Social and structural factors that influence refugee women's use of mental health care services in Canada: A narrative review

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Abstract

Background: There is an increasing number of female refugees entering Canada with mental health service needs. The aim of this paper is to identify social and structural factors that influence Canadian refugee women's use (or lack thereof) of mental health care services.

Methods: This review follows Rosella Ferrari's Narrative Review Framework. The PRISMA statement was used for the search strategy. A total of 430 articles were retrieved across PubMed/Medline, Scopus, and ProQuest. A final 24 articles were used in our paper after full-text screenings. Data presented in the review were organized by themes that emerged in various papers. The final section is used to highlight the main points of this review, establish future research directions, and explain how the review as achieved the research objective.

Results and Discussion: Our findings unveil the complexities of refugee status, discrimination and stigma, the social experience of gender, and previous health experiences in relation to how they influence mental health service use. Additionally, culture and cultural competency as they are regarded in health care offer insightful explanations for understanding the relationships between patient and physician which ultimately influences use of services. Finally, this paper uncovers policies and power divides between patients and doctors that impacts how mental health care is welcomed by women who are refugees.

Conclusions: Data suggest that social support innovations are desirable by refugee women in Canada but that further research is required to mitigate social and structural barriers to seeking care. Practice and research recommendations are provided for agendas focused on improving mental health service use.

Riassunto

Introduzione: C'è un numero sempre maggiore di rifugiati di sesso femminile in Canada che hanno la necessità di utilizzare i servizi di salute mentale. L'obiettivo di questo studio è di identificare i fattori sociali e strutturali che influenzano l'uso da parte di tali donne di tali servizi.

Metodi: Questa revisione segue la teoria sulle revisioni narrative di Rossella Ferrari. Il Prisma Statement è stato usato come strategia di ricerca. Un totale di 430 articoli sono stati cercati attraverso PubMed/Medline, Scopus e ProQuest. Alla fine 24 articoli sono stati usati nel nostro lavoro dopo la lettura di tutti gli articoli. I dati presentati nella revisione sono stati organizzati secondo i temi emersi dai vari articoli scientifici, La sezione finale è stata usata per evidenziare i punti principali di questa revisione, stabilire le future direzioni di ricerca e spiegare come sono stati raggiunti gli obiettivi di ricerca.

Risultati e Discussione: I nostri risultati rivelano che la complessità dello stato di rifugiato, la discriminazione e lo stigma, l'esperienza sociale della differenza di genere e le precedenti problematiche di salute influenzano il modo in cui vengono utilizzati i servizi di salute mentale. In aggiunta, la cultura e la competenza culturale per come vengono considerate in sanità offrono interessanti spiegazioni per comprendere la relazione tra il paziente ed il clinico che in ultima analisi influenza l'uso di tali servizi. Infine, questo studio rivela le politiche e le divisioni di potere che esistono tra i pazienti ed i medici che influenzano il modo in cui il servizio di cura mentale viene accettato dalle donne con lo status di rifugiato.

Conclusioni: I nostri risultati suggeriscono che le innovazioni di supporto sociale sono gradite alle donne rifugiate in Canada ma ulteriore ricerca è necessaria per ridurre le barriere sociali e strutturali relative ai comportamenti di ricerca della cura. Vengono fornite raccomandazioni per la pratica e la ricerca focalizzati sul miglioramento dell'uso dei servizi sanitari di salute mentale.

TAKE-HOME MESSAGE

Policy makers and clinicians should recognize and be knowledgeable about the various social and structural factors that play a part in refugee women's decisions to seek mental health care services. Doing so will help to improve physician practices and policies associated with the mental health care required by this population.

INTRODUCTION

In 2013, 8.9% of all immigrants fell under the female refugee class [1]. In order for these women to integrate into, feel part of, and become members of society, it is imperative to address their health needs. Moreover, these women are often the primary caregivers of children, and suffer the effects of migration uniquely, in emotional, mental, and social realms [2]. Given the conditions under which women leave their home countries and need to transition in a new, and culturally and geographically distinct spaces, it is unsurprising that mental health issues are amongst the most prevalent health concerns that face female refugee populations [2]. Indeed, the combination of negative experiences in their home countries along with the newfound fear and anxiety of being in an unfamiliar host country exacerbate the declining mental health state of these individuals. Though it is known that internationally between 10% and 40% of refugees face mental health challenges [3], the mental health of refugees in Canada is poorly understood. What is known however is that social and structural factors in host countries can plays a role in women's use of available mental health services.

In Canada, the Interim Federal Health Program (IFHP) provides all refugees with basic healthcare necessities including acute care facilities [4]. However, research identifies that refugee claimants and asylum seekers may not use such services. Research suggests that refugees often consider themselves to be a burden, feel that they receive culturally inappropriate care, and have difficulties navigating the Canadian health system [5]. While the IFHP does cover mental health services, allied health professionals that are designated to deliver these services are often not equipped with the tools and knowledge required to treat patients with cultural competency in a way that users feel safe and valued [6]. Camphinha-Bacote (1999), explains cultural competency as practitioners making the effort to "understand and appreciate differences in health beliefs and behaviours, recognise and respect variations that occur within cultural groups, and are able to adjust their practice to provide effective interventions for people from various cultures" [7]. In order to improve use of services, it is important to further identify the social and structural factors that influence Canadian refugee women's use [or lack thereof] of mental health care services [8]. Doing so will advance knowledge on the subject and will aid in informing policies that employ best settlement practices regarding mental health to address these factors as they pertain to service-use implications [5].

Bearing this in mind, the aim of this review was to identify and explain the social and structural factors that exist Canada's society that influence their service-use and service-seeking habits. Further, we strive to create a pointed understanding of various social and structural aspects that affect refugee women's use and non-use of mental health care services for purposes of mental well-being of refugee women. This understanding will come from both academic authors' discussions within peer-reviewed research but importantly, from a secondary analysis of personal reports from women within the data presented in existing peer-reviewed literature.

METHODS

Study design

A narrative review design was chosen for this study in order to explore the question pertaining to refugee mental health, as a platform for discussion and further insights. However, in order to address the typical limitation of narrative reviews due to inclusion criteria bias, inclusion criteria and a detailed overview of the process of analysis were established.

The study's framework

Ferrari's framework was used for this review, which outlines four main sections [10]. The introduction includes the rationale as well as a description of our objective, limits, and scope [10]. The second section includes the search strategy (databases). We have extended this section, as noted, to provide the inclusion criteria. Unique to Ferrari's approach

in Narrative Reviews is the central discussion section. Also unique is the fact that she states that "the assumptions and the planning are not often known. Selection and evaluation biases not known and results are not designed to be reproducible [10]." She notes that the discussion and evaluation of previous research should be presented and summarized in relation to the research question – in our case; identify the social and structural factors affecting mental health service use. This involves analysing existing data presented in peer-reviewed literature in light of the proposed research question [10]. This approach differs to a scoping review, for example, in that the researcher not only synthesizes the main arguments present in reviewed paper but interrogates the data within the literature to identify how they help to answer the existing research question. Consequently, data presented in the existing review were organized by themes that emerged in various papers. Research studies that have overlapping themes were talked about in complementary terms, as well as directly compared in order to unpack the nuances of various authors' opinions and findings in light of our research question. The final section, according to Ferrari, is to highlight the main points of this review, use the research to establish future research directions, and explains how the review as achieved the research objective [10].

Search strategy and inclusion criteria

Following the 'Preferred Reporting Items for Systematic reviews and Meta-Analyses' (PRISMA) guidelines, three databases were used to gather all articles for this review. Initially, 430 articles were found in PubMed/Medline, ProQuest, and Scopus. RefWorks was used to organize all articles and remove duplicates. After duplication removal and title-screening, 69 articles remained. Following title screenings, full articles were screened leaving 24 articles to be included in the review (see Figure 1). Both title screenings and full screenings were conducted based on basic inclusion and exclusion criteria. Following the narrative review protocol as outlined by Ferrari, inclusion and exclusion criterion were identified and further developed through an iterative process as literature revealed thematic patterns [10]. The electronic search strategy used keywords related to the topic under investigation properly combined by Boolean operators. Existing research findings lent themselves to the following themes presented: refugee status, discrimination and stigma, previous health experiences, the social experience of gender, culture as a moderator to care-seeking behaviours, culturally appropriate social support and health care, policy used to mediate the power divide between patients and physicians, and mitigating power imbalances. It is important to note that these themes are not mutually exclusive; rather, they work together to create use patterns and need-expression (seeking help for health care service). Further, these themes are central to understanding how refugees actually report feeling when seeking mental health services. The narratives they provide are important for understanding and answering the proposed research question. Identifying themes in relation to refugee experiences helps identify the social and structural factors that influence their mental health service use.

Inclusion criteria were:
- Female-specific discourse
- Canadian-based studies (in English) from 2000 to 2017
- Experiential accounts of refugees living in Canada
- Self-reported accounts of physical, social, and mental well-being
- Peer-reviewed journal articles
- Qualitative and Quantitative studies

RESULTS AND DISCUSSION

Refugee status

There are various classes of refugees whose use and access to healthcare is dependent upon on their refugee class status [11, 12]. Conventional or sponsored refugees refer to those who have been sponsored by the Canadian government or by a private group before their actual arrival – these individuals have been living in
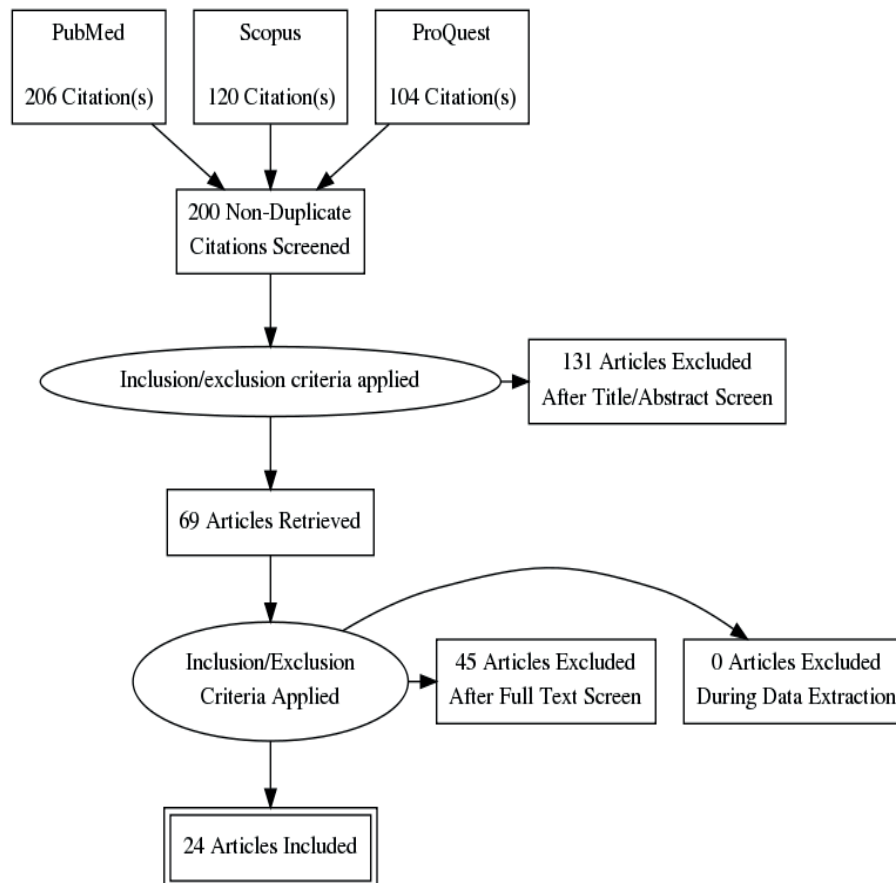
Figure 1. Article selection algorithm (PRISMA 2009).

refugee camps for any period of time [11, 12]. Refugee claimants or asylum seekers include those who flee their home countries because of fear of persecution or other volatile circumstances and arrive in Canada before they have received refugee status [11, 12]. These refugee claimants can live relatively freely in a community as long as they possess sufficient identification documents; any inadequacies of such may require refugee claimants to await approval their status in detention [11, 12]. It is important to understand different classes of refugees because the way in which the system defines them can influence their use of mental health care services.

Discrimination and stigma

The experience of discrimination and stigma felt by women influences their service-seeking behaviours differently than that of men. According to Merriam-Webster, discrimination refers to the unjust or prejudicial treatment of different categories of people or things, especially on the grounds of race, age, or sex, whereas stigma refers to a mark of disgrace associated with a particular circumstance, quality, or person. Multiple articles noted that discrimination affects women differently than men, where women are actually less affected [13]. However, various forms of discrimination exist for men and women [13]. Therefore, directly comparing mental health rates between men and women is inappropriate. Discrimination exists specific to women when considering refugee women's health interactions in addition to the discrimination faced based on their education, career or jobs, and their home country's economic and political standing [14–17]. Additionally, women explained that discrimination existed in layers, where emotional discrimination and gender-role discrimination caused them

the most mental distress. Due to this, mental health service need-expression was stated to be withheld for fear of further discrimination and stigmatization [16–18]. As a result, understanding that discrimination and stigma is experienced differently by men and women is helpful in understanding their need-expression and service-seeking behaviour. The literature identifies both ethnicity-driven and refugee type-driven discrimination. Specifically, service use patterns are typically analyzed with respect to ethnicity rather than immigration status [18]. Ethnicity is defined as a social construct that is separate from race. Race in health research "consists of personal identity and group identity facets as well as the more familiar biological indicators. Ethnicity, in contrast, is most commonly used as an entirely social–political construct, referring to the sharing of a common culture, including shared origin, shared psychological characteristics and attitudes, shared language, religion, and cultural traditions" [19]. Thus, ethnicity is another term that idealizes cultural identification, which can change over time depending the place one lives, languages they speak, and people they interact with. While both ethnicity and immigration are appropriate proxies for understanding service use, they serve different functions. Both variables produce information that is valuable to understanding service use. However, the absence of immigration status-based analyses increases the stigma around the different patterns of service use based on ethnicity [20]. This is important to consider when identifying the social and structural factors that impact service use because the over inflation of ethnicity-based analysis tends to increase stigma around socio-cultural beliefs, therefore preventing use of mental health services.

Self-stigmatization of conditions by refugees also imposes changes in their perceptions of how they and their illnesses will be viewed within the Canadian health system. Literature shows that this is common amongst refugee women with HIV or postpartum depression (PPD) specifically [12, 15–17, 21]. Experts explain that self-stigmatization

is common because women have a general lack of knowledge and treatment options for PPD, they feel uncomfortable revealing their illnesses to those outside of their families and are reluctant to seek treatment for what they perceive as an 'unfixable state of mind' [15]. Women have also been reported as worrying that if they are to reveal their issues to anyone, that they will shame their families for being labelled as mentally ill or risk being separated from their children by authorities. These stresses surrounding seeking mental health care services may perpetuate a decreased state of well-being and increase self-inflicted stigma, therefore further increasing the need for mental health care. As a result, a dichotomous cycle of denial of illness and desire for care exists.

Previous health experiences

Previous health experiences in addition to how they are perceived by both refugees and their surrounding society was found to impact mental health care seeking behaviours in Canada. The previous health experiences of refugees and asylum seekers are argued to play a role in the mental health services individuals seek and identified as important or helpful [20–22]. Seven articles spoke about PPD and HIV/AIDS as previous health experiences [12, 15–17, 21, 23, 24]. HIV positive patients reported that feelings of shame, fear, and stigma often prevented them from seeking HIV care and education services. Additionally, they often created self-stigmas due to society's negative construction and perception of individuals who identify as HIV positive and that if there were more social groups available, that they would not be as afraid to seek help openly [20, 22]. Individuals reported that social groups would decrease their feelings of isolation and discrimination and would help normalize the experience of living with HIV. In a similar respect, women who experienced PPD identified that they felt forced to internalize their feelings, as clinicians were reported to focus on the reaction to PPD instead of the events that led to it – this was argued to make many women feel unhe-

ard and misunderstood [16]. Consequently, many women were said to live with PPD in silence and feel as though modern medicine was not suitable to address their needs. While the physical experiences of PPD and HIV can greatly differ, they are both suggested to involve feelings of shame and internalized stigma, thus preventing individuals from seeking care.

The social experience of gender

The social experience of being a woman was identified as factor influencing service-seeking behaviours. Authors presented the overarching idea that gender can influence care-seeking behaviours by way of perceived gender roles and gender socialization [25]. Gender socialization refers to the process by which individuals learn the social expectations and attitudes that are to be associated with one's sex [25]. Gender socialization of women works by the notion that they are homemakers, caretakers, and that their inability to execute these roles for any reason renders them illegitimate. By this thought process, women may fear seeking mental health care. Other authors however explain that current rebelling against gender socialization exists in the tool of resiliency that some women exhibit [25, 26]. Resiliency means that women are able to bounce back from negative experiences and continue living their lives normally [25]. Specifically, service-use patterns tend to be lower amongst groups of women who shame themselves for needing care and higher amongst women who accept that they need help and actively seek it, when compared to each other [26]. Thus, the experience of being a woman and undergoing the social acceptability of being a woman via adhering to society's 'womanly' roles can influence service-seeking complacency or engagement behaviours.

Culture as a moderator to care-seeking behaviours

The various cultures that refugees identify with can impact how these individuals seek mental health care. Culture is operationalized in two distinct ways in the health world: An essentialist view and a constructionist view [27]. In the essentialist view, culture is seen as stable, and identifies how religion, nationality, and race influence behaviours related to health and disease. In the constructionist view, culture is seen as a social construct which is highly context specific and arises from interactions between individuals [28]. While these two distinct views exist, they are very rarely ever taught in medical education and instead medical school have traditionally focused on alleviating barriers to effective health care [29]. However, literature shows that people face different experiences when coming into Canada seeking refugee status and understanding their rights as refugees [20, 21, 22, 26]. Often these experiences and understandings are influenced by the essentialist view of culture [19, 20]. Some refugees experience family separation or reunification, past traumatic experiences of war and/or domestic violence, and treatment by authorities based on whether they are asylum-seekers or sponsored. In addition, many refugees identify with a non-North American culture, and have minimal knowledge of the English language. These unique experiences or socially constructed circumstances were identified as impacting women's general and mental health and well-being, thus requiring a myriad of services and treatments even though some women were said to be unaware of their necessity [22]. However, due to the moderator of culture, it is inappropriate to assume that lack of knowledge about service availability is the main factor in current service use patterns [20]. Culture acts as a moderator in women refugee's mental health by influencing how enthusiastic a woman may be about using available mental health services as a refugee in Canada. Specifically, South Asian, Southeast Asian, and Caribbean cultures are argued to not accept mental health support for issues that may be seen as fixable or resolved through medicines and treatment [18]. In the aforementioned countries, it is not culturally acceptable to identify as having any mental health problems; if a person does not *look* sick,

then they are considered healthy, thus having no reason to use health care services [20]. These cultural groups were found to not demonstrate appropriate knowledge of help-seeking behaviours for mental health care and have grown up not believing in the legitimacy of modern treatments of mental health illnesses [20]. These various experiences and refugee's opinions on mental health care influence their service-seeking behaviours.

Culturally appropriate social supports and health care as a moderator for service-seeking patterns

Data suggest that the availability of culturally appropriate social supports influence how women seek mental health care services. Various women cited the lack of social support they face when they come to Canada, which can lead to stress and an increased need for mental health services [8]. Further, a lack of social support was viewed as highly effective in promoting service-seeking behaviours of women [24]. Social supports include the use of refugees' mother-tongue languages by professionals and women being able to meet other women that have been through similar situations. Families also play a large role in how women seek care; this lack of social support in the form of decreased family presence was found to affect the motivation women have to seek care, especially when women have children to care for without alternative childcare arrangements [24]. In many cases, social support is seen as an alternative to mental health care because of the cultures that individuals come from – it can help to normalize the pain experienced when there is a variety of trauma and ethnic differences faced by refugees [8]. This sense of cultural appropriateness among the support given and received can actually change the need for formal mental health services, where some individuals feel that they do not need to seek services and others feel safe and confident to admit they need help overcoming mental health discomfort [17]. In culturally appropriate social support, ethnicity is argued to be important as it serves as a proxy for cultural illness views and help-seeking behaviours [20]. For example, ethnicity and culture may come together to propel a person to make the decision to seek traditional healing instead of modern supports, thus impacting their patterns of use. Also, a lack of appropriate translation and interpreter services may push individuals to seek out care that they will be able to understand, commonly associated with traditional healing practices. South Asian women were specifically identified as a group who commonly avoid primary care because they do not want to rely on modern medicine and feel ignored by doctors [20]. By having culturally appropriate social supports available, women may feel that they have options to seek mental healthcare, either through traditional or modern means, or a combination of both.

The data identify that while some women express a desire for social support, others fear the negative consequences it may bring. Some individuals noted that their existing social support networks could be diminished if they were to seek help for their mental health [21]. This stopped them from seeking help in traditional healing and modern therapies. The concept of social capital, tied to the notions of social inclusion, support and cohesion was identified as crucial to thriving in a new country [22]. Understanding the interconnections between ethnicity, culture, and desire for social support is important in gauging and predicting how refugees will adapt to Canadian life and as a result consult traditional and/or modern mental health services [21]. This speaks to the fear of discrimination and stigma as discussed in the former part of this review. This fear revalidates the idea that there is a dichotomous cycle of desire for care, yet an external denial of illness. Both thought processes behind the use of social supports influence how women seek mental health care.

Policy as mediating the power divide between patients and physicians

The relationship between physicians and their refugee patients is critical for service-use in that how a patient perceives their provider shapes their help-seeking behaviour. Data

has identified that some new refugees view physicians as 'godly' figures [30]. This may be related to the fact that physicians working in Canada likely are more knowledgeable about the health system than their refugee patient counterparts are. The fear associated with medical exam scrutiny along with the idea that patients put doctors on a pedestal creates a barrier to patients feeling safe and secure professional relationships with their providers, which can prevent them from seeking care. Canada has responded to this by designing health policies that balance the relationship and put appropriate responsibilities on each party, where providers serve as pseudo kinship proxies [11, 16, 31]. Therefore, the humanistic and professional relationships patients and physicians share have influenced the decisions individuals make about seeking care.

The Interim Federal Health Program (IFHP) lays out insured services for refugees. However, policies limit IFHP eligibility based on refugee status and sponsorship. In addition, refugees fear that by using the IFHP they are more likely to be heavily scrutinized by physicians during their medical exam that allows them safe status in Canada [32]. Negative medical exam results could prevent refugees from being able to stay safely in Canada. When solutions are not focused on immigrant type enough, women can face deeper marginalization, as they are inadvertently left out of consideration for mental health care and forced to try and operate in a system that is not properly equipped to handle their needs. This also limits their ability to self-advocate, thus reinforcing the idea that policies are interpreted in a way that allocates a majority of the power to health care providers, thus influencing use. Further, the introduction of Bill C31 has be argued to have reversed the once positive and welcoming nature of refugees into one that feels the need to 'protect' citizens from all immigrants or non-citizens; this groups various immigration classes together, thereby endangering fair treatment of these individuals [16]. Bill C31 gave the federal government increased control over refugee claimants through powers to deport, delay,

or deny health care [16]. This may go on to negatively affect their health and exacerbate the need for mental health services. Specifically, delayed care, or denial of health care can cause mental health issues to go undiagnosed and untreated for a longer period of time, where new experiences in Canada can congregate and create further stress for refugees trying to adjust to a new way of life.

Policies have also shaped the way that society view mental illness and influences responses to those who need mental health services. For example, increasingly common are instances of postpartum depression (PPD) in new mothers whom are refugees; healthcare professionals tend to take a surface approach to treating it based on patients' depressive characteristics, rather than understanding the actual events that have led to it [16]. Canadian health professionals are not always aware of a refugee's home country experiences or its social, political, and economic culture – this can make it difficult to truly understand a patient's PPD symptoms and how to effectively treat them.

Mitigating power imbalances

Power imbalances created by policies between patients and physicians can be mitigated to allow for better environments in which refugees feel safe to seek care. Brown-Bowers and other authors' work shows that the health care system would benefit from adopting a framework that considers the power imbalances created by politics (policies) and the socio-economic lives of refugee women in order to treat them effectively. By taking this approach, health professionals can move away from the commonly used traditional health psychology that focuses on behavioural changes, which have shown to be somewhat ineffective long term [16]. Behavioural psychology focuses on a mother's past mental state and her general health, thus putting pressure on her to fix herself, rather than understanding how the current health system and her experiences have done a disservice [16]. Making comparisons of a woman's sociopolitical position pre and post migration is more effective in understan-

ding her experience of motherhood and the external factors that influence it. Understanding this experience may prove more helpful in effectively treating cases of mental illness in the population, ultimately increasing the chances of improved service-use rates as refugee women may begin to feel heard and understood.

The limitations of this study

Limited by the literature included in the review, we were only able to capture the perspectives of refugee women from around Asia, Africa, the Middle East, and the Caribbean and recognize that service use and help-seeking will vary in different refugee population groups. While this review identifies a range of social and structural factors that influence mental health care service use, it should not be assumed that these same factors apply to all refugee populations. Rather, these factors warrant fair consideration amongst many others that may exist and provide appropriate evidence to illustrate the themes by which refugee women identify as influential in their care-seeking behaviours. Further, reviewing the accounts and experiences of individuals with the aim of identifying social and structural factors affecting service use provides novel insight from existing data that may aid researchers and policy makers in their understanding of how to mitigate barriers to mental health service use by refugee women.

CONCLUSION

Our objective was to identify and explain the social and structural factors influencing refugee women's use of mental health services in Canada. Existing literature and refugee accounts of mental health services allows us to identify and explain factors that speak to each social and structural aspects of service use. Social factors that influence mental health service use are associated with discrimination and stigma, past health experiences, gender, ethnicity and culture. Our review identified that discrimination from other Canadians and within the refugee, community affects women uniquely, often creating a dichotomy

between internal desire for care and external denial of illness. Discrimination and external stigma can also increase self-imposed stigma, thus impacting need-expression of care. Further, self-perception and provider perception of past health experiences can impact the ways in which mental illnesses are treated, thus influencing service-use. Gender role expectations, gender socialization, and the general social construction of gender lays out the rules of how a 'good' woman should act, thereby implicitly influencing service-seeking behaviours, such as resiliency and how she engages in need-expression. Ethnicity-based analyses of refugee behaviours can increase stigma around sociocultural practices of refugee groups. Last, identifying with non-North American cultures impact behaviours and opinions regarding mental health treatments that will truly work.

Structural factors that influence mental health service use are associated with knowledge of health care refugee definitions, institution practices, and health policies. Specifically, the healthcare services available to a refugee depend on whether she is seeking asylum or if she is sponsored. Thus, permission to use healthcare services impacts service-seeking and need-expression. Canadian health care professionals most often employ traditional psychology to understand a patient's experience of mental health illnesses, instead of using behavioural psychology to understand how a patient arrived at her current mental health state. This institutional practice has been taught during their training and impacts how heard refugee women feel when seeking mental health services; while culturally competent care is becoming more widespread, there is still space in the health realm for health care professionals to engage in cultural competency more through the facets of behavioural psychology to truly understand the needs of women who are refugees. Health policies and programmes, such as IFHP and Bill C31 influence the ways in which power is distributed between patients and physicians and can impact patients' self-advocacy behaviours and use of services.

A culmination of the data shows that interactions between discrimination and stigma, gender, culturally appropriate social support and health care, and distribution of power among patients and doctors and policy's mediating roles, impact service-use in the mental health care arena among the female refugee population in Canada. With the ever-rising rates of refugee women arriving in the country, amalgamated with the knowledge of refugees' experiences, policy makers and researchers may broaden their understanding of the social and structural factors that play a role in refugee women's decisions to seek mental health care services. With regard to clinical practice, this article potentially may increase readers' awareness and understanding of the complexity and clinical implications of refugee women's care needs, and links to health care policy development. Overall, physicians and policy makers become more cognizant of the needs of refugee women, it may be possible to improve physician practices and policies associated with the mental health care required by this population.

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