EXAMINING COMMUNITY CAPACITY TO SUPPORT KAREN REFUGEE WOMEN’S MENTAL HEALTH AND WELL-BEING IN THE CONTEXT OF RESETTLEMENT IN CANADA

by

Nancy Clark

B.S.N., The University of British Columbia, 1993
M.S.N., The University of British Columbia, 2005

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

in

The Faculty of Graduate and Postdoctoral Studies

(Nursing)

THE UNIVERSITY OF BRITISH COLUMBIA

(Vancouver)

April 2015

© Nancy Clark, 2015
ABSTRACT

From 2005 to 2009, Karen refugee women and their families living along the Thailand Burma border were the largest group to be resettled in South Western British Columbia. Research suggests that communities located at the metropolitan periphery lack capacity to provide equitable, inclusive and accessible services for minority populations. Moreover, there exist growing inequities in health and health care for refugee women. As a result of historical oppression, many Karen women arrived in Canada with lower literacy, lower education and exposure to trauma and violence; however, little is known about Karen women’s needs for resettlement. The purpose of this study was to examine community capacity in the context of Karen women’s resettlement, i.e. to understand the social and structural processes that impacted their mental health and well-being, the factors that intersected to support their resettlement process, and the ways the receiving community responded to their resettlement needs.

Ethnographic data was collected over a seventeen-month period, including participant observation and, in-depth individual and focus group interviews with Karen women, settlement workers, health care and social service providers (N=38). Drawing on postcolonial feminist theory and tenets of intersectionality and cultural safety, findings suggest that non-government organizations promoted successful resettlement and mitigated the effects of trauma by supporting Karen women’s health literacy. However, settlement reforms underpinned by neoliberal governance structures resulted in gendering and mainstreaming of settlement services, negatively impacting the Karen women and families’ ability to access health care
services and social supports. The overall lack of knowledge about their needs, integrated support for translators and formal social support systems challenged nurses, allied health care providers and settlement workers in their attempts to provide equitable health care and social resources. These structural aspects of community capacity created contexts of increased vulnerability and dependency for Karen women. Capacity-building strategies fostering advocacy, collaborative partnerships, reciprocal support, and flexibility across service sectors (non-government organizations and primary and public health) facilitated community capacity to support the mental health and well-being of Karen women during resettlement. Recommendations are proposed for integrated systems of care that promote social justice and that are culturally safe and trauma- and violence-informed.
PREFACE

Ethics approval for this study was received from the University of British Columbia, Behavioral Research Ethics Board. This study was originally approved in May 2012; the last annual renewal was received in January 2014 (Approval number H12-00702). The Fraser Health Research Ethics Board FHREB under the Fraser Health Authority also granted ethical approval for this study in July 2012. The last annual renewal was received in July 2013 (Approval number 2012-039).

This dissertation is the original, unpublished, independent work by the author, Nancy Clark.
# TABLE OF CONTENTS

ABSTRACT ................................................................................................................................. ii

PREFACE ................................................................................................................................. iv

TABLE OF CONTENTS .............................................................................................................. v

LIST OF TABLES ......................................................................................................................... x

LIST OF FIGURES ....................................................................................................................... xi

LIST OF ACRONYMS .................................................................................................................. xii

ACKNOWLEDGEMENTS .............................................................................................................. xv

1. SITUATING THE STUDY ......................................................................................................... 1
   1.1 Introduction ......................................................................................................................... 1
   1.2 Locating the Problem ........................................................................................................... 6
   1.3 Research Purpose and Objectives ......................................................................................... 12
   1.4 Organization of the Dissertation ......................................................................................... 13

2. BACKGROUND AND LITERATURE REVIEW ................................................................... 17
   2.1 Introduction ......................................................................................................................... 17
   2.2 Globalization, Transnationalism and the Construction of Refugee Identity ................... 19
   2.3 An Overview of the Discourses and the Sociopolitical Historical Context of Canadian Immigration .......................................................................................................................... 30
   2.4 The Evolution of Karen Refugee Resettlement in BC ......................................................... 49
   2.5 Primary Health Services and Settlement Support for Refugees in Canada ...................... 52
      2.5.1 Overview of settlement services in BC ........................................................................ 54
      2.5.2 Nongovernment organizations and settlement .......................................................... 55
      2.5.3 Overview of structures of settlement and GAR outcomes in BC ................................. 62
   2.6 Health and Health Care Access for Refugee Women ......................................................... 77
   2.7 Examining Language and Literacy Barriers of Refugee Women ...................................... 88
      2.7.1 Lack of integrated official language policy ................................................................. 97
   2.8 Refugee Women’s Mental Health and Well-being ............................................................ 103
   2.9 Refugee Women and Social Support ............................................................................... 109
      2.9.1 Intimate partner violence relating to immigrant and refugee women ........................ 114
3.4.2 Validity ................................................................................................................................. 212
   3.4.2.1 Threats to descriptive validity ............................................................... 214
   3.4.2.2 Threats to theoretical validity ................................................................. 214
   3.4.2.3 Threats to interpretive validity ............................................................... 218
3.5 Ethical Considerations ............................................................................................................. 223
   3.5.1 Reciprocity and remuneration ............................................................................. 227
3.6 Study Limitations ..................................................................................................................... 228

4. KAREN WOMEN’S EXPERIENCES OF RESETTLEMENT ............................................. 230
4.1 A Context of Stress and Worry ......................................................................................... 230
   4.1.1 Resettlement and mental health—“A lot of stress and worry” ..................................... 231
   4.1.2 Dependency—“You don’t need to wait for me” ............................................. 238
   4.1.3 Re-visioning agency—“Standing on other people’s feet is not the same as walking by yourself” .............................................................. 244
   4.1.4 Fitting into the mold—“It seems like they don’t have the time” .................................. 246
   4.1.5 Seeking safety and the potential for traumatization—
       “Somebody step in and help her!” .............................................................. 253
   4.1.6 Gender, identity and resettlement—“It’s invisible...” .................................... 261
   4.1.7 Education, language and gender—“It’s a big thing for me to go to school...” .......................................................... 266
4.2 Summary ................................................................................................................................. 270

5. EXAMINING COMMUNITY CAPACITY: HEALTH CARE AND SOCIAL
   SERVICE PROVIDER PERSPECTIVES ON SUPPORTING
   RESETTLEMENT AND THE MENTAL HEALTH AND WELL-BEING OF
   KAREN WOMEN ................................................................................................................. 274
5.1 Culture, Healthcare Provision and Karen Women’s Resettlement ...... 274
   5.1.1 Mental health, culture and health literacy—“Why are you bringing me here today? I feel well...” .............................................................. 274
   5.1.2 Volunteerism and resettlement—“Flying by the seat of our pants” .......................................................... 285
   5.1.3 Challenges to community capacity—“The funding dictates” ....... 291
   5.1.4 Increased need for social support—“They leave you high and dry” .......................................................... 299
   5.1.5 Accompaniment—“If we don’t help who will?” .................................... 302
   5.1.6 Structural violence—“Let me talk to someone who speaks English; I don’t have time for this!” .......................................................... 308
Appendix I. Consent Form for Karen Women to Participate in Individual and Focus Group Interviews

Appendix J. Selected Fieldnotes

Appendix K. Translator Confidentiality Agreement Form

Appendix L. Script of Oral Consent to Conduct Participant Observations

Appendix M: Consent to Participate in Field Observations

Appendix N. Consent for Karen Women’s Family Members to Participate in Individual and Focus Group Interviews

Appendix O. Interview Guide for Karen Family members

Appendix P. Consent for Policy Makers to Participate in Individual Interviews

Appendix Q. Interview Guide for Policy Members
LIST OF TABLES

Table 1. Total Participants .................................................................................................................... 188
Table 2. Karen Women’s Demographic Data (n = 12) ........................................................................ 190
Table 3. Health Care and Social Service Provider Data (n = 26) ......................................................... 193
LIST OF FIGURES

Figure 1. Framework of the Critical Theoretical Approaches ...........................................176
LIST OF ACRONYMS

Aboriginal Health Center ................................................................. AHC
Acquired Immune Deficiency Syndrome ........................................ AIDS
Affiliation of Multicultural Societies and Services Agencies of BC .......... AMSSA
American Psychological Association ............................................... APA
Boston Centre for Refugee Health and Human Rights ....................... BCRHHR
Bridge Community Health Clinic ................................................... BCHC
British Columbia ........................................................................... BC
Canadian Nurses Association ......................................................... CNA
Canadian Psychiatric Association .................................................... CPA
Census Metropolitan Area ............................................................... CMA
Citizenship and Immigration Canada ............................................... CIC
Early Childhood Educator .............................................................. ECE
Early Years Refugee Program ........................................................... EYRP
Edinburgh Postnatal Depression Scale .............................................. EPDS
English Language Skills Assessment ............................................... ELSA
Gender Based Analysis ................................................................... GBA
Government Assisted Refugee .......................................................... GAR
Greater Vancouver Regional District ................................................ GVRD
Health and Social Services Center ................................................... HSSC
Healthcare Interpretation Network ................................................... HIN
Human Immunodeficiency Virus ...................................................... HIV
Immigrant Services Association ....................................................... ISA
Immigrant, Refugee, Ethno-cultural or other Racialized person ............. IRER
Immigrant Services Society of BC ..................................................... ISS of BC
Immigration and Refugee Protection Act ....................................................... IRPA
Immigration Refugee Board ................................................................. IRB
Institute for Research on Public Policy .................................................. IRPP
Interim Federal Health Program ......................................................... IFHHP
Internally Displaced Person ............................................................... IDP
Intimate Partner Violence ................................................................. IPV
Mental Health Commission of Canada ................................................. MHCC
Mohawk Valley Resource Center for Refugees ....................................... MVRC
New Public Management .................................................................. NPM
Non-Government Organization ......................................................... NGO
Nurse Practitioner ............................................................................... NP
Post Traumatic Stress Disorder .......................................................... PTSD
Post-partum Depression ....................................................................... PPD
Primary Health Care ............................................................................ PHC
Privately Sponsored Refugee ............................................................. PSR
Public Health Nurse ............................................................................ PHN
Refugee Assistance Program ............................................................. RAP
Ryerson University Resettlement Project ............................................. RRP
September 11, 2001 (World Trade Center/Pentagon terrorism attacks)..... 9/11
Southeast Asia ..................................................................................... SEA
Tuberculosis ........................................................................................ TB
United Kingdom .................................................................................. UK
United Nations ................................................................................... UN
United Nations High Commissioner for Refugees ................................. UNHCR
United States of America ................................................................. US or USA
Vulnerable Immigrant Populations Program

World Health Organization

World War Two
ACKNOWLEDGEMENTS

There are many people I would like to thank for supporting me in pursuing this academic endeavor. First, I would like to acknowledge and thank the Karen women and families who contributed their time and shared their stories with me. I also would like to extend my heartfelt thanks to the NGO that kept the door open and allowed me to do this study; thank you Bill and Jane. In particular I extend my deepest appreciation to Sharon, who has been an integral part of my learning throughout this journey. I am grateful for the kindness extended by Tamira, Saw Jo and Herman, who took time out of their schedules to support this research. I am also in gratitude to the Karen women who provided translation for this study: Candy, Zipporah, Hser Chri and Hser Gay; without your assistance this study would not have been possible.

I am sincerely grateful to my supervisory committee, Drs. Annette Browne and Sheryl Reimer-Kirkham and my research supervisor, Dr. Victoria Smye, who provided ongoing support and encouragement. I also extend my gratitude and thanks to Vicky Bach who provided ongoing support during the early phases of this study. Thank you to my friends, colleagues, and family who stood beside me, who listened and regularly checked in with me to make sure I was still moving forward. I am also grateful to the support from Lynn, John and Sue who provide their expertise and support. Thank you, Augie and Harvey for your support and lastly, to my husband Chris who stood by me and inspired me to continue, I am truly grateful.
1. SITUATING THE STUDY

1.1 Introduction

The process of migration and context of resettlement are important determinants for the mental health and overall well-being of refugee women in Canada. By the end of 2010, women and girls at risk represented 49% of refugees worldwide including asylum seekers, stateless women and internally displaced persons (IDP).\(^1\) (United Nation High Commissioner for Refugees [UNHCR], 2010b). Since 2007 the percentage of refugee women at risk\(^2\) has risen from 6.8% to 11.15% in 2011 (UNHCR, 2013). Resettlement is recognized as a key protection tool for refugee women and girls at risk to ensure protection and well-being, but only if their gendered specific needs are recognized and addressed (UNHCR, 2013).

Decades of state sponsored violence in Burma has resulted in wide human displacement of Karen ethnic minorities within Southeast Asia and abroad. In response to the growing refugee crisis, recognition of gender violence, Karen refugees from this region were identified by the United Nation High Commission for Refugees (UNHCR) and Citizenship Immigration Canada (CIC) as refugees in need of

---

1 Refugees are individuals who are considered to need protection under the United Nations High Commission for Refugees (UNHCR). Stateless persons are not considered under international law to be nationals of a particular state (UNHCR, 2010b). Internally displaced persons (IDP) are “individuals that have been forced to leave their homes in order to avoid armed conflict, violence and violation of their human rights but who have not crossed an international border” (UNHCR, 2010b, p. 35). Asylum seekers are refugees whose refugee status has not yet been determined but who also require protection for humanitarian reasons (UNHCR, 2010b). The UNHCR has the responsibility for identification and referral of refugees for resettlement world-wide. I discuss the implications of these identity formations in Chapter Two.

2 The UNHCR (2013) defines a refugee woman thus: “a refugee woman who faces threats to her safety and well-being that is unresolvable in her current location may be deemed to be a woman-at-risk requiring resettlement” (p. 5).
rapid and large scale resettlement. Between the years 2005-2009 the province of British Columbia (BC) received 4,026 government assisted refugees (GARs). The largest group of 786 represented Karen refugees from Burma [Myanmar], and 33% of this original group were destined outside of metro Vancouver, making them the largest refugee group in south west region of British Columbia (BC) (ISS of BC, 2010).

In 2002, Canadian immigration policies changed to reflect the growing demand for refugee resettlement, which resulted in the Immigration and Refugee Protection Act (IRPA). The IRPA represents a historical landmark in Canadian history because it resulted in the removal of barriers that historically limited the admission of immigrant groups into Canada, including those with complex chronic medical and psychological conditions and limited language and literacy ability and education. The IRPA has set the stage for a protection policy framework which could have direct implications related to the settlement and health care sectors designed to support and mitigate challenges faced by newly arrived refugee groups. In this context Karen women and families were recognized as a high-risk group since many came with long histories of colonial oppression, including limited access to education, and protracted camp situations (CIC, 2006; 2008).

---

3 GARs refer to government assisted refugees who also fall under the category of convention refugees. As discussed by Chambers and Ganesan (2005) “under the Immigration and Refugee Protection Act (IRPA) there are two main pathways through which refugees can become accepted as refugees in Canada: (1) the Refugee and Humanitarian Resettlement program, for people applying outside of Canada as "convention refugees", and (2) the In-Canada Refugee Protection Process, for persons applying from within Canada [such as] ‘asylum seekers’” (p.293). In this dissertation I use the short term GARs respectfully recognizing that I would not normally reference people in this way, i.e., this is for the purpose of brevity and conceptual understanding of categorization of refugee groups and their entrance into Canada.
A review of research studies suggests that refugee women’s mental health and well-being is related to broad intersecting factors associated with gender roles, social support, literacy and education and domestic violence (Mahler & Pessar, 2006; Mason & Hyman, 2008; Merry, Gagnon, Kalim, Bouris, 2011; Simich, 2009; Simich, Beiser, Mawani, 2003; Zanchetta, Kaszap, Mohamed, Racine et al., 2012).

Refugee women’s gendered experiences of migration and resettlement are qualitatively different than men’s, and socially determined by access to economic, health and other social resources in the receiving country (Beiser, 2009; CIC, 2006; 2008; Deacon & Sullivan, 2009; Guruge & Collins, 2008; Kirmayer et al., 2011; Oxman-Martinez & Hanley, 2011). Post migration, studies show that refugee mental health is socially determined by access to adequate housing, unequal job opportunities and pay, poverty, racial discrimination, and lack of linguistic support despite resettling in developed countries with better economic and social opportunities (Baya, Simich, & Bukhari, 2008; Beiser, 2005; 2009; CIC, 2008; Deacon & Sullivan, 2009; Porter & Haslam, 2005; Newbold, 2009; Morris, Popper, Rodwell, Brodine & Brouwer, 2009). In particular refugee women that are older, single and who are heads of households are identified as experiencing greater risk for health inequities during resettlement (Citizenship and Immigration Canada (CIC), 2006; 2008).

---

4 Health inequities are defined as inequities that are “socially produced; systematic in their distribution across a population; and unfair” (Health Inequities in British Columbia (HIBC): Discussion Paper, p. 17). Drawing on the definition from the World Health Organization, in the document ‘Health Inequities in British Columbia,’ health inequities are systemic differences resulting from differences among socioeconomic groups. Health disparities or inequalities are defined by differences in health status among individuals due to a genetic predisposition or behavior. Inequities can be further defined by ‘upstream’ systemic differences that ‘structure’ and shape “the differential vulnerability of people to health-affecting conditions and are powerful determinants of health”
Studies have also shown that refugee women are at greater risk for postpartum depression (PPD)\(^5\) (Ardiles, Dennis & Ross, 2008; Collins, Zimmerman & Howard, 2011; Kirmayer et al., 2011; Pottie, Greenway, Feightner, Welch et al., 2011). Structural barriers related to lack of adequate service provision, vis-à-vis language interpreters are one of the major barriers for health care access for refugee women and this has resulted in discriminatory health practices that socially exclude many refugee women from access to culturally safe\(^6\) health care provision (Johnstone & Kanitsaki, 2007; Merry et al., 2011, Mortensen, 2010). Access to employment and language skill differ between refugee men and women (Akhavan, Bildt, Franzén & Wamala, 2004; Khoo, 2010). In particular, government assisted refugee (GAR) women experience significantly greater challenges in resettlement in comparison with other migrant groups, due to low literacy levels in their original language (CIC, 2006; 2008). English language fluency (HIBC, 2008, p. 8). Downstream is often referred to the behavioral aspects of health (individual) where the individual is perceived to have some measure of control.

\(^5\) According to the American Psychological Association (APA) (2013) postpartum depression (PPD) is a “serious mental health problem characterized by a prolonged period of emotional disturbance, occurring at a time of major life change and increased responsibilities in the care of a newborn infant” (p.2).

\(^6\) Cultural safety is a concept that originated from nursing scholars in New Zealand. It is an approach to healthcare practice that addresses health inequities that have resulted from a processes of colonization. In response to addressing issues of cultural difference various frameworks and practices have been adopted by health care and social service providers in Canada. These frameworks include cultural sensitivity, cultural competence and to more critical approaches such as cultural safety. In this research I adopt a critical cultural approach which extends the culture focus beyond the individual and individual difference to a focus on power imbalances within social relationships that produce inequitable access to health and social services through discriminatory practices (Browne, Varcoe, Smye, Reimer-Kirkham et al., 2009). Gustafson (2008) argues, “cultural identities emerge from a dynamic interplay between micro-level relations ... and macro-level relations reflected in organizational policies and practices” (p. 40). I discuss theoretical underpinnings of cultural safety as an important approach for examining Karen women’s resettlement and access to healthcare in Canada in Chapters Two, Three and Four.
and unemployment are also significant predictors of depression amongst refugee women during resettlement placing less educated women and elderly refugees at greater risk for social isolation and psychological distress (Beiser, 2009; CIC, 2008; Chung & Bemack, 2002; Deacon & Sullivan, 2009; Hyndman & Walton-Roberts, 1999; Zanchetta et al., 2012). Even in contexts where refugees receive English as Second Language training in Canada, there is evidence to suggest that these training programs are insufficient to meet the demands of language skill required for employment, moreover language skill training is structured to facilitate the labour employability of men (Beiser, 2009, Hyndman & Walton-Roberts, 1998; Kirmayer et al., 2011; Sherrell, 2003). In addition, emerging research suggests that literacy and health literacy of minority women determines women’s access to social resources and health (Kickbusch, 2001; Peerson & Saunders, 2009; Simich, 2009; Rouhani, 2011; Zanchetta et al., 2012). Although critical scholars have drawn attention to broader systemic inequities experienced by immigrant and refugee women (Anderson, 2000; Anderson, Tang & Blue, 1999; Drennan & Joseph, 2005; Bannerji, 2000; Collins, Yogendra, Shakya, Guruge & Santos, 2008; Fung & Wong, 2007; Mawani, 2008; O'Mahoney & Donnelly, 2010), very little is known about Karen refugee women’s experiences of migration and resettlement in Canada. The purpose of this research was to conduct an in-depth study of Karen women’s perspectives on what they found had supported their resettlement process, including their access to health care services and social supports during their resettlement in Canada.

Moreover, evidence shows that even five years after resettlement, many GARs in BC continue to lack accessible health care services and social service
supports necessary for successful integration (Marchbank, Sherrell, Friesen, Hyndman, 2014; Rouhani, 2011). The second aim of this research was therefore to gain an in-depth understanding of the social and structural factors that facilitated and/or challenged the receiving community’s ability to promote Karen women’s mental health and well-being in the context of their resettlement.

1.2 Locating the Problem

The research problem that this study aims to address can be framed in two interrelated themes. First, equality and issues of distributive justice vis-à-vis distribution of services or resources does not address issues of equity and complex needs of refugee women. In addition, an ethos of liberal individualism and a climate of neoliberal economy have perpetuated marginalization of immigrant and refugee groups that come to Canada with limited skills for successful resettlement through mainstreaming of services and restrictive mandates to settlement policy (Creese, 1998; Geronimo, 2000; Marchbank, et al., 2014; Sadiq, 2004). Canadian multiculturalism, underpinned by values of liberal individualism and egalitarianism, assumes that all members of society have equal access to health care, social services and support, independent of social constraints (Anderson & Reimer-Kirkham, 1998). Although various options and strategies across Canada have been implemented to promote the mental health and well-being of refugee women during resettlement, including the development of community-based program initiatives that reduce cultural and linguistic barriers to care, establishment of immigrant refugee health clinics, delivery of health programming in refugee communities and
the use of outreach workers or cultural brokers\textsuperscript{7}, trends in settlement reflect neoliberal\textsuperscript{8} governance structures in which a market economy remains the main driver for the restructuring of health and social policy (Geronimo, 2000). The distribution of equitable, inclusive and accessible services and support varies between and within Canadian provinces. In BC, municipalities located at the periphery of metropolitan cities have been shown to have minimal capacity for equity-oriented services and supports for newly arrived refugee groups (Edgington & Hutton, 2000; Geronimo, 2000; Sadiq, 2004; Sherrell, 2003). Research related to equity oriented mental health and primary health care services has shown that relationally based governance structures in which non-dominant groups have a voice in developing policy, integration of social determinants of health\textsuperscript{9} through

\textsuperscript{7} Miklavcic & LeBlanc (2014) trace the genealogy of the term cultural broker from its anthropological origins to describe “a process of cultural contact in various contexts of domination, including trade, colonialism, nation-state building, and modernization” (p.117). In contemporary understanding cultural brokering in health care may vary and includes various levels of expertise that require mediation between different knowledges and perspectives. For example, “Categories of individuals who may act as culture brokers include health practitioners, nurses, social workers who function as cultural brokers by virtue of their bilingual/bicultural identity or direct knowledge of a specific community…” (p.117).

\textsuperscript{8} Smith (2005) defines neoliberalism as an ideological discourse based on “economic theories that stress the paramount significance of a free market for general prosperity; government is viewed as costly and inefficient; concepts of citizenship stress individual responsibility for economic well-being and so on” (p. 217).

\textsuperscript{9} In this research mental health is recognized as a construct that may have different cultural meanings amongst and within different cultures and ethnic groups. The World Health Organization (WHO) (2014) defines mental health and well-being broadly as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (para 3). The WHO further defines social determinants of mental health to include multiple social, psychological and biological factors including poverty, low levels of education, rapid social change, gender discrimination, social exclusion, risk of violence, physical ill health and human rights violations as associated with poorer mental health.
inter-sectoral collaboration, advocacy and long term funding partnerships are needed in order to promote health equity of vulnerable groups (Creese, 1998; Lavoie, Browne, Varcoe, Wong et al., 2014; Mental Health Commission of Canada (MHCC, 2009); Geronimo, 2000).

Moreover, growing inequities are perpetuated by discursive practices – which construct stereotypes and position refugee groups as a threat to public safety. Scholars have drawn attention to how racialization\textsuperscript{10} serves to portray the ways in which dominant culture constructs race and conceptualizes issues of migration, in a pre-occupation with national security (Bradimore & Bauder 2011; Kirmayer, 2007; Tomasso, 2012). In turn, dominant discourses are embedded in broader social and geo-political processes that shape policy related to minority health.

Secondly, dominant Western discourses have constructed refugees as traumatized victims, dependent and vulnerable (Marlow, 2010; Pupavac, 2008; Malkki, 1995). Although many refugee women experience trauma pre-migration, studies suggest that 80\% of refugees do not go on to experience psychological conditions such as post traumatic stress disorder (PTSD) (Pottie, Greenaway, Feightner, Welch et al., 2011). Rather, evidence suggests that over time refugee

\textsuperscript{10} Racialization in this research is used to mean “a relationship based on power—the power to define, contain and neutralize and other. Other is not a neutral category, but is understood as inferior, and the process of Othering is a process whereby the inferior position is sustained” (Berman & Jiwani, 2008, p. 138). A particular form of othering is racialization. According to Tomasso (2012), “racialization is a process whereby race is constructed and negotiated according to systems of power in specific temporal contexts and places.”(p.332). I employ the terms racializing or racialization as does Tamasso, as a non static term and where connotations of race are not based on a phenotype but where “notions of whiteness and discourses of racialization are fluid, and always changing over time and in relation to others.” (Tomasso, 2012, p.332). It can be argued that the outcome of racialization produces multiple forms of marginalization and othering through various economic, gendered and political discourse.
groups experience systemic forms of *Othering*\(^{11}\) based on race, gender and class differences which determine poorer health outcomes (Beiser, 2005; 2009; Kirmayer, Narasiah, Munoz, et al., 2011). These findings open up space from which to re-examine the complexity of trauma beyond individual and pre migratory events (Lester, 2013, Marlowe, 2010).

Reducing refugee women’s barriers to accessing health, social services and supports to cultural differences mask the systemic inequities that are embedded in histories of colonialism\(^{12}\) and ongoing dominant cultural practices that fail to integrate social determinants of refugee women’s mental health. For example, culturalism\(^{13}\) often evoked in multicultural societies is used to address issues of

\(^{11}\) Grove and Zwi (2006) conceptualize *Othering* as a process of differentiation that “defines and secures one’s own identity by distancing and stigmatizing an (other). Its purpose is to reinforce notions of our own “normality”, and to set up the difference of others as a point of deviance.” (p.1933). The outcomes of this process lead to marginalization, disempowerment and social exclusion (Grove & Zwi, 2006). However, Canales’ (2000) foundational work on othering suggests that othering can be both inclusive and exclusive processes whereby exclusionary othering utilizes the power within relationships for domination and subordination. Conversely, inclusionary othering attempts to utilize power within relationships for transformation and coalition building (Canales, 2000). Othering therefore occurs within multiple levels and social contexts, both within interpersonal relations (micro) contexts as well as broader (macro) levels such as institutional health and social policy.

\(^{12}\) Colonialism is a term used to define a “specific form of cultural exploitation that developed with the expansion of Europe over the last 400 years” (Ashcroft, Griffiths, & Tiffin, 2000, p.40). However Aschcroft et al. go on to note that “European colonialism in the post-Renaissance world became a sufficiently specialized and historically specific form of imperial expansion...as a distinctive kind of ideology” (p.40). Post-colonialism originally described the post-colonial state referring to post-independence period (Aschroft et al., 2000). The term post-colonial is now widely used in diverse ways to not only study European conquests but also to study the impact of European imperialism and as such is concerned with “the process and effects of, and reactions to, European colonialism from the sixteenth century up to and including the neo-colonialism of the present day” (Aschcroft et al., 2000, p.169).

\(^{13}\) Browne, Varcoe, Smye, Reimer-Kirkham et al. (2009) define culturalism as a process in which people are viewed through constructions of culture “defined narrowly as shared values, beliefs and practices, and often conflated with ethnicity” (p.10). In a similar vein I argue that the construction of
diversity and refugee women’s lack of access to mental health care services. These explanations obscure the impact of structural factors on refugee women’s health. However, studies show that while beliefs and values about cultural practices may determine different explanatory models about illness and health, health care practices are also structured by “culture” (Fernando, 2010; Fung & Wong, 2007; Kirmayer & Minas, 2000; Kirmayer, Lemelsen & Barad, 2007). The lack of access to health and social services for refugee women has been linked to systemic violence embedded in institutional structures and practices that undermine and socially exclude refugee women, which results in unequal opportunities (Oxman-Martinez & Hanley, 2011).

Nurses are at the forefront of delivering public health and primary health care services in the context of local communities in which refugee groups are resettled. However broader structural sociopolitical, historical and economic factors have increasingly constrained the distribution of equitable health and social resources, challenging nursing’s ability to uphold its broader mandate of social justice. Nursing scholars have drawn attention to the need to examine various dimensions of social identity (race, gender and class) of migrant women within broader ecological contexts (Collins, Yogendra, Shakya, Guruge & Santos, 2008; Guruge & Khanlou, 2004; Guruge & Collins, 2008) and advocate for a comprehensive framework that is responsive to the holistic and gendered aspects of refugee women’s mental health and well-being during resettlement. However, a holistic

---

refugees as traumatized victims stems from dominant cultural frameworks that work to narrowly define trauma as only embodied by refugee groups.
response requires an analysis of broader structural processes that are rooted in differential power relations experienced by refugee women and specific historical contexts including the social and structural aspects of community that shape women’s mental health and well-being. This research contributes to advancement of nursing knowledge of refugee care in that it draws attention to historical, sociopolitical and economic contexts that structure refugee identities and the factors that shape gender in the context of resettlement. Examining Karen women’s experiences of resettlement and the intersecting factors can inform nursing practice and policy in Canada and promote social justice.

It is predicted that immigration will increase by 58% in BC; particularly in suburban communities that have not traditionally experienced rapid influx of diverse groups who come with linguistic barriers and complex health and settlement needs (Edgington & Hutton, 2000). GARs will increase to 8,000 within 36 communities across Canada, including 13 communities in the Province of Quebec, (Sherrell, Friesen, Hyndman & Shrestha 2011). This trend suggests that there will be increased demand for primary health and mental health services to promote equitable responsibility in receiving communities to accommodate the needs of diverse refugee women and families, who arrive with high needs, and increasing demand for settlement and health resources. Because of an increased emphasis on social determinants of health and primary care, the Canadian Nurses Association (2010) has advocated for an urgent call to pursue research and practice that promotes the aims of the social mandate in nursing, underpinned by a social justice agenda.
1.3 Research Purpose and Objectives

The purpose of this research is to examine community capacity to support Karen refugee women’s mental health and well-being in the context of resettlement in British Columbia, and to understand the social and structural processes that impact the mental health and well-being of Karen women, the factors that intersected to support their resettlement process and the ways the community was able to respond to their resettlement needs.

The specific research objectives of this study were to:

1. Explicate, from the perspective of Karen women, those aspects of suburban community and mental health and social services and supports that facilitated and/or challenged their resettlement process.

2. Explain, from the perspective of health and service providers, the social and structural factors that facilitated and/or challenged community capacity to support the resettlement and mental health and well-being of Karen refugee women in a suburban context, including their access to mental health services and supports.

3. Use the findings of the study to make recommendations regarding the social and structural aspects of community capacity to inform related health and social policy and practice on what promotes mental health and well-being of Karen refugee women.
1.4 Organization of the Dissertation

Having introduced the background to the research problem and specific objectives of this study in chapter one, I now turn to the outline of this dissertation. This outline is premised on an empirical body of evidence that suggests refugee women’s mental health and well-being is shaped by multiple social intersecting factors during resettlement.

In chapter two I situate the study against a backdrop of international political, social and historical policies and processes that shape refugee migration and identity. I then discuss the historical and social context that necessitated the mass resettlement of Karen women and families to BC. In particular I discuss what is known about community capacity in relation to settlement and health of government assisted refugee women in BC. I discuss community capacity as an important construct to understanding social and structural aspects of community. Drawing on constructs of social capital and critical public health I foreground the social and structural factors necessary for promoting mental health and well-being of vulnerable groups including Karen women. In the remainder of chapter two, I discuss how racializing discourses reinforce and construct refugee groups as Other which adds to exclusionary health and social practices. I draw attention to broader definitions of culture beyond individual values, beliefs and practices and link this with the construct of structural violence; dominant cultural practices and policies within societal institutions may unwittingly cause harms and potential re-traumatize refugee women and families that come to Canada seeking protection. I
follow this discussion with a cultural critique of dominant constructions of trauma and the related empirical evidence.

In chapter three I discuss the theoretical underpinnings of critical theoretical perspectives and link them with postcolonial feminist theory, tenets of intersectionality and cultural safety. I discuss the integration of these approaches as fitting with feminist scholarship that seeks to promote research in nursing with the overall aims of social justice. I also draw on tenets of intersectionality to discuss potential axes of inequities that are related to refugee women. I discuss the epistemological and ontological underpinnings of cultural safety as congruent with postcolonial feminist theory and intersectionality in foregrounding subjugated voices that have been historically marginalized. I then discuss cultural safety as a viable lens for examining unequal power relations between Karen women and health and social service providers as well as broader macro institutional contexts. Following this I discuss how I employed critical ethnography and Smith's (2005) standpoint method of inquiry to understand from the subjective positions of Karen women what they found supported their resettlement. Fitting with aims of social justice work I then discuss the inherent tensions in conducting research with emancipatory aims and the key elements I used to guard against validity threats. I end this chapter with a discussion of ethical considerations for conducting research with Karen women and the limitations of this research.

In chapter four I foreground Karen women’s voices and present findings from the standpoint of Karen women related to what they perceived as supportive to their resettlement. In this chapter I draw attention to how policies and practices
constrained Karen women’s agency, reinforced women’s dependency and created situations for increased vulnerability and safety risk. I also discuss how gender intersected with language and access to education produced advantage and disadvantage between Karen men and women.

In chapter five I provide a more in-depth contextual analysis of the process of resettlement of Karen women and families from the perspectives of health care and social service providers. This analysis provides another analytic lens with which to explore structures and social processes of community capacity. In particular, I highlight how settlement reforms increased barriers to health access and worked to shape inefficient health and settlement practices. I then discuss how coalitions of community capacity building often provided by faith based volunteer groups, worked to identify service gaps, promote health literacy and build collaborative partnerships to support the mental health and well-being of Karen women.

In the sixth chapter I provide the overall tenor and key themes that emerged from the data. I further discuss the forms of structural violence and the effects of Karen women’s identity in relation to vulnerability and dependency. I draw attention to how systemic forms of discrimination vis-à-vis lack of professional language interpreters, and immigration policies related to higher English language attainment worked to socially exclude Karen women and deny them full citizenship. I also discuss how funding arrangements underpinned by neoliberal ideologies of efficiency and time intersect with notions of multiculturalism at the expense of addressing structural factors that impacted the health and well-being of Karen women. I close this chapter with an overview of what worked to support Karen
women’s mental health and well-being, including aspects of social capital that promote mental health and well-being of Karen women. Health literacy intersected with education and gender to increase literacy and access to health and social services.

I dedicate the final chapter to highlighting the need to expand the definition of social justice in order to decrease structural inequities and enhance settlement and primary health care provision for Karen women, other minority women and families. I argue that promoting community capacity must integrate culturally safe, and trauma- and violence- informed responses in order to promote social justice and decrease health and healthcare inequities. This includes increased advocacy by NGOs as well as nurses practicing across and within primary healthcare and public health services. I conclude with recommendations for future research and some methodological reflections.
2. BACKGROUND AND LITERATURE REVIEW

2.1 Introduction

The overall purpose of this literature review is to present an overview of the existing literature pertaining to community capacity and the social and structural factors that shape refugee women’s mental health and well-being in the resettlement context. In conducting the literature review I searched the following data bases: Medline (OvidSP), CINAHL (Ebsco), PsychINFO (Ebsco), Women’s Studies International (Ebsco), Cochrane Database of Systematic Reviews, Database of Abstract of Reviews of Effects (DARE) and Web of Science. Initial academic search terms included: women, gender, inequity and/or disparity, mental health and refugee and/or displaced. A second review was done in order to focus on studies that specifically examined community capacity in relation to refugee women and resettlement, using the following key words: community capacity, social capital, refugee women, and resettlement. Much of the research literature examining the mental health and well-being of refugee women is limited. Therefore, I have also included articles on immigrant women. Where possible I reviewed what is known about refugee women in relation to resettlement and mental health specifically. I also searched bibliographic references for all the evidence-based articles that I reviewed.

I reviewed both academic and web-based resources pertaining to settlement and health care policies and practices in Canada and BC. This included a review of Governmental web sites including Citizenship Immigration Canada (CIC) and web
based resources pertaining to settlement in BC such as Welcome BC and ISS of BC. The majority of studies reviewed fell within the years 1999-2011.

I begin the story of Karen refugee migration in the context of the broader processes that shape migration and resettlement of refugees, in particular I draw attention to the social context of resettlement, and the factors that shape identity, mental health and well-being by shifting the gaze to structures, i.e. institutional policies of immigration and what actually happens in practice. In this review I examined policies and practices and the structures to foreground gaps in service provision and potential factors that promote greater service integration and support for refugee women in Canada.

To situate this study in a wider historical, socioeconomic and political context, I felt it was important to first describe the historical and political climate in which refugee groups have been categorized; this categorization has implications for global resettlement policy and distribution of health care resources once refugees are resettled by nation states. I briefly discuss the categorization of refugee discursive practices against the backdrop of humanitarian policies which fail to capture the diversity of refugee experiences but also a systemic failure in ensuring safety and protection of groups deemed vulnerable by sociopolitical and historical processes. Following this I review outcome studies on various refugee groups, settlement and health practices in BC, as well as international reviews on the effects of migration and refugee women’s health. I conclude this chapter with summary and key reflections of the literature including gaps in evidence and what this study
contributes to the discipline of nursing policy and practice in relation to refugee women’s mental health and well-being.

2.2 Globalization, Transnationalism and the Construction of Refugee Identity

The categorization of refugee is not a neutral process and is historically influenced by wider political, global bureaucratic and social processes (Malkki, 1995; Pupavac, 2006; Zetter, 2007). In mapping out the genealogy of the birth of the “refugee,” Malkki (1995) argues that although there may be justification for categorization, there is no proto-refugee of which the modern refugee is a direct descendant. Moreover, the category of refugee does not represent a homogenous grouping or single representation of forced migration patterns of any group. Hyndman and Walton-Roberts (1999) observe that the concepts of “immigrant” and “refugee” are defined by juridical and political apparati of national governments, premised upon the territoriality of nations... a refugee is defined as one who is outside the borders of her nation-state due to violence or persecution, and displaced from what has become the centered norm of citizenship or placement within her country, in contrast an immigrant is seen to replace one nationalist identity with another (p. 6).

Prior to World War II (WWII), mass migration of refugees in the west was rooted in religious exile where protestant groups fled to neighboring European countries. The categorization of people who are oppressed and hunted first appeared “in the 17th century [when] Louis XIV cancelled the Edict of Nantes, thereby giving the Catholic majority of France carte blanche to turn on the Protestant minority whose rights the Treaty had guaranteed” (Beiser, 2009, p. 540).
This revocation of the Edict of Nantes stopped the protection of the religious rights of French Protestants also called Huguenots. Beiser (2009) further explains that those Protestants who escaped persecution later “became known as ‘refugees’ in Holland, Germany, England and later, North America” (p.540). However, it was not until after World War II that a new dimension to the concept of refugee resulted in a socially shared responsibility and legal imperative (Beiser, 2009). Malkki (1995) discusses the category of the refugee as “built on a whole history of differences, not only of race, class and world region, and historical era but of different people’s very different entanglements with the state and international bureaucracies that characterize the national\textsuperscript{14} order of things” (p. 513). Post WWII techniques for managing mass displacement of people first became standardized and then globalized (Beiser, 2009; Malkki, 1995; Zetter, 2007).

Globalization and the process of human displacement led to the development of refugee camps as a legal domain and generalizable technology of power (Malkki, 1995). Technologies of power were linked with earlier forms of confinement such as quarantine and concentration camps in which the refugee was marked and controlled by the military through spatial concentration and ordering of people throughout Europe (Malkki, 1995). International refugee law and related legal definitions resulted in the Universal Declaration of Human Rights in 1948 and the

\textsuperscript{14} By national order of things, Malkki (1995) is referring to the fact that refugees “do not constitute a naturally self-delimiting domain of anthropological knowledge” (p. 496). Rather, the label of refugee is embedded within bureaucratic and international humanitarian realm. Thus the term ‘refugee’ has “analytic usefulness not as a label for a special, generalizable ‘kind’ or ‘type’ of person or situation, but only as a broad legal or descriptive rubric that includes within it a world of different socioeconomic statuses, personal histories, and psychological or spiritual situations” (Malkki, 1995, p. 496).
subsequent 1951 United Nation High Commissioner for Refugees (UNHCR). The UNHCR (2010a) *Convention and Protocol Relating To The Status of Refugees*, defines refugee under the Geneva Convention 1951 as someone who “is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion” (p. 3).

Pupavac’s (2006) historical analysis of humanitarianism suggests that despite the formation of the UNHCR as being the formal advocate for the global refugee crisis, human rights are increasingly interpreted within a wider international stage, where increasingly refugee concerns are mitigated through the international community, e.g., nation states and their approved Non-Government Organizations (NGOs) (Pupavac, 2008). The Geneva Convention, as cited in the UNHCR, represents international law pertaining to the human rights of refugees and their need for protection. However, as Malkki (1995) explains, “the widely cited definition of what constitutes a refugee was only intended to address the European refugee situation (covering events occurring before January 1, 1951) and not refugees as a universal phenomenon” (p. 501). Similarly, Pupavac (2008) critiques the sanctity of the 1951 Refugee Convention by stating that the main drivers of the Convention were European dissidents after WWII and where national European interests welcomed migrant labour and Western preference for European refugees. In a recent inaugural address to the UNHCR, Friesen (2013) noted there are currently “45 million displaced persons worldwide and the number of places for UNHCR submissions sits at 86,000 representing approximately 1/8 actual need” (p.
Although countries with strong economies are more capable of absorbing and supporting refugees, only 2 million refugees were received by developed nations (19%) with more than 38% of refugees residing in Asia and the Pacific region in comparison to 8.5 million (80%) refugees received by developing countries (UNHCR, 2010). This suggests that global policies, including those such as the UNHCR, have less influence over nation states’ interests in resettling refugees. Pupavac’s (2006) central argument rests on the fact that refugees are no longer greeted as members of a political community in another country. This has led to exclusion of refugees and construction of refugees as lacking capacity to determine their own interests. The issue, as Pupavac (2008) discusses, is that “refugees as a category needing protection do not enjoy the protection of citizenship or the rights that flow from political membership” (p. 3).

Likewise, Zetter (2007) has argued that the labeling of refugee is a highly politicized reproduction of institutional fractioning embedded in a wider political discourse of resistance to migrants and refugees which has significant material and political consequences for refugees in the context of displacement and resettlement (Tomasso 2011; Zetter, 2007). Zetter (2007) discusses that in the past political discourse on refugees focused on rights and entitlements. Now, the analysis of labeling as public policy practices show how this discourse is preoccupied by notions of identity and belonging embedded in debates about citizenship and the Other in an era of global migration (p. 190).

Similarly, Kirmayer (2008) further argues that the creation of nation states has mapped the world in terms of citizenship, giving everyone a place where they legally belong. This
creates the possibility of being pushed aside by the state into an ambiguous place where individuals do not belong to the land on which they stand (p. 18).

In the context of resettlement, global processes are decentered from national territories (Hyndman & Walton-Roberts, 1999). Grove and Zwi (2006) add that the process of asylum and resettlement do not necessarily guarantee membership or a sense of belonging. In response to the current mass flow of migration and refugee crisis, bureaucratic labels are made to differentiate categories of eligibility and entitlements in the state’s interests. Thus, labels do not exist in a vacuum, rather as Zetter (2007) notes “they are the tangible representation of policies and programs, in which labels are not only formed but transformed and differentiate categories of eligibility and entitlements … instrumental practices and interests of the state” (p. 180). Bauder (2013) further argues that “nation states exercise significant control over the international mobility of people through laws, policies and policing practices” (p. 57) and shape identities through the maintenance of material differences, that afford some migrants citizenship, access to resources and protection and expose others to economic exploitation and political marginalization. For example, the refugee label has resulted in distinguishing between the deserving refugee such as those who are government assisted to enter into Western countries while “asylum seekers” must prove their need for asylum and refugee status as per the Geneva Convention.

Zetter maintains that “labels such as asylum seeker transform identity into something which conforms to the politicized image of the label – destitute,
dependent, above all an alien because they have no right to belong” (p. 186). He also argues that globalized processes and patterns of forced migration in the contemporary era were shaped by refugee crisis, regionally contained in the global south during the 1970s and 1980s, “as a proxy for wider geostrategic and post-colonial conflict” (Zetter, 2007, p. 175). Malkki (1995) observes that

the period of rapid decolonization in the 1960’s saw a watershed period in the modern phenomena of refugees and refugee settlement practices … [and the emergence of refugees as a Third World problem] (p. 503).

However Malkki also contests that “if we accept that poverty, political oppression, and the mass displacement of people are all global or world-systemic phenomena then it becomes difficult to localize [refugees to the] Third world” (p. 503).

Moreover, contemporary forced migration may be the result of more subtle forms of persecution which, “reflect a less categorical interpretation of the label … minority groups [including women] are persecuted through insidious forms of social, political, and economic exclusion, often without explicit violence and over protracted periods” (Zetter, 2007, p. 177). For example, Zetter has drawn attention to conditions of injustice where prolonged socioeconomic exclusion of ethnic minorities has created sufficient reason for refugees and asylum seekers to flee against the backdrop of economic globalization.

Another thematic tendency regarding refugee identity is the contemporary “prominence of psychological interpretations of displacement” (Malkki, 1995, p. 509). Marlowe (2010) has argued that
while having this [refugee] status affords a number of rights from countries signatory to the 1951 UN convention, the concept of “refugeehood” within resettlement contexts can become a master status that defines a person above and beyond any other form of identity (p. 184).

Pupavac's (2006) historical analysis of refugees in the ‘sick role” sheds light on the west’s tendency to construct refugees as traumatized victims. Pupavac observes that in the 1980’s reports from Cambodian, Vietnamese, and Latin American refugees and holocaust survivors began to stimulate American interests in psychological conditions such as post traumatic stress disorder (PTSD). As she writes, “contemporary concern for refugee health involves a changed perception of refugee identity from refugee as political exile to refugee as patient, casting refugees in the sick role” (p. 20). Informed by Parson’s theory of permissive empathy, Pupavac argues that the refugee as patient presents a double-edged sword: on the one hand constructing refugees as victims depoliticizes their need for migration and self-determination, and on the other, refugees become the object of professional management with no greater rights. In addition, Pupavac suggests that states govern refugee access to social resources and support in resettlement as a form of institutional control embedded in discourses of pathology:

Even non-health refugee programmes may represent a form of therapeutic governance. Employment training programmes or other integration programmes such as youth or gender empowerment classes are often not so much practically oriented towards direct job related skills but life skills, essentially emotional management directed towards their self-esteem, interpersonal relations and attitudes (2006, p. 20).
This form of governmentality\textsuperscript{15} in the guise of permissive empathy obscures power relations between refugees and professionals and creates a relationship of dependency which undermines individual autonomy (Pupavac, 2006). In a similar vein, Malkki (1995) points out that discourse of development has colonized refugee issues, and that other intellectual or political connections have been erased. Drawing on Malkki (1995), Sampson and Gifford (2010) suggest that essentialist understandings of refugee identity run the risk of perpetuating the marginalization of refugees as outside of their “natural place” and viewing displacement as pathological.

This does not negate the fact that many refugees experience significant distress and, as Malkki argues, 

\begin{quote}
we cannot assume psychological disorder or mental illness \textit{a priori}...nor can we know the actual sources of a person’s suffering.
\end{quote}

\textsuperscript{15}According to Gordon (1991) the French philosopher Michel Foucault coined the term governmentality to mean the “...a form of activity aiming to shape, guide or affect the conduct of some person or persons” (p.2). Government in a broad sense concerned “the relations between self and self, private interpersonal relations involving some form of control or guidance, relations within social institutions and communities and, finally, relations concerned with the exercise of political sovereignty” (Gordon, 1991, p.3). For Foucault, the term governmentality was historically situated in three things including 1) “the ensemble formed by institutions...that allow the exercise of very specific...complex form of power, which has as its target populations, as its principal form of knowledge political economy, and as its essential technical means apparatuses of security; 2) the tendency which, over a long period and throughout the West, has steadily led towards...all other forms (sovereignty, discipline, etc.) of this type of power which may be termed government, on the one hand, in the formation of a whole series of specific governmental apparatuses...;3) The process, or rather the result of the process, through which the state of justice of the Middle Ages, transformed into the administrative state during the fifteenth and sixteenth centuries, gradually becomes ‘governmentalized’. (p.102-103). Originating in theological foundations, Holmes and Gastaldo (2002) discuss a particular aspect of governmentality, pastoral power. Pastoral power is mediated by caring professions, including nursing, which simultaneously manage, control and survey populations as well as provide therapeutic governance. In a similar vein Pupavac (2006) argues that emotional management of refugees is governed by disciplinary techniques that reinforce normalcy and dependency.
This does not mean ...that health professionals have nothing to say or do about refugees and [effects] of displacement...many refugees have survived violence... [However] we mustn’t assume that refugee status in and of itself constitutes a recognizable, generalizable psychological condition (1995, p. 510).

In the current context of globalization and changing patterns of human displacement, refugee identity is shaped by cultural constructions that coalesce around health and human rights (Pupavac, 2006). For example Pupavac argues that the construction of refugees as traumatized may dramatize their suffering and underscore the validity for their claims for asylum, but casting refugees in the sick role problematizes the capacity of refugees to determine their own interests and tends to legitimize the external management of refugees (2006, p. 24).

External management can be framed within a sociocultural context where “the universality of human rights demands careful attention to the social contexts of potential application and the hidden agendas of powers that may use the claims of culture to justify their oppression” (Kirmayer, 2008, p. 3). Culture in this way is viewed not as narrowly defined by ones values and beliefs but as a complex construct embedded in relations of power (Dirks, Eley & Ortner, 1994). A static categorical approach to refugee identity leaves out and/or ignores broader cultural values that serve hegemonic political and economic interests of the state (Kirmayer, 2008). In a similar way, contemporary understandings of trauma are understood not only as they are linked with the predicament of refugee migration but also, as Kirmayer argues, “violence is embedded in the structures of most receiving societies
[and] indeed the mental health outcomes of migration depend on the quality of reception by the host society" (Kirmayer, 2007, p. 377).

From another perspective the substantive changes in refugee migration have been attributed to a growing gap between the Geneva Convention definition of refugee and contemporary understandings of those seeking refuge. Contesting territorial boundaries, Sampson and Gifford (2010) have argued that globalized contexts have opened up new dialogues regarding people, place and identity. These authors suggest that “non-essentialist understandings of identity and connection to place have challenged the commonly held assumption that once a refugee always a refugee” (p. 117). Sampson and Gifford further argue that identity is framed in a world that continues to distribute rights and social membership along territorial boundaries and therefore

the relationship between people who become refugees and place is a position somewhere in between: one that recognizes the strong sense of connection to places left behind and their associated traumas while at the same time recognizing the possibility of constructive (re)-building of connections to place within a context of resettlement (2010, p. 117).

Similarly, Sherrell (2003) observes, contemporary understandings of refugee identity have abandoned essentialist and gender blind constructions of refugee in favour of a more fluid and dynamic understanding of refugee identity. In this regard, transnationalism is a useful analytic concept that recognizes the multiple identities and cross border connections refugees have. In short, transnationalism16 is about

16 Hyndman and Walton-Roberts (1999) explicate the definition of transnationalism as “constituting distinct social, cultural, political and economic spaces, which do not adhere to straightforward categories of nation, class, ethnicity and gender” (p. 4). These authors argue that transnationalism
identities with multiple places (Hyndman & Walton-Roberts, 1999). Hyndman and Walton-Roberts (1999) make salient the notion of belonging for refugees who arrive in Canada under extenuating circumstances and where “people whose sense of identity is defined by collective histories of nation, culture, as well as shared visceral geographies of displacement and violent loss, do not simply forget or abandon these connections upon arrival in a new country” (p.25).

Sherrell (2003) outlines several ways in which transnationalism impacts refugee resettlement. These include activities such as economic remittances, ongoing political involvement with sending nation and ongoing social relations across territorial boundaries of resettled states. Sherrell observes that it is only recently that scholars have paid attention to gender\textsuperscript{17} and gendered relations as a central axis of analysis related to refugee men and women in resettlement. Sherrell argues that

\begin{quote}
it is impossible to consider the process of resettlement without considering the ways in which gendered relations shape it ... [rather] settlement entails the negotiation of identities, roles and relations between women and men, some of which may be in conflict with gender ideology in the country of origin ... consequently, relations and
\end{quote}

extends from diaspora where transnationalism does not presuppose a territory defined by geopolitical lines. Similarly, Faist (2010) suggest that while both transnationalism and diaspora are prominent lenses through which to view the aftermath of international migration and the shifting of state borders across populations, “diaspora has been often used to denote religious or national groups living outside an (imagined) homeland, whereas transnationalism is often used both more narrowly—to refer to migrants’ durable ties across countries—and, more widely, to capture not only communities, but all sorts of social formations, such as transnationally active networks, groups and organizations” (p. 9). Both transnationalism and diaspora however, “refer to phenomena that occur within the limited social and geographical spaces of a particular set of regions or states” (Faist, 2010, p. 9).

\textsuperscript{17} In this research gender is defined as “a process that operates on multiple spatial and social scales (e.g., the body, the family, the state) across transnational terrains” (Pessar & Mahler, 2003, p. 815).
identities in both the countries of origin and resettlement influence identities formed during resettlement (2003, p. 9).

Refugee migration has led to increased debate about nationalism, construction of identity and human rights. Globalization and colonialism are salient to the constructions of refugee identities and point out the need to examine universal human rights across national boundaries and territories. However, the intersections of gender and migration have not adequately been explored in the plight of refugee women. Discursive practices also shape refugee identities and consequently impact national resettlement policies in Canada. In the following I briefly outline how current discourses constructed refugees in the context of Canadian immigration.

2.3 An Overview of the Discourses and the Sociopolitical Historical Context of Canadian Immigration

Before embarking on an examination of Karen women’s resettlement in Canada, and the contexts that led to their resettlement it is important to discuss the broader sociopolitical and historical context of Canadian immigration as this provides a background for how health and social policies are structured within the framework of multiculturalism. Multiculturalism has been described as an important part of Canada’s identity (Strong-Boag, Grace, Eisenberg & Anderson, 1998; Tomasso, 2012). Multiculturalism is underpinned by a pluralist ideology which reflects a model of citizenship that values diversity and cultural difference while at the same time espouses respect for justice under a collective Canadian
citizenry which seeks common interests based on general human rights (Brascoupe & Waters, 2009).

However, critical scholars have come to question Canada’s explicit ideology of multiculturalism as a model of citizenship which valorizes diversity and simultaneously espouses a collective Canadian identity. Prior to Canada’s adoption of an explicit ideology of multiculturalism, Anderson and Reimer-Kirkham (1998) have argued that the period of colonization “was critical in constructing the Indigenous peoples of Canada as savage, other, and inferior, and it had disastrous effects on health, beginning with early pandemic infectious disease (such as smallpox and typhus brought by European explores and settlers) and continuing to today’s higher morbidity and mortality” (p. 245). Alterity (otherness) is the social condition that frames people or groups as other, and the moral stance that allows us to recognize, respect and value diversity as a positive resource for individuals and society without shying away from the ways in which culture and difference are used to stereotype and oppress people or divert attention from various forms of structural violence18 (Kirmayer, 2012, p. 159).

Eisenberg (1998) has observed political ideologies vis-à-vis Canadian multiculturalism have not upheld the obligation to rights of Aboriginal people:

---

18 Structural violence is a complex term that can be taken to mean a violence that is exerted systematically and indirectly by a particular society (Farmer, 2004). Galtung (1969) defines structural violence as a corollary to social injustice. This form of violence is built into social and political economic systems where resources are unevenly distributed, as when income distributions are heavily skewed, literacy/education unevenly distributed and, medical services exist in some districts and for some groups only; above all the power to decide over the distribution of resources is unevenly distributed. The situation is aggravated further if the persons low in income are also low in education, low in health, and low in power, as is frequently the case because these rank dimensions tend to be heavily correlated.
While the cultural values reflected in the representative system have excluded many cultural minority groups in Canada, the treatment of Aboriginal peoples is unique, partly because of the many treaties signed between Aboriginal peoples and the Government of Canada that state or imply that Aboriginal societies will co-exist with non-Aboriginal society and be protected from the latter’s influence. In spite of the explicit understandings reflected in the treaties, the Canadian government has vigorously pursued policies to assimilate Aboriginal peoples against their will (1998, p. 48).

These historical processes have implications for the ways in which various minority groups are positioned in Canada. From a historical perspective, Satzewich and Liodakis (2010) add that Canada’s immigration policy was developed out of obstacles amongst colonial relations with First Nations people, and in light of the fact that “European authorities felt that their [Aboriginal] culture did not translate well when economic priorities shifted to the requirements of commercial agriculture and capitalist industry” (p. 47). Processes of assimilation have reinforced the construction of Canada as a white eurocentric nation (Abu-Laban, 1998; Anderson & Reimer-Kirkham, 1998; Tomasso, 2012).

Between the years 1896 and 1905, large numbers of immigrants were settling in Canada from the United Kingdom, Europe and the United States, primarily to promote industrial growth and building of nationhood (Satzewich & Liodakis, 2010). However, the Immigrant Act of 1910 prohibited entry of foreigners

---

19 The terms ‘settler and settlement’ cannot be divorced from their historical meaning in the Canadian context. In order to talk about resettlement there is a need to address its origins of European and Euro-American colonialism. The process of settlement of newcomer groups is understood “not in old terms in which the settler is conceived as an empowered agent remaking the land into something new, but in the new terms in which the existing society is conceived as an already settled entity and the newcomer is figured as someone who has to adjust to that society in order to become settled” (Kataoka & Magnusson, 2007, p. 4).
who were not deemed to have mental fitness for settlement (Satzewich & Liodakis).

As Beiser (2005) discusses, the “sick immigrant paradigm” reflected the values and beliefs of Canadian society, in which immigrants were viewed as carriers of disease or as people who were afflicted with mental health problems. Based on these beliefs, Canada expelled approximately 10,000 immigrants annually between the years 1900 and 1940, and in addition some 1,000 immigrants were expelled specifically for psychiatric reasons alone (Beiser). Pre WWII, Chinese immigrants were encouraged to come to Canada since contractors were looking for cheap labor to build Canada’s transcontinental railroad (Satzewich & Liodakis). For example, in BC, out of concern for competition in the labour market, government tried to resolve labour conflicts by enforcing the “Chinese head tax” in which Chinese male and female workers and family members had to pay the government when they arrived in Canada (Satzewich & Liodakis).

In 1952 the Immigration Act continued to prohibit people from entry into Canada based on nationality, ethnic group, and poverty as well as educational, health or other conditions (Satzewich & Liodakis, 2010). However, immigrants who

---

20 Beiser (2005) discusses three general paradigms related to immigrant and refugee health. The “sick immigrant paradigm proposes that it is the least healthy and well-adjusted people who choose to emigrate from their home countries of origin” (S31). The healthy immigrant paradigm suggests that in general, immigrant health slowly worsens over time to match Canadian born populations, this is also referred to as “healthy immigrant effect” (Beiser). Beiser proposes that neither of these paradigms address the complexity of factors that shape mental health and overall health in the post migration/resettlement context. This is in part due to the great heterogeneity within migrant groups and the contextual factors that shape mental health during resettlement. Beiser proposes a third paradigm called the convergence model in which “exposure to the physical, social, cultural and environmental influences in a destination country sets in motion a process in which migrant patterns of morbidity and mortality shift so that they come to resemble the (usually worse) health norms of the resettlement country” (S33).
brought in resources, skills and education were ranked according to a point system in the 1960s (Anderson & Reimer-Kirkham, 1998). This point system continues as part of Canadian immigration policy today (Reitz, 2011). Reitz’ examination of contemporary Canadian views on pro-immigration suggest that two major discourses are prevalent. Those who are pro-immigration view immigrants as an economic benefit while “opponents of immigration argue that economic benefits are exaggerated and that immigrants depress wage levels, undercutting native born workers ... and over-reliance on welfare [are] a significant burden for the country” (p. 5). Anderson and Reimer-Kirkham have observed that while overtly racist policies were replaced in the 1960s, the more recent point systems are classist. However, as I discuss in the following sections, public discourse continues to Other immigrants and refugees through discursive social practices.

According to Satzewich and Liodakis (2010), multiculturalism policy is underpinned by four central issues that include: i) a demographic reality; ii) part of a pluralist ideology; iii) a form of struggle among groups for access to economic and political resources; and iv) a set of government policies and programs. Reitz (2011) discusses that “the issues of racial difference and visible minorities became prominent in the 1980’s, since the elimination of discriminatory selection criteria in 1962 led to a shift from predominantly European to about 80% non-European immigrants by the 1990s” (p. 8). As a pluralist ideology, multiculturalism reduces issues of difference to racial and ethnic differences without attention to the role of power in shaping systemic inequities between racialized groups. However, Anderson and Reimer-Kirkham (1998) have discussed that the Multiculturalism Act
passed in 1988 in order to not only recognize differences among ethnic, racial and cultural composition of Canada’s diverse groups but to ensure “equal access and participation for all Canadians in the economic, social and cultural and political life” (p. 248-249). However, as critical race scholar Bannerji (2000) points out, “multi-ethnic, multinational state, with its history of racialized class formation and political ideology, discovering multiculturalism as a way of both hiding and enshrining power relations, provided a naturalized political language even to the others of the Canadian society” (p. 31). Similarly, Tomasso (2012) explains that “liberal multiculturalism puts forth a discourse of colour-blindness that constructs racism as aberrational...or as a symptom of individual pathology...and, lastly, multiculturalism contributes to...powerful cultural mythologies about equality of opportunity and access to power” (p. 334).

Thus many scholars have come to question what Anderson and Reimer-Kirkham (1998) call a disjuncture between discourse of the state and actual practice. For example, since the institution of formal multiculturalism by the Canadian government, many immigrants and refugees have poorer economic outcomes in comparison to other immigrants (Beiser, 2009; Hyndman & Walton-Roberts, 1999; Kirmayer et al., 2011; Newbold, 2009; Reitz, 2011). Migrant women in particular have been shown to experience increased risk to their overall health as a result of their lack of access to health and social services and linguistic support (Anderson, Reimer-Kirkham, Waxler-Morrison, Herbert & Murphy, (2005); Kirmayer, & Minas, 2000; Anderson, Tang, & Blue, 1999). Drawing on research with immigrant women Anderson and Reimer-Kirkham argue that women's gendered
responsibilities of child care and lack of labour market protection, unequal pay and language ability intersect with institutional systems in a way that perpetuates their marginalization in Canadian society. These realities not only bring forward issues of citizenship, individual rights and collective belonging, but also shift the gaze toward structural processes that reinforce inequities. Moreover racialization of immigrant, refugee and other groups occurs when culture is narrowly defined by ethnicity/race. Tomasso (2012) argues that

the underlying concepts of official multiculturalism are not complex enough to permit an understanding of people’s nuanced identities.... The conflation of race and culture reinforces hegemonic whiteness by perpetually relegating racialized people, including Aboriginals and Canadian born citizens, to subjectivities ulterior to “Canadian” (2012, p. 333).

Nursing scholars have called for a reorientation of the meaning of culture within liberal multicultural nations that espouse egalitarian values of fairness and justice on the one hand but on the other are blind to the social and structural processes that create context of marginality and vulnerability (Browne, Varcoe, Smye, Reimer-Kirkham, Lynam & Wong, 2009; Anderson & Reimer-Kirkham, 1998). It is argued that when culture\textsuperscript{21} is conflated with ethnicity/race it obscures the

\begin{flushright}
\textsuperscript{21} In \textit{Culture/Power/History} (1994), Stuart Hall discusses different ways of conceptualizing culture. The first is to conceptualize culture as “descriptions through which societies make sense of and reflect their common experiences” (p. 522.). In this context culture is regarded as “the summits of civilization—that ideal of perfection to which, in earlier usage, all aspired” (p. 522). Similarly, Kirmayer and Minas (2000) argue that “the concept of culture, which is a grand abstraction, has its origins in a metaphoric contrast between the cultivated and the wild” (p. 439). The second form of understanding culture stems from the field of anthropology and more contemporary understandings of culture. Culture “is not a practice; nor is it simply the descriptive sum of the “mores and folkways” of societies—as it tended to become in certain kinds of anthropology. It is threaded through \textit{all} social practices, and is the sum of their interrelationship” (Hall, 1994, p. 523). And, as Hall further adds, a cultural analysis is “the attempt to discover the nature of the organization which is the complex of
\end{flushright}
conditions which create cultural risk (Papps & Ramsden, 1996). Unsafty and
cultural risk are produced when acts endanger the well-being of persons and where
personal identities are demeaned and/or disempowered (Nursing Council of New
Zealand, as cited in Papps and Ramsden, 1996). Contemporary understandings of
culture are not linked with ethnic identities, rather they shift the gaze toward power
structures and social practices which promote or constrain patterns of valuing or
devaluing by constituting some members of society as Other, inferior and
potentially dangerous (Smye, Rameka & Willis, 2006). This politicized view moves
beyond tolerance for difference, and locates culture “within broader macroeconomic
and political structures and discourses that shape how [institutions and] health care
systems are organized “ (Anderson, Tang & Blue, 1999, p.2). Broadening the notion
of culture in this way allows for an examination of structural causes of inequities.

Drawing on the work of nursing scholars in New Zealand, cultural safety
challenges assumptions about cultural identity as a set of fixed set of beliefs
ascribed to particular people, and moves the discourse of culture as a fluid socially
constructed category. Included in contemporary understandings is the claim that
“culture” is a process, not a thing. Postcolonial scholar Stewart Hall (1994) defines
culture as:

these relationships” (p. 523). Culture therefore is not a matter of group membership, individual
traits, values and beliefs, and fixed set of characteristics, but rather “culture involves flexible ongoing
processes of transmitting and using knowledge that depends on dynamics both within ethnocultural
communities and at the interfaces between institutions of the larger society, like the health care
system” (Kirmayer, 2012, p.155). This view of culture lends itself to non-essentialist understandings
in which culture is not reduced to a form of culturalism that often conflates race/ethnicity with
culture and produces stereotypes (Browne et al., 2009).
both the meanings and values which arise amongst distinctive social
groups and classes, on the basis of their given historical conditions
and relationships, through which they “handle” and respond to the
conditions of existence; and as the lived traditions and practices
through which those “understandings” are expressed and in which
they are embodied (1994, p. 527).

Anderson and Reimer-Kirkham (1998) have argued “the present discourses
of multiculturalism, ethnicity, visible minority...overlook the social relations
inherent in the production of these categories, mask the processes that determine
people’s experience and create stereotypes” (p. 255). For example, the conflation of
culture and ethnic identity has reinforced discourses of national threat,
securitization and refugee pathology. Tomasso (2012) writes that “the present
Canadian sociopolitical landscape, which serves to delineate the ways in which
dominant culture constructs race and conceptualizes issues of migration, is a
preoccupation with national security” (p. 334).

Some scholars reflect that since the terrorist attack of 9/11, many states have
become increasingly restrictive about protecting refugees, and that concerns about
national security have been used to justify restrictive policies and practices on
immigration (Baker, 2007; Bradimore & Bauder, 2011; Kirmayer, 2007;
Piwowarczyk & Keane 2007; Tomasso, 2012). For example, the restrictions on who
can claim asylum are increasingly played out in judicial hearings within Canada’s
Immigration Refugee Board (IRB). Refugees seeking asylum are increasingly
vulnerable to psychological adversity as they must prove their claim to warrant
refugee status (Kirmayer).
In this context, Kirmayer (2007) explains that personal stories vary and do not fit neatly with some larger account or master narrative. Moreover, providing a background biography of trauma may unwittingly retraumatize claimants who “may have tried to forget...to survive socially, may have been prohibited from speaking (and hence recollecting) certain details or events; or [the claimant] may have developed alternative stories and, perhaps, to develop one version that will maximize his or her chances of acceptance into a safe haven” (Kirmayer, p. 368). In addition, the “disbelief when faced with the refugee’s story serves defensive or protective functions. It keeps individuals from encountering a destabilizing otherness that would call their assumptive world into question” (p. 376). Experts in trauma note that PTSD does not necessarily follow a clear beginning and end (Lester, 2013; Young, 1990). Constructions of narratives of PTSD and stereotypes absorbed by the media have real world effects on the lives of refugees. Thus “the stories we find credible depend on a backdrop of narratives in constant circulation controlled by interests that are not neutral and would have us imagine our world in a certain way” (Kirmayer, 2007, p. 378). Refugee mental health and well-being is framed by what Oxman-Martinez and Hanley (2011) term systemic violence, which is implicated in public policy, government practice, and the educational, social, and health system, as well as the justice system. Symptoms of violence manifest “in an increased level of vulnerability, depression, mental distress, and are often associated with feelings of social exclusion and isolation” (p. 230).

The effects of 9/11 and public discourse in Canada on terrorism have had ongoing cultural effects on many immigrant and refugee communities. Baker (2007)
examined the effects of globalization and the aftermath of 9/11, and the social health of a small immigrant community of Muslims in a relatively homogenous region in Eastern Canada. Findings showed that both Asian and Middle Eastern immigrants experienced a shift from cultural safety to discourses of cultural risk post 9/11. Cultural safety was linked with immigrants’ sense of integration and feelings of belonging with the communities in which they lived. Cultural risk was related to Muslim immigrants heightened visibility post 9/11 and their experience of increased distress due to a process of racialization and parochialism (Baker, 2007). For example, Baker explains that African and Arab immigrants were perceived differently and made visible based on their presumed religious faith post 9/11. Baker notes that “Muslim immigrants from Africa believed that the mainstream community had responded to them as members of a visible minority before the terrorist attacks, because of their skin colour rather than their religion” (p.301). In contrast, Christian immigrants from Arab countries experienced increased visibility post 9/11 in the sense that mainstream communities attributed their ethnicity with a presumed religious, Muslim identity (Baker, 2007).

Baker’s findings also showed that the greatest source of cultural risk was associated with racialization of Muslims as terrorists as many felt that they were under public surveillance, including increased police surveillance in prayer rooms post 9/11 (Baker, 2007). Overall, Baker’s findings suggest that the collective social health was noted to deteriorate due to sudden increased visibility of Muslim faith and its conflation with terrorism. As Baker notes, “they became a cultural category
within the community, and the categorization process placed them in a situation of cultural risk” (p. 303).

Congruent with Baker’s findings, the study Piwowarzcyk and Keane (2007) examined N=63 participants’ (asylum seekers as well as refugees) perceptions of personal safety, fear of war and self-reported health status, before and after 9/11, at the International Mental Health Program of the Boston Centre for Refugee Health and Human Rights (BCRHR); after 9/11 refugees and asylum seekers were more fearful of deportation, arrest, detention, imprisonment, discrimination, physical violence and destruction of property. Factors such as religious background, dress and English language ability were also identified as contributing to participants’ fears with the effects of 9/11. Of note is that of the 63 participants, 46 (73%) were female, with 14% of women being widowed or having a missing spouse, and 41% married. Although the participant sample varied in country of origin, many were of the Muslim faith (44%), approximately 56% of the sample spoke English fairly or not at all and almost 78% of the study samples were torture survivors (Piwowarzcyk & Keane). Although asylum seekers were noted to have concerns over personal safety prior to 9/11, findings from Piwowarzcyk and Keane showed that all participants described increased deterioration of emotional and physical health post 9/11 (Piwowarzcyk & Keane). Prayer and reliance on social support from informal and formal networks, as well as increased substance use, were viewed as methods of coping with events of 9/11. The most salient consequence of 9/11 was that refugees and asylum seekers felt that they had lost their sense of safety, which Piwowarzcyk and Keane argue “was particularly poignant as they had come to the
USA fleeing persecution in search of protection and safety” (p. 572). Piwowarczyk and Keane close by arguing that it is important to consider the role of community in the context of societies that are more community oriented and where community-based solutions to trauma are often fragmented during migration and settlement contexts.

Changes to Canada’s immigration policy have also been influenced by global migration trends as a result of increased political tensions between democracy, “freedom” and totalitarian regimes. In the years 1975-1980 almost 2 million people fled Southeast Asia. Sixty thousand Cambodians, Laotians and Vietnamese refugees, commonly referred to as “boat people”, were admitted into Canada between 1979 and 1981 (Beiser, 1999). Following this, in 1999, 599 refugees fled from the Fujian province of China and arrived off the coast of Vancouver. Between 1987 and 1986, 152 Sri Lankan Tamils reached the shores of Nova Scotia, followed by the arrival of Sikh refugees (Bradimore & Bauder, 2011). More recently, between 2009 and 2010, the arrival of Tamil refugees on Canada’s west coast has been described as prompting even tighter controls over the admittance of refugees into Canada (Bradimore & Bauder).

In 2002 the Immigration and Refugee Protection Act (IRPA) replaced the former Immigration Act of Canada, 1976. After several amendments, Bill C-31, (now Bill C-11), is known as the Immigration and Refugee Protection Act (IRPA) and was

---

22 Beiser (1999) points out that most of the refugees that fled Southeast Asia left by land routes rather than by sea but are referenced as “boat people”. Labels and terms such as “boat people”, or “illegal boat migrants” denotes a lexicon that Bradimore and Bauder argue dehumanizes migrants and distorts public discourse about refugees arriving by boat.
formalized in 2002 (Canadian Healthcare Association, 2012). The IRPA is currently the legislation framework that allows for Citizenship and Immigration Canada (CIC) (under the Minister of Citizenship and Immigration) to admit refugees. The IRPA became an historical landmark in Canadian immigration because it allowed large scale resettlement of refugees who would have previously been denied access based on lack of skill, education and resources. Moreover, this allowed for refugees, particularly those categorized as government-assisted, to enter Canada with complex medical conditions including communicable diseases such as TB, who would have been previously denied entrance. These changes can be interpreted as appealing to global humanitarian dispersal policies. However, the rise of global terrorism has compounded Canadian sociopolitical and historical debate about refugees. These discourses place many refugees in different positions of marginality and vulnerability in Canadian society.

Refugees represent approximately 11% of Canada’s total newcomers (Kenney, 2013-2014). In 2012 Canada admitted 23,056 refugees and families. Of these, 5,412 were GARs, 4,212 were privately sponsored refugees (PSRs) and 8,578 were refugees landed in Canada (AMSSA, 2013). 3,747 of the GARs were women. This represents 3.05% of all refugees (including privately sponsored, at 12.8%, protected persons, at 4.85% and dependents abroad, at 18.22%) (CIC, 2008). Approximately 7,300-7,500 GARs arrive in Canada annually (by plane), destined for thirty-six communities across Canada, with between eight and nine hundred (10-12%) arriving in BC (Sherrell et al., 2011). According to Sherrell et al. the city of Vancouver receives the largest concentrated number of GARs in Canada. Sherrell
(2003) observes that post WWII, Canadian immigration was predominantly an urban phenomenon and adds that “in the 1990s, three-quarters of all newcomers to Canada settled within three census metropolitan areas (CMAs): Toronto, Montreal and Vancouver” (p.4). However, current government interests in regionalization have shifted away from economic migrants, toward GARs resettling into smaller mid-size communities (Sherrell).

It is evident that Canada has a unique history of immigration and refugee resettlement that predates 9/11. In particular, a small number of migrants arriving by boat have been constructed as illegal, a burden on Canadian society and a threat to public safety and made highly visible through media, unlike the invisibility of refugees categorized as GARs.

Bradimore and Bauder (2011) conducted a discourse analysis of Canadian media’s portrayal of the seventy-six Tamil refugees who arrived off the coast of Victoria BC in 2009. This analysis consisted of N=37 articles and headlines from three major newspapers (National Post, Vancouver Sun and Toronto Star). Findings suggest that fears of global terrorism underpinned by historical and global control over mass migration of people have reinforced a discourse of security management and restriction of who constitutes a “real” refugee, moving the discussion away from human rights to one of security and risk management (Bradimore & Bauder). Bradimore and Bauder argue that a paradigm of securitization reinforces a cultural politics of risk and . . . attached these risks to the migrant body . . . [therefore] as global risk become personified in the immigrant, the state attempts to manage the risk by increased security and management of human development (2011, p. 14).
Grove and Zwi (2006) similarly argue that concern over a risk to public safety “inverts health concerns such that the receiving population is seen to be under threat rather than attending to the health needs of the displaced” (p. 1937). The safety and well-being of all people remains a public concern in Canada; however, an over-emphasis on risk and security management has continued to not only reinforce stigma and racialization of minority groups but also shape Canadian politics and practice. For example, after the release of the Tamil refugees, a new Bill C-11 was enacted to prevent and protect Canada from refugees arriving by boat (Bradimore & Bauder, 2011), despite protests from advocacy groups. Bradimore and Bauder argue that the spectacle which surrounded the Tamil boat arrival had created the necessary discursive environment and sense of urgency to push Bill-C11 through parliament...[this] fostered a sense of anxiety around a multitude of issues...like terrorism, and national security [and] as in previous cases a small group of “boat people” became a symbolic catalyst for political action and legislative reform (2011, p. 34).

Tomasso (2012) conducted a more recent discourse analysis on the Canadian public’s views about the arrival of 492 women, children and men from Sri Lanka off the coast of Vancouver Island in 2010. Despite changes to immigration policy vis-à-vis IRPA, at that time fifty-four children were under the care of approximately

---

23 In 2002 the Immigration and Refugee Protection Act (IRPA) replaced the former Immigration Act of Canada, 1976. After several amendments Bill C-31, (now Bill C-11), is known as the Immigration and Refugee Protection Act (IRPA) and was formalized in 2002 (Canadian Healthcare Association, 2012). The IRPA is currently the legislation framework that allows for Citizenship and Immigration Canada (CIC) (under the Minister of Citizenship and Immigration) to admit refugees. The IRPA became an historical landmark in Canadian immigration because it allowed large scale resettlement of refugees who would have previously been denied access based on high barriers to integration into Canadian society.
twenty-five mothers, held at the Burnaby Detention Centre. Tomasso’s findings showed a convergence of discourses of racialization, national security, multiculturalism and neoliberalism as powerful cultural narratives reflecting Canadian public opinion of Tamil refugees. Consistent with the findings of Bradimore and Bauder (2011) Sri Lankan refugees were viewed as terrorists and as a threat to Canadians. However Tomasso argues the Canadian government found only one person linked with Tamil Tigers. In addition, Tomasso draws attention to the comments posted reflecting the Canadian public’s resistance to Sri Lankan migrants who do not speak English, for example, twenty-eight readers described a collective belonging as “we” who speak “our language” (Tomasso, p. 340).

Tomasso (2012) argues that these discourses reflect a particular brand of Canadian nationalism overshadowed by Canada’s white settler national imagery. In addition, Tamil refugees were perceived as fraudulent queue jumpers. Tomasso writes that “these types of commentaries blend a discourse of Canadian benevolence and civility with neoliberal notions of what it means to be a productive member of society. Believing in fairness and waiting one’s turn are ontologized as Canadian” (p.341). Reflecting the perspective of multiculturalism, many Canadians responded to Tamil refugees depicting them as objects needing to be “tolerated.” Drawing on Brown (2006) Tomasso further argues that those who tolerate choose to do so, and this power of choice paves the way to superiority through benevolence. Tolerance language also makes use of works like “sensitivity” and “respect” to negotiate political solutions to issues of diversity, which … is a dangerous practice of depoliticization that reduces issues of social justice to sensitivity training (2012, p. 342).
Anderson and Reimer-Kirkham (1998) remind us that “there is a real risk of oversimplifying the concept of culture, with the concomitant cultural stereotypes that this produces.” Culture, vis-à-vis ethnic identity, “is only one aspect of the complex nexus in which people’s experiences are located. When “difference” is reduced to the culture of the individual or the ethnicity, the structural factors that shape inequity may be overlooked, and “Western culture” taken as the norm against which others are judged, goes unquestioned and unscrutinized” (p.256).

Moreover Tomasso (2012) observes that racialized and objectified images of refugees depict forms of Orientalism that have historical and political roots intertwined in academic, political and mainstream discourses (Said, 1998). Said argues that Orientalism is defined by and maintained through configurations of power,24 and closely tied to socioeconomic and political institutions whereby “Orientalism is not an airy European fantasy about the Orient, but a created body of theory and practice in which, for many generations, there has been a considerable material investment” (p. 6). Drawing on Gramsci’s notion of hegemony, Said further argues that Orientalism depends on a “flexible positional superiority, which puts the Westerner in a whole series of possible relationships with the Orient without ever losing him the relative upper hand” (p. 6). In this way the “ontological identity”

---

24 Drawing on Gramsci, Said points to direct and indirect forms of domination. Indirect forms of domination, Said notes as “culture … operating within civil society, where the influence of ideas, of institutions, and of other persons works not through domination but by what Gramsci calls consent. [Thus] certain cultural forms predominate over others, just as certain ideas are more influential than others; the form of this cultural leadership is what Gramsci has identified as hegemony” (p. 7). Said argues that hegemony gives power and/or sustains Orientalist discursive practice.
created through “racialized imagery” suggests that any future incoming boats are “ipso facto ‘illegal’ and Chinese/Asian” (Bradimore & Bauder, 2011, p. 11).

Globalization, terrorism and mass movements of people have challenged Canada’s multiculturalist ideologies that are also intertwined with geopolitical and economic markets (capitalism). Historical colonial processes of settlement, compounded by 9/11, shape societal constructions of refugees as a national security threat and permeate immigration discourse Canada. The process of categorization and conflation of refugee identity with terrorism has had negative social as well as mental health consequences. This fractioning and categorization of “refugee” has not only shaped policy responses to the ways in which refugees gain entrance, but also access to resources and support once inside Canada’s borders. Fractioning of refugee identity through various categorizing processes raises concern over Canada’s appeal to humanitarian resettlement policy and reinforces the idea that the “label ‘refugee’ is no longer a basic convention [human] right, but a highly privileged prize which few deserve and most claim illegally” (Zetter, 2007, p. 184).

And, as Tomasso (2012) writes,

since 2001, we have seen individual rights trampled, and the intensification of violent state interventions directed at specific communities, such as increased detentions and deportations. These forms of sanctioned state violence are racialized in that those targeted and predominantly the “Them” constructed by mainstream discourse (p. 335).

A brief overview of immigration in the Canadian contexts suggests that many refugee groups are racialized and marginalized against the backdrop of globalized and national discourses that have shifted the focus on human rights to one of
national threat and risk management. It is within these broader sociopolitical and historical contexts that Karen women and families were resettled in Canada. I now turn to a brief discussion of the factors that shaped Karen migration, and their resettlement in BC, Canada.

2.4 The Evolution of Karen Refugee Resettlement in BC

In response to the global refugee crisis, Canada is one of 147 nations to have signed the UN convention on refugees, and offers both temporary protection and the option of permanent resettlement (Beiser, 2009). As a result of the IRPA, between the years 2005-2009 the top source countries of resettlement in BC were Burma (Myanmar), Afghanistan, Iran, Iraq and Somalia. The Karen, pronounced (Kah-Ren) people are considered descendants of the Mongols and are represented by some 20 ethnically diverse sub groups that are living within Burma (International Organization for Migration (IOM), 2006). Karen communities are indigenous to mountainous and plains regions of southeast Burma and western Thailand and differ in language, geography and name (Neiman, Soh & Sutan, 2008). According to

---

25 Resettlement refers to the larger global processes of migration that are structured through global policies between the UNHCR and nations who are signatories of the United Nations (UN). The UNHCR (2010) defines resettlement as a process which provides “protection to refugees when their lives, liberty, safety, health or other fundamental human rights are at risk in their country of asylum” (p. 18).

26 According to Norsworthy and Khuankaew (2004) the renaming of Burma to Myanmar occurred as a result of the military junta’s refusal to “to allow legally elected democratic government party, the National League for Democracy, led by Nobel Peace Prize laureate Aung San Suu Kyi, to take office following elections in 1990” (p. 261). It is also recognized that some ethnic minority groups within Burma’s borders prefer sovereignty over their states, recognizing that even Burma was the name given to the territory by British colonizers (Norsworthy & Khuankaew, 2004). In recognition of Burma’s colonial past and ongoing state violence toward minority ethnic groups, I use both Burma and Myanmar throughout this dissertation.
Neiman et al., during WWII the Karen aligned with the British and the Burmese with the Japanese. Although resistance movements against the Burmese have been ongoing since the time of Burma’s independence, the military regime continues to deprive its indigenous people of natural resources and traditional ways of life that sustained the Karen and other ethnic minority groups (Neiman et al., 2008; Norsworthy & Khuankaew, 2004).

Despite Canada’s economic and trade sanctions with Burma, the current leadership, the State Peace and Development Council (SPDC) (formerly known as State Law and Order Restoration Council (SLORC)) continues to govern Burma through military decree, obverting their power through state-wide sponsored violence which deprives its people of fundamental human rights (Norsworthy & Khuankaew, 2004). This has resulted in one of the largest internally displaced groups of people and refugee population in Southeast Asia (CIC, 2007). Refugees from Burma are the fifth source country of refugees worldwide, including 200,000 refugees who are resettled to Bangladesh (UNHCR, 2010).

As a result of ongoing threat of violence, forced relocation, and dependence on humanitarian assistance Karen refugees are considered by the UNHCR as refugees in most need of protection and in need of third country resettlement. Under the humanitarian assistance program vis-à-vis Canada’s recent changes to immigration policy, Karen refugees were resettled as part of larger familial groups that arrived in Canada in 2005 with the most recent arrivals in 2009 (ISS of BC, 2010). These groups were known to come from the Mae La Oon and Mae Ra Ma Luang refugee camps in the remote regions of Northern Thailand (CIC, 2009). These
camps are considered the most difficult to reach, the most overcrowded and in threat of serious public health risks to women and families (CIC, 2007, 2006). Marchbank, Sherrell, Friesen & Hyndman, (2014) discuss that “Karen refugees [are] a distinct group with particular protection needs” and therefore called upon the international community to assist in their resettlement (p.5). In addition to living in protracted refugee camps it is also noted that literacy (reading and writing in their traditional language) and education among both adults and children is very low (Marchbank et al.). Most Karen speak two dialects, S’gaw or Pwo Karen, and some speak Burmese and Thai languages.

In the years 2005-2009, approximately 786 Karen GARs were destined disproportionately across three different regions within Greater Vancouver Regional District (GVRD). Two of these regions are considered larger metropolitan centers with longer-standing immigration and refugee services, including specialized immigrant and refugee health and settlement services. Approximately 250 Karen women and families were relocated to a smaller a suburban community located along the Fraser Valley in southwestern British Columbia (BC). This smaller suburban region covers approximately 10 square kilometers, with a population of 100,000 people (Marchbank et al., 2014). Historically this receiving community was largely a farming and trade community developed by European foreign settlers as

27 Marchbank et al. (2014) note that “[t]he Karen settlement initiative was an example of ‘group processing’ whereby the Canadian Government designated specific refugee groups in protracted situations and/or high protection needs” (p. 8). For example, Marchbank adds that “Somali and Sudanese refugees from Kenyan camps were the focus of early group processing, followed by the Karen and Bhutanese who had been living in Nepal for almost two decades. All of these contexts are defined by extended exile whereby access to health care, education, and employment were all restricted” (p. 8).
well as Sikh, Chinese and First Nations people who contributed to the economic and social fabric of this region (Sommer, 1999). Throughout the late 1800s, faith-based communities shaped the identity of this region and were represented by various religious denominations which continue to this day and have been described as “a community of faith, strength and purpose and spirit of community” (Sommer, p. 180). The vast majority of Karen in BC are noted to be Baptist Christian while the minority are Buddhists and Seventh Day Adventists (ISS of BC, 2010). However many Karen people also believe in animism (Oleson, Chute, O’Fallon and Sherwood, 2012). These variations of religious practices reflect Burma’s history of colonization as well as indigenous belief systems. I discuss the significance of religion and associated faith based groups as an important aspect of Karen resettlement under the section titled “Overview of Structures of Settlement and Outcomes of GARs in BC”. I now turn to discuss the structures both national and regional policies and practices that shaped Karen resettlement as well as other refugee groups. These policies and practices reflect broader structural aspects of community capacity.

### 2.5 Primary Health Services and Settlement Support for Refugees in Canada

In Canada, each of the provinces has different governance structures in relation to providing settlement services and support, including health care.

---

28 Said (1994) argues that colonization refers to many creations including religious, military and cultural. In regards to Islam, he writes that “Britain felt that it had legitimate interests, as a Christian power, to safeguard. A complex apparatus for tending these interests developed” (p. 100). These various missions added to other interests in the expansion of European trade and their implantation in the Orient (Said, 1994).
Although each of the provinces differs in how services are distributed, organized and structured, other factors such as migration flow and existence of immigrants and refugees also shape community responses and ability to meet the needs of refugee groups (Smith, 2008). In addition, national immigration policies shape the structures and social aspects of settlement and health care services throughout provinces and territories.

In 2014, CIC introduced a massive reform to immigration that impacted settlement polices throughout provinces and territories in Canada. At the time of the resettlement of Karen GARs the Federal Government of Canada (CIC) developed a centralized policy for all the resettlement services across Canada. This means that delivery of programs and services would become standardized and mainstreamed across provinces and territories. Previous research related to settlement services in Canada has shown that mainstreaming of programs does not fit with different settlement needs of immigrants and refugees (Creese, 1998; Geronimo 2000). In addition, the devolution of settlement services to various levels of immigrant services and smaller NGOs has resulted in a tiered system of dependency in which the smaller NGOs which provide ethno-specific services are increasingly dependent on the larger ISA’s for funding (Sadiq, 2004). Sadiq has argued the devolution of settlement services by both government and non-government agencies is compromised by the emerging newcomer needs in geographical locations. This argument has been supported by a growing policy trend in which GARs are resettled further away from urban centers to suburban and rural communities (Sherrell, 2003). However, the recent changes to settlement policy vis-à-vis a centralized
system suggest even tighter funding constraints. For example, large resettlement of GARs has shifted toward a multiyear settlement strategy (AMSSA, 2013). Incoming GARs will be decreased by 1,000 per year (AMSSA, 2013) an approximate 18.5% decrease from 2012. Following this, CIC plans to increase private sponsorship of refugees in a blended visa program where private sponsors pay part of the support costs for resettlement (AMSSA, 2013).

The CIC (2013a) report on Plans and Priorities 2013-2014 highlights that CIC policy on refugee protection will continue to meet international and legal obligations; however, the overall spending for refugee protection will decrease by $5 million in 2014-2015; there is also a reduction in human resources related to refugee protection (CIC, 2013a). Research in Canada and BC specifically, has already shown that the convergence of neoliberal policy agendas and emphasis on geographical distribution of resources has significantly impacted resettlement outcomes for GAR groups (Creese, 1998; Cubie, 2006; Geronimo, 2000; Marchbank, Sherrell, Friesen, Hyndman, 2014; Sherrell, Friesen, Hyndman & Shrestha, 2011). In the following I discuss the impact of recent reforms on settlement and health care services and their potential impact on GARs.

2.5.1 Overview of settlement services in BC

Larger immigrant service organizations such as ISS of BC are responsible for providing settlement support for GARs in BC. This includes not only accessing specialized health care services but also finding temporary housing accommodation and employment and language support. The shifting landscape of settlement is increasingly influenced and governed by a neoliberal climate in which refugee
women and families have been relocated and/or "settled" into communities that lack the infrastructure to support their resettlement needs. At the time of Karen resettlement in the province of BC, “Welcome BC,” in partnership with ISS of BC, received funding from CIC to design, administer, and deliver settlement and integration services for immigrants and refugees. Many of these services are operated and carried out by non-governmental organizations. However, as Creese (1998) has argued, despite the long history that NGOs have had in administering social service support to new immigrants and refugees, “successive cuts in federal government spending in Canada during the 1990’s have threatened the validity and stressed the importance of the non-governmental sector” (p. 1). As will be discussed throughout the following sections, these reforms have not abated in Canada, while the settlement needs of newcomer groups becomes increasingly more complex. In general, the non-governmental sector’s role in service provision for newly arrived refugee groups in Canada has been understudied. The following review of studies suggests that neoliberal climates shape the administration and services provision of NGO’s in ways that disempower migrant groups and potentially create new barriers for settlement.

2.5.2 Nongovernment organizations and settlement

In 1998, Creese examined the contradictions facing the nonprofit sector’s engagement in providing settlement services for new immigrants and refugees in Vancouver. At that time the province of BC experienced massive government restructuring, which significantly impacted the NGO sector in their ability to administer and provide social services for newly arrived immigrants and refugees.
Creese conducted interviews with several lead NGOs, including ISS of BC, the Multilingual Orientation Service Association for Immigrant Communities (MOSAIC) and the United Chinese Community Enrichment Service Society (SUCCESS) in order to explore consequences of Federal government restructuring of programs and funding for immigrants and refugees, as experienced by the main settlement service organizations in Vancouver, BC.

Drawing on settlement workers’ experiences, Creese (1998) notes, “restructuring and devolution has widened the gap between community needs and services provided, [and] threatened to compromise the mandate and philosophy of settlement agencies in order to pursue fiscal health in an increasingly uncertain funding regime” (p. 10). This process resulted in mainstreaming of services where settlement workers are forced to provide programs geared toward the general population and where it is assumed that immigrants and refugees with distinct needs would be able to adapt to services in a short period of time. For example, employment programs became geared toward assistance in finding work and not skills training.

Creese (1998) further argues that the renewed “celebration” of volunteerism and the community further obscures the role of market-based regimes in settlement of immigrants and refugees. Moreover, settlement workers themselves were found to experience increased stress in providing services while immigrants and refugees face increasingly complex issues and service barriers. Some NGOs also experienced increased risk to their safety as a result of the gap between clients’ needs and the restructuring of programs and services. Creese argues that the bureaucratization of
NGOs has led to increased safety risks because of increasing anger and frustrations among immigrants and refugees when services do not meet their needs. As a result of these frustrations, some agencies developed safety protocols which included, for example, the installation of plexi-glass barriers and restricted entry to reception areas at some NGO agencies.

Creese (1998) concludes by arguing that while restructuring and devolution of settlement work has produced vendorism in competing for governmental funding and restricted service provisions to deliver equitable services, social advocacy can be leveraged to reinstate the voice of immigrants and refugees and those who provide settlement support to challenge government policies. In particular, coalition advocacy through the Affiliation of Multicultural Society and Service Agencies of BC (AMSSA) has worked to bridge mainstream anti-poverty groups with immigrant and refugee activists. Creese suggests that while restructuring poses challenges, it also provides opportunity to open new space for political advocacy and expansion of meaningful partnerships in order to promote government policies that are in keeping with immigrant and refugee needs.

Recent government policies have continued to perpetuate a market-driven policy agenda, impacting the work of NGOs while, at the same time, the complexity of immigrant and refugee needs has increased. Geronimo (2000) conducted a report funded by the Ontario Administration of Settlement and Integration Services (OASIS) and Citizenship and Immigration Canada (CIC). Drawing on bibliographical sources and interviews with funders and settlement service providers, as well as immigrants and refugees, this report included a synthesis of literature on models of
collaboration and coordination in settlement and human services for newcomers in Canada. Geronimo’s analysis suggests two models for settlement, adaptive and transformative. The adaptive typology (also known as the survival response) is characterized by: i) a consumer oriented model; ii) contracting out settlement services to smaller NGOs; iii) control over service provision by the funder (usually larger ISAs); and iv) amalgamation of several resources so that duplication is avoided (Geronimo).

Geronimo (2000) argues that under an adaptive model, “NGOs are now required to submit to a competitive and often complex process of tenders and purchase of service agreements ... [and] as a result many smaller immigrant service agencies have found it difficult to compete with larger organizations” (p. 6). He equates an adaptive model of governance as a direct offshoot of globalization, downsizing and efficiency. An adaptive model of settlement relationships between smaller NGOs and governments are based on collaborative partnerships that are forced, and based on competitive funding contracts (Geronimo). These findings confirm Creese’s (1998) analysis of vendorism where market-based accountability and the push toward partnerships and collaboration challenges equity oriented settlement services.

In contrast, a transformative model of settlement focuses on the development of relationships amongst collaborators and service sectors. This involves a critique of power relations between partners and collaborators where systemic and historical barriers to settlement are made explicit (Geronimo, 2000). In addition, the goals under a transformative model are to promote democratic
participation of newcomer groups in policy making, which fosters interdependency between newcomer groups and the broader society. Geronimo argues that a transformative model which adopts an anti-racism focus enhances equity and access and participation in decision making within settlement services and across different sectors. Like Creese (1998), Geronimo has advocated for an increased voice of marginalized groups in development of settlement policy. Extending from Geronimo’s research, Sadiq (2004) concurs by arguing for a transformative model which “rejects downsizing, purchase-of-service agreements, and forced collaboration, in favor of core agency funding and greater government and community alliance” (p. 25).

A recent study conducted by Lavoie, Browne, Varcoe and Wong et al. (2014) draws attention to how funders can best structure their contractual relationship with NGOs in order to produce equitable outcomes for marginalized populations. Lavoie et al. draw on two competing paradigms of contractual relations between funders and NGOs, the new public management (NPM) and the primary health care (PHC) paradigm. Similar to Geronimo’s adaptive and transformative typology of contractual relations between ISAs and NGOs, the findings of Lavoie et al. suggest that the PHC paradigm is underpinned by a determinants-of-health approach and is relationally based on trust between service users and providers. In contrast, the NPM paradigm focus is on competitive contracts in which service users are viewed as consumers.

Lavoie et al. conducted an in depth document analysis of health authorities’ and provincial government policies in BC that led to the development of Aboriginal
health centers (AHCs) as NGOs, in both urban and regional contexts. Similar to the analysis by Creese (1998) of the development of NGOs in BC, Lavoie et al. note that AHCs were created as a result of community activism and the policy shift that evolved out of the 1991 Closer to Home Report, BC Royal Commission on Health Care and Costs. From this report Lavoie et al. note that

AHC mandates are to provide primary healthcare services to Aboriginal and non-Aboriginal people whose health is shaped by experiences of marginalization, high levels of poverty, historical trauma, social exclusion, racialization and discrimination...with an advocacy focus (2014, p. 7).

Drawing on findings from their analysis and interviews with health care decision makers, administrators and health care providers (N=30), the findings of Lavoie et al. show that the AHC and partnerships with health authorities at a northern regional center in BC allowed for longer term funding arrangements, more flexible and comprehensive provision of health care services and paralleled a primary healthcare paradigm. In contrast, NGOs that provided health and social services to vulnerable groups in urban contexts were funded through top down approaches and competitive funding regimes. Interestingly, NGOs located in a northern region of BC had fewer services available while those located in a larger urban context had increased distribution of services located closer together. However, the NGO located in northern BC was found to have an increased equity-oriented service provision as a result of relationally-based collaborations between the NGO and health authority. This finding suggests that relationally-based contracts may play a greater role in provision of equity-oriented services beyond geographic
contexts. Relationally based contracting also brings attention to the complex web of social relationships and issues of social justice beyond a distributive paradigm\textsuperscript{29}.

Findings further suggest that the AHC in regional BC developed meaningful engagement with the health authorities as a result of increased Aboriginal participation and increased dialogue and shared goals committed toward delivering comprehensive and effective services for service users. Lavoie et al. argue for the need to recognize the important role that NGOs play in the health care system in meeting the complex health needs of vulnerable groups and the need for stronger relationships between government and NGOs in order to promote equitable health services for these groups.

A review of these studies highlights the role of NGOs as important actors in service provision in meeting the needs of immigrants and refugees and other vulnerable groups. Studies discussed above further point to the need to promote advocacy, the inclusion of marginalized voices in policies that directly affect them and collaborative partnerships based on equitable relations between funders and NGOs in order to better fit with the needs of clients. Funding, political activism and inclusion of voices of those affected most by settlement policies are highlighted as key factors that structure provision of settlement. In the following section I provide

\textsuperscript{29} Political feminist scholars Iris Young (1990) and Nancy Fraser (1999, 2001) have drawn attention to expanding the notion of justice and equity by arguing for not only a (re)distribution of social goods and services but also an intersecting dimension of social justice such as recognition of difference and the systemic exclusion of non-dominant groups in policy decision making. Fraser's work particularly argues for recognition of difference between social groups which is fundamental to the notion of equity as many refugees have not had voice in the construction of policies that directly affect them.
a brief overview of some of the impacts that neoliberal governance structures have had on GARs’ resettlement in BC.

2.5.3 Overview of structures of settlement and GAR outcomes in BC

In BC, Early Years Refugee Programs (EYRPs) are NGOs identified by Citizenship and Immigration Canada as part of best practices for refugee families that arrive in groups\(^{30}\). Early Years Refugee Programs are one of several pilot programs designed to support services for refugee women. There are six EYRPs scattered throughout Metro Vancouver, and their mandates are described in the following:

The Early Years Refugee Project (EYRP) is a culturally competent early-learning center tailored to meet the settlement and early childhood developmental needs of refugee children and their families. Its goal is to minimize the impact of the trauma experience that most refugee families experience and to support their children’s development in the Canadian context; facilitating access to resources in the community and helping them feel more welcomed and connected. The overall goal is to help transition this population into mainstream services and resources (CIC, 2013b, p. 1).

A key mandate of the EYRP is to mitigate trauma experiences during resettlement by assisting women to access services and resources in the communities in which they are resettled. As pilot projects, the overall goal is to

\(^{30}\) The CIC (2013a) identifies that best practice in settlement includes six specific domains of settlement which include, i) accessibility of services as close geographic proximity of services to where refugee families live; ii) newcomer involvement in program service development; iii) stakeholder collaboration involving public partnerships with various levels of government, community stakeholders and representatives from grassroots community organizations; iv) accountability processes in place to provide feedback to pilot sites from the BC Ministry of Regional Economic and Skills Development; v) promotion of positive outcomes for newly arriving families and foster welcoming communities to support childhood development; and vi) the linking of families with settlement and health care resources and make sure supports are in place within provincial boundaries.
transition refugee women into mainstream resources. All EYRPs are funded by two ministries, The Ministry of Education, and The Ministry for Children and Families, and provide some public health services under regional health authorities. Other pilot projects that address refugee needs include Immigrant Parents as Literacy Supporters (iPALS) and Vulnerable Immigrant Populations Program (VIPP). The VIPP is a model based on a case management system that shares and distributes settlement support to various communities across service sectors and geographical boundaries in the Lower Mainland (Welcome BC, 2011-2012). Other settlement supports are received through the refugee assistance program (RAP) funded by CIC; all GARs receive one year of financial assistance equivalent to provincial social assistance (ISS of BC, 2010). However, as studies have shown, many of these NGOs are dependent upon funding from securing contracts with larger immigrant service associations such as ISS of BC (Creese, 1998; Geronimo, 2000; Sadiq, 2004).

In 2014, CIC instituted a centralized policy on settlement services across Canada based on economic reforms. This has meant that many community organizations that provide settlement support, specifically smaller NGOs, will not receive direct funding from the provinces and have to compete for funding. The implications are that the sustainability of existing NGOs such as EYRPs will be greatly compromised in their ability to provide equity-oriented services to refugee women and families who arrive in Canada with high barriers for settlement.

In the context of government reforms at the time of this research, all GARs are required to sign a government transportation loan document in which they repay the costs of their medical and transportation expenses. According to Johnson
(2010), Canada is one of few countries that require refugees to pay a transportation loan. In addition, if the loan is not repaid within three years the government starts charging interest (Johnson). Thus all GARs are expected to start repayment of their transportation loan 30 days after their arrival and as noted by ISS of BC (2010) in “2009 individual loans were $1,563 and $7,010 for a family of five with a single mother and a child less than six” (ISS of BC, p. 6). Single mothers receive monetary government support in the sum of $685/month per individual, and families of four receive $1,215/month (ISS of BC).

A review of outcome studies in BC of GARs resettled in their first five years suggests that the repayment of this government loan is an added stressor for GARs who come to Canada with no skills for employment (Brunner, Hyndman & Friesen, 2010; Cubie 2006; Munchbank et al., 2014, Sherrell Friesen, Hyndman & Shrestha, 2011). Other intersecting factors such as religious beliefs also compounded resettlement stress. For example, in a study conducted by Brunner, Hyndman and Friesen (2010) with Achenese GARs in BC it was found that the Islamic practice of this refugee group prohibited paying interest on loans, therefore Achenese were needing to repay the government loan quickly by taking on manual jobs. Thus there is a need for increased recognition of how cultural differences within refugee groups intersect with broader determinants of health such as employment as these factors may contribute to resettlement distress.

At the time of the Karen resettlement in BC, there were voiced concerns by local service providing organizations and municipal governments about the ability of existing infrastructure and services to meet the new demands of Karen GARs
(Marchbank et al., 2014). To examine the degree to which multicultural policies and programs are distributed within geographic regions throughout Metro Vancouver, Edgington and Hutton (2000) conducted a survey of 22 municipalities and case studies of three core municipalities (Vancouver, Richmond and Surrey) with measures of 47 indices related to equitable, inclusive and accessible services within each municipality. Findings showed a strong correlation between a low percentage of visible minority populations and low coverage of inclusive, equitable and accessible policies, with less than 10% in outer and peripheral municipalities (City of White Rock; City of Langley; City of Pitt Meadows; Township of Langley; City of Abbotsford) in comparison to 25% in core municipalities located in GVRD core regions (City of Vancouver; City of Richmond; City of Burnaby; City of New Westminster).

Findings from Edgington and Hutton (2000) suggest that policy conflicts around building innovative equity-oriented pre-programming and service provision in outer municipal districts are dependent upon the quality of the relationship between city council and government, as well as attitudes regarding multiculturalism. For example, in outer municipalities, the lack of resources for multicultural programs was perceived to be related to low levels of non-English speaking populations.

In addition to their survey report, case studies representing different municipalities (Vancouver, Richmond, and Surrey) showed that local community government involvement and planning with various NGOs and school districts, parks and recreation departments helped to address community needs for
knowledge and city planning related to diversity and immigration. Edgington and Hutton (2000) explain that prior to 1999, “federal funding for settlement services went directly to NGOs in BC on a project by project basis” (p. 7). These new partnerships were designed to avoid overlap in service and funds, giving BC greater control of immigrant policy in the context of economic reforms and, as I have discussed previously, several government and NGOs provide funds and/or services under the policy of immigrant settlement services; ISS of BC being the largest funder for immigration programs in BC.

Edgington and Hutton (2000) conclude that municipalities located on the periphery of the Greater Vancouver Regional District (GVRD) lack organizational structure and local political support which may constrain local responses to international migration. In addition, these authors predict that immigration will increase by 58%, or another 1.2 million people, between 1996 and 2021, in BC alone. Suburban communities along the Fraser valley will have to absorb much of this population growth. However, the concern over the lack of policy structures in municipalities along the Fraser valley suggests that a response to the changing demographic in BC may place newly arrived refugee groups in positions of cultural risk. It has been argued that not only do GARs require increased and flexible time frames for achieving successful resettlement, whether measured by successful employment, good health or language acquisition, but also that resettlement of GARs requires more time to get communities ready for refugee resettlement (Marchbank et al. 2014; Sherrell, Friesen, Hyndman & Shrestha, 2011).
The ISS of BC report conducted by Cubie (2006) examined the outcomes and insights from government-assisted refugees who arrived in BC between 2003 and 2005. Surveys were conducted with 152 GARs from twelve different countries including Myanmar, Afghanistan, Iran, Iraq, Rwanda, Somalia, Sudan, Vietnam and Liberia, on several indices related to pre and post arrival. The surveys included questions regarding access to English classes, education, health, housing, family well-being, employment, racism and discrimination, local community and longer-term plans.

For GARs who arrived in both 2003 and 2005, English language proficiency remained low. In 2003, 58% of all respondents self-rated as being a beginner in English– or with no English language ability– in comparison to 59% in 2005 (Cubie, 2006). Education skills also remained low as only 9% of the total respondents reported to have undertaken any skills or educational training. Similarly, employment was found as a major factor in resettlement and 26% respondents relied on food banks to feed themselves while receiving refugee assistance program (RAP) assistance (Cubie, 2006). For GARs who arrived in 2003, 53% were still unemployed in 2006 and 78% reported that employment did not match their skills. Family well-being was related to family income and poverty, followed by health problems and stress of repayment of government loans. Overall health outcomes were poorer for the GARs who arrived in 2003. I discuss health outcomes further under the section titled “Health and Healthcare Access for GARs and Refugee Women”.

67
In terms of resettlement and place, the majority of respondents reported they did not want to have ties with their own community. Seventy five percent of respondents preferred to live in the city, as it was perceived that there would be more services than in smaller urban areas. Fifty one percent of GARs who arrived in 2003 had left BC for other provinces in search of employment; similar trends were noted for GARs in 2005. When asked about long term plans, employment topped the list of things respondents identified, followed closely by education and language skill development. As rental markets remain high in the greater Vancouver regional district, 24.5% of GARs in 2003 reported not having faced housing difficulties in comparison to 40% in 2005. Of all GARs sampled it was noted that approximately 80% live in households with less than six family members and 90% live in 3 bedrooms or less. This suggests that many GARs are living in lower income rental accommodations that may not meet their family needs.

In addition, Cubie (2006) found that approximately 83.55% of GARs reported they did not experience racism or discrimination. However, the 12.5% who did report experiencing racism and/or discrimination were predominantly women. Thirteen of the nineteen women who reported racism were from Afghanistan, Iraq and Sudan. Of the 12.5% that included refugee women and men, 74% reported that they were subjected to verbal abuse in public spaces, 21% experienced physical violence and 5% did not comment (Cubie). Cubie concludes by recommending increased pre arrival and post arrival orientation for GARs, as well as the need to address immediate needs such as financial assistance, employment and secure housing. Cubie’s analysis demonstrates economic marginalization of GARs though
high rental costs and low financial assistance and those services need to be provided in the municipality of residents of GARs. Lastly, Cubie recommends that there needs to be further examination of the healthcare needs of GARs and the current service provision model being used, since there was evidence to support a decline in overall health of GARs resettled in 2003.

The decision to destine Karen families for a smaller suburban community outside of the metropolitan periphery was largely based on housing affordability and welfare support for Karen GARs (Marchbank et al., 2014). It is noted by Sherrell et al. (2011) that in Canada, housing is considered affordable if it accounts for no more than 30% of monthly household income. However, research by Marchbank et al. (2014) regarding resettlement outcomes of Karen GARs in BC showed that rates of income insecurity were high even in suburban contexts as Karen households were found to be spending more than 30% of their monthly income on rent, a percentage that is significantly higher than the general population (Marchbank et al.). Marchbank et al. found that “approximately 1 in 5 [Karen] families spend upwards of 70% of income on rent, placing them at risk for absolute homelessness” (Marchbank et al., p.20). In addition, due to larger family composition, approximately two-thirds of Karen families of five or more persons live in two bedroom apartments.

Although many NGOs and larger immigrant services offer assistance with accommodation, access to language services and monetary support, these services are provided on a short term basis with the view of transitioning newcomers to mainstream services. This is problematic because studies suggest that many refugee
groups, as well as other newcomers’ groups, require settlement support long term (Creese, 1998; Geronimo, 2000; Marchbank et al., 2014; Sadiq, 2004). The period of time for settlement support is arbitrarily decided and is usually based on citizenship status (Sadiq). This means that once citizenship status has been obtained many refugee families can be denied access to formal access to language classes. This is primarily due to the fact that in 2014 CIC changed its immigration policies in which naturalized citizens are no longer eligible for settlement services or language classes across territories and provinces in Canada (Marchbank et al., 2014). Marchbank et al. examined Karen refugees’ experiences of resettlement five years after their resettlement in Canada and the ability of the larger community to respond to their resettlement needs. Drawing on a sample of N=74 adults, including n=46 women and n=28 men, the findings of Marchbank et al. showed that many Karen women and families did not access English classes due to lack of childcare and costs associated with English language classes. Karen family members over the age of 64 required more time to learn English and were ineligible for government-funded English language classes because they had obtained naturalized citizenship (Marchbank et al.).

In addition, changes to the citizenship test also included up front evidence of language ability which increased to level four in speaking and listening in one of Canada’s two official languages (Marchbank et al., 2014). Thus, Karen families, for example, would have to provide objective evidence of their language ability at the time of their citizenship application. Moreover, the benchmark pass for the citizenship test has risen from 60% to 75%, and includes a higher level of English
language ability, posing additional challenges for refugee groups that arrive in Canada with limited education and literacy; this is particularly challenging for older adults (Marchbank et al.).

Kirmayer et al. 2011 have summarized results from a systematic review of risk factors for mental health amongst senior immigrants in Canada. Findings showed that immigrant seniors experience slower rates of learning and have mobility difficulties. In particular, risk factors for psychological distress include being of female sex, having less education, unemployment, poorer self-rated health, chronic disease, lack of social support, loss of status as a respected elder and having fewer opportunities to find meaningful work (Kirmayer). Although this research pertains to immigrant groups, it can be argued that Karen refugees face increased risks for mental health and well-being due to lower literacy levels and limited access to education. Moreover, a review of outcomes studies with GARs in BC suggest that refugees experience significant health challenges related to the social determinants\(^3\) of health on every level.

Marchbank et al. (2014) note recent changes to immigration policy are "particularly troubling in light of recent changes to program eligibility, effective April, 1, 2014 under CIC, in which naturalized Canadian citizens are no longer eligible for settlement services and language classes" (p. 32). Perspectives of Karen

---

\(^3\) The Public Health Agency of Canada (PHAC, 2011) includes the following key determinants of health: 1) income and social status; 2) social support networks; 3) education; 4) employment/working conditions; 5) social environments; 6) physical environments; 7) personal health practices and coping skills; 8) healthy child development; 9) culture; 10) gender; 11) biology and genetic endowment and 12) health services.
adults showed that education, language and employment were key factors contributing to their resettlement needs, findings consistent with several outcome studies in BC. In particular, findings from Marchbank et al. also showed that the decision made by Karen GARs to migrate to Canada was based on the need to provide a better future for Karen children, as over 30% of respondents did not have access to formal education.

In addition to needs for housing, employment and language skill, the role of faith-based institutions also played a key role in settlement of Karen GARs in BC. Unlike previous research that has examined resettlement outcomes of GARs in BC, findings from Marchbank et al. 2014 showed that at the time of Karen resettlement both the Catholic and evangelical churches played a key role in initiating settlement support, including free language classes, assisting groups to medical appointments, development of volunteering initiatives, and academic and homework clubs to assist Karen youth in schools.

As previously discussed, the region in which Karen GARs were resettled has a long history of various European settlement and various religious denominations along the Fraser valley. The study findings of Marchbank et al. (2014) showed that religious organizations initiated several grass roots community supports for Karen families including the development of a refugee advisory committee, which comprised various community stakeholders and professional organizations. This was a Karen initiative in which families were assisted with settlement such as accessing health care services, obtaining furniture and household items and youth-
based initiatives that promoted sports and recreation alongside after-hours school programs (Marchbank et al.).

Of note is the fact that many of these settlement initiatives were carried out by community volunteers in the absence of any formal settlement services in the area. Community volunteerism, mostly through faith based institutions, were instrumental in providing settlement support. However, many volunteers perceived that the abundance of help contributed to high levels of dependency among the Karen (Marchbank et al., 2014). Marchbank et al. surmise that the lack of pre arrival planning for Karen GARs resulted in the lack of formal services and policy planning around the specific needs of this refugee group.

In light of current policy trends to destine refugees outside of traditional urban centers, studies have drawn attention to the social factors that determine health and well-being of various refugee groups that have resettled in Canada, and specifically in BC. However, the arrival of Karen GARs was not the first time a large group of refugees were resettled into smaller communities.

In 1995, 905 Kosovar refugees were resettled in BC as part of the UNHCR humanitarian evacuation from Macedonia (Sherrell, 2003). At that time Sherrell conducted individual interviews (N=41) and seven focus groups with Kosovar refugees and immigrant and refugee serving agencies in order to identify the characteristics of place that contributed to the positive experience of resettlement for Kosovar refugees. Participants were sampled from smaller mid-size cities as well as from those who relocated in larger cities. At that time findings showed that 71%
of Kosovars remained in their original host city due to existence of strong family networks and employment.

However, there was an inverse relationship with level of education, language skill and employment and geography. For example, Kosovars who came from smaller villages had significant difficulties obtaining employment whereas Kosovars who had more education experienced greater success in gaining employment, findings consistent with the experience of Karen arrivals in 2006. Sherrell (2003) surmises that lack of employment in smaller cities may have been related to unemployment trends in the region as well as spatial mismatch between the jobs available in the city and the job experience of refugees in general.

It was also found that gender differences, level of education and job-finding skills were also factors associated with employment. Sherrell (2003) concludes that smaller centers do not necessarily facilitate faster integration, rather,

the degree to which communities are equipped with the conditions necessary for settlement (e.g., job opportunities, settlement services and presence of family and friends) will ultimately affect retention. Prior to the destining of refugees to smaller centers adequate supports must be made in place...Capacity mapping and capacity building are needed to assess the degree to which services exist to meet the needs of incoming immigrants and refugees (p. 100).

Based on previous outcome studies with GARs in BC, Sherrell, Friesen, Hyndman and Shrestha (2011) examined pre arrival planning process and outcomes of Bhutanese GARs in BC. This was the first time in the history of refugee resettlement in BC that all levels of government including federal, provincial and local municipalities were represented and participated in resettlement strategies,
addressing policy initiatives and the development of a common framework for meeting the needs of GARs. As a result of the community forums a pre-arrival local community preparedness checklist was developed to assist local stakeholders to prepare resettled refugee movements into their community. As a result, several capacity-building strategies emerged, including enhanced volunteer services, assessment of housing options and availability of English language services and local school resources. In addition to conducting a local inventory of local community resources, general receptivity, presence of pre-existing newcomer populations and mechanisms of community engagement, such as inclusion of local media, were assessed and further developed.

Overall, the strategic initiative planning process demonstrated that increased community collaboration through building partnerships was a key factor in promoting integration and the receiving community’s knowledge of Bhutanese refugees in BC. Drawing on interviews (N=16) with adult Bhutanese GARs, findings again showed that high rental markets, lower incomes and the obligation to repay resettlement loans significantly contributed to Bhutanese stress during resettlement. Analysis of gender difference related to employment was limited but showed that four out of sixteen men were employed (4/16). Lack of accessible transportation, health problems, location and childcare services were also identified as barriers to accessing language resources. Noteworthy is the fact that individuals who had English language ability could not advance in English language classes because they were measured to have higher levels of English. This finding may be
related to previous studies that suggest a mismatch between economic climates and job availability and the refugee skills (Sherrell, 2003).

Specific indicators showing the integration of Bhutanese refugees included early attachments to the labour market through paid or volunteer work. In addition, Bhutanese GARs were shown to utilize both formal and informal services and programs. Accessing formal services such as employment and language programs was related to the lack of pre-existing social networks. It was surmised that pre arrival planning and development of intersectoral partnerships prior to the arrival of Bhutanese GARs also facilitated increased flexibility in responding to the needs of the Bhutanese. However, Sherrell et al. (2011) note “there is a long way to go before success can be claimed [although] the lower affordability challenges and higher employment being experienced [by Bhutanese] are in stark contrast to earlier groups, including Acehnese and Karen GARs” (p. 26).

Recommendations put forward by Sherrell et al. (2011) include the recommendation of an increase in pre arrival planning for communities receiving GARs, including assessment of community capacity and the use of a pre arrival preparedness checklist. Further, it was recommended that there be an establishment of national shelter rates for GARs to offset local housing costs, the elimination of the government transportation loan and a review of existing capacity of child care provisions connected to formal language classes such as ELSA to increase participation of women. Refugee youth and young adults were identified as underserved population groups who require enhanced language and educational services (Sherrell et al., 2011). Although the health authorities were included as key
stakeholders of the forum and pre planning process vis-à-vis specialized refugee health care services, there was limited information as to how primary care services located outside of the jurisdictional boundaries could best facilitate health care access for diverse newcomer groups. In addition, very little attention has been paid to gender as a key factor in promoting equity oriented settlement services.

### 2.6 Health and Health Care Access for Refugee Women

Since recent changes to the IRPA in 2002, refugee health has brought the issue of health as a human right to the foreground given that excessive demand on health and social services is presumed to be no longer an impediment to health access. However, many refugees continue to experience inequities in health and healthcare. GARs are eligible for health benefits under the provincial health plan as well as supplemental coverage under the IFHP, which covers emergency dental, vision and pharmaceutical care (Cubie, 2006). However, reforms to settlement across Canada have raised concerns over who is eligible and legitimately entitled to these health benefits (Stanbrook, 2014).

Extending from the Immigration Refugee Protection Act (IRPA), Canada introduced the interim Federal health program (IFHP) as a formal health policy to “provide limited, temporary coverage of health care costs for specific groups of people including protected persons, refugee claimants and certain persons detained under the IRPA” (CIC, 2012, p. 1). All GARs receive screening and treatment for diseases that fall under public health risk such as HIV and TB (Pottie, et al. 2011). In the context of changes to immigration policies in Canada, a paradox exists where on
the one hand Canada has made particular allowances for refugees such as the Karen who come with complex medical conditions compounded by trauma and on the other hand the policies of surveillance and medicalization are being reinforced.

As Pottie et al. (2011) make clear,

Canadian immigration legislation requires that all permanent residents, including refugees, refugee claimants and temporary residents undergo an immigration medical exam. Screening is undertaken to assess the potential burden of illness and limit the number of public health risks. [However] the examination is not designed to provide clinical preventative screening, as is routinely performed in Canadian primary care practice, and it is linked to ongoing surveillance or clinical actions only for Tuberculosis (TB), syphilis and HIV infection (p. E2).

Thus, evidence suggests that contemporary immigration policy has not let go of the “sick immigrant paradigm” present in the discourse of public health. While there is increased understanding that health is constituted by the individual and the environment, a review of studies on refugee health suggest that paradigms such as the “sick immigrant” or “healthy immigrant effect” converge and overlap, drawing attention to the broader systemic and political social factors that shape health and well-being. I discuss some of the risks to mental health in later sections of this dissertation.

In relation to TB, Beiser (2005) points out that major source countries for contemporary immigration are burdened with high rates of TB. In addition, studies have demonstrated that high rates of TB are spread as a result of inadequate living conditions, overcrowding and hazardous working conditions endured by immigrant groups (Beiser). A recent study conducted by Reitmanova and Gustafson (2012)
lends further support to a growing racialized discourse that confounds disease risk with refugee status. Reitmanova and Gustafson (2012) examined the relationship between press-constructed discourses of immigrant health and current tuberculosis control policies in Canada. Analysis focused on TB and immigrant populations as covered in 273 news article editorials and letters to the editor from ten major Canadian newspapers. The findings of Reitmanova and Gustafson showed two primary themes; the first was the fact that TB was associated with being an immigrant of Asian descent, and the second, that the responsibility for health and disease was located in the individual immigrant body and not the social, economic and political factors that influence risk of disease.

Ethnocultural association (being Asian) was the presumed risk for TB rather than being impoverished. For example, in 33% of the articles reviewed (n=91), TB was presented as an exotic disease– that was imported by immigrants and travellers. TB was linked to poverty in only 8% (n=23) of the articles and only 11% (n=29) articles linked TB more broadly with the social determinants of health.

Second, medicalization of TB was related to a lack of attention to social, economic and political factors (Reitmanova and Gustafson, 2012). Similar to Pottie et al. (2011) these authors argue that the “mutually constituting racializing and medicalizing discourses continue to frame the immigrant body as a threat and reinforce the need for screening and surveillance of immigrants rather than addressing social inequalities underlying the problem of tuberculosis” (Reitmanova and Gustafson, p.911).
The authors conclude by recommending that the social inequalities that put immigrants and other groups at risk for TB be addressed; this would include an examination of the social determinants that increase vulnerability to TB, increased education of media and inclusion of minority voices to redress the medicalization and racialization of TB in immigrant populations.

In addition to the problem of racialized discourses associated with immigrant and refugee populations, newly arrived refugee groups have not been able to access health care services as a result of government funding cut backs as well as refugee status. In June of 2012, CIC introduced substantive health care cuts covering basic health care costs for refugees under the asylum category; through the IFHP (AMSSA of BC). These cuts were later followed by additional funding cuts to trauma services for victims of torture. Health reform was based on the grounds that “the reform was necessary to ensure fairness for Canadians vis-à-vis government-funded health coverage of the supplemental benefits previously covered by the IFHP, which for most Canadians are not covered by their provincial and territorial insurance programs” (Canadian Healthcare Association, 2012, p.4). The minister of citizenship, immigration and multiculturalism reinforced these justifications for health reforms. At the time, the Honorable Jason Kenney stated:

Our government’s objective is to bring about transformational changes to our immigration system so that it meets Canada’s economic needs. Canadians are a very generous people and Canada has a generous immigration system...however, we do not want to ask Canadians to pay for benefits for protected persons and refugee claimants that are more generous than what they are entitled to themselves (CIC, 2012, para 2).
The justification for health reforms reinforce the equality perspective (neoliberal) whereby an equal playing field exists rather than an equity perspective, which recognizes a need for more resources given the differential circumstances within and between immigrant and refugee groups. In response to this immigration health reform, the Canadian Health Care Association (CHA) position statement has called for a health impact assessment of the policy changes; failing this the CHA are advocating for a reversal of the IFHP policy. However, underpinning the reforms to the IFHP is what Tomasso (2012) has described as a neoliberal dominant north American cultural value.

In contemporary Canadian society, it seems as though it is possible to assign everything—and everyone—a quantitative value. It has become increasingly difficult to make the case for afore-considered basic social services without including a quantitative assessment of anticipated economic outcomes...neo-liberalism discourse perpetuates the falsehood that wealth and power deservedly go to those who merit them through hard work (2012, p. 335).

Moreover, notions of belonging are embedded in a Canadian cultural value in which only those who pay into the welfare state are deserving. Nursing scholars have drawn attention to the need to move beyond a liberal ethic of justice that narrowly presumes that all members of society have access to social goods and resources even if equitable. Anderson and Reimer-Kirkham (1998) argue that the ideologies of egalitarianism and individualism result in the assumption that all citizens have an equal opportunity to achieve optimum health because all have equal access to health care services. Thus, a level playing field is assumed and individuals are seen as being largely independent of social constraints (p. 243).
Drawing on the work of political feminist Iris Young and Nancy Fraser, Reimer-Kirkham and Browne (2006) advocate that a broader framework for understanding social justice needs to extend beyond a distributive justice paradigm. This requires an analysis of the root causes of social inequities. Riemer-Kirkham and Browne write

with associated marginalization, one begins to see sustained intergenerational patterns of ill health and human suffering not as examples of poor individual choices or flawed social communities but as the results of diminished life opportunities that have systematically...been denied through complex institutional policies (2006, p. 335).

In BC, all GARs receive healthcare screening and treatment through three specialized immigrant and refugee health clinics such as the Bridge Community Health Clinic (BCHC). Refugee clinics are staffed by nurse practitioners and medical practitioners and are closely linked with settlement services. The BCHC also provides access to trauma counselling and support services. These immigrant refugee designated health clinics have mandates to “provide short term care during settlement with an aim to help refugees transition to accessing health care within the larger Canadian public system. Options for primary care include family doctors’ offices, community health care centers, walk in clinics and emergency departments” (Gabriel, 2013, p. 269).

Although translation services are provided at the specialized clinics, not all refugees receive this service. For example, there has been increased responsibility of refugee families to find their own interpreter for sponsored refugee groups. Refugees who are sponsored and who access specialized refugee health clinics are
typically not offered interpreters as it is assumed that sponsors and/or refugees themselves will be able to provide or organize interpreter services. Private sponsored support for refugees in BC has had mixed results related to resettlement success (Sherrell, 2003).

Specialized refugee health clinics are also limited to three geographic areas located in larger urban centers in BC. Although few studies have examined the impact on geographical distribution of specialized immigrant and refugee health clinics and refugee access, there is evidence to suggest that GARs prefer to access specialized health care clinics instead of primary health care clinics because they provide interpreters (Cubie, 2006; Marchbank, Sherrell, Friesen & Hyndman, 2014; Omeri, Lennings Raymond, 2006; Rouhani, 2011).

In a study that examined the healthcare access of GARs resettled to BC in 2003 and 2005, Cubie (2006) found that 30% of GARs in BC stated that they had a medical, dental or optical problem that was not covered by the IFHP and respondents further noted that lack of access to health care had financial and physical implications. GARs reported accessing medical treatment by borrowing money or using funds out of their RAP benefits. In addition GARs who arrived in BC in 2003 self-reported poorer health than GARs who arrived in 2005. Cubie (2006) observes that

with the introduction of the IRPA in 2002, and the removal of the requirement that resettled refugees could be held to be inadmissible on the basis of excessive demand on health and social services, one would have expected that a larger proportion of GARs from 2005 would rate their health as “Fair”, “Poor” or “Disabled”, and that those who have been in Canada for a couple of years would have been able
to access medical treatment and therefore their health status would have improved (p. 35).

However, findings from Cubie (2006) suggest the opposite. GARs who arrived in 2003 rated their health as poorer than those that arrived in 2005. Cubie suggests this decline in health status may have been attributed to self-report based on Canadian standards. However, findings from Cubie also highlight that in 2005 fewer GARs (32%) were able to access primary health care services compared to GARs in 2003 (79%) and that a vast majority still accessed a specialized immigrant and refugee health clinic located in Vancouver despite having to travel a long distance to get there. In addition, participants reported use of interpreter 45% of the time for health care access while others relied on family, friends and children (Cubie, 2006). These findings are further supported by the study by Marchbank et al. (2014) that specifically examined Karen GARs experiences of resettlement in 2014.

The survey report from Cubie (2006) also notes that the mental health of GARs in 2003 compared to 2005 showed that overall, both cohorts reported to have “good” or “excellent” mental health. In relation to the latter, the authors surmise that recent memories of persecution and the trauma effects may have been less intrusive because many of the participants had been living outside their country of origin for extended periods of time and/or that they perceived themselves to be in a safe country of resettlement. However, it was also noted that across studies, GARs experience a significant amount of resettlement distress. As noted by a Somali female, stress was related to issues such as finding a place to live (Cubie).
Findings from Marchbank et al. (2014) show that five years after resettlement many Karen GARs could not access primary health care services in their community because of lack of interpreter services and an over-reliance on family and volunteers to provide interpretation and accompaniment. Dental health, blood disorders, TB and hepatitis were cited as common health problems for the Karen (Cubie, 2006; Marchbank et al., 2014; Power & Rebekah, 2012). Similar to other studies conducted with Karen refugees in the US, language barriers were identified as significant part of understanding the health care system and—most likely related—making appointments was very challenging for Karen families (Power & Rebekah, 2012; Oleson, Chute, O’Fallon & Sherwood, 2012). Power and Pratt also found that mental health concerns for Karen men was related to a rise in alcohol use during resettlement, and, in contrast, reproductive health issues posed health challenges for Karen women.

The decline in health status and lack of access to health care services is concerning, given recent changes to the IRPA. In addition, the fractioning of the refugee label suggests that not all refugees are eligible for expanded health care coverage, since asylum refugee women and families can be denied access based on the legitimacy of their status. Moreover, the suggested decline in health status of GARs in BC may be reflective of broader social determinants of health that have been found to influence health of immigrants generally (Beiser, 2005; Kirmayer, Narasiah, Munoz, Rashid, Ryder et al., 2011). Oxman-Martinez and Hanley (2011) argue that health is a key human rights issue and therefore lack of access to it (based on gender, race, age, class) is a form of systemic violence “exercised by the
state when there is a lack of access to health and social services” (p. 222).
Importantly, structural contexts that limit women’s access to resources and supports, including formal networks of community resources and supports, can have a profound effect on refugee women’s mental health and well-being during resettlement. A review of national studies on refugee women’s access to health care services suggests that access is a significant structural barrier for refugee women (Fung & Wong, 2007; Merry, Gagnon, Kalim & Bouris, 2011).

As part of a larger four year multisite prospective cohort study entitled “The Childbearing Health and Related Service Needs of Newcomers”, Merry, Gagnon, Kalim and Bouris (2011) report on findings from a subsample of 112 refugee claimant women living in Montreal and Toronto. Women who had received home visits by public health nurses at two weeks and four months post-partum were assessed for maternal and infant physical and psychological health. Records of refugee claimant women who had five or more unaddressed concerns at two weeks and four months post birth in Montreal and Toronto women were qualitatively analyzed.

Findings from Merry et al. showed that 26/50 refugee claimant women in Montreal and 27/58 women in Toronto had symptoms of post-partum depression. Many of the refugee women were also reported to have spent time in Canadian detention centers and experienced armed conflict pre migration (Merry et al., 2011). However, very few women were followed by a support program, and most were denied access to health and social services based on their asylum status and language barriers. Lack of accessible services resulted from inaccessibility of
interpreter services and confusion over Canada’s interim Federal health plan (IFHP). In addition, findings showed that public health nurses had difficulty providing health services due to low literacy levels of the women and their male partners. These systemic and individual level barriers resulted in increased isolation and a difficulty for public health nurses in providing health care services and support for refugee women postpartum. Informed by a health capability framework, these authors argue that “it is socially unjust for any individuals to be deprived of capabilities to be healthy as a result of sub optimal health care; inhibiting health agency (i.e., the ability to engage with and navigate the health care system to prevent mortality and morbidity)” (p. 286).

The study by Fung and Wong (2007) examined the factors influencing help-seeking amongst east and south Asian immigrant and refugee women in Toronto, Canada. Drawing on a sample of 1000 ethnically diverse Chinese Canadian (Hong Kong, mainland Chinese and Taiwanese) women, Korean Canadian women and Vietnamese women, their findings showed that cultural variability exists in relation to women’s health beliefs; East and southeast Asian women did not represent a homogenous group in their beliefs about mental health. Moreover, systemic factors related to culturally, linguistically and gender appropriate health care influenced immigrant and refugee women’s health seeking.

Fung and Wong (2007) argue that improving access to culturally responsive mental health services needs to include a closer examination of systemic sociopolitical factors that affect inequitable access, such as an examination of the economic demands that are placed on women during resettlement (e.g., women who
work long hours and as a result cannot access care). These authors suggest that mainstream mental health practices that tend to reduce barriers to healthcare access to individual cultural differences have consequences as “other systemic issues will be tantamount to unfairly blaming the patient population and justifying the inequitable service provision for racial minority populations” (p. 227). In other words, barriers in access to mental health services must consider the intersecting factors that affect refugee women’s mental health and well-being beyond issues of language and cultural practices. These findings suggest that current structures lack comprehensive approaches to service delivery that encompass the social determinants of women’s health despite advances made in immigration policies that allow for admission of refugee groups that come to Canada with complex medical conditions, including those that are trauma related.

2.7 Examining Language and Literacy Barriers of Refugee Women

Census data (2011) reports that 20.6% of Canadians (6.8 million people) reported a mother tongue other than English or French (Statistics Canada, 2011). Evidence suggests that in comparison to other immigrants, refugees have less language ability (in English or French) (Welcome, BC, 2011). Language ability varies among categories of refugees with GARs having the lowest language ability, (28.9%) compared with asylum refugees at (94.7%) (Welcome BC, 2010). In 2004-2008, for refugees over the age of 25, 53.5% had secondary education or less, in comparison to 52.6% of all other immigrants who have university education and 20.7% with less than secondary education (Welcome BC, 2010).
In addition to proficiency in one of Canada’s two official languages, English and French, some refugee women and their families arrive with lack of reading and writing skills in their own language. An emerging body of literature suggests that basic literacy and health literacy also impact refugee women’s access to health care and settlement (Kickbusch, 2001; Merry et al., 2011; Mitschke, Aguirre, & Sharma, 2013; Rouhani, 2011; Simich, 2009; UNHCR, 2013; Zanchetta, Kaszap, Mohamed, Racine et al., 2012).

Rouhani (2011) conducted a secondary data analysis from a study on government assisted refugees (GARs) in BC who attended a specialized refugee health clinic between the years 2005-2007. A multivariate logistic regression was used to develop a model to explain the factors associated health, mental health, physician visits and barriers to health care access. Drawing on a sample of GARs (N=177), 91 (51.4%) women and 86 (48.6%) men, findings showed that being of west African origin, having a financial burden, no English proficiency and being female were statistically significant at the 0.05 level in relation to the reporting of mental health problems. Results of the logistic regression analysis showed that women were less likely than men to report having excellent health, and overall, GARs with less English language proficiency were less likely to report having excellent health than those with English proficiency. This finding is also consistent with Marchbank et al. (2014) and Cubie (2006) where GARs with lower literacy found it difficult to explain complex illness and to navigate the health care system.

Rouhani (2011) argues that language alone is not sufficient to account for lower health status and that language may have greater meaning when evaluated
within a health literacy framework. Rouhani suggests that health literacy may be a strong predictor of self-reported health and is related to multiple factors. Although women were more likely to report poorer health, literacy, unemployment, physical and mental health problems, Rouhani notes that these findings are further complicated by inaccuracy of instruments measuring mental health, i.e. cultural differences may not have specific terminologies to express Western constructions of mental illness.

An interesting finding of the research conducted by Rouhani (2011) was that where there was an increased prevalence of health care workers who spoke the primary language of the refugee, in local and specific geographic locations, there also was an association with increased health care access. For example, west Asians were reported to have increased access to specialized refugee clinics because they also had access to health workers who spoke their primary language, (Persian, Dari or Farsi). Ninety-two percent of GARs reported to speak Persian, Dari or Farsi with health care workers, compared to 36.3% of east and southeast Asians who spoke Chinese, Karen, Burmese, Vietnamese or Jirai with their health care workers.

Zanchetta, Kaszap, Mohamed, Racine et al. (2012) examined health literacy from the perspective of linguistic minority of Francophone families in Canada, and their findings corroborate Rouhani’s (2011) in that Francophone women were perceived to experience increased barriers to healthcare services due to their gendered roles of providing healthcare to other family members. In contrast Francophone men were perceived to be more connected to community by their jobs. Thus, being employed and having school aged children determined the extent of
women’s interactions with the broader community, which translated into social support (Zanchetta et al.). Health literacy of Francophone women was related to formal and informal social networks. Women were perceived to experience increased social isolation due to lack of connections with extended social networks and therefore relied heavily on immediate family members to assist in addressing and accessing health issues. Zanchetta et al. argue that the social environment reflects communicative, interactive and relational dimensions of health literacy which may explain why minority language communities do not access healthcare resources.

Increasingly, literacy also has been recognized as encompassing more than the ability to read and write but includes comprehension ability and knowledge of a particular subject (Peerson & Saunders, 2009). Drawing on Zarcadoolas et al. (2005), Peerson and Saunders define health literacy as encompassing a “wide range of skills and competencies that people develop to seek out, comprehend, evaluate and use health information and concepts to make informed choices, reduce health risks and increase quality of life” (p. 288). Stemming from the field of health promotion literature, Nutbeam (2006) has extended the definition of health literacy to include the health promotion behaviours that shape individuals, as well as a population’s ability to respond to social, economic and environmental factors that impact health. Nutbeam’s analysis of health literacy is based on an empowerment model that engages individuals to participate in making health care decisions. This view of health literacy moves beyond functional health literacy (basic reading and
writing skills to understand and follow simple health messages) to an interactive approach that requires partnership with professionals and the broader community.

Kickbusch (2001) offers a more critical analysis of intersecting factors affecting women’s health and literacy. Drawing on HIV/AIDS research with women in developing countries, Kickbusch argues that despite women having access to education, other factors such as gender and sexual violence also impact health literacy. Kickbusch adds:

The high death rate in teachers can partly be explained by the fact that many teachers are women and in most of these cultures, women do not have much power in relation to their family roles and their husbands’ sexual demands (2001, p. 291).

Thus, health literacy cannot be examined only by a woman’s level of education but needs to be analyzed in terms of social context that promote women’s agency. As a key public health issue Kickbusch (2001) further recommends that investing in social approaches to building literacy and health literacy can close the education and health divide, however, “short term efficiency gains in health care reform are constantly highlighted...health literacy as a major health investment and health development strategy needs long-term commitment, strong partnerships and powerful spokespeople” (p. 295).

Simich’s (2009) report on health literacy and immigrant populations in Canada suggests that health literacy is the strongest predictor of health status and important to maintain health. Simich defines health literacy as “a multidimensional communication process. It also involves health care providers competencies, the ‘legibility’ of the health care system for diverse groups and appropriate policy and
programs to achieve effective communication” (p. 3). Simich’s findings also suggest that low health literacy has been linked with poorer mental health outcomes for southeast Asian women and interlinked with depression and [un]employment (Simich). In addition, consistent with the findings of Rouhani (2011), Simich concludes that immigrant women were found to have lower literacy than immigrant men (Simich, 2009).

Simich (2009) recommends that health literacy should be a part of mainstream language classes and that policy and program recommendations for enhancing health literacy include a focus on the needs of immigrant and refugee women, working across services and sectors such as employment agencies, public health services and cultural interpreter services; all to support the development of health literacy skills.

Drawing on social determinants of health literacy, Mancuso (2011) developed a framework for building community capacity and health literacy skills with Indonesian refugees in the US. This community development project used local public health nurses and community pastors to develop networks of support in building health literacy skills. Through a collaborative engagement process Indonesian refugees were able to obtain increased knowledge of diabetes and cardiovascular health. Reciprocally, health care providers and local community stakeholders gained increased knowledge about refugee needs. A conceptual model for action was developed for promoting health literacy that included, i) civic literacy (role of interpreters and health systems), ii) cultural literacy such as addressing providers' expectations and iii) group decision making and enhancement of
scientific literacy, which includes but is not limited to knowledge building about mental health and health screening. Findings from Mancuso draw attention to the role of community and, like Simich’s (2009), suggest a systemic approach for building health literacy with refugee groups who may lack reading and writing ability in their language of origin.

Mitschke, Aguirre, and Sharma (2013) conducted a group-based intervention study on financial education for Bhutanese refugee women in the US. Their review of settlement and mental health suggest that some refugee groups are not able to navigate the nuances of the American financial system. Both language and literacy are required for the ability to perform and understand how loan payments and interest rates work (Mitschke et al.). Findings showed that the mental health of Bhutanese women improved through shared learning, where learning occurred through an innovative social enterprise project that involved knitting market-quality scarves. In contrast, control participants were found to have poorer mental health over time.

Morris, Popper, Rodwell, Bordine and Brouwer (2009) conducted a qualitative pilot study in San Diego, California, exploring health care access issues of refugees after government assistance ended. Similar to Vancouver, the city of San Diego was the third largest settlement site for GARs in the US during the years 2001-2009. The researchers aimed to understand the social and structural barriers preventing resettled refugees from fully accessing health care services. Their sample included qualitative individual interviews (n=40) with refugees from Somalia, Iraq,
Vietnam, Sudan, Iran, Afghanistan, Ethiopia and Russia as well as settlement workers and health care providers.

Findings from Morris et al. (2009) showed that health care providers, settlement workers and refugees perceived that they were still not receiving adequate health care one year after resettlement. Language and communication was the most common perceived barrier to health access across refugee groups and service providers. Even when language services were provided some refugees felt that they did not have a choice but to access a health provider who spoke their native language. Health care providers identified that knowledge of how to navigate the health care system, fill out forms and make appointments was also perceived as a barrier to access. These findings also supported by Marchbank et al. (2014) and Rouhani, (2011). All refugees were found to be reliant on family, friends and settlement workers for interpretation. Settlement workers reported being understaffed and undertrained. The authors recommended that alternative resources such as over-the-phone interpreters, enhanced face-to-face professional interpreters and video conferencing could enhance language resources and health access.

Deacon and Sullivan (2009) examined barriers to health access for refugee women in the US and found language skill to be a significant predictor for accessing services. These authors conducted a needs assessment with 31 refugee women from Iraq, Afghanistan and the horn of Africa who had recently settled in the US. Their findings showed that learning English, financial support and employment opportunities, social support, agency resources, and access to resources generally
were not adequate. Of the refugee women, 94% stated that English language needs and language skill was a significant barrier to accessing resources such as housing, and public transportation. For women who were single heads of households, 69% were employed in comparison to only 20% of women whose partners were residing with them. Language needs also prevented women from being able to complete medical forms and was a significant concern. In addition, single women indicated that they wanted more skills and language training and access to transportation. However, single women were less knowledgeable about where to go for help.

In summary, a review of these studies suggests that language and basic literacy and health literacy are important social determinants of mental health and well-being of refugee women and that these factors need to be integrated when planning health care services and settlement supports. Critical health literacy approaches address the need for increased resources, empowerment pedagogical approaches that acknowledge gender as a key determinant for education, employment and literacy for refugee women. While many studies report language barriers as a predictor of health care access, an additional focus on health literacy shifts the gaze toward building literacy by including multiple community resources beyond and including health care services. Language resources vis-à-vis interpreter services have been linked with geography and prevalence of ethnic groups that speak minority languages (Rouhani, 2011; Zanchetta et al., 2012). However, the availability of interpreter services and built in linguistic support for newcomer groups and groups who speak minority languages are not well integrated across health systems in Canada. Fewer studies provide a gender analysis regarding
refugee women’s gendered responsibilities for family health and intersection with literacy and education. Consistent findings suggest that many minority women who are not proficient in English and who have lower literacy are not able to access healthcare, employment and education.

2.7.1 Lack of integrated official language policy

Refugee access to settlement resources, including health, has been linked across studies with English language proficiency. However, the lack of official guidelines and policies on language services for newcomer groups in Canada is a cultural risk and violates health legislation in Canada that advocates universal, comprehensive and accessible health care services. An overview of interpreter services and language access across Canada shows inconsistent use of interpreters, a lack of knowledge amongst service providers regarding use of interpreters and inconsistent policies (Abraham & Rahman, 2008; Bowen, 2001).

Research conducted in the late '90s by a nursing scholar in BC drew attention to the impact of health reforms on health care access for ethnic minority groups. Tang (1999) examined the effects of economic reforms in BC in the 1990s as a key factor in the provision of accessible language resources for minority groups who do not speak English or French. Tang points out that reforms have direct implications for health care service delivery and argues that there is a need to balance financial considerations of institutional efficacy with equitable access and quality care. At that time Tang made several policy recommendations; these included: 1) share resources amongst institutions, e.g., to foster partnerships so that language resources could be shared; 2) identify factors that hinder equity oriented policy; 3)
develop community interpreter services and; 4) use a centralized interpreter service. Although each province varies according to central and local language resources, it is often the case that minority languages are not represented. Moreover, there are no national standards for legislating language support for health care services.

In 2001, Bowen conducted a report for Health Canada entitled “Language Barriers in Access to Health Care”. This report summarized the structural effects of the lack of language interpreters and their effects on health care access. Key findings of this report were that: 1) health care accessibility was not only linked to physician and hospital care but also various health prevention and promotion programs where first point of contact is often made by non-English or -French speaking users; 2) reduced access to mental health and specialty services was linked to language barriers; 3) language barriers resulted in increased hospital admissions and medical problems; 4) there was an overall decrease in quality of care since professional groups are unable to provide ethical standards of practice; and 5) no national standard in Canada exists on language access in health care. Bowen points out that in the absence of legislation requiring health interpreters, many community services and institutions resort to informal interpreters and translators. Current systems in Canada rely on unpaid volunteers, family members, friends and other professionals to assume the role of language interpreter. Another finding is that health care professionals want direct communication unmediated by a third party.

Bowen (2001) has argued that there are several legislative acts in Canada that have not fully addressed the issue of language access in Canada, including the
Canadian Charter of Rights and Freedoms, the Canadian Human Rights Act, the Canadian Health Act and the Canadian Multiculturalism Act.

In Canada, The Canadian Human Rights Act has been challenged by a court ruling (Eldridge vs. British Columbia) in which interpreter services were deemed necessary for deaf individuals to communicate with care providers (Bowen, 2001). As a result of funding cut backs in sign language and interpreter services in 1990, language interpretation for deaf individuals severely compromised health care treatment and medical access for individuals who are deaf.

The Canadian Human Rights Act (1985) states that

> every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability (p. 5).

It was claimed that the lack of provision for sign language interpreters resulted in misdiagnosis and treatment and therefore violated the existing charter, which identifies equal benefits under the law and declares any discrimination based on disability as a violation of human rights (Bowen, 2001). However, the state argued against language provisions for non-official-language speakers in Canada. As a result there is a lack of Canadian policy around the mandatory use of interpreters for individuals who do not speak one of Canada’s two official languages. The lack of interpreter supports for Karen women in BC has created a barrier to accessing health care services and supports (Marchbank et al. 2014).
A recent survey conducted by Brisset, Leanza, Rosenberg, Vissandjée et al. (2013) of primary care practitioners from six community health and social services centers (HSSCs) in Montreal showed that 35.4% of practitioners had access to linguistic resources through their institutions and 23.9% had provided interpretation services. Although 62.3% of practitioners used professional interpreters, only 2.6% had received training in how to work with interpreters. Approximately 57.1% of practitioners were reliant on someone close to the family to interpret. Allophone clients were more likely to keep appointments when there was an interpreter available, but less likely to attend when an interpreter was provided by the institution (Brisset et al., 2013).

Practitioners found working with interpreters time consuming and, in addition, interpreters required more training overall (Brisset et al., 2013). Providers felt they had more control over the health care encounter with professionally trained interpreters than non-professionally trained (family or friends). The findings of this study further suggest that practitioners found working with interpreters neither advantaged nor hindered their ability to assess the client’s emotional state, nor fostered the practitioner client relationship. Practitioners wanted interpreters to provide accurate translations as well as sociocultural information; however, overall, primary care providers preferred unmediated communication. Patient advocacy vis-à-vis interpreters were not viewed by primary care providers as significant to the health encounter (Brisset et al.).

In 2007, The Healthcare Interpretation Network (HIN) (2007) developed a national standard guide for community interpreting services. However, there has
been very little uptake of these standards to guide addressing the needs of low English/French proficiency populations (Abraham & Rahman, 2008). This has resulted in a myriad of challenges for health care providers who work with women from an increasingly diverse range of ethno-racial and linguistic backgrounds (Abraham & Rahman). Abraham and Rahman provide an overview of the Canadian literature on working with community interpreters and offer a model for best practice as well as suggested guidelines for working with interpreters in mental health. Their findings showed that there continues to be a lack of public policy addressing linguistic barriers in Canada. Abraham and Rahman further argue that “there needs to be a concentrated effort on the part of all actors—service providers in the social, legal and health care services, advocates for social justice and equity, and the government of Canada—to push for legislative and policy change” (p. 117).

Although this brief overview shows gross inequities related to provision of language services in Canada, there is evidence to suggest that minority ethno-cultural language groups are underserved internationally. Gerrish, Chau, Sobowale and Birks (2004) conducted a study in the UK in which they examined the utilization of interpreter services from the perspective of primary care nurses, interpreters and minority ethnic communities. Interpreter services were viewed as inadequate by all participants; the study found that most non-English speaking women were reliant on family and friends for this support. For health care providers, there was an overall lack of awareness of how to use interpreters and their various roles. Lack of time and financial considerations were also shown to be barriers for integration of interpreters. Overall, Gerrish et al. noted that when interpreter services were
utilized rapport was enhanced and relationships and quality of care improved for minority language groups. Similarly, Johnstone and Kanitsaki (2007) examined the construct of cultural safety in the context of health care provision in Australia. Although these authors critique the ambiguity of cultural safety, their findings revealed that despite lack of conceptual clarity, “there was strong congruence in the data across all categories of participants that patients from diverse racial, ethno-cultural backgrounds did not feel safe…” (p.252). Processes underpinning a patient's sense of safety were identified as, the

inability to communicate with service providers; lack of respect, not having family present; not being listened to or understood; not knowing what was going on; inflexibility of the system; not having access to safe and competent interpreting; and feeling shamed and/or embarrassed on the account of having to rely on children or other “inappropriate relatives” as interpreters (Johnstone & Kanitsaki, 2007, p. 252).

These factors suggest that language and communication remain key factors essential for mitigating unsafe cultural practices.

However, Johnstone and Kanitsaki (2007) also showed that providers of care (e.g., nurses, interpreters, allied health professionals and doctors) also experienced vulnerability and cultural risk within the health care environment. For example nurses who were immigrants and had an accent experienced discrimination from other providers. The enactment of cultural safety requires that health care providers examine power relations that have been historically and socially embedded in institutional settings and practices (Kirmayer, 2012). The lack of policy and clear guidelines for use of professional interpreters remains a significant structural barrier for refugee women accessing primary health care services.
Structural violence, according to Oxman-Martinez and Hanley (2011), “...reflects pre-existing social and economic drawbacks in Canadian society, and therefore, grants unequal opportunities to different groups and categories of persons within Canada” (p.230). Moreover, the lack of enactment of and/or instituted policy on translation services is a form of structural violence because it creates cultural risk and demeans and disempowers women from accessing services.

Oxman-Martinez and Hanley (2011) examined the health and social service experiences of women migrants to Canada. Their review of both the Canadian Council for Refugees and the role of NGOs’ responses to immigrants and refugees’ health and well-being suggest that many newcomer groups lack confidence in accessing health care and that they receive a higher rate of diagnosis of mental health problems. Oxman-Martinez & Hanley argue that structural factors such as policies that exclude migrant women from access to health, social services and supports, are a form of violence that manifest in increased symptoms of vulnerability, depression, mental distress, and further isolation. Similarly, Kirmayer et al. (2011) note that many immigrants and refugees are at increased risk for mental health problems “when faced with enduring obstacles to advancement in their new home because of structural barriers and inequalities aggravated by exclusionary policies, racism and discrimination”(p.E961).

2.8 Refugee Women’s Mental Health and Well-being

A review of studies suggest that mental health outcomes are better understood by more complex models that show how various intersecting factors
shape refugee women’s mental health during resettlement (Beiser, 2009; Fung & Wong, 2007; Kirmayer et al., 2011; Donnelly et al., 2011). For example, although language and literacy are significant barriers for many migrant women’s access to health and social supports, these factors cannot be separated from the way in which gender structures the lives of refugee women and men transnationally and during resettlement. It has been argued by Pessar and Mahler (2003) that there is a need to examine gender relations and how these facilitate or constrain both women’s and men’s experiences of settlement. Moreover “people do gender work through gendered practices and the discourses they produce and/or contest hierarchies of power and privilege” (Pessar & Mahler, 2003, p.813).

Examining contextual factors of place and health, the ethnographic study by Dossa and Dyck (2011) with south Asian Sikh immigrants and Afghan Muslim refugee women, examined how place, health and home constituted the health and well-being for migrant women. Drawing on women’s everyday experiences, their findings suggest that place and location are influenced by factors of race, nationality and class, that intersect with broader aspects of the political economy, process of migration and local community contexts (Dossa & Dyck).

Contrasting the similarities and differences between Afghan Muslim women and south Asian immigrant women, Dossa and Dyck (2011) found that although south Asian women entered Canada as family class immigrants, with lower education, they lived in extended family households and cultural communities in which their everyday cultural practices of food and prayer supported their health and well-being. In contrast, Afghan refugee women were found to be single heads of
households, have higher education and were employed part time. Health and place
converged differently in a complex “spatiality of home space and belonging” (Doss &
Dyck, p. 254). For both Sikh and Muslim women, indigenous healing practices and
prayer were constitutive activities of healthy space (Doss & Dyck, 2011). Like food,
prayer and religious community were attached to the women’s neighborhoods and
institutional spaces. For example, Afghan women were more isolated and attended a
makeshift mosque in a neighborhood school; in contrast, Sikh women had access to
an established Gurdwara temple. Despite these differences, Dossa and Dyck
concluded that both groups of women expressed a collective experience in Canadian
society as Other and maintained transnational identities with their home country
though food and prayer. In addition, both groups of women “experienced normative
constructions of gender, associated with the domestic realm, where reinscribed by
state policy through migration... [and where] both groups of women were taking
primary responsibility for health and care work” (Dossa & Dyck, p. 245). While it is
important to address the issue of gender and gender blind theory, Henderson and
Waterstone (2009) warn that

the assumption that women universally (and perhaps historically) are
primarily engaged in home and child care may reflect stereotypes of
Western culture in the recent past, but can lead to inaccurate
generalizations. Models and theories that simply assume all
households are “traditional” nuclear families are not useful for
understanding changing urban spatial structure as a function of
fundamental or demographic social changes (p. 39).

It is therefore salient to point out, as do Dossa and Dyck (2011), the
contradictions and differences within migrant women and the social structures that
pattern gender and perhaps reinforce patriarchal organizations of society.

Henderson and Watersone (1992) argue that “women’s work outside of the labour force is unrecognized and within the labour force is not broken down by occupation as it is for male heads of households on whom the social status index is therefore based” (p. 39). Gender conflict over changes in roles related to the employment of women may threaten previous gender roles post migration (Guruge & Collins, 2008; Omeri, Lennings, Raymond, 2006). These changing roles and positions may also be a contributing factor in mental health for refugee men and women post migration (Baya, Simich & Bukhari, 2008).

A community-based study conducted by Baya, Simich and Bukhari (2008) examined Sudanese immigrant and refugee women’s resettlement experiences in Ontario, Canada. Drawing on a sample of interviews with newly arrived Sudanese families (N=220) across various cities in Ontario, findings showed that the family sphere and women’s roles were essential for social support for settlement and mental health. Respondents indicated that marital relations and changes to gender roles post migration contributed to resettlement stress. These authors surmise that race, culture, gender and class intersect to shape mental health and well-being of men and women during resettlement. For example, gender role reversal where women work inside and outside of the home may challenge familial patterns of power. Sudanese men also reported experiencing gender role changes as many were not able to gain employment. This resulted in their inability to fulfil their culturally defined responsibilities and resulted in experiencing ongoing source of shame and strained family relations and mental distress. For example, obligations to send
money to help extended family members may elevate women’s status. This finding has been found in other studies where patriarchy is challenged and buttressed transnationally when remittances are sent by women who maintain the primary bread winner role (Pessar & Mahler, 2003; Hyndman & Walton-Roberts, 1999).

Sudanese women from southern Sudan were found to have lower education than men and were more disadvantaged in employment, with only 22% of female respondents being employed compared to 53% of Sudanese men. The majority, 70% of employed men, held full time jobs, whereas only half of the employed women did (Baya, Simish & Bukhari, 2008). Both Sudanese women and men acknowledge the non-recognition of pre-migration education, professional training and work experience as exclusionary and discriminatory. Baya et al. found that 60% of Sudanese women found getting around independently, and language and communication more difficult than their male counterparts. In addition, for women, mental distress was associated with difficulties related to language, in particular communicating with medical professionals. This finding is supported by other research that suggests refugee women experience an added burden of responsibility for family health (Simich, 2009; Zanchetta et al., 2012). Sudanese women were willing to take on any jobs to ensure the survival of their families (Baya et al., 2008). This gave some women work opportunities otherwise denied prior to migration. However, because Sudanese women lacked an English language proficiency, they tended to take on lower level jobs with longer hours and no job security.

In the absence of extended family networks and affordable childcare, many Sudanese women experienced increased isolation and found it difficult to access
language training and adult education. Seventy nine percent of Sudanese women reported that housing was significantly related to social support, social interaction and assistance. Half of Sudanese women reported that they were not able to use settlement services due to experiences of cultural insensitivity, lack of awareness of services and language barriers. Although the study findings are not dissimilar to other outcome studies of newly arrived refugee groups, findings from Baya et al. point out how gender is structured both familially and institutionally post migration.

Pessar and Mahler (2003) have argued that “gender should also be understood simultaneously as a structure that is a latticework of institutionalized social relationships that...organize and signify power at levels above the individual” (p.813). As part of the impact of the Immigration and Refugee Act (2008) the CIC generated a report that was to identify important differences between refugee men and women, boys and girls. The gender based analysis (GBA) is intended to focus on the social and economic differences between men and women and different groups of refugee men and women in relation to existing policies, programs and legislation. The CIC’s strategic framework for building and maintaining departmental capacity related to the GBA is focused on building knowledge of the gender related issues related to immigration and integration (CIC, 2006). The CIC (2008) analysis revealed several gaps in existing immigrant and refugee services related to women’s needs.

The findings from CIC (2008) suggest that service provider organizations such as the refugee assistance program (RAP) need to incorporate gender sensitive
orientation services that include services related to family violence, legal rights and gender roles of men and women. In addition, CIC (2008) recommends that a specific teaching strategy be incorporated for individuals with lower literacy levels. However, these policy recommendations have not been fully adopted in the context of wide scale settlement reforms affecting resettlement needs of refugee women. For example, current employment skills require high language and literacy ability which many refugee women do not have, thus limiting their access to secure employment.

### 2.9 Refugee Women and Social Support

Although it is generally accepted that social ties, both formal and informal, support psychological well-being, the inclusion of gender as a factor in health and migration is complex (O'Mahony & Donnelly, 2007; Vissandjée, Thurston, Apale & Nahar, 2007). There is some evidence to suggest that increased social ties through social network participation may account for a higher prevalence of psychological distress among women compared to men (Kawachi & Berkman, 2001). Examining the contextual dimension of social ties, Kawachi and Berkman have argued that human relations consist of multiple layers embedded in social networks that may provide a sense of belongingness that promotes psychological well-being. However, Kawachi and Berkman argue that “it is not always the case that tight-knit social structures always lead to better mental health outcomes” (p.463). Drawing on the work of Durkheim (1951), Kawachi and Berkman add that oppressive consequences maybe imagined for the mental health of individuals who reside in close-knit
communities in particular, “social connections may paradoxically increase levels of mental illness symptoms among women with low resources, especially if such connections entail role strain associated with obligations to provide social support to others” (p.458).

Recent studies into gender and migration have drawn attention to gender relations “yielding toward a more praxis oriented perspective wherein gender identities, relations, and ideologies are fluid, not fixed” (Mahler & Pessar, 2006, p.29.). Moreover, while there has been some analysis of gender in research and social policy in Canada, gender is for the most part treated as an isolated variable and not as a social construction that structures the lives of women and men and that intersects with other axes of differentiation (Mahler & Pessar). Like Kawachi and Berkman (2001), Mahler and Pessar maintain that migrant social networks can be highly contested social resources, not always shared with family groups or wider networks.

Donnelly, Hwang, Este, Ewashen et al. (2011) conducted a study of immigrant and refugee women from China and Sudan (N=15) who have known mental illness to explore the challenges to women’s help-seeking. Their findings showed that social support was the most significant component in helping women managing their mental health. However, for migrant women over-reliance on informal support had mixed results; many women had lower education and experienced marital abuse or stigma. Barriers to formal help-seeking were related to fear, experiences of trauma, loss and distrust of authority as well as a lack of awareness of services (Donnelly et al.). Reliance on informal sources of support
resulted in some women experiencing distress, particularly around confidentiality issues. Women who experienced marital abuse also feared that their mental illness would allow their partners to exert more control and power over them. In addition, community based services where language services and interpreters were available and where women received written translated information about mental health issues enhanced access for mental health services and community based health promotion programs (Donnelley et al.).

In conjunction with the “Canadian Collaboration for Immigrant and Refugee Health,” Pottie et al., (2011) conducted a comprehensive review of the existing evidence-based clinical preventive approaches and existing public health services regarding health inequities and gaps in current knowledge related to newcomer health. Their review showed that for newly arrived pregnant immigrant and refugee women in Canada, the lack of social support and social isolation impacted their pregnancy and care. Their review also found that 14.6% of asylum seekers and 7.7% of refugee women live alone, in comparison to 2.7% of Canadian-born women. Migrant women have higher rates of pregnancy as a result of sexual abuse and higher rates of cesarean sections than Canadian born women.

Similarly, social support and stress were also found to be related to an increase in postpartum depression (PPD) in a study by Collins, Zimmerman and Howard (2011). Collins et al. conducted a review of 1,174 articles across ten databases about the risk factors and prevalence of postnatal/postpartum depression (PPD) among immigrant, refugee and asylum seeking women. Their review of studies showed that immigrant and refugee women experienced up to
42% risk of PPD in comparison to 10-15% risk for native born women. Most studies used the EPDS\textsuperscript{32} scale to identify depressive symptoms. However, the authors note that this scale may lack validity in contexts where migrant women have different cultural expressions of illness. In addition, the cut-off point for measuring depressive symptoms was not standardized across studies. Collin’s et al. review identified that common risk factors for PPD across immigrant and refugee and asylum women (these included stressful life events prior to and during pregnancy and an absence of social support, cultural factors and language barriers as well as stigma) increased risk for PPD for all migrant women. Refugee women who had experienced violence or problems with authority in their countries of origin had a greater risk (p<0.05) for PPD. In addition, asylum-seeking women who lacked public funds for health care were also at risk for PPD. Six studies identified social support as consistently associated with PPD across all women including immigrant, asylum and refugee women.

For immigrant, refugee and asylum women PPD was also related to language barriers, lack of knowledge about health care systems, loss of family networks and dependence on their husband’s family for support. The authors recommended that pre and post migration factors such as exposure to violence, social isolation and cultural practices must be integrated with healthcare planning and provision of health care.

\textsuperscript{32} The Edinburgh postnatal depression scale (EPDS) is commonly used for assessing women at risk for postpartum depression. Scores >13 indicated depressive symptoms (Collins, Zimmerman & Howard, 2011). It is noted by experts in the field that the EPDS “may provide unreliable results due to words or phrases that cannot be literally translated into another language”(Ardiles, Dennis & Ross, 2008, p.303). Furthermore because of “cross cultural differences in expression of depressive symptoms, appropriate cut-off scores may vary for different populations” (Ardiles et al., p.303).
services to migrant women. In addition, there needs to be greater awareness of the differential needs across different migrant women as non-homogenous groups.

These findings are consistent with a Canadian review conducted by O’Mahony and Donnelly (2010) of immigrant and refugee women’s experiences of postpartum depression (PPD). Findings from O’Mahony and Donnelly’s analysis of the literature showed that immigrant and refugee women experience significant risk factors for post-partum depression (PPD) and that factors such as social support, gender and institutional and organizational structures were identified as barriers related to women’s help-seeking. O’Mahony and Donnelly’s review also suggests that there is an inverse relationship between social support and symptoms of depression across immigrant women with lower socioeconomic status. Socio-economically disadvantaged women were less likely to report good health, have increased symptoms for PPD and were more likely to be discharged from hospital earlier than economically advantaged women. In addition, their findings show that refugee women were more likely than Canadian-born women to score above the cut-off point on the Edinburgh postnatal depression scale (EPDS) but less likely to ask for help.

Using a health promotion framework to identify protective as well as psychosocial risk factors, a review of studies conducted by Ardiles, Dennis and Ross (2008) substantiate findings by Collins et al. (2011) and the work by O’Mahony and Donnelly (2010). Ardiles et al. argue that social support is cited as the most significant psychosocial stressor and immigrant status itself may be a predictor for PPD. Factors such as acculturation and women’s experiences of discrimination may
also deter women from seeking formal support related to post-partum care. Protective factors such as practice rituals related to motherhood are noted as promoting positive mental health (Ardiles et al.). These may include changes in eating habits or avoiding hot and cold, however, Ardiles et al. argue these rituals may protect some women against PPD, others may find that the rituals create added stress and isolation for the new mothers. Like Collins et al. (2011), Ardiles et al. recommend that “apart from improving existing services, evaluating the effectiveness and people’s satisfaction with existing programs may also help with the planning and implementation of new programs that address maternal preferences and promote evidence based practice” (p.312).

2.9.1 Intimate partner violence relating to immigrant and refugee women

Some studies suggest that migration may increase the risk of intimate partner violence (IPV), between men and women (Mason & Hyman, 2008; Pottie, Greenaway, Feightner, Welch et al. 2011), however, empirical evidence is limited. Drawing on Hassan, Brett, Thombs, Rousseau et al. (2011), Pottie et al. define intimate partner violence as a “physical, emotional, financial and/or sexual abuse perpetrated against the victim by his or her intimate partner” (p. E60). Pottie et al. conducted a systematic review of IPV amongst immigrant and refugee women in Canada. Their findings showed no systematic reviews or evidence-based guidelines on screening, prevention or treatment related to IPV amongst immigrant and refugee women. Based on two systematic reviews, however, findings showed the highest prevalence rates of IPV in women born in developing countries, followed by Canadian-born women (pp. E60-E63). However, when other variables were controlled for, findings
showed that newcomer women who had been in Canada less than ten years had lower odds of IPV than longer term immigrant women and Canadian-born women. Another finding was that single, divorced, separated and widowed immigrant women were ten times more likely to report IPV than married women. Overall, immigrant women reported higher emotional abuse than Canadian women (14.7% vs. 8.7%), with the strongest risk factor being the low education level of their partner (Pottie et al., 2011). In addition, gender roles, education, and women having experienced displacement in refugee camps in their countries of asylum were factors associated with a risk for IPV (Pottie et al., 2011). Pottie et al. argue that there are no clear benefits from screening immigrant and refugee women. These authors recommend that screening may have potential benefits and risks; screening may increase support but also could result in women feeling judged, being at increased risk for further abuse and for being reported to child protection services. Moreover, when compared with the general population, there may be greater risk among immigrant and refugee women for harm directly related to screening (e.g., risk of loss of migration status and sponsorship agreements). Harm may occur indirectly through impaired patient-physician rapport and subsequent reduction in use of medical and mental health services (Pottie et al., 2011, E 60).

Pottie et al. conclude by further recommending a need for increased social support and tailored community services with attention to language and culturally competent approaches in order to increase supports and decrease risk for IPV.

Mason and Hyman (2008) conducted a literature review of IPV amongst immigrant and refugee women. Similar to Pottie et al.’s (2011) findings, they found
that IPV intersects with resettlement stress associated with gender roles and experience of trauma and that these experiences usually are underreported. Their findings suggest that IPV may be more prevalent for women who come from patriarchal societies. In addition, migration and resettlement may also improve gender relations between men and women and potentially decrease IPV. Barriers for not disclosing IPV included differing customs and beliefs around acceptable behaviours and unfamiliarity with the concepts of abuse, language barriers and lack of knowledge about services. Their review suggests that immigrant and refugee women experience slightly lower rates of IPV compared to Canadian-born women. Although IPV may be lower for some immigrant and refugee women, their research supports the evidence that women experiencing IPV have higher rates of depression, PTSD and anxiety compared to women with no history of abuse (Mason & Hyman).

A review of research on refugee women and mental health suggests that gender must be treated, not as an isolated variable, but as a social and relational construction. Various intersecting factors may predispose refugee women to resettlement stress, including changes in gendered relations, different aspects of social support, and gender parity. In summary, a review of studies recommended that social determinants of mental health be included in health and settlement supports as well as the differential needs and experiences of migrant women. Capacity to promote health and well-being of refugee women requires women-centered approaches that address broader health determinants such as migration history, gender, and social support.
2.9.2 The role of social support and mental health

Mitschke, Aguirre, and Sharma (2013) note that the everyday life of resettlement for refugees shifts toward navigating the barriers of culture, language and access to care. This reality draws attention to social support as a protective factor for mental health and well-being (Kawachi & Berkman, 2001). Supporting Sherrell’s findings, Simich, Beiser and Mawani (2003) examined the role of social support as a determinant of refugee well-being and migration patterns during early phases of resettlement. This multiphase study drew on in depth interviews with immigration and settlement service providers (N=38) in Ontario, Quebec and overseas, to understand the process of migration and the factors that lead to secondary migration once refugees had been destined for a particular Canadian province. Phase two of this study also included semi-structured interviews with secondary migrants (N=47) to identify types of social support that were most meaningful to refugees. Lastly, phase three of this study included two focus groups Ottawa (n=15) and Toronto (n=7) with secondary migrants (N=22) to discuss findings and ground interpretation of the results. Findings showed that refugees identified different aspects of social support including informational, instrumental, and emotional support as important factors in their resettlement process.

Simich et al. (2003) note that “among 47 secondary migrants...30 had expressed a preferred destination because of the presence of family or friends but were destined elsewhere” (p. 879) as a result of bureaucratic imperatives to fill refugee targets for provincial communities. Refugees discussed that having advanced information about informal supports such as housing, education and
employment helped reduce stress associated with resettlement. Most secondary migrants noted that they received very little orientation and knowledge about the context in which they were being resettled. Instrumental support was perceived as authoritative. This meant that refugees often turned to those who had a shared experience of settlement. The authors argue that affirmation support from those who have successfully adapted was an important source of emotional support for newly arrived refugees. Simich et al. conclude that affirmational support was the overriding concern for refugees in this study. The search for secondary migration once inside Canada was contingent upon refugee perception of social support.

Similar to findings from Smith (2008), recommendations from Simich et al. suggest that peers with previous migration experience can be a valuable aid to supporting the health and well-being of newly arrived groups. In addition, supporting relations with family and friends may also enhance well-being (Simich et al.).

Extending findings from Simich et al. (2003), Simich, Beiser, Stewart and Mwakarimba, (2005) examined the meaning of social support from the perspective of policy makers and settlement health and social service providers (N=37) across three of Canada’s largest metropolitan cities (Toronto, Vancouver, and Edmonton). Qualitative interviews with service providers and policy makers showed that both formal and informal support systems were viewed equally as supporting mental health and well-being of immigrants and refugees. Integration of formal support networks such as resettlement agencies were viewed as fostering empowerment, community and social integration. Outreach and advocacy, known to provide a bridge among service users, were severely curtailed (Simich et al., 2005). Service
providers acknowledged how limited resources, lack of integration and narrow service mandates created barriers toward meeting newcomers’ needs. In particular, increased communication and coordination of the services needed increased accountability for translation and interpretation services. Simich et al. argue that underfunding of health and immigrant services confound accountability for service gaps across national, provincial and local jurisdictions noting “the holistic social supports necessary to promote health, economic and social integration are inadequate due, in part, to these systemic barriers and governance issues” (p.266).

It was also recommended that public discourse shift “from a tendency to categorize newcomers as needy service recipients to an emphasis on newcomers’ contributions” (Simich et al., 2005) In addition “participants recommended more consistent use of mainstream contact points, such as schools, health centers, libraries and community centers to reach immigrants and refugees “ (Simich, et al., 2005, p.265). Overall, building community capacity requires the integration of government, targeted members of communities, NGOs and health sectors to foster immigrant health and well-being.

A greater evaluation of community capacity is required in order to fully understand what works for refugee women in resettlement, and the organization of health care services and supports in order to promote mental health and well-being and to mitigate social and structural inequities that refugee women continue to experience.
2.10 Community and Community Capacity

The processes of migration and resettlement are embedded in a complex web of political, socioeconomic and historical processes. These larger structures implicate local community contexts in which settlement and resettlement occurs. Outcome studies of Karen GARs in BC suggest that local community contexts play a great role in determining settlement resources and the social inclusion of refugees (Marchbank et al., 2014). Scott, MacKean and Maloff (2012) suggest that “when people think of communities they think of geographic or demographic boundaries” (p.104). However contemporary understandings of community as synonymous with place are outdated and are critiqued in “the current era of post (or late) modernity, [and where] individuals are constantly constructing and reconstructing their communal belongings and relation to others [and their environment]” (Whitely & McKenzie, 2005, p.81). Similarly, other scholars have argued that communities are profoundly unstable where “no one belongs to just one identifiable social group or community; no community entirely encompasses all its members” (Pandey, 2005, p.409). Nursing scholars have also problematized the notion of community, pointing out that community is not viewed as a homogenous group of people, society and identity, and suggesting that “community is viewed as a fluid, social construct that has political, social, religious, and cultural relevance at different points in time” (Anderson, Khan & Reimer-Kirkham, 2011, p. 26). Similarly Pandey (2005) suggests that communities can be conceptualized as having wider ideological implications to describe an existing set of relationships. However, Guruge and Khanlou (2004) argue that for migrant women, adjustment during resettlement needs to be
understood both across national borders as well as within informal and formal networks of support that constitute their resettlement community. Importantly, community can define refugee women’s sense of place and belonging in the context of resettlement (Dossa & Dyck, 2011; Guruge & Khanalou, 2004).

According to Labonte and Laverack (2001), “community” is defined as “specific groups and networks of groups organizing around specific issues, generally but not always spatially bound” (p. 116). Similarly, Scott et al. (2012), note that “thinking of communities as collectives of people who share common values and concerns provides a broader definition that more accurately reflects the way that people think about and organize their social relationships” (p.104). Importantly, scholars have also drawn attention to how spatial and non-spatial understandings of community play an important role in psychological well-being, migration and the need to develop supportive community structures for refugee (Dossa & Dyck, 2011; McKenzie, 2008). In this regard community can be viewed “not so much as a state of being [but] as a political project” (Pandey, 2005, p. 410). Pupavac (2008) observes that in the United Kingdom dispersal policies have meant that refugees are being settled into areas where they are not joining existing communities from their home country...thus people cannot rely on émigré networks to provide informal help on an everyday basis and depend more on public resources (p. 18).

Similarly, in Canada regionalized dispersal policies to resettle migrant groups further away from similar ethno-cultural communities and outside of larger metropolitan centers has necessitated a need to examine the underlying structures
and social aspects of the host community’s ability to support the complexity of health and settlement needs of newly arrived refugee groups. In this research community is conceptualized as embedded within an ecological context\(^{33}\): the social and structural features, networks of support and relations between community structures and Karen women and families. Using an ecological context shifts the focus onto human interactions in the context of their environment (Shookner, Scott, Robinson Vollman & Hofmeyer, 2012). Fernando (2010) advocates for a public health approach that is flexible and integrates social and cultural understanding of what mental health means in particular contexts. This includes an “ecological approach [that] can respond to what is seen as necessary on the ground and culturally acceptable to the people in receiving services” (p. 101). A critical focus on community capacity shifts the focus toward social structures of society and the interaction effects of agency and structure with the aims of facilitating an analysis of social and structural aspects of community that promote social inclusion and well-being of Karen women and families.

From a public health perspective Labonte and Laverack (2001) outline nine domains of community capacity that include: 1) community participation through enhancing social support and networking and where “citizen participation is associated with better forms of public governance” (Labonte & Laverack, 2001, p. 118); 2) leadership with a potential to benefit mobilizing resources and influencing

\(^{33}\) Ecological contexts differ from community in the sense that a social ecology draws on environmental aspects of health such as air and water as well as broader environmental factors that include political, economic, sociocultural and biological environmental influences on health (Shookner, Scott, Robinson Vollman & Hofmeyer, 2012).
policy; 3) organizational (community) structures that include church groups and other organizations in which people come together to address concerns or problems; 4) problem assessment in order to identify problems and the process that assists communities in developing self-determination and power; 5) asking “why?” in order to address the social, political and economic causes of inequity and where critical reflection is necessary for sustained group action and a key element of participatory learning; 6) resource mobilization to address gaps in services; 7) links with others involved in relationship building (power sharing), partnerships and coalitions and voluntary alliances (networks are considered elements of social capital); 8) consideration of the role of outside agencies and the effects of community empowerment; and 9) program management where roles and responsibilities of stakeholders are defined. These domains have been validated through other studies conducted by Maclellan-Wright et al. (2007),

Importantly, Labonte and Laverack suggest that these community capacity domains are treated as descriptors of a system and are not neat or discrete functions that one can simply checklist, nor is community capacity an inherent property of a particular locality, rather, “it is a function of the resource opportunities or constraints (economic, political and environmental) of the conditions in which people and groups live” (Labonte & Laverack, 2001, p. 114). As outcome studies with GARs in BC have shown, the redistribution of programs and services stem from broader geopolitical and economic policies.

Community capacity building has been identified as a key component of community capacity (Scott, MacKean & Maloff, 2012). Alternative to traditional
views of capacity building (top down approaches to development), Scott et al. argue that capacity building is a strength-based approach that acknowledges community strengths and utilizes resources for specific goals (Scott et al., 2012). This includes building collaborative partnerships within and between various community services and structures. Capacity building does not necessarily mean the provision of services but emphasizes opportunity, empowerment and community assets, and is an alternative to viewing communities as lacking resources and capacity.

Capacity building can be viewed as an outcome or a process in community development. For example, Labonte and Laverack (2001) discuss that capacity building in health promotion is an outcome that can be measured by more efficient program delivery or sustainability, versus a process where capacity is strengthened through community action and empowerment. Community capacity is a resource influenced by "peoples’ day-to-day relationships, conditioned and constrained by economic and political practices, that are important determinants of the quality of their lives, if not also of communities’ healthy functioning” (p. 112). Scott, Mackean and Maloff (2012) argue that key aspects of community capacity building involve community commitment, perseverance, resources and skills; and flexibility.

The notion of flexibility has also been understudied in relation to structural aspects of community capacity building. Smith (2008) has argued that adaptation and resettlement occurs in a bidirectional process and is influenced by socioeconomic climate, historical background and social norms (of the host community) and organizational structures of agencies. Situated in an ecological
framework, Smith (2008) examined the community responses of different refugee groups (Burmese, Somali Bantu, Sudanese and Bosnian) and representatives from health care, social services and government (N=38) to a large influx of refugees in a small population of 65,000 residents who were resettled in Utica, New York over a ten year period (1989-2004). Findings from Smith suggest that behavioral flexibility and perseverance within four areas of community including housing, education, employment and health care influenced successful resettlement and adaptation. Findings showed that a community commitment to support refugees was related to the historical identity of the community, which had a long history of immigration, primarily from Europe. This meant that many health and social service providers’ historical or personal experience as immigrants and/or refugees were factors in how they responded to refugee needs.

Smith notes that 43% of all interview participants, including 50% of individuals working within the Mohawk Valley resource centre for refugees (MVRC) shared some kind of immigrant experience which influenced social norms and behaviors toward mutual aid and a community ethos of volunteering. These community characteristics were noted to increase the housing and education and employment needs of refugees, despite US alarm and suspicion toward immigrants in general (Smith, 2008). Evidence of behavioural flexibility and perseverance was evident in the organizational structures of health care and education. For example, government initiatives facilitated access to expanded language assistance programs, language coordinator positions and an increase of medical interpreters in all health care settings. These initiatives were demonstrated by the increased on-demand
translation services via phone; visual language translation cards and translated medical forms and cards were also used to increase health care access in emergency rooms. In the context of education, teachers where noted to take on the role of social worker and case manager, which enhanced refugee students’ access to extra-curricular activities and higher education. As health promotion strategies can be shared across community services, Fownes and Robinson Vollman (2012) observe that “schools are uniquely positioned to inspire action on many determinants of child development—are situated in the community and have connections with health related services”(p.147).

Despite local community responses, broader factors, such as a downturn in the ’80s and ’90s in the US, resulted in refugees being employed in low paying and entry level jobs and working long hours. Similarly, outcome studies conducted by Sherrell, (2003) Sherrell et al., (2011) and Marchbank et al. (2014) showed that meeting employment needs was challenging for Burmese, Somali Bantu and Sudanese refugees who came from agrarian cultures and who did not have recognized skills for labour employment. Smith’s findings draw attention to the historical relations between refugee groups and receiving communities and how these relations contributed to promoting flexible policies amongst community agencies (education, employment, health).

However, there are inherent dangers to capacity building with community groups who are already at risk. These dangers include both a romanticized view of community and an overemphasis on communities taking on individual responsibility for health while the state seems to disappear (Mohan, 2006). Reid
(2004) writes that even in feminist action research which aims to promote inclusion and enhanced participation of marginalized women, social exclusion can result from challenges related to low literacy and poverty. In short, not all women have the same capabilities, problems or needs and therefore not all women’s voices can be heard. These pitfalls therefore must be weighed against the strengths of conducting community capacity building. Moreover, some studies have also shown that community capacity building can reinforce notions of dependency and lack of agency amongst some resettled refugee groups (Marchbank et al., 2014). In addition, notions of empowerment[^34] may unwittingly reinforce marginalization of community groups, especially when refugee groups are already in an asymmetrical relationship with host communities (Smith, 2008). Both Scott, MacKean and Maloff (2012) and Labonte and Laverack (2001) suggest that it is important to recognize whose agendas are being addressed in building community capacity. While public participation and collaboration is fundamental to addressing community needs, there is a need to recognize the role of power in shaping inequities amongst different communities.

Empowerment of local communities through top down approaches or purely bottom up approaches negates the materiality of the development process (Mohan, 2006). The work conducted by Sherrell et al. (2011) with Bhutanese GARs suggests

[^34]: Mohan (2006) argues that although it is laudable that participatory approaches seek to alter power relationships in favour of the marginalized, much participatory development work reinscribes power relations between expert and other. “The danger from a policy point of view is that the actions based on consensus may in fact further empower the powerful vested interests that manipulated the research in the first place.” (p.11). Similarly, Young (1990) defines various oppressions as a matter of concrete power in relation to others. In the context of community capacity and capacity building empowerment may reinscribe what Young refers to as cultural imperialism.
that inter-sectoral collaboration, and advanced knowledge and inclusion of social actors such as media can influence policy directions towards supporting the diverse needs of GARs during resettlement. Importantly, this community building process includes the voice of refugee groups. According to Labonte and Laverack (2001), capacity building requires an analysis of the social and organizational relationships within three primary actors, these include:

- government or non-government organizations (NGOs) that design programs and offer funding;
- health promotion practitioners that implement programs; and
- community members, individuals/groups who are program “targets” or participants

There is considerable overlap between community capacity building at a broader structural level and community capacity aimed at developing health promotion programs. In this research, I use community capacity to refer to the structural aspects of community (levels of government, societal institutions and their practices) and the social processes that shaped and or responded to the mental health and well-being of Karen women during resettlement. Community capacity is conceptualized broadly as a community’s ability to support resettlement of Karen women and, in particular, those aspects of community (social and structural) features that promote mental health and well-being for Karen women and not specific health programs themselves, although these can also contribute to overall community capacity.
2.10.1 Social capital and community capacity

As already discussed, there is a danger to capacity building when a well-functioning integrated, cohesive community may serve a utilitarian purpose for the majority of the population. This kind of community may be dependent on homogeneity and obedience to social norms—not all subgroups of the population will experience some positive effect of social capital. Although there has been some critique of social capital theory in relation to community capacity building (Labonte, 2004), features of social capital may have utility in understanding relational aspects of capacity building in a community and ecological context. Social capital can be defined as a “network of social relations that may provide individuals and groups with access to resources and support” (Policy Research Initiative 2005, as cited in Shookner et al. 2012). Social capital conceptualized broadly concerns how networks of reciprocity enhance civic engagement and features of organizations (Putnam, 1995). Drawing on the work of Putnam (1993), McKenzie (2008) summarizes five key aspects of social capital that can determine communities’ overall response to refugee resettlement needs, these are:

- Community networks, voluntary, state, personal networks and destiny;
- Civic engagement, participation and use of civic networks;
- Local civic identity, sense of belonging, solidarity and equality with local community members;
- Reciprocity and norms of cooperation, a sense of obligation to help other and confidence in return of assistance; and
- Trust in the community.
Whitley and McKenzie (2005) emphasize that in order to understand the social and environmental impact on health, an ecological framework must include an analysis of social capital. Extending beyond notions of social network theory and social support, social capital consists of four primary features of societal structures, these include networks, relationships, norms and trust (Whitley & McKenzie, 2005).

In delineating levels at which social capital operates, Whitley and McKenzie (2005) employ the notion of “capitals” signifying plural rather than a single ontological entity. These social capitals are defined as structural and cognitive social capital; bonding and bridging social capital; and horizontal and vertical social capital. Cognitive social capital emphasizes values, norms, reciprocity, altruism and civic responsibility, drawing attention to relationship between the individual/group and the ecological context. Bonding social capital places emphasis on group norms and homogeneity, loyalty and exclusive reliance on intra group ties. In contrast, bridging social capital is outwardly focused, linking diverse groups of people (Whitely & McKenzie, 2005). Similarly, Shookner, Scott, Robinson Vollman and Hofmeyer (2012) discuss that “bonding social capital relates to the value assigned to social networks...where most members have close connections with one another” (p.80). In contrast, “bridging social capital is the value generated from social networks that cut across groups, creating connections that have the potential to bring in resources that a group does not currently have or to share information between groups” (p.80). For example, ISS of BC’s pre-planning initiatives for Bhutanese GARs could be considered a form of bridging social capital where multi-
sectoral agencies and different levels of government strategize to either build and/or share resources to support specific needs of newcomer groups.

Whitley and McKenzie have drawn attention to social inequality as a result of horizontal and vertical aspects of social capital. These authors contend that both horizontal and vertical social capital is necessary for understanding issues of power embedded within macro systems. This view is also supported by Labonte, Polanyi, Muhajarine, McIntosh et al. (2005) who argue that community engagement must extend beyond the idealization of localism and tokenism, rather community groups including NGOs must also address constraining structures such as global capitalism.

Analogous to bonding social capital, horizontal social capital pertains to linkages between groups of an equal standing in society. Conversely, vertical social capital is the degree of integration and social efficacy of groups within a hierarchical society. Although community capacity building often results in mobilization of community resources from the ground up, “Vertical aspects of social capital are needed to mobilize community resources, influence policy. For example, Whitley and McKenzie (2005) suggest that efforts imply to increase community spirit in an economically deprived immigrant neighborhood by building a community center maybe insufficient if the immigrant group still have unequal access to employment, education, lobbying power, and other important resources (p.75).

Thus the norms and networks of civic engagement also powerfully affect the performance of government (Putnam, 1995).
The central tenets of social capital and community capacity run in opposition to biomedical individualism\(^{35}\) which reduces mental health to a set of biological factors. Although community capacity indices and social capital are helpful for building inclusive communities related to newcomer groups, other indices may also include broader contextual factors such as history and race\(^{36}\) relations (Geronimo, 2000; Percy-Smith, 2000; Smith, 2008). Drawing on Posner (1998), Percy-Smith (2000) adds that “a community’s co-operative capacity is a function of the degree of social and political inequality that the community has experienced over the course of its historical development” (p. 7). Other scholars have argued that promoting equitable and democratic settlement policy agendas requires anti-racist advocacy and community empowerment to foster social justice and make systems work better for people that are socially disadvantaged by systemic inequities (Geronimo, 2000; Lavoie, 2012).

Promoting equity requires a reorientation of health services and shifting a gaze toward what (Fownes & Robinson Vollman, 2012) call a “settings approach” in

\(^{35}\) By biomedical individualism I am referring to the reduction of illness to individual biomedical processes without inclusion of social determinants such as migration, literacy ability and gender. As Azétosop and Rennie (2010) note there are two kinds of medical individualism, one based on biomedical ethics, the other on clinical health care practices. In either case medical individualism is premised on the idea that individuals are autonomous agents able to make independent decisions concerning their health and having the capacity to act on their decisions. Thus responsibility for health care access is largely placed on the individual as they are assumed to act as free agents who have power and decision making ability over their health. This narrow view of health is problematic because it has the potential to negate a social responsibility of health care access and social conditions that may equally play a role in a person’s ability to access health. A full adoption of a biomedical model, “fails to address issues of wider social injustices that are responsible for health related vulnerability and risk” (p. 6).

\(^{36}\) I use Winant’s (2000) definition of ‘race’ as “a concept that signifies and symbolizes sociopolitical conflicts and interests in reference to different types of human bodies” (p. 172).
which the purview of health involves coalitions of municipal, provincial/territorial and national organizations to better understand health in relation to economic, environmental and social contexts. Similarly, Lanbonte, Polanyi, Muhajarnine, McIntosh et al. (2005) advocate that “in order to create conditions that improve health and well-being of people and equity in the distribution of [conditions] between people requires deliberate engagement in three areas: theory, community and policy” (p. 10). Theories of governance that encompass the social and historical contexts shape power relations and the social stratifications which shape health and illness across diverse groups. Community engagement therefore requires social action outcomes. Lastly, addressing inequities through community engagement strategies also requires policy engagement that begins to transform the conditions that lead to ill health (Labonte et al., 2005). In summary, Labonte et al. contend that the goals of critical population health research requires both moral and political praxis necessary for social change.

Drawing on critical theories of social justice and equity, Browne, Varcoe, Wong, Smye et al. (2012) conducted a mixed-method study in order to examine equity oriented health and healthcare services across two primary healthcare centres (PHC) that provide services to marginalized populations in BC. The study was conducted with service providers, recipients of care and policy decision makers, (N=144). Findings showed four interrelated dimensions as central to promoting equity oriented PHC.

Inequity-response care encompassed the integration of social determinants of health such as housing security through advocacy and building collaborations
across services. Trauma- and violence-informed care encompassed education and service provider recognition of systemic violence and historical traumas experienced by specific population groups such as refugees and Aboriginal communities. Strategies to promote practitioner and client safety included fostering healthy and emotionally safe work environments. Contextually-tailored care was also an important dimension in promoting equity through promoting patient agency and choice; this included provision of increased and flexible time frames for patients who required more time, and evaluation of different funding strategies such as fee-for-service vs. salary-based physician care. Lastly, culturally competent care included a reflexive approach to service provision in order to redress and/or prevent discriminatory practices; for example providing language services and offering choice to patients regarding their care. In keeping with a critical population health approach, the Browne et al. research also stresses the importance of advocacy and participatory engagement with community and policy makers in order to address socioeconomic constraints and promote equity oriented health care services.

In summary, a reorientation of healthcare services means “embracing movements that are outside the traditional health purview...coalitions form that bring people together municipal, provincial/territorial, and national organizations (public, private, nonprofit) with individual citizens to better understand and address priority health and quality of life issues” (Fownes & Robinson Vollman, 2012, p.149). Reorientation implies a shift toward something better and more effective (Fownes & Robinson Vollman, 2012). This requires a movement away from
the dominance of biomedicine toward integration of the determinants of health “allowing an opportunity to reflect on . . . contexts of multiple health determinants and to shift the gaze toward upstream factors related to health and illness and to engage debate about social justice issues” (Fownes & Robinson Vollman, 2012, p. 143).

2.11 Mental Health Policy and Community Capacity

The mental health and well-being of refugees has been cited as the most pressing concern for primary health care clinicians in Canada (Kirmayer et al., 2011). Of particular concern are known barriers to accessing mainstream mental health care services and addressing the complex care needs of refugee groups in primary care. However, despite the evidence about known barriers to service access, there is a lack of policy intervention and uptake of universal approaches to improving service integration between mainstream mental health and other services sectors such as primary care and settlement services (Vasilevska, 2010). In Canada, provinces and territories are responsible for planning and developing mental health services.

In BC, Vancouver Coastal Health is one of six health authorities in the region responsible for coordinating mental health services, including cross-cultural mental health services. With recent population growth and changes in patterns of immigration, an emergent body of literature has shown that immigrants, refugees and other ethno-cultural and racialized groups (IRER) have poorer mental health than other Canadians (Hansson, Tuck, Lurie and McKenzie, 2009). The World Health
Organization (WHO, 2001) takes a public health approach to mental health and defines mental health as “not merely the absence of disease or infirmity, but rather, a state of complete physical, mental and social well-being” (p. 3). According to the WHO an integrated approach to mental health services requires government responsibility, community based services, establishment of national policy, programs and legislation, and linking of mental health resources with other sectors such as NGOs and supportive local initiatives.

Mental health policy initiatives in BC grew out of issues raised by immigrant groups in the 1970s and 1980s; as a result a national task force was developed and a report produced entitled “The Federal Response—After the Door Has Been Opened” (Beiser, 2009). Hansson, Tuck, Lurie and McKenzie (2009) summarized the outcomes of this report and identified the following themes: 1) the threat of mental health is not incurred by migration alone and only increases when additional risk factors are combined with the stress of resettlement; 2) immigrants and refugees, including people living with mental health illness, do not have a voice in the mental health system; and 3) no single governmental body of level of government can be responsible for Canada’s immigrants and refugees.

In 2009 the Mental Health Commission of Canada (MHCC) undertook another research project to specifically identify issues and options for service improvement for IRER groups across Canada. Findings of this work showed that First Nations, Inuit, Métis, immigrant, refugee, ethno-cultural and racialized groups (IRER), women, children and seniors are the most vulnerable to experiencing health inequities (Hansson, Tuck, Lurie and McKenzie, 2009). The mental health and well-
being of IRER groups was associated with social determinants of health including income and social status; IRER groups experiencing the greatest income inequality and financial insecurity were most likely to have poorer mental health. The Hansson, Tuck, Lurie and McKenzie review of the literature also highlights the fact that immigrant women belonging to minority groups were found to exhibit higher depressive symptoms than other women born in Canada (Hansson et al., 2009). Consistent with other research, increased social networks, literacy and education were also identified as factors supporting mental health and well-being of IRER groups.

The overall recommendations for the report above included: 1) increased emphasis on prevention and promotion of mental health and wellbeing; 2) improved services through broadly addressing cultural competency; 3) increased diversity of treatments and providers; 4) linguistic competence and improved community plans to meet Canada’s diverse groups; 5) increased flexibility of services and structural change with coordination of policy, community involvement; and 6) the building of community connections and increased training to facilitate clinicians’ knowledge, attitudes and skills concerning cultural competence and promoting access and partnerships (Hansson et al., 2009)

As an outcome of the MHCC study, advances have been made in Canada to develop a national mental health strategy. The document “Changing Directions Changing Lives—The Mental Health Strategy for Canada” the Mental Health Commission of Canada (MHCC, 2012) has identified several strategic directions and priorities for promoting mental health and well-being and preventing mental illness.
The mental health national strategy has made further recommendations for policy action related to IRER groups including expanded standards for cultural competency and cultural safety, as part of accreditation policy within professional associations. This includes the Canadian Nurses Association (CNA) and Canadian Psychiatric Association (CPA).

In addition, the strategic 4.2.5 initiative of The Mental Health Strategy for Canada (MHCC, 2012) includes the development of mental health plans in all jurisdictions (across Canada) to address mental health needs of IRER groups, with their full involvement. With regards to the MHCC recommendations and the current evidence related to refugee resettlement and mental health, it is unacceptable that Canada does not have strong legislation to enact mandatory language interpreters. Despite these initiatives, at the systems level there exist service gaps across service sectors, including primary health care, mental health and mainstream settlement services (Vasilevska, 2010). Moreover, the settlement sector has not included mainstream mental health in its pre planning policy initiatives in BC.

Drawing on Wayland, (2010), Vasilevska states that “immigrant human service needs must not be viewed as something to be relegated to the settlement sector. The mainstream must take responsibility for serving a broader population.” (p. 11).

Canadian policy initiatives regarding diverse needs of refugee women have started to address systemic barriers in local community contexts. Collins, Yogendra, Shakya, Guruge et al. (2008) review of access and equity oriented services of settlement services for refugee and immigrant women in Canada, showed that
newcomer women benefit from co-location of services and the linkage of settlement services with mainstream mental health services. These authors suggest that across service sectors there is an increased need for service collaboration to improve equity, accessibility and quality of services for newcomer women.

In particular the Collins et al. (2008) suggest that: 1) all community agencies review institutional policies and services to meet the needs of newcomer women; 2) mainstream agencies reconfigure their institutional capacity to reflect the needs of immigrant and refugee communities; 3) increased collaboration amongst service providers across sectors to improve equity, accessibility and quality of services including interpreter services and linguistic barriers. Similarly, recommendations as set out by the Alberta Health Services (2008), document, “Improving the Health and Well-being of Refugees in Calgary” have addressed community responses to refugee need which include: building of language and cultural competency within health care systems; expanding health services/programs for refugees; health outreach workers or “brokers”; and providing community-based programs to address issues identified by refugees. These findings suggest that greater responsiveness of social and mental health services are required, including service integration amongst mainstream services such as mental health, primary health care and other ethno-specific social services, in order to address specific health care needs of refugee women.

The UNHCR (2013) executive summary, “Resettlement and Women-at-Risk: Can the Risk Be Reduced?” argues that resettlement is one of the key protection tools for reducing risk of violence. The UNHCR considers a woman or girl at risk “if
she has protection problems particular to her gender and lacks effective protection
... Women-at-risk cases may be single heads of households, unaccompanied, or
accompanied [women]” (p. 2). Referrals of women at risk for resettlement outside of
their first countries of asylum have risen from 6.8% in 2007 to 11.1% in 2011
(UNHCR, 2013).

The UNHCR conducted a report based on US statistics of 4,720 women
arrivals in the US between January 1, 2010 and June 30, 2012. Data was collected
from UNHCR and US government policies pertaining to refugee women, and
included interviews with 19 experts including representatives from the UNHCR,
international and national non-government organizations (NGOs), US state
resettlement offices, local resettlement patterns and refugee women themselves.
Their findings suggest that currently there is a lack of standard practice regarding
how the demographic profiles, persecution histories or need for resettlement
developed abroad is shared with resettlement partners (UNHCR, 2013). However, a
summary of this report suggests that at the community and program level several
strategies facilitated refugee women's resettlement including 1) the strategic use of
case workers to ensure there was both linguistic capacity and appropriate gender
sensitivity; 2) tailored pre-literacy training and support including child care; 3)
community responses required nuanced capacity where some women at risk might
be better served by case workers who speak the same language but do not
necessarily share the same nationality; 3) building capacity to support linkages
between refugee women and the receiving community could be achieved through
use of micro-enterprise grants, links with local religious or volunteer programs and
peer supports; 4) advanced knowledge of resettlement plans increases understanding of refugee women’s needs during resettlement.

The UNHCR (2013) highlights that variability amongst refugee women must be taken into account when planning programs where trauma and histories of violence vary amongst refugee women. For example, Iraqi widows witnessed their husbands’ executions and suffered abuse and discrimination in their first country of asylum, and Burmese, Chin and Karen women experienced violence and ostracism. It is important that services and practices be able to provide support tailored to women’s different histories and experiences. In addition, their findings showed that mainstream mental health services were inadequate to support the emotional and behavioural health needs of refugee women.

The UNHCR recommended longer time-frames for host societies in order to promote integration and development of community support and education about the refugee groups they are receiving. This might allow for local resettlement actors to develop new requests for funding proposals and extended services. Broadening educational resources given to various community services was also recommended as a way to increase understanding about protection risks and vulnerabilities of refugee women. In addition, the UNHCR (2013) has recommended that refugee women be at the center of service planning and that diverse language services be facilitated.

2.11.1 Examining the role of trauma and identity

The health and well-being of refugee women is affected by almost every measure of social determinants of health. Despite improvements in immigration,
Canadian immigration policy studies continue to show decreased access and utilization of mental health services among refugee groups (Li & Browne, 2000, MHCC, 2009). Browne et al. (2012) have argued that trauma is increasingly framed by not only individual traumatic experiences but also as a part of broader structural and social inequities that are historical and systemic. Lester (2013) argues that trauma is relational both in a response to a particular event (the context that produces the trauma) and the social response to the aftermath. In addition, Lester (2013) suggests a need to conceptualize trauma as nonlinear, not fixed in time with a beginning or an end; and a need to reflect upon the “critical rebuilding of social connections—this is the work of recovery” (p. 759). Research by Waldron (2008) has shown that systemic and structural discrimination significantly impacts the mental health and well-being of racialized groups including refugees and asylum seekers as well as immigrants and Canadian-born racialized groups. Similar to Lester (2013), Waldron argues that there is interplay between past trauma and the everyday trauma that racialized groups experience through discrimination. These broader conceptualizations of trauma provide a contextual analysis of the systemic processes and factors shaping mental health and well-being beyond a single pre-migratory event.

As I have outlined at the beginnings of this chapter, trauma and refugee identity are often constructed synonymously in public discourse, partly owing to human experiences of war. However, drawing on the World Health Organization (WHO), information, Fernando (2010) argues that it is problematic when developed countries obscure the refugee problems they face after migration with a narrowly
defined trauma paradigm that is exclusively negative and one in which narratives of social suffering are narrowly constructed as post traumatic stress disorder (PTSD). Similarly, Kleinman (1980) argues that the culture of health systems and institutions themselves shape “causes of illness; norms of governing choice and evaluation of treatment; socially-legitimated statuses, power relationships, interaction settings and institutions” (p.10). There is a need to examine the role of cultural practices in shaping discourses of trauma and refugee identity. Ahmad (1996) writes: “professional ideologies reinforce (perhaps even construct) dominant notions of normalcy and as main arbiters of definitions of and solutions to problems in health and social services, act as potential mechanisms for social control” (p.4022). A review of empirical evidence suggests a parallel discourse between the “sick immigrant” and the “traumatized refugee”, however neither construction is valid, rather there is a need to develop more contextual understandings that surround refugee women’s mental health post migration.

Studies suggest that there is no single factor or event that determines individual or group responses to trauma. Rather as Kirmayer, Lemelson and Barad (2008) have argued, PTSD “covers only a small part of the complex response to trauma and that excessive focus on PTSD medicalizes social problems and predicaments that demand a more comprehensive social and political response” (p. 150).

Samuels-Dennis, Bailey and Ford-Gilboe (2011) provide a critical analysis of how gender plays a significant role in the trauma and PTSD process. The authors contextualize gender beyond individual personal and social resources and suggest
that understanding women’s experiences of trauma must also include “how privilege and disadvantage implied by women’s multiple and intersecting social statuses shape their experiences and their access to resources” (p. 276). Moreover, these authors argue that trauma is not a “monolithic phenomenon; instead, social location directly and indirectly influences the nature of trauma, the interpretation of the experience, the response of others, and the personal and/or social resources available for responding to trauma” (p. 276).

Similarly, Marlowe (2010) argues that “from an exclusive trauma-focused understanding, a thin description of the individual is created where other important considerations of identity and history (social, political, cultural) are easily lost or hidden” (p. 183). Although the global effects of 9/11 have had a negative impact on public perspectives on refugees as well as associated policies and practice, Marlowe presents another side of public discourse which refugees are often presented as “traumatized, lost, psychologically damaged and overwhelmed by grief” (p. 186).

Drawing on Nancy Fraser’s political theory, Marlowe examined the experience of twenty-four Sudanese men resettled in Adelaide, Australia. Writing against a traumatized and essentialized discourse of refugee identity, Marlowe’s findings show that the Sudanese men experienced resettlement distress as resulting from racism and discrimination. Marlowe adds that the Sudanese community in Australia has the highest unemployment rate, fewer economic resources to afford housing accommodation and basic necessities. Similar, to Tomasso’s (2012) discourse analysis of Tamil refugees in Canada, Marlowe’s findings shows that while Sudanese men spoke about their experience of war they also were cognisant of public
perceptions of them. Growing public discourses within Australian society constructed Sudanese refugee men as failing to integrate, not adjusting quickly and a burden. Thus the concept of burden, Marlowe argues, is “often derived from medicalized and individualized discourses of trauma as expressed in unemployability, adverse mental health, lawlessness and incompatibility in resettlement contexts; the outcomes of war trauma” (p.190). In contrast, Sudanese men spoke about their “everyday” lives and what sustains them through trauma; this included community life, cultural practices and spirituality.

Marlowe links Fraser’s critique of misrecognition and social subordination with institutional structures of resettlement. Fraser (2001), as cited in Marlowe, “acknowledges that recognition through misrecognition can cause social subordination as ‘insitutional patterns of cultural value constitute actors as inferior, excluded, wholly other, or simply invisible, hence as less than full partners in social interaction’”(p. 24). This form of othering can devalue refugees as important members of community and “lead to exclusionary practices related to education, education and other types of resources” (Marlowe, 2010, p. 188). Drawing on Fraser (2001), Marlow maintains that “recognition politics can quickly descend into identity politics which can reify particular groups within a master status and obscure important redistribution considerations” (p. 188). Marlowe recommends bringing stories forward in order to provide insight into oppression and injustice. At the same time, there is a need to open up a space for understanding people’s lives and the ordinary stories that shape effects of trauma and the context of refugee migration.
2.11.2 Trauma and idioms of distress

Evidence suggests that mental health clinicians often overlook people’s experiences of trauma due to different forms of illness expression (Li & Browne, 2000; Kirmayer 2001; Kirmayer, Dao & Smith 1988). Vasilevska’s (2010) review of studies focused on refugees and trauma showed that only about one-third of the studies used culturally sensitive instruments to measure psychological effects of trauma and that the majority of studies suggest that female, older refugees and those with more education are more likely to experience incidence of PTSD and/or emotional distress. Vasilevska argues that the cultural constructions of mental health are not shared across cultures “begging the question of what exactly is being measured” (p. 7). Drawing on Ryan, Dooley and Benson (2008), Vasilevska (2010) argues that innovative service delivery models of care are needed to address personal, material and social aspects of refugee lives; service models that recognize that refugees are not passive victims of trauma, rather “they are active survivors in a new environment which affects their mental health and adaptation” (p. 9).

Gagnon, Tuck and Barkun’s (2004) systematic review of questionnaires measuring the health of resettling refugee women showed that out of fifty-six studies only five had strong evidence for use with resettling refugee women. Results further showed reliable measurements of trauma, PTSD, anxiety and depression are needed to better inform health care delivery. Keyes’ (2000) integrative review of twelve quantitative research studies published between 1987 and 1998 showed that only eight of the studies included culturally appropriate measures of mental health, i.e., instruments that were worded in the native language of the participant.
In general, measures of PTSD, depression and anxiety lacked culturally relevant information. This finding suggests that some behaviours might have been misinterpreted as disorders rather than an adaptive response to experiences of trauma, such as cultural bereavement. The analysis by Keyes (2000) suggests that mainstream approaches to understanding trauma experiences of refugees tends to focus on torture or a single stressor and not on the culturally different meanings and responses to trauma that may be better understood as “cultural bereavement.”

Kirmayer et al. (1998) discuss somatization as a set of clinical processes often “transforming or transducing psychological conflict into bodily symptoms (often including medically unexplained and functional somatic symptoms)” (p.233). However, these authors argue that somatization is not confined to specific ethno cultural population groups, rather “research confirms somatization is ubiquitous” (Kirmayer, 2001, p.22). Rather, Kirmayer suggests that somatic symptoms serve as cultural idioms of distress, are a part of the larger language of distress and therefore need to be interpreted within wider social meanings. In addition Kirmayer observes that “the most common somatic symptom of depression and anxiety are musculoskeletal pain and fatigue” (p. 24). Similarly, Kinzie (2007) reflects on findings from twenty-five years of clinical experience in working with refugees and trauma. Kinzie suggest that trauma symptoms such as those confined to PTSD often co-exist with complex medical disorders such as diabetes and hypertension. In addition, Kinzie argues that the notion of confronting trauma through Western approaches which master the problems does not make sense for many cultures. Rather, Kinzie (2007) suggests that “The whole concept of openly
recounting and confronting trauma may be foreign or even opposed to some core cultural values shared by the patient and his or her family or community” (p. 198). Gender and cultural variation amongst different population groups also may play a role in expression of trauma (Kirmayer, Lemelson & Barad, 2008).

Omeri, Lennings and Raymond (2006) explored the health and resettlement issues and barriers for Afghan refugees in New South Wales, Australia. Drawing on two focus groups of Afghan women (N=14) and one focus group of Afghan men (N=9), findings showed that Afghan refugees experienced emotional responses to trauma including feelings of sadness, shame, guilt, lost, depression. These emotional responses where interlinked with other themes of migration and resettlement, culturally specific health maintenance strategies such as prayer and religious support, settlement barriers based on Islamic beliefs and practices, and lack of services in their language. Recommendations by Omeri et al. suggest that increased outreach support, community leadership, participation and advocacy could promote mental health and well-being of resettled refugees in Australia.

In their study, Mustafaeva and Shercliffe (2009) examined health issues for Karen refugees in the context of primary health care access during resettlement in Regina, Canada. Findings suggest that symptoms of depression among Karen refugees are high but that current culturally appropriate screening tools for depression are lacking. These authors note that many Karen refugees present with somatic complaints such as headaches, body weakness and heart problems; however, medical tests have failed to find physical pathology. This has resulted in misdiagnosis and increased medical costs. In designing a culturally appropriate
screening tool for diagnosing and treating depression among Karen refugees, the authors employed narrative storytelling to allow individuals to describe their experiences and somatic symptoms of depression. Focus groups were used with Karen men and women to ascertain their understanding of depression. Through a case study analysis and feedback from Karen participants the authors were able to validate a culturally sensitive screening tool for depression for Karen refugees.

As part of the Canadian Collaboration for Immigrants and Refugee Health, Pottie, Greenway, Feightner, Welch et al. (2011) conducted a systematic review of the literature to develop evidence-based clinical guidelines for immigrants and refugees in several key areas related to primary health care. The purpose of their review was to improve health using evidence-based guidelines and preventative approaches to complement existing primary health care approaches, and to consider health inequities and gaps in existing knowledge.

Findings from their review showed that mental health remains one of the most challenging areas for clinicians working with refugees. In addition, reviews showed that serious mental disorders amongst refugee groups had higher levels of post traumatic stress often associated with depression and anxiety when compared with immigrants. Findings from their review showed that mental health remains one of the most challenging areas for clinicians working with refugees. In addition reviews showed that serious mental disorders amongst refugee groups had higher levels of post-traumatic stress often associated with depression and anxiety when compared with immigrants. Specifically, refugees who have lower income as well as limited English or French language proficiency were found to have greater risk for
poorer health. Although Pottie et al. (2012) recommend the use of validated screening tools for depression best practices require integrated primary health care programs with various mental health and social service supports. Recommendations by Pottie et al. include screening immigrant women during each trimester of pregnancy, increased availability of childcare facilities, transportation and group meetings (including family) in order to increase social support and health promotion. In addition, use of professional interpreters or trained cultural brokers and integrated systems of care were recommended. In addition, Pottie et al. recommend family centered approaches, and integrated supports for refugee groups living with PTSD.

Pottie et al. conducted another systematic review to determine the burden of PTSD within immigrant and refugee populations, and to evaluate effectiveness of screening tools and treatments and to identify system barriers. The sixteen reviews included the guidelines commissioned by the National Institute for Clinical Excellence for the management of PTSD, the Cochrane reviews, the International Society for Trauma Stress Studies, and the treatment of PTSD in asylum seekers and refugees. Findings showed that 40% of Canadian immigrants and refugees who come from countries involved in war have been exposed to trauma pre-migration. However, an estimated 80% of refugees who experience trauma recover after reaching safety (Pottie et al., 2011). A meta-analysis further showed that prevalence of PTSD in adult refugees was 9% in developed countries, however among adult refugees diagnosed with PTSD, 71% also had major depression. Similar to Kirmayer et al. (2011), the strongest predictor for trauma was found to be torture. Screening
tools for PTSD have not been tested for diagnostic accuracy. Pottie et al. recommend that clinicians working in primary care need to be alert for associated symptoms of PTSD, including chronic pain and sleep problems as well as other mental health problems such as panic or depression. Empathy, reassurance, advocacy and not pushing disclosure of PTSD as part of initial screening processes were recommended.

2.11.3 Trauma: pre- and post-migration

The Ryerson University resettlement project (RRP) conducted by Beiser (2009) is one of the largest longitudinal studies on the resettlement of southeast Asian (SEA) refugees from Vietnam, Laos, and Cambodia who resettled in Vancouver, B.C. This research drew a sample of 60,000 refugees admitted to Canada between the years 1979-1981. The RRP study examined the settlement experience, social cost of resettling refugees, factors that promoted or hindered integration, risk and protective factors for refugee mental health and the use of mental health services. The findings from Beiser’s report showed that 90% of refugees considered maintaining their traditional language, cultural traditions and values and saw them as being very important to managing their well-being and mental health. The findings also suggest that there is significant cultural invariability when comparing SEA refugees and native Canadian samples, i.e., that “symptoms of distress are more alike than they are different across cultures” (p. 551). Moreover, Beiser notes that cultural difference has more to do with the shaping of illness categories and what is and what is not included in them than determining experiences of distress. While cultural variations exist in expression of illness symptoms, the tendency to
overemphasize cultural variations can result in cultural stereotyping and lack of culturally appropriate treatment interventions. Beiser (2009) argues that
diagnostic categories designed to describe patterns of suffering are very much the products of culture. Aside from describing syndromes, diagnostic systems reveal limits of societal tolerance, define behaviours that threaten group solidarity...the degree to which unwanted behaviours can be managed and controlled (p. 550).

Findings by Beiser showed that, overall, the SEA refugees did not experience mental health problems as a result of their experiences of torture, war and abuse of human rights, over time. However in 1981 when refugees arrived, men were noted to have higher rates of depression than women, with rates of depression declining for men more than for women years later. Beiser notes that after the first decade of resettlement, women were shown to have depression scores in 1981 which were predictive of their depression scores in 1983. When depression was measured in women in 1983 the scores were less predictive for depression levels in 1991. Beiser surmised that men refugees were more likely to have experienced acculturative stress because they were more likely to be in the labour force and charged with the burden of needing to provide for their families. However “the longer they [women] remained in Canada, the more likely refugee women were exposed to the structural factors in society”(p.552) which suggests that external factors of resettlement play a role in the mental health and well-being of refugee women. Lack of English language ability was a significant predictor for depression and employment among refugee women, which is consistent with research finding by Baya et al. 2008. Although this study draws attention to gender, it does not provide a contextual analysis of the
lives of refugee women and the factors that structure their experience of resettlement. However, like Baya’s et al. (2008), these findings support gendered effects of migration and resettlement over time.

Overall rates of depression steadily decreased in SEA refugees from 7.5% in 1981, and after ten years were reported to be as low as 2.3%. However SEA refugees were more likely to experience mental health problems due to discrimination the longer they were in Canada (Beiser, 2009). In addition, SEA refugees who did not have personal and social supports had an increased risk for depression 12 months after arriving in Canada. These findings are in contrast to studies conducted with immigrant groups. For example Kobayashi and Prus (2011) applied an intersectionality perspective to the study of the healthy immigrant effect in mid to later life, using quantitative methods. Kobayashi and Prus analyzed data from a Canadian Community Health Survey (CCHS) which consisted of a sample of 132,221 Canadians aged over 12 years. Multiple variables were measured such as length of time in Canada, employment, income data and gender. A logistic regression was used to model health outcomes for adults, 45 years or older.

Findings by Kobayashi and Prus (2011) showed that immigrant men between the ages of 45-64 years had better functional and self-reported health than Canadian-born men. However, over time, immigrant men’s health decreased to converge with Canadian born-men in mid-life. For immigrant women, however, findings suggest that health disparities are significantly related to their visible minority status. Unlike immigrant men, Kobayashi and Prus note that mid-life women aged 45-64 years are disadvantaged in health on self-reported measures.
when compared to Canadian-born cohorts, even after controlling for
sociodemographic, socioeconomic status and lifestyle factors. Their findings suggest
that older men and mid-life women of colour may have increased needs for services
due to poor health status. The authors recommend that policies and programs
address older immigrant women’s health needs. It is not surprising that differences
exist between immigrant samples and refugee populations regarding health and
well-being since each group has different experiences based on reasons for
migration, education and immigration status.

However when compared with outcome studies in BC, there is some evidence
to suggest that refugee health status for women also decreases over time (Cubie,
stress explains immigrant overshoot, although immigrant health converges
overtime with that of native-born populations in Canada Longitudinal studies
suggest that immigrant health not only resembles that of the general population but
gets worse. In addition, factors such as age and gender, economic disadvantage and
health literacy moderate mental health in the context of resettlement (Beiser).

Examining differences and common health problems between immigrants
and refugees, Kirmayer, Narasiah, Munoz, Rashid, et al., (2011) conducted a
comprehensive literature review that included ten systemic reviews and five meta-
analyses for a total of (N=113) articles that address clinical considerations for
assessment, treatment and prevention of common mental disorders among
immigrant and refugees in primary care. Their review suggests that each phase of
migration (pre-migration, migration and post-migration) is associated with distinct
risk factors for mental health for both immigrants and refugees. Pre-migration, immigrants are usually healthier than Canadian born populations and have lower rates of mental illness; however, over time, the health of immigrants worsens to match that of the general population. This is known as the “healthy immigrant effect”. Drawing on a 2000-2001 Canadian community survey, newly arrived immigrants (less than four years in Canada) had the lowest rates of depression (odds ratio [OR] 0.33%, 95% confidence interval [CI] 0.26-0.41) and alcohol dependence (OR 0.05, 95% [CI] 0.02-0.12), compared to Canadian born populations. In contrast, refugees arrive in Canada with multiple risk factors related to exposure to violence and have up to 10 higher rates for developing post traumatic stress, elevated rates of depression and chronic pain (Kirmayer et al., 2011). A review of studies also shows that immigrant women have two to three times the risk of their Canadian-born counterparts for PPD. These risks are attributed to a lack of knowledge, stigma and feelings of shame and isolation. These findings are substantiated by previous research (O’Mahoney and Donnelly, 2010). Power and Pratt’s (2012) research with Karen refugees in an American midwestern city showed that experience of torture and mistreatment were associated with persecution from the Burmese army. Karen refugees described their mental health concerns as constant worry and concern over unemployment and housing, and feelings of loss (Power & Rebekah, 2012). Porter and Haslam (2005) conducted a meta-analysis of fifty-nine reports published between 1959 and 2002 on the mental health outcomes of refugees and the factors that moderate their mental health. Their findings point to social
determinants of mental health and suggest that the mental health of refugees is related to multiple factors beyond a single post traumatic stressor. They argue that despite the historical focus on acute stressors of war, the enduring contextual post migration stress that refugees face including marginalization, socioeconomic disadvantage, acculturation difficulties, loss of social support and “cultural bereavement” must be recognized (2005, p. 603).

Consistent arguments across studies examining pre- and post-migration factors suggest that there needs to be improved public policy addressing factors post-migration in order to mitigate negative mental health consequences related to lack of labour training and job access as well as integration of social determinants of health as predictors for resettlement distress (Beiser, 2005; Kirmayer et al., 2011; Maximova & Krahn, 2010; Porter & Haslam, 2005). It is argued by Kirmayer et al. that “the main domains of resettlement stress include social and economic strain, social alienation, discrimination and exposure to violence” (p. 4). These factors can have a compounding impact on refugees who experience PTSD (Kinzie, 2007) as well as contribute to resettlement distress (Beiser, 2005, Omeri et al., 2006).

2.12 Reflections of the Literature and Summary of Key Points

A review of the literature suggests that resettlement policies are embedded in broader political and historical processes in which many refugee groups have little say in their resettlement. Importantly, systemic cultural practice and policies that fail to integrate context for migration and what is needed to support the health and well-being of refugee women has been largely ignored. Public discourse and media portrayal of refugees as a burden on Canadian society have further created
contexts of marginalization and cultural risk for many refugee women who require appropriate access to primary health and mental health services. In addition, broader shifting immigration policies underpinned by neoliberal values have significantly affected social determinants of health for many refugee groups and GARs who come to Canada with limited skills for employment and limited education and literacy.

A review of evidence suggests that multiple forms of violence, including structural violence, shape the lives of refugee women in resettlement. Overlapping with principles of health promotion and primary health care, community capacity is a process and outcome that requires collaborative action to promote public policy and address systemic and structural inequities and identification of community needs through a broader lens of health that acknowledges social, economic, environmental components including resettlement of newcomer groups. This approach shifts the gaze away from biomedical and individually-oriented approaches to health towards ecological perspectives that encompass the role of host communities in their ability to respond to the diverse needs of refugee women and families.

Outcomes studies in BC highlight inequities related to the settlement services of GARs destined outside of the metropolitan periphery. Although these studies point to the growing inequities and the need for greater resources and pre-planning initiatives, little attention has been paid to how gender and other intersecting axes of inequities play out in the lives of refugee women. Importantly, an over-emphasis on distribution of services, vis-à-vis policies that enact principles of fairness
overlooks the multiple social constraints experienced by refugee women. The Mental Health Commission of Canada (MHCC) (2009) as well as national mental health strategies have called for increased research that includes various dimensions of culture and structural determinants on the health and well-being of immigrant, refugee, and ethno-cultural and racialized (IRER) groups in Canada.

Promising primary care research examining inequities in health suggests that service provision should include a trauma- and violence-informed approach that addresses structural policies and practices and their impact on meeting the needs of marginalized groups, including the need for building in translation services for refugees with minority languages (Browne et al., 2012). However, language and health literacy for refugee women remain significant barriers to health and access to healthcare in Canada. There is also some evidence that these factors intersect with gender to shape gender relations between women and their families post migration (Merry et al., 2011; Simich 2009). The persistent lack of equitably oriented services, language support, and education and experiences of discrimination are systemic forms of violence that exclude refugee women from participating as full citizens and constrain women’s access to services needed to rebuild new lives in the Canadian context.

While there is evidence to suggest what works to build equitable health and settlement services, a paucity of research exists regarding what works to build increased access, equity and inclusiveness from the perspective of refugee women themselves. As Fernando (2010) has argued, if issues such as race, culture and gender are to be addressed, then women need to be included in policy decisions that
affect them, where a commitment to social equity and social justice is foregrounded through community mobilization of its human, financial and material resources. Several studies suggest that trauma incurred by refugee groups needs to be contextualized in the context of broader structural processes post migration. This includes an examination of the social determinants and structural constraints many refugee women and men experience during resettlement, as well as culturally competent and culturally safe responses.

Karen refugee women represent one of the largest groups to have been resettled in the province of BC. Karen women and families came to Canada with limited language ability, education or literacy. Drawing on postcolonial feminist theoretical approaches, intersectionality and the lens of cultural safety, I examined Karen women’s experiences, the various factors that intersected to shape their resettlement process and aspects of community capacity and community capacity building that promoted Karen women’s mental health and well-being in the context of their resettlement. This study brings a significant contribution to the field of refugee women’s mental health and draws attention to important intersections of gender, language and literacy/health literacy as contributing factors for promoting Karen women’s agency and access to health care and social service supports.
3. METHODOLOGY AND METHODS

3.1 Introduction

In this chapter I begin with an overview of critical theoretical perspectives that informed my analysis of the findings. Embedded within critical theoretical paradigms I used a constellation of theoretical lenses, particularly postcolonial feminist theory, intersectionality and cultural safety. Although each of these approaches adds something different to my analysis, all three have in common the aim of social justice. In the following paragraphs I describe how I applied postcolonial feminist theory, intersectionality and cultural safety to analyze Karen women’s experiences of resettlement and community capacity.

In order to gain an in depth understanding of Karen women’s day-to-day experiences and the social contexts that shaped their resettlement I outline my use of standpoint and ethnographic methods. Following this I discuss methods used in sampling and recruitment, data collection and analysis, and address issues of validity that were relevant to this study. I end this chapter with a discussion of ethical considerations that were germane to conducting research with Karen women in the community context.

3.2 Theoretical and Methodological Approaches

3.2.1 Critical theoretical perspectives

Critical theoretical perspectives draw upon a constellation of theories and methods to understanding the dominant ways that culture works to disadvantage and/or privilege certain groups of people in society. By “culture” I am referring to
broader aspects of structures and practices that are shaped by power and history (Dirks, Eley & Ortner, 1994). This critical reading of culture is advanced by nursing scholars Browne, Varcoe, Smye, Reimer-Kirkham et al. (2009) who argue that culture is “a dynamic, power laden process created by people in relation to one another” (p.173) and is embedded within broader historical, sociopolitical and economic factors. (Browne, et al., 2009). Drawing on Geertz (1973), Crotty observes that, in the past, culture was viewed as static and concrete sets of behaviours defined by habits and traditions, therefore “culture could be viewed as the outcome of human thought and behavior” (Crotty, 1998, p.53). However, contemporary understandings suggest culture is a process and not a thing, (Kirmayer, 2008). And as Smye, Rameka and Willis (2006) have argued, a critical reading of culture pays attention to power relations embedded in broader political, historical social and economic processes.

Another conviction underpinning critical theoretical perspectives is the idea that knowledge is socially situated and constructed upon the values and beliefs of society. Thus, critical theory provides a cultural critique of dominant cultures, assumptions and structures. Crotty (1998) suggests that for critical inquirers “culture is not a realm apart from the give-and-take of everyday society but mirrors its contradictions and oppressions” (p. 159). Drawing on the work of Bhabha (1994), Anderson (2000) defines culture as a negotiated dynamic process (not fixed within identities), that occurs “through colonization, diaspora and displacement, and recognizes [that] spaces in which culture is constructed are not neutral, but fraught with relations of power, subjugation and domination between the colonizer
and the colonized” (p. 14). Culture viewed in this way has potential to unmask the structural inequalities that can result from gender, race and class relations (Ahmad, 1996).

The term “critical theory” has been conceptualized as a coherent body of thought developed by the Frankfurt School also known as The Institute for Social Research, initially set up in 1924 (Crotty, 1998). Although earlier tenets of the Frankfurt school were advanced by Marxist thought, many forms of social theory have “sprung from the Enlightenment’s understanding of reason as instrumental rationality...[which] splits subject from object, renders control over nature and therefore renders it predictable” (Crotty, 1998, P.141). Disputes about uniformity as well as ongoing evolving critical thought have led to contemporary definitions of critical theory (Crotty, 1998; Kincheloe & McLaren, 2005).

Although there are different schools of thought and considerable hybridity within critical theoretical perspectives, including variants of postmodernism, critical feminism and post structuralism, the main thing that binds researchers of a critical orientation is a concern for the social injustice of identifiable people (Apple, 1996, as cited in Carspecken, 1996). Kincheloe and McLaren (2005) make the claim that “research thus becomes a transformative endeavor unembarrassed by the label ‘political’ and unafraid to consummate a relationship with emancipator consciousness” (p. 305). Extending the works by earlier European social theorists, Horkhiemer and Habermas, critical theory today calls ideologies into question to initiate action and therefore “keeps the spotlight on power relationships within society so as to expose the forces of hegemony and injustice” (Crotty, 1998, p.157).
Applying critical theoretical approaches to health care research, Labonte, Polanyi, Muhajarine, McIntosh et al. (2005) summarize two distinct goals, these include to

1) deconstruct how historical-specific social structures, economic relationships and ideological assumptions serve to create and reinforce conditions that perpetuate and legitimize conditions that undermine the health of specific populations; and 2) a normative political project that, as a result of deeper understanding, seeks the reconstruction of social, economic and political relations along emancipatory lines (p. 10)

Feminist movements evolved from variants of critical paradigms to examine gender as a central construct. However, as critical paradigms have divergent and common perspectives, feminism is equality diverse. Variants of feminism may include but are not limited to liberal feminism, radical feminism, socialist feminism and womanism (Campbell & Wasco, 2000). Campbell and Wasco (2000) observe that “feminisms are similar in that they focus on the experiences of women’s lives and the oppression of women in this culture, yet they are different in how they conceptualize that marginalization” (p.775). Similarly, Lather (1991) has argued that the “goal of feminist researchers in the human sciences is to correct both the invisibility and distortion of female experiences in ways relevant to ending women's unequal social position” (p. 71) and in so doing shift the status quo. However, Campbell & Wasco observe that “what centrally defines research as feminist is its guiding philosophy on the nature of knowledge (epistemology) and the process by which research is created (methodology). Feminist research seeks to respect, understand, and empower women” (p.778). Crotty (1998) observes that what sets feminist researchers apart is “feminist values…[which] transform these common
methodologies and methods” (Crotty, 1998, p. 182). For example, feminist empiricism, derived from positivist and post positivist paradigms, treats race, gender and class as variables, which does not reflect the critical stance adopted by feminist standpoint theory, which “claims that class, race, gender, and sexual orientation structure a person’s understanding of reality” (Campbell & Wasco, 2000, p. 781).

It is important to note that each variant of feminism brings different issues of women’s and men’s oppression to the table, and therefore the boundaries that have been drawn between feminisms can be considered artificial (Crotty, 1998). For example, Crotty adds that there cannot be just one single way that patriarchy permeates thinking and therefore there cannot be only one standpoint. In the following sections, I discuss how postcolonial feminist theory, intersectionality and cultural safety provide a different lens with which to examine Karen women’s experiences of resettlement.

3.2.1.1 Postcolonial feminist theory

Postcolonial discourse is taken up in various disciplines (i.e., philosophy, literary criticism and geographic thought) and does not represent a specific period in time (Ashcroft, Griffiths & Tiffin, 2007); rather, postcolonial theory draws attention to how the non-Western Other is constructed transnationally and works against ongoing neocolonial processes (Anderson, 2000; McConghy, 2000). As Racine & Petrucka (2011) observe, the central aims of postcolonial critique provide both a theoretical lens as well as a process for understanding the ongoing neocolonial relations that perpetuate oppression of non-dominant groups. Anderson (2000)
specifically draws attention to a nursing postcolonial scholarship that examines the processes of racialization and the discourses that reinterpret “the behaviour of people who are seen as being from a ‘different’ so called ‘race’ [however] postcolonial feminist theory does not extend from critical theoretical perspectives developed within a Euro-American tradition” (p.18). This is an important point because Anderson is drawing attention to the fact that historically the voice of racialized women and men have not been privileged in Western knowledge production. Therefore postcolonial feminist theory critiques dominant discourses and ideologies of the non-Western Other (Racine & Petrucka, 2011; Anderson, 2000). Therefore postcolonial feminist theory critiques dominant discourses and ideologies of the non-Western Other (Racine & Petrucka, 2011). For example, the dominant stereotypes that operate to construct refugees as dependent, traumatized and a threat to Canadian society reinforce marginalization and Othering, and impact social policy regarding resettlement of refugee groups. And, as trauma theorists have argued, there is a need to expand understandings of trauma as embedded within social relations and forms of structural violence (Lester, 2013; Kirmayer, 2007).

Although postcolonial critique offers a contextual analysis of “race” relations in the aftermath of colonialism, Anderson (2000) observes that it does not offer a gender analysis which underscores feminist scholarship. Similarly, Monk & Hanson (1982) make the claim that “the result of general omission of gender in welfare and equity research is that race, class and the political economy dominate explanations, while the contributions of gender and the patriarchal organization of society to the creation of disadvantage remain invisible” (p.38-39). Mills and Mullany (2011)
discuss that postcolonial feminist theory is in keeping with third wave feminist approaches in that there is a need to consider differences between and within Western women and men alongside women and men from other cultures and cultural groups. Thus, postcolonial feminist scholarship shares an epistemological concern that the views of the Other are not based on stereotypes but based instead on empirical research and consultation with women and men (of interest) themselves.

A postcolonial feminist scholarship specifically draws on the voice of women and men who have been subjugated historically and shut out of the knowledge production process; to unmask the taken-for-granted ways in which knowledge is produced (Anderson, 2000; Hooks, 1984; Racine & Petrucka, 2011). Thus, Anderson converges Black feminist scholarship with postcolonial theory to 1) contest the historical construction of the non-Western Other through racialized discourse and practice and 2) to bring an analysis of gender, and other factors such as “race” and class relations as important forces in shaping peoples experiences. Thus the aims of a postcolonial feminist scholarship is “…to address issues of gender from the perspective of the postcolonial female subject [necessitating]...multiple social and historical locations from which men and women speak” (Anderson, 2000, p.9).

Since British colonialism in Burma (Myanmar), Karen women and their families have experienced ongoing historical displacement as a result of ongoing colonial and neocolonial processes that brought about conflicts over land, resources and ethnic cleansing. As a result of these sociopolitical and historical conditions, Karen women have been historically marginalized and oppressed by state sponsored
violence and subjugation. In the context of resettlement in Canada and internationally, Karen women have not had a voice in the systemic processes that affect their mental health and well-being. In this study I sought to bring forward the voice of Karen women and their experiences of resettlement to decenter the taken-for-granted understandings of healthcare access and to shed light on delivery of health care services and settlement supports, to make visible the interrelations of what Racine and Petrucka (2011) call new colonial ideologies. At the core of postcolonial feminist scholarship is an analysis of “race” relations and the processes of racializing discourse and practice as products of colonialist and neo colonialist ideologies. I examined the process of racializing discourses embedded in health care practices and settlement supports to interpret how Karen women and families were perceived. For example, embedded in policy and practice were narrow constructions of trauma which in some contexts constructed Karen women and families as unable to learn how to adjust to Canadian society. In particular, dominant views of dependency overshadowed the overall tenor of settlement which constructed Karen GARs as vulnerable immigrants. Young (1990) writes that

oppression carries a strong connotation of conquest and colonial domination...[however] oppression designates the disadvantage and injustice some people suffer not because a tyrannical power coerces them, but because of the everyday practices of a well-intentioned liberal society ... Oppression in this way is structural, rather than the result of a few people’s choices or policies (p. 41).

In examining the structural and social aspects of community capacity, post-colonial feminist theory also provided a lens with which to analyze historical colonial practices that reinforce marginality and vulnerability, as well as what
promotes health equity related to Karen women during resettlement. For example, health promotion through community capacity and capacity building have had limited impact on social advocacy and activism, despite a plethora of evidence on health disparities and growing inequities related to health of refugee groups. I examined how broader structural processes shaped the everyday lives of Karen women through dominant patriarchal and gendered relations. Drawing on Yan (2008), Connell (2012) writes “Colonial and postcolonial societies produce new gender orders, including new gender divisions of labour, which continue to evolve in neoliberal economies today” (p.1679).

To conclude, postcolonial feminist theory shares a critical orientation towards emancipation from oppression, a view shared with earlier positionings within the Frankfurt School of social, critical thought and contemporary critical theories (Anderson, 2000; Kincheloe & McLaren, 2005). This means that nurse researchers who engage in postcolonial feminist research have a moral obligation towards addressing injustice and inequities by “taking [their conclusions] forward into the community and to clinical and policy arenas with the aim of influencing health and social policy decisions” (Anderson, 2000, p. 22). A postcolonial feminist approach to research, however, comes with inherent tensions concerning representation (Racine, 2011, Tuhiri Smith, 1999). In this regard I have made efforts to present findings to Karen women and community partners as referred to earlier in this chapter. In addition, I have made plans to disseminate the findings from this research to a joined health literacy and primary health care scientific café organized
by a large health authority in the region. I discuss the implications of this research for broader policy and practice initiatives in my concluding chapter, chapter seven.

3.2.1.2 Intersectionality

Extending from postcolonial feminist theory, intersectionality has its roots in Black American feminism and was developed by Black feminist scholars, Patricia Hill Collins and Kimberlé Crenshaw to address the complexity of social inequities of black women (Cole, 2009; Dhamoon & Hankivsky, 2011). In this research I employed Dhamoon and Hankivsky’s (2011) conceptual framework of intersectionality to examine the various intersecting factors that shaped Karen women’s experiences of resettlement. This conceptual framework included four major domains of analysis.

The first was a common epistemological and social ontology with Black feminist scholarship in which knowledge is situated and where lived experience of Karen women is foregrounded.

The second was an analysis of how social categories of difference such as race, class and gender mutually constitute a context of advantage and/or disadvantage. For example, drawing on “third world” feminist views, postcolonial critic, Gayatri Spivak (1988) deconstructs gender to examine intersecting colonizing discourses when she states:

---

37 Anderson (2000) notes that Black feminist scholarship reflects a particular social and political location, that reflects the positionality of black women living in countries of the north. Similarly, Racine & Petrucka (2011) talk of postcolonial feminisms to draw attention to “plurality of contexts, locations, positionalities, and voices of participants and postcolonial feminist researchers” (p.13). In this regard different positionalities of the researcher as well as participants may address different aspects of these theories and therefore may produce different contextual knowledges.
Clearly if you are poor, black and female you get it in three ways. If however, this formulation is moved from the first-world context into the postcolonial...context, the description “black” or “of color” loses persuasive significance. The necessary stratification of colonial subject-constitution in the first phase of capitalist imperialism makes “color” useless as an emancipatory signifier (p. 90).

Spivak (1998) draws attention to intersecting categories of race, class, and gender intersect to shape marginality of third world women and how these categories are constituted through social historical processes of gendered colonialism.

Importantly, intersectionality departs from postcolonial feminism because it foregrounds simultaneous axes of inequities, both structural and social. In this way intersectionality does not privilege race or class or gender as static categories; rather, intersectionality provides a lens to expose how various factors intersect to produce inequities amongst differential groups, depending on the time and place. As Reimer-Kirkham and Sharma (2011) have observed, other structures and cultures have also been theorized to include sexuality, age and religion. Reimer-Kirkham and Sharma further argue that adding religion to an intersectional analysis complicates intersections of race, class and gender to examine the complexity of lived experiences. Similarly, empirical evidence examining refugee women’s health suggests that refugee women experience multiple and simultaneous axes of inequities related to literacy, education and gender (Mahler & Pessar, 2006; Merry et al., 2011; Simich, 2009; Zanchetta et al., 2012). Therefore, intersectionality theory is not related to simply adding in social categories of difference, but aims to examine how social
constructs of gender might be constituted when race, religion, sexuality and other social categories interface.

Thirdly, intersectionality draws attention to the process of differentiation and systems of domination such as racialization, gendering and colonialism. As Dhamoon and Hankivsky (2011) discuss, “systems of domination are those that organize the privilege of some norms and some subjects over others” (p. 24). Similarly, Malkki (1995) has argued that an essentialist understanding of “refugee” “reflects a wider tendency, in many disciplines, to seize upon political or historical processes and then to inscribe aspects of those processes in the bodies and psyches of the people who are undergoing them” (p. 511). For example, privileged norms in the context of Karen women’s access to services meant that they would be able to navigate healthcare systems and access healthcare without difficulty. From another perspective, mainstreaming of settlement services has been shown to be incongruent with settlement needs of diverse groups (Creese, 1998; Sadiq, 2004). I examined how institutional processes influenced Karen women’s access to resources in the context of their resettlement and the gap between governmental distribution of settlement services and Karen women’s resettlement needs.

Fourth, and lastly, intersectionality shifts the gaze toward broader systems of domination (social, political, economic) in order to understand “how power operates, is resisted and how difference is governed on a discursive structural level” (Dhamoon & Hankivsky, 2011, p. 25). In this regard I employed a policy lens to examine multiple levels of governmental policies, such as broader immigration policy vis-à-vis the Interim Federal Health policy and various settlement policies
that structured Karen women’s access to health care services and social supports. Drawing upon the larger macro structures allowed me to examine political, economic and social processes that organize the way that health and social supports were distributed at the time Karen women and their families arrived in BC. This provided an analysis of the embedded policies and practices of community capacity and capacity building shaped by larger macro structures such as the political economy. Situating Karen women’s experiences within wider sociopolitical, historical and economic forces allowed me to critically analyze the systemic processes that challenged/constrained and/or supported Karen women’s mental health and well-being during resettlement and evolving policy directives.

### 3.2.1.3 Cultural safety

Culture safety is closely aligned with postcolonial feminist theory and tenets of intersectionality in that cultural safety privileges the voice of marginalized groups who have experienced historical, social and political forms of oppression. Drawing on the voices and experiences of Maori populations in New Zealand, cultural safety has been developed as a model for practice which draws attention to health disparities and inequities experienced by Maori populations as a result of colonization (Papps & Ramsden, 1996). Examining the fundamental differences between transcultural nursing and cultural safety, Ramsden (2002) argues that cultural safety differs because it draws attention to structural and multifaceted social inequalities between Maori and non-Maori groups. However, cultural safety has also political currency when been applied as an integral aspect of nursing practice across culturally diverse refugee and migrant groups in Canada, the US and
Underpinned by a constructivist paradigm, the epistemological and
ontological underpinnings of cultural safety do not place emphasis on cultural
sensitivity or cultural competence; rather, attention is placed on processes of
differentiation. Therefore, culture is conceptualized as a fluid construct shaped by
historical, social, political and economic lenses focused on race and race relations
and other aspects of identity such as gender, class, religion etc. (Gregory, Harrowing,
Lee, Doolittle et al., 2010; Gregory, 2009). Papps & Ramsden (1996) particularly
draw attention to relations of power that are embedded in these broader social
processes and that impact health and well-being of non-dominant, non-Western Other. Therefore, cultural safety draws attention to power relations that are
historically and politically mediated (Smye, Rameka & Willis, 2006). In this way
cultural safety promotes social justice by changing the way we think about power
relationships and the rights of individuals and groups. As Papps & Ramsden note,
the central aim of cultural safety is for “nursing and midwifery action to protect
from danger and or reduce risk to the patient/client/community from hazards to
health and well-being” (p.493). In order to analyze micro relations of power, I
applied the lens of cultural safety to examine not only Karen women’s experiences
but their perspectives about what promoted their safety and well-being during
health care and other social encounters in their everyday lives.
Cultural safety can also be applied more broadly to examine macro level relations reflecting policy and practices that are designed to promote the health and well-being of diverse population groups through principles of partnership, participation and protection (Gustafson, 2008; Mortensen, 2010). Embedded within a critical cultural approach, cultural safety moves beyond sensitivity and tolerance in our day-to-day engagement with individuals—a hallmark of the cultural competence approach—toward a...theoretical shift...that requires that we appreciate the dominant discourses of cultural diversity that are grounded in and emerge from institutional practices and processes create and sustain power dynamics that impact on the everyday work of engaging with newcomer women and their families (Gustafson, 2008, p. 40).

In this study I examined how dominant discourses that constructed refugee groups as traumatized victims and threat to public safety shaped underlying discourses of dependency and experiences of vulnerability of Karen women in relation to their interaction with settlement and healthcare services. Nursing scholars in the Canadian context have drawn attention to epistemic violence that non-Western populations have incurred as a result of lack of consultation and participation with non-Western groups in the delivery of healthcare and practice (Anderson, Perry, Blue, Browne et al., 2003; Smye & Browne, 2002). I applied a lens of cultural safety to examine broader social structures of community capacity (social relations between services and structures) in relation to the health and settlement needs of Karen women. Drawing on larger power relations, I linked values of multiculturalism with mainstream institutional practices and their impact on Karen women’s access to services and supports. This analysis framed processes of
structural and systemic forms of violence in which Karen women were denied access based on their language and literacy ability.

Lastly, Smye and Browne (2002) have argued that a cultural safety lens allows nurse researchers to critically examine not only policies but also research practices that may recreate traumas and place individuals at risk so that cultural safety “becomes a vehicle for translating post-colonial concerns into praxis, pushing beyond culturalist approaches to policy” (p. 47). Similarly, drawing on the work of hooks (1984), Racine (2003) points out that cultural safety provides an ethical lens for conducting research with women of the south, “to be aware of their social locations to avoid essentializing the culturally different Others in new, normative or authoritative discourse” (p. 97). And as Donnelly (2000) points out “representation involves unequal power relationships between researchers and their participants... as such, an analysis of power relations between researchers and the participants in their research is essential in representation of research results” (p. 60). Cultural safety therefore also provided me with an ethical stance to examine and critically reflect on my position (power), values and biases which might unwittingly misrepresent the standpoint of Karen women.

In summary, I applied postcolonial feminist theory to examining Karen women’s experiences of resettlement as they are embedded in the wider colonial and neocolonial processes. I applied an intersectionality framework in order to analyze specific axes of social and structural inequities shaping health and well-being of Karen women and families during resettlement. Lastly, I employed cultural safety as a lens to examine micro and macro power relations between Karen
women, health and social service providers and broader institutional practices and policies. Below is a visual representation of how I triangulated postcolonial feminist theory with tenets of intersectionality and the lens of cultural safety into a framework of the critical theoretical approaches (Figure 1).

![Figure 1. Framework of the Critical Theoretical Approaches](image)

3.2.2 Critical ethnography

Fitting with critical theoretical perspectives of postcolonial feminist theory, critical ethnography is a method which moves beyond traditional ethnographic approaches that objectify perspectives of the known subject toward a dialectical process and performance and engagement with experiences of research participants (Madison, 2005). In taking a critical stance, critical ethnographers engage in a reflexive process of interpretation where meanings are constructed with individuals and groups (Crotty, 1998). In this research, the dialectical process involved an
analysis of social structures that shaped Karen women’s experiences of resettlement as well as other community perspectives (health care and social service providers) on factors that facilitated and/or challenged community capacity. Through a process of shifting back and forth between community policies and practices and Karen women’s experiences, I gained a deeper understanding of the contextuality of Karen women’s everyday experiences. The final product of “doing ethnography” is to gain what Creswell (2013) calls a cultural portrait in which the researcher gains an emic (a participant’s) “insider” view. In contrast to traditional ethnographic methods, critical ethnography places at the center the values and beliefs of the researcher. At this juncture, critical ethnographers have a moral obligation to reflect upon how the preconditions of the researcher’s values, biases and beliefs represent the individuals and groups they study. Alternative to positivist paradigms, critically oriented researchers cannot assume anything a priori, for example emphasis is placed on how people themselves ascribe social meaning to categories such as gender, ethnicity and class (Emerson, Fretz & Shaw, 1995) and thus take a self-critical stance toward assumptions that are incorporated in research (Lather, 1986).

Meanings and interpretations are constructed by the ethnographer, however it is the ethnographer’s task to “represent in written text what local people consider meaningful...and making their concerns accessible to readers who are unfamiliar with their social world” (Emerson, Fretz & Shaw, 1995, p. 108). In keeping with an ethical stance of cultural safety, the act of “doing” critical ethnography requires what Lather (1991) calls a “reciprocal reflexivity and critique both of which guard against
the central dangers to praxis-oriented empirical work: imposition and reification on
the part of the researcher” (p. 59).

Another tenet of critical ethnography is that the knowledge generated is always evolving and never static (Kincheloe & McLaren, 2002). As Madison (2005) discusses, the dialogic relationship with the Other is not static or unchanging, rather “dialogue moves from ethnographic present to ethnographic presence by opening the passageways for readers and audiences to experience and grasp the partial presence of a temporal conversation constituted by the Other’s voice, body, history” (p. 10). In this way the relationship between the researcher and research participant is understood as historically and culturally situated to create not a “single truth” but a meaningful understanding of the experience of the Other.

Although both critical ethnography and traditional ethnographic methods involve immersion in a local context, critical ethnography does not simply describe social life, rather its aims are to provide a critique of “culture” in order to use knowledge for positive social change (Thomas, 1993). Congruent with decolonizing approaches to generating knowledge, critical ethnography situates knowledge production in the actual lives of individuals. In this regard I situated Karen women’s experiences as a starting point of inquiry in order to uncover dominant cultural understandings and constructions of health and bring to light how structural inequities brought about by social, historical and political colonial relations impacted Karen women’s access to health care and social services and supports. Thus the central aims of critical ethnography are to transform knowledge and
promote social justice by privileging the voices of subjects whose stories are otherwise out of reach (Madison, 2005).

3.2.3 The standpoint method of inquiry

Fitting with the aims of critical ethnography and the philosophical underpinnings of postcolonial feminist theory, I drew on Smith’s (1992; 2005) standpoint method of inquiry. From this perspective Smith (1992) argues that standpoint method is not a totalizing theory but a sociological method that begins with the actualities of women’s experiences. From this position it was my intention to start with the everyday experiences of Karen women who participated in the Early Years Refugee Program (EYRP).

At the heart of standpoint as a method of inquiry is the fact that women’s experiences are not objectified and decontextualized from social relations. As Smith (1992) asserts, the standpoint method is a commitment to explore how things work in the everyday in which “there is no place outside: hence it must be an insider’s sociology. There are no outsiders; we are all participants—we discover ourselves in exploring the relations in which we participate and that shape how we participate” (p. 94). In this regard I participated in the day-to-day practices of Karen women such as attending medical appointments, engaging in early childhood education classes with them and their children, as well as participating in home visits with outreach workers and public health nurses.

Smith (1992) is clear that the standpoint method does not take up a position or category of knowing; rather, the aims are to understand how people’s everyday lives are coordinated and organized within what Smith calls “ruling relations.” From
this viewpoint social relations are embedded in forms of power and are enacted as a result of text mediated discourse. For example, in this research I became consciously aware of how Karen women’s lives were gendered through policies and practices that constrained access to health care services on the one hand while on the other, changes to Canadian immigration policies called for the inclusion of gender as a central component to enhance equity oriented settlement supports for government assisted refugees including the Karen. Moreover, reforms to settlement policy and practice shaped Karen women’s identities as dependent and vulnerable and constrained their ability to enact agency. In keeping within the theoretical underpinnings of cultural safety, the standpoint method allowed me to analyze relations of power from the perspective of Karen women, and examine how these social relations were embedded within broader and complex institutional processes of resettlement.

3.3 Research Objectives and Methods

As noted in Chapter One, the specific research objectives of this study were:

1) To explicate, from the perspective of Karen women, those aspects of suburban community and mental health and social services that support their resettlement process; 2) To examine, from the perspective of health and service providers, the social and structural factors that facilitated and/or challenged community capacity to support the resettlement and mental health and well-being of Karen refugee women in an suburban context, including their access to mental health services and supports; and 3) To use the findings of the study to make recommendations
regarding community capacity to inform related health and social policy and practice about what promotes mental health and well-being of Karen refugee women.

3.3.1 Negotiating entrance into community

Negotiating entry and engagement with the community in which this study was conducted included the establishment of relationships with the community gatekeepers, some of whom were providing direct community-based services for Karen women and who had built established trusting relationships with Karen women. Relationship building was a lengthy, difficult process as I was not a part of the community into which Karen women and families were resettled. Many community service providers provided hands-on support during the initial Karen resettlement and were skeptical about research and what I was doing there. However, if I was going to be able to understand Karen women’s experiences I needed to establish trust with, and the buy-in of, key gatekeepers. In this regard I was transparent about my role as a researcher and my background as a nurse. I explained why I wanted to do this study and tried to elicit community perspectives on the focus of this research and its relevance to them. This process required me to be flexible and open to the community’s understandings of what they saw as important. For example, the idea of community capacity came from the community service providers themselves and was identified as a key issue for meeting the needs of Karen women and their families. This transparency and flexibility thus afforded me an entrée. In addition, my participation as a community volunteer at a
local community program designed to build kids' literacy through sport, demonstrated my commitment to the research.

3.3.2 Sampling strategy, recruitment and rationale

The central purpose of this research study was to examine the social and structural factors that both facilitate and challenge community capacity building to support Karen refugee women’s mental health and well-being in the context of the resettlement process. Drawing on critical ethnographic and standpoint methods, over several months, I conducted participant observations of the day-to-day experiences of Karen women as they accessed health care services and engaged with community service organizations. Research participants were purposefully sampled throughout a community of people who had established long term relationships with the community services as well as Karen women and families. Purposeful sampling in ethnographic research can include both the participants as a unit of analysis as well as a social context (Hammersley & Atkinson, 2007). In this research the aim was not to study the culture of Karen women, rather the culture of community capacity building within a local context. Purposeful sampling of data in this research meant that key informants who had direct experience and knowledge about working with the Karen women and families during resettlement would be able to inform the research objectives and purpose of this study. This also included purposeful sampling and analysis of other sources of data such as documents and policy reports that were relevant to understanding resettlement issues in Canada and BC.
To further develop my analysis, I also used theoretical sampling. Theoretical sampling is a process used to decide where to sample next according to emerging codes and categories in the analytic process of qualitative research (Coyne, 1997). For example, in my initial interviews with settlement workers and observations of the day-to-day challenges that Karen women experienced in accessing healthcare services, I became aware of the lack of interpreter services available for Karen women. In order to gain a better understanding of these structural constraints, I interviewed both public health nurses as well as nurse practitioners who worked in different healthcare contexts. Each of these participants provided a different window into access of language resources. For example, nurse practitioners emphasized the need for increased collaboration and integration between mainstream mental health services and language interpreters. Similarly, public health nurses viewed interpreter services as central to increasing accessibility across mainstream and specialized health resources such as reproductive and mental health services. Both public health nurses and nurse practitioners viewed health literacy as promoting mental health and well-being. I then discussed and analyzed health literacy from the perspective of early childhood development workers who provided literacy support in the Early Years Refugee Program (EYRP). I employed both purposive and theoretical sampling in order to gain an in depth perspective on how current settlement policy and practices supported Karen women. Through this process I was able to conceptualize relationships between the emergent themes in the data in order to better understand the social and structural process that were pertinent to community capacity building.
Only Karen women who accessed the EYRP in a specific geographic location (City A) were purposefully sampled and invited to participate in this research. Thus, other government-assisted Karen refugee women who lived in another city and who were accessing EYRP’s that also provided services to other GARs were not included in this research. This was primarily because the central aims of this research were to examine community capacity in a geographic location that was located further away from the metropolitan periphery.

Karen women were purposefully sampled through key informants who worked with Karen families on a daily basis and who had experience in the resettlement process. This included community volunteers, and leaders in the community who initiated settlement resources and development of the EYRP tailored for Karen families. Drawing on each of these groups facilitated a deeper analysis of the social and structural aspects of community capacity. Thus most of the key informants were community leaders in the area of volunteer church led organizations and/or program managers who helped to establish resources for Karen women and families. In this regard they were not necessarily stakeholders who had invested funds and resources into the community. These key informants were also invited to participate in the study. All participants who expressed an

\[38\] City A represents the location and context in which the second Karen group were resettled and in which I conducted this research. In the remainder of this study I refer to City A as the primary site in which this research was conducted. City B refers to a neighboring metropolitan center in which many Karen women and families accessed specialized refugee and immigrant health clinics. City C refers to a larger metropolitan city located further away from City A and B. In many cases Karen women had to travel to City C in order to access specialized medical care for themselves and their children.
interest in the study were able to contact me directly and/or provide information to the key informant as to how I could contact them.

Although a recruitment poster for Karen women (Appendix A) was provided and displayed in both S’gaw Karen and English at the EYRP and at a local library, none of the Karen women contacted me this way. All recruitment was done through an informal process (word of mouth) referred to as snowball sampling, between key informants and two Karen women who were identified as leaders in their community and who were interested in the study. In this regard key informants played an integral role in recruitment because they had longstanding relationships built on trust with many Karen families. To maintain confidentiality of all research participants in this research, key informants were not informed about Karen women or community members who participated in the study.

I also advertised the study to other community members, (i.e., administrators, managers, settlement workers, health care providers, and volunteers) via a recruitment poster (Appendix B); however, all participants contacted me through word of mouth. Drawing on service providers’ views provided another perspective from which to contextualize the social and structural aspects of community capacity. All community members were provided with information about the study and were given at least 2 weeks to review the consent form. Throughout the study I reminded participants of the voluntary nature of their consent. As part of the recruitment process I also provided key informants with an recruitment/information letter explaining the purpose of this study and how they could contact me as part of my recruitment strategy (Appendix C).
3.3.3 Research setting

The primary setting for conducting field observations and recruitment of participants took place at the Early Years Refugee Project (EYRP) which is located within a larger nonprofit service organization in a suburban community located within the Fraser valley region. The EYRP provided support services to refugee children and their families settling in the suburban community, City A. There are eight EYRPs located in lower mainland BC, which provide services to different groups of immigrant and refugee women and provide services in Karen, Mandarin, Korean and Spanish languages. All EYRPs provide early childhood education, life skills training, language translation and outreach services and receive funding from three main government Ministries including the school boards, the health authority and the Ministry of Childhood and Family Development. The context of the EYRP in which this study was conducted primarily provided services to Karen women and their families.

I requested ethical approval to conduct participant in field observations from the service agency in which the EYRP was located (Appendix M) as well as the University of British Columbia Behavioural Ethics Research Review Board, and Fraser Health Research Ethics Board. Once ethical approval was obtained I conducted participant observations at the EYRP as part of my ethnographic field work and recruitment of participants. Spending a prolonged period of time at the EYRP allowed me to develop relationships and participate in the day-to-day practices involved in supporting Karen women. This provided a rich social context from which to develop a deep understanding of many of the challenges that
community providers and Karen women experienced as well as community strengths. Although the EYRP was the primary site in which I started the study, much of my time was spent traveling with a community outreach worker to various community health clinics and homes of Karen families.

### 3.3.4 Sample size

Due to the qualitative nature of this study sample size was dependent upon the amount of data necessary to provide a contextual analysis of the phenomenon under study (Sandelowski, 1995). In qualitative research this is often called reaching a theoretical saturation point (Mason, 2002). Several thematic patterns emerged when I analyzed Karen women’s experiences of resettlement with other study participants. For example, discourses of dependency and trauma and illiteracy were often used to explain Karen women’s social position in the community. Alternatively, while almost all service providers constructed Karen women’s identities as dependent, themes of increased knowledge and literacy were also used to describe women’s identities in relation to Karen men. Likewise, these themes intersected with Karen women’s enactment of their agency and their need for autonomy. The decision to stop interviewing was made once theoretical data saturation was reached, that is, once I was no longer gaining new information from the study participants.

Although I did not conduct confirmatory focus groups I conducted an informal interview with two Karen women leaders who participated in the study to discuss my findings and interpretations of the data. I also conducted a secondary interview with a key informant to discuss my findings in light of shifting settlement
policies. Sandelowski (1998) discusses how the use of knowledge experts can be an integral part to member checking or member validation. Thus I drew on two Karen women leaders and a community expert to verify and contest my interpretations of the key themes. This process strengthened my analysis of the data and made me accountable to the community.

In this study, I conducted two focus groups which comprised of Karen women participants (N=8), and in depth individual interviews were done with Karen women (N=4), for a total of N=12 Karen women participants. Two focus groups were also conducted with service providers, one with public health nurses and allied health professionals (N=7); the other with community women’s support workers and allied health professionals at a community center (N=6). In depth individual interviews were conducted with nurse practitioners, public health nurses community midwives, settlement workers, community outreach support workers and early childhood educators (N=13); for a grand total of N=38 participants. Table 1 provides a summary of the participant sample.

<table>
<thead>
<tr>
<th>Participants</th>
<th>Number of focus groups</th>
<th>Number of focus groups participants</th>
<th>Individual interviews</th>
<th>Total participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Karen women</td>
<td>2</td>
<td>8</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Health care providers</td>
<td>1</td>
<td>7</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Settlement workers, community support workers and volunteers</td>
<td>1</td>
<td>6</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4</strong></td>
<td><strong>21</strong></td>
<td><strong>17</strong></td>
<td><strong>38</strong></td>
</tr>
</tbody>
</table>
3.3.5 Participant characteristics

3.3.5.1 Karen women

During individual and focus group interviews Karen women were given the option of filling out a sociodemographic form for research participants (Appendix D). These were descriptive statistics analyzed using Excel software. For the Karen women, the mean age was 37 years (age range: 26-60 years); the number of years in Canada ranged from 3-7 years; two women had obtained their Canadian citizenship, 10 were permanent residents; all women identified as Christian; 11 women were born in Burma and only one in Thailand; four women reported having schooling less than three years (33%), two women identified having up to 8 years of schooling (17%) and six women reported having at least nine years of schooling (50%). The women’s highest level of education was self-reported to be level 10 which may not be equivalent to grade 10 in Canada. This was surprisingly high given the reported lower literacy level of Karen women documented by Marchbank et al., (2014). However, the level of education may have been related to being able to access education while growing up in refugee camps in which basic education was provided by humanitarian NGOs as well as religious organizations. In addition, the women discussed that having children in the refugee camps precluded them from continuing with their education. Five of the women reported having attended English as a second language class at some point during their resettlement. All the women (100%) were renting and living in lower income housing. Ten Karen women (83%) reported that they were dependent on their spouse for income and also received welfare and/or child care subsidies and two women were employed (one
as a settlement worker the other had seasonal employment) (17%). The sociodemographic profiles of the women who participated in the study are provided in table 2.

Table 2. Karen Women's Demographic Data (n = 12)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>Mean</td>
<td>36.7</td>
</tr>
<tr>
<td></td>
<td>Min</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Max</td>
<td>60</td>
</tr>
<tr>
<td><strong>Citizenship</strong></td>
<td>Canadian Permanent Resident</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Citizen</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>(17%)</td>
<td>(83%)</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td>Christian</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>(100%)</td>
<td></td>
</tr>
<tr>
<td><strong>People in household</strong></td>
<td>Mean</td>
<td>4.9</td>
</tr>
<tr>
<td></td>
<td>Min</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Max</td>
<td>8</td>
</tr>
<tr>
<td><strong>Number of children</strong></td>
<td>Mean</td>
<td>2.5</td>
</tr>
<tr>
<td></td>
<td>Min</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Max</td>
<td>6</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>Level 3 or lower</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Level 4 to 8</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Level 9 or higher</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>(33%)</td>
<td>(17%)</td>
</tr>
<tr>
<td></td>
<td>(50%)</td>
<td></td>
</tr>
<tr>
<td><strong>ESL classes</strong></td>
<td>Yes</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>(42%)</td>
<td>(58%)</td>
</tr>
<tr>
<td><strong>Housing</strong></td>
<td>Rental</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>(100%)</td>
<td></td>
</tr>
<tr>
<td><strong>Source of income</strong></td>
<td>Dependent of spouse/child</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>subsidy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Employed</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>(83%)</td>
<td>(17%)</td>
</tr>
<tr>
<td><strong>Years in Canada</strong></td>
<td>Mean</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Min</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Max</td>
<td>7</td>
</tr>
</tbody>
</table>

Most of the Karen women reported having a generally good health status; this may be related to the fact that most women who participated were of a younger age. Many women talked about their health concerns informally during home visits and health care encounters, many of which I documented in field notes and memos. When I asked Karen women about their health concerns, three of the twelve women interviewed reported diabetes as a health concern. Headaches and
sleep problems were also of concern for a few of the women, as well as high blood pressure. It is noted that these women did not describe problems related to mental health or maternal health. Rather women talked about their mental health in relation to worry, stress, and thinking too much. I discuss Karen women’s perspectives in relation to their mental health in chapters four and five.

3.3.5.2 Community health and social service providers

In order to gain an in depth understanding of access to healthcare services for Karen women, I interviewed nurse practitioners who worked in specialized immigrant and refugee clinics as well as public health nurses providing direct services for Karen women and families. Two nurse practitioners (NPs) were interviewed together\(^{39}\); their work experienced ranged from 7 months to 17 years. Both NPs provided specialized health care services to government assisted refugees at one of the specialized refugee and immigrant health clinics located in a large metropolitan center, City B. All of the health care and social service providers indicated that they had post-secondary education. The registered midwife interviewed had fourteen years of experience in the community, and extensive experience working with Karen women during their resettlement.

Although some Karen women were also accessing primary health care services for their prenatal care, most women preferred to see a community midwife,\(^{39}\) In some cases healthcare providers such as NPs and registered midwives preferred to be interviewed in pairs. This may have affected the ability of participants to speak freely, however each of these paired interviews showed a range in experience from novice to having many years of experience working with refugee groups including Karen women. The fact that these groups chose to interview together may have provided a learning experience for more novice practitioners.
which was culturally congruent with Karen women since many of the women received maternal care from midwives in the refugee camps and villages. The interviews revealed that in the resettlement context access to pre- and postpartum care was facilitated by community outreach workers and public health nurses.

As NGOs provided the majority of settlement work for Karen families, I was interested to gain an understanding of settlement in terms of support services offered from the perspective of settlement workers. Due to the limited amount of settlement workers in the area, I conducted in-depth individual interviews with two male Karen settlement workers. Both had received post-secondary education outside of Burma and Thailand, held graduate degrees and did not self-identify as having refugee status. One of the settlement workers had experience working with the United Nation High Commissioner for Refugees (UNHCR) to assist with resettlement of Karen refugees from Thailand to Canada.

Public health nurses (PHNs) were also interviewed, nurses who provided direct health care services and education to Karen women either through the Early Years Refugee Program and/or through a local public health unit that was located within walking distance from where Karen women were living.

Two community dieticians were very involved with providing services and support to Karen women either through public health, and/or the women’s community drop-in center. These dieticians also participated in focus groups alongside other health care providers.

Two of the community volunteers who represented different church-based organizations and who were actively involved in assisting Karen women and their
families during the early phases of resettlement were also interviewed. These community volunteers continue to provide settlement support for Karen women and families through other government organizations (i.e. local schools).

All other social service providers worked and/or provided outreach support to Karen women including early childhood educators (ECEs). Health care and social service providers also had the option of providing sociodemographic information which is listed below in table 3. The decision to include religion as a sociodemographic category was premised on the fact that previous research with Karen refugee groups has shown that ties with religious organization and communities influence the degree to which Karen groups feel a sense of belonging and connectedness (Marchbank et al., 2014; Power & Pratt, 2012). However, as is noted in table 3, most participants did not identify a religion or faith. This may be related to the fact that religious organizations vis-à-vis volunteer groups played a larger role in initial phases of resettlement whereas mainstream care providers may not have been associated with similar faith based organizations (see table 3).

**Table 3. Health Care and Social Service Provider Data (n = 26)**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Citizenship</th>
<th>Religion</th>
<th>Education level</th>
<th>Role</th>
<th>Years in Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>Canadian</td>
<td>Anglican</td>
<td>Post-secondary</td>
<td>Volunteer</td>
<td>8</td>
</tr>
<tr>
<td>Female</td>
<td>Canadian</td>
<td>NA</td>
<td>Post-secondary</td>
<td>Dietitian</td>
<td>8</td>
</tr>
<tr>
<td>Female</td>
<td>Canadian</td>
<td>NA</td>
<td>Post-secondary</td>
<td>ECE</td>
<td>3</td>
</tr>
<tr>
<td>Female</td>
<td>Canadian</td>
<td>Catholic</td>
<td>Post-secondary</td>
<td>Life skills coordinator</td>
<td>34</td>
</tr>
<tr>
<td>Female</td>
<td>Canadian</td>
<td>NA</td>
<td>Post-secondary</td>
<td>NP</td>
<td>0.5</td>
</tr>
<tr>
<td>Female</td>
<td>Canadian</td>
<td>Christian</td>
<td>Post-secondary</td>
<td>NP</td>
<td>NA</td>
</tr>
<tr>
<td>Female</td>
<td>Canadian</td>
<td>NA</td>
<td>NA</td>
<td>Outreach worker</td>
<td>NA</td>
</tr>
<tr>
<td>Gender</td>
<td>Citizenship</td>
<td>Religion</td>
<td>Education level</td>
<td>Role</td>
<td>Years in Community</td>
</tr>
<tr>
<td>--------</td>
<td>-------------</td>
<td>----------</td>
<td>----------------</td>
<td>------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Female</td>
<td>Canadian</td>
<td>Christian</td>
<td>Post-secondary</td>
<td>Outreach worker</td>
<td>21</td>
</tr>
<tr>
<td>Female</td>
<td>Canadian</td>
<td>Anglican</td>
<td>Post-secondary</td>
<td>Outreach worker</td>
<td>15</td>
</tr>
<tr>
<td>Female</td>
<td>Canadian</td>
<td>Christian</td>
<td>Post-secondary</td>
<td>Program manager</td>
<td>17</td>
</tr>
<tr>
<td>Female</td>
<td>Canadian</td>
<td>NA</td>
<td>Post-secondary</td>
<td>PHN</td>
<td>2</td>
</tr>
<tr>
<td>Female</td>
<td>NA</td>
<td>NA</td>
<td>Post-secondary</td>
<td>PHN</td>
<td>NA</td>
</tr>
<tr>
<td>Female</td>
<td>Canadian</td>
<td>NA</td>
<td>Post-secondary</td>
<td>PHN</td>
<td>6</td>
</tr>
<tr>
<td>Female</td>
<td>Canadian</td>
<td>NA</td>
<td>Post-secondary</td>
<td>PHN</td>
<td>6</td>
</tr>
<tr>
<td>Female</td>
<td>Canadian</td>
<td>NA</td>
<td>Post-secondary</td>
<td>PHN</td>
<td>NA</td>
</tr>
<tr>
<td>Female</td>
<td>NA</td>
<td>NA</td>
<td>Post-secondary</td>
<td>PHN</td>
<td>10</td>
</tr>
<tr>
<td>Female</td>
<td>Canadian</td>
<td>NA</td>
<td>NA</td>
<td>Registered midwife</td>
<td>14</td>
</tr>
<tr>
<td>Male</td>
<td>Karen</td>
<td>Christian</td>
<td>Post-secondary</td>
<td>Settlement worker</td>
<td>NA</td>
</tr>
<tr>
<td>Male</td>
<td>Karen</td>
<td>NA</td>
<td>Post-secondary</td>
<td>Settlement worker</td>
<td>NA</td>
</tr>
<tr>
<td>Female</td>
<td>Karen</td>
<td>Baptist</td>
<td>Level 10</td>
<td>Settlement worker</td>
<td>6</td>
</tr>
<tr>
<td>Female</td>
<td>Canadian</td>
<td>NA</td>
<td>Post-secondary</td>
<td>Speech language pathologist</td>
<td>5</td>
</tr>
<tr>
<td>Female</td>
<td>Canadian</td>
<td>Christian</td>
<td>Post-secondary</td>
<td>Volunteer</td>
<td>28</td>
</tr>
<tr>
<td>Female</td>
<td>Canadian</td>
<td>Sikh</td>
<td>Post-secondary</td>
<td>Program assistant</td>
<td>17</td>
</tr>
<tr>
<td>Female</td>
<td>Canadian</td>
<td>NA</td>
<td>Post-secondary</td>
<td>Program assistant</td>
<td>15</td>
</tr>
<tr>
<td>Female</td>
<td>PR</td>
<td>NA</td>
<td>Post-secondary</td>
<td>Project facilitator</td>
<td>25</td>
</tr>
<tr>
<td>Female</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Dietitian</td>
<td>NA</td>
</tr>
</tbody>
</table>

### 3.3.6 Data collection methods and procedures

Data collection occurred over a 17 month period extending from the beginning of May 2012 to end of September 2013. To establish ongoing relationships with the community I volunteered at least one day a week at an after-hours school program in the community, referred to as homework club. However, these aspects of my participation were a form of reciprocity in which I did not collect data or document my community volunteer hours.

I gathered data through a variety of sources including semi-structured individual interviews and focus groups and participant observation. Karen women
preferred to have interviews conducted at their homes. Interviews with health care and social service providers were conducted at various locations of their choosing that were convenient and confidential. The use of multiple data sources (participant field observations, in depth interviews, focus groups, and field notes) allowed me to integrate different data sources into my analysis. I combined field notes and reflexive memos with all transcribed interviews that were stored in the QRS N-Vivo 10™ software program. Audio recorded interviews were erased after I downloaded them into the QRS N-Vivo 10™ software program. Audio recordings were transcribed verbatim. Electronic copies of all transcribed interviews were also stored in the QRS N-Vivo 10™ software program.

3.3.6.1 Focus groups

In this study, two focus groups were held with multidisciplinary community service providers and two with Karen women. For these focused discussions, the goal is usually not to come up with general conclusions but to facilitate a focused discussion to elicit perspectives across a diverse group of people who share a common interest (Krueger & Casesy, 2009). One of the challenges of conducting focus groups is maintaining participant confidentiality (Morgan, 1997). In this regard all focus group participants were asked to refrain from discussing the group’s responses outside of the focus groups. In addition to the consent process, participants were informed that their names would not be used in the analysis of the research findings and or any research publications; instead, a code number or pseudonym was used.
Focus group discussions with multidisciplinary community service providers were held in order to stimulate discussion about what community capacity means to health care and social service providers. They lasted approximately 60-90 minutes in duration and were audio recorded and transcribed verbatim. I used focus group interview guides to help stimulate the discussion and introduce the topic Focus Group Interview Guide for Karen Women and Focus Group Interview Guide for Health Care and Social Service Providers (Appendices E & F). One of the focus groups was held with the public health nurses and health professionals who provide direct health care services to Karen women. Several weeks prior to the health care providers’ participation in the focus group I provided a short presentation about the research as part of my recruitment strategy. This also gave the nurses time to review the information about the research.

A public health nurse who had participated in an in depth individual interview and who shared an interest in the research topic helped facilitate the focus group. This allowed me to make notes and general observations of the group discussion and these observations were later recorded in memos attached to the transcribed version. This focus group consisted of five public health nurses, one speech and language pathologist, and one registered dietician. Many nurses were constrained by time but expressed interest in participating. To address this issue, I provided catered food over the lunch break in the meeting room of the public health clinic.

I conducted a second focus group with community outreach workers who provided direct outreach support to Karen women during the postpartum period.
This focus group was conducted in a similar fashion as the focus group with public health nurses and allied health care providers, and was held at a local community drop-in program site. Participants in this group included one registered dietician, two program assistants, one volunteer, and women’s outreach workers. The purpose of this focus group was to gain a different perspective on how community outreach workers and volunteers provided support to Karen women in the context of resettlement. This focus group was held in a community meeting room after program services had finished for the day. I also provided light snacks and beverages. All of the participants worked with Karen women and provided outreach support and postpartum health promotion and education. This focus group allowed me to gain another perspective on community capacity from community members outside of the EYRP. For example, the public health nurses, dieters and women’s outreach workers were also providing services at a local community drop-in center so that the women could get a nutritious meal and postpartum support. These connections with Karen and other women also included outreach support.

The variety of health care and social services providers within each of the focus groups that were conducted provided rich discussion and insight into the community's challenges and strengths around community capacity building. Typically, at least three focus groups are needed to compare and contrast data across groups (Krueger & Casey, 2009). The last two focus groups were held with Karen women.

The Karen women’s focus groups took place in two different homes of women who agreed to host the focus groups. Child minding was provided by family
members of the women. I provided fruit and snacks. Two Karen women helped me to facilitate the groups by providing language translation. These focus group sessions lasted between 2.5-3 hours since many women needed assistance to fill out a consent form for Karen women to participate in individual and focus group interviews (Appendix I) and demographic data forms. In addition, extra time was taken to review the consent process prior to the taped interviews. I spent time with the Karen women translators before the focus groups and in individual interviews to review the interview process. Sessions with the Karen women translators were held after all the focus groups to elicit any concerns and questions about the nature of the interview. It was difficult to facilitate the focus group’s discussions with the women who provided translation due to the language barrier. I discuss this process further under issues related to validity threats below.

In addition to the challenges of language, holding focus groups with members of the same community may mean participants are reluctant to share their experiences (Krueger & Casey, 2009). This issue is particularly salient for Karen

---

40 The literature on interpretation and translation often draws clear distinction between these two terms. However, for the purpose of this research I have chosen to use the term translation to mean both face to face interactions and interpretation of meanings, rather than just working with written texts. Drawing on Temple and Edwards (2002), I define the term translation to mean both written and oral communication across languages. Drawing on the work of postcolonial and feminist scholars, Temple and Edwards draw attention to the fact that the act of translation involves more than literal transfer of information through language but also “an understanding of the way language is tied to local realities, to literary forms and to changing identities” (p. 3). There is considerable overlap between interpreter and translator roles, and points of distinction pertain to interpreters’ ability to advocate, provide mediation and cultural mediation (Bowen, 2001). However, even in cases where interpreter services are utilized such as over the phone or other technologies it is not assumed that they can advocate or provide cultural mediation (Bowen, 2001). In the research findings I use both terms since they were used by the participants, however, it should be noted that professional interpreters were not used in this research.
women who come from a very small, tight knit community. In this regard I offered to conduct individual interviews with women who may not have been able to voice their perspectives within the focus groups. One out of the eight (1/8) women who participated in the focus group interviews also participated in an in depth individual interview.

Karen women preferred and felt more comfortable having interviews conducted at their homes. During one of the focus groups Karen women sat on the floor in a circular fashion and food was provided in the middle of the circle. Sitting on mats on the floor is a cultural norm for Karen families and facilitated comfort. This approach facilitated a lively discussion amongst the women and many stories were shared. The Karen women who provided translation suggested that focus groups were a good way to facilitate discussion and storytelling. These Karen women helped to moderate and translate the Karen women individual interview guide I had developed, in order to facilitate the discussion (Appendix H).

3.3.6.2 In-depth interviews

All in depth interviews with participants were approximately 60-90 minutes in length, tape recorded and transcribed verbatim. Participants were invited to participate in a second interview in order to clarify themes and research findings. An open-ended interview guide was used to facilitate the focus group interviews and individual interviews with health care and social service providers (Appendix F). In-depth individual interviews were conducted with one program manager, one early childhood educator, one life skills coordinator, one outreach worker, one community volunteer, one program facilitator, one Karen woman translator, two
male Karen settlement workers, two NPs and two registered midwives. The interviews with the NPs and midwives were dyad interviews because they indicated that they preferred to be interviewed together. Consent was obtained from health care and social service providers, and all participants had the option of participating in individual and/or focus group interviews (Appendix G).

Four individual in-depth interviews were conducted with Karen women, facilitated by a Karen woman who translated the conversations. All of the interviews with Karen women were conducted at the Karen women’s homes. I used an open-ended interview guide for focus groups and individual interviews with Karen women that were translated by a Karen woman (Appendix E). Translation during interviews with Karen women was done question by question. The interview guides were not translated prior carrying out focus groups or individual interviews with the Karen women. The Karen women’s interview guides were not translated prior to the interviews because many women had lower reading and writing skills in their own language, also interview questions were open ended and subject to change depending on the interview context. The Karen women preferred to have questions framed in stories of their experiences. The more unstructured the interview guide was, the more likely that the Karen women would be able to provide contextual detail of their experiences and perspectives. None of these interviews would have been possible without the assistance of the Karen women providing translation as there were so few professional interpreters available. I used a consent form to explain to the Karen women how confidentiality would be maintained throughout
the research process (Appendix I). The consent also allowed for the voluntary participation for both individual and/or focus group interviews.

3.3.6.3 Participant observation in the field

As Emerson, Fretz and Shaw (1995) explain, gaining participants’ meanings of a particular phenomenon cannot be gained only through people’s words, rather ethnographers “must notice what people do in relation to others, in order to produce, situated meanings” (p. 133). In this regard I spent three days a week (on average) conducting participant observations; this included accompanying the outreach worker to home visits and outreach medical appointments. The specific units of analysis included my observing the day-to-day activities within an Early Years Refugee Program (EYRP) and included how support services were provided through settlement activities such filling out paper work for housing, citizenship, medical forms etc. I also observed the day-to-day participation of Karen women in early childhood education with their children (e.g. learning through story telling with their children). I also observed the Karen women’s participation in learning about health promotion with public health nurses who provided education within the EYRP. I used Chabot and Shoveller’s (2012) fieldwork observation guidelines to observe the social relations between the Karen women and other members of the community who were providing support. Consent to participate in field observations was obtained through the director and program manager at the EYRP (Appendix M). However, consent to accompany Karen women to appointments and observation of outreach visits was negotiated and elicited on a day-to-day basis between the Karen women and the outreach worker and was obtained through the
script of oral consent to conduct participant observations (Appendix L). Total approximate hours of observations were (24hrs/week x 68 weeks) approximately 1,632 hours. As noted earlier, I also spent time in volunteer activities such as community field trips.

In keeping with a standpoint inquiry, my participation in the field entailed not just direct observation but participation in the actual day-to-day activities in which Karen women and community providers were engaged. As Smith (1992) notes, “standpoint is always about ourselves as inquirers— not just our personal selves but ourselves as participants” (p. 94). Despite my participation, I was also mindful of the fact that I was a visitor and not a natural part of the day-to-day fabric, even though at one point I was described by employees of the EYRP as “part of the furniture.” Observing the day-to-day organizational interactions with Karen women, how and what services are provided in relation to women’s mental health and other health promotion strategies made it possible for me to observe the everyday world of the Karen women. Participant observation enhanced my understanding of Karen women’s day-to-day interactions with service providers, and the service provider’s responses to women. This include behaviours and actions that facilitated resettlement needs and those that constrained the Karen women’s ability to access services and resources they needed. This is what Smith (2005) refers to as the researcher’s work in which “getting down to the everyday organization of people’s doings...puts into place not only what people do but the time it takes...the conditions under which it gets done” (p. 162). For example, I noted the Karen women’s interactions with each other and their responses when services were being
restricted. Similarly, I observed how service providers would bend the rules and/or extend beyond their mandates to facilitate Karen women’s access to medical appointments by organizing a translator and/or accompanying women to appointments.

In addition to the activities I note above, I attended multiple community advisory meetings and front line workers’ meetings. This allowed me to gain an insider view of how various community services collaborated to build capacity and support for Karen women and families. However, while this form of participant observation afforded me the ability to become a participant in the community, it also created increased ambiguity around my role as a researcher. This kind of participant observation can be challenging to processes where the ethnographer must constantly negotiate and balance their marginal position while at the same time continue to establish rapport (Hammersley & Atkinson, 2007). I reflect on some of these tensions further under my discussion of interpretive validity threats.

3.3.6.4 Fieldnotes

Fieldnotes are direct accounts of the researchers experience in the field under study. Drawing on Geertz (1973), Emerson, Fretz and Shaw (1995) explain that “fieldnotes are a method of capturing and preserving insights and understandings stimulated by...deep immersion and sense of place...[and is what] enables the ethnographer to inscribe the detailed, context-sensitive and locally informed...thick description” (p. 10). However, as Madison (2005) explains, field research has a long history of scientific empiricism without the reflexive practice of the researcher’s subjectivity, emotion and ideology. Contemporary critical
ethnographic methods are in contrast to traditional ethnography in that the researcher subjectivity must also be held accountable. As Thomas (1993) explains, to begin from a premise that social constraints exist and that research should be emancipatory and directed at those constraints is an explicitly value-laded position. The fact-value problem centers upon the distinction between scientific claims, which are produced by evidence and demonstration, and value claims, which are produced by rhetoric and reason. (1993, p. 21)

Thus, critical ethnography reconciles the traditional banner of scientific objectivity vis-à-vis “objective” field notes through critical reflexive analysis of one’s own position and how this produces knowledge. In addition, positionality requires that we direct our attention beyond our individual or subjective selves. Instead, we attend to how our subjectivity in relation to the Other informs and is informed by our engagement and representation of the Other (Madison, 2005, p. 9).

Feminist standpoint epistemology employs what Harding (1993) calls strong objectivity, in other words researchers not only take women’s day-to-day lives as the starting point of inquiry but also examine women’s social interactions with others. In this regard, I used field notes to document the social and interactional processes between Karen women and health and social service providers. A sample of my selected field notes can be found in (Appendix J). My observations were usually documented at the end of my field observations since writing field notes was not always feasible or appropriate during my participation in the day-to-day interactions with Karen women at the EYRP and/or outreach visits. Because I was consciously aware of how writing notes might negatively impact my ability to establish rapport with participants, I often made notes while I was in the waiting
room during medical appointments. In some cases the informal conversations I had with the outreach worker were of particular importance to what I was observing and required me to jot key words or phrases into my field book. I also documented my personal reactions and observations of focus group and in depth interviews which I attached as memos in the QRS N-Vivo 10™ software program. This process allowed me to keep my fieldnotes together with my interview data and assisted me in analyzing emerging themes.

3.3.6.5 Policy lens

In order to analyze the resettlement policies and practices that shaped Karen women’s access to services and social support, I employed an interpretive theoretical approach to analyze policy documents in order to better understand the social and structural factors that facilitated and/or challenged community capacity to support the mental health and well-being of Karen women during resettlement. In particular, I linked the Interim Federal Health policy as laid out by Citizenship and Immigration Canada, with broader systemic reforms impacting settlement support for refugee women and their access to healthcare. Government documents and policy reports such as ISS of BC reports and publications, the Welcome BC 2011-12 Annual Report on Settlement and Integration Services and the CIC Report on Plans and Priorities 2013-2014 were downloaded into the QRS N-Vivo 10™ software program so that I could code and link sections to themes that were emerging from the coded interview data. I also applied a policy lens to examine the lack of integrated professional interpreter services for minority languages in Canada and the disjunctures between access to interpreter services with individual rights and
freedoms. I further critique and thread these policies with Karen women’s experiences of resettlement by providing a contextual analysis in chapters five and six. Based on the study findings, and existing literature, I discuss some important considerations concerning policy directions for community capacity related to Karen women in chapter seven.

3.3.7 Data analysis process

As is the case in qualitative studies, analysis is nonlinear and iterative (Creswell, 2013). While the process I undertook was not straightforward, there were three general components or phases that I undertook in keeping with the work of Creswell: 1) organizing the data; 2) reading and memoing and 3) interpreting and making meaning of the data. I delineate these phases below; however, due to the nature of qualitative analysis many of these phases overlapped and were continuous.

3.3.7.1 Organizing, reading and memoing

The first phase of analysis in this data analysis was a process started with my entrance into the field. My recorded field notes and observations became the foundations of my data. Because I did not have a prior relationship with the community, it was important for me to develop relationships. In this regard my initial data gathering was done at the EYRP where I engaged with participant observation. After spending time in the community I was able to conduct interviews and organize and manage the data (transcribed interviews) in the QRS N-Vivo 10™ software program. I began the analysis by first reading the transcripts and attaching my fieldnotes (observational data) to the transcripts so that they could be viewed
together. I called these memos and entitled them *context of interviews*. I reviewed all the transcribed data against the audio recordings to check for accuracy. Additionally, I read each of the transcripts and made handwritten notations on the transcripts; this was done in order to get a sense of the interview as a whole (Creswell, 2013; Sandelowski, 1995). At this point I became familiar with the interviews and contexts, and as part of my process I read several transcripts with my research supervisor to shed light on how my proposed theoretical framework fit with the data. Making notations in the transcript later became part of the analytic memos that were attached to each individual and focus group interview transcript. This process comprised the initial stages of the data analysis.

**3.3.7.2 Describing, classifying and interpreting data into codes and themes**

Once all the transcripts were uploaded I read through them again and started coding the data to develop an open coding structure based on what participants said, words or phrases they used (Maxwell, 2013). I developed different coding structures so that I could analyze and compare the Karen women’s data to the health care and social service providers’ data. Constantly comparing the data between the different code structures allowed me to cross-analyze between data sets to look for similarities and difference.

This initial coding and classifying the data was a process I used to aggregate text into smaller categories of information (Creswell, 2013). The initial coding structure consisted of 58 codes that came from health care and service provider transcripts. Although Creswell (2013) suggests no more that 25-30 categories of information, it is common for novice researchers to have anywhere from 50-80
codes (Bernard & Ryan, 2010). The women’s data had 53 original codes. All codes were later collapsed into higher order categories. N-Vivo (QSR International, 1999-2014) describes this coding process as developing parent nodes. For example, social support was a parent node into which smaller codes were classified, such as accessing support, family support and community support.

Although I created descriptive codes based on what participants said (in vivo codes), this was also an interpretive process that required me to describe what was said in light of the literature and theory. In this case I created analytic memos throughout all of the transcripts to describe insights, experiences and relationships between the codes/categories and theory. Because qualitative data analysis is an iterative and interpretative process (Sandelowski, 1995) I frequently went back to re-read sections of transcripts to add in new analytic memos. It was through writing my analytic memos that I started to develop analytic insights and ideas about the intersecting factors that shaped the resettlement process for Karen women. As I started to write my findings I continued to re-read the transcripts and memos that contained my field notes. This back and forth process allowed me to see relationships between the categories and themes I was developing. I also re wrote and/or created new analytic memos as the themes emerged. Writing analytic memos assisted me to write a thematic account of the data.

3.3.7.3 Interpreting and making meaning of the data

Creswell (2013) describes this process of analysis as involving “organization of key themes into larger units of abstraction to make sense of the data” (p. 187). For example, a key emerging theme stemming from Karen women’s experiences of
resettlement was dependency and vulnerability, so I looked for excerpts that could describe these analytic categories. These themes were further analyzed in relation to policies and practices (structures) that created contexts of dependency and vulnerability, such as inequitable funding arrangements and how they were linked to lack of resources and time. For example, they were linked with theoretical perspectives of cultural safety and the broader structural processes that intersected to shape women’s experiences in accessing support and health. Through this process I was able to think about why these relationships existed and how they came about. In this process of analysis I went back to reviewing the empirical evidence (in chapter two) in light of my interpretation of the research findings.

Although language barriers are frequently cited in the empirical evidence, policies and practices have overlooked the fact that most Karen women came to Canada with limited literacy in their own language as well as a lack of English language ability. This research adds to the existing empirical and theoretical understandings of what access means in situations where women come to Canada with limited literacy as well as lack of language ability. Incorporating a policy lens to the findings of this study also furthered my understanding of the structural processes that reinforced as well as facilitated access to services and that promoted mental health and well-being of Karen women’s resettlement.

Another theme, “collaborative relationship”, was linked to factors within organizational structures that mitigated some of the challenges of health access for Karen women. When I asked participants about what community capacity meant, categories of collaboration, working together, partnerships, and learning described
the relational, interdependent nature in which services worked together to support Karen women (the social process). While these strategies worked to build community capacity, many developed partnerships were constrained by short term funding contracts. I drew on tenets of intersectionality to identify how broader structural process and ideologies challenged and/or facilitated community capacity to support the mental health and well-being of Karen women. I discuss these themes in chapter six.

3.4 Ensuring Scientific Quality

3.4.1 Positioning myself in this research

In order to carve out a research design that seeks to address issues of health inequities, I positioned myself within an emancipatory paradigm, which seeks to not only inform practice but build theory through action inspired research (Lather, 1986). The concept of positionality is important for critically oriented scholars because it concerns the need to make explicit the research aims and what drives us to do the research (Reimer-Kirkham & Anderson, 2010). As Thomas (1993) adds, “to begin from a premise that social constraints exist and that research should be emancipatory and directed at those constraints is an explicitly value-laden position” (p. 21). Importantly, the way in which researchers position themselves can be framed in the ethics of ethnography (Madison, 2005). This includes a critique of the ways in which knowledge is produced, the aspiration of doing social justice work, and the ways in which research relationships are constructed (Madison, 2005; Varcoe, Browne, Calam, Buchanan & Newman, 2011).
These theoretical positions reflect my own value orientation toward social justice and stem from my personal experiences of working with populations marginalized/rendered vulnerable by social and structural inequity as a community mental health nurse. In addition, my experience of immigration and resettlement as a first generation immigrant woman made me sensitive to issues about dominant perspectives that construct difference and create Othering. Positioning myself this way required me to critically reflect upon the imposition that this research might have on the community and possible harms. As England (1994) explains, “fieldwork is inherently confrontational in that it is the purposeful disruption of other peoples’ lives...maybe potentially exploitative...more so than traditional research methods” (p. 249). Similarly, using the lens of cultural safety, Reimer-Kirkham, Smye, Tang, Anderson et al. (2002) advise that “even though some of us come from groups that have historically been racialized, our class positions us in ways that we can now be constructed as oppressor” (p. 230).

I was frequently reminded by Karen women of my class and privilege; for example, many women would not allow me to sit in the back of the car while driving with the outreach worker to medical appointments. This symbolic gesture reflected my epistemic privilege and the inherent hierarchical relationship between me and the Karen women, as well as other members within the community who participated in this research. In addition, the Karen women valued the advice of medical professionals and perceived me to be in the role of a teacher. This was a commonly held view amongst the Karen women for anyone who had higher status as result of their education.
To minimize potential harms and negotiate the power imbalances, I built alliances with community support workers and continually elicited feedback about what was appropriate in terms of, for example, honoraria, when and where I could accompany the women and the possibility of not being able to conduct participant observations or interviews in particular contexts. I also had discussion with the program manager about my role and what was in and out of scope, such as not being able to drive women to appointments. This helped clarify my role as a researcher and the need to develop transparency about my multiple roles as researcher/nurse and advocate.

3.4.2 Validity

In this research I apply and define validity to mean not a value neutral or objective and simply descriptive explanation of participants’ accounts, rather on what grounds can the knowledge produced in this research be credible, as distinguished from what is not (Madison, 2005; Maxwell, 2013). However, the concept of validity is fraught with debate in emancipatory praxis oriented research (Lather, 1991; Reimer-Kirkham & Anderson, 2010; Maxwell, 2013). The central problem of this debate stems from the philosophy of what it means to do “rigorous science” for those who conduct interpretive (value-laden) and critically-oriented research that has emancipatory aims. In this sense, the outcome of this research is not to “attain some ultimate truth” but to produce relevant knowledge that addresses the ways in

---

41 Here I use Lather’s (1991) account of praxis-oriented scholarship to mean the production of theory that is relevant to producing knowledge that is practical, i.e., that can be used to shape theory, knowledge and practice toward decreasing inequities. This remains a central challenge of interpretive, critically oriented scholarship.
which social inequities are reproduced. Thus, knowledge is dialectical and interwoven between the researcher and what Lather calls propositional, objective knowledge or theory. Essentially, in critically-oriented methods, to ensure validity, the researcher needs to attend to what Lather (1991) describes as “research that invites reciprocal reflexivity and critique, both of which guard against the central dangers to praxis-oriented empirical work: imposition and reification on the part of the researcher” (p. 59).

An important epistemological and methodological distinction in interpretive, critical ethnographic research is that the researcher’s subjectivity “in relation to the Other informs and is informed by our engagement and representation of the Other” (Madison, 2005, p. 9). This conceptualizing of validity as dialogical engagement with those with whom research is conducted “demands vigorous self-reflexivity” (Lather, 1991, p. 66). A cultural analysis in critical ethnography is incomplete without having some way of testing and rigorously engaging (critically and reflexively) with the participants in this research; as Maxwell (1996) points out, there is a need in qualitative research to determine what are the plausible alternative explanations to the research findings. To this end I employed several strategies to promote validity of the findings. Drawing on Maxwell’s (2013) typology of descriptive validity, theoretical validity and interpretive validity I address the process and strategies I undertook to enhance scientific quality of this research and potential validity threats below.
3.4.2.1 Threats to descriptive validity

The first threat to validity concerns accurate description and recording of field interviews. To this end, I audio recorded all of the in-depth individual and focus group interviews. These were later transcribed verbatim by an experienced transcriptionist. I listened to all of the audio recordings against the transcribed interviews in order to check for accuracy of the data. For the interviews that were conducted in S’gaw Karen, the transcriptionist signed a translator confidentiality agreement form to maintain confidentiality and only transcribed the English translated responses (Appendix K). The translated responses were later checked by an independent consultant, a Karen woman who I enlisted, to ensure accuracy of the transcribed data. This involved checking the transcribed data against the audio tapes. This was done to catch misinterpretation and to ensure a more accurate understanding of the Karen women’s responses in relation to the English translation; this is a recommended procedure for conducting research with non-English speaking participants (Suh, Kagan & Strumpf, 2009; Squires, 2008). Since descriptive validity involves other aspects of factual data, field notes were used to document my observations and were kept in a journal. I also made notes about the context of interviews, that were later attached to memos. Most of my insights and analytic thoughts were recorded as memos that were also linked with individual transcripts and participants. All field notes were dated.

3.4.2.2 Threats to theoretical validity

As Maxwell (2013) outlines, researcher bias and reactivity can affect the scientific quality of interpretive studies without a way to ensure or address validity.
Threats to theoretical validity occur when researchers only see what they want to see (Thomas, 1993). This threat is defined as confirmation bias where evidence is sought that reinforces the researchers' own personal beliefs and values. This has also been referred to as academic bias in which the researcher imposes their own beliefs onto the data. As Lather (1991) adds “building emancipatory theory requires a ceaseless confrontation with and respect for the experience of people in their daily lives to guard against theoretical imposition” (p. 67). Similarly, Thomas (1993) adds that without rigorous reflexivity a study is doomed to simply be “another polemical exercise that is passionately rhetorical but scientifically unpersuasive” (p. 62).

Threats to theoretical validity also include what Lather (1986) calls construct validity. This means reflexivity in relation to how researcher biases and positions inform the research and how researchers consciously engage with theory building. Lather suggests that enhancing validity in research must attend to “participants’ critical reactions to our accounts of their world” (p. 64). Fitting with feminist standpoint epistemology, I situated myself in the day-to-day experiences of Karen women to generate knowledge and bring meaning to the data from women’s perspectives.

I also looked for opportunities to obtain validation of my findings, and was open to alternative interpretations. This included systematically getting feedback from participants in order to rule out possibility of misrepresentation and misinterpretation of meanings derived from the data (Maxwell, 2013). In order to guard against these validity threats, I obtained diverse perspectives from various community members, and conducted regular debriefing sessions with the
community outreach worker who also participated in a secondary in-depth interview. These debriefing sessions and the secondary interview helped me to tease out some of my preliminary assumptions and ideas about how I was interpreting the data, and were invaluable to my learning process.

In order to attend to potential theoretical validity threats, I frequently held discussions with research participants (Karen women and members of the community) about some of my interpretations from the data. I also drew on the community’s perspectives by presenting preliminary findings to various community stakeholders and members, some of whom participated in interviews. For example, a community member identified that it was important that recommendations regarding mental health promotion are broadly applicable to all community sectors. This was recommended by a stakeholder:

Your recommendations seemed really focused on health—and I would suggest that other areas that have an impact on mental health are social service sector, education sector, business sector, etc....if some of your findings did point to these other areas, I would include them in your recommendations. If the sectors are clearly referenced in the recommendations, then the folks representing them will likely be more open to receiving the recommendation (and maybe doing something with them).

Sandelowski (1998) advises that debriefing sessions with individuals outside the project may be useful in maintaining trustworthiness and ethical issues related to dissemination of research findings. While I drew upon broader community perspectives about my interpretations and findings, I also consulted my research supervisor regarding possible approaches to disseminating research results as well as the community of participants that were involved in this research. Karen women
who provided feedback stressed that it was important that the government hear their voice, particularly in relation to the women’s need for enhanced supports, around child minding services, as this would help women to obtain employment and/or allow women to go to school. Feedback from these conversations was incorporated into the analysis and recommendations.

My prolonged engagement in the field allowed me to gain an in-depth understanding of Karen women’s day-to-day lives and to build relationships and trust with community members; however, this kind of involvement created a potential to over-identify with the participants and limit my ability to stay with a critical analytic perspective. This has been described by ethnographic researchers as “going native” where the “task of analysis be abandoned in favour of the joys of participation, but also, even where it is retained, bias may arise from ‘over rapport’” (Hammersley & Atkinson, 2007, p. 87). To counter some of these threats to validity, I withdrew from the field and minimized my participation from time to time to be able to “see” from an analytic viewpoint and maintain a critical reflexive position.

In addition, the dangers in spending time with only one individual could potentially hinder my relationships with other members of the community and provide a limited or narrow view of the local community practices. To minimize this risk, I sought new opportunities for participant observations outside of the day-to-day activities at the EYRP and spent time at a community center with other support workers where Karen women attended. Varying the sites of participant observations allowed me to gain a vantage point from a different perspective in a different
context, so that I was able to compare different and similar view points and community practices.

Although most of this research focused on the everyday experiences of Karen women, I also situated myself in the day-to-day experiences of settlement support workers and various community outreach workers, early childhood educators and other community members who provide services for Karen women and their families. This included attending regular refugee advisory meetings and frontline workers meetings. My participation in the day-to-day work of settlement and support workers allowed me to gain a different window of understanding of the social and structural factors that build community capacity in relation to health care, health services and supports. These kinds of participant observations greatly enhanced by ability to analyze emergent themes in the data and provided contextual elements of community capacity from the perspective of community members that support Karen women.

\textit{3.4.2.3 Threats to interpretive validity}

In this study there were specific and unique threats to interpretative validity. These threats concerned the inclusion of Karen women who acted as key informants and as translators, and who informed the analytic process. In adopting the lens of cultural safety, it was critical that Karen women were included in the knowledge production of this research. As Reimer-Kirkham and Anderson (2002) suggest, giving voice means that “we can no longer justify only English speaking participants in our research if we are serious about the epistemological implications to our nursing knowledge” (p. 12). Similarly, Temple and Young (2004) have argued that
translators who provide cross language translation need to be brought out of the shadows “if we are to move on from the objectifying gaze on difference” (p. 174). However, doing cross language translation in emancipatory work proved to be a challenging process; threats to validity concerned third party translators who are members of the same community. This can be problematic in two ways.

First, translation is not a neutral process and a simple exchange of words from one language to another (Temple, 2002). Drawing on the work of Spivak (1992), Temple argues that there is a need to recognize the perspectives that the translator brings to the research. Creese, Huang, Frisby, and Kambere (2011) have also argued that language can also be an instrument of power and therefore the act of interpretation from solely Western cultural frameworks is highly problematic.

In this study I employed three Karen women from the community to participate in and facilitate translation of the interviews with Karen women. Two of the interpreters are Karen women who were identified as “Karen women leaders” in the community and had interest in participating in the study. The third Karen translator was a woman who provides settlement support to some women in the same community and who self-identified as a refugee in a later in-depth interview. In reviewing the transcripts and listening to women’s experiences it became evident that boundaries were blurred between women’s multiple identities. For example, some Karen women preferred to be interviewed as a Karen refugee woman but disclosed issues around providing settlement support to other Karen women in the community. In other cases, women who were interviewed as settlement workers gave their own account of the challenges they had as a refugee woman, e.g., gaining
access to employment and furthering their education. Second, to guard against potential threats to validity, I employed a Karen woman as an independent consultant who provided backwards translation (listening to translated conversations in Karen and ensuring accuracy of English translation). This consultation process allowed me to see potential discrepancies between what the Karen women said in the focus groups and individual interviews and what was translated. The independent Karen translator (consultant) is proficient in English and Karen, and has a university education. In addition, the independent consultant was a member of the Karen community but was not a refugee. The consultant also provides settlement support and has extensive experience in providing interpretation and translation services for Karen women and families in another geographic location.

Consulting included checking all of the audio recordings conducted in S’gaw Karen language against the written English translated transcripts. The Karen woman consultant’s role was to assist me in understanding cultural meanings and potential misunderstandings and misinterpretations of the interviews conducted with Karen women. Unlike the other Karen women translators, the consultant was not interviewed as a research participant in this study.

Working with multiple translators and consultants is a challenging process and issues of translation can lead to misunderstandings and interpretations (Creese, Huang, Frisby, & Kambere, 2011; Suh, Kagan & Strumpf, 2009; Squires, 2008; Temple & Edwards, 2002; Temple & Young, 2004). The work of the Karen women translators and consultants shaped the data collection process and analysis. During
the analysis process the independent consultant drew attention to the fact that some of the Karen women who were facilitating translation were actually imposing their own views on what other Karen women were saying in the interviews. This method of accessing women's accounts of their lives made me aware of how the translators were also constructing women’s experiences. I provide an example of the consultant’s account here to illustrate this interpretative challenge:

Karen woman interpreter: They first can't speak English. She feels very upset, because always she needs to call people to help, like the interpreter and somebody like that.

Independent consultant: An interviewee said “having to rely on others in whatever she has to do because of language barrier” is the hardest thing. She didn’t mention being upset.

In this example, there were some discrepancies in how translators interpreted what some of the women were saying as their own experiences. As a result of these discrepancies, I invited the Karen women who facilitated language translation to be interviewed to gain their perspectives on what they found supported their resettlement experiences. Interviewing the Karen women translators provided analytic variation to emerging themes.

Another challenge was that some women were only providing one word answers and did not elaborate on their experiences. Cross language researchers have validated that this can be a potential challenge when concepts and words may contain different meanings (Squires, 2008; Suh, Kagan & Strumpf, 2009). It was only later during discussions with the translator that I realized that the women's overfamiliarity with the translator may have shaped the context of the interview. In
addition, in some cases the Karen translators also had difficulty understanding some of the questions I was asking. This required that I rephrase questions and words that were ambiguous. For example, access was not a word that women would use to explain how they manage their health, rather women talked about “getting help.” In this regard I modified the open ended interviews to increase cultural understanding, and discussed with the Karen women who were providing translation, their views about the interview. These discussions facilitated my understanding of the interview and potential misinterpretations.

While there were many challenges to employing multiple Karen women as translators, the inclusion of “Karen women leaders” who did not have experience as translators was important to the knowledge production process. The Karen women who were interviewed were comfortable in sharing information with people whom they knew and trusted. As Creese, Huang, Frisby, and Kambere (2011) aptly point out, language is an instrument of colonial power in which some ethnic minority and racialized groups have been subjugated by historical colonizing processes. Likewise, Temple and Young (2004) have argued that

the question of who is best able to represent others when translating has many parallels with discussions by researchers in race and ethnicity and the “racial matching” of interviews ... it is increasingly recognized that insider/outsider boundaries cannot be as easily drawn as racial matching suggests (p. 168).

Moreover, the intellectual biography of translators moves away from a “baseline of understanding that situates the English-speaking world at its center” (Temple & Edwards, 2002, p. 171). Although the use of Karen women as translators

222
has potential interpretive validity threats, the engagement of Karen women in this role helped to foster relationships of trust and contexts for reciprocal learning. On the other hand, this also created challenges during the interviews as some of the women translators’ overfamiliarity with the Karen women participants resulted in their imposing their own views and interpretations onto the Karen women being interviewed. As I discussed above, having regular discussions with the translators about their views on the interviews, interviewing the Karen women translators and employing an independent consultant were strategies that I used to address potential threats to interpretive validity.

3.5 Ethical Considerations

Ethics is a fundamental concern for critical ethnography (Madison, 2005). As Madison (2005) states:

because we are involved in entering into the domains of Others and in the interpretive practice of both representing them and the multiple ways they construct their experiences and their worlds. And, because ethnographers are in the business of both crossing borders and representation, the power and the politics of their enterprise demands ethical responsibility (p. 90).

To uphold ethical conduct in the research, I obtained ethics approval from two research ethics boards, including the UBC Behavioral Research Ethics Board (BREB) as well as the Fraser Health Authority Ethics Review Board. In accordance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (2011), there were several ethical considerations that I undertook to ensure the safety, confidentiality and voluntary participation of those involved in this research. Firstly, women, and in particular refugee women, have been socially
excluded from the knowledge production process; in accordance with fairness and equity in research participation of women as per Article 4.1 and 4.2 of the Tri-Council Policy Statement, Karen women were included as participants in this research to bring their voice to the decision making processes related to health care services and supports and resettlement policies that affect them. Karen women were also employed as key informants, consultants and translators to bring attention to potential harms that can result as a consequence of field research. To ensure the safety of the Karen women participants in this study, only translators who the women felt comfortable sharing information with were used. All Karen women translators and consultants signed a confidentiality form as part of the research process (Appendix K).

In addition, information sessions with Karen women translators were held to discuss the informed consent process and related issues such as women’s voluntariness to participate in this study and how confidentiality would be maintained. During the interview process the women’s understanding of the consent process was explained and audio recorded. Once understanding was achieved between me, the translator and the Karen women, the consent forms were signed by the Karen women.

As most of the women in this study did not have English language ability and cultural familiarity with formalities of obtaining consent for the purposes of research, there were challenges in ensuring consent was understood. To ensure that the women understood their voluntary participation and purpose of this research the consents were translated for them by a Karen woman translator. Voluntary
participation was discussed with the women and the Karen translator throughout the research process. The formality of signing a consent document held less relevance for some Karen women; however, for other women the consent was used as a learning tool to enhance their literacy skills in the English language. All the women were able to keep a copy of the consent, although it was only provided in English. Because of limited resources it was not possible to accurately transcribe the Karen women’s consent forms from English to S’gaw Karen.

There are no clearly defined guidelines in conducting research with ethnic minority groups (Gabriel, 2013) or with refugee women who are deemed vulnerable based on gender. Assessing potential harm or exclusion from participation in research is based on assessing a safety risk and contingent upon on women’s experiences of migration and refugee status. Drawing on Kleinman (1995), Gabriel (2013) has noted that researchers must attend to inequalities in power to open up space for variation, pluralism and cultural understandings. However, at the same time, the researcher needs to acknowledge their social position and limitations must be accepted. To maintain the safety of Karen women during this research, I did not attend all outreach medical appointments or accompany the outreach worker to home visits with some of the women. Attending visits required that I be critically reflexive of the potential harms that could result by my presence. Not all women were comfortable with me knowing the details of their lives. For example, a few single mothers were particularly vulnerable to issues concerning trust and safety. In this way participant observation was always a negotiated process and in some cases I had to step back from any participant observations or interactions in which the
women’s safety and trust might have been potentially threatened. Consent to conduct participant observation at the research setting (EYRP) as well as a script of oral consent was used to allow me to participate in observing interactions with community social service providers and the Karen women (Appendix L). Related to this issue, Madison (2005) maintains that

an ethics of critical ethnography does not use human beings as a means to an end. We do not gain rapport and trust to simply get the data and then run in order to accomplish our own goals while leaving subjects vulnerable or feeling exploited. An ethics of ethnography [must] consider the direct well-being of the Other as the first priority (p. 84).

In this study, interviews with Karen women were conducted in their homes; this was perceived as safe and comfortable by the women. I also held sessions with key informants and community outreach workers in the community as well as the Karen women themselves to ascertain who they felt most comfortable with regarding translation. This was particularly significant as trust and relationship building is a key tenet of conducting culturally safe research. In addition, all of the Karen women participants were also made aware that an independent consultant would be used to ensure accuracy of the translation.

Similarly, my position as an outsider in the community in which this study was conducted necessitated that I build trust, accommodation and respectful relationships with members of the community which provides services for Karen women. Building safety and trust with other community members meant that I needed to be flexible in relation to when I could and could not conduct participant observations. As I discussed previously community health and social services
providers were recruited through a key informant in the community and were provided with a letter of information explaining the purpose of this research. Participants then contacted me by phone and or email to set up a mutually agreeable time to meet to go over the consent process. All participants were given a copy of the consent for their records.

To ensure confidentiality of research participants each participant was assigned an identification number on transcribed documents that stored in the QRS N-Vivo 10™ software program, that was password protected. All paper copies of field notes, written transcripts, original consent forms and demographic data of participants were kept in a locked file cabinet in my home office. Informed consent of non-Karen women participants was obtained by reviewing the consent form with each participant prior to the interview and participants were reminded of the voluntary nature of their participation.

3.5.1 Reciprocity and remuneration

According to Lather (1991), reciprocity is “a mutual negotiation of meaning and power...and the junctures between researcher and researched and data and theory” (p. 57). This view of reciprocity holds practical implications for how knowledge is produced through research. In this study Karen women not only facilitated translation but were actively engaged in organizing focus group interviews as well as providing feedback about what the process was like for them. The inclusion of Karen women beyond the role of translators opened debate and space for alternative interpretations in meaning.
The decision to provide a choice of honoraria for Karen women was developed in consultation with the community. Remuneration in the form of a $30.00 gift certificate to SuperStore and/or cash was provided for Karen women who participated in this research. Food and refreshments were also provided during focus groups.

### 3.6 Study Limitations

There were several limitations to this study. First, due to lack of professional interpreters in the area, as noted above, Karen women were used as translators. This proved to be a very challenging process for the women as they did not have training or skills required to provide translation and/or interpretation. These women volunteered to do this because they wanted to learn from the experience, moreover they identified that the women in the community would feel comfortable in sharing their stories with each other. In addition, due to the cost and the limited availability of professional translators in the province, it was not possible to have the consent forms translated into S’gaw Karen. Consent processes may have been improved had the consent form been translated via audio tape and a copy of the audio tape provided to all the Karen women that were preliterate in English and S’gaw Karen. However, what was gained from the process used was relationship building with the broader community who were engaged in assisting with consent.

In addition, in this study, interviewing a few Karen men may have added contextual data and provided a deeper analysis related to gender and settlement. Single mothers were also not interviewed. However, the majority of Karen families
came to Canada in large family groups. At the time this study was conducted a few single mothers allowed me to take part in settlement support visits but due to ethical considerations it was not appropriate to interview these women. Interviewing a few single mothers might have provided a deeper analysis of the broader intersecting factors shaping the lives of Karen single mothers during resettlement.

Gaining perspectives of policy makers and other decision makers would have also provided an in depth policy analysis. Ethical approval was obtained to interview family members of Karen women as well as policy makers. To this end I developed consent forms and associated interview guides (Appendices, N, O, P, and Q). However due to time limitations, interviewing these potential participants was not possible. It was also difficult to arrange a focus group with various stakeholders and community partners who had come together at immigrant and refugee advisory meetings, due to time constraints. However, being able to participate as an observer at these meetings facilitated my understanding of the processes of community capacity building. Lastly, although community mental health workers as well as primary care physicians in the area were invited to participate in this research, they did not agree to be interviewed. Gaining perspectives of community mental health practitioners and primary care physicians would have brought an important voice to policy and practice related to resettlement and community capacity.
4. KAREN WOMEN’S EXPERIENCES OF RESETTLEMENT

4.1 A Context of Stress and Worry

In this chapter I present and discuss several themes that represent Karen women’s experiences of resettlement in a smaller suburban community in western Canada. A review of the literature suggests that many refugee women carry the responsibility for healthcare for their families transnationally and experience increased barriers related to accessing healthcare, social services and supports during resettlement (Merry et al., 2011; Simich, 2009; Zanchetta, et al., 2012). I was therefore interested to find out Karen women’s perspectives on what supported their resettlement process and what Karen women perceived as barriers to care.

Despite the evidence of complexity of factors influencing mental health post migration, trauma is often foregrounded as synonymous with refugee identity and reduced to a pre migratory event where social and structural determinants of mental health such as gender, age, education and literacy and so forth are either treated as discrete variables and/or overlooked in the lives of refugee women. Applying an intersectional perspective helped illuminate the intersecting factors that created contexts of vulnerability and dependency. Cultural safety helped me to ground the analysis in what Karen women themselves found to be safe healthcare practices, services and supports.

In light of Canada’s historical legacy of colonization and the current climate of globalization, transnationalism and neoliberalism, I also wanted to draw on Karen women’s voices to explain how shifting landscapes in settlement and healthcare shaped Karen women’s access to healthcare services, settlement supports and their
social interactions between themselves and community service providers in the everyday context of health care provision and contact with settlement organizations. Many of the themes that I discuss in the following sections describe a context of stress and worry, and I present Karen women's experiences as conversations between themselves and those who provided community services and supports to them. Although each of the themes are not mutually exclusive, each theme draws attention to different aspects of settlement that Karen women identified as important.

4.1.1 Resettlement and mental health—“A lot of stress and worry”

Historically, Karen families were self-sufficient by hunting and cultivating farms on their own land by their own means. Due to ongoing state violence and the exploitation of ethnic minority groups in Myanmar (formerly known as Burma), Karen women and their families fled from their land to seek safety in refugee camps. This loss of independence meant that many families became dependent on large non-government organizations for rations of food and medical services. These experiences of colonization and historical oppression had implications for the ways in which Karen women and families began their lives in Canada. As this community health care provider notes:

P042: They’ve got a thing – elements of family life that we don’t have, and they’ve got it – they have extended families that are close-knit, ... most of them have been in camp 10-14 years, or more – if they remember the village they came from before they went to the camp, you ask them about the village and the villages are about 60 people in size, roughly. They farm, they grow rice, they have chicken and pigs. They have an elephant to help build their houses. There’s deer...they weave, ... They’re an agricultural, strong family group. That doesn’t need adjusting at all, that needs preserving. I really feel we’re blessed
to be at the beginning of their integration because that's probably what's going to change, to their detriment.

As explained by this health care provider, elements of family life are contextualized in place and sense of interconnectedness and were viewed as a value that is being changed by the process of Karen resettlement into social systems and structures that were perceived as increasingly disconnected from land, place and kinship. The healthcare provider is making the point that resettlement may potentially negatively affect the Karen way of life and sense of community.

Adapting to a new environment was distressing for many women. As this Karen woman explained:

P0028: The first one is when [I] first arrived, learning the language is very difficult and I worry a lot about learning the language. It's difficult. The second thing is coming from the village and not from the big city, it's very different for the children to grow up here and to parent them is – always worried how to...how to lead them, how to take care of them and for their future. Always worry about that.

Many Karen women perceived childcare work as part of their gendered responsibility. However in the context of resettlement Karen women faced an added burden of parenting and educating of their children, as many Karen women did not have formal education themselves. My field notes further explicate the perspectives of Karen women and early childhood education. Field note excerpt May, 02, 2013:

We went to visit Susie\textsuperscript{42} with the childhood educator and settlement worker. The outreach visit was intended to support Susie to attend the Early Years Refugee Program (EYRP) so that her daughter can be prepared for preschool. The worker’s impression was that Karen women don't want to send kids to the center or engage with early childhood development because of their belief that they [children]...
will learn once they get to school. So I think this is related to pre
migration context and yet how to provide supportive services to
support families when they are meeting their needs for daily life.

The culturalist discourse of Karen women believing that it was not their
responsibility to provide educational support for their children was problematic
because of the difference in cultural constructions of early childhood education in
Canada, which assumes that families take an active role in teaching their children.
However, pre migration, many Karen women in this study did not have access to
formal education and their traditional work only included agriculture and farming.
This broader context shaped the Karen women’s identities and responsibilities post
migration. Thus, taking on the role of teacher for their children during early years of
childhood development increased the Karen women’s stress and worry. Many
women were deeply concerned about their children’s education as this was the
main reason they came to Canada, as this Karen woman stated:

P0030: A lot of stress. For women just have to deal with the children
and have to ... yeah, after looking after the children and then they –
some of them feel lost, like “my children don’t listen to me because I
don’t speak English. I don’t know how to raise my kids in this
country.” A lot of women – a lot of families – when you ask them “why
you come here?” “I come here for my children education,” but they
feel like they lose.

During resettlement many Karen women worried about becoming
increasingly disconnected from their children as younger children were learning
English quickly and the women felt that they would not be able to parent effectively
as a result of the language barrier. Similarly, another Karen woman explained how
her children’s education affected her decision to come to Canada:
P0025: we live in camp but we always feel in the future my children’s life will be good or bad, I’m not sure because people they have a lot of, they have much, ... they have money they can send their children to the high education like high school or school is a little bit higher level like they go to that city and they have a chance—and we’re going to [do] better. But I feel in the future if my children, if my children grow up that they will go to get an education.

The decision to come to Canada was, for many families, primarily based on the fact that they could not afford to send their children to school to receive higher education. This would include high school and university. Accessing formal education outside of the camp was extremely difficult and dependent on how much money they had. For many women, leaving the camp and coming to Canada was not only about safety and freedom from political oppression, but also about the right to education, either for themselves or their children. Although supporting children in their education was a source of stress and worry, Karen women also received a lot of support through programs that promoted literacy and education for newcomer parents. As this Karen woman discusses:

P0028: The one thing that I’ll never forget is when we first arrived here and the people that knew – the kids already in school talking about they got lost – how to help their kids ... in school – how to prepare their kids in school. I was worried for my children, if they go to school I want to prepare them before they go to school. We talk about that with other parents... the program called [name]. Parents as a Literacy Supporters. It’s really helped me and I will never forget. ...It’s really helped me and given knowledge to help my kids because I’m so worried for my kids.

The support systems in place in local schools were perceived by the Karen women as helpful and supportive, allowing them to understand the school system and to engage with the learning process their children were going through.
Institutions of learning were also viewed as an important aspect of community
capacity as primary schools became an important point of healthcare access and
other resources and supports for Karen women. As one public health nurse
explained:

Focus group participant P0031: I really found the school was a
wonderful place, because the children are there, [name] is there, the
families come there – that would be the greatest place for moms to get
education.

Primary schools in particular were viewed as community resources in which
education and literacy could be fostered for Karen women and children and families.
Local schools provided primary links with public health nurses, as well as
settlement support workers, which fostered community capacity building and social
support for Karen women with young families. Because local schools enhanced
social supports for Karen women with young families, older women would have to
draw on people they knew in the community and or extended family for settlement
support.

In addition to worrying about their children’s future and adapting to their
new roles as parents, many community volunteers as well as Karen women
themselves were overcome by the challenges of resettlement. Community
volunteers who provided initial support discussed how many Karen women and
families felt:

S01: ... I think the community wasn’t at all prepared for such high
needs refugees and I don’t think the government was really prepared.
... and so they were all just sent basically in taxis to [city A] – ... – a bad
part of [city A] and ... left like so they didn’t know how to get into their
apartments, they didn’t know how to put together the furniture that
arrived, they didn’t – so there was just a lot of really high needs – and a lot of them you know, didn’t come out of their house for 2 weeks because they were scared. They didn’t know how to use an ATM machine or where to go to the grocery store. So there was just a lot of – I think it was pretty traumatic when they first came. Most of them just wanted to go home.

A large part of social support for the initial resettlement of the Karen came from community volunteers. Community volunteers perceived that Karen women and their families were re-traumatized as a result of culture shock. There is increased attention being paid to pre planning processes in which government assisted refugees (GARs) are exposed to educational sessions and material prior to arriving at their final destination. In addition all GARs including Karen women and families spent two weeks at Welcome House BC where they received their welfare assistance and temporary shelter after their arrival, and general health care and settlement resources. However, as is evidenced by local community responses and Karen women’s experiences of resettlement distress, factors such as literacy and gender, were not fully taken into policy directives. The omission of these social determinants of health resulted in many Karen women and families just wanting to go home.

The overall lack of initial formal and informal social support systems created increased vulnerability for Karen women. Many Karen women were afraid and did not know how to manage everyday issues most Canadians take for granted. As this Karen woman explains:

P030: Yeah. Like so many things happen in our mind. Imagine like how it’s going to look like. It’s a bit different from what we imagine. Then some volunteer came in, help us to buy food, all that. It was
really scary and hard to handle the money and the bus stops at that time because we didn't get much. Like the first time I got $42 and I was scared to – how do I use this? And how can I survive with this money for a week, $42 for the food and transportation, everything. But... I was scared to buy stuff, especially food, right? That time the main thing was food.

Many Karen women expressed feeling scared and simply did not anticipate the magnitude of the challenges they would face. Simply receiving money for food did not mean that women would be able to buy it. Underpinned by models of liberal individualism and fairness, Karen families were given government welfare support as well as some pre arrival and post arrival information about life in Canada. However, the needs of Karen families were great given their lack of access to education, and low literacy. In the following excerpt another woman explains how she felt when she first arrived:

P046: I was so scared and now it's getting better. Before I never go in the bedroom alone, and now if I go to the laundry room when my husband has to go with me. Sometimes it bothers him because I'm scared too much. If I have to see doctor, like when I went to see doctor in [city B], [s]he [the settlement worker] always help me and tell me – and if you don't help me then who's going to help me. No one is going to help me.

Feelings of abandonment and isolation were perceived by this woman who needed increased support. Many Karen women expressed how increasingly vulnerable they felt when there is no one around to help them access health care services and supports. Karen women's lack of English language ability, education and literacy ability made many women feel increasingly dependent on formal social supports and settlement support workers who were from their own smaller community.
4.1.2 Dependancy—“You don’t need to wait for me”

In BC, provincial settlement services and supports are varied and primarily the responsibility of non-government organizations such as immigrant service agencies and smaller ethno-specific agencies. Many of these organizations provide settlement services such as assisting newcomers to gain language and employment skills. BC’s policy for building inclusive and welcoming communities recognizes that refugees coming to Canada under current immigration policy may have specific and settlement integration requirements as a result of their limited literacy skills in their own language, and lack skills necessary for employment (Welcome BC, 2011-2012). Welcome BC has described these refugee and immigrant groups as vulnerable immigrant populations. As a result of settlement reforms, the Vulnerable Immigrant Populations Program (VIPP) has been implemented to provide individually based services and support. However, because this program contracts out services such as outreach, it was often difficult for settlement workers to travel across different cities and connect with Karen families. In addition many Karen women felt pressured to become more independent as a result of the losing existing safety nets, e.g. Early Years Refugee Programs, which provided services in their own language. This has meant that generally there is a disjuncture between what women needed and the kinds of supports they were receiving. For example, there was limited availability of interpreters vis-à-vis settlement organizations and language services that could respond to the Karen women’s need for accessing health care, social services and supports. Here a settlement worker speaks to these challenges:
P006: For example ... you don’t need to wait for me sometimes on a holiday for two weeks and you’ve got to wait for me with the Ministry paper for two weeks. No you can go to the service and access it and things like that and it seem like they’re not really keen to go, maybe I have no idea. I ask them but they say we prefer you or something like that. I don’t want to go into detail, when you go in detail then I might lose the trust with people dealing with trauma and depression and you don’t really want, very fragile, some families are very like sensitive.

The perception of Karen women and families as traumatized, depressed and fragile reinforced the perspective of dependency and pathology. However, waiting for someone they knew was also related to the Karen family's needs for social advocacy in the context of inequitable service provisions such as lack of settlement workers who spoke their language. Lack of advocacy and trusted relationships with formal supports created increased contexts of vulnerability for Karen women. Although some settlement workers adopted the discourse of dependency, there was also a growing sensitivity toward the need to assist Karen women and families to build literacy skills.

All of the settlement workers were Karen themselves but did not necessarily share the same identity, e.g., refugee status, class, gender and/or ability. Because settlement workers were perceived to be more educated, and therefore a higher social class, Karen families perceived that having settlement workers with them would increase the probability that their settlement needs would be addressed.

Unlike other refugee and immigrant groups there was no pre-existing Karen community prior to their arrival in City A. As per CIC policy on group resettlement, the majority of Karen women and families were resettled together. While group
resettlement policy potentially enhanced informal social supports for Karen women, many families also required extended support networks of formal support systems. Although many Karen women spoke about how health care was better in Canada, the main problem was accessing health care. The lack of resources related to interpreters for example, had consequences for many Karen women. A Karen woman provides an example in the following:

P0011: Always when she calls the interpreter, so she feels very sorry. She feels upset. She feels worried... She feels very different, Canada and the camp. When she lived in the camp, she has big problem about health. So every time she needed to see the doctor, to see the medic, ... but she can by herself in the camp... she [went] by herself... But here, when she comes to Canada, oh she has a big problem. But always she needs to see the doctor. But she’s scared, she’s worried, she feels sorry to call the interpreter. Like for example, the last two days she called the interpreter and today she needs to go to see the doctor again. She worries. She waits and waits and waits until her daughter feels very sick ... she tries to close her eyes and call the interpreter. But when she sees the doctor, the doctor says “why you not come earlier? Your child is very sick. ... it will be too late.” But she says “I’m worried because I’m scared to call the interpreter.

Many Karen women felt not only disempowered but increasingly vulnerable and dependent when they had to call upon someone from their own community to assist them to access healthcare services. Karen women felt that calling upon a settlement worker was a great imposition and that they were a burden to others. In the excerpt above, the doctor unwittingly created doubt in the mother about her mothering skills. Importantly, this health care encounter points to the importance of having easily accessible culturally trained interpreters; the lack of interpreters puts

---

43 Translators for Karen women’s focus groups tended to not speak in the first person thus they conveyed the meaning of how women were responding to the questions.
women in a position of dependence on those with whom they may not feel safe. The overall lack of resources and safe practices placed women and their families in positions of risk and unsafety.

In order to compensate for the lack of social resources such as outreach support as well as professional interpreters, a Karen settlement worker discussed the approach taken to accommodate the gap in service provision:

P006: We do have some like a problem with that in hospital. The client go there and then nobody can serve the causes, language problem even though it’s emergency they can’t help them because they can’t talk to the client so they are waiting for somebody to come to talk. ... it is a big problem ... so, for case management if we teach them how to do ...again and again, repeatedly you know, to do the things you don't know how to do it because we know there are very vulnerable a lot of barriers, ... it’s not good at all. So to do nice things we have to like accompany them, ... help them to increase their confidence. And at the same time I teach them how to do it again and again until they learn something.

Waiting for an interpreter to come to the emergency department was difficult for Karen families and resulted in increased demands on healthcare providers’ time. Although accompaniment was viewed as a way of supporting Karen women in building confidence, settlement workers who provided translation were reluctant to do this because this was out of their scope of practice and because they lacked professional training. Therefore settlement workers felt compelled to teach “them” again and again so that Karen women could become less dependent on them. The main driver behind the need to become independent was that settlement workers were experiencing larger demands on their time in the context of
settlement reforms. Similarly, another community support worker underscores the growing discourse of dependency in the context of diminishing system support:

P0036: ... we have to help them get there not help them we have to walk beside them to get there not do it for them ... I’m really being more, ... direct and more pointed ...Like even today someone with B.C. Housing rent assistance application every year ...they all have B.C. Housing rent assistance and every year they have to renew it. So this person has been here five years and every year someone fills it out for her. But we’re never teaching her how to fill it out right? So the last six or eight months I’ve really been trying to make people at least write their name, their address and their kids names and birth date like you have to be able to do that right? So really for the first number of years all frontline workers were guilty of it, we did everything for them. But yet they were just not in a mental space to be able to even try like they were just so overwhelmed with everything the basics of life that now it’s time so and a little bit overdue so we have to push them, we do have to push them more.

The rapid resettlement process did not allow time for frontline workers to be able to provide literacy support to Karen women and families. It is important for Karen families to acquire skills such as filling out everyday forms and applications in order to maintain their housing. Housing applications and rental assistance applications were one of many examples where Karen women required day-to-day assistance. On the other hand service providers had limited supports in place to assist women to build on their individual capacities. These tensions were also expressed by a public health nurses working with Karen women:

P0031:... it’s trying to understand that balance of how much do you help and how much do you do for [them] rather than empowering them to do it for themselves. That’s, again, where the language piece comes into it. I think ... some of the expectations are that these individuals should know so much English because they’ve been here six years. But then also remembering that when we [come] across the medical terminology and things, they’re not going to understand. It’s going to be critical that they understand. This is a very important part
of their transition, and healthcare professionals being involved with them is so critical, in terms of them progressing and improving and assimilating, integrating.

There was a general expectation that Karen women would be able to have language and literacy ability within a few years of after their resettlement. However as I discussed in chapter two, their length of time in Canada did not determine language ability. The majority of the Karen women who participated in this study arrived between the years 2005-2009. Almost all of these women had difficulty in accessing health care and community service supports during the time of this study, which was six years after their arrival. The tendency is to view a lack of integration or assimilation into Canadian “culture” reflects a form of liberal individualism, when, in reality, their language ability and understanding is not examined in the context of the social constraints that many Karen families experience. For example, Citizenship and Immigration Canada’s (CIC) new rules for citizenship require evidence of post-secondary and secondary education in English or French as well as meeting the Canadian benchmark of level four. Karen families would also need to pay for applying for a citizenship test (Marchbank, Sherrell, Friesen & Hyndman, 2014). The notion of citizenship was particularly important for Karen women and families as this fostered a sense of belonging. An examination of these broader systemic policies reveals that lack of language ability and not learning quickly enough is not simply an individual matter. Overall, the shifting landscape of diminishing settlement supports and lack of knowledge about how to support Karen
women and families during resettlement reinforced the discourse of individual responsibility and the Karen being dependent on the system.

4.1.3 Re-visioning agency—“Standing on other people’s feet is not the same as walking by yourself”

There was a reciprocal relationship between the Karen women being constructed as dependent by the receiving community and the Karen women themselves feeling dependent on others. In both cases dependency reflects the general lack of parity the women had in being able to make decisions and access the resources they needed in their everyday contexts. Importantly, for many Karen women, being reliant on others for accessing health care services, especially members of their own ethnic group, was a major source of distress and a potential safety risk. In the following excerpt, a Karen woman discusses asking for help as part of her everyday experience:

P030: ... But the thing is, of course they get a lot of support but it’s still – it’s not the same thing as you can do yourself and you have to ask somebody else to do for you. Because it’s stressful to go and ask somebody to help you all the time...And then, plus, if you don’t speak the language, you have to take your kids to the doctor and you need help. If you need to apply for renter assistance, you need help. Standing on other people’s feet is not the same as you walking by yourself. .. it’s not the same

Asking for help was not easy for Karen women; dependence on others often served to reinforce a sense of powerlessness and lack of confidence. Postcolonial feminist scholarship aims to disrupt and resist ongoing subordination of people affected by colonization. However broader neocolonial practices and structures reinforced being in dependence in both macro and micro contexts.
In the context where community services and supports were not available, many women relied on friends and family for accessing services they needed, including translation. As described by this Karen woman:

P011: ... – one of my kids has asthma so sometimes when he can’t breathe or something like that happen, it’s sometimes midnight on the weekend, so there’s nobody working the office and no clinic open, so I just call other Karen family to help me. But if they – sometimes they can’t help me so I just – even though I’m scared and I can’t speak the language, I just go with my older children and they just help me.

The use of friends, family and children to provide translation was a common practice among the Karen women especially in situations where services and supports were not available after hours. While Karen women enacted their agency by drawing on friends and family for support these practices also jeopardized their safety and the safety of their children. Karen women were often met with disappointment and discouragement as a result of the lack of interpreter services.

As this Karen woman explains:

P0030... They blame the family. It's happened to many families ... ... and sometimes ... The interpreter would cancel the appointment because they can’t make it and then they didn’t let the patients know. The patients would go and it cost them money for the bus fare, ... $2.50 is a lot of [money for] them who are begging for $5. It’s a lot of money for people that start their life from zero here. And they don’t think. To the doctor they said “this family didn’t show up” ... And a lot of ... times some doctors say “you have to find the doctor that speak your language.”

Access to healthcare is a human rights issue and embedded in principles of universal healthcare. The lack of equitable healthcare services vis-à-vis professional interpreters was profound for Karen women as they had experienced many injustices prior to coming to Canada. In some contexts Karen women decided not to
attend medical appointments if interpreters cancelled or where not available.

Asking women and/or families to find a doctor who speaks their language was an added burden of responsibility and reflects lack of recognition of differential needs of different groups of people.

The reorientation of primary healthcare services has called for health equity and social justice, however, current practice, as experienced by the Karen women suggest that primary healthcare services privileges those who can speak the language and those who can afford it. Narrow visions of social justice such as distributive allocation of resources remain fair only to the dominant majority. Thus the Canadian healthcare system remains raced, classed and gendered, reproducing marginality which can result in victim blaming.

4.1.4 Fitting into the mold—"It seems like they don't have the time"

Another aspect of dependency was related to the concept of mainstreaming in which many health care providers only had a specific amount of time to provide healthcare services. By “mainstreaming” I am referring to the dominant ideologies that shape health and settlement services which negatively impacted on the everyday lives of Karen women. In the following excerpt a public health nurse speaks of the current model of health provision, time constraints and the needs of a Karen woman:

P031: I actually had a similar experience with the Child Health Clinics just last week. We had a Karen family booked in and it was for the 12 month immunization, which again is a lot of informed consent. They did not speak enough English to really thoroughly be able to understand and consent in English. So I had called an interpreter, like [name] was saying ... on the phone for the interpreter, and then by the time the health history and you explain the immunizations, the visit
took close to an hour and we’re allotted 25 minutes for an
appointment. So it’s challenging to handle that in the clinics where
they’re fully booked and they’re usually very busy.... We all want to
make sure that those families are getting the best care that we can
provide, but the process is a little bit clumsy ... for sure.

Mainstream policies and practices related to health care provision did not fit
with the needs of Karen women. The allotment of twenty five minutes for a standard
appointment constrained the ability of public health nurses to provide culturally
safe health services to Karen women and their children. Cultural safety in this
context meant that current health care policies and practice were not flexible
enough to provide equitable health care services.

Public health nurses also experienced significant challenges related to
accessing appropriate translators during community home visits. As explained
nurse explains in the following:

P0030: Nurse two: ... you think “oh it’s just a little thing to call and see
if somebody’s home,” but it’s not when they don’t understand you and
you can’t speak their language. Yeah, it doesn’t start things off very
well a lot of times.

Public health nurses perceived that the cultural norm of simply calling to
make an appointment was not an efficient and/or culturally appropriate way to
connect with Karen women and families. When interpreter phone services were
used, nurses also had great difficulty in providing public health services to Karen
women. As another public health nurse who participated in a focus group explains:

P0030: Nurse one: In that process, [name of institution] ask us to find
out if that individual is home, so you can understand that if we’re
doing a cold call to a family and saying (yeah), “are you home, we’re
going to get – connect with an interpreter,” they’re not going to
understand it (no), it’s not going to start the conversation very well. So it’s a challenge when we’re using those services.

Nurses perceived that an important part of health care access was establishing a connection with Karen women. Thus connecting over the phone, even when translators could be coordinated, was perceived as incongruent with making a connection and building a relationship with Karen women. Similarly, it was perceived by a Karen settlement worker that making an appointment over the phone was an added challenge. As a Karen worker explains in the following:

P007: If the family doesn’t know English well, when they phone they don’t know, when they hear English … they will hang up they don’t know how to answer.

Karen women were not accustomed to using the phone as a means for talking with service providers, especially where they had no prior relationship with the provider. The concept of making an appointment was also challenging as described by a settlement worker in the following:

P007: No they don’t have the time I think, too rushed, so sometimes I feel so sorry for myself, she doesn’t want to listen to me because of maybe I don’t know really the Canadian way like the first language. When you book appointment you go by yourself, you speak by yourself, you don’t need interpreter so it’s easier for them I think, easier for the reception. So like for like Karen woman or Karen family who doesn’t speak English it’s hard for them also for me, hard for me like explain to them that I can’t go with them.

Karen settlement workers also experienced stress when they were not able to accompany women and families to medical appointments. While there were primary care clinics available, the distribution of these resources did not necessarily
mean that Karen women and families were able to access them. For Karen women, access was relational as it required the orchestration of multiple formal and informal supports. When these supports were not available many Karen women felt discriminated against as they did not know how to do things the “Canadian way”. This resulted in their needing to take more time, and this led to feeling sorry for themselves. Many Karen women discussed the difficulties they had with medical appointments even when translators were available. The following excerpts are from two different Karen women in one of the Karen women’s focus groups:

P0012: woman one: ... before we have – we have interpreter but we still have difficult to understand. We only get to see interpreters at the medical appointments for a short while and then they have to leave ... especially for the women and elderly women... because our kids – in the future their English will grow... I know we are slow ... for moms. Because some moms they have a little child like me ... they don’t go out, so very hard. But especially for a mom – all of them said, especially for a mom, it would be great if the government ... hires someone who is fluent in English and Karen to take care of our health care needs, especially for our elderly people. We, younger people, can handle things a bit better ourselves.

P0012: Woman two: when our kids grow up they may speak better English, they may be able to help us or they may not because they will be busy with their own businesses by the time they become adults and are fluent in English.

Many Karen women discussed that it was important for the government to understand the different needs of women, especially for older women and women with young children. Although many women were reliant on family members, including their children, for medical interpretation, women felt that they would become further isolated when their children grew older and were no longer available to support them. This brings attention to the need for increased formal
support systems in the context of Karen resettlement, as well as other newcomer groups in Canada.

The mandates of many programs and health services such as the New Canadian Clinics\textsuperscript{44} and Early Years Refugee Programs require that Karen women and families transition into mainstream services and supports within a short period of time, a period of time that is arbitrarily decided within service delivery programs. Women in this study were feeling the impact of current settlement reforms and narrow service mandates of existing services. A settlement support worker also provides a glimpse into this problem in the following:

P007: When I went to the family ... that's difficult, yeah the doctor mostly are friendly, the receptionist sometimes when I phone them they are not patient, they just want _to leave_ it seems like they don't have the time. I want to explain to them sometimes I book appointment for this family I couldn't go so I just told them why you don't tell the doctor ... and then if they want to have time or they want to remember.

Often the first point of contact for settlement workers and Karen women is the receptionist at a primary health care clinic. In many cases the receptionists were perceived by women to not want to take time to help women make appointments or as being unfamiliar with their health care needs, i.e., “if they want to have time or they want to remember.” This unfamiliarity also speaks to the larger challenges of transitioning Karen families to primary care clinics. Overall, Karen women felt that

\textsuperscript{44} There are two New Canadian clinics that service immigrant and refugee populations specifically, however neither of them are located in the geographic location in which this study was conducted, i.e. where the second wave of Karen women and families were located at the time of this study.
they needed to have more time around health access. Another Karen woman discussed how taking time made her feel:

P0028: I feel like – I don’t speak English and I don’t speak much English, so I feel scared, but when I went to see my doctor, he speaks so slow and very nice, and if I didn't understand he repeated it again to make me feel like he’s a nice person. So encouraged me to speak out and not scared anymore, when they are very nice, the same as [name]. She tried to speak very slow and repeat every time I don’t understand. It helps me to more confidence to speak up.

Feeling scared was commonly described by many Karen women in the context of the health care encounter. Women felt empowered when the care provider took their time and spoke slowly as this gave the women confidence to speak and to be heard. Reflecting on my field observations, I did not observe Karen women being scared. This was related to the fact that they were always accompanied by either a settlement support worker and/or outreach worker. In addition to accompanied support, taking time to listen was also viewed as important for the Karen women. Another older Karen woman explained what taking time meant to her:

P043: The doctor – when doctor listen carefully and patiently and when they talk nicely. It's nice. But the only thing is hard when – because we don’t speak the language so if we get sick right now and I have to wait until they are available because they have to see so many patients. Because I can't speak English so I have to wait until they can make appointment for me.

For this older Karen woman, waiting to be able to access healthcare occurred on multiple levels. As I have already discussed Karen women were reliant on other community and personal support systems in order to access healthcare. When literacy, language ability and historical experiences of oppression are taken into
consideration, taking time and talking nicely become important for promoting culturally safe practices for Karen women. In addition, having to wait, for this older woman, had potential negative consequences to her health. A settlement worker speaks to what is supportive for Karen women, in relation to accessing health care:

P007: I think for the doctor and the nurse they need to understand Karen people who are from lower level, speak ... simple words to the family so they can understand so that the family will be happy to go by themselves. Oh my family doctor speak slowly and then clearly and friendly so I can do it all by myself because the doctor they don’t have the time a lot I heard that. So all they want to do is fast, fast, fast, they speak fasts you have to answer them fast, feel more patient, a little bit patient and then the family will feel more comfortable to see their doctor.

Many Karen women perceived themselves to be from a lower level, meaning that they perceived their disadvantage as having lower education and lower status. Therefore speaking slowly was a matter of respect and feeling valued. Conversely speaking fast and being rushed during a health encounter made Karen women feel demeaned and disempowered. As another Karen woman remarked:

P0030: I guess I didn’t really ask because everyone was too busy that time. I tried to ask a couple of times about my school but no one really cared so I guess I gave up.

Women gave up asking for help and support in contexts where they perceived that the people who could help were too busy. While there seemed to be a recognition of the complexity of resettlement needs of Karen GARs, the perceived lack of time allotted for resettlement is reflective of an ideology of individualism and the notion of independent citizen; thus, the expectation that people are able to
attend to their own needs regardless of social constraints did not fit with Karen women’s settlement needs.

However, models of liberal citizenship vary when intersections of gender relations, multiculturalism and individual human rights are taken into account. For example, studies suggest that refugee women’s experiences are embedded in the social relations of family life (Dossa & Dyck, 2011; Hondagneu-Sotelo (2001); Mahler & Pessar, 2006) and that multiculturalism policies vis-à-vis respect for diversity and commitment to group rights for minority cultures may fail to protect the rights of refugee women by abdicating responsibility for the vulnerability of women and children (Okin, 1999). For Karen women, their gendered responsibilities and a liberal model of citizenship challenged their need for increased time and adjusting into Canadian society.

4.1.5 Seeking safety and the potential for traumatization—“Somebody step in and help her!”

Contemporary trauma discourse suggests that there is a need to move beyond defining trauma as a monolithic event but rather as interwoven with the structures and oppressive forces that are embedded in most receiving societies (Kirmayer, 2007). Critical readings of culture must be taken seriously in order to abate forms of structural violence. The level of resettlement distress that many Karen women experienced during resettlement cannot be easily disentangled from institutional practices and policies that are outcomes of historical and sociopolitical processes such as colonialism. These structural processes have consequences. A
settlement worker describes working with a newly arrived Karen single mother in Canada:

P006: ...She came to me on Friday evening and she talks to me nicely and she ... seemed very sad about her family but she didn’t say that she wanted to die. .. the girlfriend that came with her said ... she wants to die, I said, oh no ... well in Canada many things full of our choices let and join our country here and she seemed like very depressing. And on Monday morning [name of health authority] call me that your client has committed suicide, very sad, very, very sad and I learned my big lesson there.

R: What was the lesson there?

P006: The lesson is like when people talk about things mental health because I don’t have that background ... And I saw at [Intensive Care Unit] and I couldn’t talk to her of course ... I made a big mistake there. She was so depressing it’s almost like woman mental health, she needs more education in that part, she couldn’t do that. I mean like if somebody step in and help her out there she would not end her life no,

... So I don’t really know I just feel she came in, she just fill out the child tax benefit form and how would you know that your client is facing difficulty just filling out the child tax?

Although there was international and national recognition of the significant barriers to integration for Karen women and their families, there seemed to be a general impartiality and misrecognition of the contextual circumstances that could potentially result in retraumatization of Karen GARs. Critically oriented readings of social justice move us to consider the need to reorient settlement services toward including equity-oriented services that encompass the differential needs of refugee women, including structural determinants of mental health. The overall lack of settlement support services often left settlement workers unprepared to support
Karen women who faced multiple barriers. Moreover, the burden of responsibility placed on the Karen settlement workers also increased settlement worker distress. As the settlement worker above went on to discuss:

P006: Very, very hard. And I was like more and sad for almost a week and my work, in my job I always have to see counselor like to help myself because I have seen a couple of deaths already... As a helper here I just give them orientations what are your rights in a work place? Be strong, it is all by encouragement otherwise living in a new country with these environments you will not be able to survive. So I have a strong feeling that they are very strong in emotions.

Lack of systemic and well integrated policy and practice for resettlement resulted in cultural safety risk. For Karen settlement workers it was incredibly hard to witness deaths in the community, particularly when the reason for the Karen refugee resettlement was premised on the humanitarian ideal to protect them from harm. Here the settlement worker is implying that many Karen women and families lack the individual strength and resources to survive in Canada. Being strong represented another form of individualism where many women felt that they needed to fend for themselves. As discussed by this Karen woman:

P0025: In our life,– sometimes we do have to face people that are not nice, in the workplace, discrimination, all that. We have to – if you have to face, we have to face – we can’t blame them, the people who oppress or discriminate us. But we have to be strong, we have to be strong ourselves, but it’s very hard that we are not strong. But if we have a group ... that – sit and talk about what we face today, and what we can do, and encourage each other – yeah, if we have a group of people like that, it’d be good I think.

Safety nets were enhanced when Karen women had increased social support through outreach programs and when women were able to have someone accompany them to appointments. Moreover, some women felt that supporting each
other through group discussions would also be helpful in managing the challenges of discrimination, particularly discrimination related to not being able to speak English or lack of education.

Many Karen women also felt that it was important that they be able to participate in decision making about their health, and that health care providers have information about their pre migration history, in order to address some of the structural inequities. The following two excerpts from Karen women explain their perspectives and what they suggest is needed in order to improve service of care:

P0011: I think it’s helpful…. one thing is I think it’s helped the person to feel that somebody understand how she feel, what’s really happened to her and it’s really painful and there is something that she has to go through. It’s good that she feel that that person understand what she go through and what she [is] feeling.

Similarly, another Karen women explained:

P0030: And I think also they really have to – the health staff provider need to get feedback from their patients. Using interpreters is not – it’s good but also you have to get feedback for them. A lot of time you see that the doctor or nurse they trust the interpreter so much and they don’t – they get only one side of the story. They never get another side story.

Karen women felt that getting their perspectives was an empowering process and one that had the potential to increase safety and minimize risk for women. In relation to interpreter services, some women felt that it was important that health care providers seek the women’s participation in the decision-making process about using an interpreter. As I discussed earlier, interpreters, particularly when they are the same ethno-cultural background, placed many Karen women in positions of vulnerability; similarly, settlement workers were often uncomfortable when they
were of a different class and social status. The United Nation High Commissioner for Refugees (UNHCR) (2013) recommends strategic use of case workers; people may be better served by people who have the same language but not necessarily the same nationality in order to ensure gender sensitivity and cultural competency for women at risk. Some Karen women asserted their agency by choosing not to communicate in the presence of a Karen translator in order to protect their confidentiality. This was described by a health care provider in the following interview excerpt:

P0042: We need more time than we actually have. With some women, we’ve sat down for our visit, the translator – like some of them won’t talk with the translator. These two ladies won’t – you notice that they don’t use [name] as a translator. Because god bless [name], she’s Karen, and lives in that community. Everyone knows everyone else’s business. ... so both those ladies, they don’t use the translator...

R: But it doesn’t sound like having an interpreter has really made a -- do you think that would make a big difference in your practice?

P0042: An independent Karen ... well how are you going to get an independent interpreter? The Karen community is so strong. They’re not independent, they’re interdependent. So mostly [name] will come in with them. They’re learning English really quickly. We don’t have enough English to do an informed discussion. We don’t have a cultural understanding of what informed discussion is. Where were we with mental health? We deviated ... Oh I know where I was going with it. Yes, so with one particular person, we’d done the complete visit, the translator had left, and she said “oh, my husband a bad man.

Confidentiality issues were addressed as paramount for maintaining safety and wellbeing for the Karen women during health care encounters. This was particularly salient in contexts where the translation was being provided by members of their own community. In this context, Karen women negotiated
confidentiality by not disclosing what was really important in the presence of the translator who was known to them. Similarly, community support workers who provide outreach services also discussed the challenges of using interpreters. These challenges were described in the following excerpts from different outreach workers in a focus group:

P0045: women’s outreach worker one: I would say specifically to the Karen women would be the language barriers. We do have an interpreter that we can call upon to come and visit, do home visits, but I’m finding that ... I’m wondering– if the woman isn’t ... able to speak freely with the interpreter there? ... I think that’s a little bit of a challenge. And I wonder if the interpreter has any influence over the person as well... that’s just a thought and just a feeling.

Similarly, another woman’s support worker speaks to how a member of the same community affected the quality of the visit:

P0045: women’s outreach worker two: I agree with what [name] saying around the interpreter or having a third person interpreting. I think it impacts the quality of the visit because ... I think there’s a perception to save face and because the interpreters may be part of the existing Karen community ... moms don’t want to share freely their issues that they’re actually experiencing, so they’re not disclosing everything. They’re not feeling comfortable enough to disclose everything that could impact the quality of the counselling session.

There was a perception that Karen women did not have the freedom to disclose what really mattered to them in the presence of someone they knew, as this could stigmatize them. Women’s outreach workers felt that providing outreach support was an important part of providing health promotion services as this helped them build relationships. This was especially true with older Karen women and women who had lived trauma experience; however, they were challenged to
find appropriate health services due to the language barrier. Disclosing information could also breach confidentiality and compromise the Karen women’s safety, an issue that points to the importance of establishing relationships of trust. These issues also were raised by a nurse practitioner in the following excerpt:

P0044: Nurse one: ... my experience with the interpreting services, is first of all you need a trained service but you also – a trained provider – but you also need to realize that things will still get lost in translation, particularly with cultural sensitivities because there are certain topics that aren’t talked about within cultures. ... even if someone’s trained professionally, you can see it happening, that there’s a loss of communication in regard to – maybe to end of life issues, mental health issues... within certain communities, where an interpreter might be from a different clan or a different tribe or, um, perhaps the communities are small and everybody knows one another, ... patients will refuse to use certain interpreters because they just don’t feel comfortable or they don’t feel safe.

Creating safe spaces during health care encounters was important for practitioners to be able to provide health care services and supports to Karen women. Many Karen women did not feel safe with members of their own community providing interpreter/translator services. As noted many times, safety was of paramount importance for Karen women; cultural training for health care providers, including those providing medical interpretation was seen as important in this regard.

Developing relationships of trust with a Karen woman was sometimes done through another person whom they trusted, which may have included a family member and/or a person outside of their own community, such as an outreach worker. The challenge of providing culturally responsive interpreter services in the
context of diminished resources was noted further by a public health nurse in the following:

P0015:... postpartum depression culturally again this is an assumption but culturally it appears that the Karen families want to say they’re doing well, ... there seems to be stigma around it and that happens everywhere but especially in this population. And so for public health nurses to help we also have screening tools that we use a postnatal depression scale which might identify a mum being at risk and needing referral, needing further assistance. We don’t have it translated into Karen; it has been translated into many other languages it’s not in Karen. So we often use interpreters to help us facilitate that, however, one example is I was doing this at a home administering this with a male interpreter and he wasn’t actually an interpreter he was an outreach worker also translating.

In this research the majority of Karen women preferred to see a community midwife for pre and postnatal care as this was culturally congruent with Karen women’s pre migration practices. To develop an accurate cultural understanding and assessment of the Karen women’s mental health and well-being, interpreters are used as part of best practices in public health. However, in most cases, outreach workers (Karen settlement and support workers) are used to provide direct translation. This points to the complexity of issues related to women’s access to culturally safe health services. Many settlement workers were employed to provide outreach support for high barrier Karen women and families through the Vulnerable Immigrant Populations Program (VIPP). However, many of settlement workers discussed that they lacked training and support in areas such as mental health. Although gender sensitivity and equity-oriented services were made explicit as part of the UNHCR policy objectives for women at risk and the CIC gender based policy framework, there seemed to be an overall lack of culturally safe and responsive
services vis-à-vis provision of language interpreters and resources of support for Karen women.

4.1.6 Gender, identity and resettlement—“It’s invisible…”

In the context of the Karen women’s resettlement, gender and gendered relations were embedded in broader political, socioeconomic and historical stratifying factors. Settlement workers and service providers constructed Karen women as more knowledgeable and educated in the context of resettlement, despite the fact that many, if not all, the women who participated in this study lacked access to formal education. In contrast, Karen men were perceived to have less education related to accessing services and supports but were receiving income through labour employment. Resettlement stress and gendered effects of resettlement may position Karen women and men to experience different kinds of vulnerabilities related to employment, child care and access to education. Karen families felt pressure to gain employment in light of the fact that they had to pay back their transportation loan for travel to Canada and the fact that they did not want to be dependent on welfare support. In general, Karen men as well as women had low literacy and English language ability, however some of the men were able to secure labour employment through family members and/or friends. Karen women who were not of childbearing age and older Karen men tended to work seasonally in greenhouses or farms. Prior to arriving in Canada it was the general belief that Karen women could not pursue their education once they became pregnant. In some cases Karen families moved out of province to access employment elsewhere and get enough money to live well.
A settlement support worker discusses perspectives on gender in the following:

P008: ... the women are much better than the men sometimes I would say. For example, I have a client who the wife is better because like ... she knows more ... in regarding like the household issue or like communication and she seems more outspoken than the husband. ... I want the mother to come, the wife to come because she knows she can grab the information more ... like ... each family is different ... sometimes you see ... the mother need more help but not really some family the wife is more better than father to take care of everything.

R: Why do you think that is?

P008: Well like because like she's educated. [more] education than the husband right? And she know how to get around ... It's not common, ... but in the Karen community I believe the women are learning more than the men... see the difference between the husband and wife when I work with them ... some people will say that Karen, woman need more help than the man whatever you said it. But sometimes it depends on family because... they like to learn more they know more than the husband, yeah.

The perception that Karen women needed more help stems from women’s gender roles of mothering and carrying the responsibility for healthcare. The majority of women who participated in this research were unemployed and/or working seasonally in greenhouses; they generally had lower earnings than their male counterparts. It was stressful for the Karen women and men to find employment; however, the mainstreaming of settlement services appears to position Karen men as the “breadwinner” which may reinforce power imbalances and different kinds of vulnerabilities related to gender relations between Karen men and women. A community volunteer discussed how gender roles were affected by resettlement in Canada:
S01: I think that ... it’s the women who are home with the kids. ...I think [Karen women] have their identity more as a mother and as you know that kind of role within the family. ... Whereas the men – ... their kind of identity shifts in a totally different way. ... I think they experience failure ...a lot more. You know whether trying to learn English ... I think that for the women the way they could shift the services, too, is you know ... more English learning programs. Where maybe they’re there with their kids or you know things like that.

Karen women’s work was related to domestic responsibilities, child care work was perceived as a cultural norm. It was generally recognized that resources and supports for Karen women needed to include child minding services which reflected the additional burdens and responsibilities that many Karen women had. In contrast, it was perceived by many settlement workers and service providers that Karen men’s identity shifted and as a result Karen men experienced different kinds of resettlement stress and vulnerabilities. An early childhood educator discussed how gender is structured in the context of Karen resettlement:

P0041: ... once in a while you will see a dad here, but not often. Most of them are working, even though they’re not working ... I kind of have the feeling that it’s like a long time ago in Canada it’s the woman’s job to have the children and stay at home and do the chores and everything. Men go out and make money and bring home, and that’s their job. And this is your job.

The current structures of settlement support were referenced to Canada’s historical past where the gendered division of labour was clearly marked. Community perspectives suggest that Karen women and men experience resettlement stress differently and that Karen men may be exposed to different kinds of mental health risks. However, an examination of broader structural factors indicates that institutional structures and policies played a significant role in
shaping gender relations between Karen men and women and reinforced static
gender roles between Karen men and women during resettlement. For example, a
support worker discussed the impact of resettlement for Karen men:

P0024: And so I think the mums have got an advantage somewhat
over the dads because the dads were ... hearing we don’t see again it’s
kind of somewhat invisible ... but we see and hear of issues that
they’re struggling and often times ... the mums are, suffering the
repercussion of some of those issues. So there’s alcohol and there’s
gambling and there’s those, types of issues that are impacting the
families ... I’m not goanna say culturally they need this or they need
that because we could say blanket men just aren’t as, as relational as
women maybe in North America but maybe in their culture it’s equal
..., I really don’t know. I’ve seen in other cultures where the men all
hang out together and just as much as the women and they’ve got that
support group, I don’t know how best to serve them that’s one of the
things that ... keeps me awake at night.

Although Karen men benefited from attending early childhood education
programs and life skills training, the structuring of services vis-à-vis settlement
reforms limited the kinds of supports that could be available to Karen men, which in
turn affected the Karen women’s mental health and wellbeing, and their gender
relations with their male partners. Mental health issues such as addiction and
domestic violence were perceived to result from stressors related to changing
gender roles during resettlement and not as a result of neoliberal reforms. These
changes had direct consequences for some Karen families. As a Karen woman
explains here:

P 0030: But for women, it’s very stressful.... a lot of Karen women,
they don’t want to talk bad about their husband. But they do when the
husband go out, come back late and drunk. It’s a lot of stress for them.
And they feel like ... “because my husband pay for everything so I have
to let him do whatever he wants.” That’s not right... I can see it in our
community. Many men ... after work ... don’t spend time with their
family. They just spend time together... I think there’s something wrong there. I just don’t know what to say.

Some Karen women perceived that family dynamics shifted during resettlement, and as a result many men were perceived to not be spending time with their families or sharing domestic responsibilities. However, this was not the case in all Karen family contexts. As this settlement worker explains:

P008: ... I talk to him, I call on like a mental health worker but he doesn’t want to get involved. He said, I’m fine, you know, I just got a headache, a little headache and I know everything, I don’t need that services. I know he has some kind of like a mental too because he rarely go out. He work a lot, he work with the kid a lot but probably at the end of the day he said like ... I have to worry about my son or my daughter-a lot that’s why I’ve got a headache. I want to work, I prefer to work to get a job, ... we create the plan. ...he didn’t want to go to see the ... the mental health worker and he want to get a job I’m trying to [get]you to get a job. ... and I find why he has a problem with the headache is because ... you know, he has like two daughters, ... and he will have to take care of her kid, a lot of kids go to parents those kinds of things . . .

There was a potential to pathologize men who were not working outside of the home. In the above excerpt, this man’s work was related to looking after his children and grandchildren in his home while supporting other family members to work. The gendered norm of gaining employment outside of the home was potentially stigmatizing for Karen men. Moreover, the medicalization discourse of trauma intersected with gender to construct Karen men who were not working as traumatized or needing mental health services. Although it was also the case that some Karen men and women may have experienced posttraumatic stress disorder, there were generally no provisions in place for supporting men’s domestic work. Moreover, institutional policies and programs shifted to limit the resources for men.
An early childhood educator further observed the effects of governmental reforms and their gendered effects of resettlement in Canada:

P0020: Well it’s tough because, it’s not often that we’ll see a dad and last year, about a year ago we had someone working with the dads so there hasn’t been someone that’s filled in that position… From what I understand that person quit but no-one was hired...

R: And the position was specifically to help with life skills for the dads or families?

P0020: Yeah and more towards like job skills and resume building and they were meeting every Wednesday night and just doing I don’t know training like what to wear to an interview, it’s just funny to me because the dads will get really involved in and the women will giggle like it’s so funny that the dads doing this like he’s cooking or. … we’ve done some quite female type classes … one of the dads [that comes] has very little English and … at the same time jumps in and does what he can …And then there’s another dad that’s very, his English is very good and … he’s fun to have around because, [he], just enjoys it. … I don’t know the dads seem to get a kick out of those classes for some reason

Karen men benefited from the services and supports provided by the early childhood refugee programs just as much as women. However, reforms reinforced traditional gender roles and may unwittingly have constructed the way services were distributed to socially exclude all family members from early childhood development support, which included settlement support. This suggests that early childhood education programs are also mainstreamed in ways that are raced, classed and gendered.

4.1.7 Education, language and gender—“It’s a big thing for me to go to school...”

Despite the fact that there was a general perception by Canadian immigration that Karen women were under educated, some Karen women, who were able to
access education prior to arriving in Canada and who had English language ability, did not feel that their education afforded professional advancement in a Canadian context. An educated, English speaking Karen woman discusses her experience of pursuing her education in Canada in the following:

P0030: ... I was thinking to – continue with my education ... use my education. I want to go to school and want to have higher education ... ... but when I came to Canada it was ... not that easy.... Because I speak English so no one help me. No one help me.... and even though I was cry out for help, I was like “help me. I want to go to school.”.... We took the test and passed ... So they said “sorry, we don’t have a class for you. Your English is highest so you should go to Douglas College or ...” any college that have English class. It was a shock. We didn't have money, how can we go to college? How ... do you do that? And we never had experience back home to do this ... And to go and apply. What are the requirements? We didn't know.... And I was really lost at that time, I was really disappointed ... Beside... [I] didn’t have a chance to go to school. It’s a big thing for me to go to school but ... I feel like no hope because now I already work and have a lot of bills to pay.

Although most research conducted with refugee groups suggests that language barriers are high, this Karen woman’s experience also supports studies that suggest language ability alone does not determine successful resettlement. Lack of recognition of credentials and skills that the Karen women bring reinforced their marginality in Canadian society. Karen women could receive education in the refugee camps through NGOs and other humanitarian organizations; however, their responsibilities related to childcare often prevented them from being able to take advantage of this opportunity. Post migration Karen women were not given equal opportunities to advance in their educational goals. Moreover, Karen women described not being able to participate in the decision making process about the possibilities related to education and professional development. Many of the Karen
women who were educated found themselves working as settlement support workers. While it was advantageous to have a job in Canada, providing settlement support to members of your own ethnic group also posed significant challenges, as this Karen settlement worker explains here:

P007: … I always fret, I always work in the lower education. So I thought oh because I don’t have enough education so people will not respect me sometimes I think like that…. but for me right now I also … decide …that, yeah, I don’t have enough education, I know that not my degree in Canada so the way that I can help the family I will try my best, … to do what I need to do, I have to do… it’s just teaching but when I come to Canada I just feel … upset that I couldn’t work the same job, the whole my life I couldn’t work. And then I’m happy that I get this job and I stay work like not that very hard but my brain has to work hard, not my physical but my brain work. [Laughter] … I have to learn English, the challenge for me also English… And I have to ask the people to explain to me then I understand.

Having an education was important for the Karen women’s identity. Additionally, most Karen people viewed having an education as having a higher status. Karen women often called those perceived as highly educated as theramu (for a woman) or thera (for a man) which means “teacher”. This cultural norm had implications for providing settlement support to other Karen families since settlement workers were often used to provide translation services. In other words, safety and trust could potentially be compromised when the settlement worker was perceived to have higher status and therefore power. Conversely, women who provided translation vis-à-vis settlement work also experienced discrimination and increased distress because they lacked training in the field of settlement. In addition, there was an embedded assumption that the Karen women who provide translation services shared the same cultural perspectives and opinions as the
women for whom they were providing translation. In some cases this had the potential to reinforce power imbalances between women who have education and those who do not.

Almost half of the women interviewed were only able to obtain the Canadian equivalent of a grade three education. In addition, older Karen women had little to no exposure to education since many of these women had lived in remote mountain villages prior to arrival in refugee camps. These factors resulted in a variation in language, education and literacy ability between the Karen women. An older Karen woman explained her challenges of resettlement in the following:

P0035: Yes. Biggest problem is language. Even, you know, whoever nationalities, ... if we understand the language, if we understand English, then we ask for help or support from anybody, ... whoever... Can you help us to find a teacher who speak Karen? And find more interpreter for the doctor?

Not being able to speak English to ask for help created a context of isolation and social exclusion for older Karen women. For this woman, finding a teacher who speaks her language was important for her learning needs as an older adult. In addition, having interpreters available was perceived to decrease barriers involved with accessing health care services.

For childbearing women, accessing English language classes presented other unique challenges. A Karen woman describes her experience here:

P0028: I'm not planning to go to school anymore because school is really hard for me... when I moved to [City B] and I went to school, but my school time and my children's school time was very close so I had to rush in the morning, one I had drop her off at the other people house, and then other two I had to drop them off in the school. And I had to rush to my school ... gives me a lot of stress. I know that it's not
much work but it’s really stressful for me... I was planning to do it in the evening and my husband dropped me off to school, but after school then my children sleep so he can’t pick me up from the school. I’m very scared to walk home alone. A lot of time I’ll walk home with other people, but those people they don’t go to school every time because they work and [missing] school a lot so that’s a problem for me.

For women with growing families, attending mainstream language schools was very stressful because they had to manage when they could go based on their husband’s work and available child care support. Although some programs are offered in the evening, walking alone at night was a safety concern. These factors were barriers to being able to attend English language classes. Karen women spoke about English Language classes as “school” and valued the opportunity to attend; however, they also experienced many challenges related to literacy levels, geographic location and gendered responsibilities—all of which created increased resettlement distress.

### 4.2 Summary

Karen women conceptualized the state of mental health and well-being as being free from stress and worry. Stress and worry were related to resettlement stress and the process of migration. The decision to migrate was made in the hopes of a better future for their children and tied to accessing education. Having access to education was highly valued and viewed as a possibility for liberation. However, with resettlement came increased distress and responsibility for Karen women as they felt required to assist their children in schooling, and to take care of the health and well-being of their families. Many women who resettled were of childbearing
age and therefore where able to receive supports through early childhood programs that offered integrated health care resources and settlement support. However, the context of reforms impacted smaller NGO’s such as Early Years Refugee Programs, who were then constrained in providing equitable family services and supports to the Karen women. For example, gender intersected with education and language ability in different ways for Karen women than Karen men. There was a general perception by settlement workers and community volunteers that Karen women were learning more than men and that they had more capacity to access services. The structures of settlement support also had different impact for Karen women than the men. Social and structural factors such as lack of support for Karen men and settlement services geared toward labour, reinforced masculine ideals, potentially leading to increased resettlement distress for men in the Karen community. These factors also potentially impacted the gender relations between Karen men and women.

The overall lack of accompaniment support and lack of professional interpreters during health care encounters placed many women in situations of increased vulnerability and dependency. Similarly, settlement support workers, as well as health care providers, were challenged to provide the kinds of supports the Karen women needed in the context of limited time and diminishing resources. Vulnerability and increased dependency emerged as the major themes describing the Karen women’s experiences of resettlement. These experiences had a negative impact on Karen women’s identity, mental health and overall well-being, as many women felt disempowered and alienated in the context of modes of governance.
underpinned by efficiency discourses, individualism and self-reliance. Karen women enacted their agency despite experiencing barriers to accessing translators, by drawing on the support of family and friends to accompany them to appointments. In an effort to maintain their own personal safety, Karen women waited to disclose what really mattered to them in the presence of health care providers who they trusted and made them feel comfortable.

Karen women experienced tension between their need for help and support and their desire to be self-reliant and autonomous. Asking for help was not an easy process for Karen women, particularly for women with a pre-migration experience of trauma and violence. Older women were identified by Karen women as becoming increasingly isolated within their own families; younger family members were perceived to be learning English faster and working. For the Karen women, culturally safe and responsive services meant that service providers knew something about their pre-migration context, and that health care environments and behaviours were structured to provide more time so that their voices could be heard. These relational responses made women feel safe, comfortable and supported and empowered them to seek health services along with other social supports, independently. Karen women’s agency was also facilitated when there was a support person available who could provide advocacy and cultural mediation between themselves and the health care and/or social service provider. For women, having a support person with them was not only about language translation but about minimizing power differences between the health care provider and themselves.
In many contexts, cultural safety was facilitated when the support person was not of their own ethnic group. What mattered was whether or not there were established relationships based on trust. Thus, the role of the support person in health care encounters did not necessarily have to be someone from their own ethno-cultural group. Karen women also felt valued when they had opportunities to participate in decision making about their education as well as the use of interpreters. Many women experienced discrimination and inequities in access to health and social services as a result of reforms to settlement support; however, there was a tendency by settlement workers and health care providers to view these service gaps as an individual limitation related to learning. This often resulted in women feeling blamed, devalued and a burden.

Examining the Karen women’s everyday experiences revealed the way in which settlement supports both challenged and facilitated resettlement for Karen women and their families, and suggests that government policies and practices need to reflect an understanding of the larger political, economic and social factors that influence the differential access to social services and supports amongst refugee women and men.
5. EXAMINING COMMUNITY CAPACITY: HEALTH CARE AND SOCIAL SERVICE PROVIDER PERSPECTIVES ON SUPPORTING RESETTLEMENT AND THE MENTAL HEALTH AND WELL-BEING OF KAREN WOMEN

In this chapter I focus on the discussion and analysis of health care and social service providers’ views of the social and structural factors that facilitated or challenged community capacity to support resettlement and the mental health and well-being of Karen women in a suburban context, including their access to mental health services and supports. Although many of the findings overlap with Karen women’s experiences, this chapter provides a different analytic lens with which to further explore the structural and social processes of community capacity. In addition, this chapter adds a more in-depth analysis of the health and social service providers’ perspectives on culture, mental health and the needs of the Karen women. Major themes of health literacy and aspects of community capacity building (collaboration and partnership) and aspects of social capital such as reciprocity are used to frame the factors that worked, and those that didn’t, to support Karen women in the context of current settlement and health policies and practices.

5.1 Culture, Healthcare Provision and Karen Women’s Resettlement

5.1.1 Mental health, culture and health literacy—“Why are you bringing me here today? I feel well...”

Many service providers identified literacy and health literacy as barriers to increasing access to health care services for Karen women. Health literacy was viewed as a broad set of skills that were linked to both cultural understandings of
health as well as the ability to navigate systems of health and settlement services. A nurse practitioner (NP) describes health literacy in the following:

P0044: Nurse practitioner one: And problem solving skills and how to navigate a system. Literacy encompasses all of this, beyond reading and writing, it also – problem solving...

Having English language ability did not necessarily mean that women would be able to access health care services and supports. Having skills to navigate health care and other systems speaks to one part of health literacy, often described as functional health literacy (Nutbeam, 2008). Similarly, a Karen woman described how language ability was culturally perceived by mainstream settlement agencies:

P025: ... my English is not good ... I have a big problem when I first came ... my daughter she’s very sick, [name] she has a high fever ... but how can I go to see the doctor, I ask my counselor. She said I’m very busy now I can’t take you to see the doctor and then she said can you speak English? I said I can speak just a little bit .... she give me the map you can go to see the doctor, you can go there ... I feel very upset the whole night I can’t sleep... and then I ask my counselor again she said I’m sorry you can speak English so you can go by yourself... why I come to Canada like this? I can’t speak English, I didn’t know this situation why I come, if my daughter dies what can I do...

Language ability created a context of Otherness when recognition of cultural differences such as health literacy and education of Karen women were not addressed. These structural and interactive processes had a direct bearing on the health and well-being of Karen women and families. Moreover, these kinds of discourses—‘go by yourself’—are underpinned by broader neoliberal frameworks that value individualism and view dependency as a negative characteristic with over-reliance on the welfare state. Health literacy became a matter of survival, life and death for this Karen woman.
From another perspective, nurse practitioners spoke about the intersections of culture and health literacy and the challenges of providing health promotion and prevention services for Karen women and their families:

P0044: Nurse practitioner two: What else is working well? There are a lot of things. They have a lot of resiliency and you build on the person's resiliency and their knowledge. So “what do you use at home for this? How do you work this out? Back where you lived, what did you do for it?” And build on that. Because, you know, our answers within our ‘medically-oriented’ … society, doesn’t work sometimes and it’s not the answer. You’ve got to really work with the Karen population and what they need out of their visit. And, yes, sometimes, because people have been under trauma for a long time, they’re not aware of their own physical health. So something that you know is a serious health issue and you have to address it and bring it home to say “these are the reasons why I care and why I’m concerned about you,” … like in refugee camps overall, you only go get health care when you’re really sick, so the concept of preventative health is a big, big, big change and view. Like “why are you bringing me here today? I feel well.” [laughs]

It was recognized by NPs that many Karen women and their families had personal resources for managing their health and that gaining a better understanding of this could not only inform dominant health care practices about what Karen women did to maintain their mental health and well-being, but also develop a starting place for building health literacy, because NPs working in specialized immigrant refugee health clinics were aware of the structural challenges and determinants of health, such as health literacy that impacted the health and well-being of diverse newcomer groups. It was often perceived that Karen women and families did not have a cultural understanding of preventative health because of Karen women’s limited health literacy. As I point out in chapter four, some Karen women used their agency to navigate formal and informal social support systems in
order to navigate the structural barriers such as lack of language interpreters. In other words, a culturalist view might confine health literacy to lack of education, where as a critical health literacy perspective would examine Karen women’s agency in the context of their social networks. These findings have been supported by (Zanchetta et al., 2012).

However, as pointed out in the above excerpt, a partnership approach helped to promote health literacy for both the provider and Karen women. Trauma and living in protracted refugee camps were also expressed as factors related to the normalization of suffering. A settlement worker discusses mental health from a Karen perspective in the following:

P006: Culturally. We don’t really think about something – the roots of something that happen. We don’t really think deep down. We usually just look and judge something that’s appear, right? It’s good to look at this deeply and see what can we do and what can we change and what can help. It’s important to talk to people about this ... Just like I said, mental issues a big thing in the community right now. I don’t even know how to help. It’s stressful if we have to deal with it. It’s stressful.

As was noted by Karen women in chapter four, resettlement distress was related to Karen women's mental health as factors such as gender intersected with women’s class position. Although it was felt that it was important to talk about these issues settlement workers generally were not prepared and/or did not have the knowledge and skill to provide this kind of support. In addition, individual capacities were often overshadowed by discourses of trauma and constructions of refugee identity, as this community worker goes on to describe in the following excerpt:
P0036: ... it’s language and, ... education, literacy, ... it’s to me almost not brain function is not the right word but ... what will be their full potential like we cannot expect those people coming with trauma and illiteracy and like the people who have had the hardest life and the least amount of education, opportunity and they’re older will never learn to speak English fluently, will never like they, it’s maybe I shouldn’t say will never [laughter] their capacity.

Individual capabilities vis-à-vis strengths were overlooked through the dominant lens of “trauma” which constructs refugees as lacking agency, dependent and incapable of learning. It was recognized that many Karen women and families had possibly experienced pre-migration trauma, however, as I discussed in chapters two and four, broader systems of oppression such as changes to immigration policies regarding higher English language requirements and increased barriers for citizenship, imposed structural constraints related to learning.

The constructions of Karen women as traumatized had important implications for building health literacy, which aims to counter oppression through participatory learning (Freire, 1970). Although health professionals generally viewed building health literacy as a two-way process, there were other instances where cultural norms were challenged, for both the health provider and the Karen women, as was highlighted by another health care professional:

P0046: ...I had a baby discharged from [name of place] ... the public health nurse didn’t want to let the baby go home because they didn’t have a crib. ... the Karen don’t sleep with their babies in a crib – they sleep with their babies, they don’t have them in a crib. They have them on the floor and they’re beside them and ... they stay there. These babies are on a special mat on the floor. I’m trying to talk to this public health nurse about what’s culturally true for the Karen. It’s not putting them in a cage with bars, on a mattress. That’s not what they do. Everyone sleeps together, and they will sleep on mattresses, because you’ve given mattresses to sleep on. Otherwise, it’s the floor.
You don’t want the baby to go home until there’s someplace for the baby to sleep that’s safe... I just said “we’ll get a box. We’ll put the baby in a box.” ... Now you know, ... I’ve seen them with cribs in their home, and they’re using them for linen storage. Because people have given them cribs, right?

The overall lack of health literacy between the provider and Karen women created a cultural barrier. It was important for health care providers to understand that dominant Western practices were not necessarily acceptable child care practices for Karen women. On the other hand it was also necessary that Karen women be informed of potential safety risks of sleeping with their children. There was a need to create a space for increased understanding and mutual learning so that health literacy could be promoted for both Karen women and health care providers. Without increased knowledge there was a potential for mis-recognition of Karen women as unsafe mothers. In this example, the health care provider speaks to the need for increased cultural understandings and advocacy that was necessary so that the Karen woman would be able to leave the hospital with her baby. In a different vein, a nurse practitioner discussed bridging the gap between different cultural understandings of health and illness:

P0044: Nurse practitioner two: ... But at the same time, a lot of the issues in regards to mental health, social determinants of health and so on, transcend all the refugee groups. ... definitively, what she said about the literacy affects things because ... that affects your whole ability to access resources in your community and deal with social assistance and paperwork and stuff. Because I can see different levels of literacy and so on with different groups. And so I see the distinct difference in – even just keeping your appointments or knowing about appointments and how to take your meds and how to navigate a system between different populations that don’t have literacy and have some literacy or education before they came.
NPs perceived that health literacy was enhanced when social determinants of health and were integrated into the healthcare encounter. Moreover, differences and similarities within and between refugee groups determined health literacy and literacy ability. For Karen women, promoting health literacy was viewed as particularly important part of managing one's health and being able to access healthcare. For example, Karen women needed to be able to navigate health care systems in addition to being able to utilize and manage settlement resources, such as filling out paper work for housing and social assistance.

Culture and health literacy also intersected with gender and Karen women’s mental health related to family planning, sexual health and addiction. Although Karen women did explicitly discuss family planning, domestic violence and substance abuse, these factors were noted by several service providers as influencing Karen women’s mental health. A settlement worker discusses how promoting Karen’s health literacy, gender intersected with mental health in the following:

P008: I think because sometimes those mental health issues are seen through the day-to-day assistance with the day-to-day life that’s the reality. So say, you know, banking, right? So, for instance, say there’s an addiction so I would call an addiction somewhat of a mental health issue and but how that appears or comes to surface is if you’re helping a person with the banking and why are you helping them with the banking because there’s no money in the bank and why is there no money in the bank because either my husband spent it all or ...he doesn’t tell me where, ... the money is or he doesn’t give me the code or ... I need to put my money separate from his money so it’s helping with the day-to-day issues that is a vehicle where you see ... what are the mental health issues.
It was important that Karen women received settlement and outreach support because this provided an important information about intersecting factors that shaped Karen women’s mental health such as gender roles, and addiction. Similarly excerpts by community midwives discuss contextual factors influencing Karen women’s mental health:

P0042: Why birth control’s a problem? Because the men don’t take any responsibility for the birth control. In the camps they gave women Depo-privera. One woman shares, and most of them don’t. He’d [family doctor] had her in his office with bruises. He was lovely when he wasn’t drinking. And he was oppressive when he was...I got the public Health Department making home visits...I don’t refer every Karen woman to the Public Health Department. They want the Karen women all referred to the Public Health Department, but I personally think that’s singling people out unfairly. Just because you’re a refugee doesn’t make you a risk factor for public health. If your spouse is abusive, it does.

This excerpt suggests that refugee groups are constructed as a public safety risk and requiring ongoing surveillance. However, the Karen women’s mental health was intertwined with a historical gendered oppression where women did not have any access to education. The safety risk was constructed as Karen women’s experiences of violence in the context of the home and their spouse’s addiction and substance use.

As I discussed in chapters three and four, most Karen women described mental health as related to their resettlement distress, broader determinants of health such as education, and employment, findings supported by (Power & Pratt, 2012). It was also noted by Karen women that when asked about health concerns in general they discussed diabetes, hypertension, headaches and sleep problems. This finding is related to the fact that mental health often interrelated with physiological
symptoms of distress and, as noted by a Karen settlement worker in the previous excerpts, mental health is not a term that is culturally congruent or part of everyday Karen language. However, it was perceived by healthcare providers that promoting health literacy within Karen families may potentially mitigate issues related to Karen women’s mental health. As a community midwife explains in the following excerpt:

P0042: Well, the last husband I had in here – because his wife had had problems, right? She’d had problems at delivery. She’d hemorrhaged and she’d had two babies like ... 14 months apart or something. It's just not healthy for her. So I was trying to communicate, right? What I actually did is drew him a picture. I drew him the picture of the cycle, the menstrual cycle, and I drew the period – I wrote out the days. I drew the period of time where she’s most fertile. And it's generally from when the period finishes to just after she’s ovulated. I said, “this time, sperm meet egg, poof = baby. Egg die ... no pregnant.” He was happy with the picture. I gave him a photocopy [from] the book and he tucked it in his pocket to take home.

Although it was the general perception that Karen women had increased health literacy as a result of the gendering of services provided to childbearing refugee women and refugee women with young children, promoting the Karen men’s health literacy also had important mental health implications for the Karen women. Through the provision of simple pictures and visual aids both Karen women and men could gain knowledge about reproductive health; health literacy was enhanced in terms of family planning.

Many service providers viewed enhancing health literacy as a strategy to empower Karen women and support their mental health; many service providers viewed enhancing health literacy as a strategy to empower Karen women and
support their mental health. For example, building basic literacy skills and education was enhanced through early childhood education, as discussed by an early childhood educator:

P0020: ... the [early childhood education] workers really teach the parents through the children ... they’re learning a lot just sitting there with their kids as they’re doing numbers and colors and seasons and months of the year right ... it feels like if you teach through the child then it’s not embarrassing them or anything right? ... there’s a lot of things that the mums can still learn like street signs, the kids are learning ... the different street signs ...I probably wouldn’t have a class on that but they are sitting with their children and learning from the preschool teacher.

Karen women gained access to education and basic literacy through attending early childhood education programs geared toward the early childhood development of their children. Although many settlement support workers and service providers found it challenging to promote literacy, teaching through the children drew on the women’s capabilities and provided information at a level that the Karen women could understand. The use of visual aids was common practice amongst service providers to facilitate and enhance literacy for Karen women. Strategies such as these facilitated literacy development in a safe environment where Karen women felt comfortable, as in the above example, where women were learning with their children. Building health literacy was perceived as a health promotion strategy that was incorporated in various social contexts and aspects of Karen women’s day-to-day lives. In the following excerpts two community outreach workers describe how they integrated cultural understandings and utilized health promotion to build health literacy around nutrition:
P0045: women’s outreach worker three: ...What I’ve tried to do with a lot of [Karen women] ... is bring samples of grains and in particular barley and how they can add nutrition to their white rice, because that’s a big piece in their diet. So “how about if you start mixing a little bit of barley when you cook your rice?” And we have conversations about that. I find that my visits have to use a lot of visuals so that information gets through, even sometimes the visuals with food. ...”I don’t know” – or vegetables – “what that is. I have no idea. I don’t know that.”

Home visits to Karen women facilitated health promotion and included strategies such as introducing Karen women to different kinds of rice and vegetables to enhance women’s health literacy. Similarly, another outreach worker discussed how health literacy was facilitated in the context of Karen women’s homes:

P0045: women’s outreach worker one: I’m drawing pictures too. I draw a lot of pictures. [laughter] But that’s OK. ... like if I’m explaining ... – why you need calcium so I’ll draw a picture of bones or teeth – a big smile with no teeth. The teeth are missing or a crooked back or things like that. That’s what I do. [laughs] I just draw pictures.

By providing simple pictures and visual aids was also applicable in other contexts concerning women’s health. Although language ability was viewed as a determinant of health, building health literacy was viewed as a strategy to support mental health through empowerment processes whereby the health care professionals built on the capabilities of Karen women and their families. Empowerment also was supported when health care professionals created space for cultural exchange, where health literacy was viewed as a reciprocal process.

The integration and focus on the social determinants of mental health intersected with health literacy to support family literacy and empowered Karen
women to manage their own health. However, a multitude of challenges emerged, related to Karen women’s resettlement needs, which affected their ability to access health care services and settlement supports. In the following section, I discuss the intersecting factors related to the policies and structures of resettlement that challenged the receiving community’s ability to meet the settlement and health needs of Karen women.

### 5.1.2 Volunteerism and resettlement—“Flying by the seat of our pants”

In the current context of the global refugee crisis and national policies of resettlement of GARs, resettlement happens rapidly. Moreover, there is a growing trend towards refugee resettlement into local communities located on the periphery of metropolitan centers. These factors shaped the organization and distribution of service resources for the arrival of the Karen refugees in the community located in the Fraser valley region (City A). Another factor that shaped the resettlement process revolved around community volunteers who were from various faith-based institutions and who lived in the local community (City A) in which the second group of Karen GARs was resettled. A community stakeholder provides a perspective on the role of volunteers in the context of Karen resettlement in the following interview excerpt:

P024: Well the refugees were actually already in [City B] so they had arrived in 2007, I think some in 2006 and so there was like a group here before this program really got up and running. And what happened was that basically there was a group of volunteers just people in the community who had heard that they were coming, which refugee camp the government had committed to bring and assist and so because there was a prior connection with that refugee camp there was requests put in to bring them out to [City A]. And so it was a combination between that and the [name of immigration
agency] who couldn't find accommodations [laughing] that [City B] was kind of defaulted upon for them to come here.

The main way that the community (City A) heard of Karen resettlement was through faith-based community volunteers who had previous relationships with the Karen humanitarian organizations in the refugee camps. As I discussed in chapter two, faith based organizations played a key role in Karen resettlement. This finding lends support for Smith's (2008) analysis of how community experience with the historical resettlement of refugee groups plays a role in how newcomer refugees are supported. The majority of settlement workers had established close social ties with the Karen women and their families through local churches, thus enhancing social support and social capital.

Many community volunteers also worked within non-government organizations; this was important as almost all of settlement and health care organizations had no prior experience or knowledge of Karen people prior to their arrival. However, many community volunteers from faith-based institutions did not feel that they had adequate resources in place and/or partnered connections with other community services to meet the high needs of Karen women and their families. For both volunteers and Karen women, the experiences of resettlement were described as “scary,” as this community volunteer explains here:

P019: When they first arrived in July 2007 there was a community call out to the local churches organized by the Karen initiative to help prepare apartments and like fill up cupboards and furnish suites and things like that. And the church that I go to was part of that, ... to help settle the Karen because there was no services in place it was all being done by volunteers and more Karen were coming at that time. Well it
was scary at first because I had no idea, I mean it was scary for me because I was like helpless I can’t talk English to them.

While there was a connection with Karen women and families through various faith based organizations, many volunteers felt helpless in trying to support Karen families when they first arrived. It is notable that the responsibility of settlement primarily befell on various church-based volunteers, seemingly with very little governmental support. The lack of community preparedness prompted volunteers from faith-based organizations to advocate for increased services and settlement support:

S01: … I mean that was a struggle … at the time. … when the refugees first arrived we went over … and … made a meeting with the program manager for the multiculturalism department and he didn’t show up. And so then … we went over to [name] office and [name] office and we were just so fed up … we were volunteers and we were just spending all of our time. Like probably 3 people at that time were just spending 100% of their time …helping these really high needs families …and saw the need to kind of advocate … on their behalf. To the … government to the people that were sending them there … I think, from [our] experience of you know sending a group of refugees somewhere that’s not – that wasn’t ready to receive them, I guess, in terms of services.

The community of City A was simply not prepared across all institutional sectors, (i.e., local schools, hospitals and community centers) to support the high settlement needs of the Karen families. Community advocacy and coalitions of support were needed to build community capacity and garner federal and provincial support for increased services and community resources. The same volunteer speaks to the implications of the lack of resources and supports that this had on the Karen families:
S01: ... it was new to all of us. ... there was no answer. ... there was no handbook or anything of what we were doing. ... this huge number of refugees that are completely illiterate, completely you know, from the jungle, ... – into this community ... It was definitely challenging. And then there was things that would come up like medical emergencies ... Like I remember ... one child ... was really sick and we’d been going to the hospital with him for months and then for whatever reason the family didn’t understand that ... to renew his medication once it ran out. ... – he was like really close to dying ... it just kind of opened our eyes– the whole medical system, ... to navigate the medical system they needed somebody – that kind of knew what they were doing ... Like all of the volunteers ... were just flying by the seat of our pants cause we had no idea what we were doing and we had no idea what we were getting into, either.

The lack of accessible and safe health care access presented as a major barrier for the settlement needs of Karen women and families. Volunteers discussed that there was a great need to have professional interpreters there to ensure the safety and well-being of Karen families. These responsibilities fell on community volunteers, which created contexts of health risk. These risks to the overall safety of Karen families have been overlooked by outcome studies in BC (Marchbank, et al., 2014) which report and promote the inclusion of volunteers as an important aspect of settlement. In the following interview excerpt another community volunteer also speaks to the unexpected arrival of Karen women:

P0045: Participant one: I remember when they first came, and it was probably four or five years ago that they started coming to [name of women’s community program]. We were just told “there’s this whole group of women and they’re refugees and they need your help.” OK. We went “what do we do?”

There was a general recognition that the Karen women would have potentially different needs for resettlement; however, having prior knowledge might have better prepared community NGOs that specifically work with
marginalized women. Community volunteers reflected on the rapid changes of immigration policy vis-à-vis refugee resettlement and the effects this had on their local communities. The following interview excerpt with a community outreach worker reflects some of the community perceptions:

P036: But I think then we would have lost the opportunity for the church community and volunteers to be involved … Maybe in a few years when the Bhutanese have been settled because it kind of added a really kind of a really neat rich relational element to the Karen. And to their settlement and they do have relationships with a lot of people in [City B]. ...I mean people see them on the street oh there’s those people with those bags… So I think the idea of what they did with the Bhutanese in Coquitlam is great. ... Had the school been prepared I think things would have been a lot different, I really do. And the timing of [name] school board going through huge budget cuts ...which happened to be at the same time. So they kind of really didn’t have time to deal with this group of kids. ... So had we had a chance to ... strategize ... it would have been in the first six months of them being here not two years later right?

Comparisons were made between the comprehensive planning efforts made for Bhutanese refugees located in another city and the Karen resettlement process. The implication is that community preparation, including having information about the resettlement of refugees, helped to build the receiving communities’ knowledge about refugee groups and fostered social inclusion. The discourse of “those people with those bags” reflects the broader community reactions to the Karen as a distinct refugee group.

Local community schools were viewed as an important aspect of providing settlement support by Karen women as well as by service providers across service sectors. In addition, broader aspects of community capacity building needed to include various levels of government planning and integration with local community
organizations. As a result of community coalition building and advocacy work, there was a gradually increased awareness of Karen resettlement. Community responses reflected the strong relational ties that community volunteers had with Karen families. This was discussed by a community support worker in the following:

P019: ... There aren’t many volunteers actually doing settlement work because it’s now established. Also people know if they need help with paperwork, they can go to Settlement or ... help with the school – they go to the school. Medical appointments, maybe the odd time. But interestingly enough it’s church groups that are still bringing refugees here, privately sponsored ones. This year there will be probably up to maybe 20 new people in [City B], brought here by churches. Churches played an important role here, but didn’t necessarily do it the right way. Because everybody was new to it. They did the best they could, but ... I always say church people have good intentions but not always the best ways of going about it. I think there was a sense of learned dependence happened here, because they were so caring and so helpful, they did too much for this group. But they had to do it because there was no one else around at first.

Discourses of dependency were prevalent amongst community volunteers, which underscored liberal notions of individualism, manifested by funding cutbacks to settlement resources. However, the need for accompaniment and increased outreach support as expressed by Karen women was perceived as learned helplessness where the volunteers were doing too much. The discourse of dependency was also related to the concept of time, as it was commonly perceived by settlement workers that Karen refugees required more time for learning new skills and adapting to everyday life in Canada. As I described in chapter two, Karen women were cognizant of the shifting changes in settlement services and this impacted their identity and agency in the context of accessing the services and supports they needed to establish life in a Canadian context.
Current trends in government refugee processing and resettlement will continue to resettle GARs with similar targets as Karen refugees, (i.e., the admission of GARs with complex medical needs and high barriers to integration). While basic health care costs will continue to be covered under the Interim Federal Health program (IFHP), assistance with accessing specialized refugee health clinics which offer translation services are not covered for privately sponsored refugees. For example, they will need to shoulder some of the responsibility for the provision of financial, social and language support during resettlement of newly arriving Karen and other refugees.

5.1.3 Challenges to community capacity—“The funding dictates”

The building of community capacity through community coalitions necessitated and prompted the development of close collaborations and partnerships amongst various service sectors. However, major structural challenges to building community capacity were funding arrangements and the organization of settlement services. Funding was closely tied to partnerships between multiple service organizations as discussed by a community stakeholder in the following interview excerpt:

P024: So what happened was that there was a number of focus groups that were held and the public partners came together to because they realized that a collaborative approach is going to be the best way to serve these families and so a number of focus meetings were held to determine ...what were some of the challenges, the service, ...emerging concerns and, how can we address these issues? And from that a proposal was put forward and a memorandum of understanding was decided, was agreed upon by the public partners and then they put that in the proposal in towards the Ministry which is right now called [name]. And, and so funding was received from that Ministry as well as [name of NGO].
Collaborative approaches were viewed as the best way to address emergent community needs so as to build social services and supports for Karen women with young families. The development of public partnerships also was closely tied to funding since services such as the Early Years Refugee Projects did not receive direct government funding support. In the following, a community worker speaks to the challenges of building community capacity:

P036: ... In the beginning, all of the programs – everything was loosey-goosey, it had to be, because the needs were just insurmountable. ... We worked – all of us worked like crazy to just put out fires. That was two-three years of just putting out fires. Like medical emergency after medical emergency, after financial disaster, after major crisis-crisis-crisis –... first with the volunteers ... And then [settlement workers in schools] , ... But now that [name of settlement agency] is here and we’ve got a settlement worker, and [Vulnerable Immigrant Populations Program] is here and we’ve got these vulnerable people, now everyone is kind of finding their groove and then finding what they’re good at, like what their focus is.

Although community partnerships were originally developed out of capacity building strategies and partnered collaborations these, kinds of capacity building approaches were necessary to meet the complexity of needs and supports for Karen women and their families. With the changes in settlement reforms, newer services such as Vulnerable Immigrant Populations Program (VIPP) were developed as a way to address the dependency of Karen women and families. Karen families were now constructed as vulnerable refugees who experienced high barriers and therefore fell within the newly developed mandate of VIPP. However, this may unwittingly reinforce a growing public ambivalence toward immigrant and refugee groups as “inferior” and dependent on the welfare state. Importantly, many Karen women had
already established relationships with the developed existing community services that were more in keeping with their needs. The restructuring of settlement services also included the development of ISS of BC which opened an office in 2010 in City A, three years after the arrival of the second Karen group. Similarly, the EYRP program opened in 2009 in City A approximately two years after the Karen group’s arrival in 2007. Many Karen families had great difficulty in adapting to the ways in which services were now being provided.

However, the restructuring of services also strained collaborative relationships and community partnerships. While collaborative partnerships were viewed as building capacity, many service providers discussed constraints that came with collaborating as community partners and the confusion about who should provide settlement support. For example, much of the work of EYRP extends beyond early childhood development and support, and includes accompaniment of Karen women to medical appointments, and filling out everyday forms for housing, taxes and various governmental documents. As a result of the current reforms these services will no longer be offered and Karen women and families will have to navigate between the various services independently. For Karen families who were not able to navigate such a system, outreach support could be provided through VIPP through settlement workers.

Partnerships were increasingly viewed as necessary for the purpose of keeping existing programs running. This experience is described by a community stakeholder in the following:
P0024: ... I would say that ... [it's] precarious, shall I use precarious ... it’s a delicate path that we kind of walk along because we don’t want to come across as pointing fingers that you guys really need to change or improve or whatever. But the reality is that there’s, ...lots to learn and ... it’s not an easy straightforward thing when it comes to building capacity and serving people. So it is precarious and I think that that’s one thing that needs to really be reinforced is that and it seems like there’s a real need for building capacity.

Reforms to the settlement sector resulted in a constant state of instability and dependency for funding for local community run NGOs from other community partners. The precarious nature of community capacity is related to the constant changes in settlement reforms that occurred at the time Karen resettlement. Many community service agencies had to develop ongoing funding proposals to keep running. Securing funding became the object of many community programs and, in particular, programs servicing women. Here a women’s community support worker describes the nature of partnerships and funding arrangements:

P0045: Participant two: We got a “x” amount of dollars in 1996 and then we had an increase to – moms to six months, because it used to be only two months post-natal. But we got an increase to support families to six months post-natal, that was in 1998 and then nothing has changed since then. And so for us to support moms until their baby is one, we have to be creative and find other partners to support that window from six months to 12 months... Being community donors, the rec centers. Our agency – we partner with them to access other space and we piggyback off of other staff that are available to do child minding and all other kinds of things. We make the dollars stretch very, very thinly.

It was necessary to develop partnerships to provide community-run support services for childbearing women who had low income and lacked social resources. Similarly, non-government organizations such as the EYRPs needed to develop ongoing partnerships and proposals to keep their program running. The precarious
nature of funding programs for marginalized women and current changes to the settlement sector were further explained in this interview excerpt by a community stakeholder:

P024: ... So there’s been a series of different extensions ... we’ve had to submit different budgets .... Now presently right now we are in the midst of doing a formal business plan so previously we’ve just submitted some budgets but now ... we’re going through a renewal where we’re going over the whole project because there has been some major changes that have happened. The Ministry Job Skills Development has announced what type of activities are in scope and what kind of activities are out of scope and so that has impact on what we do and, and so we are writing up basically reviewing the governance that we have, the structure that we have, the activities that we have, the staffing that we have and submitting that business plan to the two funders ... and, of course, we’re in a huge transition because the whole settlement service, is being taken over by ... the umbrella of the federal government. And so, it’s moving from provincial management to federal.

At the time of this research the EYRP was continually operating under short-term funding contracts which were dependent upon partnerships with larger organizations for funding and who contracted out services to smaller NGOs like EYRP. However, these changes had direct implications for the kinds of activities that the EYRP were able undertake. In other words, providing settlement support, a much needed service for Karen women, was no longer part of the EYRP mandate. Changes to program mandates as a result of funding arrangements created tensions between the various community organizations and those working on the frontline providing settlement support. These challenges are discussed by a community frontline support worker as follows:

P036; All our program managers, ... They’re looking out for what funding stream they can access and then designing the program to match that. ...[I] do what I think needs to be done. But I think that ... will tighten – as policy changes over the next year, when it becomes all Federal, ... like, we’re going to have to conform to whatever the
funding dictates. The funding is for “this”, you have to say within these parameters. ...– I mean, there’s all this collaboration and partnership and blah-blah, it all sounds great. But everybody kind of is protective of their turf, right? And that’ll be the same everywhere.

Having to conform to whatever the funding dictated constrained the ability of frontline workers to provide support to Karen women. This in turn had direct implications for the Karen women’s ability to adapt to shifting policies. Karen women found themselves with fewer and fewer resources for support. In addition, Karen women did not have a voice in the decision-making processes that directly affected them.

Designing settlement programs around short-term funding streams meant that services became narrow in scope and mandated by larger immigrant service organizations. The focus on funding also constrained relationships between services providers as program managers became more protective of their turf. In the following interview excerpt, the same community frontline worker as above explains the impacts of settlement policy on Karen families:

P0036: The first year we were mandated to help the children zero to six that’s it. ... later ... our program recognized that we kind of have to help ... the whole family... The changes coming to the funding of our program, the streamlining of the government ... settlement and integration versus vulnerable immigrant something populations... the way the funding is going, ... anything to do with paperwork or documents or household – anything to do with families accessing the normal everyday things, I’m supposed to refer to settlement.

Streamlining of settlement services resulted in the narrowing of service mandates and fragmentation of settlement services. In addition settlement reforms impacted the ability of Karen men and women to access programs like EYRPs which
provided assistance with everyday things like filling out paper work. Here, an older Karen woman discusses how changes to settlement policies affected her everyday needs:

P033: sometimes letters in the mailbox, we don’t understand everything and we don’t know much about Canada. Any paper that we have to do something and we don’t understand is a problem also.

As highlighted by Citizenship and Immigration Canada (2006) as well as emerging literature on the intersecting factors affecting access to health and health care services of refugee women, older adult Karen women needed enhanced social support. A community outreach worker further reflects on these relational aspects of supporting Karen women in the context of current settlement reforms in the following:

P019: ...I always have to remind program ... managers, ...that – ... these moms that actually do come here we get an opportunity to work with them and their children, but as an outreach worker, I have probably five or six moms that never come here, that I visit. ... being able to do a little bit of paperwork is the only time they ever contact me or ... I can go there and say “hey, have you thought about this? How about if I come and show you and do this with you?” ... it could be registering for BC Housing or ... applications for premium assistance or something like that. It gives me something to go and visit and do with them. It gives me something to build relationship on.

And it’s when they have a relationship – with a few of the moms now that had maybe a baby, a first baby and I helped them find a midwife and whatever, did birth certificate, a few things like that because I could go to their home and do it – ... They have a relationship with me. Then they can come here and they’re comfortable coming here because I’m a familiar face... being allowed to be an outreach worker and go out to them is really important for not losing the ones that don’t come here.
Building relationships with Karen women was observed to be vital for assisting women with their resettlement. In particular there were some Karen women and families who would not access EYRPs, such as women without children who also required settlement support. In this context, placing restrictions on settlement support (i.e., outreach and accompanied services) directly impacted the Karen women’s ability to manage everyday tasks and responsibilities. Building relationships and trust was viewed as an important part of providing support for Karen women and families who could not access services. Similarly, a community stakeholder discusses here how Karen women valued having access to agencies in which trust and relationships were established:

P0024: ... And because they have a program where it’s comfortable and ...it’s very easy for them to be here. So it makes it easy for health to access the families rather than the families to access health it makes [community health service] easy to access the families because we have a site, there’s no barriers for the families so then they can come in.

The provision of health care services in a location in which Karen women and families were already accessing settlement support, in addition to early childhood education, was viewed as mitigating some of the structural barriers and the complexity of service systems which women would had to navigate. It was important that women felt comfortable, and the familiar location enabled the health care services to access families and provide a model of service provision in keeping with the Karen women’s needs.
5.1.4 Increased need for social support—“They leave you high and dry”

Many health care providers working within specialized primary health care immigrant and refugee clinics as well as public health services were also impacted by the lack of agency resources and the supports needed to support Karen women during their resettlement. A public health nurse discusses Karen women’s need for increased support in the following:

P0031: Nurse one: I recall when they came, and there were medical issues and they were settling in [City A], and we set up a clinic to update some of their vaccines, and there was some concern as to how are these people going to access and get back to the [name of refugee] Clinic for follow-up, and I’m not sure how that was resolved, whether it was through volunteers at the churches who were sponsoring the families, or through [name of NGO], somebody driving them there – taking them there – I’m not sure what the process finally was. But I think some of them did go back, but they were I think encouraged to find doctors in the area who would support them.

Reflecting on Karen women’s social contexts and determinants of health, public health nurses pointed out that it was important that health care providers ask about how women accessed health care clinics, as health literacy included drawing on Karen women’s personal, social resources. However, in many contexts public health nurses also discussed that the coordination of multiple resources for support may not be efficient in the context of reforms and so few formal networks for support.

However, many Karen families continued to travel to specialized immigrant and refugee clinics because they provided translator services on their behalf, through links with settlement service agencies. Overall, it was perceived that the Karen families carried the burden of responsibility to be able to navigate health care
systems in a Canadian context. A nurse practitioner (NP) reflects on the lack of resources and support when working with refugee populations in the following:

P0044: Nurse two: ... And it’s a big government issue overall, politically, because you bring refugees to your country and then you – ... leave them a bit high and dry. ... if you’re with the Karen population a day a week, you can see those issues pop up over and over again. ... I just think our system is failing quite a bit. There’s lots of positives and I mean to get to Canada’s a big thing, but some people are disillusioned by that too. You have this dream to come to Canada and then you’re faced with all these issues, right? ... It’s not easy. It’s not what you expected. I think the system’s not totally deficit, but I think there is a lot for improvement in regards to resources and support. If you know – equality, every Canadian deserves good housing and good food access and so on, and I guess that’s a universal issue.

Nurses explained that many Karen women and their families experience increased inequities related to accessing health care and other resources needed for successful adaptation. While resources such as health care, housing and government assistance were provided for Karen women and their families through settlement and immigration policies such as the Refugee Assistance Program (RAP), there was an embedded assumption that having basic resources would address issues of inequities in accessing services and supports. These underlying assumptions are reflective of broader egalitarian ideologies embedded within Canadian multiculturalism. The Canadian Nurses Association (2010) has advocated that equitable access and fair distribution of conditions are required for good health. However, as reflected in the above observations made by NPs, social justice must extend beyond the distribution of services and include integrated responses for addressing the social determinants of health.
Many health care providers, particularly NPs working with refugees, discussed that most of their health promotion activities were related to addressing social determinants of health such as housing and food security issues. In addition, the lack of resources for interpreter services was a central theme, cutting across all service sectors and a key factor underpinning the ability of Karen women to access health care services. This lack of access to health care services contradicts Canada’s commitment to comprehensive, universal and accessible health care services.

Another health provider discusses ethical and moral dilemmas experienced when working with vulnerable groups:

P0031: Allied Health participant... I think the only way it’s going to happen is – when we start seeing that there’s a lot of medical issues happening within this population, and they’re impacting the healthcare system. ... all of a sudden the light bulb is going to be “oh we better do something about this, because you know what, they’re eating up a lot of our healthcare dollars. ... To me, I just feel like ...It has to be a ...higher up. It’s a leadership direction, that this is a priority, this is how we’re going to work, and this is what we’re going to do. We can of course move things up and inform, but ultimately the decision making has to come from – it’s not within our realm. It is up at a higher level.

There was a general perception that health care providers felt disempowered about being able to shift policy. Statements such as “eating up healthcare dollars” underscore neoliberal values as a pervading theme in health care provision. From another perspective, nurses as well as allied health care providers experienced what Holmes and Gastaldo (2002) describe as forms of governmentality. As reflected in the above quote, many health care providers viewed themselves in positions of powerlessness. Although there was increased social advocacy by volunteer groups
during the initial arrival of Karen families, political action and social advocacy were not brought forward as possible strategies for fostering social justice with regard to health care access for Karen women. These views potentially reinforce the status quo where health care is viewed as apolitical and neutral, and, most importantly, increase the cultural risk for vulnerable groups that are disempowered through processes of systemic marginalization.

5.1.5 Accompaniment—“If we don't help who will?”

Efficiency discourses and the streamlining of services are examples of how neoliberal ideologies played out in the context of Karen refugee resettlement. As I discussed previously in this chapter, these structural changes impacted the provision of NGO programs such as the Early Years Refugee Programs, where best practices in settlement focus on decreasing the impact of trauma experiences by helping refugee women feel welcomed and connected (CIC, 2010a). In the following excerpt, a service provider discussed specific impacts that settlement reforms had on the provision of accompanying and therefore the Karen women’s ability to access health services:

P024: [Laughing] impossible, it’s impossible because what they’ve indicated is that there is to be no accompaniment of for to help and that [City B], has been the number one huge component of accompaniment ...  
R: Accompaniment to appointments?  
P024: To appointment, to registering for delivering at the hospital facilitating like just forms that are needed for diagnostic testing, ... that’s a huge component of what our outreach worker does. And they’re saying that would be out of scope... So the reality is that I can understand how the government wants to streamline or create
greater effectiveness in use of money that’s puts towards the families. ... I think that’s why some of these policies have been put in place but unfortunately what happens is it’s not as simple ... what it may look like on paper and the factor that’s not taken into is that there’s been relationships established with the families that then create stronger network and support system to enable families and build that resiliency and ability to move along that continuum. ...I don’t think that ...all of the families have say made a shift or even been made onto their list of if they’re deemed appropriate for that type of assistance and so there’s a quasi land right now.”

It was continually emphasized that building networks of support through relationships with Karen women and families facilitated their resettlement in terms of building Karen women’s individual capacities. These networks of support were being jeopardized in the context of the erosion of NGOs that facilitated the building relationships and outreach support. In short, the streamlining of settlement support meant that agencies such as the EYRPs could no longer provide settlement services such as accompanying Karen women to appointments. Again, this created a situation of health risk, and reinforced dominant ideologies of individualism. A community support worker describes these risks in the following:

P019: ... doctor’s appointments are challenging because they can’t get an interpreter there so they need someone to come with them ... between the frontline workers there are a number of interpreters available but there’s always a balance between [what] you really are capable of going by yourself and pushing them because ... Karen themselves are so intimidated they just have this sense, it’s actually very deeply ingrained in their culture that word I can’t do it.

As I discussed in chapter four, the Karen felt intimidated and unsupported when they were not able to participate in the decisions being made about them. In particular, Karen women were consciously aware of their lack of education and status as a result of their history of oppression. Frontline workers also felt
increasingly pressured not to attend appointments with the women, since outreach support was being restricted. The same community support worker mentioned above goes on to discuss the implications of diminishing support and responsiveness to Karen women’s health care needs:

P019:...So there’s some that we’ve pushed to say try, ... your son has a fever you know how to say my son has a fever for two days, he’s probably got an ear infection right? So that’s one, one side of the spectrum, the other side is pushing too hard and ... them not understanding what the doctor says, they really don’t understand it. And especially for serious medical things ... if they don’t have an interpreter available and they bring along a friend and between the two of them they get it, they can't follow the directions of take this medicine, ... they just don’t have enough English. And so ... you’re at risk there ... I’ve been in a doctor’s office where a nine-year-old daughter is my interpreter. Can she really follow the directions of a doctor and translate that to her mother, no, she really can’t. So if you don’t make the interpreters available you’re [going to] have people not following instructions, not getting well, not taking their medicine, ... But yet the more you have interpreters available the more dependent they’re becoming on an interpreter. So it’s, I don’t know what the right answer is but I just, it’s a challenge it really is.

In many situations, family and children provided interpretation for medical issues. This practice created situations of health risks for the Karen women and families. Due to time restrictions and lack of linguistic resources, outreach workers and health care providers used families and children as a last resort. In the context of the erosion of accompanied appointments through neoliberal policies, Karen women were increasingly expected to take on the responsibility of finding their own interpreters. A settlement support worker discusses the current climate of settlement support in the following:

P006: You accompany the client, you’re a settlement worker ... you are not allowed to go but we do it even though our manager said no
we do it because … its necessary unless you accompany the client nobody can serve the client and as far as like a healthcare provider if they don’t know how to speak the client’s language how can they help the client? …We’re not supposed to but if we don’t help who will?

R: So you, take people to the doctor or the nurse?

P006: … I do many, many times I do, … can I talk about the gap [?] because interpretation part is really important because, … I am not the interpreter I only speak the language and I’m not the certified interpreter so when it comes to liability issues it is scary.

Settlement workers were also positioned in situations of vulnerability and risk since they did not feel they had the qualifications to provide medical interpretation. Although settlement workers recognized a gap in settlement and health care services vis-à-vis the provision of interpreters, they felt morally responsible to not only provide translation services for Karen women and their families but to protect them. These practices are a reflection of Canada’s lack of official policy on the mandated use of interpreters (Bowen, 2001). This gap in settlement services was also discussed by another settlement worker as follows:

P008: You accompany the client, … well we have to help the client to look for interpreter by, you know, in here [City B] area it’s really hard to look for interpreter like I said if I want interpreter, the only interpreter they have available so even though it’s not our mandate we do that, those kind of services just to supplement.

For legal reasons, it is not within the mandate of Karen settlement support workers to provide interpreter services; however they felt morally obligated to assist members of their own community to access health care services and other supports that were needed. All in all, government streamlining of service resources vis-à-vis reforms to the settlement sector constrained support for Karen women.
across all service sectors. As a result of restructuring the settlement services, many service providers are changing their practices. This change was described by a nurse practitioner in the following excerpt:

P0044: Nurse practitioner one: There weren’t that many [language resources ] available. I think things are changing now. I think across the board, in the health authorities, we are mandated to use the [name of language service] team. And I think people are starting to change that, since they’re just grabbing anyone who speaks the language. People are learning you have to call, get a specially-trained, medically-trained interpreter.

It was increasingly acknowledged that a centralized system such as the provincial language services offers services for professional translators. However, the majority of public health nurses, as well as primary care clinics, were unable to access interpreter services through the provincial language resource, because the majority of the time the interpreters would not travel to City A. In addition, there were only a few interpreters for S’gaw Karen language. This also reflects the virtual absence of integration of language services in the metropolitan periphery and the lack of preplanning initiatives for minority language groups. In the following a public health nurse explains:

P0031: Nurse T: No, what happens is in terms of the interpreter, so historically I think when people come up against these barriers and challenges, they go directly to “oh I know somebody who can do this,” and this is not what we’re supposed to be doing. We’re supposed to be going through [name of language service]. Then that individual, that person at [name of service agency] becomes overwhelmed with what she needs to do.

In many cases it was simply not possible to access medical interpreters.

Therefore many health care providers had no choice but to call upon settlement
workers working in local schools or agencies such as the EYRPs. While this seems like an effective short term solution, settlement workers became overwhelmed because they were already providing settlement support to Karen women and families through their own agencies. In addition, they were not trained to provide medical translation which can also be a potential health risk.

It was assumed that accessing a centralized provincial language service would solve the gap in meeting the health needs of Karen women. However, this policy did not seem to mitigate health risks for Karen women. A community support worker provides a window into this complex problem in the following:

P0019: [name] worker who has been helping this family, knows all their history and has not handed the case over to VIPP. ... She tends to help them on her own time as a volunteer. ... she'll make all their appointments after school so that she can go. Because even in the schools, they are not allowed to accompany anymore, so she does it more as a volunteer. So where settlement workers in the schools used to be allowed to do some accompanying, ...Now nobody's allowed to do accompanying. But yet the same week, I had a mom -- she'd collapsed at the ... the lab I think. Been taken by ambulance to [name] Hospital. The person with her could interpret but they called me to come up there because she’d asked Emergency to get an interpreter for this mom who was now in a stretcher. But as long as that person who could speak both languages, who isn't a [name] Health interpreter, was standing there, Emergency would not get an interpreter because they just say “well you interpret.” And she would say “but I’m not a medical interpreter. You need to get [name of language service] ...medical interpreters to help you.” So she texted me to come to the hospital. I went in to sit with this patient so that this girl who could speak both languages escaped. So then the doctor and the ambulance driver came back and said “where’d the interpreter go?” I said “she’s not an interpreter. You need to call an interpreter.”

In emergency situations, lack of time made it difficult to access interpreters. Although it was convenient to ask a Karen-speaking settlement worker for language
interpretation, they were no longer able to provide “official” accompanied support due to the reforms. Asking the medical professional to call upon a professionally trained interpreter potentially strained relationships with settlement workers, outreach workers and Karen women themselves, since most health services, including mainstream hospitals were simply not prepared to call an interpreter. The situation had negative consequences for this Karen woman who was left without any clear understanding of her medical condition or how to manage it. The Interim Federal Health Program (IFHP) is premised on fairness and equality. However, the lack of legislative provision for mandated language interpreters and translators for minority groups reflects a growing inequity for minority language groups and contradicts the human rights and protection needs of refugees. In addition, the lack of equitable distribution of language resources potentially leads to unequal distribution of illness amongst refugee groups in comparison to Canadian born population and constitutes a human rights issue.

In almost all cases, settlement workers needed to expand beyond the geographic boundaries of their work to facilitate medical interpretation, including the provision of VIPP outreach support. The increasing restrictions on accompanied support, as well as the lack of coordinated services for Karen interpreters in the health care sector, resulted in increased inequities in health care access.

5.1.6 Structural violence—“Let me talk to someone who speaks English; I don’t have time for this!”

The lack of access to health care services caused by constraints placed on accompaniment access and the lack of available medical interpreters is a form of
structural violence that many, if not all, Karen women and families experienced during their resettlement in Canada. These experiences were systemic and did not only occur in the specific local community [City A] but also across geographic regions. Even in contexts where Karen women were accompanied there was a perception that health care providers did not have time to support these Karen women’s needs. In the following a community support worker highlights these structural barriers:

P019: ... I've had it with someone who was almost at the point where she could go to simple appointments by herself ... I was encouraging her go up to the desk, show your care card and they're going to ask your name and your address and I'll just stand back and you just try it. And she was quite confident like she was happy that she could do this and so the lady asked for her card and then what's your address? Well still understanding that when you say your address even though they've heard this ... you start with the smallest thing your apartment number and then it goes to your building number, your street, your town, your province, your country can’t, ... So ... she said her apartment number and her building number backwards, ... so then I stepped in and said it's actually apartment [number], the building number is this. The receptionist grabbed the care card, threw it on the desk and said let me talk to someone who speaks English I don't have time for this. So that just set that girl back like she for a year ... she was too afraid to go to a doctor by herself right?

Karen women did not have experience with making an appointment, nor had they ever lived in apartments with addresses, therefore these Canadian norms were experienced as completely foreign. The narrative of “let me talk to someone who speaks English” reflects what Tomasso (2012) calls the presumed colonial, white European origins of “real Canadians”. Cultural safety examined through the lens of postcolonial feminist theory draws attention to the race, class and gendered relations that play out in the context of Karen women’s access to primary health
care services. This form of Othering is also a form of structural violence because it causes harm to people (Farmer, 2005). In the above excerpt, the lack of knowledge about this Karen woman’s needs traumatized her and she was not able to return to a doctor for over a year.

Although Karen women were becoming increasingly literate, being able to make a health care appointment on their own was extremely challenging and required an understanding and inclusion of difference within primary health care services in their community. Therefore it was not surprising that many Karen women wanted to have someone with them who could advocate on their behalf.

Structural racism and violence were experienced by many women and support workers as they assisted women to access health care services. The same community support worker goes on to explain the effects of structural violence in community in the following:

   P019: So again every doctor’s office is different, it’s people, .... There was a misunderstanding right, someone didn’t believe someone that they really don’t have the same last name as their brothers and sisters. And this kid was traumatized by it like was really ... traumatized, very upset that the police wouldn’t believe him and said you have to come they’ll believe you if you’re white, right?

Karen names were often changed by visa officials to create surnames prior to their arrival in Canada. This resulted in family members having different names or names being reversed. It was not part of Karen culture to have a surname before arrival in Canada. Given surnames and hyphenating original names is a standard practice and reflects an assimilationist policy in which Karen names become more like Canadian names. Just as Karen women negotiated disclosing their personal
health concerns when a settlement worker was not present, women also appreciated having a trusted support person available to mitigate power imbalances in the presence of authority. Whiteness was perceived as having power, being educated and higher class, which was perceived as advantageous in negotiations between Karen women, families and authority figures, including health care providers. In the following I provide experts from fieldnotes June 7, 2012:

We chatted and x stated that some moms say that the doctor is nicer to me when they have someone come with them. We also spent a lot of time talking about the green house workers and the discrimination that many Karen feel mostly from the East Indian workers. We also spoke about the xxx optometrist and dentist that have worked with the Karen community in providing some medical services (need to get the list from x).

Karen women and families experienced different forms of racism and discrimination related to their names as well as having lower class status. Many immigrant and refugee groups work in lower paying jobs in greenhouses and farming communities in the region. However getting a job was difficult and competitive amongst immigrant groups.

In other health care contexts, forms of structural violence resulted in the inability of Karen women to receive health care services for their children. In the following interview excerpt a health care provider gives a case example:

P0031: Speech and Language participant:: ... For me, it was actually the family that initiated the ... interpreter to come, ... because ...Mom was getting frustrated. ... so that we could get her little boy in to be seen. ... she had come on multiple occasions only for the interpreter not to show up. They’d be sitting in the waiting room and then I’d have to try and find a way to explain to her ... I was like “... – we can’t do a session because the interpreter hasn’t shown up.” And then to send her away it’s horrible.
... I was never able to book an interpreter, ... they always were either cancelled or just not available. We weren’t actually even able to connect via the telephone, so it was often [name of agency] ... So I had a family who waited – ... nine months for their first appointment ... we can’t just call this mom and call her and say, “hey, how’s it going?” like we do with most of our typical families. ... it’s really, really difficult. So this family has gone without speech services for quite an extended period of time ... continuously, because there’s no direct way to get in touch with each other. Or to be able to understand each other. So ... finally –

She did come in ... without an interpreter. I don’t think she understood everything that went on during the appointment but we tried our best. ...I still don’t think I was really able to reinforce what her child’s needs were, even though there were no needs – thankfully – but the mom was still really unsure of everything.

In the above interview excerpt the health provider explains that a Karen woman had to find her own resources for language interpretation to access health care for her child. The lack of language interpreter services caused by systemic inequities caused significant moral distress for the health care provider as well as the Karen woman and child.

One of the main structural barriers that Karen women faced was connecting with their local primary health care service. The implication of transitioning to primary health care services from specialized immigrant and refugee clinics was described by an NP working in a specialized immigrant refugee health clinic in City A in the following:

P0044: Nurse two:...in regards to structure, I think we’re very setup very well within our clinics in the sense that both our doctors and us, we’re on a salary-based, so you have that flexibility for appointments. You know, you don’t have to tick the box because you have a timeframe and charge the dollars. So one of the barriers we find, because we are ideally a temporary stopover so people can get connected to the community and primary care providers within the
community – however, most of those are fee-for-service, so our whole system is set up without the access to provide that. Because if you have a fee – and it’s nobody’s fault, it’s just its facts, if you’re getting fee for service, …ideally our clients to integrate the best is to connect to GPs and they don’t – the time it takes, they’re not going to call up a language service. …– Canada does not have … a legal mandate … to provide language services for anyone with a second language. Alright, different health authorities take that on, but it’s not a government law throughout Canada, whereas say for Australia, it is. And I think America has that as well.

NPs described how structures for accessing language interpreters were set up differently between themselves and primary health care services; they viewed these structures as further contributing to inequities in access of health care services for Karen and other refugee groups. NPs were aware that many refugee clients do not access primary care services due to lack of interpreter services even when those primary care clinics were located within walking distance. Being a specialty clinic based on salary and not a fee-for-service funding structure meant that there would be more flexibility in the time needed to conduct a health exam and set up translation services. Flexibility in terms of time fit with the Karen women’s needs, as discussed in chapter four. NPs noted how proximity of settlement services also influenced health care access for Karen women as follows:

P0044: Nurse one: I think in terms of being fairly close to [name of settlement agency] it’s helpful because quite often patients who don’t have the language skills to call and make an appointment or they’ll just stop in – when they’re here in the building anyways or they’re close by anyways.

Having resources for settlement support in close proximity to the health unit was viewed as advantageous for Karen women since they could just drop in often without needing to make an appointment. Likewise, NPs and other health care
providers could access settlement workers if they needed to collaborate on specific issues related to social determinants of health such as housing or employment issues. This was in contrast to primary care health clinics where medical practitioners are paid a fee for service and have less time. Coordinating and setting up interpreter services is time intensive and primary care providers are also challenged to provide interpreter services for minority languages for diverse refugee groups. Thus, the lack of access to trained interpreters and restrictions on the health care provider’s time decreased access to services for Karen women.

Similarly, public health nurses located in City A faced significant challenges in the provision of health promotion and prevention services to Karen women and families due to the lack of resources for interpreters:

P0031: nurse F: one of the biggest issues we have with the public health nurses [with] this population-is accessing health services because of the language barrier.

Similarly, another public health nurse explained:

P0031: nurse Y: And you can only really do a half assessment, anyways, because at that point you’re just doing consent. ... – I like to get the whole picture. Like, how is Mom adjusting, how is the rest of the family adjusting. Are there are other things that I need to refer you to, or that I can help you access in the community. And when your interpreter isn’t available, or you feel crunched in your time, you can only do what has to be done instead of getting that whole picture. So it’s not really great care you’re giving, you’re just doing the minimum that you need to do. They’re missing out – I think. They could be missing out on services.

Many public health nurses identified that Karen women were missing out on potentially beneficial health services. The greatest challenge in promoting public health was not being able to communicate and connect with Karen women.
Although there were perceived difference between specialized refugee health clinics and primary health care services and public health, there were also some commonalities related to accessing mental health services for Karen women amongst NPs and public health nurses as discussed here:

P0044: NP, Nurse one: ... I mean, I don’t hesitate to refer ... at all. But the resources out there are really lacking. The mental health team – it’s a huge wait. It can be months long. I’ve actually received a phone call saying “sorry, we will not work with an interpreter.” I said “well, you know, as a [name of health authority] employee, ... you are required to work with an interpreter.” I mean, I understand for group therapy, which is mostly all that is offered, I understand ... how it might not work, not in that context. I think for us, one of the biggest challenges is that there’s not that many resources.

Similarly, a public health nurse explained:

P0031: Nurse F: We’ve been told if we have women with mental health issues to send the referral to [name of community mental health service]. They can’t really do anything but if there’s the need, they might set something up... You have to keep sending referrals.

Trauma has often been synonymous with refugee identity and has been foregrounded in many international and national statements regarding the need for protection and resettlement. While most refugee groups vary in terms of pre-migration trauma experience, most experience significant resettlement distress.

There were also some Karen women and family members who did have pre-migration trauma and histories of violence who were denied access to mainstream mental health services. According to CIC’s integration for a gender based policy framework, post selection strategies for minimizing risk of resettlement distress include the provision of trauma counselling and mental health support (CIC, 2006). There seemed to be a disjuncture at the community level for mental health service
provision, including access to interpreter services that support the promotion of the mental health and well-being of Karen women. Many nurses noted that supporting Karen women’s mental health and well-being was a significant component of their work during Karen resettlement:

P0044: Nurse one: We don’t see any straight forward sore throats here. We don’t. Like every person has pretty complex health care issues ... I would say, almost every week there’s someone who feels suicidal... I remember one Friday afternoon in particular, every single person I saw bawled their eyes out and ... you do the best you can with the situation. ... if anyone’s at absolute risk, then I will send them to hospital. I have called “Car 67” or have called the RCMP when someone floods the office ... So we really have to do a good job of this, trying to assess the risk. The suicidal ideation risk. But it is challenging– maybe ... they just feel down in the dumps and are bawling their eyes out and there’s three other people waiting for their appointment. [laughs] One time, this one woman, she just couldn’t – I think once she started to cry, she probably hadn’t cried for a long time, and it just kept on coming and coming and coming and it wasn’t stopping.

Not all Karen women needed trauma counselling or even a mental health referral; however, NPs witnessed the complexity of issues that Karen women were faced with during resettlement. In particular, the Karen women needed emotional support and sometimes increased nurse time in order to assess their potential safety risk. Nurses’ experiences suggest that many Karen women experienced suffering and psychological distress and required a safe place and support to express their emotions.

Public health nurses also discussed that there was a need for increased access to reproductive mental health service for Karen women. Public health nurses in a focus group raised the following concerns:
P0031: Nurse F: No, we would love to have one. We would love to have something to support women; we wish for one.

P0031:Nurse T: And there was that period of time where we couldn’t refer because they were only accepting clients that lived in [City A]. ..We had to send them to [name of hospital], and so then they have to cross the bridge. That’s scary. It’s scary for me and I live here.

Public health nurses discussed the scarcity of resources for specialized services for Karen women such as reproductive health services, and stated that they would love to have such a service in their community. Currently, Karen women have to travel across cities to access specialized health services; this requires extra resources and nurses’ time to organize someone to accompany the women, usually a settlement worker.

Coordinating services and resources was particularly challenging for NPs as well as public health nurses in the context of funding arrangements and limited resources. NPs provide another view into how funding services were negotiated amongst service organizations in the following:

P0044: Nurse one: Even the most straightforward appointments take twice as long when everything’s being interpreted. Even within this system, we’ve had challenges of clinics under the health authority not wanting to book interpreter because of the cost to their particular clinic, even though it’s within a health authority, they always want our clinics to pick up, book it for them, so they would be charged to our clinic.

Similarly another NP explained:

P0044: Nurse two: ... who’s going to pay them for their time to take with this population in regards to phoning? And there is no money that they have to order up a language service, unless they’re in a health authority, right? Your care provider office is – you know, a family practice office, doesn’t have the money in place to pay for translator services. So it’s a big, big issue overall.
Coordinating and negotiating for interpreter services came down to cost. It was perceived that specialized clinics and primary health care services did not want to incur the cost of payment for interpreter services. Although all health care services in the province of BC have a mandate to ensure accessibility of GARs to health care, health interpretation services are not considered necessary under the Canada Health Act (Bowen, 2001). In some cases telephone access was viewed as a time saving measure and alternative resource to the lack of interpreters available. In the following interview excerpt a NP explains the process of telephone interpreter access:

P0044: nurse one: We only use [name of language resource] interpreters. There’s a local branch where we can book an interpreter to be physically here, so we’ll book them for an appointment, which is best. And if they’re not available, then we use the telephone service and just put the interpreter on speaker phone.

However, as noted here, Public Health Nurses viewed accessing interpreter services over the phone as problematic:

P0031 Nurse T: I think in that experience, it speaks to part of our services is this connecting and relationship building. If there isn’t that service there, the interpreter service, we can’t do that.

Public health nurses identified that phone interpreting was not ideal and they preferred to build relationships with Karen women face to face. Relationship building was viewed as a key component to providing culturally safe services for Karen women. Mitigating forms of structural violence involved advocacy and enhanced supports for Karen women and families to provide safe and accessible health care. Facilitating connections between different kinds of health services, for
example, primary care and specialized clinics, involved addressing structural aspects of service provision such as funding arrangements, time constraints and negotiating and advocating for increased collaboration with mental health services. A community outreach worker discusses “coaching” as a strategy to potentially facilitate health literacy and increased access of health care services for Karen women in the following:

P0036: I ... accompanied the mom in for a check-up, I was given an opportunity to just kind of fill the doctor in on a little background on the family. ... once the doctor kind of understood what she was dealing with, ... the family's background was, she was very patient and really understanding. So then when the little boy had a relapse two weeks ago, I could just phone the doctor’s office, say “this is the situation. What should we do?” And the doctor gave instructions for testing and to come and meet her the following day. And was open to trying to book a [name of service] Language interpreter and work through that. So because she understood the situation, she was open to understanding that there are interpreters out there. She didn't know that [name of service] had interpreters. And I could coach their receptionist as to how to book that ... it changes the way people deal with them.

Although many primary health care providers felt constrained by time, the provision of increased knowledge about Karen women’s needs and information about their history was viewed as one way of addressing the health inequities that many Karen women and families experienced. The Karen women also felt supported when health care service providers knew something about them since they felt this mitigated some of the challenges they experienced in health care encounters. Another service provider discussed the need for increased recognition and knowledge of the Karen women’s needs in the following:
P024: Like I know that there’s a constant challenge when it comes to ... healthcare providers not being aware of interpretation services. ... I don’t call that capacity building I just call that collaborating it’s like you have this, take advantage of it. And so we’re kind of still back at square one when it comes to all that ... Say there was some service that, ...[Karen women] needed ... it just points to the great need that someone within all these different projects needs to have this on their forefront not on the back on the forefront we need to really make this a priority if these families are going to be served well.

It was stressed that there needed to be more collaboration across service sectors in order to serve the Karen families well. It was through community collaboration that relationships were formed across services so as to increase service capacity for Karen women. However, as discussed in chapter four, in almost all cases the Karen women would take on the responsibility of having to find their own interpreter. The inaccessibility and exclusionary health care practice created by the lack of professional interpreters, and discrimination and failure of accepting referrals when the Karen women required mental health services were examples of structural violence that occurred systemically for Karen women.

5.1.7 Building community capacity—“You have to work from a different model”

In the context of settlement reforms and structural constraints, community coalitions and network building necessitated the creation of relationships across and within multiple service sectors. This resulted in the reciprocal help and support that was needed to respond to the resettlement needs of Karen women and families. A support worker reflects on the social and structural aspects of capacity building:

P036: ... the refugee advisory committee personally at the beginning it really was a great place to go to collaborate but over time it kind of really dwindled and changed a lot. And then now for some reason it’s
become more program managers get together which is also important because the agencies need to collaborate especially with all the changing of the funding and ... the way that they’re making all the settlement funding [names of programs] and how it’s all coming through the federal government and they’re trying to eliminate duplication. It will be important that ... those, agencies are talking ... it would be a shame for that to stop so hopefully that will keep going ... Without that, I think [City B] would be a lot more fragmented and ... people would fall through the cracks a lot more. But because we get together regularly ... [to] make sure that no one is falling through the cracks. If certain programs are doing certain things, then we can do something different. Or ... we can alert other people: “watch out for this.” Or we can strategize on “OK, we see this trend of, let’s say, all the men drinking a lot. What can we do about that?” And start collaborating as a community.

Increasing community collaboration between those working on the frontline—volunteers, community stakeholders and health service providers—was viewed as integral to identifying problems and gaps so that Karen families would not fall through the cracks and gaps in services. Collaboration amongst different agencies was also viewed as a necessary practice in order to address silos between service organizations. Silos run counter to community capacity building since it requires collectivity to address the complexity of settlement needs of Karen women and families. The act of working together assisted various community stakeholders, public partners and service providers to draw on community strengths so that problems could be identified and mitigated. As a byproduct, community capacity building through collaboration was a form of resistance to address the increasing fragmentation of services brought about by settlement reforms. From another

---

45 By silo I am referring to the process in which services operate in isolation from each other.
perspective, public health nurses also reflected on the factors which helped to build those relationships which enhanced the community capacity to support Karen:

P0031: Nurse F: Then I also think that flexibility within the kinds of services that are provided, ...Being flexible, that may be some of this has to be done on their turf, developing that trust, developing those relationships. Also, ... prioritizing where they’re at in their lives. .... Working closely with the GPs because that’s somebody they trust, that’s something that’s cultural. And finding a champion within that group of individuals to be the one person that maybe can start to also be flexible in how they provide support to these families... – I think you have to work from a different model. I don’t think that the traditional model necessarily would work for this group of people.

The current cultural model of practice in which individuals are independent and responsible to access services on their own did not fit with Karen women’s needs as they required a collective response to address and support their resettlement needs. What was lacking was flexibility within and between service mandates of various programs. Building relationships and fostering trust required working closely with community leaders within the Karen community as well as health care providers and other community service organizations in order to develop practices that were culturally safe and congruent with the needs of the Karen women and families. Similarly, a community volunteer shared perspective on the need for service integration and flexibility:

S01: ... I think ... – one of the big challenges has been working with organizations that won’t collaborate, that won’t participate and share and you know work together instead of working against each other. And so I think ... we do collaborate together. Like we’ll call each other or we’ll you know bounce things off each other so that we’re ... supporting what each other ... not competing for clients ... you know?
Community collaboration was also perceived as supporting each other so as to draw on community strengths and potential resources. Mutual support was also an important part of capacity building. Working against each other was related to the tensions that can arise when collaborative relationships are forced and/or developed through necessary funding arrangements. Ultimately, strong community networks were necessary to support health care access for Karen women, as another health provider noted:

P0042: Well, it’s not just the Karen women. Developing relationships with other healthcare providers has been a process ... We’re very, very fortunate to have a good strong relationship with the healthcare professionals of [name] Memorial Hospital.

Community capacity building meant that it was important to build relationships so as to strengthen resources and support for Karen women. Having strong relationships with health care providers as well as community partners in local schools was echoed by public health nurses in community:

P0031: Nurse F: It would often be checking with [name] and finding out how the families are doing. ... And she would tell me about a family who had a little one in hospital, or even the principal ... and it was very often through those connections, those relationships with community partners as to what’s going on. And how can we support the moms, because the moms often bring their kids to school, and we catch them there. Education and having cultural sensitivity towards understanding what they’ve been through, and where they’re coming from.

As was noted in chapter four, school systems provide a valuable place for enhancing community support for Karen women and families and offered a place of direct connection with families through other community partners. Through making connections and building relationships with local community partners such as
settlement workers in schools, public health nurses were able to gain important
information about the needs of the Karen families. These strategies protected
communities from fragmentation and helped to address gaps in services. A women’s
outreach worker also discussed what community capacity meant from her
perspective:

P0045: women’s community support worker: And I think our
partners also have learned from us as well and ... – how we
communicate with the Karen families ... because – ...I do remember
[name] from [place] would come a few times, and it was like she was
observing what I was doing. And I thought “that’s fair enough,”
because that’s what it’s all about, is community development and
learning from each other.

It was perceived that community capacity building required shared
community learning facilitated through collaborating. For some service providers
community capacity building was seen as a process of development. In other
contexts, community capacity was viewed in terms of being able to respond
effectively to community needs. These differences were described by a community
stakeholder:

P0024: ... I see it collaborating ... as different from capacity because
collaborating can be organizing some things and setting things up but
... that may all be well and good but it doesn’t necessarily mean that
it’s the best scenario or its delivering the best service. And I see that
as what capacity is, capacity is the ability to truly give effective,
quality service. So I see them as being two different things and
sometimes one will lead into the other but I think that collaboration is
just step one. And then it’s a continuum ... like learning’s that we’ve
had from it because we want to let other agencies know too that we’ve
had to learn and we’ve had to adjust and hopefully ... they’ll realize
that everybody has to adjust because if you’re not adjusting ... you
don’t have the ability to make ...that service as quality as it could be.
Community collaboration did not necessarily ensure that community
capacity would be the end result. Rather community capacity building was
constantly negotiated on a continuum that was constantly in flux and that required
adjustment and changes in the policies and practices that resulted from current
reforms to settlement. For example, because smaller settlement service agencies are
dependent upon larger Immigrant Service Agencies (ISAs) for funding support, this
can set up an unequal power dynamic in which smaller organizations feel obligated
to shift their mandates and policy. This may have the effect of structuring services
away from the needs of Karen women and toward the interests of the funders.
Community capacity was viewed as a two-way process in which existing
communities also had to adapt to their changing community demographic. As this
community support worker adds, it requires a different approach:

P036:...it [community capacity building] really did a lot for the actual
whole Karen community ...appearing as oh these poor people that
need help. It’s like look what these people bring to our community,
their culture, ... their skills, ... Like one thing I have learned ... is
...people don’t naturally do this is look at the assets, look at what they
have don’t look at what they don’t have right?

Building community capacity meant that a different model and approach to
community response was needed. Such an approach recognized the strengths that
Karen women and families bring and the potential for building inclusive
communities.

5.2 Summary

The central themes that emerged from health and social service providers’
perspectives on supporting the mental health and well-being of Karen women and
families, revolved around structural constraints, feelings of powerlessness and discourses of dependency. Structural constraints were related to unstable funding arrangements, lack of integrated pre-arrival and service planning and dominant approaches to care that were underpinned by models of liberal individualism. An emphasis on streamlining cost and efficiency overshadowed both health and settlement sectors and worked against the needs of Karen women who required more time during medical visits as well as advocacy and support to navigate services. The fragmentation and structuring of services resulted in an ineffective and efficient use of existing public health resources. Nurses and allied care providers and settlement workers identified the complexity of needs and lack of community capacity to support Karen families. In some cases this led to moral distress and feelings of powerlessness in making change. Importantly, forms of structural violence that denied Karen women access to health care services, and mental health care reinforced Karen women’s marginality and resulted in traumatization.

Mitigating health inequities for Karen women included making space for promoting health literacy and providing increased education to service providers. Building health literacy was a viewed as a two-way process that empowered the women to develop the new knowledge and skills needed for everyday living, in addition to facilitating the provider’s cultural awareness of the Karen women and their needs. Promoting health through building health literacy was something that multiple service providers practiced across service sectors, and this contributed to Karen women’s empowerment. Social capital was fostered through the organization
of various church-based institutions and volunteers who provided advocacy, and the
development of settlement supports that were otherwise not available. However,
discourses of dependency echoed in many volunteers’ and service providers’ views
and reflected broader societal discourses and assumptions that cast refugees as
traumatized and in unequal positions of power.

Refugee advisory meetings were examples where meeting as a collective
brought together service providers across and within various service sectors to
identify the community learning needs. The inclusion of members of the Karen
community (i.e. settlement workers) who worked on the front lines with various
agencies including public health, facilitated community capacity building increased
formal social support systems for Karen women and families.
6. DISCUSSION AND SUMMARY OF KEY RESEARCH FINDINGS

6.1 Introduction

In this chapter I discuss the central themes that structured community capacity, including the social and structural processes that supported Karen women during their resettlement. This discussion is framed by three interrelated themes, systemic and structural violence in the context of community capacity and structures of primary health care; intersections of language, health literacy and gender; and community capacity. I compare the findings of this research with empirical studies discussed in chapter two and draw attention to the contributions of this research.

Informed by postcolonial feminist theories, intersectionality and cultural safety, I examined both the nature in which individual subjectivities of Karen women were constructed through wider political, socioeconomic and historical policies and practices as a homogenous at-risk group, often overshadowed by discourses of trauma, vulnerability and dependency. The critical theoretical perspectives (postcolonial feminist, intersectionality and cultural safety) provided a wider lens with which to examine community capacity; specifically these lenses foreground social justice in the context of community capacity and community capacity building. In this context community capacity is viewed not only as having a set of resources in place but also includes the recognition of Karen women and the inclusion of their voices in settlement policies. I argue that in order to build community capacity, a broader lens of social justice is required, that recognizes the
differential needs of refugee women and that promotes political advocacy, in order to redress systemic and structural forms of violence.

Karen women were subject to multiple forms of systemic as well as what Farmer (2005) refers to as structural violence.  

Farmers violence “considers violence to be induced by the Canadian sociopolitical framework and expressed by laws, policies, and practices that structure migrant [women’s] experiences in [Canadian] society” (Oxman-Martinez et al., 2007 as cited in Oxman-Martinez & Hanley, 2011). Karen women experienced Othering as a result of the erosion of settlement support, systemic lack of access to health care services due to unavailable interpreter services, lack of knowledge and recognition of their needs.

Moreover, Farmer, Nizeye, Stulac and Keshavjee (2006) argue that structural violence is embedded “in the political and economic organization of our social world: [however] they are violent because they cause injury to people” (p. 1686). Inequitable access to health and social services and supports created situations of traumatization, increasing distress and vulnerability for Karen women. Farmer et al. (2006) add that although a sole focus on structural interventions may not eradicate the inequitable distribution of disease, structural interventions may have a great impact on disease control and equitable health care resources. Structural violence draws attention to the narrow constructions of culture which verge on cultural determinism and essentialist understandings to explain suffering (Farmer, 2005). In

46 Drawing on the work of Johan Galtung, Farmer (2003) uses the term structural violence as a “broad rubric that includes a host of offensives against human dignity: extreme and relative poverty, social inequalities ranging from racism to gender inequality, and the more spectacular forms of violence that are uncontestably human rights abuses” (p. 8).
other words, this study examined structures (policies and practices) that represent
dominant cultural practices which unwittingly create contexts of social exclusion.

Although settlement services were initially available through NGOs, such as Early Years Refugee Programs (EYRPs), these services were increasingly restricted as a result of settlement reforms and overall lack of resources. The Canadian Healthcare Association (2012) has argued that the Interim Federal Health Plan was introduced for humanitarian reasons, and that the current budgetary constraints imposed by the federal government are unwarranted in light of refugee health vulnerabilities. In this regard I focus this discussion on the broader systemic reforms that intersected with policy and practice and impacted Karen women’s access to health care and social services and supports. The findings stem primarily from the standpoint of the Karen women themselves; I sought to give voice to Karen women so that their experiences can be used to inform policy and practice related to settlement, health care and other service sectors.

I begin by discussing the implications of systemic and structural forms of violence in the context of community and community capacity building. I highlight the structures and organization of health care services and policies and practices in the context of neoliberal reforms that were germane to settlement services and health care practices, and draw attention to the implications of these structures as they intersected in ways that directly affected Karen women’s identity and agency, producing situations of both advantage and disadvantage. In keeping with a postcolonial feminist analysis, findings from this research demonstrate how intersections of gender, race/ethnicity, and class are embedded in neocolonial
relations within Canada and stem from Canada’s historical white settler society (Abu-Laban, 1998; Tomasso, 2012).

I close this chapter with a discussion of the factors that “worked”. While there were several structural constraints, there were also forms of coalition-building and mutual knowledge-sharing and collaboration, which fostered reciprocity and learning across service sectors to build community capacity. Many studies have drawn attention to individual human capital such as the education, skills and experience that refugee groups bring to Canada. This research examined aspects of social capital in relation to the process of integration related to Karen resettlement. Aspects of social capital were fostered by community capacity-building strategies such as bridging across service organizations increased Karen women’s access to resources during resettlement and supported building literacy and health literacy. In addition, the role of faith-based institutions were embedded in geographic histories of the region and played a strong role in advocacy and support for Karen women and families. It is argued that these collaborations opened up new space for integrating the social determinants of health and the possibility of enhancing community capacity to support the mental health and well-being of Karen women during their resettlement.

6.2 Systemic and Structural Violence, Settlement and Community Capacity

Resettlement of refugee women and their families is an international humanitarian response to the global refugee crisis. Thus, resettlement is both an instrument of protection and a durable solution, but only so as long as the needs of
refugee women at risk are recognized and addressed in the countries of resettlement (UNHCR, 2013). According to current immigration policy in Canada, vis-à-vis IRPA, between the years 2005-2009, British Columbia received 786 Karen government assisted refugees (ISS of BC, 2010). The Karen women were recognized by Citizenship Immigration Canada (CIC) as arriving in Canada with the highest barriers to adaptation, which included low literacy, extended protracted camp situations and having minimal education.

Overall, there was a lack of infrastructure to support the resettlement of the Karen women and families, who were resettled in a smaller community located on the periphery of a larger metropolitan center. This was an important finding since Edgington and Hutton’s (2000) survey report on multicultural policies and programs, showed poor uptake and provision for interpreting and translation services, as well as a lack of equitable and accessible services for visible minorities located in the Fraser valley. However, evidence also suggests that diverse ethnocultural groups had a long history of settling in the Fraser valley and that this area was not necessarily homogenously European. This suggests that diverse (East Indian, Chinese and Aboriginal) communities remain invisible in their valuable contributions to Canada’s social and economic development. Canada’s history of colonization was also reflected in racial hierarchical structures in which the Karen refugees were Othered by other racialized groups working in the agricultural services sector in this geographic region.

In the context of neoliberal settlement policies there is an implicit value of efficiency, individualism and self-sufficiency so that refugee groups are expected to
integrate into Canadian society within a short period of time (Sadiq, 2004). Several Canadian immigration policies—including the repayment of an interest-bearing transportation loan by GARs, increased language testing requirements, denial of language classes for naturalized citizens (i.e. GARs over the age of 64 years) as well as emphasis on skills and labour employment—echo Canada’s earlier immigration bias toward economic migrants. Abu-Laban (1998) has concluded that immigrants who cannot provide an economic benefit are positioned as dependent, and a burden on Canadian society. Abu-Laden further argues that Canada’s preference for immigrants who provide economic benefit due to their human capital produce differential advantages based on class, gender and race/ethnicity. For example, the point system designed for independent immigrants ironically affects refugees in which

the so-called indicators of worth are socially constructed and reflect the prevailing Canadian political and economic power structure. This can be seen in the emphasis on knowledge of the French and/or English language and the fact that applicants to Quebec are judged on a different version of the point system, which awards more potential points for knowledge of French (Abu-Laden, 1998, p.76).

These policies “deny Canadian citizenship to the majority of the world’s inhabitants and show where the racist character of immigration policy has influenced gender and class composition for immigrant groups” (Abu-Laden, p.70). The findings from this research suggest that Karen women were particularly disadvantaged by their lack of educational opportunities pre and post migration. Moreover the majority of Karen women were unemployed and “dependent” on welfare support and the income of their male family member. Although Karen
women were perceived as having increased literacy and knowledge as a result of
their learning through EYRPs, they were disadvantaged by their dependence on
their spouse’s income. This set up an unequal power structure within gender
relations between Karen men and women as well as in the Karen women’s informal
social networks. Many Karen women relied on family, friends and even their
children to accompany them to medical appointments. Drawing on family may be a
preferred way to enhance health literacy and access health care services for some
refugee groups (Omeri, Lennings, Raymond, 2006; Zanchetta et al., 2012), however
an over reliance on family and the lack of formal support created contexts of
vulnerability. As previous studies suggest, drawing social support from like ethnic
communities may or may not increase social support and may cause unintended
harm for refugee women (Sadiq, 2004; Sherrell, Friesen, Hyndman, Shrestha , 2011;
UNHCR, 2013).

Fraser (1996) has argued that gender is the basic organizing principle of the
economic structure of capitalist society where there are fundamental divisions
between “paid ‘productive’ labour and unpaid ‘reproductive’ and domestic labor,
assigning women primary responsibilities for the latter” [and]...gender specific
forms of distributive injustice includes exploitation, economic marginalization and
derprivation.”(p.15). Fraser therefore argues for redressing gender injustice through
both distribution and recognition.

This study draws attention to a gap in research related to how gender is
constructed during resettlement and draws attention to the mental health and well-
being of Karen women and men when there is a socially constructed dichotomy
between women’s “domestic work” and men’s labour work. In the broader context of reforms, Karen men were socially excluded from resources such as EYRPs that enhanced learning through settlement support. Karen women and service providers reflected on the effects of the gendered differences and possible mental health risks, including increased alcohol use amongst Karen men. Although Power and Pratt (2012) have examined increased substance abuse during resettlement amongst Karen refugees in the US, this study draws attention to how gender intersects with language and literacy ability to produce axis of inequity and risk of substance abuse. In the absence of fewer supports and resources for Karen men it is possible that Karen men experienced resettlement distress which affected the mental health and well-being of Karen women. In some contexts Karen men’s domestic work was pathologized. However, for both Karen men and women, identities were shaped by broader systemic processes which constrained their ability to achieve substantive citizenship. Abu-Laban (1998) describes substantive citizenship as related to “equal rights and opportunities; treatment and life condition; and, not least, participatory involvement that ought to come from holding formal citizenship” (p.70).

While Canada will continue to honor its commitment to refugee protection through humanitarian programs, the Federal government plans to resume responsibility for settlement services, including the design, delivery and management of federally funded settlement services that were previously administered by the provinces (Kenney, 2013-2014). This means that the provision of settlement services will be tied to federal funding, which suggests a standardization of settlement policies and practice. Standardization vis-à-vis the
mainstreaming of settlement services has already imposed resettlement distress on Karen families. Karen women and families felt like they were being shuffled around from one service to another, ultimately not getting the help they needed.

Under current Canadian immigration policy reflected in the CIC Report on Plans and Priorities (Kenney, 2013-2014), the aims are to increase “efficiencies, strengthen program integrity, develop seamless service delivery of programs and services and respond better to the expectations of its clients” (p. 7). Under this policy, strategic family and humanitarian migration organizations that offers refugee protection for the displaced and persecuted will decrease their planned expenditures from 33.4 million to planned spending of 29.8 million (Kenney, 2013-2014). The erosion of smaller community-run NGOs, such as the one in which this study was conducted, occurred under a funding structure that was short-term and undermined by broader economic policies that reflect a neoliberal ethos. The lack of adequate knowledge and preparation for Karen resettlement created a context of cultural risk for Karen women, particularly in health care encounters. Drawing on Foucault (1977), Young (1990) suggests that there is a need to reexamine dependency where oppression involves power relations amongst groups; in this regard “the exercise of power as the effect of often liberal and ‘humane’ practices of education, bureaucratic administration, production and distribution of consumer goods, medicine and so on” (p.41).

In addition many volunteers, primarily from faith-based organizations, struggled to support Karen women and families when they first arrived. Although a great deal of support came from community volunteers, the discourse of
dependency was explicit within the receiving communities view on resettlement findings consistent with Marchbank et al., 2014. However, dependency and vulnerability cannot be disconnected from the way in which resettlement was more broadly laid out and reflected neoliberal ideologies of citizen self-reliance and individualism. As Kataoka and Magnusson (2007) have argued:

ideas about multiculturalism, respect for difference, and the possibilities for social change play at the edge of this model ... there is still a clear sense, both amongst the responsible authorities and amongst the broader population to which those authorities must account, that the main responsibility for adjustment rests with the newcomer rather than with the receiving society (p. 4).

In other words, a narrow distributive understanding of justice rests on discourse of equality and fairness. Reimer-Kirkham and Browne (2006) have argued, a postcolonial feminist reading of social justice moves beyond individualism and requires a collectivist orientation toward the root causes of health and health care inequities. For example, the community capacity to support mental health and well-being of Karen women would include building community capacity with Karen women and families in order to implement policies and programs that employ a knowledge of Karen women’s unique needs. As Reimer-Kirkham and Browne explain, drawing on subjugated voices provides expanded notions of social justice “toward inclusive, community-based, and relational ideals” (p.335). Although research has acknowledged that immigrant, refugee, ethno-cultural and racialized (IRER) groups do not access mainstream mental health as well as primary health resources, a postcolonial feminist understanding of social justice seeks to shift the
gaze toward historical and broader structural inequities at the intersections of race/ethnicity, class and gender. It is only by making visible the historicity of constructions of “difference” with associated marginalization, one begins to see sustained intergenerational patterns of ill health and human suffering not as examples of poor individual choices or flawed social communities but as the results of diminished life opportunities that have systematically and repeatedly been denied through a complex institutionalized policies and widespread societal discourses of Othering (Reimer-Kirkham & Browne, 2006, p.335).

Thus, discourses of learned dependency were entrenched in hierarchical power relations and embedded in increasingly restrictive policies regarding who can and cannot gain Canadian citizenship. In contrast, studies have shown that when models of service provision are promoted through meaningful engagement there is an increased capacity for NGOs, as well as health care services, to meet the needs of vulnerable groups (Browne et al., 2012; Geronimo, 2000; Lavoie et al., 2014). These relational practices move beyond a distributive paradigm of justice because there is recognition of embedded power relations and their impact and effect on the lives of individuals and groups who are most vulnerable to trauma.

It was in the broader context of settlement reforms that Karen women and families experienced resettlement distress through mainstreaming of settlement and health care services. Mainstreaming resulted in further marginalization of Karen women, as they experienced risks to their personal safety due to a lack of interpreters and settlement supports, which in many cases resulted in the provision of language translation by their children. Older women were particularly vulnerable because they had to wait for someone to make an appointment for them and were
often refused service in emergency situations. In particular, this affected Karen seniors who had lacked access to formal education pre migration and came with complex, chronic medical problems. These factors placed older Karen women and men at increased risk for resettlement distress, vulnerability and social exclusion.

Moreover, the current settlement policies and practices such as the Vulnerable Immigrant Populations Program (VIPP) have been implemented in order to address the needs of high barrier immigrant and refugee groups in lower mainland BC (Welcome BC, 2011-2012). I bring attention to this current settlement policy because it has implications for reinforcing discourses of dependency and construction of the “vulnerable refugee”. Through these programs, settlement workers were contracted out to smaller NGOs to provide outreach and case management services to women deemed “vulnerable.” Although Karen women appreciated outreach support, however, a program that explicitly labels all immigrants as vulnerable can unwittingly risk perpetuating culturalist discourses which construct refugee identity as traumatized and dependent, and lacking in human capacities. The Vulnerable Immigrant Program (VIPP) is based on a case management model underpinned by a neoliberal ideology of individualism whereby the focus is on individuals who are seen as lacking skills for successful adaptation.

In such a model structural inequities are masked by a focus on individual deficiencies. Vulnerability, as argued by Reimer-Kirkham and Anderson (2010) “is not a static or preexisting category belonging only to certain individuals affiliated with particular ‘marginalized’ groups; rather, vulnerability can be situational and dependent upon the negotiation of the micro politics of power in any given
Similarly, drawing on Wood (1985), Zetter (1991) poignantly adds that such a policy agenda objectifies refugees in order to portray convenient images which standardize and desegregate people into clear cut categories. Ultimately, these processes ascribe a set of needs to a client group based on presumed needs in order to satisfy underlying political interests of the state and institutional control (Pupavac, 2006). Similarly, Donnelly (2002) argues that “These organizations represent and reflect a society’s dominant relations and ideologies, which then become a standard against which other forms of social relations, behavior, and productions are interpreted and judged” (p.65). Without attention to the relational, contextual and intersectional factors that influence vulnerability, there is a propensity toward Othering and constructing refugee women as dependent. Young (1990) has argued that oppression is structural and occurs through systemic constraints on groups that are not necessarily the result of the intentions of a tyrant, rather...its causes are embedded in unquestioned habits, norms and symbols, in the assumptions underlying institutional rules and the collective consequences of those rules (p.41).

Thus, under hegemonic conditions (e.g. Citizenship and Immigration Canada’s implementation of vulnerable immigrant programs) the programs are viewed as acting in the best interests of newcomer groups. Expanding notions of social justice, Young (1990) argues that “Social justice...requires not the melting away of difference, but institutions that promote reproduction of and respect for group differences without oppression” (p.47).
The discourse of dependency was embedded in service providers’ views of Karen women and, as noted several times in the dissertation, reflected a neoliberal ideology of individualism. In addition, settlement workers frequently reflected on their views of how services were being streamlined in an effort to reduce duplication and cost containment. Fiscally driven policy agendas have had direct implications for relationship building and partnership collaborations that were developed to support Karen women and families. Under the new partnership model, NGOs have to compete for funding, which has resulted in inequitable power relations between organizations and increased fragmentation of services, leaving community-based agencies most vulnerable.

Findings from this study showed that Karen women experienced systemic and structural inequities based on their group identity. These identities were intertwined with the broader collective multicultural policies and neoliberal policy agendas. Geronimo (2000) has argued that adaptation is fundamentally structured by a multicultural paradigm where a one-size-fits-all approach potentially leads to the loss of linguistically/culturally appropriate services...without regard for inequitable power relations and where specific delivery strategies will tend to be determined by the needs and values of the dominant group (p. 11).

Mainstreaming of programs such as the Vulnerable Immigrant Population Program (VIPP) potentially reinforce a prescribed set of needs for refugee women and in so doing hold considerable institutional power to transform individual stories into a case or category (Zetter, 1991). Likewise, Hankivsky (2004) maintains that an imbalance of power can ascribe inappropriate needs and silence the voices
of those most in need of help. Thus, dependency and vulnerability must be examined in the context of settlement reforms which denied accompaniment, outreach support and day-to-day services such as filling out forms to obtain housing, welfare support or child subsidies. These issues for Karen families were basic needs that needed to be met in order to survive in Canadian society. However basic needs cannot be easily dissociated from well-being. Smith (1994) discusses, the “extent to which people’s needs are satisfied and their well-being enhanced depends on how this structure operates, and patterns of inequality are a matter of common observation” (p.138).

Karen women did not represent a homogenous group to which a single identity could be ascribed. For example, although the majority of Karen women did not have access to education, particularly older women, some Karen women had been teachers and educators in the refugee camps. Many other women were nurses and midwives. In general, the Karen women’s capabilities, and skills went unrecognized. This finding is similar to outcome studies conducted with GARs in BC which showed that even refugees that have language skills and education have not been able to access meaningful employment (Cubie, 2006; Sherrell, 2003; Sherrell, Friesen, Hyndman & Shrestha, 2011). Parallels can also be made with other immigrant groups who are not recognized for their education and skills and where many migrant groups experience lower income status when compared with Canadian-born counter parts (Satzewich & Liodakis, 2010). Satzewich and Liodakis suggest that there is now a “new colour-coded vertical mosaic, with racialized
minorities at the bottom of the socioeconomic structure and non-racialized, white Canadians at the top” (p.137).

Some Karen women came to Canada with pre-migration experiences of violence and trauma. For these women, services such as reproductive mental health and mainstream mental health services were generally inaccessible due to intersecting factors of health literacy, lack of linguistic resources and refusal of health care providers to take referrals. These factors resulted in women waiting until it was absolutely necessary to call on someone they knew who could help them and this created a context of health risk. Kirmayer (2008) has noted that “it is not poverty itself that is the cause of mental illness but the physical, psychological and social impact of structural inequalities and injustices that are evident to all” (p.10). Kirmayer goes on to discuss that it is the “unequal distribution of illness and of access to services in itself [that] constitutes a human rights challenge” (p.10).

Similarly, Oxman-Martinez & Hanley (2011) add that “if one conceives of health as a key human rights issue, lack of access to it is a form of systemic violence” (p.224).

Many Karen women were refused access to health services in general on the basis of language and their need professional interpreter services. This finding is similar to research by Gerrish et al. (2004) in the UK, where nurses and other health care providers often did not know how to access interpreter services. Nurses represent the largest health care discipline working within communities and institutional settings. In this research there was an implicit moral distress amongst health care providers related to not being able to provide comprehensive care in part due to the lack of interpreters. Leanza, Miklavcic, Boivin and Rosenberg (2014)
argue that the use of interpreters in health care contexts is an ethical imperative. Leanza et al. (2014) review of the literature about the use of interpreters showed that medical costs are often identified as a barrier for lack of interpreters, however studies also showed that the use of interpreters may actually reduce costs and improve quality care. In this research, public health nurses and local community hospitals did not know about accessing interpreters. Moreover it was felt by some that only when the Karen where “eating up health care dollars” would attention be paid to the need for increased support. In addition, nurses identified that specialized immigrant and refugee clinics differed in their experiences and knowledge about how to use interpreters in comparison to public health nurses and mainstream primary health care centers.

Leanza et al. have argued that a dedicated budget “provides structural incentive for health care practitioners to collaborate with interpreters” (p.95). Institutional guidelines have been established for working with interpreters in Canada in order to develop overall cultural competence and safe practices. However in the context of the Karen women’s resettlement into a smaller suburban community, there were extremely few resources, an overall lack of knowledge and reluctance of health care institutions to use interpreters. Interpretation befell on settlement workers who were not mandated to provide this service. Moreover, Karen-speaking settlement workers and healthcare providers experienced increased moral distress as a result of not being able to provide adequate health care and support due to the lack of interpreters.
Importantly, this study has drawn attention to the need for increased resources and language support for Karen women and families in order to mitigate inequities related to health care access. This structural constraint has not been adequately addressed as part of community capacity building initiatives for refugee resettlement across larger immigrant services in BC.

6.3 Structures and Organization of Primary Health Care Services

A central challenge for nurses and nursing in Canada is meeting its ethical mandate to achieve social justice in the context of broader neoliberal reforms and increasingly diverse and complex communities. The Canadian Nurses Association’s (CNA) position statement (2009) acknowledges that “cultural issues are intertwined with socioeconomic and political issues and the organization is committed to social justice as central to the social mandate of nursing” (p.1). The CNA position statement further outlines that governments are responsible for:

- Fostering a climate of acceptance;
- Enacting legislation to protect the individual’s human and cultural rights;
- Ensuring that healthcare organizations provide culturally competent care; and
- Provide funding to provide culturally competent and safe care and to conduct research related to diversity in the health care workplace (p.2).
Social justice from the perspective of the CNA is also embedded in seven primary nursing values that “safeguard human rights, equity and fairness and promoting the public good” (CNA, 2010, p.5). However, this reading of social justice is based upon a distributive justice framework which does not account for the political advocacy and voice of immigrant groups and individual refugee women, nor the specific differences amongst refugee women as a group. Drawing from a postcolonial feminist view, social justice must also include not only the distribution of resources but also the way in which immigration policies and practices structure the health and well-being of refugee women during resettlement. As Reimer-Kirkham and Browne (2006) have argued “…the interpretations of social justice in nursing tend to rely on distributive models within the realm of access to health care and resources, and interpret this as an allegiance to the principles of equity and fairness in terms of access to healthcare resources proportional to individual needs” (p.333). Findings from this research support a critical view of social justice in examining Karen women’s experiences of resettlement and the ways social policies constrained their individual and collective sense of agency, belonging and well-being.

One of the most significant findings was the Karen women’s need for safety and the difficulty they had in asking for help, since these experiences could not be disentangled from their history of political, social and colonial oppression. It was therefore particularly important that the social environments as well as the healthcare encounter itself foster experiences that were safe and accessible. However, as I discussed in chapter four, Karen women delayed help-seeking
because they felt blamed or discriminated against on the basis of their lack of language ability. In addition the lack of adequate time devoted to making space for Karen women to discuss their concerns was also a factor related to seeking medical care. This finding is consistent with Whitley, Kirmayer and Groleau’s (2006) research concerning West Indian immigrants in Montreal. Whitley et al. found that dismissive attitudes and a lack of time deterred the use of health care services. Language ability and lack of health literacy and education were also barriers to help seeking and access to health care services for Karen women.

Studies consistently report a language barrier as a major barrier to health care access and the lack of integrated, legislated use of interpreters in Canada for minority language groups (Bowen, 2001). Although Provincial Language Services in BC provides official interpreter services for healthcare institutions including primary care centers, there were no pathways established to connect with interpreters for Karen women. This was partly related to the limited number of interpreters available and the geographic location of the Karen women and families who were resettled outside of the metropolitan periphery (i.e. in the Fraser valley). Provision of culturally safe and competent care would include access to appropriate linguistic support for Karen women in health care contexts. This demonstrates a form of structural violence in which principles of fairness and equity were not upheld and a need for redistribution of linguistic support for women who come to Canada with minimal literacy and language ability. From the perspective of nurse practitioners (NPs) and public health nurses, the provision of professionally trained interpreter services was identified as a major barrier toward providing equitable
health care. This also included a general lack of knowledge of how to use interpreter services and the associated costs for integrating interpreter services within primary health care. This was a finding consistent with other studies in which refugees and other racialized groups could not access health care as a result of language barriers vis-à-vis lack of access to cultural interpreters (Bowen 2001; Johnstone & Kanitsaki, 2007; Gerrish et al., 2004; Merry et al., 2011). Critical readings in health literacy have opened the door for examining the broader contextual factors that promote health and well-being for women that come to Canada with limited access to education. Karen women navigated the service gaps by drawing upon informal supports, i.e., family and volunteers. In healthcare contexts some interpreting was provided by a settlement worker who was from their own community. This finding suggests that the practice of relying on settlement workers who are of the same ethno-cultural group to provide translation may in some cases be a barrier. Several studies have reported newcomer women’s experiences of stigma related to their mental health concerns and the need for enhanced formal knowledge of refugee women’s social circumstances service provision (Collins et al., 2008; Guruge & Collins, 2008; Kirmayer et al., 2011; MHCC, 2009; O’Mahony & Donnelly, 2010).

This study advances cultural practices related to refugee women’s health in that promotion of health literacy was identified as a participatory approach to enhancing learning about health and the factors that facilitate health access. In particular, Karen women acknowledged that integrating strategies for promoting health literacy such as speaking slowly, having prior knowledge about Karen women, allowing increased and flexible time frames, and provision of interpreters
and translators, were viewed to be culturally safe. Karen women sought health care services where providers knew something about them, where providers took time to listen and where the social determinants of health were integrated into women’s health, i.e. knowledge of the women’s social supports.

Moreover, Karen women described feeling safe and supported when provisions were made for enhancing health literacy in which they could participate in decisions being made about their health. This included their participation about use of interpreters and access to midwifery and community outreach support. Many Karen women had great difficulty accessing mainstream primary health care services outside of the jurisdiction of specialized immigration and refugee clinics. This was primarily related to the lack of available translators and structures of primary health care clinics where they needed to make an appointment. This finding has been supported by Power and Pratt’s (2012) work with Karen refugees in the US. Although health insurance was another structural barrier to health care access, Power and Pratt describe not knowing how to make medical appointments and confusion about how the appointment system worked; fragmentation and increased time-consuming steps were added barriers to health care accessibility.

Scheduling and making appointments, for example, were major barriers for Karen women accessing primary health care, since in the refugee camps medical services had been provided on an as-needed or drop-in basis. Making appointments required an increased set of competencies that women did not have, and resulted in use of formal and informal social support systems (i.e., family, friends, and settlement workers). Accompaniment was viewed by Karen women as facilitating
access to care—including making appointments. However, environmental factors and practices often did not allow for the time and integration of accompanied support that Karen women and families required. Increased time and flexibility have been supported by studies as advancing positive settlement and health care access (Browne et al., 2012; Sadiq, 2004; Smith, 2008).

The disjuncture between the amount of time Karen women needed to address their health needs and the actual time health care providers had available was partly related to contractual funding arrangements tied to models of governance that favoured efficiency and cost containment. NPs discussed how fee-for-service versus salary-based health care services influenced the amount of time and flexibility NPs and public health nurses had to attend to the special needs of many of the Karen women. In addition, a lack of service integration between primary health care services, in the settlement sector and public health created gaps in service provision. Although specialized immigrant and refugee clinics provided models of best practices in meeting the complexity of health care needs of diverse refugee groups, their short term mandates and the resettlement of GARs outside their jurisdictional boundaries made it difficult for Karen women and families to continue to access them. Sustained engagement with primary health care services was difficult when Karen women had to navigate between primary health care services that were located in different jurisdictional boundaries.

The added lens of cultural safety can also be used to critique health policy and practice (Smye, Browne, Josewski, 2010). For example Smye, Browne and Josewski draw attention to how Aboriginal peoples in Canada have not had equal
access to health and healthcare as a result of ongoing colonizing practices and policy structures which limit health care access and influence health disparities by Aboriginal people’s status. These authors point out that “First nation ability to access is determined by a complex question of ancestry (status or not) place of residence (reserve or not) legislation (province or federal)” (Smye, Browne, Josewski, 2010, p.13). In a similar vein, it can be argued that health and health care access for refugee women is determined by their status (immigrant or refugee, asylum seeker or government assisted), and language (English or not). I concur with Smye, Browne and Josewski’s arguments for a call to action and social policy in order to mitigate the racialization, institutional discrimination and culturalism (narrowly defining culture as individual traits while delimiting structural factors that impact health, i.e. immigration policies and racializing processes). In particular, these advances must be made in primary health care and mainstream mental health services in order to counter discriminatory practices and institutional harms that can result when adequate language supports are not provided.

In accordance with Calnan and Lemire Rodger’s (2002) position statement Primary Health Care: A New Approach To Health Care Reform, five principles of primary health care must include: principles of accessibility, health promotion, use of appropriate skills and technology, and inter-sectoral cooperation. In addition, Fownes and Robinson Vollman (2012) argue that there are three major impediments to accessing primary health care: lack of supports for inter-sectoral collaboration, fee-for-service remuneration schemes and funding instability. Nurses identified that overall, the current model of service provision and practice did not
work to meet the needs of Karen women, who required more time for appointments and support to participate in health care decisions.

Accompanied support and health care access for Karen women included but was not limited to settlement workers and translators. While these findings point to broader structural barriers they also uncover the need to integrate relationally-based approaches to primary health care access in which trust, reciprocal support and safety can be enhanced. As Pothier (2012) has argued,

A relational model goes beyond social determinants of health. By itself, a social determinants model would see the individual as a passive recipient. A relational model, in contrast, in emphasizing connections, sees the self as an active participant in relations with others. (187).

Processes of institutional discrimination and exclusionary practices were heightened in situations where gatekeepers of primary health care offices did not have time to allow for outreach workers to support Karen women to provide their medical information. The focus on the individual Karen woman in this context does not allow for the integration of outreach support with families who could provide contextual information. Many Karen women discussed that it was important that health care providers know something about them; this was viewed as a way to address some of the discriminatory practices they experienced. In the context of specialized immigrant and refugee clinics, the salary-based funding of GPs and NPs and integrated interpreter resources along with settlement support mitigated some of the structural barriers that Karen women experienced. This may move toward increasing relationally based approaches in which the Karen women’s individual agency and autonomy are supported rather than reinforcing culturalist discourses.
of dependency. Moving toward a social justice agenda, there is a need to counter the
dominant cultural norms and persistent inequities that refugee women experience.
This would include a broader conceptualizations of social justices. As the CNA
(2010) policy discussion paper on social justice points out, equity, human rights,
democracy, capacity building, ethical practice, advocacy and partnerships are key
attributes to promoting social justice.

6.4 Language, Health Literacy and Gender in the Context of Resettlement

In the following discussion I aim to highlight the intersections of health
literacy, language and gender as axes of inequities Karen women experienced, as
well as advancing health literacy research regarding refugee women by drawing
attention to the various ways that critical health literacy was used to potentially
empower Karen women and facilitate their access to health and health care services.

Consistent with other research examining barriers to health access, Karen
women identified that language remained the biggest barrier to accessing health
care services and settlement support. Many women who could not read and write in
their own language (predominantly S’kaw Karen) but who could speak a few words
of English were perceived as having health literacy, in comparison to their male
partners. This research foregrounds health literacy and gender as key factors
affecting gender roles in migration and resettlement. In contrast to previous
research that focuses on refugee women, this study highlights the social processes
that facilitated education and knowledge and gender. For example, it has been
acknowledged that women carry the primary responsibility for health care for their
families (Anderson & Reimer-Kirkham, 1998; Simich, 2009; Zanchetta et al., 2012). Fewer studies acknowledge the role of literacy and education and the way it intersects with refugee women’s agency. Findings from this study showed that while many Karen women lacked access to formal education, they had increased health literacy as a result of community capacity-building efforts across service sectors and programs that integrated the broader factors that shape refugee women’s health. Moreover, this suggests that Karen men may not be getting support services to enhance their health literacy and that may potentially disadvantage them. Pessar and Mahler (2003) have argued that when it comes to gender, “the pendulum has shifted in the opposite direction [where] the male migrant as a study has disappeared” (p.815). Kickbusch (2001) discusses that health literacy and education does not necessarily go hand in hand when issues of gender and broader social contexts are omitted from an analysis of women’s health. Vissandjée, Thurston, Apale and Nahar (2008) similarly draw attention to the fact that resources are not equally distributed between men and women in the context of migration. Findings from this research suggest that Karen men and the broader family contexts intersected with education, literacy and education (beyond the acquisition of the English language) to both challenge and/or support Karen women’s health and access to health.

It has been further argued by Peerson and Saunders (2009) that “social and interpersonal relationships may influence the context in which information is addressed” (p. 291). Environmental contexts and encouraging relationships facilitated the Karen women's basic literacy as well as their health literacy when
they learned with their children and as a family. These services are provided at NGOs such as Early Years Refugee Programs (EYRPs), where Karen women received direct health education and health promotion services. Previous policy recommendations about refugee women’s health suggest that social determinants of mental health can best be addressed when women receive services within a single location (Collins et al., 2008). While these institutional policies enhanced Karen women’s basic literacy, health literacy and education, Karen women were also burdened by their multiple responsibilities related to child care.

Limited funding and changes to settlement policies resulted in Karen men’s decreased access to resources and supports for building literacy and health literacy. This may have further implications for addressing Karen men’s health and the overall family health. Some evidence suggests that there is a potential for increased power imbalances and a risk of intimate partner violence when refugee men’s literacy needs are not addressed (Merry et al., 2011; Pottie et al., 2011).

Education was very important for Karen women and many were not able to pursue their education when they arrived in Canada. This study showed that Karen women were empowered when literacy was enhanced through various strategies that incorporate critical pedagogical approaches to learning, and when families were included. Drawing on WHO(1986) and its Ottawa Charter on Health Promotion, Nutbeam (2006) discusses that health literacy is more than transmitting information and developing skills to read pamphlets or successfully make appointments; rather, health literacy is about empowerment through community-based outreach support. In addition critical health literacy requires social action in
order to address social and economic determinants of health. Karen women benefited from outreach support when they were able to learn about banking and were empowered through community capacity building strategies such as learning how to support their children through school. Health literacy is an important aspect in community capacity because it requires alliances between health care sectors and education in which health promotion is done “with” people rather than “to” people.

6.5 A Move Toward Addressing Structural Inequities: What Worked Well?

Strategies for supporting the mental health and well-being of Karen women were grounded in building community capacity that focused on strengthening community relationships so that mutual collaboration, trust and reciprocity could be developed. Studies have also shown that increased resources and equitable access to health and social services have evolved from coalition building and the promotion of civic engagement in order to promote greater awareness and inclusivity of diverse groups resettling into smaller communities (Creese, 1998; Edgington & Hutton, 2000; Sherrell, Friesen, Hyndman & Shrestha, 2011). Specifically, pre-planning initiatives that targeted the attitudes and perceptions of local communities and which integrated multiple levels of government and services (e.g., health, school boards, NGOs) have been recommended for enhancing social services and supports for refugee groups in BC (Sherrell, Friesen, Hyndman & Shrestha, 2011). This may lend further support for community capacity building in which resources are redistributed based on increased recognition and social
participation of the refugee groups that are the most affected by policies and practices.

Research by McKenzie (2008) found that "values, norms of reciprocity, altruism and civic responsibility all need to be re-evaluated and renegotiated" (p.371). Smith (2008) also lends support to notions of behavioural flexibility and historical experiences of migration as fostering social inclusion of newcomer refugee groups. However, in drawing attention to the relationship between structures, community capacity and mental health, McKenzie argues that, in general, high levels of social capital are associated with environments with fewer risks for mental health in urban environments where migrants are settled. Drawing on the United National Centre for Human Settlement, (2001) McKenzie adds that "good urban governance extends beyond the conventional law-enforcing services that are the domain of the state, to imply a process of development that is participatory and takes into consideration the interests of all stakeholder groups in society, especially of the most excluded and disadvantaged sections" (p.372-373).

This study has drawn attention to collective cultural practices that structure and build community capacity through the collective workings between NGOs such as work provided by Early Years Refugee Programs, community volunteers, and settlement and healthcare services. In the context of neoliberal and multiculturalist policies, community capacity building was fostered through bridging social capital. For example, access to community agencies were enhanced by collaboration amongst front line workers and community refugee advisory meetings in order to bridge and form links between settlement and health. However, in the absence of
governmental support, and exclusion of Karen voices in the planning of settlement initiatives could be viewed as a form of tokenism and cultural imperialism (Young, 1990).

This study adds to the dearth of literature about the benefits of inter-sectoral collaboration and access to primary care services for refugee women. Through regular meetings with advisory groups, inter-sectoral collaboration was achieved to identify gaps in services as well as community strengths. Through these processes it was possible to enhance integration between services that were traditionally siloed from each other, in particular the health and settlement sectors. The outcomes of community capacity-building enhanced support and resources for Karen women and made them feel connected to the community. Community capacity-building strategies of mutual collaboration and the sharing of information and resources worked to significantly address gaps in service provisions so that the Karen women could draw on support through multiple community based organizations, including local schools.

The role of religion and faith-based institutions in settlement has had less attention in migration literature, although there is extensive research on the role of spirituality and religion and mental health (Koenig, 1998). Riemer-Kirkham and Sharma (2011) have noted that the role of religion/spirituality has not been examined in the intersecting social determinants of health and health inequities. This research draws attention to the role of faith-based organizations in their relationship with Karen women and families as an important complex aspect of structuring settlement. The historical and geographic contexts in which Karen
women and families were resettled played a significant role in promoting social integration. This was related to the fact that the region had been described as a community of faith developed by European settlers in the 1800’s.

Smith (2008) has discussed that settlement and integration occurs in a bidirectional process in which the receiving communities’ experiences of migration and relationships with newly arrived refugee groups promote behavioural flexibility. In this research, the majority of the Karen women and families identified as Baptist Christians, and shared a belief system with many community volunteers. Thus, religious organizations and associated NGOs play an important actor in social capital related to refugee resettlement.

However, consistent with Marchbank et al. 2014, many volunteers in this research perceived that their assistance contributed to higher levels of learned dependency. Donnelly (2002), argues that sympathy related to the cause of the refugees can easily turn into doubt in the context of social political and economic ideologies. Similarly, Young (1990) argues that “even when material deprivation is somewhat mitigated by the welfare state, marginalization is unjust because it blocks the opportunity to exercise capacities in socially defined and recognized ways” (p.54). Thus the broader discourse of dependency can be linked with unequal relations of power. As Pupavac (2008) has noted, welfare dependency compromises political autonomy of refugees and an ethos of permissive empathy negates refugee rights.

As I found in this study, many services were constrained by the lack of support and the dominant ideologies of refugees as having minimal capacity to self-
determination. Pupavac (2008) also argues that dependent protective relationships are linked with broader discourses that construct the refugee as a victim in which rights are transformed into governance as public policy. In the same way, religious institutions are also embedded in broader historical, political, economic and social processes. The fact that the responsibility for settlement befell on community volunteers has resulted in what some scholars conceptualize as compassion fatigue (Vasilevska, 2010) and relates to previous findings by Creese (1998) in which there is a significant lack of support for settlement workers who also experience moral distress. Kirmayer (2008) argues that

> Asserting and protecting human rights does not mean simply drawing a line in the sand and intervening forcefully in emergent situations, but depends on fostering a dialogue that includes the voices of the oppressed, those who desire change, and the conservative elements of a culture, community, or society that resist it (p.28).

Thus, in order to achieve broader goals of social justice, support workers and volunteers require enhanced support in providing services to refugee groups who come to Canada with complex needs. In particular, increased support is needed for the gendered aspects of women’s lives. Findings from this study suggest that without a well-developed infrastructure to support the front line workers, refugee women are at risk for negative mental health outcomes. Relationally based partnerships formed foundations of public governance that provided a holistic and more comprehensive approach to the provision of services for Karen women. Moreover, these processes highlighted the interdependencies required to build mutual support.
There is a need to re-conceptualize community capacity not only through a narrow distributive paradigm, but also from an equity perspective in which differential needs of women are recognized. For example, Karen women were able to benefit from the development of a community-run organization in which multiple services could be provided at a single site and where Karen women had input as to what they needed. This addressed some of the gaps in service and the structural inequities that many Karen women experienced, and also enhanced equitable access to health and settlement services through tailored approaches that addressed literacy and education.

Other resources, such as health promotion and prevention services, were also enhanced when Karen women were able to receive health education, dental screening for their children, and coordination for interpreter supports at a single site. In addition, strategies for building health literacy was enhanced by the work of public health nurses who provided education about multiple health related topics, within NGOs such as the Early Years Refugee Programs. The local library also provided enhanced resources for early childhood education by allowing library service personnel to provide storytelling during staff shortages at the NGOs in which this study was conducted. These practices were the result of fostering relationships across service sectors, e.g., local schools, public health clinics and local libraries. This model served to provide integrated networks of social support which promoted the safety and well-being of Karen women.

Karen women were also empowered to participate in learning strategies that built upon their capabilities and strengths. This model of service provision is
consistent with current practices that address the diverse needs of women with histories of trauma and violence and who have experienced significant barriers to care (Collins et al., 2008; Peck & Capyk, 2012; UNHCR, 2013). Peck and Capyk (2012) have argued that building community capacity for trauma-informed practice does not require trauma counselling per se, but, rather, that trauma informed practice include “various educational initiatives with partner organizations that provide a large range of community services” (p. 253). This would include training for service providers in four main areas including: awareness of trauma effects, understanding of client contexts, client empowerment and fostering safety through relationships and trust (Peck & Capyk, 2012).

Karen women also welcomed outreach support where they could receive health promotion strategies in their own home environment. Increased outreach support has also been welcomed by other refugee groups (Omeri, Lennings, Raymond, 2006). This also facilitated relationship building with public health nurses and other community outreach workers. This finding was particularly relevant because of its merit as a strategy for reducing social isolation that many refugee women experience resettling into new communities (Merry et al., 2011), i.e., they could connect with services and those individuals could assist them to make other connections in the community. Another significant finding was that the “coaching” and community development work undertaken to increase provider (primary health care organizations’) knowledge of the needs of the Karen families’ needs; this served to facilitate access to health care services as well as other services. Coaching facilitated knowledge sharing amongst community providers and
mainstream primary health services. This facilitated increasing awareness of Karen women’s needs and also made space for the Karen women’s voices to be heard so that interventions could be tailored to their needs. Kirmayer (2011) has argued that there are at least three main reasons for recognizing the individual’s cultural background and identity in health care. These include, first, a recognition of the individual differences that result from not only biological determinants but also social and cultural variations that may be causing health problems; second, Kirmayer adds that “cultural differences demand recognition for more overtly political reasons because they are associated with health disparities that affect whole groups of people defined by culture, race or ethnicity” (p.411); and third, there are structural reasons where “disparities reflect histories of racism, discrimination, violence, and exclusion that contribute to maintain structures of inequality [and] that are major determinants of health and illness” (p.411).

Enhancing community capacity, therefore, must also be examined through the lens of cultural safety to redress the inequitable social relations amongst refugee groups and build social capital. Labonte, Polanyi, Muhajarine, McIntosh and Williams (2005) argue that theories of governance (the role of democratic and participatory forms of government in creating health promoting conditions) if community capacities/organization (the role of social networks, economic activities, services programs and research itself [is needed] to build local ability to sustain health and to change unhealthy living conditions); and of power (the role of social and psychological power relations in creating health or disease, and in building capacity to ensuring participatory democracy) are all important (p.12).
In summary, Karen women experienced many forms of structural violence which hindered their access to the services and supports they needed to meet their health and settlement needs. The erosion of community programs, the lack of tailored support and language-based services, and the limited availability of providers to promote health literacy, created barriers to the Karen women’s successful resettlement, and has a negative impact on the mental health well-being for many of the women. Underpinned by ideological structures of neoliberalism, and fiscally driven policy agendas, constrained collaborative relationships between service organizations and created unequal power relations, ultimately narrowing service mandates and moving away from equity oriented models of practice.

In some ways these challenges might have propelled the need for increased advocacy and building community capacity in a geographic region where there were no resources to support Karen women. Mutual collaboration with front line community workers and Karen settlement workers fostered development of reciprocal relationships of mutual support and relationally based partnerships which provided a more holistic approach to meet the differential needs of the Karen women. Culturally safe approaches were facilitated by addressing social determinants of health through health literacy, providing safe environments during health care encounters (i.e., language translators women felt safe with, and allowing more flexibility and time). These approaches empowered the Karen women and supported their learning. Likewise, health literacy facilitated settlement and healthcare providers’ understandings of Karen women’s needs.
7. RECOMMENDATIONS FOR POLICY AND PRACTICE AND CONCLUDING COMMENTS

In this final chapter I present my recommendations based on the findings of this study regarding the community capacity to support Karen refugee women’s mental health and well-being in the context of resettlement. I begin by delineating the overall framework for addressing the following policy and practice recommendations; the concepts of culturally safe and trauma- and violence-informed policy and practice provide the scaffolding of this framework. I argue that in order to meet nursing’s ethical practice standards for social justice, there needs to be increased political advocacy and increased integrated support for Karen women and other refugee women who arrive in Canada with complex histories of trauma. Thus, social justice must include the voice and perspectives of the Karen women, recognition of the differences between and within refugee women, and a redistribution of services such as language supports across geographic regions.

In the final sections, I discuss my critical reflections on this research and provide recommendations for future nursing research, related to refugee women’s mental health and resettlement. I conclude this chapter with my overall methodological reflections and contributions of this research.

7.1 Culturally Safe, Trauma- and Violence-Informed Policy and Practices

Culturally safe and trauma- and violence-informed policy and practice is the scaffolding for the conceptual framework I am proposing in order to mitigate the potential harms caused by institutional policies and practices that impact refugee
women. In order to operationalize this proposed framework it is necessary for nurses as well other care providers and community workers to address culturalist discourses and practices by examining and critically reflecting on structures (policies and practices) that create barriers to equitable health and health care practices for refugee women. Canada’s explicit multicultural ideology is embedded in mainstream mental health policies and practices in which cultural difference has been narrowly defined by individual-level attitudes, values and behaviours. However, as I argued throughout this dissertation, a lens of cultural safety was used to unpack the micro and macro relations of power enacted through dominant cultural structures, institutional policies and discourses which reinforced an ethos of liberal individualism, leaving Karen women and families “high and dry” in the initial phases of their resettlement. In order to transform policy, there needs to be greater emphasis on the structural aspects of health and settlement provision which constrain agency of refugee women and their access to social support systems.

Drawing from the research evidence to date on the mental health and well-being of refugee women during resettlement, it is clear that there needs to be a radical shift in resettlement and health care policy in order to better meet the needs of refugee women who have been recognized as having significant barriers to mainstream cultural models of care and practice. Recognition of the Karen women’s social and historical context can nurture their mental health and well-being. In response to the findings of their research in primary health care with people marginalized by social and structural inequity, Browne et al. (2012) argue that a framework for addressing inequities for primary health care organizations must
seek to promote the integration of health determinants and intersecting factors that
determine the health needs of vulnerable individuals and groups; they recommend
equity-oriented approaches that include the incorporation of contextually textually
tailored, culturally safe and trauma- and violence-informed policies and practices.

Trauma and violence however, must be re conceptualized in the context of broader
systemic structures that reproduce inequities in health and healthcare (Oxman-
Martinez & Hanley; 2011; Waldron, 2008). This study showed that Karen women’s
mental health and well-being was shaped simultaneously by systemic inequities and
a lack of infrastructure to support them, which reinforced Karen women’s
marginality and social exclusion from substantive citizenship.

Drawing on the World Health Organization (2008) the Canadian Nurses
Association (2010) has argued that “Social justice is a matter of life and death…”
(p.3). This study highlights how lack of language translators, formal social supports
and government funding all played a role in shaping settlement resources which had
negative mental health consequences for Karen women as well as other community
members (e.g. moral distress and compassion fatigue).

NPs and public health nurses and allied health care providers working in
primary health care systems have advocated that there needs to be a different
model in place in order to meet the needs of Karen women and other refugee
groups. New approaches require creating pathways for the integration of minority
languages across service sectors and health care institutions. Kirmayer (2011)
further argues for structural changes in the health care system (e.g., allowing
adequate time and resources for intercultural communication using interpreters
and culture brokers, attention to diversity in the workforce, education of practitioners to increase their social and historical background knowledge, moves toward patient empowerment, giving voice to ethno-cultural communities in the governance, and the administration of health care institutions as well as policy planning). The recognition of cultural differences, therefore, can lead to “structural and systemic changes that speak directly to a maldistribution of health care resources” (Kirmayer, 2011, p.418).

As other research has shown, cultural constructions of the identity and trauma of refugee women are embedded in histories of colonization, marginalization. Therefore, an understanding and application of culturally safe and trauma- and violence-informed policy and practices can begin to shift the gaze away from a primary focus on the individual (refugee) woman as an autonomous agent and towards recognizing the sociopolitical, economic and cultural practices that have reinforced learned dependency and oppression. A shift in consciousness then invites a relational process and dialogue, and moves toward the root causes of social and structural inequities that refugee women experience in the context of migration and resettlement in Canada.

Here, the outlined recommendations incorporate principles and reflections of community capacity in the broader context of culturally safe and trauma- and violence-informed policy and practices, aimed at minimizing health risks and promoting effective and efficient provision of health and settlement support and services for Karen women, but these recommendations may also have implications for other minority women who arrive in Canada under similar circumstances.
7.1.1 Recommendation for restructuring health care and settlement services

The UNHCR (2013) has recommended that a critical reflection and evaluation of health care services and settlement supports must center on the resettlement needs of refugee women. This would require health care organizations to:

1. Develop pathways for addressing language/literacy needs of Karen women and the facilitation of interpreter services. As this study showed, health care providers working in primary health care contexts were unaware of referral processes for interpreter services. Increased training and education for language translators for minority language groups must be integrated into governmental organizations such as the Provincial Language Services of BC so that a standardized referral process is in place for providing language interpretation to health care and access to specialized mental health services, while allowing for flexibility in service provision such as making a space for accompanied appointments. Standardized referral processes and developed pathways for provision of language resources can potentially save time and increase efficiency for health care providers. In addition, cultural brokers have been used in other areas across Canada, because language is only one aspect of working with diverse cultural groups. Cultural brokers (also called cross cultural mediation) can provide coaching and knowledge translation concerning different understandings of health and illness. These do not only include linguistic dimensions but also include an explanation of cultural values; the brokers serve as advocates and help the patient to find resources and accompaniment to
appointments (Leanza et al. 2014). In BC, this role has not been implemented but it may serve as a valuable resource for health care providers and Karen families. In order to facilitate social action, these recommendations, in the light of findings from this research, will be presented in collaboration with the New Canadian Immigrant and Refugee clinics at a scientific café sponsored by the local health authority;

2. The use of patient navigators has been found to be useful in primary care practices for assisting medically compromised elderly women in the US to access health care services (Ferrante, Cohen & Crosson, 2010). This strategic initiative may also be a useful approach to developing culturally and linguistically competent patient navigators for refugee women and families who arrive in Canada with lower levels of health literacy and general literacy. Patient navigators can assist refugee families with obtaining services, and can facilitate access across services and systems. However, this kind of initiative would require that alternative funding arrangements be supported by resettlement policies;

3. In relation to the above recommendations there is also a need for restructuring the environment of primary care agencies by promoting more welcoming environments. This would include increasing the awareness and knowledge of Karen women’s needs by developing guidelines for referral processes, and providing language interpreters. Leanza et al. (2014) advise that gatekeepers play a crucial role in setting the tone of the agency and that gatekeepers can ask simple questions such as “Are you new in Canada?” and “Would you like to have
an interpreter?” and that the training of all staff, including reception staff, should be prepared to facilitate consultation appointments with newcomer women. This is supported by the findings in this research, where coaching all the staff members within the health care services was viewed as potentially mitigating the forms of systemic and structural violence that may occur when a lack of guidelines and/or knowledge of women’s needs prevails within mainstream primary care practice;

4. Reorganization of health and settlement services to increase their flexibility, particularly with regard to altering appointment systems so that they are more in keeping with the Karen women’s needs. This could include rescheduling services on a drop-in basis, which would also address the women’s experience of help-seeking in which they felt that they were always a burden on others. Flexible drop-in medical appointments could also address emergency health concerns, as well as the issue of exclusionary health care practices, which tend to locate the problem within the individual rather than as a feature of the organizational practice. Some initiatives amongst local primary health clinics have already started this initiative and are being considered within new Canadian clinics. This may mitigate challenge of making appointments for the refugee groups;

5. In the current climate of government reforms, increased political and social advocacy and coalition building are needed to shift policy directions that are currently fiscally driven. This requires an increased dialogue between CIC and municipal and local organizations. For example, the Canadian Healthcare
Association (2012) has written a position statement for the federal government of Canada and argues that policy decisions regarding health should be made on the basis of available evidence about refugee health and health services. This strategy can enhance community capacity for health organizations to increase service provision for equitable oriented healthcare. Thus, nurses (NPs and public health nurses) who work with refugee women and families need to engage in political advocacy with allied health professions in order to build coalitions that can redress current immigration health policy. The Canadian Healthcare Association’s (2012) position statement on governmental cutbacks for refugee health has been shown to have political leverage, informing immigration policy of the inequitable effects of reforms on refugee groups;

6. To enhance community capacity, there needs to be an integrated approach across multiple institutions. In addition to schools and primary health care services, faith-based institutions must also be included in policy planning initiatives as CIC will be increasing the admittance of refugees who are privately sponsored, many of which are sponsored by community volunteers and faith-based organizations. However, sponsorship has had mixed results (Sherrell, 2003; Beiser, 2009; Whitley, Kirmayer & Groleau, 2006). Faith-based organizations play a key role in settlement work and social support but are often left out of pre-planning initiatives involving refugee groups. Their inclusion in governmental multi-level pre-planning initiatives may mitigate compassion fatigue and promote greater self-efficacy amongst newly arrived groups who come with complex needs for support;
7. Enhancing community capacity to support the mental health and well-being of refugee women and families must also include greater service collaboration between mainstream mental health services and pre-planning initiatives for the arrival of refugee groups. Mainstream mental health practitioners have been absent in settlement planning and initiatives, and need to be integrated in future pre-planning initiatives, considering the nature of the trauma and violence affecting the lives of refugee women;

8. Provisions need to be made for enhancing education and training for settlement service providers and community volunteers who provide a range of resources and support for newcomer groups. Frameworks for building community capacity for trauma-informed practice and policy have been effective when training occurs at all levels of human service organizations, including those who work at the front line (Peck & Capyk, 2012). This can be accomplished through the use of community experts from various faith-based institutions in collaboration with settlement and larger immigrant service agencies (ISA’s).

7.1.2 **Recommendations for promoting health literacy and integration of language resources**

Public policy and pre-arrival planning initiatives have not adequately linked with provincial language resources to address the resettlement needs of Karen women and families, and other potential GARs located outside of the metropolitan periphery.

Provincial language resources must be included in future pre-planning initiatives to address the challenges associated with the provision of interpreter
services and promote enhanced language resources and support for minority languages in BC. This remains a paramount issue facing Karen women and other minority groups arriving in Canada as a result of displacement. Increased advocacy and political action are required to change government policies which support an influx of refugee groups with low literacy and language barriers. There need to be mechanisms in place for the participation of Karen women and families in policy-making decisions about where they are resettled, and an evaluation of existing services prior to arrival, including the provision of professional interpreter services so that links can be made with health care services. It could be argued that the lack of access to interpreter services violates Canada’s commitment to human rights and international convention of the UNHCR which aims to protect the rights of refugees.

Strategies for building health literacy need to incorporate attention to the social determinants of health as well as the broader intersecting factors that shape women’s experiences of resettlement. This includes Karen women’s gender roles. Karen women recommended that government institutions take into account their need for child-minding support so that they could attend school and English language classes. This was very important for Karen women since they valued having access to education. Local schools and daycares could advocate and develop a policy for child minding to facilitate Karen women’s learning needs and decrease the burden of their gender responsibilities.

In addition, intersecting factors of age and literacy disadvantaged older Karen women since they were reliant on friends and family to support them in meeting their settlement needs. Future strategies for health literacy interventions
must take these contextual intersecting factors into account when providing services and support. This can be facilitated by creating safe environments in which plain language is used, plus diagrams and pictures to convey meaning, and the techniques of talking slowly and adopting the stance of an interested listener. These were found to support Karen women in accessing health and settlement support. Health literacy can also be facilitated by health care providers asking Karen women about who they use to access services and supports and how this is working for them. This would facilitate greater knowledge on the health providers and may promote health literacy.

Family centered learning needs to be promoted across services to promote health literacy and build basic literacy skills across the lifespan. This could include provision for basic literacy classes in less formal educational settings such as churches, libraries and/or other community centers. These community agencies can also facilitate health literacy by providing health resources and education. In this study, it was pointed out by a community stakeholder that there is too much emphasis on responsibility for health within the health care sector and that health needs to be integrated across and within various levels of community and government. Karen women found that many mainstream language classes were not offered at convenient times. In addition, older Karen women and families were identified as having increased challenges related to language, literacy and health literacy, particularly in the context of shifting immigration policies that required greater English language ability and education in order to obtain citizenship status.
In summary, future strategies for integrating language resources, building literacy and health literacy interventions and development of equity oriented services must take the contextual and intersecting factors discussed in the above into account when planning and developing strategies for enhancing settlement support for Karen women and families, if a culturally safe, trauma- and violence-informed framework is going to be realized. This includes building alliances across the service sectors such as education and health, alliances that promote participatory learning and community-based education through outreach support. The provision of restructuring the settlement service toward a centralized system of settlement support can be fostered if programs such as VIPP integrate social determinants of mental health and promote health literacy; however, this will require increased outreach support and resources.

7.2 Recommendations for Future Research

This study highlighted the resettlement experiences and needs of Karen women. However, several gaps in the research still exist. Future research needs to be directed toward refugee men’s health. Many of the settlement services and supports were tailored toward Karen women’s needs; this resulted in increasing their networks for social support and health literacy and education. However, generally, men were excluded from these services due to budgetary constraints and settlement reforms that structured Karen men’s needs toward labour employment.

More research is required to examine the intersections of gender and migration/resettlement from the perspective of the men. This may have important
implications for policy and practice and for the lives of the women and children. In addition, many refugee groups arrive with senior family members; older Karen women were identified as having significantly more challenges during resettlement. Future research with older members of refugee groups is required to inform health care services and supports regarding their specific needs during resettlement, as studies suggest that refugee elders may experience greater social isolation and arrive with even more complex medical needs (Marchbank et al., 2014).

More community-based research should be undertaken to evaluate the experiences of refugee women and their families so as to inform international policy on resettlement outcomes and their service needs. The UNHCR (2013) has called for an evaluation of what resettlement and integration success looks like, in order to move toward evidence-based programing. I would add that such programming needs to be considered in light of community capacity, since it is communities that receive refugees and also influence settlement outcomes for refugee women.

Communities and their aligned structural practices have the potential to mitigate potential for re-traumatization during refugee resettlement. Examining the structural processes that shape refugee women’s experiences can inform social policy on the integration of trauma- and violence-informed care and its potential impact on the mental health and well-being of refugee women during their resettlement in Canada.

Lastly, nurse practitioners and public health nurses are at the forefront of delivering health care to diverse refugee women and men. However, their experience and knowledge have not played a significant role in the health care
literature related to cultural safety in the Canadian context. Since cultural safe
practices and culturally competent care are a fundamental aspect of Canadian
nursing ethics and incorporated into a social justice framework, more research is
needed from the perspective of nurses and allied health providers into how they
enact culturally safe practices in relation to refugee health in Canada. Similarly,
although the Mental Health Commission of Canada has taken a leadership role in
promoting inclusivity and culturally safe and competent care there has been little
evidence in the uptake of cultural safety related to culturally and linguistically
diverse groups in Canada. Gaining a better understanding of health care providers’
views can also inform policy and practice in order to make better service provision
in rural and suburban contexts.

7.3 Methodological Reflections

The process of conducting field research was a challenging process, as I was
unfamiliar with the geographic context and the community in which I conducted this
study. Traditional processes of utilizing consent forms to ensure full informed
consent, convey confidentially and develop trust to prevent potential harms seemed
at times incongruent with conducting community-based research with the Karen
women. Development of relationships underpinned by trust and mutual respect
cannot be overstated. My ongoing engagement with the community and the Karen
women themselves facilitated the need for ongoing relationship building which was
always negotiated and mediated by my relationships with community collaborators
and the organization that agreed to open their doors. As Creese and Frisby (2011)
point out, conducting feminist community-based research always produces opportunities and challenges when the research aims to “disrupt dominant frameworks, disciplinary silos, and taken-for-granted assumptions that maintain the status quo... [this] involves the complicated negotiation of relationships with community” (p. 4).

The notion of reflexivity was a key aspect of conducting ethnographic research as I was constantly reminded of how my own position and privilege could potentially harm or misrepresent the voice of Karen women. Drawing on intersectionality and the lens of cultural safety, I aimed to position myself as an active learner, reflective of the multiple social conditions and contexts that shaped the Karen women’s lives. It is my intention that these findings positively inform access to health and settlement support for Karen women and that they may also have applicability for other refugee women in similar circumstances.

The use of multiple Karen women translators added another methodological challenge as professional language translators were not available. There has been very little written about conducting research across language differences, or with women who cannot read and write in their own language. I learned that language is not a neutral medium. Working with various Karen women translators necessitated mutual cooperation and flexibility. Karen women translators also brought their own assumptions and concerns to the interview process. Drawing from the work of feminist researchers Temple and Edwards (2002), I was prompted to interview the Karen women who were providing translation and interpretation. As these scholars explain, there is a need to make interpreters visible in ways that challenge and
enrich our understandings of other people’s views. I was also challenged by maintain confidentiality and respecting the anonymity of the Karen women due to the smaller sample size of women who were drawn from a smaller geographic location. In this regard I did not disclose their unique mental health problems as this would readily identify them and potentially cause unintended harms.

7.4 Conclusion

This research has contributed to better understanding of the social and structural factors of community capacity related to the Karen women during resettlement. Previous research has drawn attention to a need for better collaboration and integration of services, however many of these reports do not directly include the healthcare sector as an important community partner in determining how resources are distributed and used. In particular, little emphasis has been directed toward the factors that promote the refugee women’s mental health in the context of their resettlement in Canada. This research focuses attention on the Karen women’s voices and the factors that supported their mental health and well-being during their resettlement process. Karen women were supported through the development of community relationships with others, and empowered through strategies for building health literacy. These strategies helped mitigate forms of structural violence which were underpinned by neoliberal ideology (e.g., individualism) and assumptions—a systemic program across the sectors affecting settlement and health. It has been suggested that recovery from trauma needs to be conceptualized as a relational process, where social ties have the potential for
rebuilding social connections disrupted by the violence of colonialism (Lester, 2013). As Lester notes, healing is not found in reintegration into a community alone but comes from building human connections.

As a form of resistance and response to existing models of service provision, community capacity was facilitated by relational approaches to problem-solving around community needs. Collaborative partnerships with the Karen settlement workers, front line workers and local volunteers allowed for shared knowledge and were instrumental in building community inclusivity for the Karen women and families across services and local contexts. This research highlights the interdependency amongst the human agents required to address systemic patterns of oppression, which significantly impacted the mental health and well-being of Karen women during their resettlement.
REFERENCES


Canadian Nurses Association (CNA), (2010). *Social justice... a means to an end, an end in itself.* (2nd Eds.). Ottawa: Author.


Racine, L., & Petrucka, P.(2011). Enhancing decolonization and knowledge transfer in nursing research with non-Western populations: examining the congruency between primary healthcare and postcolonial feminist approaches. *Nursing Inquiry,18*(1), 12-20.


Smith, R. S. (2008). The case of a city where 1 in 6 residents is a refugee: Ecological factors and host community adaptation in successful resettlement. American Journal of Community Psychology, 42, 328-342.


Health Association of Canada, Building Cultures II Project, & Mental Health Commission of Canada.


Appendix A.
Recruitment Poster for Karen women
Appendix B.
Poster for Health Care and Social Service Providers

THE UNIVERSITY OF BRITISH COLUMBIA

If you are a health care or social service provider that has experience in working with Karen government assisted refugees this study might interest you!

What is the study about?
The purpose of this research study is to examine the factors that both facilitate and/or challenge community capacity to support Karen women’s mental health and well-being in the context of resettlement.

Why participate?
By participating in this study you will be able to contribute to the development of knowledge on what helps communities plan for culturally appropriate support and [mental] health care services for Karen women and potentially other newcomer women.

Where, When and How?
I would like to meet with you to discuss your perspectives on the social and structural factors that facilitated and/or challenged your ability to provide health, social service and support for Karen women at a time and location that is convenient for you. The meeting will take between 60 to 90 minutes.

If you are interested in participating or would like to know more about this study, please contact

Nancy Clark RN PhD (Candidate) at xxx-xxx-xxx or email
Appendix C.
Recruitment/Information Letter

THE UNIVERSITY OF BRITISH COLUMBIA

Examining Community Capacity to Support Karen Refugee Women’s Mental Health and Well-Being in the Context of Resettlement in Canada

July, 2012

Hello,

Further to our community consultation(s), I wanted to follow up with you regarding the study that I am conducting for my PhD dissertation, which has been funded by the Bottom Billion Fieldwork fund through the Liu Institute for Global Issues at the University of British Columbia. The purpose of this study is to examine the social and structural factors that facilitate and/or challenge community capacity to support Karen women’s mental health and well-being in the context of their resettlement. As you may be aware there is a growing amount of evidence showing that the availability and accessibility of social services and supports to newcomer groups such as immigrants and refugees greatly affect the mental health and well-being of these groups during their resettlement process. In particular, refugee women may face greater challenges due to a combination of pre migration and post migration stress such as conditions of migration, access to language training, education and culturally specific supports and services during resettlement.
Therefore the aim of this research project is to better understand the social and structural factors that support Karen women during the process of their resettlement. In gaining a better understanding of what the social and structural factors are within a community I hope to inform existing health care, social services and policy on what supports Karen women’s mental health and well-being during the process of their resettlement.

My intention is to interview Karen women over the age of 19 years that have been resettled in Langley, as well community service providers such as health care providers, settlement workers, and volunteers. I will be asking questions about what services and support the women perceive as most helpful during the process of their resettlement, how they came to use health and community services as well as what aspects of community support and services would better meet their needs. Community service providers will be asked questions about the factors that helped to support their work with Karen women and challenges that they experienced in providing care and social support for Karen women. In order to gain an in depth understanding of the factors that facilitated and or challenged a community’s ability to support Karen women, I plan to conduct participant observations as well as individual and focus group interviews with Karen women and community service providers.

An important part of conducting this research includes participant observation in the field. The purpose of conducting participant observation is to gain a better understanding of the local culture and to gain exposure to the day-to-day activities that take place within a specific context or place. For example,
participant observation in this research may include observing how health care and social service providers interact with and provide services for Karen women. It may also include taking field notes about the environment, content of conversations and/or speaking with individuals that provide health care and other services for Karen women. In order to conduct my research I am hoping that you might allow me to conduct participant observations at your agency.

I am wondering if you might help bring this study to the attention of individuals who might be interested in participating in discussing their experiences of accessing services and/or those who provide health care, social services and supports for Karen women. This could be done by either posting or distributing the enclosed notice to potential participants and/or by obtaining permission for participants to give their telephone number to me so that I can contact them directly and provide more information. All interviews may last anywhere from 60 to 90 minutes. With their permission a second interview of similar length may be requested in order to clarify what was discussed or said in the first interview. All of the interviews will take place at a time and location of the participant’s choice in order to provide a safe and comfortable place for discussion. Focus group interviews will take place at a nearby and central location in Langley City, such as a community centre or meeting room at a church. It is anticipated that all interviews will be within walking distance for the majority of the participants. However, should some participants have to travel by bus travel expenses will be provided for by myself and will include a bus ticket. Karen women who participate will be given a $30.00 honorarium.
All interviews will be audio-taped. I will arrange for a Karen interpreter for women who find it easier to be interviewed in a Karen language. I would like to illicit your assistance in helping bring this study to the attention of Karen women or individuals that have experience in providing social service supports and health care to Karen women. If you have more questions about this study, please don’t hesitate to telephone me at xxx-xxx-xxxx or email me at email. You are also welcome to contact my PhD supervisor, Dr. Vicki Smye, at xxx-xxx-xxxx or email her at email for further information. Also, if at any point, you are interested in discussing the emerging findings, I’d be happy to meet with you and would welcome your feedback. Copies of any reports or publications will be available to you upon request as well. Your help with this project would be very much appreciated! Please call if you have any questions or would like to know more about it.

Thanks again for your interest and support.

Sincerely,

Nancy Clark RN PhD (C)
Appendix D.
Socio-Demographic Form for Research Participants

Examining Community Capacity to Support Karen Refugee Women’s Mental Health and Well-Being in the Context of Resettlement in Canada

Dear Participant,

You are being invited to fill out this form in order to help the researchers of this research project learn about your social characteristics and demographic information. During the consent process the researcher will advise you on how to fill out the form as some questions may or may not pertain to you. This information will only be used for research reports related to this study. Filling out this form is completely voluntary. In order to protect your privacy, your name and contact information will be removed and you will be given a participant number. Upon completion of this research, this form will be shredded in order to protect your privacy.

Name: ________________________

Address: _______________________

Phone number: _________________
Email: _________________________
Age: __________ Your Birth Date: ________________________
Sex/Gender: __________________
Country of Origin/Birth: __________
Ethnicity: _______________________
Citizenship Status: ______________
Languages spoken: ______________
Religion: ________________________
Marital Status: __________________
Members in the household: ________________________________
Number of Children: _________________________________
Level of Education: _________________________________
Housing (Public/subsidized/rent/own/no housing: __________
Source of income: (government assistance/Employed/support from family and friends/_____________________________
Health status or health care treatment received: ______________
Have a regular doctor/nurse practitioner/other: __________
Have a health care card: ________________________________
Profession/occupation: _________________________________
Number of years in occupation: __________________________
Special training received: ______________________________
Place and number or years in current (Langley, Surrey, Burnaby, Vancouver) _________________________________

Version 1, January 1, 2013
Appendix E.
Focus Group Interview Guide for Karen Women

1. Since coming to this area what have you found to be the most supportive for your resettlement?

2. Can you describe specific supports or people that you found to be and that continue to help you in your process of resettlement in Canada?

3. How have you been able to access services and supports that you need to help in the process of your resettlement?

4. Do you feel that you are part of a larger community?

5. In terms of accessing health care services what have you found to be most helpful?

6. From your experiences, can you speak about what would help future refugee women in the process of their resettlement?

7. In your experience what has been the most challenging aspect or factor related to your health and well-being during the resettlement process?

8. Are there any traditional things that you do within the Karen community when people get sick? Either physically or psychologically?

9. What do you feel would be needed in order to improve or facilitate Karen refugee resettlement? and what do you feel would facilitate future influx of refugee resettlement to this community/region?

10. What recommendations would you suggest that could help other communities be able to support resettlement of immigrants and refugees?

Focus group interview guide Karen women, Version 1, January, 01, 2013
Appendix F.
Focus Group Interview Guide for Health Care and Social Service Providers
(Health care providers, social service workers, community volunteers)

1. What has the Karen refugee resettlement been like for your community?

2. When did you first hear about Karen refugees?

3. How have you been able to come together to change and/or adapt to Karen refugees?

4. Do you feel that the community has changed as a result of Karen refugee resettlement? and if so how?

5. What have been the community’s main strengths in supporting Karen refugee resettlement?

6. This community has specific services in place for helping Karen people in the process of their resettlement such as The Early Years Refugee Project, The SWISS (Settlement workers in Schools, The New Canadian Clinic, and a new Immigration Services Society in Langley) for example, can you speak to how your services are able to individually or collectively meet the unique settlement needs of Karen?

7. In your experience, have you identified any specific needs related to Karen women during the process of their resettlement?

8. What have been or continue to be the factors that challenge this community’s ability to meet the needs of the Karen people or of Karen women’s needs specifically?

9. What do you feel would be needed in order to improve or facilitate Karen refugee resettlement? and what do you feel would facilitate future influx of refugee resettlement to this community/region?

10. What recommendations would you suggest that could help other communities be able to support resettlement of immigrants and refugees?

Focus group interview guide, version 1, January 01, 2013
Appendix G.
Consent Form for Health Care and Social Service Providers

THE UNIVERSITY OF BRITISH COLUMBIA

Examining Community Capacity to Support Karen Refugee Women’s Mental Health and Well-Being in the Context of Resettlement in Canada

Principle Investigator: Dr. Victoria Smye
UBC School of Nursing
Telephone: xxx-xxx-xxx

Co-Investigator: Nancy Clark PhD (Candidate)
UBC School of Nursing
Telephone: xxx-xxx-xxxx

The purpose of this research study is to examine the factors that both facilitate and/or challenge community capacity to support Karen women’s mental health and well-being in the context of resettlement. This research is important because mental health and well-being for refugee women has been shown to be related to their experience and access to health care and social support during resettlement. It is hoped that the findings from this study will assist community mental health, primary health care providers and social service providers develop practices and policies that support Karen refugee women’s health and well-being.

This study is being conducted as part of the requirements toward a PhD for Nancy Clark and is funded by the Bottom Billion Fieldwork fund through the Liu Institute for Global Issues at the University of British Columbia.

If you decide to participate in this study you will meet with Nancy Clark to discuss your perspectives on what factors help support and or challenge your work in providing health care and other social services and supports for Karen government assisted refugees. Please note that the aims of this interview is not to gain information about individual clients, but about your own experiences in providing health and social service supports to Karen women. In particular, she
will ask you questions about your experiences of the social and structural factors that help and or challenge your ability to provide services and supports for Karen women. Interviews may last up to 60 to 90 minutes. If you are willing, another interview of similar length may be requested in order to clarify or discuss some of what you said in the first individual or focus group interview. All meetings will take place at a time and location of your choice. With your permission, the interviews will be audio-taped and a copy of the interview transcript will be given to you upon request.

Your participation in this study is voluntary. You have the right to refuse to answer any questions, to request that the audio recording be stopped at anytime, and to withdraw any information you do not wish to have included in this study. You also have the right to withdraw from this study at anytime. Should you withdraw from the study, the information you have provided up to the point of withdrawal will be used in the data analysis, unless you state that you wish to have it removed. Your decision to withdraw or not participate in this study will in no way jeopardize your work within your organization.

The information you provide will be kept confidential unless you specify otherwise in writing. Please be aware that if you participate in a focus group interview only limited confidentiality can be offered. However, we encourage all participants to refrain from disclosing the contents of the focus group discussions outside of the group, as we cannot control what other people do with the information discussed. Consent forms, transcripts and audiotapes of all interviews will be kept in a locked cabinet in the secured offices of the Principal Investigator and/or Co-Investigator. Your name and any other identifying information will be removed from all transcripts; pseudonyms will be used to reference you. All electronic files will be kept on a password-protected computer in the secured offices of the Principal Investigator and the Co-Investigator. Access to these offices and files is strictly controlled and limited to the Principal and Co-Investigators.

It is not anticipated that your participation will cause any physical or psychological harm, however we recognize that talking about your experiences may cause some distress or make you feel uncomfortable. You are not obliged to answer any questions that make you feel uncomfortable or that you do not wish to answer. Should you experience any distress or discomfort with the interview, it will be stopped immediately, and Nancy Clark will assist you in accessing the appropriate support. Nancy Clark will also provide you with a written list of support services prior to the interview(s).

While there are no direct benefits to you, some people find it beneficial to talk about their experiences of providing health care and support services for newcomer groups. In addition, by participating in this research you may help contribute to helping communities plan for support and services for Karen women as well as other newcomer women.
The findings of this study will be reported in Nancy Clark’s dissertation, research journals, conferences, community presentations and workshops. We recognize that there is the possibility that participants could be recognized by others by the community in which they work given the small number of participants and ethnic identity of participants involved in this study. However, all efforts will be made to insure that you are not identified by others by changing or removing information that might otherwise readily identify you.

If you have any questions or desire further information about any aspect of this study, you are invited to contact Dr. Victoria Smye at xxx-xxx-xxxx or email or Nancy Clark at xxx-xxx-xxxx or email. Furthermore, if you have any concerns about your treatment or rights as a research participant you may contact the Research Subject Information Line at the Office of Research Services at the University of British Columbia at 604-822-8598, or email to RSIL@ors.ubc.ca.

Thank you for considering involvement in this study. If you agree to participate, your signature is required below.

Sincerely,

Vicki Smye, PhD RN  
Nancy Clark, PhD (Candidate) RN

I understand that my participation in this study is entirely voluntary. I may choose not to participate or may withdraw from the study at any time.

My signature below indicates that (1) I consent to participate in this study, and (2) I have received a copy of this consent form for my own records.

________________________
Participant’s Signature

Printed name

Date

I do/do not (please circle) give permission for the research investigators to use information that I am providing for future studies conducted by them related to this topic, assuming that the study is reviewed and approved through a university Ethics Review Committee.

________________________
Participant’s Signature

Version 2, January 1, 2013
Appendix H.
Karen Women Individual Interview Guide

(Invitational questions)

1. Since coming to Canada, what have you found to be helpful in moving here?

2. How long have you been living in the Langley area?

3. What has helped you to put down roots and stay living in the Langley area?

4. What supports have you found to be most important to you since coming to Canada and Langley?

5. Was there anything that you found to be significantly helpful during this process?

6. Since coming to Langley what did you feel was the most welcoming or what have you found to be most helpful in feeling like you belong?

7. How has the process of coming to Canada affected your health and well-being?

8. What is the most important health concern that you have?

9. Are there specific things that you do to maintain your overall health and well-being?

10. Is there anyone that helps you to stay healthy and/or when you are not feeling well?

11. Health care providers often use the term mental health to refer to emotional or psychological problems, what does mental health mean to you?

12. Are there any special words or phrases that convey that someone in your family or community may suffer from a mental health problem?

13. For these kinds of problems what do you feel is the best kind of treatment? And would you feel comfortable in accessing treatment and support for mental health problems within or outside of your community?

14. Overall what do you feel is the most important thing for you in helping you stay healthy and happy?

15. Where do you go when you are feeling unwell either physically or emotionally?
16. What has been the most helpful for you to stay healthy? Was there anything about the health care or other services that you received that supported you to stay healthy?

17. How have you been able to access the health care services that you need?

18. From your perspective what would you recommend is needed in order to support your health and well-being? And what do you think is needed in order to improve health and other services so that you can maintain your health?

19. How would you like this information to be used?
Appendix I.
Consent Form for Karen Women to Participate in Individual and Focus Group Interviews

THE UNIVERSITY OF BRITISH COLUMBIA

Examining Community Capacity to Support Karen Refugee Women’s Mental Health and Well-Being in the Context of Resettlement in Canada

Principle Investigator: Dr. Victoria Smye
UBC School of Nursing
Telephone: xxx-xxx-xxxx

Co-Investigator: Nancy Clark PhD (Candidate)
UBC School of Nursing
Telephone: xxx-xxx-xxxx

The purpose of this research study is to examine the factors that both facilitate and/or challenged Karen women’s mental health and well-being in the context of resettlement. This research is important because mental health and well-being for refugee women is related to their experience and access to health care and social support during resettlement. It is hoped that the findings from this study will assist community mental health, primary health care providers and social service providers develop practices and policies that support Karen refugee women’s health and well-being.

This study is being conducted as part of the requirements toward a PhD for Nancy Clark and is funded by the Bottom Billion Fieldwork fund through the Liu Institute for Global Issues at the University of British Columbia.

If you decide to participate in this study you will meet with Nancy Clark to discuss your experiences of accessing health care and other social services and supports during your resettlement. She will ask you questions about what supports your health and what you have found to be most challenging in supporting your health care needs. This meeting may be conducted through a one on one discussion with Nancy and/or you may be requested to participate in a focus group interview with other Karen women. These discussions may last from 60 to 90 minutes. If you are
willing, another interview of similar length may be requested in order to clarify or discuss some of what you said in the first interview. One on one interview(s) will take place at a time and location of your choice—this could include your home. Focus group interviews will be located within walking distance or short commute from your home. If you require transportation costs, you will be provided with a bus ticket. With your permission, the interviews will be conducted in the language of your choice, audio-taped and transcribed; a copy of the interview transcript will be given to you upon request. A Karen language interpreter will be available during the discussions if you request one.

We recognize that talking about your experiences of accessing services and supports may be distressing or uncomfortable. You are not obliged to answer any questions that make you feel uncomfortable or that you do not wish to answer. Should you experience any distress or discomfort with the interview, it will be stopped immediately, and you will be assisted in accessing appropriate support by Nancy Clark. You will also be given a list of support services and resources prior to the interview.

While there are no direct benefits to you, some women find it beneficial to talk about their experiences of accessing health care services and supports during their resettlement. Some women also appreciate the opportunity to share information about their experiences that may help to improve social services, supports and health care for other newcomer women. Your participation in this study is voluntary. You have the right to refuse to answer any questions, to request that the audio recording be stopped at anytime, and to withdraw any information you do not wish to have included in this study. You also have the right to withdraw from this study at anytime. Should you withdraw from the study, the information you have provided up to the point of withdrawal will be used in the data analysis, unless you state that you wish to have it removed. Your decision to withdraw or not participate in this study will in no way jeopardize your involvement with any health services or programs that you are or will be using.

The information you provide will be kept confidential unless you specify otherwise in writing. Please be aware that if you participate in a focus group interview only limited confidentiality can be offered. However, we encourage all participants to refrain from disclosing the contents of the focus group discussions outside of the group, as we cannot control what other people do with the information discussed. Consent forms, transcripts and audiotapes of all interviews will be kept in a locked cabinet in the secured offices of the Principal Investigator and/or Co-Investigator. Your name and any other identifying information will be removed from all transcripts; pseudonyms will be used to reference you. All electronic files will be kept on a password-protected computer in the secured offices of the Principal Investigator and the Co-Investigator. Access to these offices and files is strictly controlled and limited to the Principal and Co-Investigators.

In acknowledgement of your participation in this research you will be provided with an honorarium of your choice of $30.00 in the form of a gift certificate and or cash in
the same amount at the beginning of the consent process. If you decide to withdraw from this study you will not be required to give back the honorarium.

The findings of this study will be reported in Nancy Clark's dissertation, research journals, conferences, community presentations and workshops. We recognize that there is the remote possibility that participants could be recognized by others given the small number and ethnic identity of participants involved in this study. However, all efforts will be made to insure that you are not identified by others by changing or removing information that might otherwise readily identify you. If a Karen interpreter is requested they will be asked to sign a confidentiality agreement form at the beginning of the focus group and prior to one on one interview(s) in order to protect your privacy. In order to ensure accuracy of the interpretation of the interview a Karen translator will also review the transcribed interviews with your permission.

If you have any concerns or complaints about your rights as a research subject and/or your experiences while participating in this study, contact Dr. Anton Grunfeld or Dr. Allan Belzberg, REB Co-chairs by calling 604-587-4681. You may discuss your rights with one of the co-chairmen of the Fraser Health REB. Furthermore, should you have any questions or desire further information about any aspect of this study, you are invited to contact Dr. Victoria Smye at xxx-xxx-xxxx or email or Nancy Clark at xxx-xxx-xxxx or email. If you have any concerns about your treatment or rights as a research participant you may also contact the Research Subject Information Line at the Office of Research Services at the University of British Columbia at 604-822-8598, or email to RSIL@ors.ubc.ca.

Thank you for considering involvement in this study. If you agree to participate, your signature is required below.

Sincerely,
Vicki Smye, PhD RN  
Nancy Clark, PhD (Candidate) RN

I understand that my participation in this study is entirely voluntary. I may choose not to participate or may withdraw from the study at any time. My signature below indicates that (1) I consent to participate in this study, and (2) I have received a copy of this consent form for my own records.

Participant’s Signature  Printed name  Date

Karen Interpreter Signature  Printed name  Date
I do/do not (please circle) give permission for the research investigators to use information that I am providing for future studies conducted by them related to this topic, assuming that the study is reviewed and approved through a university Ethics Review Committee.
### Descriptive fieldnotes (June 5-7/12)

#### Neighborhood

The Early Years Refugee project is situated or located at the back of several low income housing apartments and is part of the main xxx family Services Bldg. The area is definitely low income and a five minute walk to the Catholic church where the after hour school program occurs.

There are many 3 to 4 story low income housing level units in view and across the street from xxx. The parking lot is in front of xxx and there is a garden in the back of the building.

There are a few small raised garden beds where the Karen community has come to plant vegetables for the summer months, located at the back of the xxx building but it did not look well planted and or the weather might have affected the crop this year.

Most of the women are able to walk over to the xxx and early years refugee project in a few minutes and I have been told that there is a senior program over in another building. There is also a small portable on sexual health, I have not been oriented to these other facilities yet.

#### Clinic (Early Years Refugee Project) site

As you come through the main door you are greeted by the receptionist who is friendly and the staff are quite diligent in making you sign in and out of the building. Directly to the right are the offices of the outreach and day care or child care workers and then the program manager. It is a fairly open space where people speak freely except the manager’s office has a door which is mostly kept open.

The main child care and play area is open to the offices and you can see it through the class but it is separated by a door. The play area is full of toys and small chairs and tables and a kitchen and small open bathroom form the moms and kids. All the small kid chairs and tables are natural wood stain and not coloured brightly, S stated that this was done deliberately so that the Karen moms could
feel more like what they were used to at the camps. I like the carpet on the floor which is in front of the main play area where all play and interaction happens. It is brightly coloured with the letters of the alphabet in large squares and over shadowed by a board on the wall that has the days of the week, month and weather forecast in felt and other coloured objects, frequently used as a learning tool with Karen moms and kids.

One thing that struck me was the fact that moms are learning too with their kids. They reinforce what is being learned and sung. A lot of singing and moving around and modeling what E the play school teacher is instructing. There are two play school teachers, E and I, one is polish and has a slight accent and the other teacher is of Asian origin but not Karen (xxx). They are both very familiar with the families and have developed a great amount of trust and rapport with them (note as they may be good to interview should they wish to participate).

<table>
<thead>
<tr>
<th>Site staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>The staff is friendly and welcoming although some of them might be wondering what I am doing there, I think by now everybody knows who and what I am doing there. Most of the staff are dressed casually and mostly in pants. A lot of the language is in Karen amongst the moms and not the other staff and some translation happens. S spends a lot of time at her desk with various requests from whoever comes in and it reminded me of my case management work where I had to do a lot of brokerage between the client and the health/social service provider. She does pop in and out of what is happening at the day care and participates in the activities. There are also other managers and some other workers that I have not met who come in and out of the centre. If anything is cooked or baked of course also draws other employees to come and participate in the centre and sample some of the food. Power dynamics, clearly there is power difference in that the outreach worker has access to a computer and has to do a lot of advocacy work on</td>
</tr>
</tbody>
</table>
In my Discussions with some of the moms, I found that they need extra support in talking with doctors or landlords to explain their situation. One example was when a mom came in to ask if she could move into another apartment because her sister was moving from xxx to xxx so they could be closer together. One of the problems is that the housing unit that they want to move into will only allow up to 2 children and the woman that is wanting to move into the other apartment has more kids, in fact I am told that the average is 4-5 children per household.

In order to minimize any potential harms and in recognizing power differences between me and the women I have not interviewed any women or social service providers and instead plan to establish rapport and interest for potential participants. Chabot & Shoveller (2012) suggest that after speaking informally and establishing rapport is particularly important when working with vulnerable groups, because many not all people may feel coerced to participate in light of power differentials between themselves and the researcher (as well as themselves and where they receive social services and supports).

<table>
<thead>
<tr>
<th>Clients/Karen mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Karen women always speak in S'Gaw Karen amongst each other, not English. Women are casually dressed and appear young in age for the most part. A few come up to me and speak to me specifically about who they are. One of the mothers in particular spoke to me about being a nurse at the camp but that she could not get that kind of work here. She would need to go back to school to get her high school and English. She has three kids and one of her children is having nightmares and allergic reaction to some kind of plant. The mom also asked me if I knew anything about the depot injection for birth control. This is in contrast to a conversation I was having with S who told me about the large families and that some of the women don’t have control/power over birth control and that they like to have large families. I was able to find out some information about the depot provera on my cell phone and quickly read about studies that had been conducted.</td>
</tr>
</tbody>
</table>
The recommendation was that women could continue to breastfeed while on the depot but that getting the depot was recommended for only up to 2 years. I recommended that she speak with her doctor about other forms of birth control after. The mom’s main concern was that she would forget to take the oral tablets. One of her kids the oldest is in kindergarten and the baby and 3 year old attend the early years refugee project.

<table>
<thead>
<tr>
<th>How long was I there</th>
<th>(day 1)time 1-330pm)Mother goose mother interactions with the babies and kids</th>
</tr>
</thead>
<tbody>
<tr>
<td>What did I observe?</td>
<td>Child care worker interactions with moms and kids, singing songs, mother interactions with kids and babies</td>
</tr>
<tr>
<td></td>
<td>The outreach worker trying to help someone with a housing issue</td>
</tr>
<tr>
<td></td>
<td>Snack time with the moms and kids I ate yogurt with moms, babies and kids and helped with clean up</td>
</tr>
<tr>
<td></td>
<td>Some of the kids were playing with some interactive toys and I did the same, basically hung out, I liked the fact that some moms came to me and introduced themselves as I was feeling a bit nervous mostly moms spoke amongst themselves</td>
</tr>
<tr>
<td></td>
<td>I think I was perceived as an outsider, as a nurse and I was casually dressed but I am not too sure, I do think that for the most part people feel comfortable with me around</td>
</tr>
<tr>
<td></td>
<td>I personally feel privileged to be able to have this kind of experience and knowledge they may perceive me as someone with an education</td>
</tr>
<tr>
<td></td>
<td>One interesting thing that came up is that one of the moms asked me if I have children and how many are in my family and where I come from: I have no children and am an only child so this may be perceived as quite different, I explained that I was not able to have children and interestingly the woman asked if I had thought about adoption. I did say that I am an immigrant and that English is my 2/3 language and that my parents didn’t speak English in the home so it was difficult and sometimes still is. Through This interaction I felt</td>
</tr>
</tbody>
</table>
like I was able to make a connection with this particular mom. Still there were some that did not look at me.

Because I am a woman, of similar size to the Karen women perhaps I am perceived as less of an outsider but my clothes, language skill and class make me different. The fact that some women voluntarily came to talk to me while I was sitting at the children’s table made me feel welcomed. Grandpa was there with his grandson as mom was not available.

Day 2 (June 7/12)
(09am to 330pm)

In the morning I spent time mostly in the side office watching the coming and goings but noticed all the action happening at the day care centre. Everyone was making doe for pretzels and I sat and watched the moms and kids work, play and make them. I went into the kitchen to try to help and helped with clean up and tried to fit it. It seems somehow I do fit in as if I work there. I don't know how I was introduced or how but it seems a very long explanation given by DK and it is also strange that I am a nurse as I don’t think anyone really is aware of what mental health nursing might be. All in all I am getting comfortable and am starting to recognize the moms they go there every day and I don’t live there and in some ways I am an outsider looking in. Yes I am the researcher after all what am I observing? Trying to take it all in and feeling overwhelmed.

During the dental screening the dad came in with his son as well as another dad that had two sons (s) said that this family does not participate in the mother goose or services of the refugee day care program but come for the dental screening. That is three men so far that I have seen in the day care centre.

It was a long day today spending the day at the early years refugee project and then going to homework club to see the kids. It sure is starting to feel like a
community a very small one and that somehow I am a part of it. One of the things that struck me the most today was the many many moms and babies that came to the dental clinic this afternoon at the early years centre at xxx. All the kids and moms are different and S was right they certainly do have a lot of children. I particularly liked talking to SG and her questions about the depot for birth control; she does not plan to have any more children. I wish I could have been more helpful, her daughter is beautiful and her husband seems so great as well. I would really want to help her start working as a nurse again.

The daycare centre was so busy and there were over 50 kids under 3 years that came in to do dental care and screening. I watched all the moms interact with their kids and watched the kids being distracted by Li while the dental hygienist examined their teeth. At least a few of the kids cried and screamed and I can only imagine what I must have been like. I felt tired, the moms seemed happy and S was good at making sure everyone came in. I think the kids might have been scared about the mask.

I sat most of the morning listening and watching the moms come in with various requests to the office, a mom wanted to move into another housing unit to be closer to her sister (yesterday). Today a mom came in because she wanted to find out if she had passed her citizenship exam. The morning was spent talking with S and getting a sense of the community and Karen culture. We chatted and S stated that some moms say that the doctor is nicer to me when they have someone come with them, i.e. S. We also spent a lot of time talking about the green house workers and the discrimination that many Karen feel mostly from the East Indian workers. We also spoke about the xxx optometrist and dentist that have worked with the Karen community in providing some medical services (need to get the list from S).

One of the things that I am still not understanding is how to say everyone’s names and how people come to adopt English names such as apple, orange, Kate Windslet, that is still quite strange but as it was explained many Karen families name their kids from
something they have seen or heard with western meanings such as success, handsome etc. I like the fact that S encourages them to keep the Karen name as well as having an English name. Chabot and Shoveller (2010) discuss that adopting a complete emic perspective may not be possible as they describe themselves as female researchers not teen mothers or service providers, similarly I am an outsider, nurse and researcher and my social position allows me to be able to do this research, I may have some privileged knowledge but I think the moms have knowledge and this is what I would like to better understand. Will this fieldwork provide sufficient exposure to the study participant perspectives so as to help ground my interpretation of the data in what is understood to be the participants everyday realities? (Chabot & Shoveller, p.113).

The day ends with homework club and helping E with her interview tomorrow for a volunteer position. I sat and helped the girls. The boys are off to one side in the big hall and everyone is seated at the usual round tables in the big hall. I am almost part of the furniture but still don’t know everyone’s names yet. But feel am getting closer as have met al most all the mothers and younger siblings of the girls who I tutor. I won’t see them for another week. S didn’t come because she was still back at the LCSS finishing up with the dental exams.

| Reflexivity                                                                 | I came at 1pm and was early and had to wait outside in the care parking lot. I reviewed my ethics application as a reminder to myself as to how I was going to conduct the study and what I would say to J. I did eventually go in and meet J and we spent some time talking mostly about me introducing myself and trying to dumb down the language i might use. It turned out that DK conducted all the introductions of me to the Karen women and it took her quite a while to describe who I am and what i do. I did tell her to mention that i am a nurse and that I work as a community mental health nurse and that I am doing a study on Karen womens mental health and well being. I am not sure that mental health will translate well and perhaps this is an area that will need to be further flushed out in both individual and focused |
| My interpretations of those I observed and interviewed.                     |                                                                                                                                                                                                 |
| What cues gave me insight into their perceptions?                          |                                                                                                                                                                                                 |
| How might my behaviours and feelings affect my interpretations of what I observed? |                                                                                                                                                                                                 |
I met all the moms and their kids there were many and they all introduced themselves to me first throwing the ball to the preschool teacher and then saying their name which was clever. I now have a list as I cannot remember or pronounce the names correctly. I sat on the floor cross legged as all the moms and babies do. I noticed that one of the kids was very hyperactive, other kids paid more attention and I remember feeling quite tired. I was also feeling quite honored that they had allowed me into their space, this felt like a special space as it was really only for the moms, the Karen moms and kids and no one else. One man a grandpa was there sitting in the background quiet and much less interactive. He came because the mom was not able to and then the next day the grandma came, his wife.

We had snacks after all the songs and games and one of the moms talked to me about her being a nurse at the refugee camp and how she can not work here as a nurse as it would be different and very difficult to get to go to school. More services need to be geared toward English language training. Another mom came up to me and introduced herself out of the blue and this happened again with a grandma that came up to me. How honored I felt.

I spent a short amount of time with J and S and then left to Vancouver when mother goose was over.

<table>
<thead>
<tr>
<th>Day 2 (June 7/12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(09am to 330pm)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Thoughts about gaining entry;</th>
</tr>
</thead>
<tbody>
<tr>
<td>It occurred to me that perhaps gaining entrance to the Karen moms and their kids is smooth because of my developed relationships with the outreach worker (cultural expert) as well as the manager and it has taken a long time to get their approval. xxx through does not know me and It may be that she is feeling that she is told what to do. I gather she is paid for her work with the moms at the</td>
</tr>
</tbody>
</table>
centre like the outreach worker but don’t know her wage.

In my informal discussions with S she told me that there is some sort of pecking order amongst some of the women so it will be necessary to figure out who is best suited to help conduct the FG interviews, there is also the issue of where the FG will be conducted and child minding services—maybe the church might work as an possibility.

<table>
<thead>
<tr>
<th>Take home</th>
</tr>
</thead>
<tbody>
<tr>
<td>I took home the early year refugee project sign-in sheet so that I could try to remember some of the names of the kids and moms</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideas for interviewing the dentists, local GP’s and optometrists if they have time or want to participate and will get the names from S.</td>
</tr>
<tr>
<td>Ask if I would be allowed to accompany moms and outreach worker on home visits and to doctors and health clinic appointments.</td>
</tr>
<tr>
<td>Ideas for interview questions—may need to ask moms about their access to language skill training, what do they see as being important in managing their health, what kinds of groups and programs would they like to see, what do they like already for instance what do they feel is supportive for their mental health and well-being?</td>
</tr>
<tr>
<td>How long is it that families wait for their citizenship? In the office one mom came in and has been waiting a year to find out the results of her citizenship exam. In addition a mom explained to the outreach worker that her husband had passed his driver’s licence but that he could not get it because he did not have valid BC ID because he did not have his citizenship card and his …card had expired, it costs money to renew this card every year while awaiting the citizenship card.</td>
</tr>
<tr>
<td>One striking feature of the outreach workers office is the myriad of newspaper articles of the Karen people in xxx and I think further analysis of the newspaper articles may give valuable insights into community capacity and provide a historical context, economy, services and social relations and information about the local culture.</td>
</tr>
</tbody>
</table>
Appendix K.
Translator Confidentiality Agreement Form

This form is being used for individuals who are hired to conduct the transcribing, interpreting, and/or translating data in the following research study titled, *Examining Community Capacity to Support Karen Refugee Women’s Mental Health and Well-Being in the Context of Resettlement in Canada.*

I, ____________________________________________________________, the__________________________________________________________
(specific job description, e.g., interpreter and or translator) have been hired to ____________________________________________________________

I agree to -

1. Keep all the research information shared with me confidential by not discussing or sharing the research information in any form or format (e.g., disks, tapes, transcripts) with anyone other than the Researcher(s).
2. Keep all research information in any form or format (e.g., disks, tapes, transcripts) secure while it is in my possession.
3. Return all research information in any form or format (e.g., disks, tapes, transcripts) to the Researcher(s) when I have completed the research tasks.
4. After consulting with the Researcher(s), erase or destroy all research information in any form or format regarding this research project that is not returnable to the Researcher(s) (e.g., information stored on computer hard drive).
5. Maintain the confidentiality and privacy of all research participants in this research.

__________________________________________  ____________________________________________  ____________________________________________
(Print Name)  (Signature)  (Date)

Researcher(s)

__________________________________________  ____________________________________________  ____________________________________________
(Print Name)  (Signature)  (Date)

The plan for this study has been reviewed for its adherence to ethical guidelines and approved by the Behavioural Research Ethics Board (BREB) at the University of British Columbia and the Fraser Health Research Ethics Board (FHREB) in British Columbia. For questions regarding participant rights and ethical conduct of
research, you may contact the research subject information line at the University of British Columbia at (604) 822-8598 or email to RSIL@ors.ubc.ca. You may also discuss your rights with one of the co-chairmen of the FHREB, Dr. Aton Grunfeld or Dr. Allen Belzberg by calling (604)587-4648.

Confidentiality agreement form, Version 1, January 1, 2013
Appendix L.
Script of Oral Consent to Conduct Participant Observations

The purpose of this research is to understand what supports and or challenges Karen women's mental health and well-being during the process of resettlement. In order to understand how women access health care, social services and supports it is often helpful to observe this process directly. Your verbal consent will allow Nancy Clark to observe our interaction for the purpose of this research project. Would you feel comfortable in having Nancy observe how we provide services and supports to you in your home\office today? If you agree to have Nancy observe our interaction, any information shared will remain confidential. Your name will not be included in any documents or reports. Should you at any time feel uncomfortable about this process, you have the right to request that Nancy not attend our meeting. Please feel free to ask questions at any time regarding Nancy’s observation of us and or her research project. Your participation will in no way affect our ability to provide services to you or your ability to access our services. If you have any questions or concerns about this research you may contact either Dr. Victoria Smye at xxx-xxx-xxxx or via email at email or Nancy Clark at xxx-xxx-xxxx or email. Furthermore, if you have any concerns or complaints about your rights and/or Nancy’s observation of your access to health care and social services and support please contact the members of the Research Ethics Behavioral Review committee that approved this study. You may contact Dr. Anton Grunfeld or Dr. Allan Belzberg, REB Co-chairs by calling 604-587-4681. You may also contact the Research Subject Information Line at the Office of Research Services at the
University of British Columbia at 604-822-8598, or email to RSIL@ors.ubc.ca. Thank you very much for allowing Nancy to observe our interactions.
Appendix M: Consent to Participate in Field Observations

THE UNIVERSITY OF BRITISH COLUMBIA

Examining Community Capacity to Support Karen Refugee Women’s Mental Health and Well-Being in the Context of Resettlement in Canada

Principle Investigator: Dr. Victoria Smye
UBC School of Nursing
Telephone: xxx-xxx-xxxx

Co-Investigator: Nancy Clark PhD (Candidate)
UBC School of Nursing
Telephone: xxx-xxx-xxxx

The purpose of this research study is to examine the factors that both facilitate and/or challenge community capacity to support Karen women’s mental health and well-being in the context of resettlement. This research is important because mental health and well-being for refugee women has been shown to be related to their experience and access to health care and social support during resettlement. It is hoped that the findings from this study will assist community mental health, primary health care providers and social service providers develop practices and policies that support Karen refugee women’s health and well-being.

An important part of conducting this research includes participant observation in the field. The purpose of conducting participant observation is to gain a better understanding of the local culture and to gain exposure to the day-to-day activities that take place within a specific context or place. This is done so as to gain an understanding of local knowledge of Karen women’s experiences and perspectives regarding their health care needs. Typically this kind of observation occurs in specific community contexts.

Your consent in this regard will allow Nancy Clark to observe and participate in the day-to-day activities of your agency and may include the accompaniment of Nancy
Clark with the outreach worker and/or participation in volunteering at community field trips through your agency for the purposes of her research. During participant observation Nancy will be taking field notes about the environment, content of informal conversations and Karen women’s activities related to the purpose of this research. However it will be emphasized that individuals who choose not to engage in conversations with Nancy or choose not be observed will not experience any repercussions as a result. If casual conversations during participant observation give rise to more substantive discussion of the research topic, individuals will be asked to sign a written consent form in order to conduct an in depth interview. We hope that participant observation can greatly improve the understandings of data gained through individual and focus group interviews.

The presence, purpose and identify of the co-investigator will be made known to all individuals being observed both verbally and by posting a notice. The presence of the co-investigator will not compromise the privacy and/or day-to-day activities within the agency in anyway. Frequent consultation for conducting participant observation will be done in order to ensure that your agency feels safe. It is not anticipated that conducting participant observation will cause any physical or psychological harm, however should you feel uncomfortable participant observations will be stopped and you have the right to refuse participant observations to be conducted at any time. Participant observations will only be conducted at specific times that your agency designates as appropriate. In order to gain cultural understandings of the day-to-day activities within your agency it may be necessary to spend longer periods of time conducting participant observations that may range from an hour, to an afternoon or series of days or afternoons, depending on your availability.

While there are no direct benefits to you, some agencies may find it helpful to have an extra person on hand that is able to provide services such as answering the phone or doing office work, for example.

The data from participant observations will be recorded in a field notebook. This data may also include diagrams, charts and detailed notes regarding the number of people in a particular space and the nature of their relationships. These notes will be later entered into a computer software program. The names and identities of people being observed will not be included in the field notes. Furthermore, no personal characteristics or personal data will be disclosed by the researcher inside or outside of the context of where the participant observation is being conducted or in presentations of the data in public dissemination events or printed publications.

If you have any questions or desire further information about any aspect of this study, you are invited to contact Dr. Victoria Smye at xxx-xxx-xxxx or email or Nancy Clark at xxx-xxx-xxxx email. Furthermore, if you have any concerns or complaints about your rights as a research subject and/or your experiences while participating in this study, contact Dr. Anton Grunfeld or Dr. Allan Belzberg, REB Co-chairs by calling 604-587-4681. You may discuss these rights with one of the co-chairmen of the Fraser Health REB. You may also contact the Research Subject Information Line.
at the Office of Research Services at the University of British Columbia at 604-822-8598, or email to RSIL@ors.ubc.ca.

Thank you for considering involvement in this study. If you consent to having participant observations being conducted at your agency, your signature is required below.

Sincerely,

Vicki Smye, PhD RN
Nancy Clark, PhD (Candidate) RN

I understand that by signing this form I consent to have the co investigator of this study conduct participant observations at my agency. I understand that giving permission to conduct participant observations at this agency is voluntary and that I may choose to refuse, participate or withdraw from the study at any time.

My signature below indicates that (1) I consent to having participant observations conducted at my agency, and (2) I have received a copy of this consent form for my own records.

Participant's Signature  Printed name  Date

I do/do not (please circle) give permission for the research investigators to use information that I am providing for future studies conducted by them related to this topic, assuming that the study is reviewed and approved through a university Ethics Review Committee.

Participant's Signature

My signature below indicates that (1) I consent to participate in this study, and (2) I have received a copy of this consent form for my own records.

Participant's Signature  Printed name  Date

Karen Interpreter Signature  Printed name  Date
I do/do not (please circle) give permission for the research investigators to use information that I am providing for future studies conducted by them related to this topic, assuming that the study is reviewed and approved through a university Ethics Review Committee.

Participant’s Signature

Consent to participate in field observations, Version 2, January 1, 2013
Appendix N.
Consent for Karen Women’s Family Members to Participate in Individual and Focus Group Interviews

THE UNIVERSITY OF BRITISH COLUMBIA

Examining Community Capacity to Support Karen Refugee Women’s Mental Health and Well-Being in the Context of Resettlement in Canada

Principle Investigator: Dr. Victoria Smye
UBC School of Nursing
Telephone: xxx-xxx-xxxx

Co-Investigator: Nancy Clark PhD (Candidate)
UBC School of Nursing
Telephone: xxx-xxx-xxxx

The purpose of this research study is to examine the factors that both facilitate and/or challenge community capacity to support Karen women’s mental health and well-being in the context of resettlement. This research is important because mental health and well-being for refugee women has been shown to be related to their experience and access to health care, social services and support during resettlement. However, family and family relationships also play an important role in understanding how new comer families manage the stress of resettlement and access to health care, social services and supports. If you decide to participate in this study you will meet with Nancy Clark to discuss your perspectives on what factors shape family relations in the context of resettlement experiences. As a family member, you will also be asked questions about your experience in accessing health care services and social supports for your family. It is hoped that the findings from this study will inform current policies and practices related to refugee women’s health as well as to assist community mental health; primary health care providers and social service providers develop practices and policies that support Karen refugee resettlement.
This study is being conducted as part of the requirements toward a PhD for Nancy Clark and is funded by the Bottom Billion Fieldwork fund through the Liu Institute for Global Issues at the University of British Columbia.

Interviews may last up to 60 to 90 minutes. If you are willing, another interview of similar length may be requested in order to clarify or discuss some of what you said in the first individual interview. This meeting may be conducted through a one on one discussion with Nancy and/or you may be requested to participate in a focus group interview with other Karen participants. These discussions may last from 60 to 90 minutes. If you are willing, another interview of similar length may be requested in order to clarify or discuss some of what you said in the first interview. All interview(s) will take place at a time and location of your choice-this could include your home. If you require transportation costs, you will be provided with a bus ticket. With your permission, the interviews will be conducted in the language of your choice, audio-taped and transcribed; a copy of the interview transcript will be given to you upon request. A Karen language interpreter will be available during the discussions if you request one.

Your participation in this study is voluntary. You have the right to refuse to answer any questions, to request that the audio recording be stopped at any time, and to withdraw any information you do not wish to have included in this study. You also have the right to withdraw from this study at any time. Should you withdraw from the study, the information you have provided up to the point of withdrawal will be used in the data analysis, unless you state that you wish to have it removed.

In order to protect your privacy and confidentiality, the information you provide will be not be shared with any other family members. Consent forms, transcripts and audiotapes of all interviews will be kept in a locked cabinet in the secured offices of the Principal Investigator and/or Co-Investigator. Your name and any other identifying information will be removed from all transcripts; pseudonyms will be used to reference you. All electronic files will be kept on a password-protected computer in the secured offices of the Principal Investigator and the Co-Investigator. Access to these offices and files is strictly controlled and limited to the Principal and Co-Investigators.

It is not anticipated that your participation will cause any physical or psychological harm, however we recognize that talking about your experiences may cause some distress or make you feel uncomfortable. You are not obliged to answer any questions that make you feel uncomfortable or that you do not wish to answer. Should you experience any distress or discomfort with the interview, it will be stopped immediately, and Nancy Clark will assist you in accessing the appropriate support. Nancy Clark will also provide you with a written list of support services prior to the interview(s).

While there are no direct benefits to you as a family member, some people find it beneficial to talk about their perspectives and experiences in relation to supporting a family member to access health care and social services. In addition, by participat-
ing in this research you may help contribute to helping communities plan for support and services for Karen refugee women and their families and help to increase knowledge about the role of family supports.

The findings of this study will be reported in Nancy Clark’s dissertation, research journals, conferences, community presentations and workshops. In order to protect your privacy and confidentiality your name will not be included in any of the data or final dissemination of this study. All efforts will be made to insure that you are not identified by others by changing or removing information that might otherwise readily identify you. In order to ensure accuracy of the interpretation of the interview a Karen translator will also review the transcribed interviews with your permission. Both interpreters and translators are required to sign a confidentiality agreement form in order to protect your privacy and maintain confidentiality.

In acknowledgement of your participation in this research you will be provided with an honorarium of your choice of $30.00 in the form of a gift certificate and or cash in the same amount at the beginning of the consent process. If you decide to withdraw from this study you will not be required to give back the honorarium.

If you have any questions or desire further information about any aspect of this study, you are invited to contact Dr. Victoria Smye at xxx-xxx-xxxx or email or Nancy Clark at xxx-xxx-xxxx or email. Furthermore, if you have any concerns or complaints about your rights as a research subject and/or your experiences while participating in this study, contact either Dr. Anton Grunfeld or Dr. Allan Belzberg, REB co-chairs by calling 604-587-4648. You may discuss your rights with one of the co-chairmen of the Fraser Health REB. You may also contact the Research Subject Information Line at the Office of Research Services at the University of British Columbia at 604-822-8598, or email to RSIL@ors.ubc.ca.

Thank you for considering involvement in this study. If you agree to participate, your signature is required below.

Sincerely,

Vicki Smye, PhD RN                                      Nancy Clark, PhD (Candidate) RN

I understand that my participation in this study is entirely voluntary. I may choose not to participate or may withdraw from the study at any time.

My signature below indicates that (1) I consent to participate in this study, and (2) I have received a copy of this consent form for my own records.

Participant’s Signature  Printed name  Date
I do/do not (please circle) give permission for the research investigators to use information that I am providing for future studies conducted by them related to this topic, assuming that the study is reviewed and approved through a university Ethics Review Committee.

__________________________
Participant’s Signature

Consent form Version 1, January 1, 2013
Appendix O.
Interview Guide for Karen Family members

(Invitational Questions)

1. What is your role within the family?
2. In your culture are there specific roles between family members?
3. Are there specific things that you do to assist family members to help manage their daily routines and activities?
4. How has your role changed since coming to Canada?
5. What is your role in relation to your family's health?
6. What role do you have in being able to assist family members to manage their daily activities, such as going to work or school?
7. What are some of the challenges that you have experienced in helping your family to access health care?
8. What assists you in helping family members' access health care or other services?
9. During resettlement some families find it difficult to manage work and raising children in a new country, how does your family manage these kinds of challenges?
10. Is there any specific health concern that is affecting your family and that you would like to discuss?
11. What do you feel would improve access to health and social services and supports for your family?
Appendix P.
Consent for Policy Makers to Participate in Individual Interviews

THE UNIVERSITY OF BRITISH COLUMBIA

Examining Community Capacity to Support Karen Refugee Women’s Mental Health and Well-Being in the Context of Resettlement in Canada

Principle Investigator: Dr. Victoria Smye
UBC School of Nursing
Telephone: xxx-xxx-xxxx

Co-Investigator: Nancy Clark PhD (Candidate)
UBC School of Nursing
Telephone: xxx-xxx-xxxx

The purpose of this research study is to examine the factors that both facilitate and/or challenge community capacity to support Karen women’s mental health and well-being in the context of resettlement. Federal and provincial policies regarding immigration and refugee resettlement affect new comer access to social services, support and health. Gaining an understanding of health policy related to immigrant and refugee women’s health and mental health can explicated how policies and practices shape refugee women’s access to health care and their social service needs. This research is important because mental health and well-being for refugee women has been shown to be related to their experience and access to health care, social services and support during resettlement. It is hoped that the findings from this study will inform current policies and practices related to refugee women’s health as well as to assist community mental health; primary health care providers and social service providers develop practices and policies that support Karen refugee women’s health and well-being.

This study is being conducted as part of the requirements toward a PhD for Nancy Clark and is funded by the Bottom Billion Fieldwork fund through the Liu Institute for Global Issues at the University of British Columbia.
If you decide to participate in this study you will meet with Nancy Clark to discuss your perspectives on the development of strategic directions or policies within your organization that are related to immigration, resettlement and or health care services. You will also be asked questions about your role in the development of policy related to refugee resettlement and or health policy specific to new comer groups. Interviews may last up to 60 to 90 minutes. If you are willing, another interview of similar length may be requested in order to clarify or discuss some of what you said in the first individual interview. All meetings will take place at a time and location of your choice. With your permission, the interviews will be audio-taped and a copy of the interview transcript will be given to you upon request.

Your participation in this study is voluntary. You have the right to refuse to answer any questions, to request that the audio recording be stopped at any time, and to withdraw any information you do not wish to have included in this study. You also have the right to withdraw from this study at any time. Should you withdraw from the study, the information you have provided up to the point of withdrawal will be used in the data analysis, unless you state that you wish to have it removed. Your decision to withdraw or not participate in this study will in no way jeopardize your work within your organization.

The information you provide will be kept confidential unless you specify otherwise in writing. Consent forms, transcripts and audiotapes of all interviews will be kept in a locked cabinet in the secured offices of the Principal Investigator and/or Co-Investigator. Your name and any other identifying information will be removed from all transcripts; pseudonyms will be used to reference you. All electronic files will be kept on a password-protected computer in the secured offices of the Principal Investigator and the Co-Investigator. Access to these offices and files is strictly controlled and limited to the Principal and Co-Investigators.

It is not anticipated that your participation will cause any physical or psychological harm, however we recognize that talking about your experiences may cause some distress or make you feel uncomfortable. You are not obliged to answer any questions that make you feel uncomfortable or that you do not wish to answer. Should you experience any distress or discomfort with the interview, it will be stopped immediately, and Nancy Clark will assist you in accessing the appropriate support. Nancy Clark will also provide you with a written list of support services prior to the interview(s).

While there are no direct benefits to you, some people find it beneficial to talk about their perspectives and experiences in relation to their work and policy initiatives that provide health care and support services for newcomer groups. In addition, by participating in this research you may help contribute to helping communities plan for support and services for Karen refugee women as well as other newcomer women.

The findings of this study will be reported in Nancy Clark’s dissertation, research journals, conferences, community presentations and workshops. In order to protect
your privacy and confidentiality your name will not be included in any of the data or final dissemination of this study. All efforts will be made to insure that you are not identified by others by changing or removing information that might otherwise readily identify you.

If you have any questions or desire further information about any aspect of this study, you are invited to contact Dr. Victoria Smye at xxx-xxx-xxxx or Victoria.smye@nursing.ubc.ca or Nancy Clark at xxx-xxx-xxxx or n.clark@shaw.ca. Furthermore, if you have any concerns or complaints about your rights as a research subject and/or your experiences while participating in this study, contact either Dr. Anton Grunfeld or Dr. Allan Belzberg, REB co-chairs by calling 604-587-4648. You may discuss your rights with one of the co-chairmen of the Fraser Health REB. You may also contact the Research Subject Information Line at the Office of Research Services at the University of British Columbia at 604-822-8598, or email to RSIL@ors.ubc.ca.

Thank you for considering involvement in this study. If you agree to participate, your signature is required below.

Sincerely,

Vicki Smye, PhD RN         Nancy Clark, PhD (Candidate) RN

____________________________________________________________________________________

I understand that my participation in this study is entirely voluntary. I may choose not to participate or may withdraw from the study at any time.

My signature below indicates that (1) I consent to participate in this study, and (2) I have received a copy of this consent form for my own records.

____________________________________________________________________________________

I do/do not (please circle) give permission for the research investigators to use information that I am providing for future studies conducted by them related to this topic, assuming that the study is reviewed and approved through a university Ethics Review Committee.

____________________________________________________________________________________
Appendix Q.
Interview Guide for Policy Members

(Invitational Questions)

1. What is your current job and role?
2. How long have you been in this position?
3. Who are the major players in strategic policy development in your organization?
4. What is your understanding of immigrant and or refugee health, mental health and well-being in relation to resettlement?
5. Are there current policy initiatives that link to health needs of immigrants and refugees within your organization? Are any of these initiatives specific to women?
6. What major documents are shaping or influencing immigration policy related to refugee resettlement?
7. Are you aware of specific policies related to immigrant or refugee health or mental health? And if so, what are the major health conditions that are priority?
8. What do you see as gaps in relation to refugee resettlement and or refugee health? And are there strategic directions that address gaps related to refugee resettlement and or health?
9. What would motivate policy makers to keep the mental health, well-being of refugee women on the agenda?
10. What factors do you think facilitate your organization's approach to resettlement and health needs of newcomers, particularly government assisted refugees and women?

11. What factors challenge or hinder your organization's approach to resettlement and health needs of newcomers, particularly government assisted refugees and women?

12. What kinds of evidence would inform policy on community capacity and refugee health and [mental health] to support refugee resettlement?