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# Literature Review: Health Issues of Government Assisted Refugees (GARS) In Canada

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## EXECUTIVE SUMMARY

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Government Assisted Refugees (GARs) are refugees who are usually sponsored by the government of Canada and supported by our Refugee and Humanitarian Resettlement Program. This literature review, commissioned by Access Alliance Multicultural Health and Community Services, aimed to identify and document best practices in the delivery of inter-professional care to GARs, to contribute to the literature on initial medical assessments processes for refugees and immigrants and inform the development of national and provincial strategies and standards and guidelines for the delivery of health services to GARs.

The literature review conducted for this report consisted of a search for Canadian and international articles and websites related to the health of GARs, supplemented by information on refugee health extracted from government reports.

Findings suggested that the phenomenon known as the “Healthy Immigrant Effect” (or the observation that newcomers are generally healthier than the host country population), does not apply to refugee populations. This finding was attributed to factors such as a longstanding lack of access to curative and preventive health care, the direct and indirect effects of war, and the psychosocial effects of war trauma and refugee camp internment prior to arrival in Canada.

Among the major health problems identified in the literature were infectious diseases, mental health problems, chronic disease, and reproductive health issues.

Since GARs typically arrive in Canada directly from refugee camps in low- income countries and/or war-torn areas that do not have sanitary conditions or access to quality health care, they are at an increased risk of infectious and other preventable diseases. The major categories of infectious diseases described were vaccine preventable diseases, hepatitis B, HIV and TB.

Refugees of all ages who experience traumatic events such as forced migration, abduction, famine, torture, and war experienced an increased risk of mental health problems such as depression, anxiety disorders and post-traumatic stress disorder. The specific health issues for refugee adults, children and youth and women were described.

There was not a lot of information about chronic diseases among refugee populations in Canada. Respiratory diseases such as COPD, common in many refugee camps, are a major health issue for many refugees upon arrival in Canada. Both environmental and genetic factors contribute to the development of cancer, Type II diabetes and heart disease post-migration.

Sexual and reproductive health care and education emerged as critical issues for many refugees. Some studies suggested that refugee women were at an increased risk of poor pregnancy outcomes

A determinants of health approach may be useful for addressing the health needs of refugees. This approach, adopted by Health Canada in 1994, identifies factors that influence

This literature review was commissioned by Access Alliance Multicultural Health and Community Services as part of the ‘Best Practices for Inter-professional Models of Care for GARs’ research project. Funding for the research project was provided by HealthForceOntario’s Inter-professional Care/Education Fund.

The objectives for this study were to identify and document best practices in the delivery of inter-professional care to GARs; to contribute to the literature on initial medical assessments processes for refugees and immigrants; and to inform the development of national and provincial strategies and standards and guidelines for the delivery of health services to GARs.

This literature review report is written by Ms. Zarsanga Popol, Dr. Najmus Sadiq and Dr. Ilene Hyman and reviewed and published by Access Alliance in May 2010.



population health, including: income and social status, social support networks, education, employment and working conditions, physical environment, social environment, personal health practices, healthy child development, health services, gender and culture. The determinants of refugee health must consider the complex issues of interdependence, the dynamic interplay between different levels of determinants, intersectionality, the lifecourse perspective and the migration context. Immigrants and refugees in Canada are more likely to experience social and economic stressors that increase health risk, limit opportunity and contribute to deleterious health outcomes.

A dearth of specific research in Canada about GARS impedes our understanding about the pre and post-migration health needs of this group. More research is needed on pre-migration health as refugee camp experience and/or exposure to trauma is significantly associated with long term health consequences. There is also a need for research on resilience.

Some of the research gaps, noted for all Canadian immigrants, include:

- Systemic barriers to accessing healthcare services, including access to interpretation services
- Policies and practices of risk identification, health promotion and disease prevention for immigrant populations
- The effectiveness of community – provider partnerships for the delivery of health services
- Cost-effectiveness of strategies for screening and treating disease among the refugees.
- Models of care and best practices for government-assisted refugees

The findings presented in this report have implications for the delivery of health and social services and for health policy. Health providers need to be familiar with the major health and resettlement problems experienced by GARS in Canada and to be able to provide health care in culturally sensitive and accessible ways. With proper screening and treatment, many of the infectious diseases observed among GARS can be prevented and treated. However, since the risk of developing other health problems, particularly those related to mental health and chronic disease, emerge over time, access to regular and timely health care is critical. Policies and programs are called for to correct the macro and community processes that contribute to unequal access to social and economic resources and to promote health equity for all.

## 1 – INTRODUCTION

This paper describes findings from a literature review on the health problems experienced by Government Assisted Refugees (GAR) in Canada. The report begins with background information on global refugee trends; identifies those who are classified as GARS in Canada and outlines the major sources of support available to this group.

Next, we describe some of the major health issues experienced by GARS as identified in the Canadian literature: physical health status, nutritional deficiencies, infectious disease, mental health status, chronic disease, and reproductive health. The report ends with a discussion of the multiple and intersecting determinants that influence refugee health and a brief review of the implications of these findings for practice and policy.

## 2 – BACKGROUND

Statistics from the United Nations High Commissioner for Refugees (UNHCR) showed that from 1980 to 2005 the number of refugees around the world had been declining, reaching 8.4 million. In 2006, the number of international refugees reached 10 million, the highest level of the previous five years (Citizenship and Immigration Canada, 2007). Two other concerning trends were also noted in 2007:

- the amount of time a refugee spends in exile has increased to an average of 17 years (a dramatic increase since the 1990s)
- the increasing number of internally displaced persons, i.e., those who have fled their homes but remain in their own countries (Citizenship and Immigration, 2007).

Afghans (around 3 million, mainly in Pakistan and Iran) and Iraqis (around 2 million, mainly in Syria and Jordan) accounted for nearly half of all refugees under UNHCR care worldwide in 2007, followed by Colombians in a refugee-like situation (552,000), Sudanese (523,000) and Somalis (457,000). Much of the increase in refugees in 2007 was a result of the volatile situation in Iraq. The top refugee-hosting countries in 2007 included Pakistan, Syria, Iran, Germany and Jordan (UNHCR, 2008).

Canada has an international reputation for being a safe and welcoming place for people who are escaping war, persecution and other devastating disasters in countries around the world. Every year, refugees from approximately 70 different nationalities are given a new start in Canada.

Although it is often assumed that Canada takes in too many refugees, or larger than its fair share, in reality, Canada takes in a relatively small number of refugees, due in part to its geographical location. Since World War II, Canada has granted



protection to approximately 700,000 refugees, less than a tenth of Canada's population per year (Amnesty International, 2008).

The critical difference between Canadian immigrants and refugees is that immigrants generally choose to come to Canada and may return home at any time, while refugees are the victims of "forced migration" and fear persecution if they return to their country of origin. Although both refugees and immigrants face common challenges, refugees may encounter additional barriers that make them more vulnerable and marginalized.

In 1976, the Canadian Immigration Act formally distinguished for the first time between refugees and immigrants and laid out a claim determination system for refugees. 1978 was the first year that the Canadian Immigration Act included a humanitarian category for refugees that need settlement and protection. The Private Sponsorship of Refugees Program (PSRP) was also established that year, allowing Canadians to be involved in the sponsorship of refugees. PSRPs continued to be popular during the late 1970's and early 1980's.

Canada categorizes refugees into two groups, based on where the refugee applies for status and who provides the sponsorship:

- 1) Convention refugees include:
  - a. Government Assisted Refugees (GARs), sponsored by the government of Canada or a private group before their arrival in Canada, and
  - b. Privately Sponsored Refugees (PSRs).
- 2) Refugee claimants, Non-status refugees, or Asylum seekers include refugees who apply for asylum after they arrive in Canada.

Among the refugee groups sponsored by the Government of Canada in the past were Vietnamese "boat people," Kurds from Iraq, Somalis, Bosnians, Albanians from Kosovo, Shia from Iraq and Afghans. In 2006, Canada became the first country to resettle Burmese Rohingya refugees living under difficult conditions in refugee camps in Bangladesh. From 2007 to 2009, Canada selected Burmese Karen refugees for resettlement as part of a multilateral effort to reduce the population of Karen refugees in Thailand. In 2008 Canada resettled between 1,800 and 2,000 Iraqi refugees, an increase from approximately 900 in 2007. Including Iraqi refugees, Canada substantially increased its Middle East resettlement target to 3,300 people in 2008. In May 2007, Canada agreed to resettle up to 5,000 of an estimated 107,000 Bhutanese refugees resided in refugee camps in southeastern Nepal (Citizenship and Immigration Canada, 2008).

Unlike refugee claimants who are supported through the In-Canada Asylum Program, GAR's are granted permanent residency status when they arrive in Canada and are supported by the Refugee and Humanitarian Resettlement Program.

### 3 – IMMIGRANT MEDICAL EXAM

All migrants to Canada must undergo an Immigrant Medical Examination (IME) to identify diseases that could put the Canadian population at risk or place an excess burden on the health care system. With the 2002 Immigration and Refugee Protection Act (IRPA), Canada waived its "burden-of-disease" barrier for refugees. Immigrants and GARs undergo this process in other countries prior to coming to Canada, while PSRs and other refugee claimants undergo their IMEs in Canada.

An IME consists of:

- Medical history and physical exam;
- Urinalysis if  $\geq 5$  years old;
- Chest X-ray if  $\geq 11$  years old (or at any age if HIV-positive);
- HIV (Elisa) and syphilis (Venereal Disease Research Laboratory - VDRL) test if  $\geq 15$  years old; and
- For HIV-positive applicants only: collection of three sputum samples for TB smears and cultures.

If a refugee has not been resettled within 9 months of the initial IME, a public health and public safety medical examination is conducted, including:

- Shorter medical history and physical exam focusing on TB and public safety; and
- Chest x-ray if  $\geq 11$  years old.

Since GARs typically arrive in Canada directly from refugee camps in low-income countries, they are at an increased risk of infectious and other preventable diseases (Pottie, 2007). GARs found to have active tuberculosis (TB) or syphilis are treated before they are allowed to enter Canada. GARs with HIV or suspected latent TB are given written notification and their reports are sent to local Canadian public health departments for further follow-up post arrival in Canada. Other than this, the IME does not focus on treatment or clinical preventive services.

### 4 – RESETTLEMENT ASSISTANCE PROGRAM - DESCRIPTION

The Resettlement Assistance Program (RAP) provides income support and other immediate and essential services to government-assisted refugees (GARs). RAP, which supports Citizenship and Immigration Canada's (CIC) strategic outcome of protecting refugees and others in need of resettlement, came into effect in April 1998 and was gradually implemented in 1998/99.

RAP represents a revised approach to the settlement and integration of refugees. It reflects a shift in CIC's role from program administrator and direct service provider to an



administrator of income support, program/contract management and a provider of immediate essential services for certain refugees and members of groups resettled from abroad who require humanitarian assistance. Essential services are delivered on behalf of CIC by service provider organizations (SPOs) in all provinces of Canada except Quebec, which delivers similar settlement services through the Canada-Quebec Accord. The SPOs provide a range of services within the first four to six weeks of a GAR's arrival in Canada. At a broad level, the services provided include:

Upon arrival to Canada:

- Meeting GARs at port of entry;
- Providing transportation to temporary accommodations;
- Arranging and ensuring temporary accommodation is provided immediately upon arrival;
- Explaining key features of accommodation (e.g., telephone access, meals, fire exits); and
- Ensuring immediate needs are met.

After settling in temporary accommodations:

- Providing information on, and links to, mandatory federal and provincial programs (e.g., Social Insurance Number, Child Tax Benefit, provincial health-care programs and the Interim Federal Health Program, if necessary);
- Providing assistance in locating permanent accommodation;
- Providing assistance in opening a bank account;
- Providing orientation sessions on financial and non-financial information; and
- Conducting client assessments and providing referrals to other settlement programs, including CIC's Immigrant Settlement and Adaptation Program (ISAP) and Language Instruction for Newcomers to Canada (LINC) (CIC, 2004).

## 5 – HEALTH INSURANCE FOR REFUGEES (INCLUDING GARS)

CIC administers the Interim Federal Health Program (IFHP), which offers up to 12 months of health insurance to refugees, protected persons, refugee claimants and their dependants in Canada who are not yet covered by a provincial or territorial health insurance plan. Coverage through the IFHP includes:

- Essential health services for preventing and treating serious medical and dental conditions (including immunizations and other vital preventive medical care);
- Essential prescription medications;
- Contraceptive, prenatal and obstetrical care;
- The immigration medical examination (only for those who are unable to pay for it themselves); and

- Eyeglasses, prosthetics and wheel chairs (with prior approval).

Once provincial coverage starts, refugees are eligible for supplemental coverage under the IFHP, which covers emergency dental, vision and pharmaceutical care. Provincial health coverage is supposed to start after three months, but it has been recently noted that provincial coverage begins at the same time as IFHP. The original policy of a three-month wait is no longer enforced.

## 6 – MAJOR HEALTH ISSUES FOR REFUGEES

The purpose of the literature review was to identify the major health issues identified among GARs in Canada.

The initial literature review (conducted by ZP and NSS) consisted of a search for Canadian and international articles and websites related to the health of GARs. This was supplemented by information on refugee health extracted from government reports (Hyman, 2001; Hyman, 2007; Hyman & Jackson, 2010).

One of the major challenges encountered in conducting this review was the dearth of information available on GAR health in Canada. For example, existing health surveys in Canada do not capture information on refugees and immigrants as a whole are typically underrepresented. Specialized surveys of immigrant resettlement such as the LSIC provide information on refugees but do not differentiate between refugee categories and do not include detailed information on health status. Therefore the findings presented in this report are largely based on a review of 112 GAR patients, the vast majority from Sub-Saharan Africa (Pottie et al., 2007), case studies of several GAR groups (Sudanese, Karen, Kosovars, Bosnian, Bhutanese) and Canadian research studies on the health and mental health of specific refugee populations (e.g. Southeast Asian refugees, Tamil refugees, Ethiopian refugees). This information is supplemented by research on immigrant health in Canada that identifies issues (e.g. acculturation, resettlement stress, poverty, access barriers) that impact on the health of all newcomer groups.

### 6.1 Physical Health Status

Voluntary immigrants are typically healthier than involuntary immigrants (refugees). The phenomenon known as the "Healthy Immigrant Effect", or the observation that newcomers are generally healthier than the host country population, does not apply to refugee populations (Miedema & Hamilton, 2008). Using data from a sample of Canadian immigrants and refugees landing between 1980-1990 (linked to the Canadian Mortality Database), Des Meules et. al., (2005) found that while recent immigrants experienced a lower rate of all cause mortality compared to the Canadian-born population, refugees clearly



experienced an increased risk.

To explain this health disadvantage one must consider that unlike other immigrants, refugees, especially GARS, may have experienced a longstanding lack of access to curative and preventive health care, the direct and indirect effects of war, and the psychosocial effects of war trauma and refugee camp internment prior to their arrival in Canada (Canadian Task Force, 1986; Beiser, 2006; Rousseau & Drapeau, 2004). This is particularly true amongst refugees from low-income countries that may not have had access to good quality health care because of shortages of qualified staff, medications, technology, and equipment (Pottie et al., 2006). When the migration process is difficult, the voyage itself may increase vulnerability to accidents, hunger, dehydration and/or exposure to infectious diseases (Oxman-Martinez and Hanley, 2005). These experiences may also aggravate latent health problems (Oxman-Martinez and Hanley, 2005).

Some of the most common physical ailments observed among newly arrived refugees to Canada are anemia, dental caries, intestinal parasites, respiratory infections, impaired visual capacity, hearing problems, gynecological problems, nutritional deficiencies and immunization irregularities (Pottie et al., 2007; Fowler, 1998; Dillman et al., 1993). As a result, refugees need special care and protection in a new country, particularly in their early stages of resettlement (Dillman et al., 1993;). Some of these problems are discussed in greater detail in the following sections.

## 6.2 Nutritional Deficiencies

Undiagnosed micronutrient deficiencies are prevalent in low-income countries. Among these is anemia, a multi-factorial disease. Iron deficiency is one of the most frequent causes of anemia in the world; however, genetic traits such as thalassemia and hemoglobinopathy (e.g. sickle cell disease, glucose-6-phosphate dehydrogenase deficiency, hemoglobin E disorder) also contribute to anemia among immigrants and refugees from Southeast Asia, Africa and the Mediterranean. The prevalence of anemia was reported to be very high among refugee women in Canada (Pottie et al., 2006). However, women are often not diagnosed because they are asymptomatic. Vitamin D deficiency is also common among refugees but this can be symptomatic as well as asymptomatic.

It should be recognized that food insecurity post-migration may also contribute to the development of health problems. Approximately 75% of Sudanese refugees to Canada experienced food insecurity.

## 6.3 Infectious Disease

High rates of infectious disease are well-documented among refugees who have spent time in refugee camps and/or war-torn areas that do not have sanitary conditions and/or access to quality health care. The major categories of infectious diseases that were identified among refugee and GAR populations were vaccine preventable diseases, hepatitis B, HIV and TB. Each is discussed here.

Since childhood vaccinations were not introduced in many low income countries until the late 1970's, many adult foreign-born immigrants and refugees are not immune to measles, mumps and rubella. One study found that among recent adult immigrants and refugees, 36% of the participants were susceptible to at least one of these three conditions. The prevalence rates of these conditions ranged from 22% to 54% depending upon the age, sex and region of origin of the immigrant or refugee (Greenaway et al., 2007). Pottie et al., (2007) found that the majority of GARS in his sample required immunization.

Another concern is varicella zoster virus (VZV), which causes chicken pox. Many immigrants and refugees have not received the varicella vaccine and are susceptible to varicella (Christiansen & Barnett, 2004). Since varicella infections occur later for people living in the tropics than among individuals living in temperate climates, adolescents and young adults represent a vulnerable group. Moreover, assertions of having had a history of varicella among these populations are not always a reliable predictor of varicella antibody status (Christiansen & Barnett, 2004). To optimize varicella immunity in refugee populations, it has therefore been suggested that it is important to screen for varicella upon arrival and immunize those refugees who are susceptible to this illness.

Several studies reported on the prevalence of infectious diseases such as intestinal parasites, Hepatitis B and C, onchocerciasis and lymphatic filariasis.

Pottie et al., (2007) found that 13.6% of his sample had positive stool tests for pathogenic intestinal parasites. About 1 in 17 refugees had HIV infection or tested positive for hepatitis B antigen. A study of 68 Karen refugees in Toronto also found a high incidence of intestinal parasites; 40% of participants were susceptible to hepatitis B (Denburg et al., 2008).

Malaria is considered to be one of the most widespread causes of mortality and morbidity among displaced and refugee populations. It is also emerging as a significant and increasing health issue in Canada, the United States and other developed countries (Ndao et al., 2004). In fact, more than 400 cases of malaria were reported in Ontario alone in 1996; in 1997 there were 1,029 reported cases across Canada. There are currently no protocols for screening travelers, immigrants or refugees from



regions where malaria is endemic. Most countries depend almost solely on questionnaire-based exclusion criteria to prevent transfusion-associated malaria. A study of the diagnosis and management of imported malaria within the Quebec health care system (Ndao et al., 2005) found errors of both omission and commission in the response to refugees who present with possible cases of malaria.

## 6.4 TB

TB was identified as a major health issue for immigrants and refugees to Canada. The proportion of TB cases among migrants (including immigrants, refugees and temporary residents) in Canada has risen dramatically from 18% of all cases in 1970 to 67% in 2004 (PHAC, 2007). It still holds today that those born or travelling in a country where TB is widespread are considered a high risk group for the developing the disease (PHAC, 2009). It has been found that the prevalence of Latent Tuberculosis Bacillus Infection (LTBI) and the incidence of active TB is directly proportional to age at immigration and incidence in the country of origin. Although the IME screens for active TB among regular immigrants to Canada and GARs, a tuberculin skin test (TST), which screens for LTBI, is not part of the routine, nor is treatment of LTBI a requirement for entry or resettlement in Canada. Recent immigrants from endemic countries are most likely to have had TB and almost 5-10% of people with LTBI will develop the clinical disease after two years of first becoming infected with TB. However, an additional 5% will develop the disease at a future time. It is estimated that 60-90% of cases of TB in Canada occur in people who have had LTBI and the rest of the cases represent acute cases following primary infection. Approximately 50% of refugees in Pottie et al., (2007)'s GAR sample had latent TB.

Most Canadian experts assert that the majority of cases of TB result from previous infections becoming reactivated post-migration, and a smaller proportion from primary infection just prior to or post-migration. The risk of reactivation is highest within the first 5 years of arrival.

## 6.5 HIV

In 2005, there were an estimated 2,300 to 4,500 new HIV infections in Canada, of which 400 to 700 (16%) were attributed to the HIV-endemic exposure subcategory. The infection rate among individuals from HIV-endemic countries (e.g., African and Caribbean) is estimated to be at least 12.6 times higher than among other Canadians (Boulus et al., 2006). Women are increasingly affected by HIV in Canada. In 2005, females from countries where HIV is endemic accounted for a substantial proportion of newly diagnosed HIV infections among women (Santé publique Québec, 2006). It is not possible to differentiate between HIV infections acquired abroad from those acquired in Canada for individuals tested in Canada. A modelling

exercise completed by Remis and Merid (2002) suggested that 20% to 60% of new infections in the HIV-endemic group in Ontario occurred after arrival in Canada.

Approximately 6.3% of a sample of GARs were positive for HIV (Pottie et al., 2007). Multiple health care organizations within the Winnipeg area reported seeing an increase in the number of immigrants and refugees seeking support for HIV/AIDS. This study suggested that post-migration infections may be due to misconceptions among immigrants and refugees that there is no HIV in Canada (Magoon, 2005). More data on HIV transmission needs to be collected to truly understand these trends.

Since most infectious diseases common to refugees are treatable and/or preventable, most will experience improvements in health status over time given appropriate treatment and follow-up (Pottie, Ortiz & Kur Tuile, 2008; Hyman, 2001).

## 6.6 Mental Health

Refugees of all ages who experience traumatic events such as forced migration, abduction, famine, torture, and war experience an increased risk of mental health problems such as depression, anxiety disorders and post-traumatic stress disorder. Forced migration may also lead to less noticeable disorders, such as social withdrawal, sleep and appetite disturbances and difficulty functioning in daily activities (Donlan-Farry, 1997). These refugees may be vulnerable to stress-related psychological and physical health disorders, combined with disturbances of hypothalamic-pituitary-adrenal functioning reflected by cortisol levels. It has been suggested that traumatic events directly influence stress-related outcomes and indirectly influence health by undermining the ability of refugees to cope with acculturation challenges (Matheson et al., 2007).

One of the most recent Canadian studies of immigrant and refugee mental health used longitudinal data from the LSIC. Results confirmed that refugees are at greater mental health risk compared to other groups of immigrants (Robert & Gilkinson, in press). Other mental health studies on Canadian refugees have largely been community specific. This section reviews research on the mental health of refugee adults, children and youth and women.

### 6.6.1 Adults

The Refugee Resettlement Project (RRP) was a ten-year longitudinal study of the resettlement and mental health of Southeast Asian refugees in Canada. Findings suggested that certain phases of resettlement are characterized by greater mental health risk. After a decade, depression rates were far lower in the study population than in the general population (Beiser et al., 1994; Beiser & Hyman, 1997; Beiser 1999). Furthermore the effect of pre-migration stress, such as the severity of conditions in the refugee camp, on mental health was salient only in the short term (6 months post-migration). Post-



migration stresses and the availability of personal and social supports were stronger predictors of mental health in the long-term (10 years post-migration) (Beiser et al., 1994; Beiser & Hyman, 1997; Beiser, 1999).

The Pathways and Barriers to Health Care for Ethiopians in Toronto project was initiated in 1997 to examine mental health and health care utilization among a random sample of 342 Ethiopian immigrants and refugees. Study variables included mental health, pre and post-migration stressors and personal and social resources. Findings reported by Fenta et al. (2004) indicated that the lifetime prevalence of depression was 9.8%, only slightly higher than that of the Ontario population as a whole. However, this prevalence rate was approximately three times higher than that of Southern Ethiopia. The risk of developing depression was low during the first few years of resettlement, but increased after a few years and reached its maximum at approximately 15 years post-migration. Contrary to other studies, rates of depression were higher among males than females. Multivariate analyses were used to identify factors associated with lifetime and post-migration incidence of depression. Factors associated with a lifetime prevalence of depression included post-migration stressful life events, refugee camp internment, no clear motive for migration and low Ethiopian identity score. In addition to these variables, younger age, pre-migration trauma, and lower levels of education were associated with an increased risk of depression post-migration. Findings raise questions about the resiliency of immigrants who do not have a clear motive for migration, the mental health advantage of women, the negative impact of post-migration stresses, the positive role of ethnic identity, and the long-term effects of pre-migration trauma.

The Tamil community in Toronto initiated a similar project in 1999. A community sample of 1,110 Tamil adults was interviewed about their health, mental health, pre-migration trauma and post-migration resettlement experiences. One third of respondents had experienced traumatic events and rates were higher for women than for men and among those, 36.2% qualified for a diagnosis of PTSD (Beiser et al. 2003).

Most of the studies reviewed suggested that pre-migration stresses exerted a negative effect on health; however, the duration of this effect was not clear. It also seemed clear that socio-demographic and historical differences between refugee populations led to differential impacts on health. For example, Redwood-Campbell et al. (2003) compared the mental health and adaptation of two different refugee groups, Kosovars and Czech Roma, in Hamilton, Ontario. These groups were chosen as they represented two different types of refugee resettlement processes, the former involving a coordinated effort and the latter, self-selection. Fifty families were interviewed in each group. Findings indicated that 21.7% of Kosovars experienced PTSD, as opposed to none of the Roma. Kosovars were more

likely than Czech Roma to report fair or poor adaptation to Canada, even after controlling for age and PTSD. The authors speculated that this was because Kosovars were different from the usual healthy immigrants to Canada – they were older, less educated, from rural areas, and they experienced more pre-migration hardship.

Finally, it is frequently assumed that refugees experience more political violence than other classes of immigrants. Rousseau & Drapeau (2004) explored the question of whether pre-migration exposure to political violence varied by immigration status at landing, using data from a population-based survey of immigrants to Quebec (1998-9). Exposure and emotional distress were measured among immigrants originating from China/Hong Kong, Haiti, North Africa and Latin America. Findings indicated that a high proportion of independent immigrants had been exposed to political violence. Mean levels of emotional distress didn't vary across immigrant groups, and distress was associated with pre-migration exposure in most groups. These findings suggest that clinicians and service providers should not assume that independent immigrants have not been exposed to pre-migration violence.

### 6.6.2 Children & Youth

Refugee children and adolescents face mental health challenges as they try to integrate past trauma and define new identities within and between two cultures. Some studies suggest that refugee youth are more likely to suffer from depression than those aged thirty-five or older (Canadian Mental Health Association, 2003). However, several studies published by Rousseau and her colleagues suggest this is not always the case. Rousseau et al., (2000) compared emotional and behavioural problems of Cambodian, Central American and Quebecois youth (Grades 9 and 10) living in the Montreal area. They found that the level of emotional and behavioural problems were lowest in Central American and highest in Quebecois. Low SES in refugee families was not a major risk factor for mental health problems, although there was an association between low income and introversion in Central American youth.

In another study, Rousseau & Drapeau (2003) followed 57 young Cambodians and 45 native Quebecers over a four year period (1994-1998), from early to late adolescence, to examine associations between mental health symptoms and social adjustment. The profile of emotional and behavioural symptoms reported was similar in the two groups, but the Quebecois youth reported more risk behaviours. Associations between pre-migration violence and post-migration psychosocial adjustment were also examined in the Cambodian youth (Rousseau et al., 2003). The authors noted that association fluctuated over the four year period, and adolescents of families who were more exposed to violence reported more positive adjustment and self-esteem. This was attributed to higher parental expectations and more emphasis on the preservation of culture in homes where



parents had experienced a lot of pre-migration trauma. This research suggests that refugee adolescents should not be globally considered a group at risk and highlights the need to further examine the resiliency of this group.

Rummens & Seat (2003) assessed the psychological impact of the 1999 Kosovo conflict on the mental health and well-being of Serbian children and youth in Toronto. Detailed survey questionnaires were administered to 80 children and their most knowledgeable parent. Findings indicated that 26.3% of the children/youth interviewed met diagnostic criteria for PTSD as a direct result of the Kosovo conflict, even though they were in Canada. However, there were no differences in the prevalence of PTSD between children who had previous war trauma experience and those who had not.

It has been suggested that refugee children, especially those who have suffered from previous trauma, lived in refugee camps, or that have been separated from their family for over a year, may be at higher risk of developing mental health problems than other immigrant or Canadian-born children (Hyman, 2001). However, several studies found that despite living in poverty, refugee children and youth experience better mental health than their Canadian-born counterparts (Beiser et al., 2002; Rousseau et al., 2000; Rousseau & Drapeau, 2003). Still, special attention is needed for children who have experienced trauma in the migration process and who present symptoms related to Post Traumatic Stress states if special attention is not given, the children will almost certainly have trouble developing the hybrid identity and the confidence that is essential to succeeding in Canadian schools (Bernhard et al., 2009).

## 6.7 Chronic Diseases

There was not a lot of information about chronic diseases among refugee populations in Canada. In their linked record study, Des Meules et al., (2005) reported that refugees had a higher incidence of and mortality rates for cardiovascular, infectious and respiratory diseases and cancer than other immigrants. The ICD-9 categories examined for cancer were: all site cancer, nasopharyngeal cancer and liver cancer. Although SMR's for the all site cancer were lower for refugees and immigrants as compared with the general population, the SMR's for liver cancer were higher among refugee males compared to the general population. According to the authors, risk factors for nasopharyngeal cancer include the consumption of salt-preserved foods, exposure to Epstein-Barr virus and genetic susceptibility. Higher rates of liver cancer are consistent with higher rates of hepatitis among Asian populations, moulds on foods and parasitic infections. Pottie et al., (2008) reported that the incidence of cervical cancer was higher among female refugees compared to Canadian-born counterparts. In their sample of GARs, most females had never had a PAP test for cervical cancer. Among 82 Kosovar refugee women, only 5.3% of women over 50 had ever had a mammogram and 34.1% had

had a PAP test. Other studies have found low rates of cervical cancer screening among immigrant and refugee women from certain regions (notably Southeast Asia) compared to Canadian-born women (Hyman, 2002).

Both environmental and genetic factors contribute to the development of Type II diabetes and heart disease. Many studies have described the increasing prevalence of diabetes among Canadian immigrants and refugees (PHAC, 2005). Recent immigrants and refugees from South Asia, Latin America, the Caribbean and sub-Saharan Africa have a two to three times greater risk of developing diabetes than immigrants and refugees from Western Europe or North America (Creatore et al., 2010). Furthermore, this elevated risk begins earlier in life (e.g., 35-49) compared to diabetes in Western European and North American immigrant populations and is equivalent or higher in women compared to men (Creatore et al., 2010). Ethnic groups in Canada show striking differences in their cardiovascular risk profiles (Chiu et al., 2010) with South Asians, particularly women, experiencing increased rates of hypertension (Kaplan et al., 2002; Anand et al., 2006).

Respiratory diseases such as COPD are common in many refugee camps. These are considered to major health issue for many refugees upon arrival in Canada.

## 6.8 Reproductive health

Sexual and reproductive health care and education are critical issues for many refugees (Promising Practices, Programs and Approaches for Improving Refugee Health and Wellbeing, Calgary Health Region, 2008). Women from countries where there is conflict and/or that have limited host-country knowledge are amongst the most vulnerable (Gagnon et al., 2007). Women who are in the pre and post-natal stages may require basic information on prenatal visits and infant care. These women and their infants' risk levels also increase during pregnancy, birth and post-birth. Refugees also need information on contracting sexually transmitted infections and treating them.

Health concerns for refugees upon arrival may include pregnancy with potential complications of nutritional deficiencies or pregnancy that was a result of rape (Magoon, 2005). Some evidence suggests that refugee women may be at an increased risk of poor pregnancy outcomes. An evaluation of the health status of 59 pregnant refugee women seeking asylum in Canada reported urinary tract infections, monilial infections, scabies, head lice, otitis media, intestinal parasites, other vaccine-preventable infections, low pregnancy weight gain, anaemia, and female genital mutilation preventing pelvic examination in this group (Kahler et al., 1996). However, the extent to which these conditions occurred among refugee women in Canada or persisted following migration was not determined. Data from Ford-Jones et al. (2000) suggested that rates of hepatitis B and rubella were more common among pregnant refugee women compared to their Canadian-born counterparts, and that these





conditions often went undetected for up to 10 years after migration.

Refugee youth may need basic information about anatomy, birth control, communicable diseases and sexuality.

## 7 – SOCIAL DETERMINANTS OF HEALTH (SDOH)

The term “determinants of health” was adopted by Health Canada in 1994 to describe factors that influence population health, including: income and social status, social support networks, education, employment and working conditions, physical environment, social environment, personal health practices, healthy child development, health services, gender and culture (Health Canada, 1994). The term, ‘social determinants of health,’ has more recently emerged to reflect the fact that health is largely influenced by social and economic factors and thus requires health promotion and policy that move beyond biomedical and behavioural risk factor approaches (Raphael, 2004; Wilkinson & Marmot, 2003).

The determinants of refugee health must consider the complex issues of interdependence, the dynamic interplay between different levels of determinants, intersectionality, the lifecourse perspective and the migration context. For example, income influences levels of stress, housing, exposure to poor environmental conditions at home and work, the availability of food and quality of diet, physical activity participation, and the degree of social exclusion (Raphael, 2007; CIHI, 2006).

Any examination of the determinants of refugee health also needs to recognize the multiple layers of factors that contribute to oppression and health inequities. Intersectionality is a theory which seeks to examine the ways in which various socially and culturally constructed categories (e.g., race/ethnicity, gender, immigrant status, age, sexual orientation, religion) do not act independently but rather interact on multiple levels creating a system of oppression that contributes to inequality in society.

For refugee health in particular, a life course approach highlights the critical importance of considering the lifespan from pre-migration through to resettlement. The life course perspective recognizes that exposures from gestation through childhood, youth, and mid-life affect health in adult and later life as well as health across generations (Kuh & Ben-Shlomo 2004). For example, some conditions (e.g., stroke and stomach cancer) depend considerably on childhood circumstances while others (e.g., lung cancer), depend more on adult circumstances, while still others depend on cumulative exposures over the lifespan (World Health Organization, 2007).

A recent literature review of critical health issues faced by immigrants and refugees found strong evidence for macro- and

community-level determinants of health (Hyman, 2009). Immigrants and refugees were more likely to experience certain social stressors and some sub-groups of immigrants were at a greater social disadvantage, increasing health risks and contributing to deleterious health outcomes. Of particular concern were studies suggesting that structural determinants and access barriers contributed to increased health risks for immigrants and refugees over time. Other determinants such as community, family and individual assets and resilience, supported by effective social policies and programs, can mitigate risks and maintain good health.

## 8. – RESEARCH GAPS

There are many gaps in research in disease pattern of refugees and therefore a lack of understanding of the disease pattern of refugees. There are not enough studies that examine refugee health in Canada, most of the research is focused on immigrant health however there are significant differences between these two populations. Equally relevant, is the lack of “best practices” when working and treating refugees.

There are no specific Canadian research studies that examine rates of measles, mumps and rubella amongst refugee populations, more research is needed particularly in adult groups. There is no research in Canada that studies dental needs of refugee populations. Also researches on the immunization status and needs of the refugees have to be understood so as to provide appropriate services.

More research is needed to understand disease patterns of TB refugee populations. As well as studies of refugees who have been identified as having latent TB during the Immigrant Medical Examination research what types of healthcare services they are accessing, any barriers to service and health outcomes of the population. More research is also needed to explore cases of TB that were detected and treated pre-migration and to better understand what happened post-arrival i.e. recurrence of TB, affects on health and possible transmission of TB.

Additional research is also needed that studies HIV and AIDS amongst refugee populations. Access to healthcare services, medications and support are important areas to understand. Research that looks at difference in access to service for between HIV cases diagnosed pre-arrival and which transforms to AIDS post-arrival, so that delays in diagnosis and appropriate treatment are understood as are the implications of that on refugee population.

More research that addresses the needs of refugee mothers and infants post-birth are needed as well as looking into pre-natal needs of refugee mothers. No research has examined the health of refugee women who conceived children in another country



and gave birth in Canada.

There has been no study on refugees with disabilities and some research initiatives need to be taken regarding this aspect too. As in the near future quite a large number of refugees i.e. Iraqis with very recent war injuries, disabilities acquired through the conflict through which they have lived will be arriving

Refugees' health issues vary greatly from immigrants' health issues. There are very obvious differences and as such very different interventions and approaches need to be taken. However, currently a few research reports have been available which looks at the health of refugees pre-migration, i.e. when refugees lived in refugee camps or in other difficult environments. Much of the research that takes place after migration is based on small sample sizes and there are very few of those studies.

There is also a very significant lack of Canadian research studies into refugee health. Much of the literature is from other countries and this is limiting when applying it to refugee groups in Canada.

Kopinak (1999) argues that much of the research that examines refugee health has shown higher rates of poor bio-psychosocial health for refugees in comparison to the host populations due to war trauma, forced migration and resettlement stress. She argues that the literature is "...replete with analyses of refugee experiences that lead to stress, ill-health and poor psychosocial function (Kopinak, 1999). There has been a failure in the research to explain all of the components that are unique to refugee experiences that may reveal more adequate coping mechanisms and health. This had also led to the questioning of prior assumptions and negative study outcomes that are associated with these studies.

Although there is a lack of research on the physical health issues for refugees, there is an even bigger gap in research around the mental health of refugees. The research that exists only touches on the broad mental health issues but does not provide a deeper understanding of mental health issues amongst refugees. Most of the research is repetitive and provides very little new insight or data.

Mental health issues and that the ability of the healthcare system to respond should be concern for countries that are re-settling refugees, however there has been very little large-scale epidemiological research undertaken to document the level of mental health and psychological distress in refugee populations; the mental health effects of post-migration, as pre-migration stressors; the individual and community factors that affect mental health; as well as a comparison of the need to the utilization and availability of services (Beiser, Simich & Pandalangat, 2003).

Studies that examine refugee health profiles are often done in international refugee camps however there is a lack of this type of information on refugee groups in the host countries (Redwood-Campbell, et al., 2003). There is also general lack of research into the health of government assisted refugees in Canada.

Masi (2007) suggests more research be undertaken that examines:

- Research on the policies and practices that affect risk identification, health promotion and disease prevention that are most relevant to the needs of immigrants and refugees;
- Research on the impact of comprehensive health assessment

It has been recognized that there are many populations within Canada that are underserved by the healthcare system. One of those groups is people who do not speak one of the official languages, French or English. However, there is a lack of research on that has specifically focused on the effects of language barriers on health outcomes, service utilization, patient satisfaction or overall costs to the healthcare system or society (Health Canada, 1994).

More research is needed that examines:

- Systemic barriers to accessing healthcare services for refugees
- Client/patient satisfaction with the healthcare system
- National studies looking at service utilization rates by refugees
- Policies and practices of risk identification, health promotion and disease prevention for specific refugee populations
- Coping mechanisms being used by service providers for providing services
- Coordination mechanism that exist between different agencies that provide health to refugees
- Cost-effectiveness of the strategies on the screening for the different disease among the refugees.

Research is also needed that addresses models of care and best practices for government-assisted refugees. These models of care need to specifically address the unique needs of government-assisted refugees and help develop best practices for working with this population and meeting their healthcare needs.

In conclusion, there is a need of research on different aspects of GARs health in order to inform the policy makers as well as service providers to provide better services to this group of clients and ensure better health for them.



## 9 – CONCLUSIONS

This report provided background information on GARs and the major health issues experienced by this group: physical health status, nutritional deficiencies, mental health status, infectious disease, chronic disease, and reproductive health issues. We also described some of the pre and post-migration SDOH that influence health and, ultimately, the social and economic opportunities of this group.

Our findings have implications for the delivery of health and social services and for health policy. Health providers need to be familiar with the major health and resettlement problems experienced by GARs in Canada and be able to provide health care in culturally sensitive and accessible ways. The research findings suggested that, with proper screening and treatment, many of the infectious diseases observed among GARs can be prevented and treated. However, since the risk of developing other health problems, particularly those related to mental health and chronic disease, emerge over time, access to regular and timely health care is critical.

We also saw that the post-migration social determinants of health among refugees increase health risk. Policies and programs are called for to correct the macro and community processes that contribute to unequal access to social and economic resources and to promote health equity for all.

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