policies and practices that aim to reduce health disparities among women in Canada.

One starting point to doing this is to pay heed to women’s own perspectives on health, as they contextualize these within the multiple historical and current circumstances of their lives. By employing a qualitative methodology that facilitates meaning-seeking, and the complementary theoretical framework of intersectionality, this research project has attempted to do just that. Through women’s narratives, stories and interviews, I have sought to shed light on how the multiple intersecting dimensions of their lives - such as their multiple identities, lived experiences, and the macro socio-political and economic structures that shape their lives – impact the way in which they understand health, health issues and needs, determinants of health and pathways to care.

## **Women's Conceptualizations of Health**

It is evident from the results of this study that the women's articulations of health are imbued with multiple and nuanced meanings, unique to each woman. These meanings are derived from a combination of unique life circumstances, larger social structures that impact their life circumstances, intimate lived experiences of health and illness, as well as those ubiquitous ideologies of health, propagated and sustained by powerful social institutions such as medicine.

For instance, Edith's tendency to define health 'as having access to healthcare' and as 'getting educated about health conditions' stems primarily from her own experiences of being denied healthcare in the past, and her perceived lack of preventative knowledge about the chronic health conditions she suffered from, such as diabetes and hypertension. While this is so, on another level, it also points to the powerful socio-economic and political circumstances that explain for instance, why she was denied care. She was denied care because she was forced to wait for a prolonged period to receive the 'IFHP paper', without which she could not access healthcare by virtue of being an unsponsored refugee. In other words, a web of intersecting and mutually reinforcing forces have contributed to her situation, such as; her legally, politically and socially constructed identity as an unsponsored refugee, and the unspoken assumptions and stereotyping that this label carries; her lowered social status that ties into this identity, that has also worked to put her in a socially disadvantaged, disempowered position; the stifling immigration policies and

practices designed to keep the flow of refugee claimants at bay; lengthy bureaucratic procedures and processing delays of documents over which she has no control. All these underlying factors and more proximal personal experiences are seen to shape the particular manner in which she defines health.

Likewise, many women's understanding of health as 'not being sick' or absence of disease [or as physical wellbeing, or as something that needed to be warranted by expert opinion] does, on the one hand, invariably reflect the predominant ideologies about health and illness in modern society. In particular they reflect the reductive biomedical models of health. At a higher level, they are indicative of the controlling grip of the modern biomedical institution on society at large. As scholars have shown elsewhere, these powerful ideologies propagated and sustained by these institutions unmistakably influence public perceptions of health (Calnan, 1987; Shaw, 2002; Blaxter, 2004; Radley, 1993). These perceptions get established as 'credible knowledge' in society, and as people take them on as real knowledge, their concepts of health and illness get inevitably filtered through these medical models of health and illness, and their representations of health get coloured by images and stereotypes derived from this public sphere of health (Calnan, 1987; Shaw, 2002; Radley, 1993). As Show (2002) argues elsewhere, it is uncertain if there could ever be 'pure' lay definitions of health.

While this may be so, on the other hand, the women's definitions of health as 'not being sick' also elicit meanings that go much beyond these reductive models of health. In effect, they also stem from the much more personal, or the

subjective and experiential domain of women's lives, from their own experiences of 'being sick' or 'not being sick', and what it meant to them. In this sense, they represent concepts of health which are, as O'Sullivan points out, more than "just diluted versions of medical knowledge, but ones that are rooted in social and historical contexts" of peoples lives (O'Sullivan et. al, 2004, p. 27). And so, for the majority of women in this study, 'not being sick' had a very real, practical meaning that derived from their lived experiences, more specifically, as it related to their functional capacity, or their 'ability to do things'. As evident from the analysis, many women talked about how important health was for them as they went about their daily chores, fulfilling familial obligations, and in terms of employment. Particularly in terms of work, being confined to the lowest socio-economic stratum in society, being denied access to much of the privileges and resources available to others in society by virtue of their precarious social identity and social positioning, and considering the type of work that was available to them (i.e. low-end, low-paid, high-risk, labor consuming manual jobs that promised no added benefits), health, or 'not being sick' emerged as a valuable resource and a 'tool' for them. In this light, the findings of this research complement with previous research that have also found 'not being sick' to be associated with functional capability, specially employment. As many scholars have shown, the idea of health as a tool or a resource is much more evident among those with manual occupations, including women (Pierret, 1993, Pill and Stott, 1982, Cornwell, 1984, Calnan, 1987, Williams, 1983).

Similarly, women's representations of health along the lines of psychological and emotional wellbeing point to a plethora of intersecting lived experiences, life circumstances and underlying systems of power as the spring wells of these definitions. For instance, as the previous analysis elucidates, the kind of terms which women used to frame emotional and psychological health, such as 'being happy', 'absence of stress', 'worry', 'peace of mind' etc. are closed tied to these varied tiers of their lives. They reflect how they felt about, dealt with and responded to many of the challenges they encountered in their lives, particularly within the current contexts of their lives. For example, the refugee determination process, the economic instability, the insecurity they felt about their future, their liminal identity, concerns about their loved ones, the threat of deportation and numerous other settlement issues were seen to create a constant stream of stressors that overshadowed their lives. All these interlocking circumstances, set in different places and times, appear to factor into the manner in which they define health, particularly in relation to mental health.

Another salient feature about the women's characterizations of health relates to the non-linear nature of these definitions. As emphasized in the analysis, I have chosen to categorize their definitions along themes, but only for the purpose of facilitating the analysis, and therefore they are not intended to be regarded as strict, mutually exclusive classifications. On the contrary, as evident from women's discussions of health, they encompass much more expansive, complex and nuanced notions of health, notions that permeate multiple realms, such as physical, social, economic, psychological, spiritual and emotional

spheres. In this sense, they “challenge the notion of health as a unitary concept” (O’Sullivan, 2004, p. 28), or something that can be neatly fitted into a cut-and-dry, ideal type of health. To this end, the comprehensive manner in which women appear to define health in this study contradicts with findings from certain other studies.

For example, other studies have found clear differences in the way women define health based on socio-economic class (Blaxter and Peterson, 1982; D’houtard, 1984; Calnan, 1987). They propose that women in low socio-economic classes tend to define health primarily in ‘physicalistic’ terms, such as in ways discussed above (i.e. ability to work). Women in upper social classes on the other hand, are seen to define health mainly in relation to mental and emotional wellbeing, or in ‘mentalistic’ terms. However this distinction does not appear to hold true with regard to the participants of this study. Although women in this study belong to the lowest socio-economic strata in society, their conceptions of health do not appear to be defined in any more physicalistic terms than in mentalistic terms. In contrast, as discussed above, their definitions derive from a complex, cross-cutting amalgam of factors that include physical and metaphysical dimensions as well as other spheres. In fact, in some cases as illustrated in the analysis, psychological and emotional wellbeing emerged as a much more predominant contributor in the definitions of their health.

## **Health Issues**

Women reported as experiencing various health issues, ranging from minor physical issues such as body aches and pains, headaches and migraines to more concerning issues of chronic health conditions and emotional health issues. Once again, some of the health issues that women reported appear consistent with previous research conducted on refugee and refugee claimant populations on similar topics. In particular, many of the emotional and psychological health concerns found in this study (such as depression, anxiety, sleep disorders, headaches and migraines) resonate with those of other studies (Silove, 1997). Yet at the same time, these women's self reports of health issues clearly exceed the limited boundaries within which refugee women's health (and women's health in general) is still understood and theorized, for instance, primarily as a site of reproductive health. In this study, the discussions around reproductive health did not take any more precedence than other health concerns that women experienced.

A notable characteristic of their self reports is that most women contextualized health issues primarily within the more proximate post-migratory circumstances and rarely referred to pre-migratory situations, except with regard to certain chronic health issues they had been experiencing over a long period of time. By doing so, similar to how they contextualized health definitions, they illustrated fine examples of how various confluencing elements of their present lives simultaneously worked to produce many of the health outcomes they experienced. That is, they sought to explain the health concerns they



experienced as emanating primarily from sources external to themselves, contextualizing these within the larger structural forces and life circumstances that hurled a myriad of accumulated stressors and rigors at them. For instance, many women blamed the deterioration of their emotional and psychological health on a combination of these events, such as the stress-filled immigration process, the fickleness of their future that left them incapacitated in making constructive decisions for themselves and their families, downward social and economic mobility that sharply contrasted with the good lives they lived in the past and their subordinate social identity.

Among the participants of this research, discussions on the topic of depression were frequent, which emerged as one of the key health challenges for many women. It was seen that the diagnosis of depression was sometimes based on self-diagnosis and sometimes through expert opinion. The women who 'felt' they had depression were hardly seen to seek medical care. It remains unclear if the depression that they talked about is in fact a characterization of daily distress; or whether it is a result of internalization of ideas of certain frontline workers they came in contact with who often suggested (based on assumptions) that 'they may be' suffering from emotional health issues; or if it is another instance of incorporating pervasive medical ideologies that increasingly tend to medicalize "emotions that are social in context" (Shaw, 2004; p. 126). It was also seen that many of the less severe physical health concerns, such as headaches, migraines and sleep disorders were in fact somatic expressions of emotional issues, more specifically, of depression.

Another important aspect relating to depression emerged with regard to the 'clinical diagnoses' of depression itself. Although some women cited their depression as being clinically diagnosed, it was evident that none of these diagnoses had been done through a standard psychiatric assessment. In reality they had been assessed by general practitioners, mental health workers or even social workers based on generalized symptoms of depression or in response to women's complaints of somatic disorders. This highlights a critical service gap in this area, which partly stems from the limited coverage of IFHP which does not typically cover such services, and partly from the unavailability of these services in the small over-crowded community health clinics where women often sought services.

### **Determinants of Health**

Interviews with women highlighted a range of determinants that influenced the health of women. In particular, women's comments and discussions illustrated apt examples of underlying societal or structural processes and circumstances that had a direct impact on the health of these women, similar to the ones described above. Among these factors, their immigrant identity emerged as one of the core determinants and this compliments findings from previous research which links precarious status to diverse health outcomes and overall wellbeing of individuals (Rees, 2003; Bernhard et al., 2007; Simich et al., 2007). The liminality that surrounded their identity as unsponsored refugees for instance subjected them to multiple disadvantages in society that curtailed societal privileges and benefits that included access to employment, education,

limited access to healthcare and housing, all of which are known to be fundamental determinants of health. Similarly, other systemic barriers such as obtaining work permits and the issues of deskilling/under-employment were closely tied into their social location and identity to create numerous barriers in accessing services for the women. As well, the draconian immigration policies, and the overbearing refugee determination system characterized by chronic bureaucratic deficiencies, such as understaffing that created backlogs in processing applications, and high rejection rates created a myriad of stressors for the women as they struggled to settle down and plan for their future. The experiences of detention and the refugee hearing process which entailed issues of credibility, telling and re-telling of painful stories, and the tremendous burden of proof that fell on the women were seen to create profound re-traumatizing effects on the participants and reflect similar findings elsewhere (Laban et al., 2004; Silove et al., 2000; Sultan et al., 2001).

The role of violence emerged as another important determinant of health for these women particularly within the context of the pre-migratory events leading up to their flight. Interestingly, women's contextualization of violence within the pre-migratory circumstances emerged as unmistakably gendered as they talked about domestic violence, female circumcision, rape and sexual abuse and political persecutions as reasons for fleeing in the first place. As well, their discussions finely elicited how these nuanced, gendered forms of violence extended beyond individual bodies and spanned across multiple layers and structures of society. For instance, these forms of violence were seen to be built

into the reinforcing systems of patriarchal values and cultural traditions and norms which defined and shaped the public psyche about how women were treated within a particular social system.

In addition, a multitude of other 'external' or structural factors, such as diverse forms of institutional discrimination, manipulation and maltreatment, unstable income, immigration and settlement experiences and various other elements were seen to contribute to their health outcomes.

### **Pathways to Care**

It was seen that women deemed self care or regular maintenance of their health to be of priority as they consistently mentioned engaging in a number of health maintenance strategies. However, these activities were seen to represent more than popular gender norms of beauty and personal care for the women. Instead their motivation to be in good health appear to emerge in response to the practical challenges of their daily lives, which required engaging in various physical activities such as doing household chores, fulfilling parental duties and in terms of obtaining and retaining employment.

While women were eligible to limited access to healthcare through the federal program of IFHP, it was evident that they continued to encounter obstacles in accessing care which were both structural and personal in nature. These included lack of knowledge of the system/IFHP program by the healthcare providers and the women alike, systemic deficiencies in IFHP program such as processing delays and complex bureaucratic procedures it involved (i.e. a large

amount of paperwork), language barriers and issues surrounding interpretation, difficulties in finding family physicians and distance to care facilities (Oxman-Martinez et al., 2005; Simich et al., 2007; Caulford, 2006; Rousseau et al., 2008; Reeves, 2006; Gagnon, 2004; Miedema et al., 2008). The high prevalence of mental health concerns and frequent mention of dental needs that are not covered by IFHP indicate critical issues surrounding access to these services.

## **CONCLUSION AND FUTURE DIRECTIONS**

This research highlights several important factors relevant to unsponsored refugee women's health. It illustrates how their unique experiences of health, health concerns and needs are shaped by a dynamic, mutually constitutive combination of lived experiences of health and illness, life circumstances and macro structural forces. To this end, it clearly exemplifies the importance of contextualizing their health within the broader and layered social, economic and political dimensions within which they live. Living at the intersections of multiple forms of oppressions and identities, this research finely illustrates how a web of interlocking identities, including, but not limited to gender, simultaneously interact with these other, larger structural frames of power to create nuanced experiences of health. The findings of this research also resonate the increasing calls, particularly by critical feminist scholars to look for innovative ways of inquiry that go beyond limited conventional approaches, to conceptualizing and theorizing women's health, such as the promising framework of intersectionality used in this research. Women's continual references to their liminal legal status and the pervasive manner in which it impacts every aspect of their lives including health may implicate the need to rethink the immigration policies and bureaucratic structures as they relate to the health outcomes of unsponsored refugees. Similarly, the high prevalence of self reports of psychological and emotional health issues among women points to the need for critical access to well

coordinated mental health services for this group of women. In this regard, the consideration of incorporation of access to mental health services for unsponsored refugees into the IFH program may be important. The results of this study are also significant in illuminating the diversity of Canadian women's health, and in terms of bringing to the forefront of women's health discourse the critical health concerns and needs of a disadvantaged group of women. The clear dearth of evidence-based knowledge relating to the unsponsored refugee women's health implicates the need for further in-depth research into the area.

## REFERENCE LIST

- Alund, A. (1995). Alterity in modernity. *Acta Sociologica*, 38, 311-322.
- Amaratunga, C. (2001) Women, diversity and access to healthcare in the Atlantic Canada: a preliminary perspective. *Network Magazine of the Canadian Women's Health Network*, 4(2), 11-12.
- Bailey, A J., Richard, A. W., Alison, M., & Ines, M.M. (2002). (Re)producing Salvadoran Transnational geographies. *Annals of the Association of American Geographers*, 92(1), 125-44.
- Battaglini, A., Gravel, S., Boucheron, L. & Fournier, M. (1999). Identification des facteurs de vulnérabilité propres aux mères immigrantes en période périnatale, rapport d'étape. Montréal: CESAF.
- Beiser, M. & Stewart, M. (2005). Reducing health disparities. *Canadian Journal of Public Health*, 96(S2), S4-S5.
- Bernhard, J. K., Goldring, L., Young, J., Berinstein, C., & Wilson, B. (2007). Living with precarious legal status in Canada: implications for the well-being of children and families. *Refuge*, 24(2), 101-114.
- Bilge, S. (2009) Smuggling intersectionality into the study of masculinity: Some methodological challenges. Paper presented at *Feminist Research Methods: An International Conference* at Stockholm University, February 4-6.
- Blackwell, D., Holden, K. & Tregoning, D. (2002). An interim report of health needs assessment of asylum seekers in Sunderland and North Tyneside. *Public Health*, 116(4), 221-226.
- Blaxter, M. (2004). *Health*. Cambridge, UK, Malden, MA: Polity.
- Blaxter, M. & Paterson, E. (1982). *Mothers and Daughters*. London: Heinemann.
- Boscoe, M., Basen, G., Alleyne, G., Bourrier-Lacroix, B. & White, S. (2004). The Women's Health Movement in Canada: Looking Back and Moving Forward. *Canadian Woman Studies Special Issue*, 24(1), 7-13.
- Boyatzis, R. E. (1998). *Transforming qualitative information: thematic analysis and code development*. Thousand Oaks, CA: Sage Publications.
- Calnan M. (1987). *Health and illness: The lay perspective*. New York: Tavistock Publications.



- Canada Health Act (1984), Retrieved 16 February 2010 from, <http://laws.justice.gc.ca/en/C-6/17077.html>
- Canadian Institute for Health Information. (2004). *Improving the health of Canadians*. Canadian Institute for Health Information. Retrieved 19 June 2009 from, [www.cihi.ca](http://www.cihi.ca)
- Canadian Institute for Health Information. (2003). *Women's Health Surveillance Report: A multi dimensional look at the health of Canadian women*. Canadian Institute for Health Information.
- Canadian Red Cross. (2008). Connecting to your new community: A resource guide for refugee claimants. Canadian Red Cross. Retrieved 11 April, 2009 from, <http://www.svdptoronto.org/v2/pdf/Manual%20for%20Refugees.pdf>
- Canadian Women's Health Network, (n.d.). *The women's health bureau*. Retrieved 10 April, 2010 from, <http://www.cwhn.ca/en/node/39529>
- Caulford, P. & Vali, Y. (2006). Providing healthcare to medically uninsured immigrants and refugees. *Canadian Medical Association Journal*, 174(9), 1253-1254.
- Citizenship and Immigration Canada. (2005). *Interim Federal Health Program: Information handbook for health care providers*. Edmonton AB: FAS Benefit Administrators Limited.
- Citizenship and Immigration Canada. (2006), *Canada's immigration system: what you should know*. Ottawa: Citizenship and Immigration Canada.
- Citizenship and Immigration Canada. (2008). *Facts and Figures 2008: Immigration Overview*. Retrieved, 15 February 2010 from, <http://www.cic.gc.ca/english/pub/facts2005/permanent/02.html>
- Cohen, M. & Sinding, C. (1996). *Changing Concepts of Women's Health: Advocating for Change*. Paper prepared for Canada-USA Forum on Women's Health. Ottawa: Health Canada. Retrieved 11 March 2010, from <http://www.hc-sc.gc.ca/hl-vs/pubs/women-femmes/index-eng.php>
- Collins, P. H. (2000). Moving beyond gender: Intersectionality and scientific knowledge in M.M. Ferree, J. Lorber, & B. B. Hess, (Eds.). *Revisioning gender*. Thousand Oaks, CA: Sage Publications.
- Collins, P. H. (1998). *Fighting words: Black women and the search for justice*. Minneapolis, MN: University of Minnesota Press.
- Collins P.H (1986). Learning from the outsider within: The sociological significance of Black feminist thought, *Social Problems*, 33(6), 14-32.
- Cornwell, J. (1984). *Hard Earned Lives: Accounts of health and Illness from East London*, London; New York: Tavistock Publications; New York: Methuen.

- Desmeules, M. et al. (2003). Introduction. In *Women's Health Surveillance Report: A multi dimensional look at the health of Canadian women*. Canadian Institute for Health Information.
- d'Houtard, A. & Field, M.G. (1984) The image of health: Variations in perception by social class in a French population. *Sociology of Health and Illness* 6(1), 30-60.
- Dill, B.T., McLaughlin, A.E. & Nieves, A.D. (2007). Future directions of feminist research: Intersectionality. In Hesse-Biber, S.N. (Ed.). *Handbook of Feminist Research: Theory and praxis*. Thousand Oaks, CA: SAGE Publications.
- Doyle, N. (1997). *Safeguarding asylum: sustaining Canada's commitments to refugees*. Report of the Standing Committee on Citizenship and Immigration, Ottawa: Standing Committee on Citizenship and Immigration.
- Dubos, R. (1961). *The Mirage of Health*. New York: Doubleday.
- Freedman J. (2007). *Gendering the international asylum and refugee debate*. New York: Palgrave Macmillan.
- Gagnon, A.J. et al., (2007). Refugee and refugee-claimant women and infants post-birth: Migration histories as a predictor of Canadian health system response to needs. *Canadian Journal of Public Health*, 98(4), 287-291.
- Gagnon A.J. et al. (2006). The childbearing health and related service needs of newcomers (CHARSNN) study protocol. *BMC Pregnancy and Childbirth*, 6(31), 1-18.
- Gagnon A. J. (2004). The responsiveness of the Canadian health care system towards newcomers. In P-G. Forest, , T. McIntosh & G.P. Marchildon (Eds.). *Changing Health Care in Canada: The Romanov Papers, Vol 2*, Toronto: University of Toronto Press.
- Gagnon A. J., Merry L. & Robinson C. (2002). A systematic review of refugee women's reproductive health. *Refuge*, 21(1), 6-17.
- Ghansham, D.M. (2002). Female Foeticide and the dowry system in India. Paper prepared for *Townsville International Women's Conference, Australia*. Retrieved 22 April 2010 from, <http://www.austdvclearinghouse.unsw.edu.au/Conference%20papers/TIWC/GhanshamDevakiMonani.pdf>
- Goldring, L., Berinstein, C. & Bernhard, J. (2007). Institutionalizing precarious immigration status in Canada. CERIS working paper No. 61. The Ontario Metropolis Centre.
- Guruge, S. & Khanlou, N. (2004). Intersectionalities of influence: Researching the health of immigrant and refugee women. *Canadian journal of nursing research* 36(3), 32-47.

- Hankivsky, O, Cormier, R. & de Merich, D. (2009). *Intersectionality: Moving Women's Health Research and Policy Forward*. Women's Health Research Network.
- Hankivsky, O & Christoffersen, A. (2008). Intersectionality and the determinants of health: A Canadian perspective. *Critical Public Health*, 18(3), 271-283.
- Hankivsky, O., (2007). Gender based analysis and health policy: the need rethink outdated strategies. In M. Morrow, O. Hankivsky & C. Varcoe (Eds.), *Women's health in Canada: Critical perspectives on theory and policy*. Toronto: University of Toronto Press.
- Hankivsky, O., (2006). Beijing and beyond: women's health and gender based analysis in Canada. *International Journal of Health Services*, 36(2), 377-400.
- Health Canada Web site, (n.d.). <http://www.hc-sc.gc.ca/>
- Hesse-Biber, S.N. (Ed.). (2007). *Handbook of Feminist Research: Theory and praxis*. Thousand Oaks, CA: SAGE Publications.
- Keller A.S. et al. (2003). Mental health of detained asylum seekers. *Lancet*, 362(9397):1721-1723.
- Laban, C. J., Gernaat, H. B., Komproe, I. H., Schreuders, B. A. & De Jong, J. T. (2004). Impact of a long asylum procedure on the prevalence of psychiatric disorders in Iraqi asylum seekers in The Netherlands. *The journal of Nervous and Mental Disease*, 192(12), 843–851.
- Lacroix M. (2004). Canadian Refugee Policy and the Social Construction of the Refugee Claimant Subjectivity: Understanding Refugeeeness. *Journal of Refugee Studies*, 17(2), 147-166.
- Lacroix, M. (2000). *The road to asylum. Between fortress Europe and Canadian refugee policy: the social construction of the refugee claimant subjectivity*, Thesis. School of Social Work, McGill University.
- Larson, J.S. (1999). The Conceptualization of Health. *Medical Care Research and Review*, 56(2), 123-136.
- Loescher, G. (1992). *Refugee movements and international security*. London: Brassey's for the International Institute for Strategic Studies
- Madore, O. (2003). *Canada Health Act: Overview and Options*. Ottawa, Canada: Library of Parliament, Research Branch. Retrieved 24 June 2009 from, <http://dsp-psd.communication.gc.ca/Pilot/LoPBdP/CIR/944-e.htm>
- Malkki, L. H. (1996). Speechless Emissaries: Refugees, Humanitarianism, and Dehistoricization. *Cultural Anthropology*, 11(3) 377-404.

- Malkki, L. S. (1995a). Refugees and Exile: From "Refugee Studies" to the National order of things. *Annual Review of Anthropology*, 24, 495-523.
- Malkki, L. H. (1995b). *Purity and exile: violence, memory, and national cosmology among Hutu refugees in Tanzania*. Chicago: University of Chicago Press.
- Mansouri, F. & Cauchi, S. (2007). A Psychological perspective on Australia's asylum policies. *International Migration*, 45(1), 123-150.
- Mayotte, J. A. (1992). *Disposable people? The plight of refugees*. New York: Orbis Books.
- Menjivar C. (2006). Liminal Legality: Salvadoran and Guatemalan immigrants' lives in the United States. *American Journal of Sociology* 111(4), 999-1037.
- Miedema, B., Hamilton, R. & Easley, J. (2008). Climbing the walls: Structural barriers to accessing primary care for refugee newcomers in Canada. *Canadian Family Physician*, 54, 335-336.
- Morrow, M. Hankivsky, O. & Varcoe, C (Eds.). (2007). *Women's health in Canada: Critical perspectives on theory and policy*. Toronto: University of Toronto Press.
- Morrow, M. (2007). 'Our bodies our selves' in context: Reflections in the women's health movement in Canada. In M. Morrow, O. Hankivsky & C. Varcoe (Eds.), *Women's health in Canada: Critical perspectives on theory and policy*. Toronto: University of Toronto Press.
- Morrow, M. & Hankivsky, O. (2007). Feminist methodology and health research: Bridging trends and debates. In M. Morrow, O. Hankivsky & C. Varcoe (Eds.), *Women's health in Canada: Critical perspectives on theory and policy*. Toronto: University of Toronto Press.
- Mulvihill, M.A., Mailloux, L. & Atkin W. (2001). *Advancing policy and research responses to immigrant and refugee women's health in Canada*. Centres of Excellence for Women's Health.
- Nettleton, S. (2006). *The sociology of health and illness*. Cambridge: Polity.
- Neuman, W. L. (2006). *Social Research Methods: Qualitative and quantitative approaches*. USA: Pearson Education Inc.
- O'Sullivan, S. & Stakelum, A. (2004). Lay understandings of health: A qualitative study. In I. Shaw & K. Kauppinen (Eds.), *Constructions of health and illness: European perspectives*. Aldershot, England; Burlington, VT, USA: Ashgate.

- Oxman-Martinez J., Hanley, J., Lach, L., Khanlou, N., Weerasinghe, S. & Agnew, V. (2005). Intersection of Canadian policy parameters affecting women with precarious immigration status: a baseline for understanding barriers to health. *Journal of Immigrant Health*, 7(4), 247-258.
- Pierret, J. (1993). Constructing discourses about health and their social determinants. In A. Radley (Ed.), *Worlds of illness: Biographical and cultural perspectives on health and disease*. London; New York: Routledge.
- Pill, R. & Stott, N.C.H. (1982). Concepts of illness causation and responsibility: Some preliminary data from a sample of working class mothers. *Social Science and Medicine*, 16, 43-52.
- Radley, A. (1993). Introduction. In A. Radley (Ed.), *Worlds of illness: Biographical and cultural perspectives on health and disease*. London; New York: Routledge.
- Radley, A. (Ed.). (1993). *Worlds of illness: Biographical and cultural perspectives on health and disease*. London; New York: Routledge.
- Rajaraman, I. (1983). Economics of bride-price and dowry. *Economic and Political Weekly*, 18(8), 275-279.
- Rees, S. (2003). Refuge or re-trauma? The impact of asylum seeker status on the wellbeing of East Timorese women asylum seekers living in the Australian community. *Australasian Psychiatry* 11, S96-S101.
- Reeves, M. de Wildt, G., Murshali, H., Williams, P., Gill, P., Kralj, L. & Rushby, M. (2006). Access to health care for people seeking asylum in the UK. *British Journal of General Practice*, 56(525), 306–308.
- Rosenstock, I.M. (1966). Why people use health services. *Millbank Memorial Fund Quarterly*, 44(3), 94-127.
- Rousseau, C., S. ter Kuile, M., Munoz, L., Nadeau, M-J., Ouimet, L., Kirmayer, & Crépeau, F. (2008). Health care access for refugees and immigrants with precarious status: Public health and human rights challenges. *Canadian Journal of Public Health*, 99(4), 290-292.
- Ruff, S. F. (1998). *After the crisis: An exploration of humanitarian workers' and Somali refugee women's narratives of health*. Thesis, Graduate Programme in Social Anthropology, York University.
- Ruzek, B., Olesen, V.L. & Clarke, A.E. (Eds.). (1997). *Women's health: complexities and differences*. Columbus: Ohio State University Press.
- Saylor, C., (2004). The Circle of Health: A Health Definition Model. *Journal of Holistic Nursing*, 22(2), 97-115.

- Schulz, A.J. & Mullings, L. (Eds.). (2006). *Gender, race, class and health: intersectional approaches*. San Francisco: Jossey-Bass.
- Shaw, I. & Woodward, L. (2004). The medicalization of unhappiness? The management of mental distress in primary care In I. Shaw & K. Kauppinen (Eds.), *Constructions of health and illness: European perspectives*. Aldershot, England; Burlington, VT, USA: Ashgate.
- Shaw, I. (2002). How lay are lay beliefs? *Health*, 6(3), 287-299.
- Silove, D., Steel, Z. & Watters, C. (2000). Policies of deterrence and the mental health of asylum seekers. *The Journal of the American Medical Association*, 284(5), 604-611.
- Silove D, Sinnerbrink I, Field A, Manicavasagar V, & Steel Z. (1997). Anxiety, depression and PTSD in asylum seekers: Associations with pre-migration trauma and post-migration stressors. *British Journal of Psychiatry* 170, 351-357.
- Simich, L., Wu, F. & Nerad, S. (2007). Status and health security: An exploratory study of irregular immigrants in Toronto. *Canadian Journal of Public Health*, 98(5), 369-373.
- Sinnerbrink, I., Silove, D. M., Manicavasagar V. L., Steel, Z. & Field, A. (1996). Asylum seekers: General health status and problems with access to health care. *The Medical Journal of Australia*, 165(11-12), 634-637.
- Spector, R.E. (2009). *Cultural diversity in health and illness*. Upper Saddle River, N.J.: Pearson Prentice Hall.
- Spitzer, D.L. (2005). Engendering health disparities. *Canadian Journal of Public Health*, 96(S2), S78-S96.
- Steel, Z., Silove, D., Bird, K., McGorry, P. & Mohan, P. (1999). Pathways from war trauma to posttraumatic stress symptoms among Tamil asylum seekers, refugees and immigrants. *Journal of Traumatic Stress*, 12(3), 421-435.
- Strauss A., & Corbin, J. (1998). *Basics of Qualitative Research: Grounded theory procedures and techniques* (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage Publications.
- Sultan, A. & O'Sullivan, K. (2001). Psychological disturbances in asylum seekers held in long term detention: A participant-observer account. *The Medical Journal of Australia*, 175(11-12), 593-596.
- Tazreiter, C. (2004). *Asylum seekers and the state: The politics of protection in a security-conscious world*. Aldershot, Hants, England ; Burlington, VT: Ashgate.

- The universal Declaration of Human rights (1948). The General Assembly of the United Nations. Retrieved 10 March 2010 from, <http://www.un.org/en/documents/udhr/>
- Thonneau, P., Gratton, J. & Desrosiers, G. (1990). Health profile of applicants for refugee status admitted into Quebec between August 1985 and April 1986. *Canadian Journal of Public Health*, 81(3), 182-186.
- Tribe, R. (2002). Mental health of refugees and asylum-seekers. *Advances in Psychiatric Treatment* 8, 240-247.
- Tripp-Reimer, T. (1984). Reconceptualizing the construct of health: Integrating Emic and Etic perspectives. *Research in Nursing and Health*, 7, 101-109.
- Turner, V. (1967). *The forest of symbols; aspects of Ndembu ritual*. New York: Cornell University Press.
- United Nations High Commissioner for Refugees. (1951). Convention and protocol relating to the status of refugees. Retrieved 10 March, 2010 from, <http://www.unhcr.org/3b66c2aa10.html>
- United Nations High Commissioner for Refugees (2006). *State of the world's refugees*. Geneva: UNHCR.
- United Nations. (1948). The universal declaration of human rights. Retrieved 24 March 2010 from, <http://www.un.org/en/documents/udhr/index.shtml#a14>
- Varcoe, C., Hankivsky, O., & Morrow, M. (2007). Introduction: Beyond gender matters. In M. Morrow, O. Hankivsky & C. Varcoe (Eds.), *Women's health in Canada: Critical perspectives on theory and policy*. Toronto: University of Toronto Press.
- Vissandjee, B., Desmeules, M., Cao, Z., Abdool, S. & Kazanjian, A. (2004). Integrating ethnicity and migration As determinants of Canadian women's health. *BMC Women's Health*, 4(Suppl 1):S32, 1-11.
- Wayland, S. V. (2006). *Unsettled: Legal and Policy Barriers for Newcomers to Canada*, Community Foundations of Canada and the Law Commission of Canada.
- Weber, L., & Fore, M.E. (2007). Race, ethnicity, and health: An intersectional approach. In H. Vera & J. R. Feagan (Eds.), *Handbook of the Sociology of Racial and Ethnic Relations*. New York: Springer.
- Weber, L., (2006). Reconstructing the landscape of health disparities research: promoting dialogue and collaboration between feminist intersectional and biomedical paradigms. In: A.J. Schultz & L. Mullings. (Eds.). *Gender, race, class and health: intersectional approaches*. San Francisco, CA : Jossey-Bass.

- Weber L. & Parra-Medina, D. (2003). Intersectionality and women's health: charting a path to eliminating health disparities. In M.T. Segal, V. Demos & J.J. Kronenfeld (Eds.), *Gender perspectives on health and medicine: key themes*. Boston: Elsavier.
- Whittaker, D., (2006). *Asylum seekers and refugees in the contemporary world*. New York: Routledge.
- Williams, R., (1983). Concepts of Health: An analysis of lay logic. *Sociology*, 17(2), 185-205.
- Wu Z. & Schimmele CM. (2004). *Immigrant status and unmet health care needs in British Columbia*. Research on Immigration and Integration in the Metropolis Working Paper Series No-04-18.
- Yu, S., Ouellet, E. & Warmington, A. (2007). Refugee Integration in Canada: A Survey of Empirical Evidence and Existing Services. *Refuge*, 24(2), 17-34.
- Zetter, R. (1991). Labelling Refugees: Forming and transforming a bureaucratic identity. *Journal of refugee studies*, 4(1), 39-62.



# APPENDICES

## Appendix 1: Interview Guide for Participants

### *Interview One*

#### **Journey and demographic information**

Can you tell me a little bit about where you come from?

How long have you been in Canada?

Could you tell me a little bit about your journey to Canada? [Probe to follow during second interview]

Who else accompanied you to Canada?

What was your country of last residence before you came to Canada?

How old are you now?

What is your marital status?

Do you have any children living with you at the moment (if any)? If yes, how many?

Could you tell me how old they are?

What is your highest level of education?

What language/s do you speak at home?

#### **Settlement Process (Social support)**

When you first came to Canada, did any person/organization help you in the settlement process? Can you tell me more about them?

Could you tell me about any other relatives/family members living in Canada?

Could you explain to me what health means to you? [Probe to follow during second interview]

Could you tell me about any health issues that you are concerned about that you may have? [Probe to follow during second interview]

## *Interview Two*

### **Perceptions of health**

Could you explain what health means to you/what comes to your mind when I say 'health'?

What are the health concerns that you may have?

What do you do to keep yourself healthy?

Did you ever visit the doctor since you came to Canada? (If yes,) can you tell me for what illness/s you visited the doctor?

Do you think your health has changed since you moved to Canada? (if yes or no) Can you explain a bit more?

### **Determinants of health and life stories**

What do you think are some factors that affect your health?

How would you describe/rate your health?

Could you tell me about what your life was like before your problems started?

Could you tell me a bit about why you had to leave your country?

Do you have family members that you had to leave behind? If so, would you like to tell me about who they are? Why did they have to stay?

What is your main source of income at present?

Could you tell me about your living arrangements in Canada?

Are you currently working? If so, can you tell me more about your work? If not, could you describe your daily activities to me?

What were the challenges you had to face when you first moved to Canada (if any)?

### **Pathways to care/barriers to accessing care**

If you or one of your family members is ill, what do you usually do?

When you first moved to Canada, how did you find out about the Canadian health system?

When you visit the doctor, do you go alone or does anyone accompany you? If so, who does? (if so), why?

Other than going to the doctor, what else do you do to keep healthy?

Do you have a family doctor? If yes can you tell me more about her/him? If no, why?

Where do you usually seek care? (i.e. walk-in clinic, community health centre etc.)

What were the challenges you had to face in accessing healthcare when you first moved to Canada? What are the challenges you still face in accessing health care?

What do you think Canadian health system needs to do to help you overcome these challenges and to provide better health care to you?

## **Appendix 2: Interview Guide for Key Informants**

Can you tell me a little bit about your organization?

What is your role in this organization? /What is your work like?

What kind of services do you provide?

Who are the people who seek services here?/What is the profile of people who come here for services?

Can you tell me more about unsponsored refugee women who come here for services?

What kind of services do they require?

Where do they come from?

Why do you think they are here in Canada?

As a service provider, what are your thoughts about the overall health of these women?

What do you think are the key health challenges and needs of these women?

Can you tell me more about access to health care for these women? (i.e. IFHP etc)

What do you think are some of the challenges they face in accessing healthcare?

What are some of the challenges that you face in serving this population?