

**Refugee women's experiences with sexual violence and their post-  
migration needs in Canada**

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## **Abstract**

### **Résumé**

La violence sexuelle est une question proéminente dans le monde entier, en particulier durant les périodes de guerre et de conflit. Pour les femmes réfugiées, les expériences de violence sexuelle sont souvent incorporées dans les motifs de migration forcée de ces femmes. Pendant le processus d'immigration au Canada, les femmes réfugiées sont invitées à partager leurs expériences et témoignages. À cette étape, ces dernières ont le choix de divulguer ou non leurs antécédents de violence sexuelle. En Juin 2012, le gouvernement Canadien a fait des coupures budgétaires substantielles dans le Programme Fédéral de Santé Intérimaire. Pour ces femmes réfugiées qui sont des survivantes de violence sexuelle, cela signifie qu'elles sont davantage limitées dans l'accessibilité aux services dont elles pourraient avoir besoin pour faire face à la violence sexuelle qu'elles ont vécues. En puisant dans les entrevues que nous avons mené(e)s auprès d'informateurs clés (n=15) et de femmes réfugiées (n=12) à Toronto et à Ottawa, cette thèse explore les expériences vécues des femmes réfugiées de même que les changements, le cas échéant, qui devraient être apportés à la prestation actuelle de services. Nos résultats montrent qu'il y a un besoin prononcé pour des améliorations, à petite et grande échelle, aux niveaux des systèmes et de la prestation de services.

### **English**

Sexual violence is a prominent issue worldwide, especially during times of war and conflict. For refugee women, experiences with sexual violence are often incorporated in women's reasons for forced migration. During the immigration process to Canada, refugee women are asked to share their narratives, at which point they may or may not disclose their histories of sexual violence. In June 2012, the Canadian government made substantial cuts to the Interim Federal Health Program. For refugee women who are survivors of sexual violence, this means that they are further limited in accessing services they might require in order to deal with the sexual violence they have experienced. Drawing from interviews we conducted with key informants (n=15) and refugee women (n=12) in both Toronto and Ottawa, this thesis explores both the lived experiences of refugee women and the changes, if any, that should be made to current service delivery. Our results show that there is a pronounced need for both small- and large-scale improvements at the systems and service delivery levels.

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## **List of Acronyms and Abbreviations**

<b>AMSSA of BC</b>	Affiliation of Multicultural Societies and Services Agencies of British Columbia
<b>BOC</b>	Basis of Claim
<b>CCR</b>	Canadian Council for Refugees
<b>CDC</b>	Centers for Disease Control and Prevention (US)
<b>CIC</b>	Citizenship and Immigration Canada
<b>DCOs</b>	Designated Countries of Origin
<b>GAR</b>	Government-Assisted Refugee
<b>GBV</b>	Gender-Based Violence
<b>H&amp;C</b>	Humanitarian and Compassionate Application
<b>HSRG</b>	Human Security Research Group
<b>IFHP</b>	Interim Federal Health Program
<b>IPV</b>	Intimate Partner Violence
<b>IRB</b>	Immigration and Refugee Board
<b>LCR</b>	Landed-in Canada Refugee
<b>PIF</b>	Personal Information Form
<b>PSR</b>	Privately Sponsored Refugee
<b>UNHCR</b>	The United Nations High Commissioner for Refugees
<b>WHO</b>	World Health Organization

## **Chapter 1: Introduction**

### **Background**

Gender-based violence (GBV) is a prominent issue worldwide, but vulnerable populations are at a higher risk of being subjected to violence. GBV is defined as violence that is targeted toward an individual or group based on gender (Centers for Disease Control and Prevention [CDC], 2004). The act itself may be physical, mental, or sexual in nature and causes harm or suffering to the victim/survivor (CDC, 2004). These acts are influenced by unequal gender rights and cultural beliefs surrounding gender roles as well as patriarchal values ingrained in society (CDC, 2004). The most prominent form of GBV among refugees are intimate partner violence (IPV) – often referred to as domestic violence – and sexual violence (World Health Organization [WHO], 2003).<sup>1</sup>

### *Intimate partner violence*

IPV can take many forms including: physical violence (e.g. slaps, punches, kicks, and assault with weapons), sexual violence (e.g. forced sex or forced participation in sexual acts), emotional abuse (e.g. ongoing belittlement or humiliation), and economic restrictions (e.g. controlling a woman's earnings or work life) (Watts & Zimmerman, 2002). IPV is perpetuated by intimate partners but can also be inflicted on women by other family members (Human Security Research Group [HSRG], 2012). IPV occurs as a result of many intersectional issues including: culture, gender, race, and class (Sokoloff & Dupont, 2005). Refugee women are more vulnerable to IPV due to their and their families' traumatic histories and experiences, especially those prior to arrival in their country of asylum (Zannettino, Pittaway, Eckert, Bartolomei, Ostapiej-Piatkowski, Allimant, & Parris, 2013).

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<sup>1</sup> "A person who is forced to flee from persecution and who is located outside of their home country" (Canadian Council For Refugees [CCR], 2010, p. 1).

Combined with the pressures associated with conflict and displacement, IPV can have profound physical, psychological, and emotional consequences (The United Nations High Commissioner for Refugees [UNHCR], 1995; Raphael, Taylor, & McAndrew, 2008).

Globally, it is estimated that IPV affects one in three women (Raphael et al., 2008, p. 16). Refugee and displaced women are impacted by both the baseline prevalence of violence and the additional risks associated with conflict (Raphael et al., 2008). Displaced and refugee women have reported experiencing sexual abuse, physical abuse, and domestic violence during their childhood before they “were [even] impacted by the violence that forced them to become refugees” (Kallivayalil, 2013, p. 321). In their report, the HSRG states, “the large majority of noncombatant sexual violence in wartime is made up of domestic sexual violence” (2012, p. 21). Despite not exclusively being their reason for fleeing, IPV is only one of many forms of violence that refugee women experience prior to immigration (Zannettino et al., 2013; World Health Organization [WHO], 2002).

### *Sexual violence*

Sexual violence may be executed using sexual acts and/or threats or advances of an unwanted sexual nature. Despite the act itself being of a sexual nature, sexual violence is an act of aggression as perpetrators are often motivated by a desire for power, control, and dominance and their acts are aimed at “violating a person’s innermost physical and mental integrity” (UNHCR, 1995, p. 4). Refugee women most commonly experience sexual violence through coercion from those in a position of power (CDC, 2004). The WHO (2002) defines sexual violence as:

[A]ny sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using

coercion by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work (p. 5)

Many other acts of sexual violence are not clearly described in the overarching definition of sexual violence including the “insertion of objects into genital openings, oral and anal coitus, attempted rape and the infliction of other sexually abusive acts” (UNHCR, 1995, p. 4) or that it can also involve the threat or use of force in order to have sexual acts performed.

Any act of sexual violence, including sexual violence associated with IPV, has a negative impact on survivors, their families, and their communities. Sexual violence is associated with an increased risk of unintended pregnancy, acquisition of sexually transmitted infections, and transmission of human immunodeficiency virus/acquired immune deficiency syndrome [HIV/AIDs] (WHO, 2003). Additionally, sexual violence can also affect a woman’s mental health, the effects of which are often “long lasting” (WHO, 2003, p. 1).

Due to the nature of sexual violence, there is a high rate of underreporting worldwide, making it difficult to determine its prevalence (WHO, 2007a). The reasons for non-reporting are complex and multifaceted. The UNHCR’s *Sexual violence against refugees: Guidelines on prevention and response* and the WHO’s *Guidelines for medico-legal care of victims of sexual violence* largely attribute the underreporting to women’s feelings of “shame, social stigma and fear of reprisal or the case going to trial” (UNHCR, 1995, p. 1) and the “fear of retribution or ridicule, and a lack of confidence in investigators, police and health workers” (WHO, 2003, p. 9). Despite the significant underreporting of sexual violence worldwide, in some countries, one in four women reported experiencing sexual violence (Chung, 2005; WHO, 2003) and one in five women will become a victim of rape or attempted rape over the course of their lifetimes (UNITE, 2009).

### *Sexual violence in conflict-crisis settings*

In times of war and conflict, violence against women may be used to reinforce power differentials and/or be used as a weapon of war. Sexual violence in times of war is destabilizing, scarring, and stigmatizing (Anderson, 2010) and is used to “demoralize the enemy” (WHO, 2003, p. 7). For these reasons, rape is very common in conflict and crisis settings (Friedman, 1992; Government of the United Kingdom, 2014; UNHCR, 1995; WHO, 2002). The UNHCR identifies “unaccompanied women, lone female heads of household, unaccompanied children, children in foster care arrangements [and] those in detention or detention-like situations” as the most vulnerable with respect to sexual violence (1995, p. 4). More specifically, women who have been detained or incarcerated face a heightened risk of being subjected to sexual violence inflicted on them by prison guards and police officers (WHO, 2003).

### *Sexual violence during the migration process*

As a result of political persecution or war, many women attempt to flee their countries of origin in search of refuge. The need for safe passage into another country further renders refugee women vulnerable (UNHCR, 1995). In many cases, women do not have enough time to gather all of the necessary documentation or proof which puts them at a heightened risk of sexual exploitation and abuse (UNHCR, 1995). A 1995 UNHCR report states that:

Refugees and asylum-seekers, including children, in many instances have been subjected to rape or other forms of sexual violence during their flight or following their arrival in countries where they sought asylum, including sexual extortion in connection with the grating of basic necessities, personal documentation or refugee status (p. 5)

The UNHCR asserts that women struggle during three separate phases: prior to flight, during the flight, and in the country of asylum (1995).

#### *Prior to flight*

The prior to the flight stage is when refugee women are attempting to flee their homes either within their country or to another country (Forum on Global Violence Prevention, Board on Global Health, Institute of Medicine, & National Research Council, 2013). During this stage, refugee women may be targeted by officials in their country or detained in state prisons and subjected to various forms of sexual violence including battering, torture, sexual exploitation, and rape (UNHCR, 1995). The violence that they experience may be heightened by internal conflict within the country of origin (UNHCR, 1995).

#### *During the flight*

During their flight, refugees are desperate and vulnerable to others' advances (Friedman, 1992; UNHCR, 1995). While fleeing, refugees run the risk of being victimized by "pirates, bandits, members of the security forces, smugglers or other refugees" (UNHCR, 1995, p. 5) as well as border guards and officials in the country of asylum (Ferris, 2007; UNHCR, 2003).

#### *In the country of asylum*

Upon arrival in a country of asylum, refugees should feel a sense of security and safety; however, refugees, both in camps and urban environments, are often taken advantage of by authority figures in an exchange for their acceptance into the country as a

refugee (UNHCR, 1995, 2003). Furthermore, past sexual violence can cause retraumatization which can deplete emotional resources, increase susceptibility to future violence, and affect social and familial relationships.<sup>2</sup>

In some cultures and due to various social dynamics, familial response to sexual violence can be one that perpetuates victim blaming in that men go unpunished and women are deemed responsible for having “lost” the family’s honour (WHO, 2002, p. 160). After having fallen victim to sexual violence, women may no longer be eligible for marriage and may be held accountable for having been raped (UNHCR, 1995). For women who are also victims of IPV and from cultures where marital rape is not recognized, they “would be less likely to label their experience [as sexual violence], or to consider what had been done to them as abusive, such that a direct disclosure may never be forthcoming” (Baillot, Cowan, & Munro, 2012, p. 282). Some women also avoid speaking about their experience because they fear losing any support they already have (both external or familial), not being believed, being blamed, or being ostracized from their families, spouses, and communities (Berman, Girón, & Marroquín, 2009; Government of the United Kingdom, 2014; UNHCR, 1995).

### *Short history of refugee immigration in Canada*

In 2013, Canada received more than 10,380 claims from asylum seekers (Government of Canada, 2014a).<sup>3</sup> Canada has a rich history of aiding those seeking refuge supported by both national and international mechanisms. In 1951, The *United Nations Convention Relating to the Status of Refugees* was the first legal document created that defined “who is a refugee” and their rights as refugees (Citizenship and Immigration Canada

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<sup>2</sup> Retraumatization is defined as “triggering [event that cause] the victim to be overwhelmed by memory and feelings from the previous trauma” (UNHCR, 1995, p. 28)

<sup>3</sup> When a person’s claim is still in process, they are known as an asylum seeker or claimant (Di Tomasso, 2010).

[CIC], 2012a; UNHCR, 2015). In 1960, Prime Minister John Diefenbaker introduced Canada's first Bill of Rights to bring about awareness of human rights issues (CIC, 2012a). Nine years later, "Canada signed the *United Nations Convention Relating to the Status of Refugees*, and its Protocol, agreeing not to return a person to their country of origin if that person had grounds to fear persecution" (CIC, 2012a). In 1989, Canada created the Immigration and Refugee Board (IRB) by amending the 1985 Immigration Act (Rousseau, Crépeau, Foxen, & Houle, 2002). By the 1990s, Canada welcomed asylum seekers from all over the world including Latin America, Eastern Europe, and Africa (CIC, 2012a).

On March 9, 1993 the IRB created the *Guidelines on women refugee claimants fearing gender-related persecution* which made Canada the first country to include gender as a "social group" under the 1951 Convention (Ramirez, 1994; Berman et al., 2009; Valji & De La Hunt, 1999). Having these guidelines in place allows for special recognition and guidance when analyzing gender differences in migration, specifically with claims submitted by women (Ramirez, 1994). Considering that approximately half of all asylum seekers, refugees, and immigrants that come to Canada are women, these guidelines were an important step in facilitating the immigration process for this group (Guruge, Roche, & Catallo, 2012).<sup>4</sup>

The 1993 *Guidelines* were created as a result of the dedication and hard work of many women fighting for social justice in Canada. The women's movement in Canada is the driving force that fueled women's fight to "redefine their place in society" and played a crucial role in the development and implementation of "abortion services, health centres...day-care[s], shelters for battered women and rape crisis centres, and organizing for equal pay" (Eichler, Lavigne, & Historica Canada, 2015). This movement in conjunction with the 1985 UNHCR recognition of women as a "social group" highlighted the need to

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<sup>4</sup> An immigrant is "a person who has settled permanently in another country" (CCR, 2010, p. 2).

acknowledge, and construct policies that acknowledge that women face gender-specific issues during war, conflict, and asylum seeking (Ramirez, 1994).

In 1990, following the UNHCR distinction, Canada created its first Working Groups comprised of many individuals representing a range of organizations and professions as well as refugee women themselves (Ramirez, 1994). These Working Groups were assigned certain gender-based claims to review. As a group, they determined the appropriate measures to be taken to ensure that sensitivity is used when hearing claims based on these grounds. Being those most familiar with refugee women's issues, the Working Groups worked to create training mechanisms for key stakeholders on the procedures concerning gender-based refugee claims. The Working Groups also consulted with a range of organizations including: CCR, UNHCR, Canadian Advisory Council on the Status of Women, Status of Women Canada, and the Canadian Council of Churches on the implementation of guidelines for hearing gender-based refugee claims (Ramirez, 1994). These Working Groups were part of the first steps in Canada to recognize the need for and importance of addressing gender issues during immigration.

Prior to changes to the Immigration Act in 2012, Canada had in place what is now referred to as the "old immigration system". Originally, refugees were required to fill out a document called the Personal Information Form (PIF) and submit their claims to the IRB. Under the old system, it could have taken as long as three years for the entire refugee determination process (the entire process a refugee claimant must go through to receive their determination) to be completed (Yu, Ouellet, & Warmington, 2007). By this time, refugees were able to argue their claim based not only on their reason for fleeing their country of origin but also on their resettlement in Canada. In general, many refugees and their families had already begun the integration process before having received refugee status in Canada.

On December 15<sup>th</sup> 2012, the Government of Canada overhauled the immigration system (Government of Canada, 2013). As a result of these changes, the Basis of Claim (BOC) form replaced the PIF. For refugee claimants, their BOC is to be submitted to the IRB within 15 days of making their claims (Government of Canada, 2012a). With the recent changes, hearings for most refugee claimants are held no later than 60 days after the claim has been brought to the IRB (Government of Canada, 2012a). However this process is further shortened for refugee claimants from designated countries of origin (DCOs).<sup>5</sup> For them, hearings will be held within 45 days after their case has been brought to the IRB. Lastly, for claimants who make their claim at the portal of entry to the Canada Border Services Agency, their hearing is to be scheduled no later than 30 days after their claim has been brought to the IRB (Government of Canada, 2012a).

In addition to the immigration changes, the Canadian government has voiced its commitment to strengthening refugee protection by enhancing the resettlement program offered to refugees (Government of Canada, 2012b). In 2011, Canada committed to expanding its refugee resettlement programs by 20% over the next three years (CIC, 2012b). This involved increasing 1) the number of refugees resettled from abroad; and 2) resettlement assistance provided to refugees (Government of Canada, 2012b). Since 2006, the Canadian government has tripled the funding allocated to immigrant settlement in furtherance of these aims (Government of Canada, 2012b).

### *Immigrating to Canada as a refugee*

Despite Canada's efforts to facilitate integration and resettlement in Canada, it is still an arduous process for refugees to gain entrance into the country. With the exception of

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<sup>5</sup> DCOs are countries that do not normally produce refugees. The DCO policy was created to deter abuse of the Canadian refugee system by those who migrate from countries generally considered "safe" (Government of Canada, 2014b).

refugee claimants, refugees attempt to gain asylum in one of three ways: 1) they can be privately sponsored through Canada's resettlement program which is partnered with the UNHCR (Government Assisted Refugees [GARs]); 2) they can be sponsored by a Sponsorship Agreement Holder, Constituent Group, Groups of Five or a Community Sponsor (known collectively as Privately Sponsored Refugees [PSRs]); or 3) they can claim refugee protection from inside Canada (Landed-in Canada Refugees [LCRs]) (Government of Canada, 2012c). The mechanism by which a refugee gains entrance into Canada affects the way in which the Canadian government recognizes them (Yu et al., 2007). Once a claim has been filed with the Refugee Protection Division, the claim will then go for review by the board (Young, 2010).

During a hearing with the Refugee Determination Division, the applicant is expected to provide grounds for claiming refugee status in Canada (Rousseau et al., 2002). Should the Refugee Determination Division decide against granting a refugee and her family entrance into Canada, she can choose to appeal her case to the federal court. This process is called "redetermination" which is made to the Federal Court of Appeal and/or the Supreme Court of Canada (Young, 2010). There are many factors that affect whether a refugee's claim is accepted including issues of credibility which highlights the importance of being truthful during a hearing. However, for women who are fleeing due to sexual violence, the circumstances surrounding the disclosure of rape during their hearing can have an impact on the claimant's overall credibility as determined by the IRB (Baillot et al., 2012).

### *Women's disclosures*

Unfortunately, the psychological fragility that women experience when immigrating to Canada as refugees has detrimental effects on the presentation of their narratives at hearings. Their disclosures are further hindered by their experiences with the unfamiliarity

of living in another country, the fear of being denied and/or misunderstood, and dealing with the psychological manifestations of trauma (Rousseau et al., 2002). Decision-makers (e.g. IRB Board Members) can interpret this reluctance to share or the misinformation as lack of credibility (Rousseau et al., 2002).

Women may feel there will be negative consequences as a result of reporting their sexual attacks (UNHCR, 1995). Some women may be shamed, further victimized, and stigmatized by their families or their larger community. As a result, they are hesitant and reluctant to report their perpetrators (UNHCR, 1995). The cultural context from which a woman self-identifies as well as the shame she feels have been used to explain and justify late or partial disclosures (Baillot et al., 2012). For refugee women experiencing IPV, they may disclose their experiences of sexual violence and also be making a claim based on the IPV which they have experienced. Despite IPV being recognized as a form of persecution and a violation of refugee women's fundamental human rights, the IRB is not adequately assessing women's need for state protections under such conditions (MacIntosh, 2009). These systemic barriers further limit refugee women's ability to gain refuge in Canada and greatly affect their trust/distrust in the system.

#### *The Interim Federal Health Program*

In the interim of waiting to obtain refugee status in Canada, the federal government only covers the basic and emergency healthcare needs of applicants (Aulakh, 2010). This means that refugees who do not qualify for provincial or territorial health insurance are given limited and temporary taxpayer-funded coverage under the Interim Federal Health Program (IFHP). However, there are further parameters such as a refugee's status in Canada

(e.g. refugee claimant, resettled refugee, other persons without status) which further limits their access to the IFHP (Government of Canada, 2014a).<sup>6</sup>

Prior to June 2012, all refugees were covered under the IFHP under one single class of health insurance (Sheikh, Rashid, Berger, & Hulme, 2013). Covered services included hospital and physician services, emergency dental and vision care, vaccinations, and “medications similar to those provided by provincial social assistance formularies” (Sheikh et al., 2013, p. 605). In June 2012, the Canadian government made substantial cuts to the IFHP (Affiliation of Multicultural Societies and Services Agencies [AMSSA] of BC, 2013). This meant that refugees from DCOs – currently, 42 countries fall under this category (CIC, 2014a) – no longer qualified for most medical services (AMSSA of BC, 2013). The new IFHP is divided into three tiers of coverage: expanded health care coverage (primarily for GARs and generally equivalent to the old IFHP coverage), health care coverage (available for PSRs and refugee claimants not from DCOs which is more limited than expanded coverage), and Public Health or Public Safety Drug Coverage which “includes prescription medications and related products, only if required to prevent or treat a disease posing a risk to public health or to treat a condition of public safety concern” (Government of Canada, 2015a) (currently made available to failed refugee claimants and claimants from DCOs) (Sheikh et al., 2013).

As a result of the IFHP changes, doctors and lawyers rallied for a return to full coverage, as the cuts greatly affected their capacity to support patients. On July 4<sup>th</sup>, 2014 Judge Anne McTavish of the Federal Court ruled that the IFHP cuts were “cruel and unusual treatment” and ordered that these changes be reversed within a period of four months (Canadian Doctors for Refugee Care, 2015; Fine, 2014). The Canadian government was not in agreement with the court order and “pursuant to ministerial authority under the

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<sup>6</sup> Person without status – “a person who has not been granted permission to stay in the country, or who has stayed after their visa has expired. The term can cover a person who falls between the cracks of the system, such as a refugee claimant who is refused refugee status but not removed from Canada because of a situation of generalized risk in the country of origin”(CCR, 2010, p. 2).

Department of Citizenship and Immigration Act the Minister of Citizenship and Immigration will implement...temporary measures while appealing the July 4, 2014, Federal Court decision concerning the IFHP” (Government of Canada, 2014a). The Temporary Interim Federal Health Program is the same coverage that was offered prior to the IFHP cuts in 2012. However as of June 2015, the Government of Canada was attempting to appeal the Federal Court’s reversal and was waiting for the hearing date.

Due to the numerous changes to the IFHP in recent years, doctors and service providers are unable to maintain current and accurate knowledge on the federal health care coverage for refugees. In Barnes’ report conducted through the Wellesley Institute, the author states that one of the unexpected impacts of the changes was the confusion surrounding the “administrative complexity” that health care providers face when determining “refugee patient eligibility” (Barnes, 2013, p. 9). Clinicians are then expected to call the insurer, Blue Cross, for every case (Barnes, 2013). This results in misinterpretations of health coverage policies and an overall decline in service accessibility. Service providers are unable to monitor what coverage is applicable to refugees in general, and there is greater confusion surrounding refugees without status, failed refugee claimants, and other types of migrants.<sup>7</sup> Ultimately, the lack of clarity and difficulty navigating the federal coverage classes results in “cases where refugees are being denied care despite being eligible for IFHP coverage” (Barnes, 2013, p. 9). This creates further barriers for women attempting to seek medical care while also attempting to gain protection under the Refugee Protection System.

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<sup>7</sup> A migrant is “a person who is outside their country of origin. Sometimes this term is used to talk about everyone outside their country of birth, including people who have been Canadian citizens for decades. More often, it is used for people currently on the move or people with temporary status or no status at all in the country where they live” (CCR, 2010, p. 2).

### *Refugee resettlement process*

The Refugee Protection System is comprised of two components: the in-Canada refugee protection system and the refugee and humanitarian resettlement program (Yu et al., 2007). The Resettlement Assistance Program provides support for temporary housing, assistance to find permanent housing, other settlement services and financial support, but this is limited to GARs (Government of Canada, 2015b). There are also integration services for refugees to access. Integration services are either direct or indirect services that are meant to facilitate social, emotional, physical, or economic adjustment and settlement for those newly arrived in Canada (Yu et al., 2007). In adapting to their new environment, refugee women are dependent on both the ability to regain lost resources as well as their ability to gain new resources that are relevant to their host environments (Ryan, Dooley, & Benson, 2008).

Refugees that are granted refuge in Canada must then begin the challenging process of resettlement. This involves starting a new life in a new cultural context within a foreign country. Women who have experienced sexual violence, especially in the context of war, are faced with a multitude of pre- and post-migration challenges (Berman et al., 2009). The societal barriers include racial, sexual, and cultural discrimination (Berman et al., 2009). Moreover, culture shock and language barriers may also impede the resettlement process and may impair refugee women's ability to navigate the social systems (Coughlan & Owens-Manley, 2006; Warriner, 2004). In cases where IPV and/or sexual violence is ongoing, the effects of these experiences can not only "exacerbate the mental health effects of refugee women's pre-arrival trauma experiences" but can also be devastating on their post-migration resettlement experience (Zannettino et al., 2013, p. 8). For those individuals who are able to prioritize their mental health, they may seek services to help deal with the pre- and post-migration trauma that they have experienced (Di Tomasso, 2010).

## **Rationale**

Refugee women face many adversities before immigrating to Canada and in response, resettlement organizations implement programs to provide them with support. Canada has been making efforts to facilitate the resettlement process for refugees, in providing additional funding for resettlement services. However, the substantial cuts made to the IFHP in 2012 and the most recent Federal Court orders have resulted in overall confusion surrounding service coverage (AMSSA of BC, 2013). Given these recent changes, it would be beneficial to have an in-depth understanding of the needs of refugee women, particularly those who are survivors of sexual violence.

In 2011, the province of Ontario had 57% of refugee arrivals, the highest percentage of all provinces in Canada (AMSSA of BC, 2013). Given this high percentage, understanding of the availability of services for refugee women in Ontario is particularly important. Further, it would be valuable to better understand how services for survivors of sexual violence who arrive in Canada as refugees can be improved. By interviewing both key informants and refugee women, we hope to both document women's personal experiences with sexual violence and identify mechanisms to address gaps in current service provision.

## **Objectives**

My project focuses on refugee women who experienced sexual violence as part of their displacement experience prior to arriving in Canada. For this population my specific research questions are:

- 1) What factors influenced women's decisions to disclose (or not) their experiences with sexual violence to immigration authorities when immigrating to Canada?

- 2) What were the needs (if any) of women who experienced sexual violence and did they receive the support that they needed upon their arrival in Canada; and
- 3) In what way(s) do refugee women with histories of sexual violence believe that counselling services and/or integration services could be improved?<sup>8</sup>

### **Outline of thesis**

This is a “thesis by articles” and is divided into five chapters. The first chapter serves as the introduction and provides both an overview of sexual violence in conflict settings as well as the overall immigration process for refugees migrating to Canada. Chapter 1 also includes the rationale for the study, a list of specific objectives (including the research questions), and an outline of the thesis. The second chapter describes the methods employed in the study including the recruitment strategy, the interview process, the analytic approach, and an explanation of the conceptual frameworks.

The third and fourth chapters are comprised of the two research articles. Chapter 3 is entitled, “Undoing the knot”: Identifying the needs of refugee sexual violence survivors”. Drawing from the in-depth interviews with refugee women, this article centres on women’s experiences with sexual violence and their lived experiences migrating to Canada. This article sheds light on the barriers that refugee women face in accessing sexual violence-related support services. This article has been formatted for submission to *Affilia: Journal of Women and Social Work* and conforms to the standard of that peer-reviewed journal.

Chapter 4 is comprised of the second article, “Networking for a stronger “Circle of Care”:

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<sup>8</sup> For the purpose of this thesis, I will define counselling services as support services (formal or informal) that women seek in response to their experiences with sexual violence. As well, integration services refer to any services that refugee women access during the resettlement process in Canada. In general, they are community-based organizations that receive governmental and external funding to provide support services.

Ensuring comprehensive post-migration services for refugee women in Canada” and describes the barriers refugee women experience in accessing available services. In addition, this article offers that both small- and large-scale changes are required to improve available services. This article is formatted for submission to *Journal of International Migration and Integration* and conforms to the standards of that peer-reviewed journal.

The fifth and final chapter begins with an overview of the two articles and how they relate to each other. By analyzing and combining the results from both articles, I aim to provide an in-depth look into the intersectional issues that affect the services refugee women access once in Canada. The chapter concludes with a section on reflexivity in the context of this thesis, the limitations associated with the study, a statement of contribution for the overall study and for each individual article, and a conclusion. The bibliography and appendices can be found at the end of the thesis.

## **Chapter 2: Methods**

Given the sensitivity of my thesis topic, I determined in consultation with my thesis supervisor that qualitative methods would be most appropriate for exploring the phenomenon of sexual violence among refugee women in Canada. The use of qualitative semi-structured in-depth interviews, in particular, allowed us to delve into women's lived experiences and document their personal stories. Moreover, we used a feminist approach, where women are recognized as experts on the subject of their own lived experiences and are best suited to inform any changes that are necessary to minimize social inequality.

For the purpose of meeting my study's objectives, I chose to conduct semi-structured in-depth interviews with two participant groups. The first component involved interviews with key informants, which for the purposes of this project are defined as those who manage agencies that provide support to refugees. The second participant group was comprised of refugee women who have experienced sexual violence. In using a broad and inclusive definition of sexual violence, my aim was to allow women to define their own experiences with sexual violence. Having two distinct groups of participants allowed me to gain a thorough understanding of the current social services delivery and the barriers that refugee women face when accessing services upon arrival in Canada.

The design of this study also allowed me to triangulate my findings. Data triangulation is the process whereby a researcher uses multiple data sources to produce more credible and trustworthy results (Cohen & Crabtree, 2006; Trochim, 2006). In collecting two separate data sets, my project aim was to provide a rich and robust account of the current social services delivery in Canada (Cohen & Crabtree, 2006). This enhances the transferability of my research findings, thus allowing stakeholders to apply the results and recommendations to other contexts (Trochim, 2006). However, it is at the discretion of

those using the findings to determine how sensible the application of the findings is to the context on which they are being applied.

### **Selection of Participants**

Our sample included 15 key informants and 12 refugee women from both Toronto and Ottawa. Data Collection ran from June 2014-March 2015. I conducted all interviews in English.

#### *Key Informants*

To provide an overview of the services available to refugee women and what services are being accessed, I conducted 15 interviews with key informants in both Toronto (n=6) and Ottawa (n=9). The key informants represented various organizations serving refugee populations (including religious outreach groups, community organizations, immigration lawyers, and settlement workers) and I contacted them through publicly available information. Once I established a working relationship with early participants, I asked them to refer other potential participants to me, thus using both purposive and snowball sampling recruitment strategies. Given the nature of the key informant interviews and the fact that perspectives and experiences are highly individualized, we did not use thematic saturation as the endpoint. However, once I felt that I had an understanding of the overall landscape, I consulted my thesis supervisor and we ended our data collection with key informants after conducting 15 interviews.

### *Refugee women*

For the second component of the project, I interviewed 12 refugee women living in either Toronto (n=7) or Ottawa (n=5). I informed all of the key informants as well as other consenting community organizations about my study and asked them to provide potential participants with information about the study. I recruited participants through resettlement agencies, shelters, immigration lawyers, and housing services. Additionally, we recruited women through online ads, recruitment posters, and the use of social media (e.g. Facebook and Twitter). These recruitment methods, however, were not as successful as our personal and informal meetings with community stakeholders and key informants. In conducting personal meetings with Access Alliance, we were able to secure a partnership and in turn, developed tailored recruitment methods for women accessing services at their organization. On multiple occasions, I set up tabling and recruitment sessions at Access Alliance's newcomer Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ) group and worked alongside their Non-Insured Walk-in Clinic to send out recruitment flyers. Those who assisted with recruitment understood how to explain the study and assured refugee women that their decision to participate was not related in any way to the government, nor the services they were accessing.

To help further raise visibility and awareness of the study, I sent an invitation to participate via multiple women's health Listservs. We gave potential participants small flyers, an online link to a Wordpress website, and/or my contact information. I was also able to recruit one participant through my personal volunteer position with a refugee outreach committee. Moreover, I employed snowball sampling techniques by inviting early participants to inform their personal contacts about the study and the eligibility criteria.

When recruiting participants, we used the following eligibility criteria:

- A refugee woman, age 18 or older, who has a history of sexual violence. For the purpose of recruitment, sexual violence was defined as any act that is considered rape (including marital rape), sexual exploitation, or forced prostitution.
- Arrival in Canada on/after January 1, 2009. By focusing on refugees who arrived in Canada in the past five years, I felt that my study was more reflective of the current service delivery and policy environments.
- Sufficient fluency in English to complete an in-depth interview.

All but one of the refugee women recruited for the study met the eligibility criteria. One woman consented to participate and only revealed during the interview that she had migrated to Canada in 1990. As this revelation occurred after the interview had begun, I completed the interview with her per the protocol for this component of the project.

### **Data collection**

Prior to commencing my recruitment, we developed two separate interview guides; one for in-depth interviews with key informants and the other for interviews with refugee women. I provided all participants with consent forms prior to scheduling the interviews so that they could attain a thorough understanding of the study and what was required of participants. I scheduled all interviews in advance. At the beginning of each interview, I reviewed the consent form orally with either the key informant or the refugee woman. This step ensured the study participants' comprehension of the study's objectives and that their participation was completely voluntary; I informed all participants they could opt out of the study at any point in time without penalty. During the interviews, I assured refugee women that their responses would remain confidential and that any personally identifiable

information would be masked and/or removed. Once I received oral consent from that participant, I began the interview.

### *Key Informants*

I conducted the interviews with key informants over the phone or in-person, depending on the preference of the study participant. For the interviews conducted in person, I met with the key informant at his/her office. The interviews varied in length, ranging from 13 to 68 minutes, with an average of 50 minutes.

Each interview contained five primary domains of inquiry: general information, services offered to refugees, services offered to survivors of sexual violence, future directions, and concluding remarks. With each question, I used probes and prompts to gather further information and explore the participant's answers. I audio-recorded all interviews using an Olympus recorder and I also took detailed field notes to ensure that key points were recorded for reference during the analysis process.

### *Refugee Women*

Interviews with refugee women were highly sensitive and required much more preparation than those conducted with key informants. I conducted all of these interviews in a private location that the women identified as being safe and comfortable. In order to create an empathetic and trusting environment, I scheduled interviews to last approximately 90 minutes. Interviews varied in length, ranging from 20-114 minutes, with the average of just under an hour in duration. With explicit permission, I recorded all interviews using an Olympus recorder and I also took detailed field notes to ensure that key points were recorded for reference during the analysis process. However, my main priority

during the interviews was to listen attentively to the women and ensure they felt comfortable and reassured.

During the interview process, women would sometimes cry or express signs of distress. As the interviewer, I would ask the participant if she would like to take a break and would also offer her something to drink. In this way, I ensured that the woman was always in control of the interview. I tried my best to be mindful and sensitive toward the participant so as to respect her personal experiences with sexual violence. The interview was divided into five sections: general information, experience with sexual violence, immigration experience in Canada, resettlement in Canada and resources accessed, and improvements that could be made to services. With each question, I used probes and prompts to gather further information and explore the participant's answers. As a thank-you for taking the time to participate in the interview I gave participants a CAD 25 honorarium. I provided this monetary gift even if women decided to terminate the interview early or did not wish to answer specific questions. I also gave participants a list of credible resources should they wish to speak with a professional regarding issues that arose during the interview. These resources were offered to all participants and were specific to the city in which the participant resided.

At the end of every interview, I engaged in the process of memoing which facilitated my awareness of the personal subjectivity that influenced my interaction with the participant. Memoing also aided in my active reflection on any key points, themes, or insights that arose during or after the interview. This was useful during the analysis process as it gave context to each interview as well as an idea of the overall post-migration situation of refugee women in Canada. Active memoing also allowed me to determine when I had reached thematic saturation.

After conducting 12 interviews with refugee women, I stopped recruiting participants because I determined that I had reached thematic saturation with respect to current service delivery and needed changes. However, the women who participated in the interviews came from different countries and had varied experiences with respect to violence. Consequently, the aim of the project was not to establish thematic saturation with respect to narratives of violence. Rather, the interview showcased a range of experiences and gave voice to women's complex experiences.

### **Analytic Approach**

I developed an iterative analytic plan such that I moved back and forth through the multiple steps in data analysis and data collection. This process occurred throughout the entire phase of data analysis. This meant that I began data analysis while collecting data which aided me in identifying, conceptualizing, and reflecting on content and themes that emerged from the data. My supervisor reviewed my interviews and memos, read transcripts, and provided me with feedback. I also attended meetings with my supervisor to discuss findings and reactions and address any questions that arose.

I began data analysis with the key informant component of my thesis. Using the transcripts, as well as notes and memos, as sources of data, I conducted content and thematic analyses and used ATLAS.ti to manage my dataset. At first, I created a codebook using *a priori* codes – codes developed based on expected answers for a given question. I began using these codes and incorporated new codes as they emerged from the data (inductive codes) and I recoded all of the interviews accordingly. Once I completed coding, I teased out the overarching themes that arose from the data (second and third level analyses). In addition to the content and themes that arose from the data itself, I also turned

to the memos for contextual information. Turning to my memos during the analysis process also helped to create links between personal observations and the data (Yin, 2011).

We used the aforementioned procedures to analyze the data set from the interviews conducted with refugee women. Although I analyzed the key informant interviews and the interviews with refugees separately, the final phase of the analysis focused on the integration of these findings and the identification of concordant and discordant results.

## **Ethics**

This study received approval from the Health Sciences and Sciences Research Ethics Board (REB) at the University of Ottawa (File # H02-14-07). The letter of approval from the University of Ottawa's REB can be found in **Appendix A**. Access Alliance Multicultural Health and Community Services Centre facilitated my recruitment efforts in Toronto. In order to work as an external researcher, my thesis supervisor and I completed an External Researcher Application and I met privately with the Senior Research Specialist to ensure that I understood the terms of our partnership. Thus recruitment took place with permission.

## **Conceptual Framework**

I present two conceptual frameworks that informed this project in **Appendix B**. The first framework, *Figure 1: Ecosystems model of refugee resettlement* (taken from Coughlan & Owens-Manley, 2006, p. 21), demonstrates the resettlement process of refugees. In this conceptual model, Coughlan & Owens-Manley identify "sustainability environment", "nurturing environment" and "refugee individual" (e.g. human and social capital) as factors

influencing a refugee's resettlement in a new country (2006, p. 21). This framework proved useful in demonstrating the multiple factors involved in the reintegration process. My study focuses on the psychological and sociocultural adaptations of female refugees and what (if any) factors affected them during their migration to Canada. I used this as a model for identifying possible barriers refugee women face while accessing services. This framework was useful in the creation of interview questions for both key informants and refugee women. For the interview guide for refugee women, I used this model to help design questions that explored how personal and individual circumstances in the lives of refugee women affect both their need for services and their ability to access such services. In regard to key informants, I asked questions surrounding a refugee's resettlement process and how this affects the needs of refugee women.

The second conceptual framework, *Figure 2: Stress, protective factors and refugee mental health* (taken from Beiser, 2006, p. 59), depicts the multiple factors that affect refugee women at the individual level. I chose this model because it helps elucidate the stressors that affect the overall mental health of refugees post migration. Using this model allowed me to explore how pre-migration stressors, access to social resources (e.g. family and ethnic community), personal resources (e.g. language fluency), and post-migration stress affect the overall well-being of a refugee. Based on this model, I designed interview questions that 1) allowed refugee women to share their personal experiences with sexual violence; and 2) allowed me to identify how the aforementioned factors affect their needs, especially those associated with surviving an act of sexual violence. Throughout the analysis phase, I also paid special attention to the influence of factors in this framework on refugee women's overall experience migrating to, and resettling in, Canada.

## **Chapter 3: Article # 1**

**Formatted for:** *Affilia: Journal of Women and Social Work*

**Title:** “Undoing the knot:” Identifying the needs of refugee sexual violence survivors

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The study team thanks all of the organizations and individuals who participated in the project. We would like to express our gratitude to the Sexual Assault Support Centre of Ottawa and the Access Alliance Multicultural Health and Community Services for their continuous support during the study. Finally, we thank Drs. Raywat Deonandan and Simon Lapierre for their feedback on earlier phases of this project. The conclusions and opinions expressed in this article are those of the authors and do not necessarily represent the views of the organizations with which the authors are affiliated or the funders.

**Title:** “Undoing the knot:” Identifying the needs of refugee sexual violence survivors

**Abstract**

Refugee, displaced, and conflict-affected women are at a heightened risk of sexual violence. Drawing from interviews we conducted with key informants (n=15) and refugee women (n=12) in both Toronto and Ottawa, this article explores women’s experiences with sexual violence, migration, and resettlement in Canada. Our results highlight the interrelatedness of sexual violence, disclosure, and social services and suggest that those working and interacting with refugees often lack an understanding of the complex circumstances surrounding the resettlement process. Ensuring that accessible, affordable, and timely counselling and mental health services and expanding trauma-informed care training for a variety of stakeholders is warranted.

**Keywords**

Refugees, asylum seekers, rape, resettlement, counselling

**Title:** “Undoing the knot:” Identifying the needs of refugee sexual violence survivors

## **Background**

Sexual violence is a global public health issue. The World Health Organization [WHO] (2002) defines sexual violence as:

[A]ny sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work (p. 5)

Many other acts of sexual violence are not clearly described in this overarching definition including the “insertion of objects into genital openings, oral and anal coitus, attempted rape and the infliction of other sexually abusive acts” (United Nations High Commissioner for Refugees [UNHCR], 1995, p. 4). Further, sexual violence can involve the threat or use of force in order to have sexual acts performed. Although sexual in nature, sexual violence is an act of aggression as perpetrators are often motivated by a desire for power, control, and domination and their acts are aimed at “violating a person’s innermost physical and mental integrity” (UNHCR, 1995, p. 4).

Globally, vulnerable and marginalized populations are typically at higher risk of experiencing sexual violence and this is especially true of refugees, displaced, and conflict-affected populations (Government of the United Kingdom, 2014; WHO, 2002; UNHCR, 1995; Friedman, 1992). Due to the nature of sexual violence, there is a high rate of underreporting worldwide, making it difficult to determine its prevalence (WHO, 2007). The reasons for non-reporting are both complex and

multifaceted. The UNHCR's *Sexual violence against refugees: Guidelines on prevention and response* and the WHO's *Guidelines for medico-legal care of victims of sexual violence* largely attribute the underreporting to women's feelings of "shame, social stigma and fear of reprisal or the case going to trial" (UNHCR, 1995, p. 1) and the "fear of retribution or ridicule, and a lack of confidence in investigators, police and health workers" (WHO, 2003, p. 9). Despite the significant underreporting of sexual violence worldwide, in some countries, one in four women reported experiencing sexual violence (Chung, 2005; WHO, 2003) and one in five women will become a victim of rape or attempted rape over the course of their lifetimes (UNITE, 2009).

### **Sexual Violence in Conflict-Affected Settings**

Refugee women most commonly experience sexual violence through coercion from those in a position of power (Centers for Disease Control and Prevention [CDC], 2004). In times of conflict and war, violence against women may be used to reinforce power differentials and/or as a weapon of war resulting in destabilization, demoralization, humiliation, and stigmatization (Anderson, 2010; WHO, 2003). The UNHCR identifies "unaccompanied women, lone female heads of household, unaccompanied children, children in foster care arrangements [and] those in detention or detention-like situations" as the most vulnerable with respect to sexual violence (1995, p. 4). More specifically, women who have been detained or incarcerated face a heightened risk of being subjected to sexual violence inflicted on them by prison guards and police officers (WHO, 2003).

As a result of political persecution or war, many women attempt to flee their countries of origin in search of refuge. The need for safe passage into another country further renders refugee women vulnerable (UNHCR, 1995). In many cases, women do not have enough time to gather all of the necessary documentation or proof which puts them at a heightened risk of sexual exploitation and abuse (UNHCR, 1995). A 1995 UNHCR report states that:

Refugees and asylum-seekers, including children, in many instances have been subjected to rape or other forms of sexual violence during their flight or following their arrival in countries where they sought asylum, including sexual extortion in connection with the grating of basic necessities, personal documentation or refugee status (p. 5)

The UNHCR asserts that women struggle during three separate phases: prior to flight, during the flight, and in the country of asylum (1995).

**Prior to flight.** The prior to the flight stage is when refugee women are attempting to flee their homes either within their country or to another country (Forum on Global Violence Prevention, Board on Global Health, Institute of Medicine, & National Research Council, 2013). During this stage, refugee women may be targeted by officials in their country or detained in state prisons and subjected to various forms of sexual violence including battering, torture, sexual exploitation, and rape (UNHCR, 1995). The violence that they experience may be heightened by internal conflict within their country of origin (UNHCR, 1995).

**During flight.** During their flight, refugees are desperate and vulnerable to others' advances (UNHCR, 1995; Friedman, 1992). While fleeing, refugees run the risk of being victimized by "pirates, bandits, members of the security forces,

smugglers or other refugees” (UNHCR, 1995, p. 5) as well as border guards and officials in the country of asylum (Ferris, 2007; UNHCR, 2003).

**In the country of asylum.** Upon arrival in a country of asylum, refugees should feel a sense of security and safety; however, refugees, both in camps and urban environments, are often taken advantage of by authority figures in an exchange for their acceptance into the country as a refugee (UNHCR, 1995, 2003). Furthermore, past sexual violence can cause retraumatization which can deplete emotional resources, increase susceptibility to future violence, and affect social and familial relationships.

### **Impact and Disclosure of Sexual Violence**

Acts of sexual violence have negative impacts on survivors, their families, and their communities. Sexual violence is associated with increases in the risk of unintended pregnancy, acquisition of sexually transmitted infections, and transmission of human immunodeficiency virus/acquired immune deficiency syndrome [HIV/AIDs] (WHO, 2003). Additionally, sexual violence can impact a survivor’s mental health, the effects of which are often “long lasting” (WHO, 2003, p. 1). Sexual violence is also often traumatic. Trauma can manifest as both diagnosable physical and psychological injuries including Post-Traumatic Stress Disorder (PTSD), depression, dissociative phenomena, substance disorders, and anxiety disorder (Di Tomasso, 2010; Wilson, 2007).

Disclosure of sexual violence is influenced by a multitude of factors and refugee survivors of sexual violence are often not willing to share their experiences or

divulge the abuse that they have suffered. Due to various social dynamics, the familial response to sexual violence can be one that perpetuates victim blaming in that men go unpunished and women are deemed responsible for having “lost” the family’s honour (WHO, 2002, p. 160) and may no longer be eligible for marriage (UNHCR, 1995). For women who are from settings where marital rape is not recognized, they “would be less likely to label their experience [as sexual violence], or to consider what had been done to them as abusive, such that a direct disclosure may never be forth coming” (Baillot, Cowan, & Munro, 2012, p. 282). Some women also avoid speaking about their experience because they fear losing any support they already have (both external or familial), not being believed, being blamed, or being ostracized from their families, spouses, and communities (Government of the United Kingdom, 2014; Berman, Girón, & Marroquín, 2009; UNHCR, 1995). However, research suggests that once resettled, refugees are more likely to share their stories and seek therapy in response to the trauma that they have suffered (Lafrenière, Diallo, & Public Health Agency of Canada, 2010; Public Health Agency of Canada, Guruge, Collins, & Bender, 2010).

### **Services for Asylum Seekers in Canada**

In June 2012, the Canadian government made substantial cuts to the Interim Federal Health Program (IFHP). At that time, as a consequence, asylum seekers from 35 designated countries of origin no longer qualified for most medical services (Affiliation of Multicultural Societies and Services Agencies of BC, 2013). Further, certain categories of refugees and asylum seekers were deemed ineligible for most

medical services. For survivors of sexual violence, these policy changes limited access to counselling and mental health services.

This context motivated our study. We conducted in-depth interviews with women refugees who identified as having experienced sexual violence and had recently migrated to Canada and key informants working with refugees in Ontario. Through these interviews, we aimed to document women's experiences and their decisions with respect to disclosure, explore their need for and access to services, and identify avenues by which services could be improved in Ontario, the province that houses the majority of Canada's refugees and asylum seekers.

## **Methods**

### **Data Collection**

We collected data over a 10-month period (June 2014 - March 2015) in both Toronto and Ottawa, Ontario. We conducted semi-structured in-depth interviews with two sets of study participants: (1) Key informants (those who manage agencies that provide support to refugees), and (2) Refugee women who have experienced sexual violence. Having two separate components of study participants allowed us to gain multiple perspectives on current service delivery and barriers to accessing available services.

We conducted 15 interviews with key informants in both Toronto (n=6) and Ottawa (n=9). We recruited key informants based on their institutional affiliation through publicly available information. Interviews lasted an average of 50 minutes and took place over the phone or in person, per the preference of the interviewee. In

these interviews we asked key informants to reflect on their professional experiences, the services provided by their organization, and the ways in which services could be improved for refugee survivors of sexual violence residing in Ontario. JS conducted all interviews in English, audio-recorded the interviews with permission, took notes during the interviews, and formally memoed immediately after each interview.

The core of this study involved in-depth interviews with 12 Refugee women living in either Toronto (n=7) or Ottawa (n=5). We used a multi-methods recruitment strategy that includes flyers, announcements, social media ads, tabling at community organizations, and early participant referral to identify participants. Women were eligible to participate in the study if they 1) Self-identified as having experienced sexual violence prior to migration to Canada; 2) Arrived in Canada on/after January 1, 2009; and 3) Were sufficiently fluent in English to complete the interview. For the purposes of this study we used an expansive definition of sexual violence that included rape, sexual assault, sexual trafficking, and forced prostitution. There were no restrictions based on age, marital status, parity, sexual orientation, or country of origin.

After completing an initial intake call, JS interviewed all refugee participants in a private location that the women themselves identified as being safe and comfortable. We used an interview guide developed specifically for this study that included five domains of inquiry: 1) Introduction and general demographics; 2) Experience(s) with sexual violence; 3) Immigration experience; 4) Resettlement in Canada and resources accessed; and 5) Suggested improvements. We used probes

and prompts with each question to gather additional information and further explore the participant's answers. We tried our best to be mindful of and sensitive toward participants so as to respect their personal experiences with sexual violence. We repeatedly reassured participants that their information would be kept in confidence, participation was voluntary, and participation would not influence their resettlement process or the availability of services. Interviews average about an hour.

With participant permission, we audio recorded all interviews. In most cases JS took notes and formally memoed immediately after the interview. JS and AF also regularly debriefed in order to discuss the interview content and create a space for the interviewer to process reactions and feelings. The act of memoing combined with debriefing allowed us to identify the point of thematic saturation. As women's experiences were highly varied and individualized we established thematic saturation; the point at which additional data will not yield new information about resource availability and utilization not however, around experiences with sexual violence.

All participants received a list of resources should they wish to speak with a professional regarding issues that arose during the interview. We created this after our key informant interviews in order to ensure that the list contained reputable, accessible, and credible resources. As a thank-you for taking the time to participate, women received a CAD 25 honorarium. We provided participants with this gift at the beginning of the interaction to reinforce that completing the interview or answering specific questions was not mandatory.

## **Data Analysis**

Using the transcripts, as well as notes and memos, as sources of data, we analyzed our data for content and themes. We used ATLAS.ti to manage our datasets. Data analysis was an ongoing and iterative process that occurred while data collection was underway. We used deductive and inductive techniques to create our codebook, which included both pre-determined and emergent codes. Once we completed coding, we turned to the interpretation of our findings which was a guided process through regular team meetings and discussion. The final phase in our analytic plan centred on integrating the findings from the two project components with specific attention to concordant and discordant findings. This also served as a method of triangulation, thus improving the credibility and trustworthiness of the study.

In this article, we focus specifically on women's lived experiences and draw heavily from the in-depth interviews with refugee women. We present women's stories as constructed vignettes in order to give a robust picture of the intersectional issues impacting the migration and resettlement experiences of sexual violence survivors. We also use quotes from both women and key informants to illustrate key themes. We have removed and/or masked all personally identifying information of the participants.

## Results

### Participant Characteristics

In our study, the survivors of sexual violence reflected considerable diversity. Of the 12 women interviewed, nine women disclosed their histories of sexual violence and three women chose not to provide detailed information about their histories or perpetrators. Women hailed from at least nine countries in Latin American and the Caribbean, the Middle East, and sub-Saharan Africa. Most participants were in their 30s at the time of the interview and ranged in age from 21 to 52. Women's experiences with sexual violence were highly varied and included rape, forced sex, early marriage, and forced female circumcision. Women reported having fled their countries of origin for a range of reasons, including intimate partner violence, political violence, gang related violence, and fear of persecution due to religion and/or sexual orientation.

### Laura's Story: Dynamics Shaping Disclosure

*At age 14, Laura was married off to a rich older man from a neighbouring village in Ethiopia. By the time she was in her early 20s she had four children. Laura struggled to parent and finish her schooling but managed to complete her secondary education and start a small business. However, over the course of their marriage, Laura's husband became increasingly violent and abusive. He would regularly beat her, sexually abuse her and threaten to kill her. He also repeatedly threatened to sell her to his friends. An alcoholic, Laura's husband destroyed their home in a rampage each night. Just when Laura thought things could not get worse, her husband began purchasing illegal weapons. One night, he took Laura and their four children outside and threatened to kill them with one of the weapons he had recently procured. A neighbour intervened and the police arrested Laura's husband, not for the abuse of his wife and family, but for possession of an illegal weapon. Laura took her children and fled to Canada for safety with the help of a hired agent. At the border, Laura disclosed her experiences to the immigration officer and was later*

*provided temporary housing at a community-based organization in Toronto. She has since moved out on her own and feels very strongly about sharing her narrative. Laura is now a permanent resident in Canada and dreams of providing support to abused and trafficked women in Toronto. For now, she holds support groups in her home for the many women she meets through her daily life.*

As Laura's story reveals, women flee their homes carrying the trauma of their many pre-migration experiences with them. Upon arrival in a new country, refugee claimants, in particular, are forced to deal with the uncertainty of disclosure of their histories of sexual violence. Laura felt fortunate, in that she was well connected upon arrival with family members and a housing/comprehensive support service in Toronto that helped her navigate the many systems in Canada. This resulted in her understanding the importance of disclosure during her hearing process. However, a number of the women that we spoke with did not have access to these resources or this type of information. As a result, women were unclear as to when and how to disclose their experiences with sexual violence.

### **Julia's Story: Challenges accessing care in Canada**

*Julia is a 32 year-old woman who married her husband after her university studies in Cameroon. Shortly after their marriage, her husband passed away. Julia was left a widow and was subjected to the traditional cultural practices of her husband's family; she was to be married off to her husband's older brother. She was also expected to undergo genital cutting. One night while Julia was sleeping, she was wakened by her late husband's older brother and raped. At that point, Julia fled and sought refuge in a local church. However, her brother-in-law was a police officer and a militant leader within their community and soon had many people searching for her. Julia's family supported her and helped her leave the country with the assistance of an agent. Julia escaped to Canada and was left to fend for herself in Halifax. She eventually made her way to Ottawa in the middle of winter. Julia received no social supports or housing and was unable to access counselling or mental health services.*

Our interviews with refugee women revealed a multitude of barriers to accessing services in Canada. As Julie's story indicates, the status of a refugee and the way in which an asylum-seeker enters the country shapes access to services. Julia's resettlement experience was difficult and frustrating, characterizations echoed by many of our participants. Julia was also unable to access counselling or mental health services and therefore had little opportunity to address the sexual violence that had prompted her departure from Cameroon. Although Julia, like our other participants, is extremely resourceful and resilient, her inability to access support services early in the resettlement process made it difficult for her to find adequate legal representation and housing later.

### **Michelle's Story: The Role of Frontline Workers**

*Despite residing in Ottawa, Michelle was accompanied by a frontline worker to Montreal for her hearing. The frontline worker was there for professional development purposes and not necessarily for the personal support of Michelle. The night prior to Michelle's hearing, the frontline worker took Michelle into a police station to explain that "we are safe in Canada". Michelle seemed afraid and gripped the frontline worker's arm throughout the entire visit. The next morning during her hearing, Michelle's lawyer had to leave the courtroom in order to inform the frontline worker that she was granted permission to observe the hearing. However, when the lawyer left, Michelle was left alone in the courtroom with a male judge and a male interpreter from her country which made her very uncomfortable. Michelle fled the courtroom, exasperated and in tears.*

*The frontline worker was confused, as she had not yet heard Michelle's experiences prior to entering Canada. The judge called Michelle to the stand when she explained that she was distantly related to a man involved in the opposition in the Democratic Republic of Congo. In an attempt to gain intelligence on her relative, Michelle explained that she had been raped in every orifice of her body by judges, police officers, lawyers, and male officials of her country. The frontline worker was shocked and felt*

*horrible for having taken her into the police station. Michelle's story ended up being a learning experience for the frontline worker and the lawyer about the importance of trauma-informed care.*

Michelle's story, which was described in detail by two key informants, highlights the need for sensitivity and trauma-informed care training for all stakeholders who work directly with refugees. Working from a trauma-informed care model would help to ensure that frontline workers are not only aware of the psychological and physical manifestations of trauma but that they also use sensitivity when working with refugees. Those who work with refugees should not only be culturally competent but also sensitive to how women with histories of sexual violence adapt during the resettlement process. This particular case inspired the frontline worker to not make assumptions about the clients that she works with and to be more sensitive to possible triggers.

## **Discussion**

When addressing the needs of refugees, the Sexual Assault Support Centre of Ottawa uses an analogy of a knotted rope; one must try to understand how a woman became "knotted" and what her experiences were prior to arriving in Canada in order to fully address her resettlement needs. However, it is often the case that immediate needs – including housing, employment, and navigating the legal process – must be prioritized. In the absence of social support this can be a challenging multi-faceted process. Supporting survivors of sexual violence who seek asylum in Canada thus requires "undoing the knot," that is recognizing the inter-relatedness of

experiences and deliberately working through different layers of needs in order to address underlying trauma.

The findings from our study also showcase the intersectional issues surrounding women's resettlement experiences in Canada. Sexual violence, migration, disclosure, and social services are interrelated. But as revealed in the experience of a number of our participants, those working and interacting with refugees often lack an understanding of the complex circumstances surrounding the resettlement process.

Increasing efforts to train a range of stakeholders in trauma-informed care might address this gap. In this context, trauma-informed care would involve sensitizing community-based organizations, frontline workers, and individuals who work/interact with refugee women on the physical and psychological manifestations of sexual violence. Frontline workers and other stakeholders would be better positioned to interact with, support, and care for refugee women emigrating due to violence. Exploring models of care that incorporate women themselves into the conceptualization, implementation, and evaluation phases and thinking creatively about different types of counselling and services delivery, could help to "undo the knot."

Qualitative research is not meant to be generalizable. The findings presented in this study are based on interviews with a small number of women recruited from community-based organizations and through social media and are in no way reflective of the refugee population at large in Canada. We are confident that the

themes we have identified are meaningful, but acknowledge that these findings are in no way representative of broader patterns or trends.

In designing the study, we knew that conducting interviews only in English would be a significant limitation. Future research in this area would benefit from being conducted in multiple languages as well as in other parts of the province.

## **Conclusion**

Our results shed light on the experiences of refugees who have experienced sexual violence. Ensuring that accessible, affordable, and timely counselling and mental health services and expanding trauma-informed care training for a variety of stakeholders appears warranted.

### **Compliance with Ethical Standards**

We received approval to conduct this study by the Health Sciences and Sciences Research Ethics Board at the University of Ottawa (File # H02-14-07). Informed consent was received from all participants prior to conducting any interviews and participants were made aware that their participation was completely voluntary.

### **Competing Interests**

The author(s) have no competing interest, financial or otherwise, to disclose.

### **Authors' Contributions**

JS is the Principal Investigator of the study and was responsible for all phases of the project, including study design, data collection and analysis, and interpretation of the findings. AF supervised the overall project and contributed to all phases of the study. JS led the drafting of the article and AF contributed to and approved the final manuscript.

### **Author's Information**

JS completed this project as part of her MSc degree in Interdisciplinary Health Sciences at the University of Ottawa.

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## **Chapter 4: Article #2**

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**Title:** Networking for a stronger “Circle of Care”: Ensuring comprehensive post-migration services for refugee women in Canada

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## **Abstract**

*Background:* In times of conflict and displacement, violence against women is often used to reinforce power differentials and as a weapon of war. Indeed, the prevalence of sexual violence is higher among refugee populations than non-displaced populations in the same setting. Research in Canada indicates that refugee women face numerous pre- and post-migration barriers to accessing services. For women who have experienced sexual violence, these barriers may be compounded. *Objectives:* This study aimed to document refugee women's sexual violence experiences, explore factors that influenced disclosure of sexual violence during the asylum-seeking process, and identify ways that services for this population could be improved in Canada. *Methods:* In 2014-2015 we conducted in-depth interviews with both key informants (n=15) and refugee women (n=12) in Ontario. We analyzed our data for content and themes using inductive techniques. *Results:* Our results indicate that refugee women who have experienced sexual violence generally lack access to affordable medical and counselling services. Some women were unaware of existing services and others were unable to take advantage of available services due to financial constraints and lack of childcare. Key informants reported that existing services are underutilized and sensitivity training for frontline staff is needed. *Conclusion:* Our findings suggest that identifying mechanisms to increase awareness of and access to medical and counselling services is warranted. Establishing programs to help women navigate the service landscape, providing child care such that women can avail themselves of existing services, and increasing the integration of existing services are priorities.

## **Keywords**

Gender-based violence, rape, refugee health, asylum seekers, integration services, counselling

## Introduction

Gender-based violence (GBV) is a prominent issue worldwide and as many as 70% of women will experience violence over the course of their lifetimes (UNITE, 2009). However, in times of war and disarray, violence against women is used to reinforce power differentials and as a weapon of war. Women in conflict-affected settings are at a higher risk of experiencing violence than non-refugee and non-displaced women. There are many subcategories that fall under the GBV umbrella, but the most prominent among refugees are domestic violence (intimate partner violence) and sexual violence (World Health Organization [WHO], 2003).

Due to the intimate nature of sexual violence and the cultural, social, community and familial taboos that often surround rape and sexual assault, there is a high rate of underreporting worldwide (WHO, 2007b). Although the reasons for non-reporting are both complex and multifaceted, in some countries as many as one in four women report having experienced sexual violence (Chung, 2005; WHO, 2003). Sexual violence in times of war is destabilizing, scarring, and stigmatizing, and is used to “demoralize the enemy” (WHO, 2003). For these reasons, rape is very common in conflict and crisis settings (United Nations High Commissioner for Refugees [UNHCR], 1995). As a result of political persecution, war, and conflict, many women attempt to flee their countries of origin and seek refuge in other countries. Upon arrival in a country of asylum, refugees should feel a sense of security and safety; however, for many women, the unfortunate reality is that they remain vulnerable to sexual violence, experience retraumatization, and lack access to support services.<sup>9</sup>

In 1989, Canada created the Immigration and Refugee Board (IRB) by amending the 1985 Immigration Act (Rousseau et al., 2002). At that time there was a demonstrated need to recognize gender-related persecution as a reason for seeking asylum, particularly for women. In response, the IRB of Canada created the *Guidelines on Women Refugee Claimants Fearing Gender-Related Persecution* in 1993 (Berman, Girón, & Marroquín, 2009). Having these guidelines in place allows for special recognition of gender differences in migration. Considering that approximately half of all asylum seekers, refugees, and

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<sup>9</sup> Retraumatization is defined as “triggering events [that cause] the victim to be overwhelmed by memory and feelings from the previous trauma” (UNHCR, 1995 p. 28).

immigrants that come to Canada are women, these guidelines were an important step in facilitating the immigration process for this group (Guruge, Roche, & Catallo, 2012).

In 2013, Canada received more than 10,380 claims from asylum seekers (Government of Canada, 2014a).<sup>10</sup> Despite Canada's efforts to facilitate integration and resettlement in Canada, it is still a very arduous process for refugees to gain entrance into the country. Refugees, other than refugee claimants,<sup>11</sup> attempt to gain asylum in one of three ways: 1) they can be privately sponsored through Canada's resettlement program which is partnered with the UNHCR (Government-Assisted Refugees [GARs]); 2) they can be sponsored by a group of five or more Canadian citizens/community sponsors (Privately Sponsored Refugees [PSRs]); or 3) they can claim refugee protection from inside Canada (Landed-in-Canada Refugees [LCRs]) (Government of Canada, 2014b). Once a claim has been filed with the Refugee Protection Division, it will then go for review by the board (Young, 2010).

On June 28<sup>th</sup> 2012, the Government of Canada passed the Protecting Canada's Immigration System Act [Bill C-31] (Government of Canada, 2013). Bill C-31 aimed to bring reform to the asylum system and add security measures to the current immigration system (Government of Canada, 2013). These changes greatly affected the way in which a refugee can apply for refuge in Canada including systemic changes, such as changing the time lines and methods of applying for refugee status. Bill C-31 also allowed for the "timely removal of failed claimants" (Government of Canada, 2013) which affected the appeal process for refugee claimants, further limiting their chances of both filing and obtaining an appeal date.

Prior to these changes, it often took as long as three years for the entire refugee determination process to be completed (Yu, Ouellet, & Warmington, 2007). However, as a result Bill C-31 the in-land process of seeking refuge has been expedited to as little as 60 days. In the interim of the determination process, only basic and emergency healthcare needs of the applicant are covered by the Canadian government (Aulakh, 2010). This means that refugees who do not qualify for provincial or territorial health insurance are given limited and temporary taxpayer-funded coverage under the Interim Federal Health Program (IFHP). However, the mechanism by which a refugee gains entrance into Canada affects the way

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<sup>10</sup> When a person's claim is still in process, they are known as an asylum seeker or claimant (Di Tomasso, 2010).

<sup>11</sup> Refugee claimants are those who make their claim at the portal of entry; however, there are also other marginalized migrants like undocumented refugees, failed refugee claimants, and those with other precarious migration statuses that are not recognized by the government.

in which the Canadian government recognizes her/him and has implications for service eligibility and may restrict a refugee's access to the IFHP (Government of Canada, 2014c; Yu et al., 2007).

In June 2012, the Canadian government made substantial cuts to the IFHP (Affiliation of Multicultural Societies and Services Agencies of BC [AMSSA] of BC, 2013). As a result, refugees from designated countries of origin (DCOs) – initially 35 countries fell under this category – no longer qualified for most medical services (AMSSA of BC, 2013). However, on July 4<sup>th</sup>, 2014 after an uproar from doctors and lawyers, the federal court ordered the Canadian government to reverse the changes to the IFHP. The Canadian government has implemented the Temporary Interim Federal Health (TIFH) coverage while appealing the July 4<sup>th</sup>, 2014, Federal Court (Government of Canada, 2014c).<sup>12</sup> Limiting a refugee's access to services may create a sense of double victimization and compounded barriers to services (Canning, 2011). In the case of refugee women who have been through trauma, there is concern that they lack access to appropriate mental health services and that cultural and language barriers may further impede a woman's ability to navigate the complex system to obtain affordable and timely service (Canadian Council for Refugees [CCR], 2011; Coughlan & Owens-Manley, 2006; Warriner 2004; Canadian Research Institute for the Advancement of Women, 2003).<sup>13</sup> The Canadian Council for Refugees has identified mental health and trauma states as a top priority for further research (CCR, 2011).

It is this overall context that motivated our study. Given the substantial cuts to the IFHP in 2012 and the recent changes resulting from Bill C-31, we undertook a multi-phased qualitative study in order to understand better 1) the factors that influenced women's decisions to disclose (or not) their experiences with sexual violence to Canadian immigration authorities; 2) women's use of services and perceived service needs (if any) of women who experienced sexual violence upon their arrival in Canada; and 3) both refugee women's and key informants' perspectives on how services can be improved. In this paper we focus on the second and third research questions with specific attention to participants' perspectives on how the needs of survivors of sexual violence could be better addressed post-migration.

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<sup>12</sup> As of June 2015, the Government of Canada was attempting to appeal the Federal Court's reversal and was waiting for the hearing date, likely after the Federal elections in October 2015.

<sup>13</sup> Trauma by definition is an injury of the mind due to a pathological state which stems from a traumatic event and results in extreme stress (Di Tomasso, 2010).

## **Methods**

From June 2014 through March 2015 we conducted semi-structured in-depth interviews with two groups of participants in Ontario: key informants and refugee women who experienced sexual violence. Having two separate study components allowed us to gain a multi-faceted understanding of current service delivery and the barriers that women face when accessing services upon arrival in Canada.

### *Study design: Key informants*

In order to gain perspective on the services provided to and accessed by refugee women, we conducted 15 interviews with key informants in both Toronto (n=6) and Ottawa (n=9). Using publicly available information, we purposively selected key informants representing different organizations serving refugee populations, including community organizations, religious outreach groups, immigration law firms, and settlement agencies. We supplemented our purposive sampling strategy with snowball sampling by asking early participants to refer other potential participants to our study team. Our interviews averaged just under an hour and took place over the phone or in-person at the participant's office, depending on the key informant's preference. JS conducted all interviews in English and all participants provided verbal consent.

We used an interview guide designed specifically for this study and centre our questions on five domains of inquiry: general information about the key informant and his/her organization, services offered to refugees, services offered to survivors of sexual violence, future directions and areas for improvement, and concluding thoughts and remarks. With participant consent, we audio-recorded all interviews and took detailed notes during the interaction. JS formally memoed after each interview to reflect content, emerging themes, and her influences on the interaction. After conducting 15 interviews, we felt that we had obtained a sufficient range of perspectives to end recruitment.

### *Study design: Refugee women*

For the second component of the project, we interviewed 12 refugee women living in either Toronto, Ontario (n=7) or Ottawa (n=5). We recruited women recruited through resettlement agencies, shelters, immigration lawyers, housing services, and personal networks as well as through online ads, recruitment posters, and the use of social media (i.e. Facebook and Twitter). We also invited early

participants to share information about the study with others in their communities. Women were eligible to participate if they: 1) Identified as a refugee woman, age 18 or older, with a history of sexual violence;<sup>14</sup> 2) Arrived in Canada on/after January 1, 2009; and 3) Were sufficiently fluent in English to complete and in-depth interview.

After obtaining informed consent, JS conducted all interviews in English. The interview guide began with basic demographic questions and then moved into questions related to the participant's experience(s) with sexual violence and her immigration experience in Canada. The interview then turned to questions about the participant's resettlement process and resources that were needed and/or accessed. The final domain of inquiry focused on ways in which services could be improved for refugees in Ontario. With each question, we used probes and prompts to gather further information and explore the participant's answers. JS conducted all interviews in a private location that the woman identified as being safe and comfortable and the interviews averaged 90 minutes. We gave all participants a list of comprehensive and credible resources should they wish to speak with a professional regarding issues that arose during the interview, tailored to the specific location of the interview. As a thank-you for taking the time to participate, participants received a CAD 25 honorarium. We provided this monetary gift even if the participant decided to terminate the interview or did not wish to answer specific questions.

With participant permission, JS audio-recorded all interviews and took field notes during and/or after the interaction. JS also memoed after each interview and debriefed with AF throughout the data collection process. Through active memoing as well as these debriefing sessions we established thematic saturation with respect to current service availability and suggested improvements to existing services at stopped recruitment after 12 interviews. However, the women who participated in these interviews came from different countries and had varied experiences with respect to violence. Nine women chose to disclose their histories of sexual violence and three women chose not to provide detailed information about their histories or the perpetrators. Consequently, the aim of the project was not to establish thematic saturation with respect to narratives of violence.

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<sup>14</sup> For the purposes of this study, we defined sexual violence as any act that is considered rape (including marital rape), sexual exploitation, and/or forced prostitution.

### *Data analysis*

Our analysis of the data involved an iterative process that coincided with data collection. Using the transcripts from the recorded interviews, as well as notes and memos, we conducted a content and thematic analysis and used ATLAS.ti to manage our dataset. We first created a codebook using *a priori* codes that is predetermined codes based on the interview questions and expected responses. We then incorporated inductive codes into the codebook based on emergent findings. Once we coded our data, we teased out the overarching themes and relationships between ideas (second and third level analyses). In addition to the content and themes that arose from the interviews themselves, we also turned to the memos for contextual information. Although we analyzed the key informant interviews and the interviews with refugee women separately, the final phase of the analysis focused on integrating the findings with specific attention to concordant and discordant themes. This process also allowed us to triangulate our findings. Regular study team meetings guided our interpretation.

In this article we focus on significant findings that emerged. We use quotes to illustrate those findings and we have removed and/or masked all personally identifying information of participants and their organizations. Although some key informants gave us permission to use their names, we have masked all quotes for overarching consistency and to prevent identification of those key informants who requested their information remain confidential.

## **Results**

### *Participant characteristics*

The refugee women who participated in our study ranged from 21 to 52 years in age, with an average age of 38. Our participants hailed from a number of countries including Brazil, Burundi, Cameroon, El Salvador, Ethiopia, Granada, Iran, Nigeria, and St. Lucia. Of the 12 women interviewed, nine women provided detailed information about their experience with sexual violence. Women reported leaving their countries of origin for a wide range of reasons, including familial dynamics, conflict and crisis settings in their countries of origin, intimate partner violence, and fear of persecution due to religion or sexual orientation. Women's experiences with sexual violence also reflected a variety of experiences, including intimate partner violence, rape, molestation, and forced female circumcision.

Key informants represented a full range of organizations providing services to refugees in Toronto and Ottawa, including housing organizations, counselling services, legal clinics, sexual violence support centres, and settlement workers. Key informants from all organization types reported that the majority of women found their services through word of mouth, typically because of established relationships with the larger cultural community, or through referrals from other organizations within refugee service sector.

*Refugee status influences the asylum-seeking experience*

I feel like in Canada, especially over the last three years, there's been a real attack on refugees in particular. (Key informant, Ottawa)

In general, refugees flee their countries of origin for a variety of reasons and many of them experience difficult, violent, and traumatic experiences. All of the key informants in our study felt that these difficulties were even greater for women. Key informants explained that women refugees often went into “survival mode” in order to get themselves and their children to safety. Although the experience of every individual asylum-seeker is unique, key informants emphasized that the process of migrating is extremely difficult. As one Programs Coordinator from Ottawa explained:

In general, any refugee experience is very difficult, like just being either forcibly displaced from your homeland or having to leave because of persecution that's individual or that's larger. And so I think that when you come to a new place, you carry with you that trauma and so you're already in a vulnerable situation and no matter where you go you know, you're an outsider.

Refugee women reported that overarching hostility toward asylum seekers shaped their migration experiences as well.

It's not easy. Sometimes you can't say too much [because] now the people feel...that we coming only to live from another people. And they don't know the situation...People say okay, why don't you go to your house? Go home! (Sofia, middle-aged woman from El Salvador)

Key informants also commented on the public reaction to refugees and remarked on the worsening dynamics over the last several years.

However, key informants also repeatedly emphasized that one of most significant initial barriers to immigrating to Canada involves status. Our key informants agreed that GARs face the least post-migration barriers when accessing services. According to key informants the migration experiences of PSRs is variable and depends on the sponsoring group(s) or organization(s). In contrast, asylum seekers and refugee

claimants face considerable challenges navigating the migration process and accessing service. Status was especially important for housing; GARs and PARs are supplied housing by the government and/or private sponsors for a minimum of a year, whereas refugee claimants do not receive the same assistance. As a result, many women and their children ended up in emergency shelters and/or transitional housing, and then began to search for additional support services.

Key informants reported that these challenges were exacerbated after the 2012 changes went into effect as providing organizations were unable to adequately support refugee claimants. Services providers in Toronto consistently advocated for designation as a “sanctuary city,” a municipally-administered agreement that one’s identity or status in Canada should not affect the services that one can access. This was implemented in Toronto in an attempt to increase the service accessibility to refugee claimants, undocumented refugees, failed-claimants, and others with precarious immigration statuses.

#### *Beyond status: Barriers to providing and accessing services*

Resettlement is a very complex and multilayered process. Refugee women participants were consistent in their reported desire for a range of services and resources. However, both groups of participants reflected on a number of barriers to accessing existing services.

#### Lack of knowledge

[N]ewcomers and refugee claimants, we don’t know how to access these services. We don’t know anything about these services. So things will happen to us and it will just go by because we don’t know. Again, we [lose] for the lack of knowledge. (Emily, 35-year-old woman from Granada)

Refugee women reported experiencing a multitude of barriers in accessing services. Most participants specifically mentioned how women’s lack of knowledge what services are available to them how to navigate the system to avail themselves of existing resources. As Julie a 32 year old from Cameroon, explained:

[W]hen you are informed, [the services] are very helpful. And because most female are not informed...they don’t know where to go, and they don’t know who to seek and who to ask...[W]hen I just came in [to a service delivery organization], somebody asked me, please do you know where they can help me here... You need to meet people you know...who can show you the right place and the right people to meet.

However, even when women have some knowledge that services are available, navigating the systems to obtain those services, including how to use public transportation, can be challenging. As a key informant from Ottawa explained:

The biggest [barrier] I think is the systems, navigating systems is the biggest barrier for many people, but from my experience, more so people who are requesting refugee status and who are new to the country and very different environments and practices. It's very challenging to them. (Key informant, Ottawa)

### Cuts in the IFHP

Ontario has been making a great segue in terms of the legal change. Although, the federal government said "Oh, well we're gonna stop the health care for refugee claimants". Ontario is the only province who said "No, we're not going to do that, we're still providing those services". So the rest of the country needs to get on board and do the same thing. And everyone as a whole needs to advocate more towards the federal government, you know, why are you making these changes? You're hurting people. (Key informant, Toronto)

According to our key informant, the cuts made to the IFHP are directly affecting the healthcare services that refugee women can access. The IFHP cuts are mostly being felt by refugee claimants who are not able to access comprehensive services offered under federal coverage. Provincial governments can extend coverage benefits to all refugees and asylum seekers, but services are inconsistent and not necessarily well publicized. Mental health and counselling services in particular are limited, which has significant implications for survivors of sexual violence. As a key informant from Ottawa explained, "Look, if I could wave my magic wand and I could have funding to operate a counselling service or something like that, I would, but I don't so I'll stay in the realms of reality."

Smaller organizations in particular have to refer women to larger organizations to get coverage for mental health services. This has an impact on availability and wait times for counselling services are long. As a key informant Toronto explained:

A lot of our clients love to have a one-on-one say counselling support, whether it's from a social worker, a psychiatrist or a psychologist would be great, but there [are] massive wait lists. Or, there's this real hole in whole system in trauma counselors. So not just someone who's a GP [general practitioner] whose done some training in counselling, but actually trauma counselor. And, they're out there, but again the waitlist [is] for 6 years sometimes.

## Language

Language is probably also one of the top three [barriers]. I think after housing, language is a really big one. Language is often a major issue. (Key informant, Toronto)

Key informants from many organizations recognized the need for language services. This includes the need for certified interpreters, multilingual staff, language evaluation services, and English as a Second Language (ESL) classes. Certain organizations had the funding and capacity to offer language services through their programming office. However, many of the smaller organizations referred women to other community-based organizations or used a sub-optimal phone-based interpreting service.

## Family and community dynamics

The stories [women] would tell you of what had been done to them and their own families selling them off, for money to make ends meet. It's just stressing to work with this on a daily basis. It really takes a toll on you emotionally. It wasn't just that, it was their husbands, their partners and their arranged marriages and their being told that they have to basically, satisfy their partner sexually or they'll be beaten and killed. (Key informant, Toronto)

When refugee women initially migrate to Canada, they often have a sense of fear and mistrust of authorities. Women are also faced with cultural and language barriers which affect their ability to communicate with others. This, in turn, affects the amount and type of information she discloses and with whom she will share this information.

Moreover, the dynamics within her family may further hinder a woman's willingness or desire to access services for support in Canada. Accordingly to key informants, many women feared the stigma of accessing any forms of counselling or mental health services due to their cultural norms and the societal stigma associated with both sexual violence and mental health disorders.

## *Integrating support services is a considerable priority*

So we have different partnerships so people can be directed to the right place. The circle of care is such that usually one worker is in contact with all these other workers. (Carmen Urbina, Ottawa)

Refugee women face a multitude of post-migration barriers in accessing services and this hinders the resettlement process. In addition to health services and housing, women consistently reported that child care and employment assistance were priorities. Frontline workers echoed these needs and reported that

women tended to come to Canada as the sole provider for their children. Attending multiple appointments with their lawyers, Ontario Works, food services, school boards, and others, all necessities for resettlement, required child care. However, many women cannot find adequate and affordable child minding services and as a result are unable to attend appointments, access services, or attend counselling sessions. Frontline workers unanimously felt that access to childcare would help women find the time and means to access such services.

Assistance in finding remunerative employment was often raised as a priority by both groups of participants. As Sofia explained:

I need to think about getting a job. I have a job, but it's not enough for pay my rent and all this. Then, I need to look for a job because to have more for pay rent...I dunno for us it's really difficult because you know, you have a life before. You have your house...[Crying] and now you don't have anything. That's really hard for us.

Many women reported to frontline workers that they wished they had access to stable employment. They participated in cashier training, computer training, food handling certification, and other skills-based training sessions in hopes of gaining the necessary qualifications to gain employment. However, employment for refugees was dependent on their status in Canada. Once again, refugee claimants and undocumented refugees faced many challenges when seeking employment. For those who were successful, they tended to be subjected to abuse in the work environment and unfair pay. However, lack of awareness of their rights and the fear of deportation prevented women from reporting their employers.

However, at the core of many of the needs expressed by both groups of participants was a desire for greater service integration. Refugee women are in need of support networks and services. This includes both formal and informal forms of counselling that empower women. Refugee women are in need of more comprehensive and accessible services that occur within a "circle of care" wherein providers collaborate to ensure that women's needs are being met.

## **Discussion**

Women who have experienced sexual violence, especially in the context of war, are faced with a multitude of pre-migration and post-migration challenges (Berman et al., 2009). The societal barriers include racial, sexual, and cultural discrimination (Berman et al., 2009). Moreover, culture shock and

language barriers may also impede the resettlement process and pose a threat to refugee women navigating the social system (Coughlan & Owens-Manley, 2006; Warriner, 2004). In their study, Berman et al. found that “other barriers identified by the women were poor housing, poor health status, lack of proper access to health care and counselling, isolation, rejection, racism and other forms of violence, culture shock, and powerlessness.” (2009, p. 160). This, in addition to their personal triggers, can cause stress and anxiety (Coughlan & Owens-Manley, 2006). Moreover, refugee women are usually the primary family caretakers and their psychological well-being directly affects the family dynamic (Bond, 2010; Chung, 2001).

The findings of our study are broadly consistent with this body of research. Although community-based organizations offer a plethora of services, both key informants and refugee women identified a number of barriers to accessing existing resources. Lack of knowledge and information, recent policy changes, language, and familial and community dynamics are all factors influencing the ability of refugee women in Ontario of availing themselves of needed resources. Housing, health care, child care, and employment assistance were repeatedly identified as priorities for service delivery.

However, key informants were particularly supportive of the creation of a “one-stop-shop” model of service delivery. In this service delivery model, women would receive services, including health care, from a single place. Service providers were in support of this idea of a “circle of care” and argued that this type of system could address the limitations that many community-based organizations experience due to their small size and funding constraints. A “circle of care” would also foster collaborative partners between organizations and has the potential to more holistically address refugee women’s post-migration needs. An informal support system and/or networking opportunities between lawyers, frontline workers, and housing organizations would be highly beneficial in responding to the needs of refugee women during the resettlement process.

The consequences of the changes to immigration in 2012 are only being seen now. Our results suggest that the 2012 changes to the IFHP are having a negative effect on refugee resettlement in Canada. Further research, particularly centred on refugee claimants and non-status and undocumented refugees is warranted. However, even in the absence of further research it appears that systems-level and organization-level changes could result in better health service delivery.

At the systems level, extending health benefits to refugees of all statuses could address a significant need, particularly with respect to mental health and counselling services. There is also a need to clarify what services can be provided under the current system and to which types of refugees. In addition, there is a need for greater networking and exchange between service delivery organizations working with refugees. By increasing the networking opportunities for all service providers, including those in the legal and social services systems, service provision could become better coordinated and integrated. Refugee women will also be able to benefit in that they will be provided with more accurate referrals to other organizations and frontline workers.

At the organization level, small changes in service provision could greatly enhance the responsiveness of organizations to the needs of women refugees. Counselling services are limited and wait times for therapy and mental health services in Ontario is protracted. Women expressed a demand for a range of counselling services, included group and informal/peer services.

### **Limitations**

The women we interviewed were from a diverse range of countries and cultural backgrounds. Upon designing the study, we knew that solely conducting interviews in English would be a significant limitation and would limit not only our recruitment, but also the depth of information a woman would be able to share. However, we tried to mitigate this limitation by creating other, more general eligibility criteria. In this way, women could participate from an array of personal situations, migratory statuses, and years of arrival.

Qualitative research is not meant to be generalizable. These semi-structured in-depth interviews were meant to provide us with an in-depth understanding of women's experiences and insight into the changes that could be made to the current service delivery. We are confident that the themes we have identified are meaningful but acknowledge that these findings are in no way representative of broader patterns or trends.

## **Conclusion**

Our findings suggest that identifying mechanisms to increase awareness of and access to services and resources is warranted. Establishing programs to help women navigate the service landscape, providing childcare such that women can avail themselves of existing services, and increasing the integration of existing services are priorities.

## **List of abbreviations**

<b>AMSSA of BC</b>	Affiliation of Multicultural Societies and Services Agencies of British Columbia
<b>GAR</b>	Government- Assisted Refugees
<b>GBV</b>	Gender-based violence
<b>IFHP</b>	Interim Federal Health Program
<b>IRB</b>	Immigration and Refugee Board
<b>LCR</b>	Landed- in Canada Refugees
<b>PSR</b>	Privately Sponsored Refugee
<b>UNHCR</b>	The United Nations High Commissioner for Refugees
<b>WHO</b>	World Health Organization

## **Compliance with ethical standards**

We received approval to conduct this study from the Health Sciences and Sciences Research Ethics Board at the University of Ottawa (File # H02-14-07). Participants provided informed consent prior to the interviews and we ensured that participants understood that participation was completely voluntary.

## **Competing interests**

The author(s) have no competing interest, financial or otherwise, to disclose.

## **Author's contributions**

JS is the Principal Investigator of the study and was responsible for all phases of the project, including study design, data collection and analysis, and interpretation of the findings. AF supervised the overall project and contributed to all phases of study. JS led the drafting of the article and AF contributed to and approved the final manuscript.

**Author's information**

JS completed this project as part of her MSc degree in Interdisciplinary Health Sciences at the University of Ottawa.

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## **Chapter 5: Discussion**

This final chapter discusses how the two articles presented in this thesis relate to one another when applied to women's health issues and forced migration. I also discuss the complex interactions between women's personal experiences with sexual violence and the prioritization of their post-migration needs. This chapter also explores the importance of positionality when working with a vulnerable population. Using these results, I hope to demonstrate the significance and implications of the study for stakeholders working with refugees as well as other services providers. Finally, this chapter includes a section on reflexivity, the limitations of this study, a statement of contribution for the overall study as well as for each of the articles, and concluding remarks.

### **Discussion and integration of the results**

When combining the results from the first and second articles, there are multiple interrelated issues between refugee women's personal experiences with sexual violence and their post-migration needs. The combination of women's minority and legal status, their pre- and post-migration experiences, their histories of sexual violence, the current service availability, and the multiple barriers posed by Canadian social systems greatly affects women's ability to not only access services in response to their individualized needs but also affects their resettlement experiences as a whole.

#### *Women's experiences with sexual violence*

Women's experiences with sexual violence can occur at any phase of their migration process: pre-migration, during their migration process, and post migration. Though our

study included 12 interviews with refugee women, three women chose to not disclose detailed information about their experiences or the perpetrators. In our study, women's experiences included intimate partner violence and marital rape, rape resulting in the contraction of HIV/AIDS, molestation, forced female circumcision, sexual harassment/threats of sexual assault, and sexual coercion. For most women, their experiences were prior to migrating to Canada, however for some of these women these experiences continued both during their migration process and post migration.

For all these women (n=9), the perpetrators of their pre-migration sexual violence included their spouses and family members (e.g. father, brother, brother-in-law) as well as unknown individuals and groups. In the case of women whose experiences with sexual violence continued post migration (n=3), it was through IPV, coercion from immigration lawyers/workers, and/or receiving threats of a sexual nature throughout the resettlement process.

Refugee women seeking asylum may be migrating for a variety of reasons and often sexual violence can be a part of their claim. However, women may be hesitant, for a variety of reasons, to disclose those experiences. In our study, of those women who experienced sexual violence, the majority (n=7) disclosed or intended to disclose their experiences with sexual violence as part of their refugee claim in Canada. One woman who experienced IPV in her past marital relationship chose to base her claim on the discrimination she faces based on her sexual orientation rather than the IPV that she experienced. Additionally, one woman is currently an undocumented refugee in Canada and is unable to submit a refugee claim for fear of deportation.

### *The refugee immigration experience in Canada*

Refugees that seek safety in Canada must not only cope with their personal post-migration experiences but also adjust to large societal differences. Coughlan & Owens-Manley explain that refugee's assimilation is affected by psychological, sociocultural, and economic adaptations (2006). As is consistent with Beiser's *Stress, Protective Factors and Refugee Mental Health*, there are many factors that affect a refugee's mental health during the resettlement process (2006). Similar to their model, my findings indicated that "social resources" such as support groups, settlement workers to help navigate the system, and support from community-based organizations, were crucial to the facilitation of a refugee's resettlement processes. Women's pre-migration stress and the trauma of their experiences took a toll on their overall well-being, especially for women whose status in Canada was not permanent.

Women's needs were multifaceted and dependent on their priorities when resettling in Canada. For many women the process of resettlement was quite difficult, especially because they were in "survival mode" and focused primarily on their and/or their families' immediate and emergency needs. The trauma that they had faced is, initially, too delicate to deal with; however, once they are more settled, women are more likely to seek services. As a result of this dynamic, key informants and refugee women reported that, in general, refugee women do not prioritize their own personal needs during resettlement. The findings from this study are consistent with the larger body of evidence in that refugee women's resettlement processes are affected by a number of systemic, social, individual, and personal factors (Beiser, 2006; Kallivayalil, 2013; Keygnaert, Vettenburg, & Temmerman, 2012; Pedersen, 2002; Ryan, Dooley, & Benson, 2008; World Health Organization, 2012).

### *Minority and legal status*

Given the many barriers refugee women face, it is perhaps not surprising that women in our study found it difficult to navigate the social services systems in Canada. No matter the reason these women flee their countries of origin, their post-migration success is highly dependent on the post-migration support they receive and from whom those services are being offered. GARs are given access to a support worker for one year and are able to readily access any other services that are offered by the government, including comprehensive healthcare and financial support. Refugees who immigrate as PSRs are covered under the IFHP and their overall resettlement experience and cost is the responsibility of the sponsoring group and/or organization. Those who immigrated as GARs or PSRs appear less likely to face a lack of support when navigating the systems in comparison to refugee claimants, refugees without status, and undocumented refugees.

Women who immigrate as refugee claimants or as refugees without status face a number of additional post-migration barriers, especially concerning service accessibility due to their lack of visibility and lack of legal identity in Canada. Both key informants and refugee women reported that the immigration changes and IFHP cuts in 2012 have had a direct negative effect on refugee claimants and refugees without status. Most services offered in Ontario are funded by agencies that prohibit the provision of services to those without status in Canada. However, larger organizations are able to compensate by offering limited access to basic healthcare and support. This does not typically include access to mental health or counselling services for which there was an identified need.

### *Navigating the social systems*

Once in Canada, refugee women are unfamiliar with available services and how to access them. Many do not know that such services even exist. In addition, women face

systemic/logistical barriers concerning their lack of or unfamiliarity with the public transportation system. For women in Toronto, this barrier was heightened by the magnitude of Toronto's transportation system and the cost associated with its utilization for themselves and their children.

Given that the lack of child minding services was one of the largest barriers to women accessing services for their own personal needs, there is a need for improvement and the incorporation of child minding services in conjunction with available support and counselling services. Moreover, key informants and refugee women felt frustrated with both the wait times and the cost of services, especially for mental health services. Access to a settlement worker would help to minimize these barriers; the settlement worker would assist women in becoming familiar with accessible social services and providing support to navigate the social systems.

#### *Service availability*

Canada has a multitude of services available to newcomers in Canada, particularly in Toronto. Both governmental and community-based organizations offer a plethora of social support services, legal support, housing services, shelters, and employment services. Refugee women have access to services that are developed from a North American framework with the traditional one-on-one counselling model, however women also wanted access to more group counselling and other alternative forms of counselling like art therapy programs and peer-to-peer support. In peer and group settings, women can interact with other women of similar histories and cultural backgrounds and would be able to more informally connect with each other. Women reported that having informal support with other women present was culturally resonant and felt it was the most appropriate avenue in dealing with the sexual violence that they have experienced.

In regards to peer-to-peer support, women cautioned the use of sensitivity because for some women their particular cultural and personal beliefs as well as the overall stigma associated with their experiences would dissuade them from seeking support with women from the same cultural communities. Additionally, many women did not necessarily identify with the term sexual violence. To mitigate this issue, for existing counselling and integration services it would be beneficial to include women at the conceptualization, implementation, and evaluation phases of the program. The WHO recommends that interventions concerning support provided to survivors be based on participatory principles, implemented with communal supports, and built on existing services and resources (2012). Further, this would allow women more control over what, when, and how they shared their personal narratives.

#### *Sensitivity training for frontline workers*

The dynamic between support services staff and refugee women is one requiring delicacy as there is both a sense of reliance and a power imbalance. However, our findings suggest that many staff were unaware and thus not sensitive to this dynamic. High staff and manager turn-over, insufficient training, lack of cultural competency, and various other factors impact the ability of frontline workers to employ culturally-sensitive approaches. Overall, this highlights the importance of sensitivity training for frontline workers, service providers, and those who work directly with refugee women.

#### *Institutional and policy level changes*

Both refugee women and key informants expressed the need for change at two levels: institutional level changes and policy/systems changes made to the existing services delivery. Institutional efforts include changes to the way in which services are offered

including increasing accessibility of these services to refugee women of all statuses.

Policy/systems level changes include both increasing governmental funding for services offered to refugee women of all statuses and also creating/changing policies that hinder the accessibility of social services for refugee women.

In order to increase service visibility, all women who immigrate as refugees should be provided with a guide on the services available to them within their city. Ideally, this guide would include services in response to their general resettlement (e.g. housing, food banks, social services, governmental services, etc.), services available to women in response to their general post-migration needs, and services dedicated to supporting women with histories of sexual violence. Keeping in mind the financial and systemic challenges, this guide should be made available through multiple outlets including governmental-based organizations, community-based organizations, and other accessible locations for refugee women of all statuses.

Many frontline workers provide support solely within their scope of practice and therefore, women do not have access to holistic and comprehensive support. On an individual level, involving networking and collaborative models between organizations will greatly alleviate the stress of women having to navigate and sort through services themselves. Frontline workers and service providers, in general, have felt in the dark about how to support refugee women given the recent changes and in creating a space for these stakeholders to network amongst each other, it will in turn, create credible relationships between organizations. More networking opportunities for service providers in various domains (legal, financial, medical, frontline, etc.) would help to not only increase the fluidity between services but also help ensure that when making referrals, services providers have strong working relationships with each other.

With the expansion of networking opportunities for frontline workers, service providers, and other key stakeholders, there is also a need for change at the policy level. The changes to immigration have had a negative effect on refugee women and the services that they are able to access given the limited health care coverage and shortened timelines, especially for refugee claimants. As part of the overall advocacy work, policy makers should be made aware of the ramifications of the immigration changes on the frontline workers' capacity to adequately support a refugee woman with the determination and resettlement processes.

As part of affecting change at the policy level, it would be highly beneficial to have more public education and advocacy campaigns, which could include personal stories from refugees. Given the prevalence of sexual violence and the identified need to provide support to this population, there is a need to also provide more sustainable funding to service providers. Public education is an important component of ensuring sustainable funding and support for any population. In this case, public education would be used to both adequately finance existing services and allow for the expansion of mental health and counselling services, specifically services accessible to refugees of all statuses.

### **Significance, implications, and future plans**

This project is particularly timely as it coincides with the appearance of the effects resulting from the 2012 changes to immigration policies and services. The information that we collected in this qualitative study promises to inform the frontline workers, counselling and integration services, as well as other stakeholders that influence the availability of services for refugee women in Canada. Additionally, the findings of this study will be shared with other stakeholders in the community through in-person presentations, a short report

of the findings, conferences, and academic journal publications. I anticipate that the results will also be used by community organizations to advocate for changes in their services provision and programming.

### **Statement of contribution**

As the Principal Investigator (PI) of the study, I completed this study in partial fulfillment of the requirements for the Master of Science degree in Interdisciplinary Health Sciences program at the University of Ottawa. Consistent with my role as a PI, I conceptualized the study, designed the study instruments, collected and analyzed the qualitative data, and led the development of both manuscripts.

My supervisor Dr. Angel M. Foster worked with me to design a feasible project in which I could report on current service delivery for refugees in both Toronto and Ottawa. She guided me throughout the research process in helping to create the proposal, getting approval from the REB, and facilitating the process of recruitment, especially for refugee women. She oversaw the project in its entirety including reading over the memos and transcripts, approving the code books, and discussing with me the overall analysis and interpretation of the findings.

### **Positionality**

When conducting interviews with vulnerable populations like refugee women it is important to be conscious of one's positionality. This involves acknowledging one's position as an outsider. In their article, Ganga and Scott make a differentiation between the interviewer who is an "insider" and the interviewer as the "outsider" (2006). The "insider"

is a researcher who shares similar “social, cultural, linguistic, ethnic, national and religious heritage” with the participant (Ganga & Scott, 2006, p. 2). This is particularly important when conducting interviews with migrant populations because it can allow for a different social dynamic in which differences between the interviewer and the participant can be brought into focus as a “shared cultural knowledge” (Ganga & Scott, 2006, p. 2). Ganga and Scott term this “diversity in proximity” such that insiders may be better able to recognize both the social similarities and social fissures between themselves and the participants (2006). This in turn, can help the “insider” gain trust and acceptance in a group (Ganga & Scott, 2006, p. 2). On the other hand, an “outsider” is someone who does not have those same ties with the participant.

Beginning with key informant interviews, I had to be mindful of my positionality as a young, female, graduate researcher conducting her thesis project. When approaching key informants for interviews, I had to ensure that, during the interview, they were made to feel like the experts they are. However, I found scheduling an interview to be quite difficult as key informants, for the most part, were extremely busy. In reviewing the memos, I realized that many key informants revealed that they were overworked. In acknowledging this throughout the recruitment process, I found that key informants were quite responsive and scheduled interviews with me usually after establishing a rapport through an informal meeting or phone conversation. I found that by being patient, understanding, nonthreatening, and most of all, present during the interviews, that key informants then entrusted me to recruit participants from the women accessing services at their organizations as well.

All of the refugee women I interviewed were both racialized and marginalized. Thus I had both an insider and an outsider relationship with my participants. At first, I did not notice that my race played a role in the interviews. However, mid-interview almost every

woman stopped to ask, “Where are you from?” After sharing my ethnicity with them, it was clear that participants felt more at ease during the interview. Women demonstrated their acceptance of me by saying things like, “you get what I am saying” or using phrases of endearment like “my daughter” or “my dear.” Indeed, by the end of the interview many women embraced me as a “niece” or a “daughter.” This dynamic helped to breakdown some of the barriers I faced as an “outsider” and in turn, allowed for a safe space for these women to share their personal narratives in their own way. However, I also acknowledge that I have not experienced the magnitude of trauma that they have nor could I completely understand their struggles as refugees.

### *Reflexivity*

In qualitative research, reflexivity allows for one to constantly assess, reassess and make decisions about “the best possible means for obtaining trustworthy information, carrying out appropriate analysis, and drawing credible conclusions” (O’Leary, 2013, p. 9). This is a powerful tool that a researcher can use to better understand their position within the research and how that positionality may influence the data collection and analytic processes. Reflexivity involves being aware of one’s own values and positionality and acknowledging the subjectivity that one brings to the research process. As part of my study design, we included memoing as a tool to acknowledge this subjectivity and my interactions with study participants.

The relationship and trust that I had built with the key informants through both my research and informal interactions translated into an open relationship with the 12 refugee women that I interviewed. These relationships were built through acknowledging my personal biases and being mindful of the dynamic that my role as a researcher brings to the interview. One such example is that during interviews with key informants, my work as a

Chair of the Refugee Outreach Committee for St. Joseph's Parish gave me grounds to empathize and "understand" their struggles at work. Since I recorded this during my memoing process, I was able to use this point as a way of building trust with future key informant interviews.

### **Limitations**

Given that a woman's personal experience with sexual violence is a very sensitive topic, I knew that interviews with such a vulnerable population would be especially difficult. In order to account for this dynamic, I networked with both community-based organizations and refugee women in communities in Ottawa and Toronto. Recruitment of refugee women as a limitation was also accounted for when designing our study. To mitigate this issue, I first interviewed potential key informants and then later, invited those key informants as well as other frontline workers to share information about the study with refugee women who access their services. In this way, I aimed to have those working more closely with refugee women reach out to explain the study. As is to be expected with this population, refugee women were a difficult population to recruit. However, the 12 women that I was able to recruit for the study were recruited through social service delivery agencies and are women who have relationships with support services agencies. In only having successful recruitment from social services delivery agencies, women who were never able to access services are not included in my study which is a significant limitation.

The women I interviewed were from a diverse range of countries and cultural backgrounds. Upon designing the study, we knew that solely conducting interviews in English would be a significant limitation and would not only limit our recruitment but also the depth of information a woman would be able to share. Selecting English as the

interviewing language was strategic so that we were able to adequately validate women as they shared their experience(s) with sexual violence. However, we tried to mitigate the language limitation by creating other more general eligibility criteria. In this way, women could participate from an array of personal situations, migratory statuses, regions and countries of origin, and years of arrival.

As this was only a small-scale study for a graduate thesis, it was not feasible to conduct the study Canada-wide. I was limited to only conducting interviews in two of the larger urban cities in Ontario. For future studies, this limitation could be taken into account and the scope of the study widened to include a sample from across Canada in both rural and urban settings.

Qualitative research is not meant to be generalizable and our study population is not representative of other populations. The semi-structured in-depth interviews allowed me to obtain a thorough understanding of participants' pre- and post-migration experiences and insight into potential systems and service delivery improvements. We are confident that the themes we have identified are meaningful but acknowledge that these findings do not represent broader patterns or trends.

## **Conclusion**

Refugee women's post-migration needs are both multifaceted and individualized. Women are very much aware of their need for services and suffer from a lack of awareness as to how to navigate the systems to access available support. Moreover, there is a need for comprehensive and "one-stop-shop" service delivery. Our results suggest that women are in search of services that offer holistic and group and peer counselling where women with

similar histories can provide support to each other. Refugee women should be integrated into all phases of developing, implementing, and evaluating these efforts.

Finally, there is a need for advocacy on behalf of refugee claimants and specifically for undocumented refugees. The Canadian government needs to recognize that the changes made in 2012 have had an especially negative impact on these sub-categories of refugee women and have left service providers confused. Further research is warranted and should be targeted toward changes at the policy level surrounding funding given organizations offering support and services to refugee women, specifically refugee claimants, non-status, and undocumented refugees.

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# **Appendix A: Ethics Approval**

## **Ethics Approval Notice**

File Number: H02-14-07

Date (mm/dd/yyyy): 03/04/2014



**Université d'Ottawa**

Bureau d'éthique et d'intégrité de la recherche

**University of Ottawa**

Office of Research Ethics and Integrity

## **Ethics Approval Notice**

### **Health Sciences and Science REB**

#### **Principal Investigator / Supervisor / Co-investigator(s) / Student(s)**

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Angel	Foster	Health Sciences / Others	Supervisor
Jessica	Silva	Health Sciences / Others	Student Researcher

**File Number:** H02-14-07

**Type of Project:** MA Research Paper

**Title:** Refugee women's experiences with sexual violence and their post-migration needs in Canada

<b>Approval Date (mm/dd/yyyy)</b>	<b>Expiry Date (mm/dd/yyyy)</b>	<b>Approval Type</b>
03/04/2014	03/03/2015	Ia

(Ia: Approval, Ib: Approval for initial stage only)

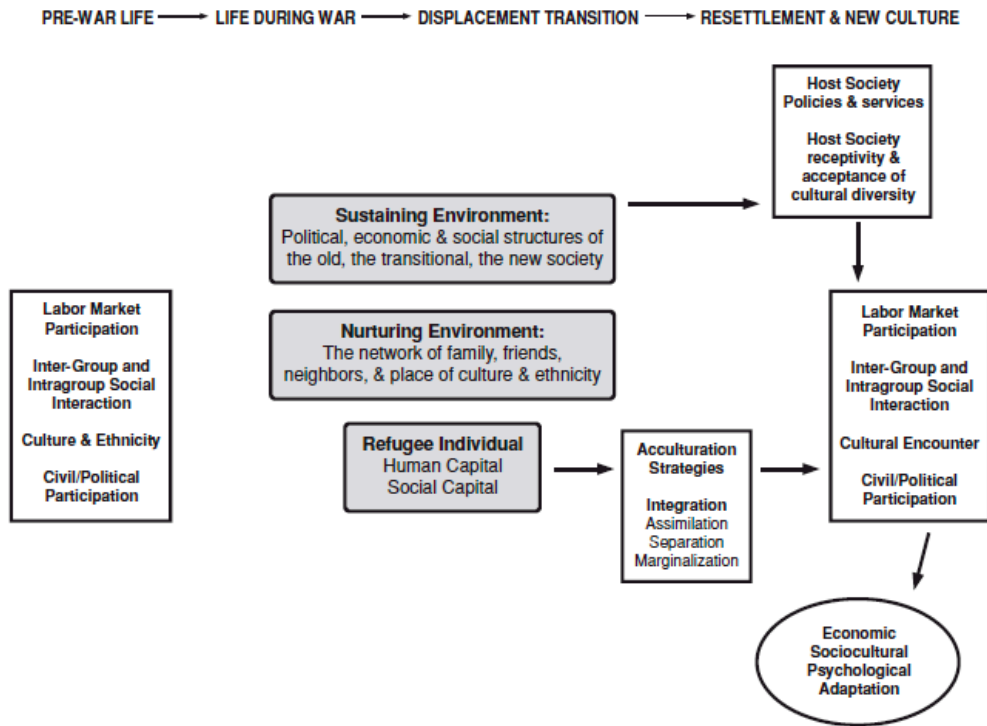
**Special Conditions / Comments:**

N/A

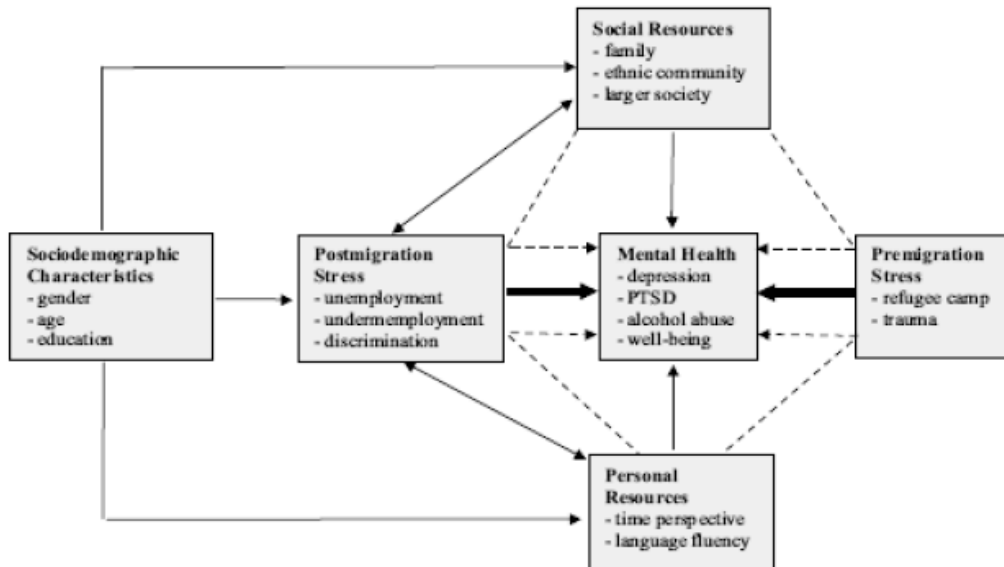
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## Appendix B: Conceptual Frameworks



**Figure 1: Ecosystems model of refugee resettlement (taken from Coughlan & Owens-Manley, 2006, p. 21)**



**Figure 2: Stress, protective factors and refugee mental health (taken from Beiser, 2006, p. 59)**