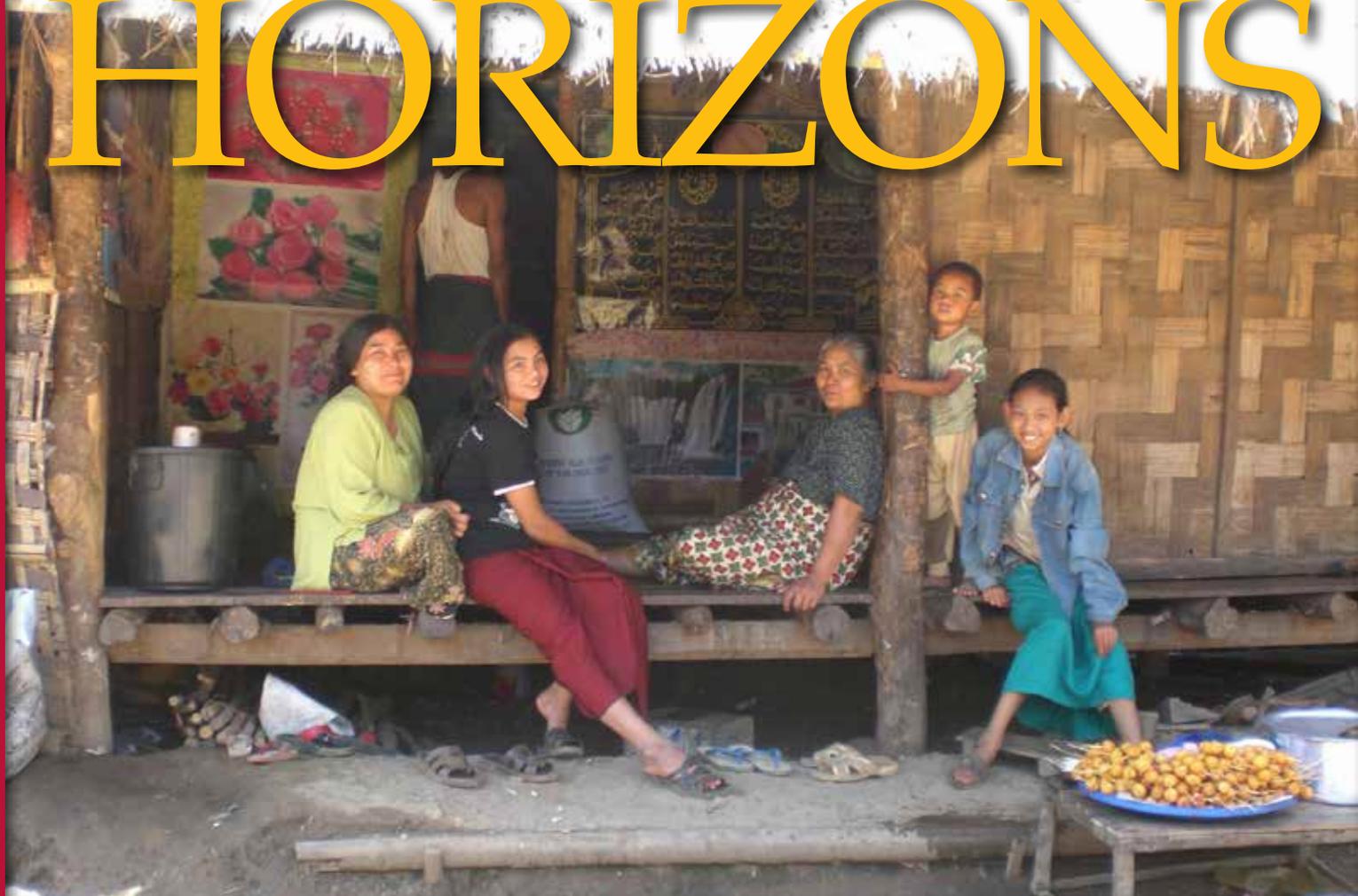


ISSUE 1 2017

# HORIZONS



## Refugees

### Canada's welcoming role

According to the United Nations High Commissioner for Refugees (UNHCR), a refugee is *a person who has been forced to flee his or her country because of persecution, war or violence. By definition, a refugee is a person who, owing to a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group, is outside the country of their nationality and is unable to or, owing to such a fear, unwilling to return.*

In this issue of *Horizons*, we focus on refugees and celebrate our opportunity to support them as they make Canada their new home.



TO LEARN MORE ABOUT OUR REFUGEE HEALTH INITIATIVE, AND UPCOMING GLOBAL-HEALTH RELATED EVENTS, VISIT OUR [GLOBAL HEALTH](#) WEBSITE.

There are more than 21 million refugees in the world today. This number counts only people who have crossed an international border. In terms of displacement, the UNHCR estimates there are more than 65 million people worldwide who have been forced from their homes. <sup>1</sup>

Most of the world's refugees are housed in neighbouring countries, however a minority seek resettlement to safe third countries, including Canada. Canada has long been seen as a leader in refugee resettlement, and is currently one of the top three countries in the world in terms of refugee resettlement.

While some refugees arrive in Canada through their own means and seek asylum upon arrival, most arrive through organized resettlement streams. Canada resettles refugees in three ways:

## 1. Government-Assisted Refugees

Government-assisted refugees (GARS) are referred by the UNHCR, and are processed and screened by Canadian government officials in their country of asylum (the country to which they have fled). Upon arrival in Canada, they are supported financially by the government for 12 months, and are given settlement support by local settlement NGOs. In Kingston, this would be Immigrant Services for Kingston and Area (ISKA).

## 2. Privately Sponsored Refugees

Privately sponsored refugees (PSRs) are named by sponsors through a variety of means including family connections, organizations such as World University Services of Canada (WUSC) or through collaboration with the UNHCR. They are also processed and screened by Canadian government officials. They are supported financially for 12 months by their private sponsorship group, and settlement support is ensured by this group as well.

## 3. Blended Visa Office-Referred Refugees

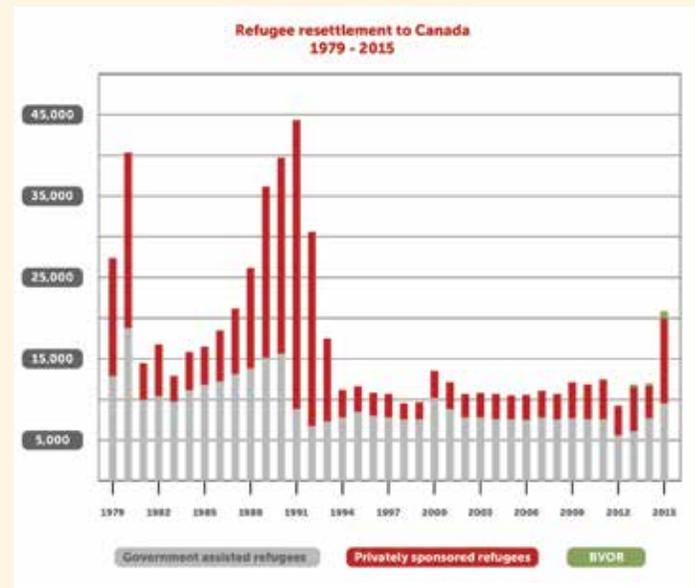
Blended Visa Office-Referred Refugees (BVORs) sit between GARS and PSRs. They receive six months of financial support from the government, and six months of financial support from a private sponsor. The private sponsorship group is expected to provide resettlement support.

In all cases, settlement support should include help with housing, language acquisition, job seeking, schooling for children, and general systems navigation (health-care systems, bureaucracy, etc.). The quality of this support varies depending on locally available resources, as well as the skill, experience and commitment of sponsorship groups.

## The Numbers

While Canada is viewed as a leader, and our private sponsorship system is currently being considered as something to be reproduced in other countries, the number of people served compared to the global need remains small. The graphic at right, from the Canadian Council for Refugees, shows trends in refugee resettlement up to 2015. It is noteworthy

that while numbers in 2016 were significantly higher than 2015, the government's commitments for GARS' resettlement in 2017 seem to be dropping back to 2010-2015 levels, with private sponsorship groups expected to pick up the slack but at significantly reduced numbers compared with 2016.



Graph courtesy of Canadian Council for Refugees

## Refugee Health Care

In a nutshell, refugees are ensured health-care coverage upon arrival to Canada. They do not need to wait for three months (as do other immigrants) to receive coverage, and are immediately covered by a program called the Interim Federal Health Program (IFHP). For some refugees (the newly arrived Syrians, for example), this augments provincial coverage that is immediately available. For others, IFH replaces provincial coverage until it kicks in. Either way, people who are looking for asylum after crossing the border through their own devices (i.e.: who have not yet been granted refugee status) are covered by the IFHP.

The IFHP includes medical care, emergency dental and eye care, and medication coverage that is usually similar to that available to people on social assistance. If a refugee does not yet have provincial coverage, a physician providing care needs to be registered with and bill the IFHP in order to get paid for a consultation.

Refugees often have unique health needs upon arrival to Canada. These will vary widely depending on where they come from (country of origin, socioeconomic status in country of origin, etc.); their trajectory of displacement, including how long they have been without medical care; their living conditions during displacement (for example, did they live in a refugee camp or with relatives in a big city?); and their own pre-existing health conditions. As opposed to other immigrants, refugees often have had a significant period of unmet health needs. Childhood immunizations lapse quickly with displacement; infectious diseases are common in centres with high population densities and low hygiene (e.g.: refugee camps); and women are at higher risk of gender-based violence during displacement (and often have unmet contraception needs as well). Finally,

many refugees have experienced significant trauma during displacement. While most will adapt well to resettlement, especially if they have support integrating into their new society, health-care providers need to remain alert for subtle signs of PTSD in both adults and children.<sup>2</sup>

## Queen's Department of Family Medicine Refugee Health Initiative

In collaboration with the South East LHIN; Immigrant Services for Kingston and Area (ISKA), which is part of Kingston Community Health Centres (KCHC); and Kingston Employment and Youth Services (KEYS), Queen's Department of Family Medicine developed a [Refugee Health Initiative](#) website in late 2016 aiming to provide information and resources on health-care services to health-care providers, newcomers, and settlement groups and services. Users are encouraged to report any inaccuracies or missing information to Dana Doll ([dana.doll@dfm.queensu.ca](mailto:dana.doll@dfm.queensu.ca)), as this is a rapidly changing area and new information is constantly forthcoming.

## QFHT Refugee Intake Clinic

In addition to supporting and housing the Refugee Health Initiative website, the department has agreed to take on as many newcomers as it can. In partnership with KEYS, the Queen's Family Health Team (QFHT) hosted two refugee intake clinics – one in December 2016 and a second in January 2017. During these two evenings, a total of 43 newly arrived Syrians were seen by a team of residents, faculty members, nurses and administrative staff members. At both clinics, we were also fortunate to have many volunteer translators through a project launched by residents Dr. Shiva Adel and Dr. Belle Song. (See *Residents Launch Volunteer Student Interpreter Program* in this issue.)

All newcomers seen during these clinics will be enrolled into QFHT practices. Not only will this provide a needed service to newcomers, it is an excellent learning opportunity for faculty, residents and staff as well.

These clinics were an excellent example of multidisciplinary partnership and community engagement, and sincere thanks is extended to all involved in making them possible. The QFHT is committed to hosting more clinics, as needed.

*Dr. Eva Purkey  
Global Health Director  
Queen's Department Family Medicine*

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1. UNHCR: [Figures at a Glance](#). 2017. [Cited: January 5, 2017]
2. Canadian Collaboration for Immigrant and Refugee Health: [Clinical Guidelines Checklist](#). [Cited: January 5, 2017]

Cover photos: Myanmar; Dr. Eva Purkey

## Residents Partner with New Canadian Centre

Residents at the Queen's Department of Family Medicine's Peterborough-Kawartha (PK) site, in partnership with Peterborough's New Canadian Centre, have continued their efforts to provide primary care for newly settled Canadian immigrants in the local area. In particular, over the past year, the number of Syrian refugees immigrating to Peterborough has risen, increasing the need for primary care.

Under the guidance of PK Site Program Director Dr. Kim Curtin and individual resident preceptors, each first-year resident has been afforded the opportunity to accept a Syrian refugee family as patients in their longitudinal family medicine practice. The response from residents has been rewarding, to say the least.

"The refugee health initiative has been an eye-opening experience," said Dr. Mathew Moore, a first-year family medicine resident. "I did not appreciate how difficult it would be to establish effective communication and prepare for relevant medical discussion in families who had been in refugee camps for an extended period of time. For the children, immunization records were not always available, so we had to use our best judgement to create new schedules for them."

To prepare for these challenges, a didactic education component in refugee health care was introduced to the curriculum early in the residency program. Each resident completes a family intake examination and schedules follow-up appointments as needed. These appointments consist of obtaining full medical histories, performing physical exams, updating immunizations, providing community resources and educating the new Canadians on Ontario's standardized health screening tests.

Although lengthy in nature and challenging due to communication difficulties, the resident group has been quite diligent when preparing for these appointments. In conjunction with local community private sponsorship groups, Dr. Moore and Dr. Shain Thakrar, also a first-year family medicine resident, are also volunteering to provide further health education to refugees and new immigrants at evening open houses. Here, their discussions have honed in on medical access, nutrition, healthy living, and in-depth teaching about health screening tools, procedures and guidelines. These meetings are held as small-group, open Q+A sessions, and have been very well received by the target audiences.

*Dr. Shain Thakrar, PGY1 Resident  
Peterborough-Kawartha Site  
Queen's Family Medicine*



Photo: Allen McAvoy

*Dr. Abdul Alkandari, Internal Medicine resident and volunteer interpreter, speaks with a patient at a recent refugee intake clinic at the Queen's Family Health Team.*

## Residents Launch Volunteer Student Interpreter Program

*By Dr. Shiva Adel and Dr. Belle Song*

One of the hardest things about arriving in a new country is finding that suddenly you have difficulty communicating even the most basic information. This is especially the case when the information you are trying to convey and understand could have serious implications for your life and health. You may have to rely on your friends or children, or even grandchildren, to express and convey your health needs – a situation that can be far from ideal. As first-generation immigrants who have served as interpreters for newly arriving relatives and friends, both of us have first-hand experience with this.

As first-year residents at the Queen's Family Health Team (QFHT) in 2016, many of our patients did not speak English fluently. (In technical terms, they had "low English proficiency.") Although we were intentionally placed in our respective clinics because of our ability to speak our patients' primary languages, we were aware that when we were not in clinic, or when our patients went to the after-hours clinic, emergency department or specialist

appointments, they were again forced to resort to using friends or family members as ad-hoc interpreters.

Numerous studies have shown that language barriers lead to health disparities and can result in worse health outcomes for patients. These disparities can be improved with the use of trained interpreters. However, the use of ad-hoc interpreters, who have no training and often are members of the patient's family or community, has been found to be associated with potentially serious misunderstandings, and presents an obvious challenge to patient confidentiality.

Although Immigrant Services Kingston and Area (ISKA) makes informal interpreters available for non-medical services, it does not offer services for medical visits. Formal interpreter services are very expensive, and are covered only in cases where domestic violence or abuse is suspected, or when individuals have been in Canada for less than a year and are coming from refugee camps where they have experienced war and trauma.

We, therefore, decided to adapt a model that has been successfully used at multiple other medical schools, including the University of Ottawa, and train health professional students to be volunteer interpreters. Given that they already have some training in health sciences, as well as an understanding of the importance of patient confidentiality, we thought they would be ideally suited to interpret at medical appointments.

To date, 39 students have undergone a brief training session on medical interpretation, confidentiality and cultural sensitivity, and have provided free interpreter services at medical intake and follow-up appointments for newly arrived Arabic-speaking refugees at the QFHT. In addition to Arabic, our volunteer interpreters speak a variety of languages including Hindi, French, Mandarin, Cantonese, Tamil, Spanish, Dari, Dutch, Punjabi, Tigrigna, Farsi, Amharic, Vietnamese, Polish and Bengali.

As part of our resident research project, we are distributing surveys to the volunteer interpreters to assess the quality of the training session and gather feedback about the program. We will also be collecting feedback from participating residents or staff members who have used the interpreter services to assess the effectiveness of the interpretation and the program as a whole. Our goal is to address gaps in the current program and ensure it is sustainable for patients, health-care practitioners and the administrative staff. In addition, we are collaborating with the Queen's Office of Global Health to expand the program and make it accessible to patients throughout the Kingston area, including those outside of the QFHT.

If you are aware of a patient who requires interpreter services for a medical appointment, or if you have any questions about our program, please contact us at [queens.interpreters@gmail.com](mailto:queens.interpreters@gmail.com).



*Dr. Shiva Adel (above)  
Dr. Belle Song (right)*



*PGY2 Residents  
Queen's Family Health  
Team*

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## Frostbite in Persons Smuggled into Canada

Since the beginning of January this year there has been an increase in reports of refugees arriving on the outskirts of Toronto with severe frostbite to hands and feet. The discussion was triggered by Dr. Paul Caulford, among others, whom you can hear interviewed on CBC's [As It Happens](#).

Basically, having been told that the U.S., under President Donald Trump, is likely no longer a safe country of asylum, refugees from Sub-Saharan Africa who previously would have arrived in the U.S. are being convinced by smugglers to travel to Canada. They are crossing the border in the back of tractor trailers, which are not heated, and dropped off in various locations on the outskirts of Toronto, at night, often with inadequate clothing.

A family Dr. Caulford recently saw at his clinic was dropped off outside a church at 4 a.m. When the church opened five hours later, church staff brought the individuals to a shelter, which sent them to Dr. Caulford's clinic at the [Canadian Centre for Refugee & Immigrant Healthcare](#). Because there is a delay in Interim Federal Health Program (IFHP) coverage for refugees who arrive through unconventional pathways, these individuals are not covered for general medical care or the care of plastic surgery, which they need if they have frostbite.

Dr. Caulford describes 11 cases at his clinic in three weeks, six of whom were children under the age of nine. In all cases, people had no gloves, and were totally bewildered by what was happening. Presumably having no idea that frostbite was a possibility, these refugees all had damaged and disfigured fingers

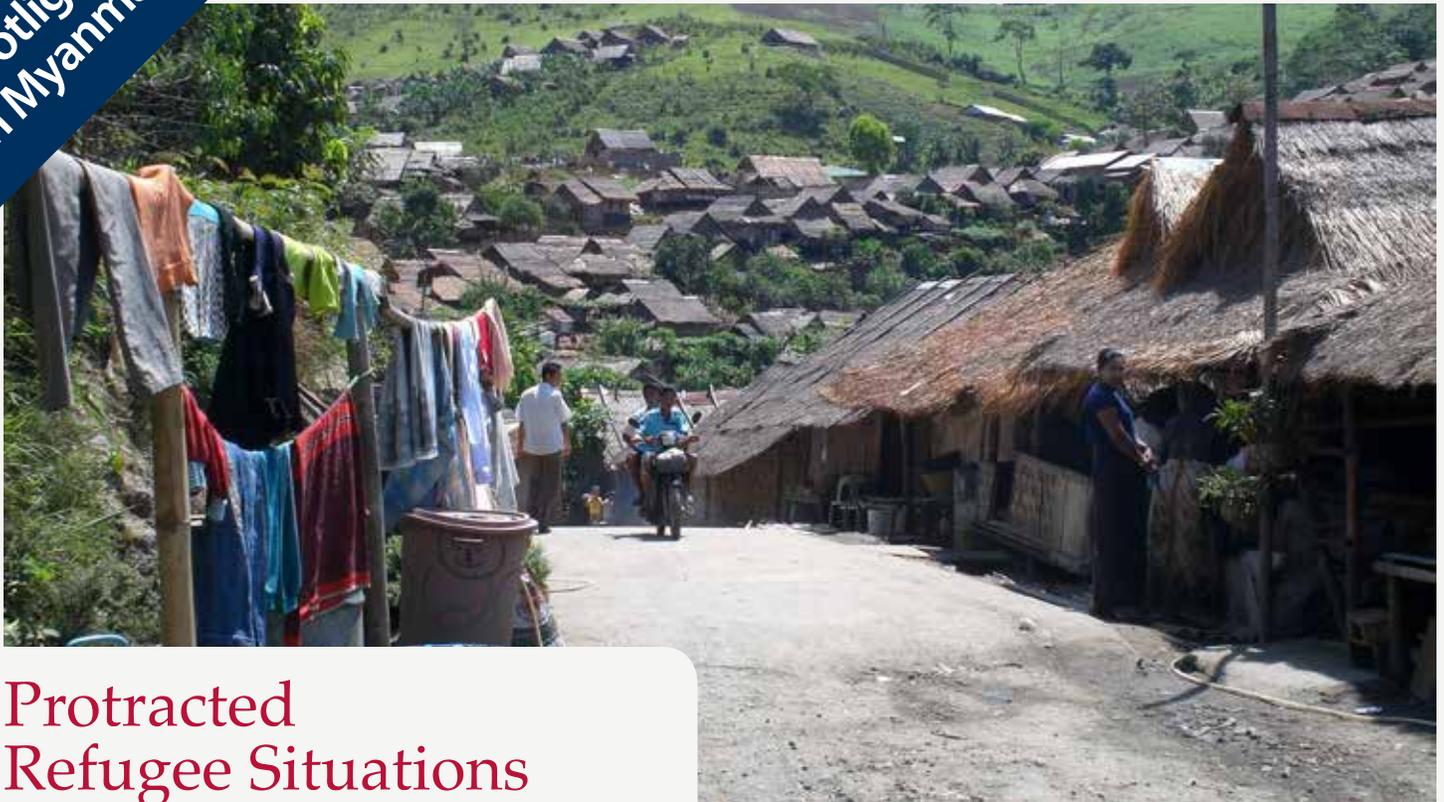
and needed plastic surgery, wound care and hand physiotherapy.

The conversation about what to do about this is complex. Too much surveillance means that people are stopped at the border and returned to the U.S., and never given the opportunity to enter Canada. Canada has a "safe third country" agreement with the U.S., which means that, technically, refugee claimants who come through the U.S. are supposed to claim status there. If people get through and apply for refugee status at an inland location, they can most often not be deported until they have a hearing. If they are detained during this time, which does not always happen, they get immediate access to IFH (and possibly less exposure to freezing temperatures), but they are then in detention for the duration of their application and hearing, which can take a long time.

Anyone interested in this conversation are encouraged to keep their eyes on the media. While refugee claimants have apparently been crossing the border on foot in Manitoba for years, thereby exposing themselves to freezing temperatures, this influx into Toronto seems to be relatively new. It raises important issues about refugee rights, trafficking and human smuggling in Canada, as well as the role of health-care professionals in advocating for a marginalized population. It's an evolving story, and is likely but one of a long line of changes to pressures on Canada's borders resulting from the election of U.S. President Donald Trump.

For other current issues in refugee resettlement in Canada, visit the [Canadian Council for Refugees](#). Current topics relevant to health include refugee detention (including the detention of children) and the protection of trafficked persons, among others.

*Dr. Eva Purkey  
Global Health Director  
Queen's Department of Family Medicine*



## Protracted Refugee Situations

At the end of a bumpy, washed-out dirt road in the midst of tall vegetation sits what initially looks like a small village of quaint bamboo houses lining both sides of a small river. Rocking bamboo bridges are suspended across the river, and the settlement is surrounded by palm trees and beautiful thick jungle.

A small spot in Paradise?

Unfortunately not. This is Ban Mae Surin refugee camp, on the border between Thailand and Karennig State Myanmar. Walking into the settlement a bit, a visitor will notice that it is much bigger than the average Thai or Burmese hilltribe community. Visitors will also notice the large bamboo warehouse where the [Border Consortium](#) stores rations of rice, chili and fish paste, etc. Visitors may also learn that the lovely river floods in the rainy season, and the entire settlement can be inaccessible due to poor road conditions and wash-out for weeks at a time. This situation is obviously a problem if you are a woman in labour needing an emergency cesarian section (three hours by road at the best of times), or if the wash-out occurs when rations have run low.

There have been refugee camp settlements on and around the location of Ban Mae Surin since 1991. The current camp is small by Thai standards, housing some 2,800 people compared with the 42,000 people in the largest Thai camp, Mae La, farther south along the border with Karen State. Mae La looks much different from Ban Mae Surin, and there is no disguising the fact that it is a large, sprawling, artificial settlement. Mae La was originally established in 1984 after the fall of a Karen National Union (KNU) base on the other side of the border. (The KNU is a political organization with an armed wing representing a substantial portion of the Karen hilltribe people of Burma.)

According to the United Nations High Commissioner for Refugees (UNHCR), a protracted refugee situation is one in

which at least 25,000 people find themselves in a prolonged state of displacement for five years or more. It is estimated that 6.7 million people currently live in protracted refugee situations, in 27 countries and 32 locations. This is in addition to 5.2 million Palestinians.<sup>1</sup> The average length of the existing protracted refugee situations is 26 years, meaning that people are born and grow to adulthood, while many others age and die, in exile.<sup>2</sup>

The largest protracted refugee situation in the world is that composed of Afghan refugees. The Syrian crisis became a protracted refugee situation in 2016. Many of the protracted refugee situations we hear little about are in Sub-Saharan Africa, with Somalis who have been fleeing their homes since the early 1990s.

Another protracted refugee situation is that of refugees from Myanmar (Burma). Conflict in Myanmar has been ongoing since independence from the British in 1948. It started with the desire of ethnic minorities to have states of their own, accompanied by brutal government repression involving the burning of villages, forced labour, and rape as a weapon of war, among other atrocities.

However, the refugee situation began in earnest in 1984 with the first wave of refugees coming across the Thai border fleeing conflict between the military dictatorship and armed ethnic groups. This conflict between the central government and the ethnic minorities (of which there are many) continues to varying degrees to this day, and there remain some 120,000 to 150,000 members of ethnic minority groups living in nine refugee camps in Thailand,<sup>3</sup> not to mention those who live outside of camp with varying degrees of legality in Thailand and those who have fled to other neighbouring countries including China, India and Bangladesh. It is estimated that nearly 1.5 million Burmese live in Thailand,<sup>4</sup> though not all are refugees.



A second and different refugee-producing event occurred in 1988 after a pro-democracy movement was brutally crushed by the existing military dictatorship. This led to the exodus of thousands of students and other pro-democracy activists, many of whom remained in exile until the most recent democratic elections of 2015. These refugees did not live in camps, and due to the Thai government being a non-signatory to the UNHCR refugee convention, were not granted refugee status within Thailand, though they would have met the international definition. Many of these people have remained active in the expatriate democracy movement over the last 25+ years.

## Living in Exile: The Camps on the Thai-Burmese Border

The camps in Thailand have existed for more than 30 years. They have developed structures and organizational systems through local capacity and the support of international NGOs, as well as camp committees – de facto governments, education systems and health-care systems, among others. There are opportunities for camp residents to learn English, which increase their options for resettlement and gaining meaningful employment working with NGOs whose working language is often English. There have been waves of resettlement to third countries, including Canada, which have brought hope as well as confusion as families debate their options: Is it better, as a Karen hilltribe person, to be “free” in a large American city where it is cold, and where you do not speak the language or have access to health care, or to be confined in camp, close to home, with the hope of possibly, one day, returning?

Ultimately, however, the camps are artificial living environments. Myanmar’s ethnic minority groups are hilltribe farmers, used to living in small, self-sufficient villages in the mountains where they practise various forms of agriculture.

Camps do not provide opportunities for agriculture, as space is at a premium, and many people simply have little to do. Disrupted gender roles, crowding and boredom lead to increased rates of substance abuse, mental illness and gender-based violence in camps all around the world. Lack of adequate nutrition, water and sanitation, despite best efforts, leads to malnutrition and disease. Housing materials that would traditionally be gleaned from communal forests are in short supply. Rations have been cut substantially as international attention and money have moved to the Middle East. The camps, made of too many bamboo structures pressed together, have also fallen victim to fires on many occasions. Small charcoal braziers can easily tip and lead to fires during the dry season, and fires are hard to control in a camp made of such wood, with dry leaves as roofing and only communal water sources. In 2015, 150 homes were burnt in one camp, and this is a regular occurrence.

That said, there is possible light at the end of this protracted refugee tunnel, as 2015 marked the first “real” democratic elections in Burma since 1990. Nobel laureate Aung San Suu Kyi’s National League for Democracy won a landslide victory, and while her performance thus far has been less than stellar\*, there is hope that this will lead to progress in peace talks, demining of areas that have been mined and thus remain unsafe for return, and increased support for health care and education.

There is great resilience in the camps. Strong community leaders have been preparing their communities for return for a long time, and organizations have helped with legal empowerment and education around gender and health. One of the great dangers of protracted refugee situations all over the world is that the international community has a short attention span. The UNHCR, international community and refugees themselves still do not feel it is safe to return home to Myanmar, and hopefully as our attention turns elsewhere, the hundreds of thousands involved will not be forgotten.

*\*Controversies surrounding Aung San Suu Kyi’s leadership concern her failure to protect the Rohingya people of Arakan State from possible genocide, the increase in conflict in certain ethnic areas since her election, and a significant and ongoing drug trade that is second to Afghanistan in terms of opium production and second to Mexico in terms of methamphetamine production. (Some say it is now the top-producing country of methamphetamines.)*

*Dr. Eva Purkey  
Global Health Director  
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Photos: Myanmar; Dr. Eva Purkey

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*Aleppo Castle before bombardment, drawn by a Syrian who was born and lived in Aleppo before coming to Kingston as a refugee.*

## Refugees in Kingston

### A Community United

*By Sandra den Otter and Margaret Moore*

The news in the past few years has been dominated by images of refugees – people seeking refuge from war, calamity, persecution and violence. Some people have climbed on to leaky boats and drowned in the Mediterranean. Others, the lucky ones, have sent their GPS co-ordinates, been picked up by boats and gained admission to Europe. Still others have walked many thousands of miles, across innumerable borders, hoping for a better and/or more secure life. Some have been stuck on the wrong side of borders, living in tents, with no durable future.

This has led to a fairly heated debate in Western refugee recipient countries. Issues connected to “the refugee crisis” and migration generally have been at the centre of a number of political debates in Western receiving countries – with Britain voting to exit the European Union (a vote fuelled by intense debate on migration) and the election of U.S. President Donald Trump (again, in significant part, fuelled by a sense of lack of control over borders).

In Canada’s 2016 federal election, the policy on refugees was also discussed, but here the consensus was that Canada should be more, not less, welcoming of refugees. Some might claim that this is not because Canadians are necessarily more tolerant or more liberal. It is the luck of geography: Canada is in a position where it can retain control both over its choice of migrants (for

those seeking to migrate for economic or personal reasons) and over the level of refugees it accepts.

It is, nevertheless, commendable that Canada took seriously the fact that we, like all countries, are under a moral and international legal obligation to accept refugees. This is dictated by the terms of the 1951 Geneva Convention, which defines a refugee as a person who, “owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, unwilling to avail himself of the protection of that country.” This definition is understood to apply broadly to people who cannot in the foreseeable future return to their home country because it is enveloped in war.

Kingston has responded to this worldwide refugee need by welcoming about 200 refugees in the last year. Although refugees have settled here from far-flung areas of conflict in the world, the greatest number of refugees to arrive in 2016 came from Syria by way of Lebanon, Turkey or Jordan. Roughly half of the Syrian refugees in Kingston have arrived as government-assisted refugees, while the other half have arrived as either privately sponsored refugees or as Blended Visa Office-Referred refugees. (Blended Visa Office-Referred refugees are those whom the United Nations High Commissioner for Refugees (UNHCR) identifies as needing settlement and special help, and for whom the government shares the cost of sponsorship with the private sponsors.)

Both of these forms of refugee support involve the close day-to-day involvement of private sponsors. One of very few

countries where private sponsorship is possible, Canada's blend of government and private sponsorship has been identified as a model that should be exported worldwide. UN High Commissioner for Refugees Filippo Grandi stated in a recent interview, "It adds more places for resettlement, but it also contributes to create this sense in civil society that it is a positive thing to do."

Newcomers benefit from being connected to the personal networks of the volunteers, and this in turn helps newcomers as they navigate new opportunities and new challenges, and seek to establish themselves in new communities. Private sponsors themselves rely on the expertise of settlement workers at such services as Immigration Services of Kingston and Area (ISKA) and Kingston Employment and Youth Services (KEYS), which have been at the forefront of resettlement work in Kingston and area. Other agencies are important too.

Some of Kingston's refugees had limited or no English when they arrived, and enrolled at Loyola College or in the city's Language Instruction for Newcomers to Canada (LINC) program for English-language education. Refugees were covered with federal health insurance for the first six months, and the Queen's Family Health Team responded to this influx by accepting all refugees who applied as new patients.

At a more personal level, we are two academics working at Queen's, an historian and a political scientist, who have academic interests in social justice and the social conditions that create these migration flows. But in 2015, and partly because the private sponsorship system afforded the opportunity, we decided to respond to this refugee crisis in a small but immediate and practical way. With a small group of colleagues at Queen's, we initiated the private sponsorship of two refugee families. Within a few months of submitting the applications to sponsor, both families had arrived. The first arrived on Boxing Day, followed closely by the second family on New Year's Eve.

As we looked for affordable places to live in the company of the newcomers, shopped for food, furnished two apartments, helped them find volunteer work and paid employment, and liaised with language teachers, we experienced our city in new and unexpected ways. We continually encountered astonishing warmth and goodwill from a community eager to assist in countless ways.

An area of especial concern was refugee health and well-being. The Queen's Department of Family Medicine's global health initiative offered to provide comprehensive health care for the newcomers who became patients in Dr. Eva Purkey's clinic, for which our families were immensely grateful and impressed.

The refugee crisis has not gone away. The problems that have created it are economic, political, institutional and ideological. Much more needs to be done, and we know in any case that it cannot be addressed entirely or even principally by migration. But for us, this has been a wonderful opportunity to have our lives touched in unexpected ways, not only by newcomers but by our fellow Kingstonians who have been supportive of our endeavour and of the families that have arrived.

*Sandra denOtter teaches in Queen's Department of History; Margaret Moore, in the Department of Political Studies. They are the lead co-ordinators of the Queen's/St. James refugee resettlement group.*

## ISKA Addresses Diverse Needs of Newcomers

Kingston Community Health Centres (KCHC) is home to Immigrant Services Kingston and Area (ISKA), which serves more than 300 newcomers per year, helping them adjust to their new community. Offering a variety of supports to individuals, families and youth, our services are free.

Since November 2015, Canada has welcomed more than 40,000 refugees from Syria. The Kingston community has received more than 250 refugees, both government assisted and privately sponsored.

The needs of our newly arrived friends are diverse. Some arrive with the skills they need to start thriving almost immediately – the ability to speak English a key component of early successful integration. Others arrive with complex needs resulting from many factors including:

- trauma from war and being uprooted (many suffer from PTSD)
- loss of social supports
- physical injuries
- worry and grief over family members and friends left behind (some killed)
- learning a new language and adjusting to a new culture
- stresses within the family

As a multi-service site, KCHC is uniquely positioned to care for the unique needs of refugees. Beyond the one-on-one support of our settlement workers and volunteers, many refugees are able to access primary health care, dental care, family support programs for all ages and social events. Together with KEYS Job Centre, their Refugee Resettlement Services team and many dedicated volunteers, refugees are supported in many other practical ways including:

- placement in English-learning classes and ongoing language support
- integrating children into local schools
- finding affordable housing
- managing the high cost of living on a tight budget
- successful cultural adaptation
- building positive relationships with neighbours
- connecting with other local community service providers
- securing employment opportunities
- building healthy social support networks
- help with getting their G1 driver's licence

The Kingston community has shown a great capacity to stretch and adapt as we welcome this recent influx of refugees. Continued support from all levels of service-providing organizations and individuals will be vital to the successful integration of our new community members. Refugees need more than just each other. They need us all.

For more information, contact [Immigrant Services Kingston and Area](#).

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# Public Health Resources for Resettlement in Kingston



**As of December 2016, more than 40,000 Syrian refugees have been resettled across Canada** as a result of the ongoing civil war and humanitarian crisis.<sup>1</sup> Kingston has been designated as a Resettlement Assistance Program Centre since April 2016, and is currently home to about 250 Syrian refugees.<sup>2</sup>

This influx of refugees presents many potential opportunities for intervention in the realm of public health and preventive medicine. From a public health perspective, there are a number of evidence-based recommendations to integrating newly arrived refugees into the Canadian health system, as well as a variety of relevant services offered by Kingston, Frontenac and Lennox & Addington (KFL&A) Public Health.

## Clinical Resources

From a clinical perspective of preventive care, [Evidence-based Clinical Guidelines for Immigrants and Refugees](#) (CMAJ) offers a comprehensive list of recommendations, while [Caring for a Newly Arrived Syrian Refugee Family](#)<sup>3,4</sup> (CMAJ) focuses specifically on Syrian refugees. Both of these clinical guidelines highlight the evidence-based recommendations for immunization and screening for new immigrants and refugees. [The CCIRH Evidence Based Preventive Care Checklist for New Immigrants and Refugees](#) is an excellent and practical clinical resource based on these guidelines, which can be filled out for an individual patient to help consider all recommendations.

Some of the key points relevant to the settlement of Syrian refugees include:

### Vaccinations

Patients without written documentation of immunization should be provided with age-appropriate vaccination, which, depending on age, may include vaccination for measles, mumps, rubella, diphtheria, tetanus, pertussis, Haemophilus influenzae type B and polio.

### Screening

- Screening is recommended for children and adults for chronic hepatitis B virus infection and prior immunity, and vaccination for those who are susceptible.
- Screening for hepatitis C and varicella (in refugees aged 13 years and older) should be considered.
- Testing for latent tuberculosis infection is not recommended, as incidence is low in the Middle East region.
- Visual acuity (at the bedside, such as using a basic Snellen chart) and dental screening should be performed.
- Screening for post-traumatic stress disorder is not recommended; however, providers should remain vigilant for signs or symptoms of mental health disorder or impaired social functioning.

## Local Public Health Resources

KFL&A Public Health offers various programs that may be valuable to new immigrant and refugee families. For example:

### Immunizations:

Vaccination of refugees can be challenging in the context of missing or unclear immunization records. It is recommended that refugees without written documentation of immunization are provided with age-appropriate vaccination.<sup>3</sup> KFL&A Public Health's Immunization Information Line (613-549-1232, Ext. 1441) can be used as a resource to answer questions concerning requirements, schedules and more. KFL&A Public Health's main office (at 221 Portsmouth Ave., Kingston) also offers immunization clinics for publicly funded vaccines on Tuesday mornings (drop-in, all ages) and Wednesday afternoons (by appointment only, from birth to age 17 only).

### Smoking Treatment for Ontario Patients (STOP)

A 2004 survey of adult residents of Aleppo, Syria, found that 57 per cent of men and 17 per cent of women were cigarette smokers.<sup>5</sup> The STOP program offers free smoking cessation counselling and a free five-week kit of nicotine replacement therapy (NRT) to eligible Ontario smokers. Interested individuals can contact the Tobacco Information Line at 613-549-1232, Ext. 1333 to find out if they qualify.

### Healthy Babies Healthy Children

According to data from the Government of Canada, about half of refugees settled in Ontario as of September 2016 are under the age of 18.<sup>6</sup> Moreover, there are an estimated 70,000 pregnant refugees worldwide<sup>7</sup> (Canadian figure unavailable). Healthy Babies Healthy Children is a free home-visiting program that provides support to expectant parents or families with children from birth to age six. Services include in-depth needs assessments and linking patients to community resources such as breastfeeding and parenting programs. Patients can access this program through self-referral or with a referral from a health-care provider or community service.

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### References:

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6. Government of Canada. September 2016. [Syrian Refugee Resettlement](#) - Open Government Portal
7. Spencer, R. (2016, February 3). [Nearly Half a Million Pregnant Women among Displaced and Refugee Syrians](#). *The Telegraph*



Heather Aldersey  
ICACBR Faculty Lead

Photo: Bernard Clark

## International Centre for the Advancement of Community Based Rehabilitation

The International Centre for the Advancement of Community Based Rehabilitation (ICACBR) was established at Queen's University in May 1991 as one of six Centres of Excellence funded by the Canadian International Development Agency (CIDA) with a mandate to advance the development of community-based rehabilitation (CBR) internationally.

Community-based rehabilitation was first promoted by the World Health Organization (WHO) after the 1978 Alma Ata Declaration as an effort to enhance the quality of life for people with disabilities and their families. While initially a strategy to increase access to rehabilitation services in resource-constrained settings, CBR has grown to include equalization of opportunities and social inclusion of people with disabilities in an effort to combat the cycle of poverty and disability. Community-based rehabilitation is implemented through the combined efforts of people with disabilities, their families and communities, as well as relevant government and non-government health, education, vocational, social and other services.

Closely affiliated with the Queen's School of Rehabilitation Therapy, the ICACBR draws from the vast resources offered by the university, Kingston and Canadian community. Its work is focused on transferring skills, building local expertise and creating an environment for persons with disabilities to engage in the development of sustainable, integrated and accessible health, education and social services.

The centre's projects include the Access to Health & Education for all Disabled Children & Youth (AHEAD) project in Bangladesh,

the Queen Elizabeth II (QE II) Scholarships for Excellence in International Community Based Rehabilitation, and a participatory project on stigma and intellectual disability in the Democratic Republic of the Congo. The AHEAD program works in concert with the Centre for the Rehabilitation of the Paralyzed (CRP) and Bangladesh Health Professionals Institute (BHPI) to improve access to health and education services for children and youth as a means of reducing poverty and promoting inclusion. The QE II project supports Canadian occupational therapy and rehabilitation science program (RHBS) students to research and train in Bangladesh, India and Tanzania, and provides opportunities for CBR leaders from low- and middle-income countries to pursue PhDs in RHBS at Queen's. The Congo project is focused on supporting families to understand and reduce the stigma around intellectual disabilities in the capital, Kinshasa.

The ICACBR also recently announced the commencement of a new, 10-year project that will be funded by the MasterCard Foundation and implemented in close partnership with the University of Gondar in Ethiopia. The partnership will provide 450 next-generation African leaders with a high-quality education at the University of Gondar, while also providing 60 of the university's faculty members with the opportunity to study at Queen's, where they will enhance their skills in innovative pedagogy and in leading collaborative research between African and North American universities. The University of Gondar and Queen's will also collaborate to develop Ethiopia's first occupational therapy program. For more information about this initiative, read this [Queen's Gazette article](#).

For more information, visit the [International Centre for the Advancement of Community Based Rehabilitation](#) website or contact Heather Aldersey, ICACBR Faculty Lead, at [hma@queensu.ca](mailto:hma@queensu.ca).

For more information about community-based rehabilitation, visit this [WHO web page](#).



# Public Health Resources for Resettlement in Kingston

As of December 2016, nearly 40,000 Syrian refugees have been resettled across Canada as a result of the ongoing civil war and humanitarian crisis.<sup>1</sup> Kingston has been designated as a Resettlement Assistance Program Centre since April 2016, and is currently home to about 200 Syrian refugees.<sup>2</sup>

This influx of refugees presents many potential opportunities for intervention in the realm of public health and preventive medicine. From a public health perspective, there are a number of evidence-based recommendations to integrating newly arrived refugees into the Canadian health system, as well as a variety of relevant services offered by Kingston, Frontenac and Lennox & Addington (KFL&A) Public Health.



Photos: Allen McAvoy

*The Queen's Family Health Team has hosted two evening refugee intake clinics, in which 43 newly arrived Syrian refugees participated*

## Clinical Resources

From a clinical perspective of preventive care, [Evidence-based Clinical Guidelines for Immigrants and Refugees](#) (CMAJ) offers a comprehensive list of recommendations, while [Caring for a Newly Arrived Syrian Refugee Family](#)<sup>3,4</sup> (CMAJ) focuses specifically on Syrian refugees. Both of these clinical guidelines highlight the evidence-based recommendations for immunization and screening for new immigrants and refugees. [The CCIRH Evidence Based Preventive Care Checklist for New Immigrants and Refugees](#) is an excellent and practical clinical resource based on these guidelines, which can be filled out for an individual patient to help consider all recommendations.

Some of the key points relevant to the settlement of Syrian refugees include:

### Vaccinations

Patients without written documentation of immunization should be provided with age-appropriate vaccination, which, depending on age, may include vaccination for measles, mumps, rubella, diphtheria, tetanus, pertussis, Haemophilus influenzae type B and polio.

### Screening

- Screening is recommended for children and adults for chronic hepatitis B virus infection and prior immunity, and vaccination for those who are susceptible.

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