INTRODUCTION

The Syrian Civil War, according to the UN Human Rights Commissioner Zeid Ra’ad al Hussein, has become “the worst [human-made] disaster the world has seen since World War II” (United Nations News Services, 2017). Over 6.5 million people have been internally displaced within Syria (UNHCR, 2016), and 5 million have fled Syria and are living as refugees in Turkey, Egypt, Iraq, Jordan, Lebanon, and other North African countries (UNHCR, 2017b). Almost one million Syrians have requested asylum in European countries (UNHCR, 2017a).

In line with our humanitarian tradition, Canadian government and Canadian citizens stepped in with a nationwide commitment to resettle Syrian refugees. The widely shared story of the tragic loss of young Aylan Kurdi, and the fact that his family had considered seeking refuge to Canada, further galvanized our response to resettle Syrian refugee families (Withnall, 2015; The Canadian Press, 2015). The Liberal Party won the 2015 federal elections on the promise that they would resettle 25,000 Syrian refugees. Initially, the plan was to accomplish this ambitious commitment by the end of 2015. The deadline was later extended to early spring of 2016. Advocacy groups and community agencies continued to rally the Canadian government to increase the Syrian resettlement numbers. By mid-2017, a total of 40,000 Syrian refugees have been resettled in Canada (Government of Canada, 2017).

Resettling this large cohort of Syrian refugees to Canada within a short amount of time was an extraordinary and complex undertaking. The last time Canada undertook such a rapid and large scale refugee resettlement was in 1979, when we resettled 60,000 refugees from South East Asia (Vietnam, Cambodia, and Laos) within a period of two years. In the case of Syrian refugee resettlement process, several international organizations and all levels of government in Canada were involved. The federal and provincial governments provided additional funding to support this process (see Figure 1). Moreover, hundreds of community agencies and many community groups (sponsor groups, faith based groups, volunteer groups etc.) across Canada came together to provide services and supports to Syrian families arriving daily in large numbers.

---

**FEDERAL FUNDING**

2016-2017

- Newcomer Settlement and Integration: $153.6 million
- Health Protection (includes screening, medical surveillance and IFH): $14.5 million
- Internal Services (administrative): $8.1 million

---

**PROVINCIAL FUNDING - ONTARIO**

2015-2017

- $10.5 million for immediate and future support:
  - Immediate settlement needs for UNHCR and UN World Food Program: $2 million
- For organizations that support private refugee sponsors: $1.8 million
- Boost community-based supports: $3.7 million
- Orientation, training, and public education: $626,000

---

Figure 1: Additional Funding Allocated to Syrian Refugee Resettlement at Federal and Provincial Levels
numbers (Hansen & Huston, 2016).

Ontario resettled more than 16,000 Syrian refugees (Government of Ontario, 2015). Of this, a third (5345 Syrian refugees) came to the City of Toronto. Region of Peel and Region of Waterloo resettled 1066 and 1495 Syrian refugees respectively. Figure 2 shows a breakdown of arrivals to these areas.

With funding from United Way Toronto and York Region, Access Alliance conducted an environmental scan study to document how service provider agencies planned and delivered settlement, health and other services in response to the arrival of large number of Syrian refugee families within a short span of time. Interviews with key informants capture the exemplary cross-sector collaborations and organizational innovations that were mobilized to meet the unique demands of rapid, large-scale delivery of services for hundreds of Syrian families arriving on a weekly basis. The study has captured the key success factors that facilitated these collaborations and innovations including engagement of senior leaders, public goodwill, and relationships based on trust. Study findings also shed light on the many challenges faced along the way including funding and communication gaps, coordination challenges, fairness and equity concerns, and meeting needs specific to Syrian newcomer families. Results from this study have important best practice implications for refugee health and settlement, particularly in terms of planning services and supports for future large-scale arrivals of refugees to Canada.

**METHODOLOGY**

The key goal of the study was to document how we responded to the arrival of large cohort of Syrian refugees within a short time frame in order to identify best practices to inform future response efforts to similar situations. In particular, we wanted to understand (i) the nature and scale of cross-sector collaborations and system navigation supports that were mobilized with attention to the institutional factors that enabled these collaborations and successes, (ii) and document challenges faced, and how agencies responded to these challenges. To provide a comparative context on how variations in regional/urban contexts affect service planning, our study focused on three urban centres/regions in Ontario: City of Toronto, Region of Peel, and Region of Waterloo.

The study was grounded in Community Based Research (CBR) principles. We
trained and meaningfully engaged two recently arrived Syrian Canadians, Tarek Kadan and Iman Malandi, in leadership capacity as “peer researchers” in research design, data collection, analysis, writing, and knowledge translation activities. Tarek and Iman came to Canada as refugees (Tarek as privately sponsored and Iman through the government assisted refugee stream) and brought their lived experience expertise to this study.

We conducted key informant interviews (n=22) with senior-level leaders as well as front-line service providers/mobilizers from healthcare, settlement, government, community development, and faith & non-faith-based organizations/groups. Study participants were recruited using purposive sampling to ensure (i) diversity of representation from different sectors and regions; and (ii) fit and relevance to study goals (participants who played direct and active role in the Syrian refugee response were targeted and prioritized). The interviews were conducted between December 28, 2016 till March 15, 2017. The interviews were transcribed verbatim and coded and analyzed using NVIVO 8 software using grounded theory framework (Glaser, 1998; Martin and Gynnild, 2011; Braun & Clarke, 2006; Robson, 2006) that allows for capturing emergent and latent patterns/findings through “constant comparison” and seamless bridging of inductive and deductive analytical frameworks. We analyzed data using collaborative data analysis (CDA) framework developed by Access Alliance, and in line with the DEPICT analysis model put forth by Flicker and Nixon (2015). Research and ethical protocols were reviewed and approved by Access Alliance’s Senior Research Scientist to ensure the study met the agency's research and ethical policies.

Figure 3: Sectors and Areas of Support in Syrian Refugee Response

Interviews with key informants show that agencies and groups from 15 different sectors were involved in some capacity in providing services and supports for the large groups of Syrian refugee families arriving in their respective cities/regions. The sectors involved during the response can be seen in Figure 3. In addition to...
settlement and healthcare sector, decision makers and front-line workers from the education sector (e.g. School Boards), housing sector (including private landlords who helped to create housing registry), police, and children’s services were directly and indirectly involved in delivering different services and supports to the newly arrived Syrian refugee families. Importantly, an impressive number of private sponsor groups, faith based organizations/groups, and existing and newly established volunteer groups put in thousands of hours of their time to help with big and “little things” like connecting Syrian refugee families to services, helping with interpretation/translation, accompanying them to their appointments etc. Hundreds of specialists (for example, ophthalmologists, plastic surgeons) and general public also dropped by on a regular basis to offer their help.

The scale of involvement and the diversity and number of agencies and groups involved was unprecedented in recent history of Canada. This large scale response from multiple sectors and agencies/groups brought many opportunities and resources, and also catalyzed organizational innovations and cross-sector collaborations that continue to have lasting positive impacts; at the same time, this resulted in many challenges, including challenges related to coordination, communication, navigation and equity. The rest of this report discusses successes, challenges and best practices from this extraordinary response.

2. Collaborations: From Regional Roundtables to Interagency Networks

A large cohort of Syrian refugees arriving within such a short timeframe was initially chaotic and confusing for service providers to plan and successfully support. However, through this chaos and confusion, exemplary and innovative models of cross-sector collaborations were mobilized in order to provide timely and integrated services and supports for Syrian refugee families.

Beginning in September 2015, service providers recognized that the imminent arrival of this large cohort of Syrian refugees was a critical time to set up collaborations between agencies and among sectors. Within three months, diverse systems of collaboration were set up to support the immediate needs of Syrian refugees arriving in the City of Toronto, Region of Peel, and Region of Waterloo.

Forming good partnerships to collaborate effectively with agencies across sectors enabled many service providers to share resources, information, expertise and skills in timely and optimal ways. Moreover, it also enabled them to overcome challenges and constrains along the way through a shared model of responsibility.

As one study participant (P8) put it, services across sectors were never "as collaborative as it has recently been," with providers "coming together" without "competing of funding for a client base", but rather "what can I support you, I can take care of this piece...". For example, in Toronto, a network of 32 different healthcare provider agencies came together to establish a system of coordinated care for Syrian newcomers arriving to the region, in order to ensure that the provision of care during the response was shared across agencies (P16). Sector leaders in each city/region organized community meetings to mobilize partnerships and gather knowledge and resources. These meetings then led to the creation of dozens of collaborative working groups that took on different shared responsibilities. In the Region of Peel for example, a large community meeting was convened:
“...with all community partners, about 200 people showed up sort of asking, what is it that we need to do? How can we do this? So we started developing methodologies or ways of having information sessions, etc, but the working group became the crux of this” - P3, Senior-level Government Official

Specifically, these interdisciplinary working groups and collaborative partnerships became effective platforms for mobilizing resources and communicating information cross-sectorally. For example, the special working group in Region of Peel helped to facilitate stronger and seamless collaboration between mental health workers and settlement workers in ways that resulted in an integrated model of settlement and mental health services for Syrian refugee families from the first weeks of coming to Canada (P3).

In the Region of Waterloo, sector leaders built on the successes of a previously existing backbone network of different organizations. This interdisciplinary network "took the lead in probably a way that had never been done before" and became the "designated agency" that would communicate information to all the partners within the network (P12). This collaboratively-led structure that included municipal and community partners "was really important for the engagement of all of the community organizations which have been carrying the heavy weights, in terms of, refugee and immigrant resettlements in the past" (P7).

In both Region of Peel and Region of Waterloo, regional government officials were actively involved in organizing and co-leading these collaborative networks.

The Syrian refugee response team established by the Ontario government provided another platform for many cross-sector collaboration initiatives between different levels of government and community agencies. For example, staff from Ontario Ministry of Children and Youth Services worked closely with other government agencies (including IRCC) and stakeholders from Peel Children's Aid, Peel Newcomer Strategy Group and other RAP and community agencies to deliver over 50 public education workshops on positive parenting and child welfare services that reached over 1100 Syrian refugees. Staff have noticed marked reduction in negative experiences with police and child welfare services among Syrian families because of these workshops.

To ensure language barriers were addressed during the provision of care, a local health integration network in Toronto "opened up the spectrum of interpretation services" to providers who did not traditionally have access (P16). This meant that many more "clinics could have access to telephone interpretation services" (P16).

These cross-sector partnerships and collaborations also served as a site for knowledge distillation and sharing about refugee health and resettlement, particularly among new stakeholders and partners (for example, school boards, police services). In the words of another participant: "we've seen the refinement of knowledge that one needs to take care of the refugee patients. For all of us... It's most striking in organizations that don't traditionally work with refugees" (P10). This refinement and sharing of knowledge about refugees and services for refugees between and across old and new partners will continue to have lasting positive impacts in refugee resettlement.
Government-assisted Refugees usually stay for a couple of weeks after arrival to Canada in temporary accommodations in “reception centres” provided by the designated resettlement assistance program (RAP) agencies for the particular city/region. In response to the mass arrivals of Syrian refugees, government agencies and designated RAP agencies had to arrange for other temporary accommodation sites (primarily hotels) that could house a large number of refugee families. Refugee families stayed in these temporary accommodation sites for several weeks or months until more permanent housing was arranged. Interviews with key informants highlight that these first sites of resettlement served as innovative service hubs and platforms for community-building.

Many of the services for refugees that typically are accessed externally, were operationally centralized at temporary accommodation sites. For example, in Toronto, these temporary accommodation sites included onsite primary care clinics, public health and dental screening services, midwifery services, as well as spaces for volunteer and other community agencies/groups. Similar collaborative response models were also set up in Region of Peel and Region of Waterloo. The on-site service collaboration model is shown in Figure 4.

Senior leaders and front-line providers from health, settlement and other community agencies worked together to create spaces, coordination framework, decision making process, and information management system to provide these multiple services within the hotels. For example, collaborating agencies created dedicated rooms in the hotels for particular services, and triage systems were set in place to prioritize urgent needs for primary care.

Moreover, study results highlight that these temporary accommodation sites helped to strengthen a sense of belonging and community among Syrian newcomer families, as it became a place to build rapport and trust with fellow newcomers, service providers, volunteers, and other community members.

"And one of the things about the hotel, because it was the largest receiving hotel, and this I think is much more beneficial than we think, is you land, but you land with your community." - P13, Frontline Primary Care Provider

4. Innovations in Service Planning and Delivery
interventions were mobilized to respond to the needs of Syrian refugee families. New staffing positions were created by agencies to help manage coordination efforts. One example of a position created was the Stakeholder Engagement Manager in Toronto, a role exclusively aimed at scheduling and coordinating people. Other staffing positions were also created and shared between collaborating agencies. For example, two positions were created for Syrian mental health workers and two positions were created for settlement agency workers which were shared amongst settlement agencies in the Region of Peel. The uncertainty about what the actual need was and the staffing requirements to meet this need made this shared staffing model an effective use of resources.

Similarly, to help coordinate the process of connecting families with housing, one agency established a centralized housing registry. Landlords and other housing partners were able to register their vacancies on the registry and this information was then shared with community agencies serving GARs as well as privately sponsorship groups. This represented a unique moment when private landlords were working closely and collaboratively with settlement agencies to meet the housing needs of refugee families; the creation of the centralized housing registry fostered this collaboration between private and non-profit sector.

In particular, front-line providers working at the hotels mobilized unique partnerships onsite to reach vulnerable families and proactively overcome linguistic and other barriers to services. For example, a key informant described the relationship established between a midwife and a professional interpreter to jointly build trust with Syrian refugee families staying at the hotels and communicate about services that midwives can provide to pregnant women. Initially no woman had come forward as pregnant.

However, once the refugee families learnt more about midwife services and developed trust with the midwife- interpreter team many women disclosed their pregnancies and were provided with necessary support services on site.

5. Reasons for Success

Results from our study show that there were multiple “success factors” that facilitated positive cross-sector collaborations, organizational innovations, and effective planning and delivery of services for the large number of Syrian refugee families that arrived from fall of 2015 to end of 2016. In this report, we highlight three key success factors mentioned by most of the study participants:

A. HUMANITARIANISM AND GOODWILL

The tremendous sense of humanitarianism and goodwill exhibited by members of the public, service providers, and volunteers made a significant impression on study participants, and was mentioned as one of the key reasons for success during this refugee resettlement response. Goodwill and enthusiasm was displayed across the general public during the Syrian refugee response (P9, P10, P22), where everyone had an interest “in making this work and actually caring about the results” (P22). Service providers who have worked with refugees and immigrants for years have “never seen this type of outreach and good will... to a time where, really, we couldn’t keep up with the phone calls from doctors who wanted to help. And that, it’s a phenomenal thing” (P10).

Crucially, the goodwill and humanitarian commitment from hundreds of people who wanted to volunteer allowed for immediate resettlement needs to be addressed in timely and personalized manner. For exam
ple, volunteers provided transportation to support refugees at their own will, taking clients in their own cars or accompanying newcomers using public transit. One participant described how volunteers took care of the little things that providers "couldn't catch up" at the temporary accommodation site (P2).

‘Cause there’s there’s little things like a mom would come and she’s like – I need a hair tie for my kids, I don't know how to tie their hair. She had (number of) girls, all with long hair and she was like I need to tie their hair, and I'm like oh go to the dollar store. Because there was a dollar store close by. But she couldn’t – she just she went to the dollar store she came back she’s like I couldn't find anything or know how to ask. So it was it was volunteers, they’re the ones who’re like you know what? I’ll follow up with that piece. So there’s a lot of little things in the moment that start to come up, and that was all volunteers. And I think they continued to do that” - P2, Frontline Healthcare Provider

Positive Canadian values such as compassion and care were mentioned by participants as motivation for the goodwill displayed by people assisting to support Syrian refugees. As one study participant noted, the tipping point to this strong national emotional response was the picture of young Aylan Kurdi who died while trying to flee Syria. Prior to that, there was "faint public awareness that there was a crisis” (P8).

B. BENDING ROPE: ENGAGEMENT OF SENIOR-LEVEL LEADERS

Many study participants suggested that access to, and engagement of senior-level leaders in planning and collaboration processes significantly helped to mobilize resources in a timely manner. Participants referenced accessibility (P15, P22), willingness (P15, P22), and supportive leadership in the collaborative response (P6, P12) as key aspects of senior-level engagement. One participant based in the City of Toronto described how having senior-level leaders from the local school board at a collaborative ministry organized roundtable facilitated the process of registering Syrian refugee children for school. The fact that school board staff came to the temporary accommodation sites (i.e. hotels) at their own costs ensured that Syrian children were registered to relevant schools right away.

"School boards actually came at their own cost with school buses. Came, got consents from the parents. They brought Arabic speaking staff to the hotel to get particulars down. They hired school buses, they send staff to the hotels to organize kids getting on the school buses and took them to the local schools. And took them to local schools like, every day. And it came from one of the roundtables with the ministries. Someone from the school boards were at the table. And I was describing the scenario we had at the hotels. And she came to me after the meeting said, why aren't those kids in schools? I said, I don't know. Can they be in schools? She said, absolutely. And she pulled it together within two days. And both school boards came on behalf. Again, high level people from the department of directors and made that whole thing happened in a flash. So, that’s just an example of the value of those collaborative relationships." - P22, Senior-level Official, Settlement Agency

A similar experience was shared in the Kitchener-Waterloo region, where senior-level leaders were "bending rope" to make it easier to deliver services:
"We have very senior community leaders, as at other steering committee. And that was important to enabling very fast decision making about delivering services. And in ways that they hadn't necessarily been delivered in the past. Or you know, if we needed to bend rope. Because it's a normal way of working with newcomers was not going to be enough with this volume of people. Like, our school boards having a history of only registering refugee and immigrant children, once they are living in at their permanent address. You know, this was causing problems because we had 100s and 100s of children in temporary accommodation and needed supervision. And our settlement agencies were not able to do the works that they were able to do with their families to support their settlement. So we asked school boards, you know, are you able to just put them into schools? Why do we have to wait? You know, they are, they may wait 2 to 3 months to go into school. And I would be better for them to start now. The next day they had people down at the hotels doing registration and the children were in school by the end of that week." - P7, Senior-level Government Official

In both examples, the positive outcome was that children were registered and in school without much delay. Study participants shared many other examples of how direct and proactive involvement of senior-level leaders from other sectors/agencies (for e.g., public health, housing) resulted in early, timely delivery of services to Syrian refugee families. Engaging senior-level leaders including executive directors, managers, and government representatives (at federal, provincial, and regional levels) at planning tables redefined "how they deliver services to refugees in this response in a very fast way" (P7) and made it "much easier to bring about change" (P15).

C. RELATIONSHIPS BASED ON TRUST

Many study participants noted that one of the key elements of success was building and sustaining relationship based on trust and shared responsibility. In particular, having previous or existing relationships enhanced leveraging of support when coordinating with partners to deliver services to Syrian refugees. Study participants conveyed that their connections with partners such as medical specialists and other service agencies that they had worked with previously made it easier to make last minute referrals (P6, P13, P18).

One participant's existing connections with RAP agency, community health centre, and mosque created "familiarity" which in turn led to greater comfort for partnering organizations to share and utilize different sources of funds. (P14). This participant described that because of these positive existing connections things could move fast based on trust, "there was never formal MOUs or. It was never any formal organizational meetings with [RAP]. It was all me discussing with [RAP], coming back to the mosque and say, listen, they do the check. So this familiarity, people knowing and understanding that there was no hidden agenda, right" (P14).

Participants also mentioned how previous connections with landlords (P22), settlement agencies and RAPs (P9), volunteers (P6), networks of university hospitals (P10), and food banks (P18) motivated collaborations and mobilized timely access to different kinds of services for Syrian refugee newcomers. Overall, trust was important among collaborating partners across sectors. Having common goals and outcomes during the response facilitated trust among partners (P3, P4), and "everyone was very respectful for what it was they were sharing" (P3).
Building trust was also key to forming positive relationships between clients and service partners, alike. Proactively reaching out and connecting with clients on a personal level (e.g. smiling, making jokes), letting them know why you are there, and ensuring good flow of information (by overcoming language and other barriers) were steps that study key informants identified as ingredients that built trust with clients. For example, P13 (midwife), shared about the "importance of [Syrian refugee families] seeing your face, right, seeing you smile at them, seeing you make a joke about midwives and pregnancy and like that made a huge difference." This personal connection that the midwife helped to establish (with the help of a professional interpreter to overcome language barriers) was significant, as P13 recalled that "within half an hour I had 9 people who were like okay I’m pregnant, oh I should go talk to that woman over there." Another participant also mentioned how consistent presence of staff onsite at temporary accommodations built relationships between service providers and Syrian refugee families in the hotels, as newcomers "began to trust us that we were providing supports and meeting their needs" (P18).

6. Key Challenges

The unique and extraordinary situation of providing services to large groups of Syrian refugee families who arrived within a short time frame also brought with it extraordinary and unique challenges. These challenges transpired at macro/system level (such as funding gaps, coordination and communication gaps, equity concerns) as well as at micro/community level (such as challenges specific to the needs of Syrian refugee families). Some of the main challenges are documented in this summary report:

A. INFORMATION / COMMUNICATION GAPS

With regards to information sharing, participants mentioned the lack of sufficient data about the arrivals of Syrian refugee newcomers as a major challenge to planning for the initial resettlement response. This led to confusion and lack of preparation among services, and increased unanticipated challenges as a result.

The number of individuals and families arriving was "vague" and although target numbers were provided initially, "it seemed to be very difficult process to really have an accurate number of incoming [refugee families]" (P21). In the case of government assisted refugees, although there was regular ongoing planning that was done in conjunction with Immigration, Refugee and Citizenship Canada (IRCC), the actual number of arrivals was provided just "more than a couple of day’s notice." One participant described how arrivals "just hit us, you know, on December 24th in a blast" (P22). Another participant described that the information on the volume of refugees arriving seemed to be timed "week to week" and vary considerably (P18). Having little knowledge about the "pattern of arrival" affected the ability of service providers to plan services and supports including adequate accommodation in temporary accommodation sites, adequate interpretation services, and to meet medical and accessibility needs (P12, P21, P22).

In particular, there were gaps in information about privately sponsored refugees in terms of their expected arrival dates and also the total numbers arriving in specific cities and communities. As one participant described: "...so many of the refugees were made available for sponsorship, but yet the papers were not completed. So it took a lot longer for some of them to be processed and created a lot of frustration among our sponsoring groups" (P6). This confusion resulted in private sponsor groups losing money because they had secured housing for arriving refugees in advance. There was also lack of clarity in terms of how many
privately sponsored refugees arrived, and where they would be settled in the community, because agencies "were more focused on the government sponsored families" (P3). Participants stressed that timely and regular information about how many privately sponsored refugees were arriving in the community would have been helpful, particularly for connecting them healthcare, settlement and other social services as needed (P18).

B. FUNDING AND RESOURCES

While the federal and provincial governments did put in additional funding, there were major gaps in funding and resources that hindered collaboration, coordination and delivery of services to Syrian refugee families. Some participants described how government bodies such as IRCC allocated additional funding to larger agencies including those that were already funded by IRCC, and neglected to fund smaller agencies that were involved in this extraordinary Syrian refugee response (P20).

Other participants mentioned funding gaps for specific kinds of services and supports; for example, inadequate funding to hire enough interpreters, service coordinators, and additional staff to meet the higher demands for services and supports. Due to limited funding and resources, agencies were pressed to rely more on volunteers. While this was somewhat helpful, agencies could only expect so much support from volunteers, as they also had jobs and family responsibilities that they had to attend to (P5, P19).

In some instances, refugees were arriving before government funding dollars were received by the agencies. Nonetheless, agencies continued to provide services to refugees upon arrival by leveraging resources and "processes that were already in place" (P21) or by using grants and one-time funds from other sources. (P15, P19).

"Interpretation is not something that’s cover under OHIP and largely not something covered under IFH, either. There are exceptions under IFH. But typically for typical primary care or specialist care appointment, interpretation is not covered. A lot of agencies have a policy of, you know, if you want an interpreter, you bring it yourself, you bring them yourself. Which is problematic for refugees. They may not have the ability to find an interpreter, or partial interpreter, or interpreter, at all, to help out with as assessment. So, yeah, I mean, I think, it’s a function of the larger health system, as well as, individual policies by healthcare agencies" - P15, Frontline Healthcare

C. “BURNOUT

Many participants also noted challenges in terms of capacity and being stretched in terms of time, hours of work and overall effort. Staff onsite at temporary accommodation sites were overwhelmed, shocked, and experienced mental and physical exhaustion, as well as burnout and isolation (P2, P3, P8, P13). It was difficult for staff when hearing sad stories from refugees and trying to be there for refugees on a personal level. There was limited space, time and support to debrief about these challenges or to address vicarious trauma that staff may have experienced (P2). During the response, many providers were also working overtime and not practicing adequate self-care as a result (P8).

For some participants, being dedicated to support Syrian refugee newcomers during the response also meant that they were stretched in their capacity to provide services. In many cases, service providers had to shift away from their existing practice and clients (P11).

Many participants echoed that several agencies, especially small agencies, did not have the capacity to deal with the large
volume of people that arrived during
the response (P7, P10, P12, P20). One partici-
pant described that "number one, nobody's
got the capacity to deal with this on our
own" (P20). Another participant described
how one settlement agency can be stretched
in capacity:

"when you have one agency that is,
kind of, the key, the central hub for
the reception of such a large group of
people, they needed to be involved
everywhere. So their capacities were
really stretched...focusing on serving
the people who were arriving, as they
were supposed to" - P7, Senior-level,
Government & Policy

Several study participants highlighted how
some key agencies were a bit territorial and
non-collaborative. This led to burnout of
staff within those agencies and hindered
service delivery. Study participants empha-
sized that in such mass resettlement pro-
cess, "one agency cannot do it on their
own."

D. FAIRNESS AND EQUITY

Many study participants raised concerns
about fairness and equity. The targeted
focus on Syrian refugees, particularly those
that arrived between September 2015 and
February 2016, resulted in unequal levels
and types of services and supports between
different groups Syrian refugees, and
between refugees from Syria and from other
countries.

Within Syrian refugees, one participant
described the wide variations in types of
services and supports depending on when
they arrived:

"...two different classes of refugees
were created. Some refugees who
arrived in Canada with loan and some
refugees who arrived [to] Canada
without. Not only that, other refugees
arrive[d] in Canada and received all
these outfits. And others arrived and
got nothing. That were received by the
Prime Minister and some didn't even
have a real people to pick them up."
- P6, Frontline Provider, Faith-based

With regards to the transportation loan, the
federal government waived the loan repay-
ment for Syrian refugee families that
arrived between X and X. The Syrian refu-
gee families that came before and after
these dates are stuck with having to repay
their transportation loan, just like other
sponsored refugees. While the decision to
waive the transportation loan may have been
well intentioned (relieve economic
stress for Syrian refugee families), study
participants recommended that the federal
government should have taken fairness and
equity into account and waived the trans-
portation loan repayment for all sponsored
refugees. Several studies have documented
the adverse economic and health impacts
on refugee families from the burden of this
transportation loan. Community agencies
and researchers have been calling the
government to waive the transportation
loan for sponsored refugees, and cover
transportation costs to Canada as part of
resettlement assistance program.

Study participants raised concerns about
differential access to services and benefits
between privately sponsored refugees and
government assisted refugees of Syrian
origin. For example, government-assisted
refugees were receiving tickets/tokens to
cover public transportation, while privately
sponsored refugees were not eligible: “Now,
try to explain to two refugees from the
same war and program why X is getting a
bus ticket and the other doesn’t” (P4).

Furthermore, service providers and commu-
nity/faith-based organizations faced ethical
dilemmas on how to use donation money in
an equitable manner. Due to the targeted
focus on Syrian crisis, most of the dona-
tions coming in were directed at supporting
Syrian refugee resettlement. Study partici-
pants shared about their moral dilemmas
and operational challenges in not being able
E. COORDINATION

Poor coordination between agencies and a lack of a central coordinating group was described as a significant challenge for participants. In the words of one participant (P10), “there were a lot of pieces but who was responsible for putting those pieces together?” Some participants described that there was not enough resources and time put into coordinating and in some cases “every organization was preparing on their own” (P10 and P11). Poor coordination between agencies led to some agencies taking on a significant load while other agencies were underutilized. This was “to the detriment of the people coming in. There should have been that recognition that nobody’s got the capacity to deal with this on their own” (P20).

Participants also described that managing the large volumes of information being received from other agencies and different levels of government was challenging and that the lack of consistent information to support planning was a barrier: “Our biggest challenge was figuring out our system for how we took all of that information in and put it all together in a consistent way” (P7).

Participants described that there was poor coordination of roles and a lack of clarity about the scope of individual roles and the roles of other agencies. This was mentioned as a major hurdle when connecting refugees with services they needed such as primary care. For example, participants described the challenge of arranging medical appointments along with other supports such as childcare, transportation and interpretation: “Transportation is a settlement piece for (local settlement agency). But then when I would approach (local settlement agency) and I know they were overwhelmed too, they’re like well, it’s transportation to a medical appointment. So it’s your piece” (P2).

Participants also described that there was an overwhelming response from volunteer groups but because there was no designated staffing to coordinate volunteers, they were “not necessarily being well received and this led to more chaos.” (P13) Furthermore, despite a large number of volunteers showing interest, most were available for limited time and hours. For example, one participant recalled “but then when it came down to it and we're like ‘I need you Friday morning at 9.’ Out of a hundred people [volunteers], three people would show up sometimes” (P2). There was a strong need for a dedicated volunteer coordinator staff who could effectively manage the large number of volunteers with varied availability, skills and interest.

F. MEETING COMMUNITY-SPECIFIC NEEDS

There were certain challenges in terms for planning services to meet needs unique and specific to Syrian refugees. This included their preference for where to settle, challenges related to large family sizes, and meeting complex health and other needs as a result of severity of war and conflict in Syria.

Initially refugees arriving in Toronto were being settled in regions such as Scarborough and Etobicoke. However, service providers noticed many families were then moving to Mississauga. This took place due to the large Syrian population, restaurants and Arab grocery stores in Mississauga. Study participants noted the challenges finding affordable rental units and transportation in Mississauga. Families also wanted to move into buildings where other families were located and preferred to cluster together. However, arranging housing close
to each other was also challenging; “A lot of families wanted to live together in the same building. You know they had already made friends with others living at the hotel. And so to find them housing close to each other in the same building, it was a challenge” (P22).

Many of the Syrian refugee families had large families, including up to 11 - 12 family members. The large family size presented a set of unique challenges for service provider agencies: “The families’ given size was completely neglected. Syrian Arab families are not the 2.2 children that we have in North America. We had families come in who had 5, 6, 7 kids” (P14).

Arranging affordable housing for families of this size was difficult, and led to families staying for longer than was expected in hotels.

Coordinating transportation was also logistically difficult and costly. When arranging transportation by car for these large families to get to healthcare appointment, front line service providers needed to spend extra time figuring out the right combination of cars and car seats.

Large family size also created challenges in terms of managing length of appointment. For example, a participant shared the case of a family of 13 that was supposed to be seen at a local CHC but the CHC’s client onboarding policy required a 1-hour visit for each individual. Seeing this family was logistically impossible and the CHC ended up seeing none of the refugees that the participant had been working with.

G. NAVIGATING THE HEALTH SYSTEM WHILE MEETING COMPLEX NEEDS

Navigating the health system was a central challenge mentioned by participants in our study, particularly in reference to refugees with complex or specific health needs. Early on in the resettlement response, providers at the temporary accommodation sites were not prepared for the “overwhelming numbers,” which simply made things feel like they were “moving too slowly” (P19). One participant on-site indicated that “there were people with really urgent medical needs and they [were] not being seen fast enough.” This led to CHCs coming onsite and opening clinics at the hotels. In spite of this service providers noted that “there was still a lot of chaos” as “there were people that didn’t know there was a clinic onsite. Or they didn’t know what kind of help they can get” (P19).

One service provider expressed how refugees would go to walk-in clinics because of their immediate medical needs, and “going to walk-in clinics could take 6 hours of waiting. So then you need a volunteer to go and sit for hours at a walk-in clinic. Or, if it wasn’t a walk-in clinic then we end up at emergency at (local hospital)” (P22).

- SPECIAL DIET
- DIALYSIS
- WILSON’S DISEASE – RARE DISEASE INVOLVING LACK OF COPPER METABOLIZATION
- NEED FOR ASSISTIVE DEVICES FOR MOBILITY
- REGULAR BLOOD TRANSFUSIONS

Service providers were heavily involved in liaising with other service providers such as specialists and caregivers, so that referrals could be made successfully (P13). However, liaising became more complicated agencies located in the city centre because of the movement of Syrian newcomers to secondary locations of resettlement, particularly in the outskirts of GTA.

Healthcare provision was good for “acute” care (P9, P13) but not for chronic or longer-term care needs, as it made “following up... challenging, because those individuals had to basically transfer care to
a clinic closer to where they go resettled, right?” (P9). According to healthcare providers in Toronto who conducted initial medical assessments, maintaining transfer of care once newcomers had settled in places like Scarborough or Mississauga was difficult, as it “caused...some breakdown in terms of communicating findings, repeating of tasks, things that were already done, once they got into contact with their new providers...” (P9). Reflecting on this challenge, one participant mentioned that “…we’ve lost a lot of dollars as like our healthcare system with that because I know a lot of people probably just went, found a new doctor, repeated everything again” (P2).

H. INTERPRETATION AS A STRUCTURAL BARRIER TO HEALTHCARE

Interpretation remains an existing structural barrier within the healthcare system, and this was expressed as a key issue, particularly in the case of hospitals and private clinics. The health system “wasn’t prepared for the newcomers” as described by one participant:

“So for example, hospitals are supposed to have translation services. But they didn’t. Every time we’d get phone calls from there and like, nobody’s understanding what we were saying. And hospitals [don’t] have translation services, even for emergencies. You know, which was messed up. So it’s kind of like, the system failing.” - P19, Senior-level, Community Agency

Partners relied on Arabic-speaking physicians, but “when they find them they are overwhelmed as one doctor isn’t enough for our community, that could speak Arabic” (P3). Another participant expressed that lack of access to interpretation was one of the “soft medical things” that made it difficult to navigate the health system:

“The interpretation services at the hospitals is not ideal. And they do have the phone service. But you know you need somebody with you. So, same thing, we would have to have volunteers that were seeing each other after 3 or 4 hours. ‘Cause you can be at the emerg’ for 12 hours, 15 hours before you get out or in. So, those were challenging. Those were very frequent. I mean, a kid has a fever at 2 o’clock in the morning. What do you tell them? They wanted go somewhere. And somebody was saying, you know, maybe you wait or. Even take a decision of whether you know, you can actually find a volunteer and go over to emerge. Or whether you are gonna recommend they stay in the hotel. And they weren’t doctors either. But I call it those soft medical things; were pretty hard to handle that we were like, for everybody. It’s not unique to refugees. It’s just when you got 600 of them in one place it becomes insurmountable.” - P22, Senior-level, Settlement

Here, it is clear that the use of volunteer shifts was implemented to support refugees in hospitals to overcome barriers to interpretation.

I. ACCESS TO PREGNANCY AND REPRODUCTIVE CARE

Another key health need that was overlooked in planning for Syrian refugee resettlement was pregnancy and reproductive care. There was not enough recognition of the fact that “people are sexually active, regardless of whether they are fleeing or living in a camp” (P13). A participant described how another “…practitioner said, ‘well how many pregnant women do you think there will be?’” which highlighted the “lack of understanding of both how many pregnant people [there] might be, the urgency of that care, what that means to settlement, and also that people are sexually active” (P13). Furthermore, women’s health exams such as pap tests and breast exams were not prioritized as part of the healthcare
Disclosure of pregnancies was also another issue that arose. Although it later was learned that for women who were pregnant ahead of time, many had “received care at the camp they were at” including ultrasounds, blood work, and paperwork documenting physical examinations, “it became very clear to them in talking to people and getting to know them” that women did not have paperwork about their pregnancy (P13). According to a service provider, this was “deliberate, they didn’t want anyone to know they were pregnant because they were really afraid that would prevent them from being able to come” (P13). Birth control was also a “huge need that was missed” which providers later had provided counselling for during the response.

Systemically, “…one of the big hindrances” to providing “basic-well-women care” is that “midwifery as a profession is not recognized at a federal level” - P13, Frontline Primary Care Provider
7 BEST PRACTICES RECOMMENDATIONS

Key informants reflected on their experiences and observations from the Syrian refugee response to share their best practice recommendations. These recommendations can inform our planning of services and support the next time we resettle large groups of refugees within a short time frame.

1. COMMUNICATION

- Communication needs to be efficient and timely, particularly data on arrivals of refugees.

  “I think the only thing, again the communication. If you can get it timely around when they are coming, how many and what’s their health status. So we can respond quicker. There’s actually an opportunity for planning. […] if we can have the ongoing information, we can effect, like, wait a second, sounds like there’s more coming. We need to pull in our planning team earlier, right. And I think, if we have that broader discussion around what the model would look like, or, here’s some key principles for that model – then we can implement it quickly, right” - P18, Senior-level, Healthcare

- Sector leaders need to establish good, ongoing communication between all the organizations involved on the ground to ensure clarity in terms of roles and responsibilities and to facilitate effective problem solving.

2. FUNDING

- Shift funding allocation from project-based funds to long-term funding strategy.

  “And I know that immigration funding is only for certain organizations but there needs to be stronger communications with other ministries and other levels of government about how funding is made available with other service areas to better support newcomers. Primary care providers in our community have welcomed newcomers into their practices that they can’t communicate with. Because no public dollars to fund interpretation in primary care. This is a big gap. So, we’ve made solutions in our community. But we shouldn’t have to make those solutions. This should be part of policy planning and development in a way that funds are allocated. Services need to be funded in order to be able to receive newcomers in communities.” - P7, Senior-level Government Official

- Promote knowledge of funding structures.

  “One thing for me that was, (our agency), we are funded by IRCC to facilitate community engagement and coordination to better support immigrants and refugees. And in our community it was given. With all our community partners our response in this community is gonna be through our (agency). That was not the case in every community. And it was months into the resettlement before IRCC even thought to come and ask us, if we had a role, at all. It’s the reason they fund us, you know. They should be using their funded structures to help facilitate this kind of stuff. This was a special project; it was a large cohort. We should have been the first point of contact, in my view. Because it is our role to already be facilitating that coordination and collaboration. So, my recommendation would be to use your funders structures. Because they have the wealth of knowledge through the (agency) and a strong history of collaboration at community level” - P18, Senior-level, Healthcare
which is where resettlement happens. That can and it should be leveraged. And we did that here. But I don’t think that it happened at the same level in every community.” - P7, Senior-level, Government & Policy

- Consider trends and community specific needs of refugee groups (such as family size – which intersects with housing, childminding, transportation) when it comes to funding resources.

- Provide adequate funding for professional, medically trained interpretation services to overcome gaps in interpretation:

  “I don’t know medical terms in Arabic. I’m not even that great in Arabic. So, it was pretty, you know, like I’m saying half hazard. And rules are important sometimes, they hamper things. But sometimes, sometimes they protect. So, it was, I don’t know, what’s worse– not having a translator or bringing someone whose not qualified? That’s the kind of mess that we’ve lend ourselves in the beginning.” - P19, Senior-level, Non-Profit & Community

3. PLANNING FOR THE LITTLE THINGS

- Plan and fund the “little things” and not just the big things – in order to provide "health with dignity".

  “I did not like seeing people carrying their life’s belongings in a black garbage bag. That was really hard for me to see. That’s not health with dignity to me. You know? Let's think if we have that time to plan ahead, can some company donate suitcases?” – P2

- This includes self-care for staff:

  “We didn’t think in the moment maybe, but what with (international NGO) what was really sweet, when they came in, they had like boxes of water bottles. And a baskets of granola bars, and it was really sweet cuz they’re like hey we noticed that you guys are working here for 8–10hrs […] So we were just like - oh wow, this is awesome. And I’m like, it’s such simple stuff, but I’m like oh I guess - it feels good. Like for, as a staff to feel like there’s bottles of water for you and granola bars, just so you know, let's keep going. Like that kind of morale boosting…” - P2, Frontline Healthcare Provider

- Share and leverage on the knowledge about agencies and their capacities by region.

- Ensure affordable housing is arranged prior to arrival.

4. COLLABORATION

- Engage previous newcomers (including Syrian Canadian community, volunteer groups) in planning and delivery of services and supports.

- Sector leaders, particularly from regional bodies, need to play an active role in promoting multi-sector collaboration that is inclusive and that mobilizes the expertise and strengths that different sector/organization brings.

- Leverage connections through collaborations with media.

  “I think, the collaboration with the mainstream media is really important. We did a lot of work here with our local TV providers, our newspapers. There was regular coverage of things that were going on. Good profiles of you know, of the progress of some of the families that we were able to leverage. Because of our structure and the involvement of the groups, you know, their connections that they had to all of the media, you know. Kind of
5. COORDINATE AND CLARIFY ROLES

- Establish a coordinating body (at city or regional level) that provides clear directions to agencies and assigns roles and responsibilities in the most optimal manner.

- Promote a shared model of roles and responsibilities to prevent one agency trying to do it all.

- Consult with staff on the ground to help shape their roles in clear and consistent, including enabling them to respond in dynamic ways to challenges.

   “They’re people who truly want to be there. They don’t mind that sometimes you stay a little bit after 5. And there are people who say no this is a job, and I’m getting out on time. And I’m not judging, there’s two attitudes of approaching work. But in that particular place where we’re understaffed, get people who are all on board and like-minded because that to me was the biggest reason that I loved the work” - P2, Frontline Healthcare Provider

6. BUILDING EVIDENCE

- Build evidence to better understand community & other contextual information about refugees ahead of time.

   "Literacy levels, number of children, exposure to the outside world. We have seen clients who have never seen the capital of their country. But the expectations were based on the previous waves of newcomers of Syria who were skilled workers, who are more savvy, so everything has been set up with that mindset. But because a lot of the organizations, this is not their core demographic, they weren’t able to adjust in time. So that’s why." - P8, Senior-level, Settlement

7. STRONGER GOVERNMENT ROLE

- Government bodies need to take a more proactive role in facilitating effective collaboration and ensuring adequate resources.

   "I think that people responded well overall. I think there was an amazing community spirit that we saw. I think that that goes so far, but as an example, that this government or any government said, you know, in two weeks from now, oh by the way, we’re going to take another 20 000, um and we’re going to have them here by, you know, by May, and you know, thanks very much for what you did the first time, do it again because you did such a great job. I don’t know that if the capacity of the community spirit would be as uh, as forthcoming as it was the first time, so you can’t rely on, I don’t think it’s appropriate to rely simply on generosity and good nature spirit of communities to support folks." - P12, Senior-level Official, Healthcare Agency


NVivo qualitative data analysis software. (2008). QSR International Pty Ltd. (Version 8) [Software].


SOURCES CITED


