CANADIAN SRI LANKAN TAMILS: ACCESS TO HEALTHCARE

CHANGES IN EXPERIENCES OF ACCESSING HEALTHCARE: PERSPECTIVES OF SRI LANKAN TAMIL CANADIANS

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ABSTRACT

Background: Currently, there is limited research on the importance and need for access to healthcare amongst refugee and immigrant populations in Canada. Amongst such populations are the Sri Lankan Tamils in Canada, who arrived in Canada as either refugees or immigrants due to the ongoing war in Sri Lanka in the late 1980s. Although Canada is home to the majority of Sri Lankan Tamils, there is minimal research showcasing the need and access to better healthcare for such individuals who have fled from a crisis, the civil war in Sri Lanka. As such, this study aims to assess and understand the experiences of the Canadian Sri Lankan Tamils in accessing healthcare upon their initial arrival to Canada and how these experiences have changed overtime.

Methods: An Interpretative Phenomenological Analysis approach was used to conduct semi-structured interviews in English and Tamil with 8 Sri Lankan Tamil Canadians who arrived in Canada during the late 1980s and are currently between the ages of 55-75 years, residing in the Greater Toronto Areas. Interviews were transcribed and analyzed using the IPA to elicit themes.

Results: The interviews revealed facilitators and challenges to access care within the past and present experiences of Sri Lankan Tamil Canadians. Past experiences revealed facilitators to access care, such as the influences of personal factors, the significance of social support systems and structural facilitators. The impacts of immigration status and acculturation in Canada were identified as barriers to access to care in the past. As for present experiences in accessing care, the degradation of the Canadian healthcare system revealed itself as a barrier to care, whereas settling down as a gradual process came up as a facilitator to accessing healthcare services.

Conclusion: While Sri Lankan Tamil Canadian's perspectives suggested facilitators in accessing care, their experiences still reveal many areas for improvement in the healthcare system for future newcomer populations in Canada. As such, these findings may have implications for

policymakers who focus on refugee and immigrant health and service providers working with these populations.

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LIST OF ABBREVIATIONS

Coronavirus Disease – COVID-19
Greater Toronto Areas – GTA
Hamilton Integrated Research Ethics Board – HiREB
Immigration and Refugee Board of Canada – IRB
Interpretative Phenomenological Analysis – IPA
The Canadian Coalition for Global Health Research – CCGHR
United Nations High Commissioner for Refugees – UNHCR
World Health Organization – WHO

DECLARATION OF ACADEMIC ACHIEVEMENT

This is a statement declaring that I, Meera Karunakaran, have completed this master's thesis research project under the supervision, guidance and contributions of Dr. Lydia Kapiriri, Dr. Amanda Sim, and Dr. Timothy O'Shea.

CHAPTER 1: INTRODUCTION

1.1 Purpose of the Study

Before the onset of the Sri Lankan civil war in 1983, the Sri Lankan Tamil population in Canada was low (Sriskandarajah, 2010). However, with increasing dangers associated with the genocide in Sri Lanka and the diversification of the Canadian refugee and immigration policies in the 1980s, there was an increase in Tamil refugees and immigrants in Canada (Vaitheespara, 1999). Since then, Canada has been home to the largest Tamil diaspora, with the majority of the population settling in the Greater Toronto Area (GTA) (Mason et al., 2008). Due to the distinctiveness of the Tamil people with their pre-exposure to the trauma experienced during the civil war, primary healthcare services are more than crucial in providing resourceful services (Rummens et al., 2013). For individuals fleeing and finding refuge in a country like Canada, the provision of healthcare, needs to be more cognizant and aware of the socio-political realm of these individuals (Beiser et al., 2015). For instance, the Tamil population in Canada has been shown to have a PTSD rate of 17%, which is around 6% higher than the national average of 9% (Beiser et al., 2015). With this being overlooked by many healthcare professionals, many of the immigrant and refugee population, including the Tamils in countries such as Canada, continue to suffer in silence and are still in constant distress (Tamil Guardian, 2020; Beiser et al., 2015). Overall, although there is a plethora of research on multiculturalism in today's current age, many of these services still do not address the health determinants associated with the well-being of populations like the Tamil community (Kanagaratnam et al., 2021).

The purpose of this study is, therefore, to explore the following research question:

How have the experiences of accessing healthcare changed for the Canadian Sri Lankan Tamil population since their initial arrival to Canada?

This study will examine the healthcare barriers faced by the Tamil population who had arrived in Canada due to the onset of the civil war in Sri Lanka in the 1980s. This population group would consist of Tamils who had come to Canada as refugees or immigrants. Provided that many years have passed since the initial arrival of Tamils in Canada, current Tamil residents may have very different experiences with the healthcare system today. Therefore, this study hopes to retrospectively look at resettlement experiences and prospectively look at present-day experiences in accessing care. Studies have identified many intrinsic and extrinsic barriers to accessing healthcare for the Tamil communities in Canada (Beiser et al., 2003). However, further identifying these challenges would probe the need for better access to healthcare resources for visible minority groups such as the Tamils in a multicultural vicinity like the GTA. Additionally, by speaking with Tamil Canadians about their healthcare experiences over time, this study aims to identify barriers or facilitators to access healthcare during individuals' initial arrival to Canada and whether such obstacles or facilitators still exist within the present-day healthcare experiences. This knowledge could be used to improve healthcare access for the Sri Lankan Tamil Canadians and other newcomer populations by understanding the gaps in the healthcare system that are yet to be changed to provide the utmost appropriate care for such marginalized people.

1.2 Refugee and Immigrant Access to Health

There are approximately 1 billion migrants globally, about 1 in 8 of the global population. This population consists of an estimated 281 million international migrants and 82.4 million who are forcibly displaced (WHO, 2022). According to the Canadian Council for Refugees (2010), a refugee is a person who is forced to flee their home country due to the fear of

persecution. An immigrant is defined as an individual who has settled permanently in another country. Immigrants, however, choose to move to a different country for personal desires. A migrant is defined as someone outside their country of origin. It is a term used to describe individuals outside their country of birth who are constantly on the move or people with temporary or no status in the country they live in. Lastly, the term newcomer is an umbrella term to define various categories of immigrants and is defined as an immigrant or refugee who has been in a country they have moved to for a short period, usually less than five years (Canadian Council for Refugees, 2010).

Access to healthcare for migrant populations such as refugees and immigrants is often overlooked despite its pivotal need. There has been increasing evidence showcased by institutions such as the WHO regarding the numerous inequalities refugees and immigrants face when accessing care in a new host country (WHO, 2010). The global scale of human displacement creates migrant health into a global priority and a global public health issue. This translates into the need to improve the models of health care practices in developed countries sought by migrants to better their health outcomes (WHO, 2008). Access to health care is a crucial determinant in the positive well-being of refugees and immigrants in a new environment as they remain the most vulnerable community members. Access to exceptional care for refugees and immigrants is a fundamental human right that needs to be satisfied by all host countries which must prioritize the provision of migrant-sensitive care such as affordable and non-discriminatory access to healthcare through the promotion of migrant catered health policies within their organizational institutions (WHO, 2022). Currently, the structures of global healthcare systems have been designed and developed with the needs of the majority population in mind while neglecting the needs of minority populations such as refugees and immigrants.

Improvements and changes to such flaws in the healthcare system should be implemented by identifying the barriers faced while accessing care, voiced by those affected the most (WHO, 2010).

Several studies have identified the barriers faced by migrant populations in their attempt to access care. Amongst such obstacles, the most notable ones reported included linguistic barriers, a lack of information readily available to navigate healthcare services, and an overall lack of representation and sensitivity towards the needs of refugee and immigrant populations (Kalich et al., 2015). Furthermore, many studies have showcased that migrant populations in a new host country often underutilize healthcare services in comparison to the current residents of their host country. Factors such as social, cultural, religious, linguistic, geographic, economic, and systemic discrimination presented as barriers to newcomer populations attempting to access care in a new environment (Fuller-Thomson et al., 2011; Kennedy et al., 2014; Whitley et al., 2006).

Refugees and immigrants are searching for a new life in their host country due to negative experiences in their previous communities, whether it was due to war, conflicts, natural disasters, environmental issues, or even economic crises (WHO, 2022). As a cause of such factors, refugees and immigrants endure both physical and mental stress from re-starting their lives in a new country, which leaves them vulnerable and susceptible to increased health problems (Kirmayer et al., 2010). Although such populations have a higher need for proper access to healthcare services, research suggests that understanding these minority populations' needs and experiences regarding their access to care is pivotal in improving their health (Campbell et al., 2014). The healthy well-being of migrant populations in a new host country cannot be achieved nor enhanced by the existence of exceptional healthcare services in a

country. The healthy well-being of such individuals must be closely related to their social determinants of health, which includes better access to healthcare as per their needs (UNHCR, 2011).

1.3 Refugee and Immigrant Access to Health Services in Canada

According to the 1984 Healthcare Act of Canada, all immigrants, regardless of their status, should have equal and adequate access to healthcare (Hogg, 2007). Despite this, refugees and immigrants still face many barriers in their attempts to access care in Canada (Ahmed et al., 2015). Studies have identified five themes of obstacles that have restricted or prohibited access to care for Canadian migrants. These barriers included cultural and communication hindrances, socio-economic status, structural factors, and a lack of knowledge. Amongst these barriers, the most pivotal barriers to care were cultural and communication barriers. Although Canada takes pride in its multiculturalism, it was shown that there was a lack of culturally competent healthcare providers who are required to understand the nuances and diversity of individuals with complex backgrounds (Ahmed et al., 2015). This form of culturally competent care is necessary for the Canadian healthcare system due to the Canadian mosaic of diversity (Ahmed et al., 2015).

Furthermore, communication was identified as another significant barrier due to a refugee or immigrant's lack of understanding of English. It was showcased that there was a lack of translators or language-friendly resources available to such populations to better their access to care (Ahmed et al., 2015). In addition to cultural and communication barriers faced by refugees and immigrants in accessing care, studies have also shown the importance of socio-demographic factors and their impacts on access to care for migrants. Socio-demographic factors such as

cultural differences, racial discrimination, or unknown previous medical histories have inadvertently led to health inequity and worsening health statuses of refugees and immigrants in Canada (Chowdhury, 2020).

As for Canada, a lack of readily available resources and information regarding the health care system has also contributed to a barrier for refugees and immigrants. Through a scoping review done by a research team, it was found that given the complex nature of the Canadian healthcare system, migrant populations struggled to navigate this new system in a new country. This complexity associated with navigating the healthcare system was further perpetuated by the lack of knowledge regarding language and cultural customs in a new environment (Kalich et al., 2015). One study specifically found that immigrants and refugees with more social support, such as older adult relatives in Canada, could navigate through the healthcare system with the assistance of these individuals. In contrast, migrants with a lack of support systems felt more isolated and lost in the healthcare system (Hyman et al., 2012). Another study looking at the effect length of residency plays on the barriers faced by migrants in Canada established that with increased residence, migrants could make more connections and thus access necessary information about healthcare resources through social support (Ahmad et al., 2013).

Moreover, studies have also reported on refugees' and immigrants' expectations for healthcare in Canada being unmet due to barriers to access to care. Provided that many refugees and immigrants in Canada came from countries that provided a certain level of access to healthcare, their expectations for care in Canada were high. Nevertheless, migrants often found it challenging to access care in Canada, and once they successfully accessed care, they were disappointed with the services provided. Not only did migrants experience disappointment with the lack of access to health care services in Canada, but they also felt distraught and struggled to

accept and accommodate the extended periods of wait time at health care facilities. Although refugees and immigrants had coverage to a certain level regarding health care privileges, certain aspects of care, such as dental care, were not covered and came with high costs, if required. Refugees and immigrants with low incomes could not meet the financial demands of care that was not covered by their health care insurance (Woodgate et al., 2017).

Overall, a common theme found amongst all studies analyzed above was the recommendation to use evidence-based practices when providing services to vulnerable individuals such as immigrants and refugees, improving their access to the health care they require. Additionally, recommendations were provided for promoting more equity awareness for healthcare access within Canadian healthcare institutions. Lastly, several studies addressed the lack of research on the needs and wants of immigrant and refugee health care access in Canada. This would provide room for culturally appropriate practices, programs, and policies to support migrants from diverse cultures in Canada (Ahmad et al., 2013; Hyman et al., 2012; Kalich et al., 2015; Woodgate et al., 2017).

1.4 History of Refugees and Immigrants in Canada

Canada's role in providing refuge to migrants can be traced back to 1950 (UNHCR, 2020). Since then, according to the UNHCR, Canada has welcomed approximately 1,088,015 newcomers (UNHCR, 2022). Over the years, Canada's laws and legislation regarding migration have changed in many facets. Canadians describe their identity as multiculturally unique and inclusive towards accepting individuals such as immigrants and refugees (Lawson, 2015). Canada has been portrayed as a model for many other countries worldwide for its contributions

and dedication as a safe haven for many vulnerable refugees and immigrants worldwide (Government of Canada, 2019).

1.4.1 History of Refugees in Canada

As for refugees, in 1951, the UNHCR established a Refugee Convention, which was an international agreement that defined who a refugee was, alongside a set of protocols outlining the connection between a refugee and their host country. Subsequently, in 1967 the UNCHR established a protocol alongside the 1951 convention to act as a safeguard for refugee protection and any required refugee provisions (UNHCR, 2011). Currently, the 1951 Convention and 1967 Protocol are the only instruments that exist globally covering the safety of a refugee's life in their host country.

In 1969, Canada showcased its role in providing a home for refugees by signing the 1951 Refugee Convention and 1967 Protocol for refugees (Liston & Carens, 2008). Adapting the definition created by UNHCR in determining refugee status, Canada recognized refugees with the provision of permanent residency upon arrival. Following Canada's acceptance of the UNHCR Refugee Convention and Protocol, in 1985, a Federal Court decision (Singh v. Minister of Employment and Immigration. 1 SCR 177) created a system named a "refugee determination system," which allowed refugee claimants to present their cases for residency in Canada to government. Since then, Canada has accepted a significant number of refugees, with Canada placing in the second and third highest destination countries hosting refugees in 2008 and 2009. This place, however, dropped significantly in 2013 following the introduction of several restricting refugee policies because of reforms including the introduction of visa requirements for individuals from certain nationalities (Antonipillai et al., 2016; UNHCR, 2014). Following these changes, Canada's refugee policies have endured a high amount of turbulence through which

many reforms were made on both a positive and negative scale, which still require a tremendous amount of work and investigation in the future (Antonipillai et al., 2020).

1.4.2 History of Immigrants in Canada

Immigration policies in Canada looked quite different before the 1970s. However, with an increasing influx of migrant populations in Canada, during the 1970s, Canada adopted a modified version of its immigration policies, which had not been changed since 1962 (Government of Canada, 2020). The pressure to bring forth this change with the past Immigration Act was associated with the lack of receptivity towards valuing the race and ethnicity of incoming migrants (Daniel, 2009). In 1976, the finalized version of the Immigration Act was passed with solid support amongst non-governmental organizations and ethnic, religious, and community organizations.

In 1980, Canada further broadened the facets of the Immigration Act due to increased economic recession and an increased number of asylum seekers. The Act was modified by identifying three main categories for newcomers: family class immigrants, refugees, and economic class immigrants, which consisted of business immigrants and skilled workers (Segal et al., 2010). In the following twenty years, in 2001, Canada curated its new Immigration and Refugee Protection Act, which took over the place of the 1976 Immigration Act and was put into place in 2002 by the liberal government (Immigration and Refugee Board of Canada, 2002). This Act provides the IRB of Canada to investigate the cases of immigration and refugee matters through principles and regulations set forth by Canada's migration plans and objectives. Since 2002, the Immigration and Refugee Protection Act has undergone numerous amendments to account for the evolving migration patterns within Canada (Jantzi, 2015).

1.4.3 Current Refugee and Immigrant Population in Canada

According to current statistics, three-quarters of the Canadian population consists of immigrants and refugees from many different parts of the world. In 2021, 184 606 permanent residents were welcomed in Canada, 906,119 travel documents were issued, and 51,011 individuals transitioned from temporary to permanent residents (Government of Canada, 2021). Statistics Canada has indicated that immigration will be essential to the growth of Canada in the next 20 years (Statistics Canada, 2017). Currently, four in ten people in Canada are immigrants or children of immigrants (Statistics Canada, 2017).

1.5 Refugee and Immigrant Resettlement Processes in Canada

All migrants are allowed to settle anywhere in Canada within the three main categories of immigration types in Canada. However, resettlement processes and nuances within them are more constrained and complicated for refugees rather than economic and family class immigrants (Haan et al., 2017). Economic and family class immigrants generally reside in larger cities such as Toronto, Montreal, and Vancouver, where many opportunities exist for jobs, education, and family reunion-related endeavors. On the other hand, refugees, more specifically, government-assisted refugees brought into Canada through the federal government, tend to resettle where the Resettlement Assistant Program is provided (Kaida et al., 2020). These refugees are also covered for any required health services for a year through the Interim Federal Health Program (Kaida et al., 2020). Privately sponsored refugees settle in communities where their sponsors are located, as these sponsors are responsible for assisting the refugees they have sponsored (Kaida et al., 2020).

While evaluating the resettlement processes for immigrant populations in a host country it is also important to assess a migrant's pre-migration journey. Economic class immigrants, for instance, generally have higher education and labor skills alongside increased linguistic abilities, which may be helpful during their resettlement processes in Canada. Family class immigrants typically have lower language and educational skills than economic class immigrants, thus impacting their resettlement experiences as their migration is not solely motivated for financial success. Lastly, refugees are forced to leave their home countries due to unfortunate circumstances. Their language and educational skills are generally the lowest among the other class of immigrants, hence negatively impacting their resettlement experiences (Kritz & Gurak, 2018; van Huystee & Jean, 2014). Studies have portrayed that refugees, in comparison to immigrants, regardless of class, encompass lower educational credentials (Neufield, 2018). Due to such differences, the resettlement experiences of refugees and immigrants may vastly vary. However, current services and resources available to such populations are often homogenized and do not meet the specific resettlement needs of unique individuals. Hence these resources may not be adequate to respond to a migrant's needs (Senthanar et al., 2020).

Moreover, Canada's migrant population comprises approximately 7 million visible minority migrants. This number is also expected to rise to 33% in the upcoming years (Statistics Canada, 2017). Given that visible minority migrant families have a diverse range of cultural, racial, or social backgrounds, such minorities often struggle to resettle within their communities successfully. By identifying the individualistic needs of such visible minorities in migrant populations through the perspectives of resettlement workers and other vital stakeholders, the overall resettlement experiences of these individuals could be improved (Agyekum et al., 2020).

1.6 Historical, Social, and Political Context of the Sri Lankan Tamil Diaspora

Much of the Sri Lankan Tamil diaspora stems from the population of Tamils who forcibly migrated from their homeland of the northern and eastern provinces of Sri Lanka, formerly known as Ceylon (Sriskandarajah, 2005). The definition of diaspora used within the Sri Lankan Tamil context is defined as a formation caused by voluntary or forced migration of members from similar origins, with lasting ties of members from a real or imagined homeland (Kleist, 2008). The result of the movement of the Sri Lankan Tamil diaspora was due to the prolonged last civil warfare in Sri Lanka, which occurred between 1983-2009. This civil warfare resulted from the social, ethnic, and political tensions amongst the majority, Sinhalese, and minority Tamils within Sri Lanka. While they resided in the Northeastern province of Sri Lanka, Tamils identified themselves as a distinct community (Sriskandarajah, 2005).

After gaining complete independence from Britain in 1948, ethnic conflicts began to increase between the minority Tamils and the majority Sinhalese. After independence the Sinhalese population grew not only in their size but in their power as they moved to work with the higher parts of the Sri Lankan government. With such positions and newly gained power, the Sinhalese created the Sinhala Only Act in 1956. This bill made Sinhala the only official language in Sri Lanka, creating many barriers for the minority Tamil population, essentially repressing, and undermining the Tamil culture and its community. An additional layer of this bill resulted in the standardization of educational opportunities in Sri Lanka. This standardization further disadvantaged the Tamil community, whereas, in contrast, it provided increased opportunities for disadvantaged Sinhalese students. The Tamil's opportunities from many ends were tied and locked not only as a cause of the Sinhala Only Act but due to the additional layer of standardization in the educational system (Anandakugan, 2021).

Left nowhere to turn, Tamils responded to this discrimination with the motivation and desire to create "Tamil Eelam," which would have become a separate state for Tamils in Sri Lanka. Although Tamils themselves had mixed reactions to the formation of Tamil Eelam, the Liberation Tigers of Tamil Eelam became the only prevailing representative of Tamils in Sri Lanka and thus the only military threat to Sri Lanka. This further escalated the tensions between the Sinhalese and Tamils, as the Sinhalese resisted the resiliency of the Tamils' fight for their rights, which resulted in the beginning of the civil war in July of 1983.

Severe violent events took place with the start of this civil warfare between 1983 and 2009. With the advent of this war, the Tamils lost the hope of establishing their own Tamil Eelam, a place to call home, and feared for the security of their lives as the Sinhalese military became colder. In the first two decades of the civil war, over 30,000 Tamil lives were lost within Sri Lanka, where the Sinhalese military groups grew more intense (Anandakugan, 2021; Sriskandarajah, 2005).

Fearing their livelihoods, several Tamils forcibly migrated to many different places, such as India, Europe, Australia, and North America (Sriskandarajah, 2010). This massive movement is where the Sri Lankan Tamil diaspora was formed. The total number of the Sri Lankan Tamil diaspora is estimated to be 800,000, despite the population count of Sri Lanka, which is 3.5 million (Sriskandarajah, 2005). However, it is also estimated that this number is higher as many Tamils are still undocumented in host countries with the support of relatives (Cheran, 2001). According to statistics produced by the UNHCR, between 1980 and 1999, 256 307 Sri Lanka Tamils claimed asylum in Europe as one of the top ten groups of asylum claimants at this time (UNHCR, 2001). Alongside asylum claimants, Tamils also migrated in many different classes, including economic, family sponsorship, private sponsorship, and government-sponsored

refugees. Within the last 1980s, around 250,000 Tamils settled in Canada, 150,000 in India, 110,000 in the United Kingdom, 110,000 in Europe, and 30,000 in Australia (Canagarajah, 2008).

1.7 The Sri Lankan Tamil Diaspora in Canada

Before the onset of the Sri Lankan civil war in 1983, the Sri Lankan Tamil population in Canada was low (Sriskandarajah, 2010). However, with increasing dangers associated with the genocide in Sri Lanka and the diversification of the Canadian refugee and immigration policies in the 1980s, there was an increase in Tamil refugees and immigrants in Canada (Vaitheespara, 1999). Since the 1980s, Sri Lankan Tamils have come to Canada in multiple waves, with an increased influx of Tamils in Canada in the late 1980s (Aruliah, 1994; Hyndman, 2003). By 2000, Sri Lanka took sixth place in bringing the most significant number of immigrants to Canada, in which Tamils took about 2.57% of the Canadian immigrant population (Statistics Canada, 2017).

Sri Lankan Tamils that migrated since the beginning of the civil war in 1983 carried a heavy sense of ties in community relations and social support. This led the Tamil diaspora to establish strong cultural and social networks, which aided the community's resettlement processes (Aiken & Cheran, 2005). Currently, the Sri Lankan Tamil diaspora is estimated at 200,000 (Cheran, 2007, p.160). Evidence of the emphasis placed on community relations can be shown through the many networks Tamils have created for themselves here in Canada. More than two dozen community newspapers, radio stations, TV stations, and Tamil community organizations are primarily based in Toronto, Montreal, and Vancouver. Additionally, over 300 Tamil Village Associations and organizations have been pivotal for Tamil Canadians to re-

establish their identities in their new homes (Aiken & Cheran, 2005). The power of the Tamil community in Canada has been praised by scholars who have stated that the Sri Lankan Tamil diaspora has been one of the most advanced communities worldwide, aided by multiculturalism's power in Canada (Sriskandarajah, 2010; Zunzer, 2004). Tamil-owned businesses developed considerably among the Sri Lankan Tamils in the GTA, home to the most significant number of Sri Lankan Tamil Canadians. Tamil youth are well represented in higher education systems in Canada, and Tamil organizations thrive in well-equipped areas, assisting Tamils in the area (George, 2011). Despite being praised as being one of the most advanced diaspora communities, Tamils still feel the burden of feeling like they are never at home. As Burgio (2016) states, Tamils belong to a "diaspora that is deprived of a homeland: a stateless diaspora."

1.8 Access to Healthcare for the Sri Lankan Tamil Diaspora

Canada has been home to the largest Tamil diaspora, with the majority of the population settling in the GTA (Mason et al., 2008). Due to the distinctiveness of the Tamil population with their pre-exposure to the trauma experienced during the civil war, primary healthcare services are more than crucial in providing resourceful services (Rummens et al., 2013). For individuals fleeing and finding refuge in a country like Canada, the provision of healthcare needs to be more cognizant and aware of the socio-political realm of these individuals (Beiser et al., 2015). For instance, the Tamil population in Canada has been shown to have a PTSD rate of 17%, which is around 6% higher than the national average of 9% (Beiser et al., 2015). With this being overlooked by many healthcare professionals, many of the marginalized populations, including the Tamils in countries such as Canada, continue to suffer in silence and are still in constant distress (Tamil Guardian, 2020; Beiser et al., 2015). Overall, although there is a plethora of

research on multiculturalism in today's current age, many of these services still do not address the health determinants associated with the well-being of populations like the Tamil community (Kanagaratnam et al., 2021).

The pressures associated with having a positive and healthy well-being for refugees and immigrants such as the Tamils in Canada are not associated just with finding their way to a new host country. Within the pre-migration journey of Tamils migrating from Sri Lanka, Tamils generally resided within war zone areas where they had a lack of access to food, water, shelter, access to medical care, all while enduring physical, mental, and even sexual assault in certain situations (Somasundaram, 2007). Such traumatic experiences in a Tamil migrant's pre-migration journey are further exacerbated by a lack of services and difficulties adapting to a new environment in their host country, impacting their post-migration phases (Somasundaram 2007; Weaver, 2005). When refugees and immigrants such as the Tamils attempt to access healthcare in their host countries, they are faced with service providers who lack the knowledge of such individuals' pre-migration journey, which encompasses historical, social, cultural, and political factors (George & Jettner, 2014).

In a qualitative study on 12 Tamil participants residing in Melbourne, Australia, researchers elicited the barriers faced by unwell Tamils attempting to access care. Participants stated they often felt too dependent on the free resources provided by the system, which deterred the quality of care they had received. For instance, Australian Tamils generally sought care through public Australian healthcare centers due to personal financial constraints. As a result of accessing such services, participants reported increased frustrations with the provision of their services due to the long wait times and lack of sensitivity shown towards the participant's traumatic history. Overall, the study emphasized improvements in the responsiveness of

healthcare systems providing care to migrant populations. An excellent recommendation was the request for primary health care services catering to Sri Lankan Tamils to find operational linkages within surrounding Tamil communities to organizations that adequately address migrants' needs (George & Jettner, 2014).

Next, a study on 51 members of the Sri Lankan Tamil diaspora community in the GTA addressed the health outcomes of Tamils from a war-torn country. Through the results of this study, researchers concluded that mental health services accessed by Tamils in the GTA did not turn about to be culturally relevant or sufficient, thus increasing the distress faced by Tamils. For example, symptoms presented by Tamils concerning their mental health did not fit into the typical fixed psychiatric classification system. The study recommended the need for more research to understand the effects of trauma on Tamil's health and how this may impact their access to care. It recommended more evidence-based practices and policies informed by the community members (Kanagaratnam et al., 2020).

In general, apart from the large-scale studies done on diaspora communities and their barriers to health care, there is still very little firsthand knowledge of the barriers to care faced by the Sri Lankan Tamil diaspora. With the lasting effects of a civil war on these community members in the past two decades, several experiences may be left unheard of regarding barriers or facilitators to access care in Canada. There needs to be more research that includes the voices of the community members themselves to understand their experiences with access to care in Canada and how such services could be improved for ethnic minorities such as the Tamil Canadians. Although the ideas and assumptions of healthcare barriers faced by the Tamil refugees and immigrants in research are pretty frequent in the academic realm, there is still a

dearth of studies focusing on individuals with actual lived experience in this field (Kanagaratnam et al., 2020).

1.8.1 Implications of this work in Global Health

This research is crucial in a Global Health context while correlating it with the Canadian Coalition for Global Health Research's (CCGHR) principle of the need for inclusion to promote the involvement of visibly marginalized communities such as the Tamil population (Forman et al., 2015). This research seeks the diverse and lived experiences of the Tamil migrant community themselves by creating an opportunity for the voices of these marginalized communities to be heard (Nieswiadomy, 2012). Additionally, when we often hear of Global Health research, the first item that comes to mind is research conducted in different countries worldwide. However, Global Health can also be local while trying to understand and overcome gaps in the health of our community around us, such as the barriers faced by the Tamil population in accessing primary healthcare services here in the GTA.

This thesis encompasses four chapters. This first chapter, Chapter One, serves as an introductory piece for this thesis. Following this, Chapter Two will outline the research study's methodology. Next, Chapter Three will share the findings of this research, which will then be followed by Chapter Four which discusses the current results of this research study in connection with previous literature and research, followed by future implications and recommendations for policymakers and service providers and limitations and future directions for the research-based off of the study limitations.

CHAPTER 2: STUDY METHODS

2.1 Study Design

This study uses qualitative research methods informed by an Interpretative Phenomenological Analysis (IPA) approach alongside constructivist perspectives to explore the experiences of Sri Lankan Tamils Canadian's changes in their experiences of accessing healthcare in the GTA.

Research studies informed by a qualitative design aim to understand and interpret phenomena regarding the meanings individuals bring to them. Qualitative research emphasizes learning the meaning that study participants bring to the researcher's research question while analyzing participants' experiences through a holistic viewpoint. This methodology is used when silenced voices need to be heard while empowering individuals to share their stories and de-emphasize any power dynamics between the researchers and participants (Creswell, 2016).

The constructivist approach in this study helped elude the past and present barriers faced by these individuals in search of assistance for their healthy well-being (Nieswiadomy, 2012; Smith & Osborn, 2008). More specifically, this design helped identify the barriers faced by the Tamil population in accessing healthcare resources during their resettlement experiences and whether they still face similar challenges in accessing care today.

Lastly, the IPA is a qualitative research approach used to undertake a two-way dynamic process in understanding participants' experiences. One way is where the participants try to make sense of the world they live in by exploring their personal experiences. In contrast, the researcher, on the other way, tries to make sense of the participant's reality and these experiences through the participant's lens (Smith & Osborn, 2008). This approach that uses both constructivist and interpretivist views was appropriate for this research study as it pays close

attention to the details of an individual's lived experiences, which is pertinent in understanding the perplexities and challenges faced by the Tamil population in accessing healthcare services in the GTA. Although such results may be less generalizable, the use of constructivism and interpretivism in this study design allowed for the generation of more context-specific data through the detailed oriented analysis of how Tamil Canadian's experiences in accessing care have changed over time.

2.2 Philosophical Orientation

This research study's design, due to its qualitative nature, uses a constructivist philosophical orientation to underpin the study's objective. This orientation aims to disseminate knowledge through open dialogues, which enables participants to identify meanings and identities through their own lived experiences (Nieswiadomy, 2012). Additionally, a constructivist approach uses a holistic view in determining the possibility for multiple realities to co-exist in one dimension rather than one true reality. According to constructivism, individuals create their understanding and knowledge of the universe through their lived experiences and interpretations of experiences. Thus, knowledge is subjective to the individual and the multiple realities that exist for these individuals (Robson & McCartan, 2016).

By using a qualitative approach with a constructivist and interpretivist view, this study intends to integrate both these components to showcase that there is no single reality nor right answer, and this reality or answer is subjective to the individual with the lived experience (Kielmann et al., 2012). Thus, by conducting interviews amongst the Tamil population in the GTA, this research aims to identify unique themes of challenges and facilitators in accessing healthcare services through a holistic lens. In this context, what is defined by a holistic lens is by

viewing the Tamil community's experiences in accessing healthcare not from a medical standpoint and instead on a more individualistic and collectivist approach (Kanagaratnam et al., 2020). Moreover, the experiences of refugees and immigrants cannot be defined by a single conceptual model but instead requires the collaboration of the many facets of a refugee's and immigrant's traumatic experiences (George, 2013). These experiences and themes, identified through the lived experiences of Tamil refugees and immigrants, will aid in developing better and diversified healthcare resources.

2.2.1 Philosophical Underpinnings of IPA

Jonathan Smith, in the mid-1990s, crafted the IPA approach as an experimental psychological approach (Smith, 1996). Although IPA is now applied in broader areas of health research, it is increasingly used in areas of clinical and social psychology, making its way to becoming a recognized qualitative approach in research (Smith & Eatough, 2018). IPA's practice is committed to examining how people make sense of their significant life experiences and, more specifically, to understand the lived experiences of research participants expressed by those with the lived experiences themselves (Smith et al., 2009). IPA was hence chosen as the most suitable method for this study to understand the experiences of Sri Lankan Tamil Canadians in accessing health care to highlight any barriers or facilitators such individuals may have faced.

Even though IPA was created to appear as a specific approach to qualitative research, it still contains connections with three theoretical and philosophical pillars, which are phenomenology, hermeneutics, and idiography (Eatough & Smith, 2008; Smith et al., 2009). The first pillar of IPA takes on a phenological perspective which can be defined as an approach to examining other people's – not one's own experiences in which IPA aims to understand others as they relate to and create meanings from their everyday actions and experiences (Smith et al.,

2009). Secondly, another major theoretical underpinning of IPA arises from hermeneutics. Hermeneutics revolves around a theory of interpretation of identifying the deeper meanings of texts that are being explored (Smith et al., 2013). Taking this into consideration, IPA takes on a double hermeneutic process where "the individual participants are trying to make sense of their world while the researcher is also trying to make sense of how individual participants are making sense of their world" (Smith et al., 2009). Lastly, the final pillar of IPA comes from an idiographic element. The idiographic facet of IPA stems from an individualistic, in-depth analysis of cases undertaken to understand participants' individual perspectives in their unique contexts (Pietkiewicz & Smith, 2012). As such, IPA allows a researcher to have a more specific and thorough analysis of a small number of cases of experiences (Smith et al., 2009; Smith & Eatough, 2012).

Therefore, IPA was identified as the most suitable method for this study as it serves the purpose of the study's objective to understand the experiences of individuals in accessing healthcare. IPA represents itself as a valid methodology in this study, as it enables us to provide rich and nuanced insights into the experiences of Sri Lankan Tamils that are yet to be heard. It is also important to note that the researcher in the IPA approach also plays a vital role in their attempt to understand their participants' experiences. As an individual who identifies as a Sri Lankan Tamil Canadian, the participants I interviewed shared deep connections and experiences that resonate with a long-standing history and background with the Tamil diaspora community here in Canada. Often, members of the Tamil diaspora community are generalized to the general migrant populations. Although general migrant populations share several similar characteristics amongst themselves, it is also crucial for researchers to thoroughly explore the experiences of

everyone before making any general claims for groups, which is a clear objective outlined in the IPA approach (Pietkiewicz & Smith, 2012).

2.3 Social Determinants of Health Framework

The framework that will be utilized for this research study is the framework created by the Commission on Social Determinants of Health (CSDH), set up by the World Health Organization in 2010 (see Figure 1 below). This framework summarizes how social determinants affect health and how social, economic, and political mechanisms perpetuate societal socioeconomic positions (Solar & Irwin, 2010). As such, populations are stratified into income, education, occupation, gender, race/ethnicity, and such positions. These positions then shape individuals' social determinants of health status (intermediary determinants) while also considering one's place within social hierarchies (Solar & Irwin, 2010).

According to *Figure 1*, the connection between the context and socioeconomic position generates one's socioeconomic status and access to resources (Solar & Irwin, 2010). With this study's constructivist nature, the research aims to identify how structural mechanisms and socioeconomic positions contribute to reinforcing the social determinants of health inequities (Solar & Irwin, 2010). Through this, the research question of this study aims to explore the barriers faced by the Tamil migrant population, whose access to healthcare services can be impacted by their immigration status as an immigrant or refugee. Additionally, it would explore the impact of social-cultural values on immigrants and refugees and how this may impact their access to healthcare. Therefore, this framework would aid with the study's purpose of bringing awareness to the barriers faced by the Tamil migrant community upon their arrival to Canada

and how the identified gaps could address the need for better healthcare services and resources for such populations.

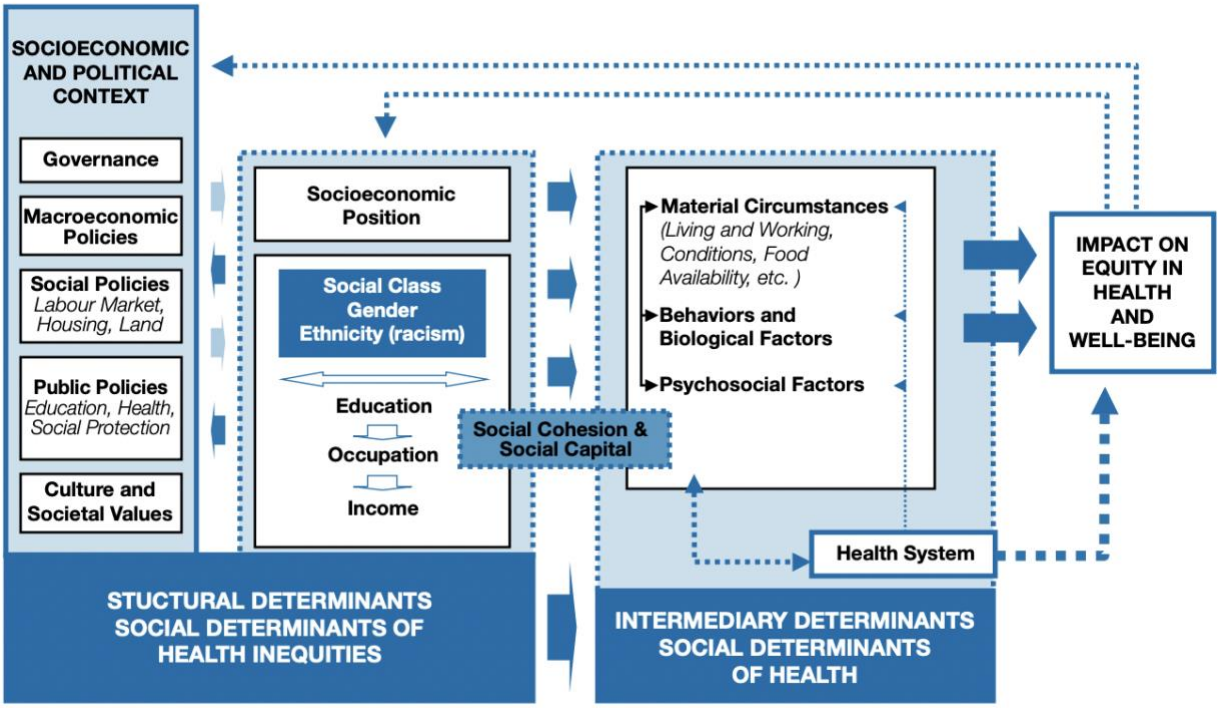

Figure 1. Commission on Social Determinants of Health (CSDH) Conceptual Framework (Solar & Irwin, 2010).

2.4 Development of the Interview Guide

To align with the flexible nature of the IPA approach, data collection instruments such as interviews are required to account for and capture the lived experiences of study participants (Smith et al., 2009). Furthermore, the usual approach taken by research studies using IPA as their foundation requires using semi-structured interviews to account for any needed probing and creating a more conversation-oriented discussion. This provides room for the participant to lead the conversation. The questions in such semi-structured tools should allow room for establishing

rapport with the study participants and allow for more freedom for the researcher to probe any interesting areas that arise within the interview (Smith et al., 2009).

A semi-structured interview guide (Appendix A) was used for this study to answer the research question: *How have the experiences of accessing healthcare changed for Sri Lankan Tamil Canadians?*

The interview guide was based on the study's research question and objectives which aimed to understand the past and present experiences of Sri Lankan Tamil Canadians accessing care in the GTA. Past and present experiences of Sri Lankan Tamil Canadians were assessed through open-ended questions to account for the similarities and differences individuals faced in accessing care upon their initial arrival and how these experiences may have changed in the present day. Additionally, with the help of the advisory committee, the interview guides were developed to avoid any complicated language to account for the participants' language proficiency and to facilitate translation of the interview guide questions into the Tamil language.

2.5 Participants and Recruitment

2.5.1 Study Population

The population of interest for this study includes Sri Lankan Tamils, who arrived in Canada in the late 1980s as refugees or immigrants, aged 55-75 years old, living in the GTA. The rationale for this age group is to capture the most age-appropriate group of the Tamil population who had arrived in Canada during the 1980s.

2.5.2 Study Setting and Recruitment

Sri Lankan Tamil Canadians were recruited from the GTA. According to the 2016 Canadian Census, Tamils comprise Canada's largest South Asian population. Approximately

240,851 individuals claimed to live in Canada, with around 80% in the GTA (Tamil Centre, 2021). As per traditions in Sri Lanka, Tamils heavily emphasize relationships within one's community (Tamil Centre, 2021). These associations have transcended within the heavily populated areas of Tamils in Canada. Not only have these associations within the Tamil communities acted to maintain traditional values, but it has also acted as a form of support (Tamil Centre, 2021). As such, the study setting was focused on participants residing in the GTA.

In terms of recruitment, participants were recruited virtually through the circulation of the study recruitment poster (Appendix B). The study recruitment poster entailed the study's details, including inclusion criteria, a summary of the research objective, compensation, and the student researcher's contact information. This poster was circulated to various Tamil community members and several Tamil community organizations. Tamil community organizations and community members then shared the study poster through their social media platforms, including avenues such as Facebook and Instagram. A snowballing technique was also used among study participants to refer individuals who may be interested in participating in the study.

2.6 Sample Size and Sampling

The sample size and sampling for this study were conducted based on the guidelines provided by the IPA approach. IPA studies are usually based on small sample sizes, as the case-by-case analysis of individual transcripts takes a long time. The study aims to provide more particular perceptions and understandings of individuals rather than group claims (Smith et al., 2009). This relates to the idiographic nature of the IPA, which aims to study a small sample, with

around 5-25 participants, in-depth with the goal of not generalizing study results to represent the general population. Additionally, IPA researchers generally use a homogenous sample through purposive sampling to find a more closely defined and similar group to answer the objective of the research question. Therefore, a total of eight participants were interviewed for this study.

For sampling, the inclusion criteria for participants included arrival in Canada during the late 1980s, between 55-75 years old, and residing in the GTA. The exclusion criteria included those not in the age group and individuals who arrived in Canada after the late 1980s, such as the early 2000s. An attempt was made to recruit an equal number of males and females, alongside an equal number of individuals who came in as refugees and immigrants. However, the final ratio of refugees to immigrants was 7:1. Through the recruitment process, it was identified that during the late 1980s, the majority of the Sri Lankan Tamils came to Canada as refugees. There was an increase of immigrants rather in the late 1990s. As such, there were more refugee participants in this study rather immigrant participants, due to the inclusion criteria being having arrived in Canada during the late 1980s.

Theoretical saturation was reached at seven interviews, where themes regarding barriers and facilitators in access to care were common and repeated amongst the participants. As such, provided IPA studies use smaller sample sizes, the study ended its recruitment with eight participants.

2.7 Study Procedure

The study procedure consisted of completing eight semi-structured interviews, which were conducted through a telephone call or Zoom and were approximately fifty minutes long. For interviews that took place through a phone call, digital recorders were used to audio record

the interview. For interviews that took place through Zoom, the Zoom audio recording feature was used to audio record the interview. Interviews were conducted in both English and Tamil. For interviews that took place in Tamil, these interviews were directly transcribed into Tamil and then translated into English.

Five interviews were conducted over the phone. Three interviews were conducted through Zoom, and one of these interviews was conducted without the participant's video due to comfortability concerns. For this interview, the student researcher's video remained turned on. Lastly, two interviews were conducted in Tamil.

2.8 Data Analysis

Transcripts from the interviews were analyzed using the guidelines created for the IPA as the foundation (Smith et al., 2009). The student researcher analyzed each transcript individually to elicit any emerging themes. This process ultimately led to understanding the Sri Lankan Tamil Canadian's experiences of accessing healthcare in the GTA.

As outlined by Smith et al. (2009), there was a set of six guidelines recommended for IPA research studies which was undertaken for this study. The first step of the data analysis process involved reading and re-reading the transcript, beginning with listening to the audio recording to become more familiar with the individual transcript. Next, the second step consisted of initial noting, where notes and comments were created for the specific transcript being analyzed. Personal observations and comments were also noted regarding content, language, and context. The third step consisted of developing emergent themes based on the data from the specific transcript analyzed. Initial notes made alongside the re-reading of transcripts were transformed into themes throughout the whole transcript. These emerging themes correlated not only with the participant's verbatims but also included the researcher's interpretation. The fourth

step consisted of looking for connections amongst emergent themes. Themes were listed and moved around to form clusters to bring together related themes. This led to the organization of themes hierarchically into either superordinate (major) or subordinate (minor). The fifth step consisted of moving on to the next individual transcript and repeating steps 1-4. This was conducted to analyze each transcript on a more individualistic level, as recommended for small sample cases by Smith et al. (2009). Lastly, the sixth step consisted of looking for patterns across the themes developed from all transcripts to form connections and look for convergence and divergence amongst all cases. This led to the creation of a final table of superordinate themes constructed with its corresponding subordinate themes. As recommended by Smith et al. (2009), themes were not only selected due to their prevalence and frequency within the data, but factors such as the richness of the transcripts that bring forth specific themes to illuminate the experiences being discussed were also considered.

2.9 Ethical Considerations

This study adhered to ethical guidelines of the Hamilton Integrated Research Ethics Board (HiREB) and was reviewed and approved under study project number 14533. The ethics board application consisted of study materials such as the study protocol, timeline, informed consent forms, recruitment posters, interview guides, letters of support, and a post-interview resource list, which adhered to the required ethical standards. All referenced materials can be found below in the appendices.

2.10 Researcher Positionality and Reflexivity

The researcher's positionality and reflexivity are critical components of IPA research studies. My researcher positionality in this research study comes from being able to reflect on my own experiences with the research topic I have chosen to pursue. I am a second-generation Sri Lankan Tamil Canadian and 25 years old. I was raised by two Tamil refugees who forcibly migrated to Canada in the late 1980s due to the ongoing civil war in Sri Lanka. Leaving Sri Lanka with nothing but one suitcase in hand, my parents were desperate for a successful life in Canada, one where they did not have to fear losing their life. They have worked day and night to mold their lives here in Canada beautifully and to be able to provide my sister and I with an endless number of opportunities, something that my parents never dreamt of having in Sri Lanka. I have always been inspired by the amount of dedication and resilience my parents have had. Having landed as refugees in Canada, although it may have had its initial challenges, my parents found themselves to be extremely grateful to pick up their lives and become successful in a country like Canada. As such, I was always curious to see the barriers others from the Tamil diaspora community may have faced during their initial arrival to Canada. I was particularly interested to see how they had navigated the system then and how the gaps in the present healthcare system could work to make such transitions for migrant populations helpful.

With that being said, being born and raised in Scarborough, a place I still call home, I have had the opportunity to participate in many different activities within a wide range of Tamil community centres and organizations. My overwhelming interest in the Tamil traditional values and culture had also propelled me to navigate and collaborate with Tamil populations from other regions in the GTA. Although this provides a way of connecting with participants, this study also allows me to be open to more knowledge I may not have been aware of before. This relationship would also be hopeful in alleviating the power dynamics between the researcher and the

participant. Contrastingly, it is also important to be aware of the conflicts and biases that I may already have due to being immersed in the community of the study population.

To ensure the rigour and validity of my findings in this research study there were two primary strategies that were used. The first strategy that was used to ensure my positionality and reflexivity in this research by talking about my experiences with this specific research topic as mentioned above. The second strategy employed in this study involved the process of "bracketing" or also noted as initial notes in the data analysis section. Within IPA, this is done where the researcher keeps consistent notes on their own biases, preconceptions and or previous experiences to not change the lived experiences of the study participants (Pietkiewicz & Smith, 2012). I had implemented this in the study by maintaining handwritten notes within my transcripts and re-listening to the audio recordings during the analysis process when required.

CHAPTER 3: RESULTS

This chapter is dedicated to showcasing the key findings of this study. This section will start with a description of the study sample, which will then be followed by the superordinate and subordinate themes that were derived from the semi-structured interviews.

3.1 Sample of Participants

The study sample included eight participants with an equal representation of males and females. Participants ages ranged from 55 to 75 years old. All participants arrived in Canada from Sri Lanka between 1985 and 1989. Seven participants came in as refugees, and one participant came in as an immigrant sponsored by family. Currently, all participants are Canadian Citizens and reside in various areas within the GTA. It is important to note that participants were asked about their reason for their departure from Sri Lanka further to understand the background and history of the study participants. All participants stated that they had left Sri Lanka due to the ongoing civil war at the time. They sought refuge in Canada in a desperate need for better lives due to the lack of freedom and rights that the Tamils had in Sri Lanka.

3.2 Key Themes

Seven superordinate themes and fifteen subordinate themes were identified by exploring the past and present experiences of Sri Lankan Tamil Canadians accessing healthcare. These themes were identified using the IPA process as a guide to further explore two main areas of the interviews: past and present experiences with the Canadian healthcare system. Five themes were found within the topic of past experiences in accessing health care: the influence of personal

factors, the significance of social support systems, impacts of immigration status, structural facilitators, and acculturation in Canada. Lastly, two themes were found within the topic of present-day experiences: the degradation of the Canadian healthcare system and settling down as a gradual process.

This chapter will outline the themes in depth in relation to their subordinate themes alongside selected excerpts of participants to further portray their experiences. The list of superordinate and subordinate themes are shown in Table 1 below.

Table 1.

Superordinate and subordinate themes.

Interview Focus	Superordinate Theme	Subordinate Theme
Past experiences in accessing healthcare in Canada	**The Influence of Personal Factors**	→ "I was young and healthy" → Expectations for Canada
	Significance of Social Support Systems	→ Family and friends → Service providers
	Impacts of Immigration Status	→ Limited coverage for healthcare services → Financial constraints
	Structural Facilitators	→ Shorter wait times → "The system was simpler before"
	Acculturation in Canada	→ Language → Cultural competency and awareness

Present experiences in accessing healthcare in Canada	**The Degradation of the Canadian Healthcare System**	→ Complexity of current healthcare system → Shortage of healthcare professionals → Longer wait times → The need for increased awareness with diverse populations
	Settling Down as a Gradual Process	→ "It gets better with time"

3.3 Past Experiences in Accessing Healthcare

Study participants described several experiences in accessing care upon their initial arrival to Canada in the late 1980s. These experiences included facilitators and challenges participants faced in an attempt to access care in a new country. Many subthemes emerged among the main themes identified to understand each individual's experience. The main themes, which include the influence of personal factors, the significance of social support systems, impacts of immigration status, structural facilitators, and acculturation in Canada, alongside their subthemes, will be analyzed below.

3.3.1 The Influence of Personal Factors

All participants in the study identified personal aspects that facilitated their access to care in Canada as newcomers. While sharing their experiences on accessing healthcare upon their initial arrival, participants alluded to personal factors that generally streamlined or simplified their access to care in Canada. Under the theme of the influence of personal factors, the subthemes of "I was young healthy" and expectations for Canada emerged through participants

who referred to their past recollections of accessing care and the simplicity associated with it due to individual characteristics and perspectives.

3.3.1.1 "I was young and healthy"

Provided that all participants in this study were 55-75 years old and had arrived in Canada during the late 1980s, it is crucial to understand that during their initial arrival, participants were generally young and ranged in ages from 20-35 years old. Hence, when participants were asked about their initial experiences in accessing care in Canada, participants generally stated that they did not have a pressing reason to access care because they were young and healthy.

> "Only thing you have to understand is that when I came here, I was a young guy so I have not experienced things like going to the emergency when I initially came. Because that time, I was not sick." – P1, 56 years old.
>
> "So, that time I was alone, and I don't get that much to go to hospital or doctor. I did not have that many difficulties, maybe I went one or two times I believe." – P2, 58 years old.
>
> "When we first came, we did not have any issues. But we would go for any daily check-ups if needed." – P3, 67 years old.
>
> "In 1987, no I did not. But when I got pregnant, end of 1987, I need to go to doctor because it was paid by our premium OHIP and OHIP covered it." – P4, 67 years old.
>
> "Before when we came, we were really young, so we didn't have much health problems." – P5, 72 years old.
>
> "I don't need health as much at that time, I was very healthy at that time when I came here." – P8, 55 years old.

It is essential to recognize here that, overall, when participants arrived either as a refugee or immigrant, they were healthy and young. Collectively these examples highlight how age and previous health influenced the need for an individual's need for health.

3.3.1.2 Expectations for Canada

As a cause of the civil war, and their fears associated with their healthy and peaceful livelihood, participants sought refuge in Canada, with many underlying expectations for this new country. Three participants spoke about their recollections of their experiences with the Sri Lankan healthcare system while comparing it to the Canadian healthcare system. Participant 1 discussed his feelings of surprise when he saw how the health systems were organized in Canada:

> "I was really impressed with how everything was done. Even the medical tests, the way they did it was good. When they do the tests and if they see any abnormalities, for example if they see any blood in the urine, you will get an appointment to immediately go and see what would happen." – P1, 56 years old.

Upon his arrival to Canada, Participant 1 identifies how he already had certain expectations for his life in Canada in comparison to how the health of individuals were treated in Sri Lanka:

> "I was kind of expecting what we had experienced here in Canada from Sri Lanka. We expected a better life here and the surprise was a pleasant one. The one thing that I know is in Sri Lanka, the doctors are more what you pay is what you get. But here in Canada, with the universal coverage, there is no preferential treatment which is good. There are no differences between social statuses of individuals." – P1, 56 years old.

While identifying the flaws in the Sri Lankan healthcare system, Participant 8 also described her experiences in accessing care in Sri Lanka, especially in a remote community:

> "Maybe because I came from a remote country, things here were way better for me in Canada. I felt safe and good compared to Sri Lanka where we faced the war. Because in my background we are coming from a very remote area in Sri Lanka and we don't get access to whatever we need for a very long time. From my knowledge, we don't know anything in Sri Lanka. I didn't even know about what is a blood test until I came here when I was 22 or 23 years old. This was all because of the war, we were in a war zone,

> there were no hospitals, there were no doctors, so that's the problem. Here in Canada, whatever the problem easily I could find access to." – P8, 55 years old.

Due to the lack of resources in countries like Sri Lanka, participants felt pleased and optimistic about the Canadian healthcare system and how facilities were organized in their host country. They felt they could access sources they never knew existed in Sri Lanka.

> "I had a lot of access to health care things which I never had or even knew about in Sri Lanka. I was looking for physical check-up completely because I did not have that opportunity back home. I did not have this service back home, so I was really happy that I was able to do this. I was glad that I received the service that I needed." – P7, 57 years old.

These statements regarding participants' expectations when coming to a country like Canada highlight how participants usually had positive expectations compared to Sri Lanka when accessing healthcare resources. This can be further analyzed through the excerpts of participants who often compared the Canadian healthcare system to the Sri Lankan healthcare system, which was lacking significantly compared to Canada. As such, Canada was more so of a "surprise" and "pleasant surprise" for these participants coming from war-torn countries such as Sri Lanka, where they had little to no access to healthcare.

In exploring the influence of personal factors in accessing health in Canada, the study found that participants were generally happy and satisfied with the healthcare resources available. The overall general well-being of individuals before they arrived in Canada influenced the need for access to healthcare services. They felt that they did not have a need to seek healthcare, as they did not have previous severe health conditions. Moreover, these participants came from a developing country, Sri Lanka, where individuals had little to no healthcare access. Individuals arrived in Canada with minimal knowledge of how a healthcare system should

function properly. Therefore, coming to a country like Canada, which had a functioning healthcare system during their arrivals, participants were surprised and happy with all the resources they had access to and hence did not necessarily face any challenges.

3.3.2 Significance of Social Support Systems

The availability of social support systems contributed to the study participants' positive experiences accessing healthcare. Social support systems that came up during the exploration of participants' experiences were the availability of family and friends and service providers .

3.3.2.1 Family and Friends

The ability to navigate the Canadian healthcare system and access healthcare resources as necessary with the help of family and friends was highly spoken by seven participants in the study. Participants who arrived in Canada in the late 1980s had family and friends who were already residing in Canada, facilitating their access to care. Participants 1, 4, 7, and 8 referred to their family members who had already come to Canada before them and acted as social support while navigating the system once participants landed in Canada.

> "So I'm lucky in that sense. My dad and mom came earlier. So accessing healthcare system was not that hard." – P1, 56 years old.

> "Yeah, when I came to Canada I was not qualified for any benefits, but my husband paid for my premium OHIP benefits, until my two babies born." – P4, 67 years old.

> "My brother arrived to Canada before me, so he helped me out, how to do and what to do. He also gave me all the information that I needed. It was just brother, he had faced these things already, because he was already in Canada, so he knew what to do." – P7, 57 years old.

> "Also like my family members like my cousins and brothers and everyone were already here so I got help from them." – P8, 55 years old.

Participant 5 spoke about some friends he had who helped him and guided him to necessary healthcare resources:

> "But I had some friends who knew English and who came before me, they were help me and guide me. So that's the way we found out about Welcome House and those things." – P5, 72 years old.

Due to social support systems such as family members and friends already in Canada, participants seemed to rely on individuals with whom they already had a relationship to help access health. This is important to note, as social supports such as families and friends have positively impacted the navigation and access to resources within the Canadian healthcare system.

3.3.2.2 Availability of Service Providers

Alongside the support of family and friends, participants also expressed their gratitude towards the availability of service providers such as governmental social workers and organizations such as "Welcome House" and "Welcome Canada" to help incoming refugees and immigrants. Five participants stated their favourable experiences with such facilities and their impact on their access to healthcare resources. Two participants recalled their relationships with the newcomer-centred organizations, which had greatly assisted them in identifying any resources they required:

> "Also the welcome Canada, there was an organization that, you know, like welcome Canada, I think you can register yourself and they will educate you on each one of the resources you can access and that is how you would come to know about your nearest doctor and all of that stuff."– P1, 56 years old.

> "That time, the Welcome House was a connecting and information centre. The lady who knew Tamil, we were able to ask any questions. She would even help me out of her way, out of her responsibility. She went out of her way. If I wanted any accommodations or anything, she knew a lot of things and if I went there and ask if I needed anything she would always help me out. She was very nice." – P5, 72 years old.

Finally, three participants stated their experiences with government-appointed social workers, who helped when they arrived in Canada and acted as guides in navigating the healthcare system in place:

> "There were social workers, so if you needed any help or something, yes they could help us." – P2, 58 years old.

> "At that time when I first came, I forgot her name, she was a social worker but she helped a lot of refugees like me. If you needed any help, we would go to her and she would help us out. She also spoke Tamil." – P3, 67 years old.

> "I had social worker when I arrived in Canada as a refugee, they directed me, they helped us with a few things such as health and financial." – P8, 55 years old.

Participants had clear recollections of these organizations and social workers who helped them upon their arrival to Canada. They were very thankful for the services and support they received whenever they had any necessities. Participants also specifically mentioned features regarding social workers, such as their ability to speak Tamil, a language they comprehended easily and were comfortable speaking. This alludes to the strength of social workers who can relate to individual needs and desires.

Overall, whether it was social support systems such as family and friends or the availability of service providers, the importance of support in and of itself is showcased through these participants' initial experiences with the Canadian healthcare system. Critical sources of support for participants that were constantly mentioned were family members, friends,

newcomer-friendly organizations, and social workers. Participants acquainted their positive experiences and comfort in accessing healthcare in Canada with their availability of social support.

3.3.3 Impacts of Immigration Status

Seven participants spoke about barriers to their access to healthcare in Canada because of their immigration status. General factors that were affected by the participant's immigration status included limited access to specific healthcare services and financial constraints in accessing these services. In the late 1980s, refugees and immigrants arriving in Canada had limited healthcare coverage due to their immigration status. Limited coverage of healthcare resources prohibited such individuals from accessing healthcare resources that were not determined to be essential healthcare services. Certain services were only attainable with financial resources, whereas basic health services, such as regular medical checkups, were free. Certain services, such as eye care or dental care, required financial resources, which refugees and immigrants were not able to access as a cause of their financial status as a newcomer in Canada and a lack of job opportunities. Refugees, more specifically, were only able to access limited healthcare services with their coverages in the late 1980s. Immigrants, specifically family class immigrants as per the example of the one immigrant sponsored by family in this study, were eligible for healthcare coverage under the family member who had sponsored them to Canada.

3.3.3.1 Limited Access to Certain Healthcare Services

Three participants spoke about their negative experiences in accessing certain healthcare services in Canada. Participant 1, a refugee, required eye care when he first arrived in Canada, as

he regularly wore glasses. However, he was not able to access eye care services due to his refugee status:

> "So except for I think if you really look back, that time, some of the things were not covered. When you initially claimed the refugee status, such as the eyeglasses, and dental those are the things that were kind of things not covered." – P1, 56 years old.

Similarly, Participant 5, who was a refugee, was not able to access eye care or dental care for several years:

> "Certain years, actually many years, I couldn't afford to go get dental or eye care because it wasn't included in the package." – P5, 72 years old.

Participant 5 stated that when he came in as a refugee in 1985, he had to pay for his own Ontario Health Insurance Plan (OHIP). This OHIP plan only encompassed coverage for basic healthcare services. This package did not cover other healthcare services, such as eye care, dental care, or prescription drugs. As such, Participant 5 found it hard to find the financial means to be able to afford dental or eye care.

Lastly, Participant 7, who was a refugee as well, considered the limited coverage of healthcare services to be one of her biggest challenges in accessing healthcare:

> "The only problem was that there was no eye or dental coverage. That was the biggest challenge for me. I am new to Canada, a refugee, start work in, and paying from my pocket was a challenge." – P7, 57 years old.

As per the experiences above, participants who came in as refugees equated their negative experiences with the Canadian healthcare system due to their limited coverage of

healthcare services as a cause of their refugee status in Canada and hence were only eligible for the coverage of basic healthcare services.

3.3.3.2 Financial constraints

Due to their immigration status as a refugee upon arrival, four participants shared their challenges in accessing financial resources to afford healthcare services that were not covered under their designated health coverages. Arriving as a refugee in Canada in the late 1980s, access to certain healthcare services such as prescription drugs, dental, and eye care was not covered under the healthcare coverage provided to refugees. As a cause of this, participants experienced financial barriers in accessing healthcare that was not under their coverage as a refugee. As mentioned before, Participant 1 required eyeglasses. However, he was limited to this service because of his immigration status and lack of financial resources. He recalled having to find help with his finances through social assistance to afford eye care:

> "For example if you had to come in and get your eyeglasses done, and with limited financial resources makes it hard for you to get access to this stuff. I do wear glasses. So when I initially came, I had to find some money somewhere to get the glasses. In the sense, at that time, they still have it, what is it called, social assistance. We just have to save enough money to go get the glasses." – P1, 56 years old.

Participant 1 also shared his experiences with not being able to work in the first couple of months upon his arrival to Canada. This further restricted his access to eye care. However, once he was able to get a job, everything changed for him:

> "I think for a couple of months when we first came, we were not able to work. Then we got a work permit, and we were able to work. Since then, everything changed. Now you can afford to get your glasses." – P1, 56 years old.

Furthermore, Participant 5 shared his experience with the Ontario Health Insurance Plan (OHIP) as a refugee. Participant 5 referred to his need to access social assistance to pay for his OHIP:

> "At that time we had to pay for own OHIP, at that time. When I came to Canada, I couldn't find a proper job. I worked as a security job and I also had another job in a restaurant. So that time my income was also very poor and low, so average I was making $3-4/hour. We actually couldn't pay OHIP at that time, I was unable to pay for this because of a low income. – P5, 72 years old." – P5, 72 years old.

Contrastingly, Participant 4 spoke about her experience with a lack of communication regarding the financial aspect of the Canadian healthcare system when she had her first baby. At this time, since Participant 4 came in as a family class immigrant, she was eligible for OHIP coverage through her husband:

> "It is hard like, when I had my first baby, the hospital sent me a bill for more than $5000, I was shocked, because people earned just around $4.80 per hour. Then I went there and I told them, I gave you my private OHIP number, like we are paying for that and then they checked it and they said it was okay". – P4, 67 years old.

Although Participant 4 was able to have finances sorted out during this event, it is important to note how Participant 4 stated that she was shocked to see a bill for $5000 for her healthcare service. It was hard for her to comprehend this as individuals were working for very low wages at that time in Canada.

Lastly, Participant 7 identified how onerous financial burdens associated with accessing care in Canada could be for a refugee in a new country:

> "It was more so a financial burden, because I had to pay from my pocket and it is really hard and it was really hard for me as a refugee in a new country." – P7, 57 years old.

Participant 7 shared her feelings on how the limited access to care in Canada was a financial burden, especially with her being new to the country and all the other stressors associated with navigating a new country.

The above examples of participants' negative experiences with accessing healthcare in Canada due to their immigration status highlights the challenges refugees and immigrants face in search of their healthy well-being. Concerns about the limited coverage and financial constraints showcase how one's immigration status can impact their full access to healthcare in Canada. It can be seen from the above, through the study participants who came in as refugees, the impacts of their immigration status restricted their access to certain healthcare services and thus created financial constraints for themselves. The one participant who had come in as a family class immigrant did not endure experiences with limited coverage to healthcare services, as she was sponsored by her husband, who was responsible for her healthcare coverage at that time. Although Participant 4 had access to health coverage because of her husband, her statement stating how shocked she was to receive the bill shows how overwhelming the cost of care may have been for certain newcomers with limited health coverage.

3.3.4 Structural Facilitators

There were certain aspects of the Canadian healthcare system that participants described that eased their access to care upon their initial arrival in the late 1980s. These facilitators included shorter waiting times to visit a healthcare provider and an overall "simpler" healthcare system that participants were able to navigate as a newcomer in Canada. In the past, such aspects

of the Canadian healthcare system helped refugees and immigrant participants in this study have easier access to healthcare when required.

3.3.4.1 Shorter wait times

Two study participants spoke about their positive experiences in accessing care in Canada due to the shorter wait times in accessing resources such as visiting their family doctor or getting access to a specialist for more specific health needs. Participant 1, for example, had a previous asthmatic condition from Sri Lanka. He reclaimed his experience with accessing care for this need to be smooth due to how fast he was able to get access to and visit a specialist:

> "If you ask me, I am asthmatic, when we initially came in, I was able to get a specialist appointment quickly." – P1, 56 years old.

Similarly, Participant 5 spoke about his experiences of having difficulty adapting to the Canadian weather, which resulted in him getting sicker often. Despite the number of times he would get sick, he did not have any barriers to accessing the care he needed as there were shorter wait times; hence there was no need for him to make an appointment to see his family doctor:

> "When I first came, I wasn't really familiar to the weather, so I would get sick often. I was able to easily access my family doctor because it was less crowded. I didn't have to make any appointments or anything and I would go talk to her and get whatever medication I needed, and it would be good for me." – P5, 72 years old.

It is evident in the examples of the experiences stated above participants' acquainted their ease of access to care with the shorter wait times they experienced. This resulted in these study participants facing little to no challenges when accessing care when needed.

3.3.4.2 "The system was simpler before"

Many participants in the study shared that their initial experiences with the Canadian healthcare system were positive due to how simple the system was in the late 1980s. Describing the Canadian healthcare system as simple and easy to understand was frequent among five participants' experiences. Participant 1, for example, described his ease with navigating the healthcare system upon his initial arrival:

> "The way we had it before, it is easy to navigate various levels in the healthcare system right." – P1, 56 years old.

Similarly, Participant 2 shares his experience with the Canadian healthcare system at that time as that was good in his opinion:

> "The system was good, already we have things that happen, like emergency, we can call 911, that was not the difficult part. We didn't have to go there, or here, we did not have any difficulties to look around. If you go to the hospital, all the facilities are there. You just need to get to one point and then from there, you can get help. Otherwise, that time I don't think so at that time there was so many difficulties with access, maybe the population then was less, maybe facilities are high? That was I am thinking, maybe there weren't much delays or maybe it wasn't hard, because we were able to access everything right away." – P2, 58 years old.

Moreover, Participant 8 described her experience with the Canadian healthcare system to be simple due to her ability to access everything that she needed with no difficulties:

> "But yeah, we came here as a refugee, and I had access to full basic healthcare because of the medical check-ups and everything. Yeah, I had directed to one of the doctors. So I didn't really get any difficult for that time." – P8, 55 years old.

Additionally, in some instances, participants described their experiences in getting access to Canadian health cards instantly when they arrived as refugees. Participants 3 and 7 spoke

about how their access to care in Canada was not as difficult as they were able to get health cards right away:

> "Once we came, we were given a health card right away. With that, we specifically found a Tamil doctor and accessed necessary resources as needed." – P3, 67 years old.

> "When I arrived to Canada, they gave me a temporary health card which was a piece paper. They said I had to stay in this province at least for 3 months to get a permanent health card. So I stay, I lived in province Ontario, after 3 months I got my new health card, which was red and white." – P7, 57 years old.

In exploring these experiences of participants accessing care in Canada, it is evident that certain structural aspects helped participants navigate and retrieve healthcare resources. Elements such as shorter wait times and the Canadian healthcare system being "simpler" in the past portrays how access to health for refugees and immigrants was attainable at their fingertips. Hence, participants' positive experiences with the Canadian healthcare system during their initial arrival were associated with such structural facilitators within the health system in Canada.

3.3.5 Acculturation in Canada

Challenges associated with acculturation and wanting to immerse within a new country's society can be seen as a burden for newcomer populations. This can be further perpetuated when refugees and immigrants attempt to access basic healthcare necessities in a new country:

> "Yes, so financially it was hard, but it was okay, it was more so, getting the access to healthcare without any language or cultural barriers." – P2, 58 years old.

> "It was very important to me find a Tamil family doctor to make sure I don't face any cultural or language barriers as a new refugee. It was also so much more easier for me because the Welcome House also had a Tamil representative, which was really important." – P5, 72 years old.

> "Of course in the beginning I had a huge culture shock, I also had trouble with the language to. It was really hard in the beginning, seeing a doctor and getting a physical checkup, I never had this type of experience back home in Sri Lanka you know?" – P7, 57 years old.

Accessing care without any language or cultural barriers was reiterated by five participants in this study. Amidst this, language and cultural awareness came up as stressors associated with acculturation in Canada. Participants searched for linguistically and culturally friendly care to accommodate their backgrounds and needs. Concerns regarding experiencing a culture shock and not knowing what to expect with events such as regular medical check-ups were also brought up amongst participants showcased through the above quotes by Participants 2, 5 and 7.

3.3.5.1 Language

One of the main barriers associated with adapting to a new country's lifestyle is communicating comfortably in the country's native language. As such, language can be seen as a barrier to accessing healthcare in Canada. As for participants in this study, coming from Sri Lanka, they were comfortable with their mother tongue Tamil, and therefore faced challenges in speaking Canada's primary language, English. Provided that these participants were native Tamil speakers, they were not affluent with the English language, given that English was not used in all parts of Sri Lanka. Participant 2, for example, first resided in Montreal during his initial arrival to Canada in the late 1980s. This posed a more significant challenge for him as he had to juggle between both English and French:

> "That time, Montreal they went with French, same time we had problem with English, we had to balance between. We had to do our best with getting a doctor." – P2, 58 years old.

Due to having to balance his language skills in a new country, Participant 2 had to seek support from someone he knew if he had to navigate more serious healthcare services such as surgery. If it was a regular check-up, Participant 2 felt confident navigating resources on his own; however, he found a barrier when he had to communicate for more serious concerns, such as speaking to a specialist as well:

> "Actually, I did not want anything like serious, so if it was just like a regular check-up, it was okay. But if it was something more serious like a major operation, definitely I need help from somebody. If you go to a specialist, the specialist can't be Tamil. They won't speak in Tamil, because there weren't many Tamil specialists back then, so more or less, you had to take a friend with you, or you had to deal with it by yourself." – P2, 58 years old.

Similarly, when looking for a potential family doctor, Participants 3 and 4 specifically looked for Tamil family doctors as this is who they felt most comfortable communicating with:

> "The family doctor was Tamil, her name was Doctor 1. At that time, we did have a language barrier, we specifically looked for a Tamil doctor." – P3, 67 years old.
>
> "Because you know even though I am able to speak English just a little bit and for the medical terms, I don't know much, so I wanted to be more comfortable with speaking in my own language." – P4, 67 years old.

Participants limited proficiency in the English language acted as a barrier for Participant 4 while healthcare providers tried to communicate the reasoning for her mother's death. Participant 4 recalled feeling burdened and stressed for not being able to understand the underlying conditions and issues her mother faced when she passed away in the hospital she was admitted to. Although she states that the healthcare providers were helpful, she was burdened with not being able to communicate how she felt due to a language barrier:

> "Mostly language challenges. Yeah, the workers are very good, even when my mom died in the hospital I can't blame the upper people, like the doctors and nurses. They were very helpful. They were very sad about my mom because she spent 30 days in the hospital. But it was very hard for me to communicate with them because I did not understand what they were saying." – P4, 67 years old.

Additionally, Participant 5 made notes of how he knew there was a running healthcare system in Canada; however, he could not access many resources due to his limited language proficiency. Therefore, to account for his limited English skills, he looked for services or resources readily available in Tamil but could not find any resources due to the lack of Tamil services available in Canada then.

> "When I first came, the barrier was accessing the information since I did not know the language. At that time there was a running system, but, it had a lack of information, we are new and we don't know what are the services available. We also had a language barrier, I didn't know English so I had to always look for things in Tamil, which wasn't readily available. This was very hard to find at that time." – P5, 72 years old.

While navigating through a new country, the stressor of not being able to understand the native language spoken by residents in a new host country can be shown as to challenge refugees' and immigrants' access to care. Participants who could find a Tamil family doctor were very grateful, as this made them more comfortable accessing resources provided by their family doctors. However, although participants did have access to limited Tamil family doctors in the late 1980s in Canada, participants still struggled to navigate the health system due to the unavailability of language-friendly resources. For these participants, it was more so the English language that prohibited them from accessing the available sources.

3.3.5.2 Cultural competency and awareness

Two study participants recalled experiences where cultural competency and awareness were important and necessary for their successful acculturation in Canada and navigating the healthcare system. Participant 2, for instance, found it essential and mandatory for his healthcare providers and, more specifically, his family doctor to be able to understand his cultural background:

> "This was for the comfort of us. They understood us and our background and I felt more comfortable in communicating in Tamil and it helped me feel better." – P2, 58 years old.

Access to care for specific newcomer populations, such as Participant 2, depends on how their cultural background is understood and valued. The need that Participant 2 had to make sure that his family doctor understood his background and who he was, showcases the need for cultural competency and awareness in health, especially in the health of newcomer populations. Contrastingly, the consequences of healthcare providers' inability to understand an individual's cultural background can be shown through Participant 4's experience with her mother. Participant 4 shared her negative and traumatic experience with the healthcare system in the 1990s, during the time she sponsored her mother to Canada:

> "In 1995, I sponsored my mother, I had a private healthcare insurance because Canada had changed their act two years ago from 1995, where the first 90 days, the immigrants who sponsor people are not covered by OHIP. So, I took a private insurance, she came from, that time she was 66 years old only. And she came from a tropical country like Sri Lanka. In the flight, almost 24 hours, she came to a cold country, she caught a cold. So when I saw her, she had swollen legs, I took her to our family doctor, the family doctor, asked me, you know the swollen legs, she can give some medicine. But the family doctor said I should figure out if she has some heart problem. So she sent me to the emergency, and she said in the emergency, they will check it. The English Canadian doctor in the emergency checked if she had any heart problem and said if anything he will give her medicine and send her home. But they kept her at the hospital, without telling my what the reason was. My family doctor actually gave me a letter to give to the emergency but

> when I gave the letter to the emergency doctor, he just threw it away in the garbage can, in front of me." – P4, 67 years old.

Participant 4's experience with her mother's death is further exacerbated by her healthcare provider's inability to understand that her mother was coming from another country with different environmental factors. When her mother passed, the healthcare providers alluded to the idea that she had asthma. However, this was not the case, according to Participant 4. The reasoning for her mother's death was the failure and ignorance of the healthcare providers not able to understand the previous history of their patient:

> "Two days later she was admitted to the hospital in Scarborough. She died a month later, on June 16th, in the hospital. But when we asked the reason, they said whatever happened, she caught some disease from the hospital. Still I have the letter from there. I thought the hospital was very ignorant about her. She came from a tropical country and was in an air-conditioned room for 24 hours. They told me they gave her asthma medicine, but she never had asthma. Even when she did her immigration medical one month before she came to Canada, she had nothing. I know at that time, some immigrant people, got treated like that." – P4, 67 years old.

It could be interpreted here in Participant 4's experience that it would have been highly beneficial for healthcare providers to understand the entire background of their patients. She also states that she knew that other migrant individuals had also been treated the same but feared seeking legal advice due to their lack of awareness regarding legal resources. Furthermore, this excerpt from Participant 4 showcases an example that goes beyond the need for cultural competency and awareness of refugees' and or immigrants' backgrounds and medical history. This participant's experience can be seen as an example of structural racism in the Canadian healthcare system through which certain individuals do not receive the equal and required care they deserve.

Overall it is important to recognize these barriers in accessing care in Canada for newcomer populations who are also burdened by the challenges associated with adapting to a new country. Language and cultural competency and awareness are a few factors impacting such individuals' access to quality health. Additionally, it is essential to recognize the example of the structural racism embedded within the Canadian healthcare system through Participant 4's experience with her mother, which goes beyond the scope of cultural awareness and competency required in healthcare for such visibly marginalized populations.

3.4 Present Experiences in Accessing Healthcare

During the second part of the interview, participants were asked to share their recent experiences in accessing care in Canada in 2022. Two main themes were identified by participants: the degradation of the Canadian healthcare system and settling down as a gradual process.

3.4.1 The Degradation of the Canadian Healthcare System

When participants spoke about their experiences with accessing healthcare in the present day, many stories revolved around negative experiences with the system. Participants constantly compared how the Canadian healthcare system functioned in the late 1980s and how it is currently structured. They described this comparison as weak and detrimental to their access to care today. The challenges that participants referred to in their explanation of the healthcare system's degradation revolved around the current system's complexity, shortage of healthcare professionals, longer wait times, and overall lack and need for awareness for diverse populations.

3.4.1.1 Complexity of healthcare system

In contrast to how participants described the Canadian healthcare system during their initial arrival in the late 1980s, which was referred to as "simple," participants now found the system to be more complex in nature. This can be seen through examples provided by three participants:

> "But now it is harder because you might not know what there is because there are many sectors and levels. It is more complicated for even common people to understand, let alone people like newcomers such as refugees and immigrants." – P1, 56 years old.

> "Now, the Canadian healthcare system I think it is more harder now. It is harder, maybe because of COVID-19, we have to make sure we have to book an appointment." – P2, 58 years old.

> "Before in 1985, if we visited a hospital, we can come home with the hope that there is a solution for our question. But now in 2022, there is very less hope for people like me. I do not know why, technology has evolved, systems have evolved. I feel like people can't go back and come back with the hope that they will be better." – P5, 72 years old.

The difficulties associated with the complexity of the Canadian healthcare system today impact the access to care for participants. Participants state that today there are more sectors and levels that one requires enhanced knowledge to navigate through. Moreover, participants found it hard to comprehend how the healthcare system degraded despite the evolution of technology in 2022.

3.4.1.2 Shortage of healthcare professionals

Four participants also shared their thoughts on the degradation of the Canadian healthcare system due to a shortage of healthcare professionals. Participant 1, for instance, spoke on his experiences with having access to specialists and shared that there are not enough specialists in Canada today:

> "But what got worse, they need to increase the number of specialists, I don't know how they are going to fix that." – P1, 56 years old.

Similarly, Participant 2 shared his personal experience with conversations he had with his family doctor. In his experience below, Participant 2 describes how the system and accessing health care services have gotten harder, especially after the COVID-19 pandemic. He explains that due to problems further perpetuated by COVID-19, individuals are growing to have more health concerns, but there are not enough staff or resources to access:

> "I think it has definitely gotten harder, especially after COVID-19, I don't want to blame on the medical professionals, they have issues too, because after COVID so many doctors are off, they have health issues, they are working 24 hours, they are frustrated, they have a shortage staff. Like even my doctor, I think he can stay for longer, but he doesn't want to, because he is tired and frustrated. He is overworked. He might take retirement early. So now we run out of medical professionals. People needs are growing too now, because after COVID, people have so many different issues, they are struggling with this for 3 years, 4 years, they have so many health issues, but when you go they don't have enough staff. Population is increasing a lot because of refugees, immigrants and new born and there is not enough staff. We have to talk about as people, to figure out how we can fix this stuff. Maybe the government doesn't have enough money to support them." – P2, 58 years old.

Sharing a similar experience, Participant 8 described her concerns with not being able to access a family doctor because all services are currently at full capacity. This brings her to describe the system today not as good as it was before:

> "Not good like before, because there is a lot of people and with the last few years with the pandemic years. But now, it is hard for me to find a family doctor because everything is full and no one is available." – P8, 55 years old.

Lastly, Participant 5 shared a relevant issue where he states that although there are a plethora of newcomers coming to Canada yearly, the healthcare system is not sufficient to support the needs of such individuals as there are not enough resources available:

> "Healthcare is always important for everyone, the population is always increasing, within a year there is around 3000-4000 people coming. So we need help for Canada, and we need healthcare providers. We need to extend the healthcare system." – P5, 72 years old.

3.4.1.3 Longer wait times

Alongside the complexity of the Canadian healthcare system, participants frequently stated their negative experiences with their access to healthcare due to the long wait times, a consequence of the subordinate theme of the shortage of healthcare professionals mentioned above. Therefore, it is important to note the connection between these two subordinate themes, where the degradation of the Canadian healthcare system can be linked to the shortage of healthcare providers available and, thus, the longer wait times required for accessing healthcare services. Specific negative experiences with increased wait times to see service providers were discussed by five participants. Participant 1, for example, considered the increased waiting times to be one of his biggest challenges in accessing care today:

> "Right now, if you ask me, the wait time is the biggest challenge. Everybody is busy and now that we work so there are issues with that. Even seeing a specialist for example, there are long wait times. Even for some time type of test, like an MRI, you must wait for a couple of months. In my opinion, if you are not that sick, then that is okay. But if you are seriously ill for example like incoming refugees, then you cannot access these resources easily. That negativity stems from the fact that waiting times are long. Yes, because that also drains you psychologically right." – P1, 56 years old.

It is pivotal to note how Participant 1 states that increased waiting times could drain you psychologically. Furthermore, Participant 1 also raises a critical point where he says that if you are an incoming newcomer encompassing serious illnesses upon their initial arrival to Canada, resources cannot be accessed easily due to longer waiting times. This can further worsen the

health condition of individuals as a cause of the delays associated with waiting to seek help from a healthcare provider.

Participants 3, 5 and 7 share experiences with delays in accessing some specialty services such as technical facilities such as X-Ray and MRI appointments, emergency room services or even a visit to specialists as needed:

> "There are a lot of waiting periods for resources such as MRI etc., that could be improved." – P3, 67 years old.
>
> "If we have to go to a walk in clinic we need to wait 3 hours. Also if we go to an emergency room, we also need to work more longer as well. Moreover, if you need to have a surgery you need to also wait at least like 6 months to 1 year, which is extremely inconvenient. The waiting times are the worst now." – P5, 72 years old.
>
> "Current experiences that I am facing right now is that say if I need to see a specialist and my family doctor recommends me to a specialist, like, I have wait for a very long time. The waiting periods are very long, which is where I am facing difficulties." – P7, 57 years old.

Additionally, two participants shared their thoughts and concerns about healthcare providers not being able to spend enough time with them. This results from longer wait periods, which disables healthcare providers from spending enough quality time with their patients. As a cause of this, participants stated that they felt left out and that healthcare providers did not have enough time to figure out what their actual problems were:

> "Now a days, you know doctor they don't spend much time, they don't explain so much. If you are in a situation, you can ask many questions as you wish. I know they have to deal with many patients, and so that requires less time with each patient and now I feel left out. So I want to get a certification, and I would expect him to explain everything to me, but they seem to like cut me off and go on to the next patient." – P2, 58 years old.
>
> "But before, since there was less people, they used to spend so much more time with us individually. This was important to me as a refugee. But now, they spend way less time

> with general populations or even newcomer populations. Doctors aren't really able to understand what problems are really are." – P5, 72 years old.

These experiences with participants sharing their thoughts about the long wait times in accessing care are vital to note. Longer wait times are not only associated with delayed diagnosis of health problems, but it is also psychologically and physically draining. The longer wait times can be seen as a result of the lack and shortage of healthcare professionals available. Provided that Canada welcomes many newcomers every year, access to care for such populations should be readily available to prevent any detrimental consequences they may face.

3.4.1.4 The need for increased awareness with diverse populations

Six participants highlighted the need for increased awareness of diverse populations within the Canadian healthcare system. These participants discussed how necessary service providers such as social workers or healthcare professionals are to understand the backgrounds and histories of individuals and, more specifically, newcomer populations to facilitate their access to health. Two participants specifically spoke about how it would be beneficial for them if the general population knew about who the Tamils were and where they were coming from:

> "Yes, that is very important. If people are aware of the struggles Tamils have gone through it would so much more helpful. Also, as Tamil Canadians, many people do not have knowledge about where we come from and what struggles we have gone through. There was a knowledge gap before and presently too." – P3, 67 years old.

Furthering Participant 3's experience, Participant 1 states how the current system works for newcomer populations today, such as the Ukrainian refugees. He describes how many people were already aware of the Ukrainian refugee's problems before they arrived in Canada; however, not many were aware of the Tamils and the Sri Lankan civil war. He suggests that perhaps this would make resettlement processes easier:

> "For example with Ukraine, there are already so many pamphlets on how they should do it. Maybe because it is because there are a lot of people coming in at once. But for us, we came in batches so maybe that is why there wasn't much awareness. I think overall, it would have been better for other people to have awareness about where refugees are coming from to make their resettlement processes more easier. For example, not many people knew about the Sri Lankan civil war and the Tamils, but a lot of people know about the context of the Ukrainian war. So maybe it would have been nice for people to understand." – P1, 56 years old.

Three participants specifically spoke about the need for more culturally aware and language-friendly resources, as there are still individuals who battle with such barriers. As stated by Participants 5 and 8 below, these services are a necessity for refugee and immigrant populations to address their underlying conditions and to understand their backgrounds and histories:

> "Because lots of people still have language barriers, or senior people don't go out and don't have many friends, so you don't know what is available, what is necessary and what is right. Basically being aware of what is available to you. Also I think all populations should be able to get all their related information in their own language. Or through their society or communities, or social service people like that." – P4, 67 years old.

> "Also another necessity is truly understanding the background and histories of incoming newcomer populations. For instance, some people come really warm climates, so their bodies may not readily adapt to the Canadian weather. Healthcare providers need to really learn about this and be more culturally competent and aware. Healthcare providers really need to study their patients backgrounds and history in depth to avoid consequences because this is really important for the positive outcomes of refugee and immigrant health." – P5, 72 years old.

> "I think people providing services definitely need to have more knowledge about refugees backgrounds as well. Because we have went through a lot of difficulties, it has to be in a balanced way, and health is one of the most important things that need to be taken care of." – P8, 55 years old.

Furthering discussing the need for awareness for diverse populations and the associated language barriers, Participant 7 brings up an interesting and pivotal example of how language barriers for diverse populations still exist within the healthcare system. She describes her experience with her elderly mother in accessing services in an emergency setting and not being able to navigate the system due to the lack of language-friendly services:

> "Now a days, healthcare providers provide different languages and stuff. Sometimes there's still need to be improve, like I have an experience for my mother, she was hospitalized for a while. They have a big sign in front of the hospital that says language like Tamil, my mother of course has a language barrier. At least I came early, so I am okay. But my mother had a huge language barrier. So they said in the front that we could have Tamil translators and stuff like that. But in real situation, there is nobody to help me or my mother. Honestly it is still very hard for people who cannot speak English. There needs to be more improvements, if they have a sign saying translators are available, they need to keep up with that. There is no people to actually translate. They did have some limited translation, but it was over the phone. Our accent, our Sri Lankan accent is still different from Indian Tamil accent, so my mom was really hard to understand who was the translator through the phone, she had a really hard time to understand." – P7, 57 years old.

To exemplify this experience, Participant 7 also adds her input on how many populations such as elderly Tamils and refugees and immigrants still face discrimination because of the lack of culturally friendly services available in Canada today:

> "But elderly Tamil adults and refugees and immigrants, still face a lot of problems, for example when they go to the hospital and people see our colour, our age, and see that some of us cannot speak, there is always discrimination, and they need to stop that. They need to treat everyone else the same. Because of the colour or age or language, the healthcare system needs to treat everyone same and the healthcare system really needs to be more aware of this and improve it." – P7, 57 years old.

A previous example of structural racism was also identified in the past experience of a participant mentioned above. Participant 7's thoughts and feelings regarding the unequal

treatment of certain patients in the healthcare system today is yet another example of how structural racism still exists in the Canadian healthcare system. Participant 7's statement that discrimination is consistent in healthcare conveys that over the years, many improvements have not been made to overcome instances of structural racism in the Canadian healthcare system.

In exploring the participants' experiences and their feelings about how the Canadian healthcare system has degraded before, it is evident that there is still plenty of room for improvement. Participants associate their negative feelings with the healthcare system today for many reasons, such as the complex nature of the healthcare system, shortage of healthcare professionals, longer wait times and a lack of awareness for diverse populations. Many of these factors should be improved significantly for newcomer populations to ensure access to care is easily attainable.

3.4.2 Settling Down as a Gradual Process

In some instances, participants described their changes in experiences in accessing care in Canada as a gradual process that took a lot of time. Participants stated that getting used to the healthcare system took some time, and their entire experience, to this date, was full of learning curves.

3.4.2.1"It gets better with time"

Three participants spoke about how their access to care improved over time, from coming in as refugees and immigrants to becoming Canadian citizens. Participants stated that they initially faced challenges such as language and cultural barriers to care. However, over time, they felt as if they were getting used to it:

> "So maybe coming to Canada I did feel a bit different, maybe it was a lack of communication, maybe we are new to the country, and they may see us differently. It was like that type of difficulty in the beginning. But now people are getting used to it. Everybody respects everyone. Definitely we did have language barriers like explaining things in the beginning, right. After wise, after being here for like more than 30 years later, we know how to talk, we know the system, we know the people, we have no problem for now. The beginning yes of course there was so many problems, we had to look for everything, sometimes we did have big challenges dealing with these." – P2, 58 years old.

Participants 4 and 5 stated that, given the time they have resided in Canada, they can now access information more easily because of their increased knowledge. Over time, alongside their knowledge gained from experiences in accessing care in Canada throughout all these years, participants also associated their ease in accessing care with forms of social support such as families, communities and readily available resources in Tamil:

> "Before there was nothing, and now we have so much more people. Now we have the knowledge, we have the resources, we are little alert. We now know, if it is a major decision, we need a second opinion. I think it gets better with time. So now we are more prepared. So if someone in our family or community had some disease, we would talk about it with them." – P4, 67 years old.

> "Now, it is not hard to find information you know? In English we are better now, even though it is a second language for us, we have more skills in this language now. At the same time, there are so many Tamils newspapers, magazines so there necessarily isn't a lack of information for new incoming or existing Tamil communities." – P5, 72 years old.

It is interesting to note how participants spoke about their access to care and, in general, their resettlement to a new country like Canada, which had improved over time. Although this is not something particularly new, newcomer populations generally take some time to adapt to the environment they are currently residing within. Individuals may still face challenges in adapting to a new environment and may positively and eventually adapt to where they live. Participants'

experiences change over time, and their statements showcase what can hinder or promote better access to care for diverse populations such as newcomers.

3.5 Conclusion

Sri Lankan Tamil Canadians shared many different experiences with the changes in accessing care in Canada, both from the perspective of a migrant and as a Canadian citizen. Among these experiences, participants discussed and reminisced on both past and present experiences in accessing care when required. Amidst the past experiences discussed by participants, most of the experiences were generally both positive and negative. Positive aspects of accessing care during their initial arrival could be associated with personal factors such as age, previous health conditions, and expectations arriving from a developing country like Sri Lanka. These factors may have eased participants' access to care during the initial stages in Canada. Moreover, participants frequently spoke about their social support systems, whether it was family and friends or service providers that had helped and guided them through the Canadian healthcare system. These forms of social support played a pivotal role in the experiences of accessing care. Lastly, participants pointed out particular positive facilitators of the structure of the healthcare system during the late 1980s, which also assisted them in accessing care rapidly and efficiently. These facilitators articulated by participants were shorter wait times and a simpler health system. Contrastingly, the study also demonstrated challenges to care through participants' past experiences. During their past experiences, participants conveyed that their barriers were due to their immigration status, resulting in limited health coverage and financial constraints. Simultaneously, participants also described challenges regarding their acculturation in Canada and, more specifically, language barriers and the lack of culturally competent care. In

terms of present experiences, participants' feelings were generally negative, and they articulated that they faced more challenges with the current health care system when accessing care. These barriers included the degradation of the Canadian healthcare system due to its complex nature, shortage of healthcare profeesionals, longer wait times, and a lack of awareness of diverse populations. However, through their years of experience, participants concluded that access to care got better over time. Therefore, this study demonstrated that changes in experiences of access to care for newcomer populations included both facilitators and challenges.

CHAPTER 4: DISCUSSION

The study findings provided in the previous chapter identified facilitators and challenges in accessing care through the experiences of Sri Lankan Tamil Canadians living in the GTA overtime. Results showed new and overlapping experiences with previous literature on access to care for refugee and immigrant populations. This section will then be followed by implications for the areas of policy, education, practice and research for policymakers and health care providers to effectively address challenges refugees and immigrants face when accessing care. Finally, study limitations and future research directions will be discussed, followed by a conclusion.

4.1 Past Experiences with Accessing Care

While interpreting the results of the past experiences of Sri Lankan Tamil Canadians in accessing care during the late 1980s, there were new and overlapping findings from existing literature. Results revolving around the themes of influence of personal factors and structural facilitators differed from results reported previously in the literature. Themes, such as the significance of social support systems, the impacts of immigration status and acculturation in Canada, was consistent with the literature.

4.1.1 The Influence of Personal Factors

Provided that participants were younger and did not have any detrimental health conditions when they arrived in Canada, participants stated that they did not have a need for accessing care. Hence, participants discussed that they did not have much experience with accessing care in the first place. This was a surprising finding in this study, as previous literature

did not report how newcomer populations' younger ages and previous positive health conditions impact their access to health, specifically. However, a study on cancer incidence rates amongst Canadian immigrants who arrived in Canada during 1980-1998 showed the impact of age and previous health conditions on immigrants' health status in their host country (McDermott et al., 2010). The analysis of the study cohort of refugees and immigrants between 1980 and 1998 identified that most of these individuals were younger at arrival, varying between the ages of 20 to 44. The cancer rates were lower for all immigrant subgroups compared to Canadians (McDermott et al., 2010). Although this study did not provide results portraying experiences in access to care, the general health status of refugees and immigrants arriving in Canada during the 1980s can be compared to general positive health statuses reported by participants in the present study.

Given the participant sample in this study arrived in Canada at a younger age, it makes sense that they did not have many challenges in accessing care in Canada. There would be no need for them to access care; therefore, they would have possibly not faced many challenges in navigating and accessing care within the Canadian healthcare system.

Additionally, participants in this study shared their expectations for Canada and how it impacted their access to care. Coming from a war-torn, developing country like Sri Lanka, participants reiterated how grateful and blessed they were to have arrived in Canada for their new lives. Fleeing from genocide and having lived in remote villages within Sri Lanka, participants were surprised with all the care they had access to, as they did not have previous knowledge or access to such care in a war zone. Hence, their expectations for care in a country like Canada significantly impacted their views on their access to care. Even access to basic healthcare tests mandatory for newcomer populations in Canada was a pleasant surprise for Sri

Lankan Tamil Canadians. Similar to this study's participants' experiences, a study conducted on the expectations of several vulnerable groups, such as newcomer populations, by Logie et al. (2016) found that newcomers could learn so much about their health and healthcare resources when they came to Canada. They felt confident in their health because of the service providers they could speak to regarding this. Thus, this made their access to care more accessible and beneficial. Participants in the study by Logie et al. (2016), similar to the participants in this present study, felt that they had access to so many different facilities for healthcare in Canada compared to where they came from. According to certain participants in the mentioned study, newcomers felt that their host country was a "free country" with the availability of many forms of resources (Logie et al., 2016).

Moreover, a study by Dias et al. (2008) examined determinants of healthcare utilization by immigrants in Portugal. In this study, many participants reported being satisfied with the available healthcare services in Portugal. This satisfaction was higher amongst African and South American immigrants than East European immigrants. The authors discussed that higher satisfaction amongst African and South American immigrants may be due to the lack of an adequate healthcare structure in their countries of origin. Thus, they may perceive healthcare services in Portugal to be better and more efficient. In connection with the present study, it is crucial to recognize how a newcomer's perception of their host country's healthcare system may be dependent on the quality and accessibility of the healthcare system in the country they are migrating from.

4.1.2 Significance of Social Support Systems

The critical and notable role played by social support systems such as family and friends and organizational facilities such as community programs for newcomers and social workers were discussed in this study. Several of the participant's past positive experiences with accessing care within the Canadian healthcare system was attributed to the availability of social support systems. These findings regarding the availability and need for social support systems have also been extensively discussed in previous literature (Simich et al., 2005; Hynie et al., 2011).

There is a heavy emphasis placed on family and friends within the Tamil culture; hence these support systems play a significant role in the lives of Tamils even in Canada (Amarasingam, 2015). Supporting this facet of the Tamil culture, participants in this study frequently shared their experiences on how their support of family and friends helped them access required healthcare sources as needed. Participants usually stated that they had known family and friends who had resettled in Canada before their arrival and hence helped them navigate the healthcare system. Hence, the availability of support systems, such as family members and friends, helped participants have a positive experience with accessing care upon their initial arrival. Additionally, due to the heavy emphasis placed on community and family linkages within the Tamil culture, it is also highly possible that study participants moved to Canada, anticipating the help and guidance of previously settled Tamil family members and friends. The value of the support provided by family and friends is also discussed in a study conducted by Simich et al. (2005) to understand the perspectives of service providers and policymakers concerning social support for refugees and immigrants. Findings from this study showcased that, according to service providers and policymakers, having social support from family and friends helped newcomers foster a sense of empowerment and positive community and social integration, thus contributing to positive physical and mental health. Contrastingly, the

lack of social support from family and friends correlated to negative impacts such as increased feelings of loneliness and social isolation. In connection with findings from this present study, it is important to note how study participants generally equated their ease in accessing care to the availability of their friends and family. Therefore, this study showcases the positivity of the impact of social support systems such as family and friends in accessing care in a new country.

Consistent with trends in the literature, this present study showcased the importance of the availability of social service programs. Adding onto the availability of social support in the form of families and friends, participants in this study heavily emphasized their thankfulness towards organizational facilities such as governmental social workers and community programs tailored explicitly for newcomer populations. Navigating Canada's healthcare system was deemed accessible and not as challenging due to the assistance participants received from the social workers allocated to them during their initial arrival and/or through refugee and immigrant-based community organizations. According to Hynie et al. (2011), access to community centres was seen as the most informational and instrumental or the only source of support for women newcomers in Canada. Similar to how participants in this present study accessed several healthcare resources through organizations, newcomer women in Hynie et al. (2011) 's study reported that when they made initial contact with newcomers' programs, they became aware of other forms of support that could be accessed at these centres. Therefore, such evidence suggests the value in the availability of organizational support regarding refugees' and immigrants' access to healthcare.

4.1.3 Impacts of Immigration Status

Participants in this study identified the impacts of one's immigration status concerning the limited coverage of certain health care services and the associated financial barriers. These statuses, whether it was a refugee or an immigrant, came with certain restrictions on their access to healthcare. Seven participants in this study arrived as refugees, while one participant arrived as an immigrant to Canada in the late 1980s. The impacts of one's immigration status could also be related to the structural determinants of health inequities part of the CSDH framework (Solar & Irwin, 2010). It is evident through this study's findings how one's immigration status influences their socioeconomic positions thus impacting their limited access to certain healthcare resources.

The emphasis and impact of limited coverage to healthcare services have been previously discussed as a barrier to healthcare in refugee and immigrant health research (Woodgate et al., 2017; Dastjerdi, 2012). A combination of federal and provincial health policies for refugees and immigrants in Canada impacts access to care due to a newcomer's immigration status. Due to different immigration policies and laws in Canada, diverse groups of newcomers are eligible for different health insurance programs and government-assisted funding services.

Participants in this present study described their distress in not being covered for healthcare services such as eye and dental care due to their immigration status during their initial arrival in the late 1980s. Participants who came in as refugees in this present study experienced more limited access to specific healthcare services and thus faced barriers to accessing such services. These findings concerning limited health coverage as one of the most significant barriers to care for newcomers have also been reported in other studies. For instance, a study done on African immigrant and refugee families' experiences of accessing primary health care services in Manitoba, Canada, also identified the stressors associated with newcomer populations

not being able to get coverage for medication and non-essential care (e.g. dental care) (Woodgate et al., 2017). With such findings, this study discussed the importance of more provincially funded programs for care such as eye and dental health and the need for increased awareness regarding such issues faced by refugees and immigrants.

Further perpetuating the barrier of limited access to care in this present study of participants' experiences in accessing care, financial constraints associated with accessing non-basic healthcare were prevalent. Participants identified that since they already had limited health coverage and lacked a job during their initial arrival to Canada, they felt that they were financially burdened in accessing the non-basic healthcare services required. Some participants stated that they could not afford the cost of dental and eye care or the prescription medication they needed. Due to their lack of financial resources, participants indicated that they had to wait to afford this care until they found a job or had to seek out social assistance. These findings from the present study are aligned with existing literature on the financial constraints faced by refugee and immigrant populations in Canada. A study focusing on Iranian immigrants in the GTA conducted by Dastjerdi (2012) indicated similar participant experiences with the lack of affordability for participants who required treatments such as medications, some special medical tests, eye care, dental care and the like. Participants in Dastjerdi's study also interviewed social workers who expressed concerns about the financial constraints immigrants face accessing non-basic healthcare. They stated that some dentists and optometrists are sometimes willing to help immigrants with limited incomes, but this is sometimes not enough (Dastjerdi, 2012). As such, this was frustrating and heartbreaking on both the immigrants' and service providers' end. In connection with findings from the present study, this has implications for improving and extending the coverage of non-basic health needs for newcomer populations.

4.1.4 Structural Facilitators

Several participants in the present study had referred to certain structural facilitators, such as shorter wait times and a simpler healthcare system which helped and enhanced their access to care during their initial arrival in Canada.

Regarding shorter wait times as a structural facilitator to their access to care, participants stated that provided the population was lower in the late 1980s; they could easily access healthcare resources without waiting longer. Interestingly, these participants, who were refugees and immigrants in the late 1980s, could easily access healthcare due to the shorter wait times.

In addition to the shorter wait times in accessing care, participants in this study also mentioned that the healthcare system was much simpler in the late 1980s, facilitating their access to care. Through the highlights of participant experiences in this present study, it is important to understand how navigating and accessing healthcare resources in a new country could be facilitated for newcomers, provided that the healthcare system they are navigating is simple and easy to comprehend. Furthermore, a comparative study conducted by Bollini (1993) regarding the health of immigrants and refugees in the 1990s in seven receiving countries elicited facets of the Canadian healthcare system during the 1990s. Regarding access to health care, Bollini (1993) illustrates that the Canadian healthcare system did not encompass any economic or administrative barriers to access to healthcare for refugees and immigrants. Barriers to care for such populations were present in Italy, France, and the United States. Therefore, through the results generated by Bollini's (1993) comparative study, the present study's identification of structural facilitators in the past experiences of access to care amongst participants can be valid, provided the nature of simplicity within Canada's healthcare system in the 1990s.

4.1.5 Acculturation in Canada

Lastly, acculturation in Canada was a salient theme identified in participants' past experiences in accessing healthcare. Challenges associated with accessing care due to the impacts of acculturation in Canada were referenced to barriers with language and the need for cultural competency and awareness.

In this present study, participants frequently mentioned challenges associated with language in accessing care in Canada. Provided that study participants who came from Sri Lanka did not have sufficient English language skills, barriers related to language were described by participants. Due to a language barrier, many participants had also mentioned that they had explicitly looked for a Tamil family doctor to discuss their concerns, as they felt more comfortable communicating in Tamil. Although participants could find Tamil doctors when accessing services in an emergency room, for instance, Participant 4 found it very hard to understand the information healthcare providers gave her regarding her mother's passing. Such language challenges described by participants' past experiences in accessing care in this present study are commonly reported in research on refugee and immigrant access to health in Canada. A study by Salami et al. (2018) on the access and utilization of mental health services for immigrants and refugees through the perspective of immigrant service providers provides similar insights associated with language barriers. In fact, this study stated that language barriers were one of the biggest challenges in accessing and using mental health services across immigrant service agencies. Immigrant service providers stated that many mental health providers do not speak newcomers' language. When newcomers finally acknowledge their mental health issues, they cannot see someone who can speak their language or must wait long periods for an eligible

translator. Unfortunately, refugees and immigrants experiencing language barriers in accessing care have also been common in current literature (Agyekum, 2020).

Further perpetuating the language barrier newcomers face in accessing care, there are barriers associated with the importance and need for cultural competency and awareness of the healthcare needs of such marginalized populations. Two study participants in this present study discussed their experiences and need to look for culturally competent care during their initial arrival. Similar to the present study, participants' desires and needs to look for a family doctor from a similar background, was identified through the findings of a scoping review done by Lau and Rodgers (2021). Several studies screened for this scoping review showed that many refugee participants highlighted the need for cultural knowledge, including knowledge of refugees' cultural and religious beliefs and practices, ethnic identities and languages and dialects in their healthcare providers. In a study conducted by Zghal et al. (2020), researchers looked at the impact of health care providers' cultural competence on new immigrants' health-related quality of life. Through a survey, the majority of the study respondents reported high levels of trust with their healthcare providers as they were degrees of ethnic and language concordance between the healthcare providers and participants. Trust in the healthcare providers thus facilitated better self-reported health and higher levels of patient satisfaction (Zghal et al., 2020).

Going beyond the need for culturally aware and competent healthcare providers, an example of structural racism in healthcare can be seen through Participant 4's experience with her mother's death. Participant 4's mother had arrived in Canada and shortly passed away within a couple of months due to the negligence of her healthcare providers. The death of Participant 4's mother is an example of structural racism in the Canadian healthcare system due to the lack of awareness and diligence in providing care to certain individuals. Lastly, Participant 4 also

stated that she was aware of similar racist behaviours amongst other immigrant populations; however, their lack of knowledge regarding legal practices in Canada and fear of a new country prohibited them from seeking assistance. In Canada, and specifically within the context of refugee and immigrant health, examples of structural racism are not uncommon. According to Edge and Newbold (2012), studies on provider attitudes and perceptions of visible minorities, such as refugees and immigrants, are rare. Moreover, evidence suggests that most racial discriminatory practices are often subtle, elusive, or systemic. However, such practices and experiences are underreported in studies (Edge & Newbold, 2012). In relation to this present study, it is evident that there are forms of structural racism and discrimination within the Canadian healthcare systems that compromise the health status of newcomers and thus impede their access to healthcare services (Hyman, 2019).

4.2 Present Experiences with Accessing Care

In contrast to the mixed positive and negative experiences of accessing care during the late 1980s, when asked about their present experiences with the healthcare system, participants generally described their challenges in accessing care in current days. The major challenge associated with accessing care expressed by the participants was the overall degradation of the Canadian healthcare system due to its complex nature, a shortage of healthcare professionals, and hence the consequence of longer wait times alongside the need for increased awareness among diverse populations. These challenges described by participants are very similar to barriers frequently noted by current newcomer populations in Canada today, which will be discussed below. In addition to the theme of the factors associated with the degradation of the Canadian healthcare system, another theme with participants' descriptions of settling down as a

gradual process was identified, where experiences with accessing care today were characterized by getting better over time. It is imperative to understand the interesting link where participants note a decline in the quality of the healthcare system over time. Still, on the other hand, they state they encompass greater familiarity with the system, which helps facilitate their access to care.

4.2.1 The Degradation of the Canadian Healthcare System

Many participants reported on the current degradation of the Canadian healthcare system, which has hindered their access to care. Participants described their negative experiences with access to care due to the complex nature of the health system and a shortage of healthcare professionals, thus resulting in longer wait times and the lack of increased awareness of diverse populations within the Canadian healthcare system today. Such findings regarding the degradation of the Canadian healthcare system are very similar to results identified in studies in the current literature (Lane et al., 2021; Woodgate et al., 2017; Asanin & Wilson, 2008; Oda et al., 2017)

In the present study, participants referenced their access to care today as a more challenging process due to the complexity of the healthcare system due to its various systems and levels. Three participants spoke about the changes in the simplicity of the healthcare system today. They stated that the present health system is much more complex and even more complicated for general populations, let alone incoming newcomer populations, to understand. Challenges in navigating the healthcare system today to access care have also been a common barrier in literature focusing on access to care for newcomer populations. In a study by Lane et al. (2021), researchers analyzed newcomer challenges accessing care in Saskatchewan, Canada.

Through the data collected, this study identified that one of the most significant barriers to accessing care was difficulty navigating the complicated healthcare system. Participants described their experiences of not understanding how and where to access care, as there were too many levels. Furthermore, another study conducted on recent newcomers in Manitoba, Canada, by Woodgate et al. (2017), identified similar barriers in which newcomers could not understand how and where to access healthcare services due to a confusing healthcare system.

Furthering the complicated healthcare system in Canada today, challenges in accessing care also revolved around the shortage of healthcare professionals available today, which could also be linked to the barrier of longer wait times. Five participants in this present study spoke about their challenges in accessing care due to the shortage of healthcare professionals and connected to the lack of resources available; five participants consequently spoke about the long wait times in accessing care today. Consistent with the present study's findings, a study conducted by Asanin and Wilson (2008) exploring the access to care amongst immigrants in Mississauga, Ontario, further examined the issues surrounding the current shortage of family physicians in Canada. Participants in this study felt that their health concerns and issues were amplified by the lack of family doctors that were readily available to look after them. However, as noted by the researchers in this study, the current shortage of physicians and specifically family physicians, available to refugee and immigrant populations is not a new topic in Canada. Similar to other research, this present study finding also showcases that the shortage of healthcare professionals poses a barrier to accessing care.

Based on the lack of healthcare professionals available to look after not only newcomer populations but the general population in Canada as well, it is no surprise that participants in this present study relayed concerns about the long wait times to access care. Similar to experiences

stated by participants in this present study, findings in the literature also identify long wait times as one of the biggest challenges to access to care for newcomer populations. A cross-sectional study conducted by Oda et al. (2017), examining the unmet healthcare needs of Syrian refugees in Toronto, reported that one of the three most common reasons why Syrian refugees had unmet healthcare needs was the long wait times in seeking healthcare services. This was showcased in the study results, where 49.0% of the study participants reported having unmet healthcare needs due to the long waiting hours in seeking advice or care from a physician. Accordant to the results of this study, a scoping review examining the immigrant experience of healthcare access barriers in Canada by Kalich et al. (2016) also reported that the most identified barriers in quantitative studies on newcomer populations were the long waiting times and lists when it came to healthcare services.

Lastly, regarding the theme of the degradation of the Canadian healthcare system, participants referred to the need for increased awareness for diverse populations accessing healthcare today. As highlighted through participants' experiences, it was noted that there are gaps within the Canadian healthcare system when it comes to diversified populations such as refugees and immigrants. Participants still felt the presence of an overlying language barrier for elderly Tamil populations in Canada. Additionally, furthering the structural racism in healthcare brought forth during participants' past experiences with the Canadian healthcare systems, Participant 7 reiterated the need for the equal treatment of all individuals, regardless of their race and ethnicity. Lastly, Participant 1 conveyed his thoughts on the need for more awareness regarding the social and political context of all incoming newcomer populations to address their healthcare needs effectively. Such findings from this present study present similar views to the existing literature on healthcare needs for refugee and immigrant populations. In a report by

Ajery (2017), the importance of addressing and considering race, country of origin, socioeconomic status, and other intersecting identities' impacts on accessing care and resources is discussed. According to Ajery (2017), understanding the diverse needs of a healthcare provider's patient population is more than just understanding one's cultural background and values, and hence being culturally aware. It is truly being able to understand the patients and their needs, such as what language they prefer to speak or whether they have the financial resources readily available to afford prescription medication (Ajery, 2017). Such barriers in accessing care have been repeatedly documented in the literature on research on newcomer populations as well (Ahmed et al., 2016).

4.2.2 Settling Down as a Gradual Process

An interesting result identified in this present study through participants' experiences in accessing care was references made to settling down as a gradual process. Six participants stated that their access to care in Canada has become more accessible and better over time. Through participants' descriptions of access to care getting better over time, the characteristic of resiliency can also be identified. According to Participant 4, during her initial arrival to Canada in the late 1980s, there weren't many resources, but today, in 2022, many more resources are available to her. She states that now she has the knowledge and the resources; hence is more aware, which she became better at through her time in Canada. Although such specific findings are not common in the literature today, it is evident that time and the resilience of individuals are seen to ameliorate several barriers faced by refugees and immigrants during their initial arrival (Beiser et al., 2011). Although the increased amount of time spent in a new country may not

always help newcomers overcome barriers in accessing care, it is interesting to note participants' optimism in stating that time does help with certain aspects of accessing care in Canada.

Additionally, as mentioned above, an interesting overarching connection could be found through the present experiences of accessing care amongst the study participants. This is evident through the perspectives of the participants' experiences, where they state that the Canadian healthcare system has degraded over time; however, their increased familiarity with the system has facilitated their access to required healthcare services. Although participants note that the quality of the healthcare system has degraded since their initial arrival, they equate their length of residency in Canada as a facilitator in accessing care due to their increased knowledge of the system. In a study by McAlpine et al. (2022), researchers examined whether race and/or immigrant or refugee status correlates with such individuals' health status. Their results showed that the racialized refugee participants who arrived in 1980 did not face any health disadvantages due to their easy access to Canada's universal health system. Moreover, with racialized Canadians who came in as refugees and are currently aged 55 and older, encompassing great social support alongside increased social trust and community involvement were associated with better health statuses (McAlpine et al., 2022). This finding from this study resonates with the present study's results, where participants describe their experiences with healthcare today, becoming better due to their increased knowledge as a cause of their family and friends. Additionally, with a longer time since immigration, McAlpine et al. (2022) distinguished that participants learned to speak English more fluently; hence, this facilitated participants' ability to form social connections, gain appropriate employment and access health care.

4.3 Study Limitations

This present study provides insight findings on the facilitators and challenges in accessing care for the Tamil refugee and immigrant populations. With that being said, this study does contain certain limitations that need to be addressed to propel future research on such topics. The limitations in this study consist of methodological limitations that are associated with the lack of previous literature, sampling, and the study design and finally, and researcher limitations as well.

Regarding the methodological limitations of this study and the lack of previous literature, it is essential to note that there is an immense gap in research studies on the Sri Lankan Tamil diaspora population. In contrast to other refugee and immigrant populations, the Sri Lankan Tamil diaspora community is often absent from the research field (Madziva, 2017; Aisling, Nel & Nolte, 2016). With the limited number of studies on the Sri Lankan Tamils, findings from this present study may have only provided a small insight into the experiences of Sri Lankan Tamil refugees and immigrants and made it more challenging, for me, as a student researcher to further interpret the findings of this study beyond my conceptualization.

Secondly, another methodological limitation of this study is the small sample size used for this research study. With the completion of eight interviews, the findings from this study only provide small insights into the experiences of accessing care for Tamil Canadians. Although there were many interesting findings within the study, by expanding the variation of the backgrounds of the participants interviewed, a richer understanding of healthcare access amongst Tamils could be understood. Additionally, seven of the present study participants arrived in Canada as refugees. Therefore it would have been more difficult to understand and acknowledge if those who arrived in other ways may have had different experiences. For instance, as an immigrant arriving in Canada, one may have had more access to basic and non-basic healthcare

services due to their immigration status. Furthermore, previous studies have indicated that both economic and family class immigrants generally have higher education and labor skills in comparison to their refugee counterparts (Kritz & Gurak, 2018). Thus, access to healthcare could have been easier for immigrants in terms of their ability to access health resources due to their increased educational and language proficiency. Therefore, with the recruitment of an increased amount of immigrant participants, this current study could have compared the facilitators and barriers to access to care between refugees and immigrants.

Thirdly, the final methodological limitation of this present study was the study design in which participants were asked to speak about their past and present experiences of accessing care in Canada. It is important to note that when participants did reflect on their past experiences of accessing care, there is the possibility of recall bias, where a participant may not have specifically remembered certain events or omitted specific essential details of their past experiences. Additionally, provided that participants in this study had arrived in Canada at such a young age and have lived in Canada for at least more than 20 years, the context and accuracy of the challenges they may have faced may not be as prominent in their thoughts right now.

Finally, it is also important to address researcher limitations for this present study as well. As an individual who identifies as a Sri Lankan Tamil Canadian, being born and raised in Scarborough, I am well connected to the Tamil community in the GTA. Although I did not know my participants personally, provided that the Tamil community is small, there may have been unsaid connections or relations that the study participants may not have addressed. This could have impacted how participants may have shared their experiences or how they may have described their experiences in front of me.

4.4 Implications for Policy, Education, Practice and Research

The findings from this study bring forth different suggestions for improved and better access to healthcare for refugees and immigrants. Implications are brought forth concerning the areas of policy, education, practice, and research.

Policy

First and foremost, policies regarding the health of refugees and immigrants in Canada should be refined to address the current inequities in access to care faced by such populations. Although Canada is praised for its universal health system, the provision of its health insurance does not provide the most equitable services for marginalized populations such as refugees and immigrants (Martin et al., 2018; Siddiqi et al., 2016). It is imperative to understand that the costs associated with non-basic health care services not covered under a newcomer's health insurance brings forth increased stress for such populations, thus resulting in adverse health outcomes. Therefore, policymakers should consider the lack of affordability and financial constraints for newcomer populations attempting to access services such as vision care, dental care, and prescription drugs and should consider expanding the health coverage policies for such individuals (Lin, 2022).

Education

Secondly, as noted in this present study's findings, there is currently a need for increased training and education provided to current medical students in Canada regarding the health needs of incoming newcomers. Medical education regarding the health of refugees and immigrants should be improved across all Canadian medical, which should harbour anti-racist and equity-oriented theories and lessons. Well-trained, future medical professionals could help reduce the healthcare disparities faced by refugees and immigrants, provided they are adequately trained. As

such, Canadian medical education systems should implement education and training focusing not only on the knowledge of specific and prevalent global health issues but should also address the rights, cultural issues and psychological traumas of refugee and immigrant populations (Matlin et al., 2017). Furthermore, valuing one's language and cultural background was crucial in this study. Therefore, a commitment should be made to increase the diversity and representativeness amongst healthcare professionals providing care to newly arrived refugees, immigrants, and the general population.

Practice

Thirdly, at the practice level, there is a need to expand awareness and competency in providing cross cultural care for refugee and immigrant populations and their diversified needs regarding health concerns. It is important to recognize that refugees and immigrants are unique in both histories of migration to a new host country and personal identifiers such as age, gender, education, and ethnicity (Gunn et al., 2021). Culturally competent practices for newcomer populations can be implemented by using increased information on ethnicity and migration available to service providers through national and provincial surveys (Hyman, 2014). Moreover, this present study's findings also highlighted overarching structural problems such as the lack of family doctors resulting in longer wait times, affecting all groups and potentially impacting future newcomers disproportionately. These issues must be addressed with an increased emphasis and priority placed on the most vulnerable and marginalized populations.

Furthermore, previous studies, alongside this present study, have showcased the importance and vitality of social support systems. As such, alongside increasing the knowledge and training available to service providers, it is crucial to increase the involvement of community members in such practices and training programmes as well as to implement a multifaceted and

holistic approach to better the access to care for newcomers in Canada. To achieve this, organizations and service providers must be equipped with sufficient resources and funding to curate and provide these essential services and programs.

Lastly, health care practioners should consider and be more aware of the CSDH framework which takes on a holistic view of health, by focusing on the root causes of an individual's health problems rather than viewing these issues from the biomedical orientation of health and illnesses (Solar & Irwin, 2010). This would be helpful in understanding the many different intersecting factors that may impede a newcomer's access to health and thus their health outcomes.

Research

Lastly, increased research is required on looking at the life course perspectives of immigrants and refugees in Canada. There need to be more studies designed to understand the longitudinal impacts on refugee and immigrant health. Although understanding experiences during a newcomer's initial arrival is essential, it is equally important to understand such individuals' health outcomes over their lifetime to understand conditions that have improved or worsened (Patil et al., 2012). Next, there is an increased need for further research on the impacts of the Sri Lankan Tamil refugees and immigrants in other host countries alongside countries such as Canada. The Sri Lankan Tamil diaspora is a sub-set of population that is widespread, with many Tamils residing in countries such as the United Kingdom, Germany, and Australia (Sriskandarajah, 2002; Orjuela, 2011). This research aimed to understand the experiences in how Sri Lankan Tamil Canadians went about accessing health care during their initial arrival and how these experiences have changed in the present day. As an expansion of this current study, due to the increased mental stigma in the Tamil community, it could be relevant for future studies to go

more in-depth and analyze the experience of accessing mental health services for newcomer populations arriving from a war-torn country. Programs supporting the well-being of newcomers and families, alongside mental health service providers, may find relevance and inspiration in such studies. Finally, future research studies revolving around the experiences of second-generation Tamils residing in countries such as Canada would be pivotal in understanding the intergenerational impacts of their parent's resettlement experiences in their lives (Warren, 2021).

4.5 Conclusion

This present study aimed to understand and explore the changes in experiences of accessing healthcare for Sri Lankan Tamil Canadians living in the GTA of Canada. With the results of this study, it was understood that there were facilitators and barriers in accessing healthcare through the past and present experiences of Sri Lankan Tamil Canadians. This study understood that each refugee's and immigrant's experiences are neither homogenous nor uniform. In fact, many factors intersect to influence the experience of healthcare access over time. Although most existing research focuses on healthcare access at one specific time point of a newcomer's journey in a host country, this research study shows how access to care was in some ways easier in the beginning due to the influence of personal factors, the significance of social support systems and structural facilitators. Additionally, access to care was more challenging in some ways due to the impact of one's immigration status alongside challenges associated with acculturation in Canada. Although access to care has gotten better over time, study results show that access to care is now more complicated due to the degradation of the Canadian healthcare system. Therefore, these findings highlight the importance and need for culturally sensitive care and the need for increasing diversity awareness and training for policy

and practice to achieve health equity for the longstanding population as well as newly arriving refugees and immigrants.

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APPENDICES

APPENDIX A: INTERVIEW GUIDE

Changes in Experiences of Accessing Healthcare: Perspectives of Sri Lankan Tamil Canadians

Interview Guide

Note: Interviews may be administered in either English or Tamil, as required by the participants.

Thank you [insert name of participant] for agreeing to take part in this study. Your time and participation are very much appreciated. I would like to audio record this interview to ensure I have a recorded copy to review if necessary. Are you willing and comfortable for the interview to be recorded?

Turn on recorder.

My name is Meera Karunakaran, and today I will be interviewing you for a research study which I am completing for my Master's thesis. *I am also of a Sri Lankan Tamil descent, as my parents came to Canada as refugees from Sri Lanka in the late 1980s.* I am conducting this research study because I am interested in how the Tamil community here in Canada went about accessing healthcare in a new country. I have seen my parents overcome many barriers in starting a new life in Canada and am curious to see if other Tamil community members have any similar experiences.

You are invited to take part in this study on exploring the Tamil Canadian's experiences of accessing healthcare in the Greater Toronto Areas of Canada. I want to look at how Tamil refugees and immigrants, aged 55-75 years old accessed healthcare resources upon their initial arrival to Canada in the late 1980s and how their experiences have changed in the present day. I am hoping to learn about the barriers that Tamil Canadians may have faced while trying to navigate the healthcare system.

I would like to reiterate some key content from the informed consent form you had signed. I would like to tell you that participation in this study is voluntary, and you may choose to not answer certain questions and may stop participating in this interview at any time if you experience any discomfort. Please also remember that whatever you share with me stays with me and no one else will know.

You may potentially feel uncomfortable with reflecting on your past experiences on arriving to Canada and in your experiences accessing healthcare. I will provide you with a resource list, with services you could access if you do feel any discomfort, after the completion of this interview. Do you have any questions for me? *[Answer any potential questions asked by participant]*.

Are you ready to begin?

We will start our conversation today by getting to know you better:

Demographic Questions

1. To start, would you please tell me about yourself:
   a. Your age?
   b. Your gender? (*probe: female, male, transgender, non-binary, prefer not to respond, other.)*

2. Can we talk a bit more about you coming to Canada?
   a. When did you arrive in Canada?
   b. Why did you leave Sri Lanka?
   c. What was your immigration status upon arrival in Canada? *Probe: refugee claimant, asylum seeker, immigrant (permanent resident, temporary foreign workers, sponsored family class, sponsored professional class).*
   d. What is your current residency status? *Probe: citizen, permanent resident, undocumented.*
   e. Where are you currently residing in Canada?

Thank you for sharing this information with me. Now I would like you to think back to when you first arrived in Canada in [insert year of arrival]. Specifically, I would like you to think back to the first few times you needed to access a healthcare service in Canada.

Experiences in Accessing Healthcare Upon Initial Arrival

1. Let's begin with you telling me about your initial experience with the Canadian healthcare system. Can you tell me what you remember about trying to get healthcare services after you first arrived in Canada?

   Probes:
   a. Why did you seek care? (i.e., any previous conditions)
   b. How did you learn about healthcare resources available to you?
   c. Did someone help you with this?
   d. Did you receive the assistance to access the care you needed?
   e. Do you think it was easy (sulapam) or hard for you to access information about the Canadian healthcare system? If easy, why? If hard, why?

2. Please tell me about your experience getting a family doctor when you first came to Canada.

   Probes:

a. *Did you have a family doctor to talk to about your health when you initially came to Canada?*
b. *If yes, was this family doctor from a similar culture as yourself?*
c. *If no, why did you have a family doctor?*

3. While thinking of your experiences in accessing healthcare services, have they been positive, negative or both?

   Probes:
   a. *Can you tell me more about your positive experiences?*
   b. *Can you tell me more about your negative experiences (if mentioned)? (If negative experiences are not mentioned at all, probe if participant has had any negative experiences at all)*

4. When you were trying to access healthcare services, what were the biggest challenges you faced?

   Probes:
   a. *What were these services?*
   b. *Why did you face these challenges?*
   c. *How did you deal with these challenges?*

5. Overall, what was important for you when you were looking for healthcare services when you first arrived in Canada?

Thank you sharing this information with me. Now I would like to talk about your current experiences in accessing healthcare in Canada now.

<u>Current Experiences in Accessing Healthcare</u>

1. Let's start off with you telling me about your current experiences with the Canadian healthcare system.

Probes:
a. *What were these healthcare services?*
b. *Can you tell me about your experience in accessing this type of care?*
   i. *Was it a positive experience? If so, what made this experience positive?*
   ii. *Was it negative experience? If so, what this experience negative?*
c. *What are some challenges you face in accessing care today?*
d. *What are some helpful and important things you use to accessing care today? (i.e, language friendly, cultural awareness).*

2. In your opinion, what has gotten better or easier about accessing healthcare today? What has stayed the same or gotten worse or harder?

   Probes:
   a. What helps you with your access to care today get better or easier over time?
   b. What is causing your access to care today get harder or worse over time?

3. You stated that you felt *[insert common emotions and feelings mentioned in the first part of the interview]* when you first tried accessing healthcare in Canada. Tell me about how you feel about these experiences now.

   Probes:
   a. Do you still feel the same way?
      i. If yes, how do you cope with it?
      ii. If no, how did you go about improving this feeling?

4. What are some lessons you have learnt from accessing healthcare in the past when you first came to Canada? Have these lessons changed the way you access healthcare today?

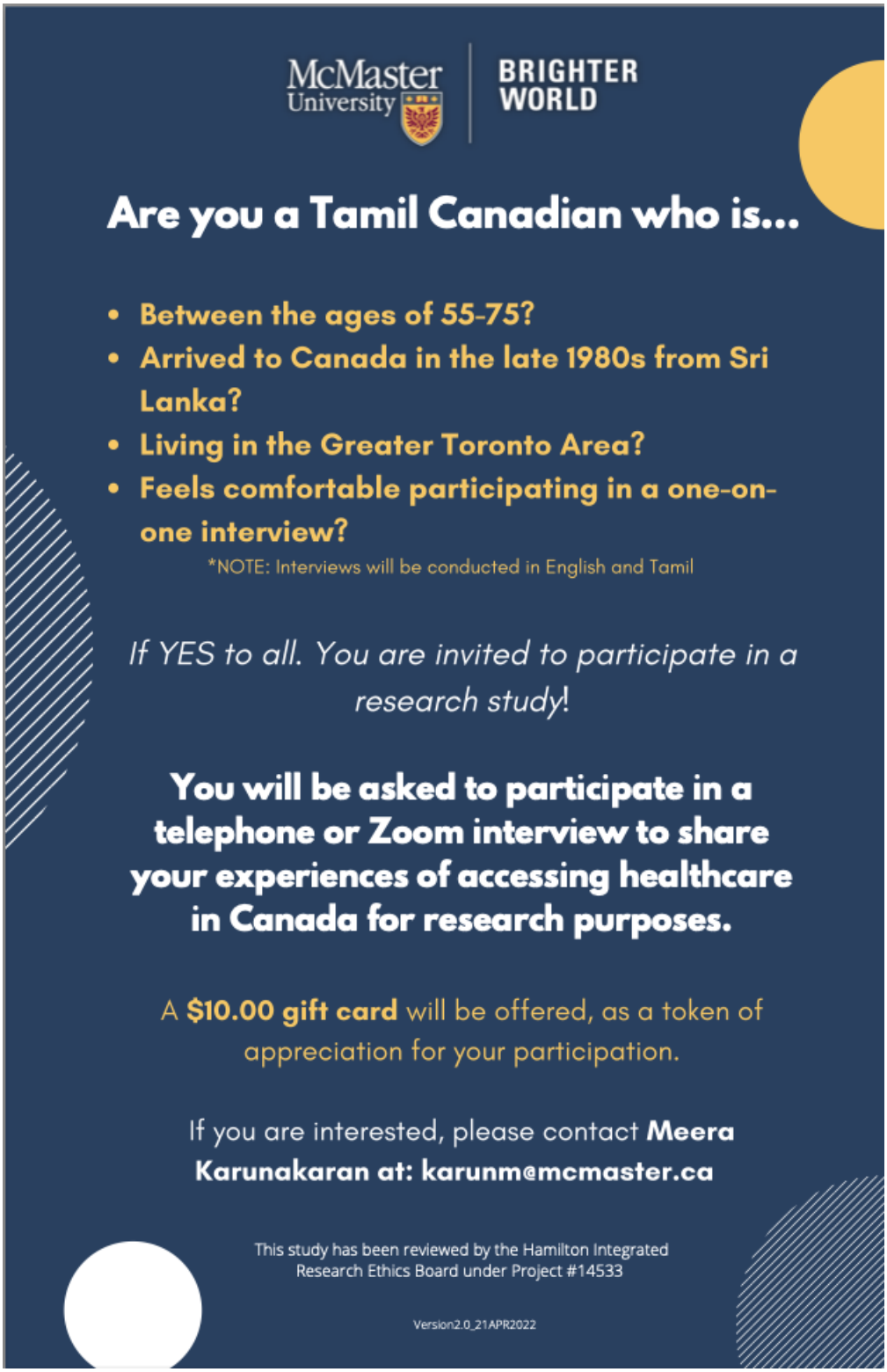
5. Given your experiences currently, could you please describe any approaches that are missing or could be improved for your access to better care today? What are some approaches that are working or helping your access to better care today?

6. Is there anything else about your experience with accessing healthcare that you would like to let me know about?

This brings us to the end of the interview. Thank you so much for your time and participation, I really appreciate it. If there are any questions or further clarifications required, would you be comfortable with me contacting you again? Additionally, at the end of the study, I would like to go over the study findings with you to validate the results. Would you be comfortable with me contacting you for this purpose?

Make arrangements with participant to provide compensation.

APPENDIX B: STUDY ADVERTISEMENT



APPENDIX C: EMAIL RECRUITMENT SCRIPT

Note: These scripts may be adapted in minor ways, as needed/dictated by participant comments/questions in order to communicate effectively about the study.

Email for individuals who requested telephone contact – to email a copy of the informed consent form

Dear [insert name],

Thank you for taking the time to speak with me. As we discussed I have attached a copy of the research study's informed consent form.

After you have had a chance to review this form, please let me know if you have any questions. I am more than happy to discuss any questions or concerns via email or by phone, if you would find that helpful.

If you would like to participate in this research study, complete the informed consent form and email it back to me. After I receive the consent form, I will follow up with you to schedule the interview.

With thanks and kind regards,

Meera Karunakaran

First email for people who requested email contact:

Dear [insert name],

My name is Meera Karunakaran. I am a student in the Global Health Master's program at McMaster University. Thank you so much for showing interest in my research study and reaching out to me. I'm emailing you to provide you with a bit more information about the research study and answer any questions you might have about the research study.

The research I am leading is on understanding the experiences of Tamil Canadians in accessing healthcare in the Greater Toronto Areas of Canada. I am looking to interview around 8-12 Tamils in the area about this. You must be within the ages of 55 to 75 years old, live in the Greater Toronto Areas and be comfortable in speaking in English or Tamil.

So, participation in this research study would involve taking part in a one-on-one interview with me and will last approximately an hour. These interviews would either take place via a telephone call or Zoom, depending on your preference. I will digitally record these interviews to analyze them for key patterns and themes over the following months. The results of this research study will be shared with you to make sure that I have captured your experiences correctly.

I have attached a copy of the informed consent form for the research study to this email for your review. It describes the research study and participation in greater detail. After you have had a chance to review this form, please let me know if you have any questions. I am more than happy to discuss any questions or concerns via email or by phone, if you would find that helpful.

After reviewing the consent form, if you don't have any questions and would like to participate in the research study, please sign the consent form and email it back to me. If you require any help with this, please let me know. After receiving your consent form, I will send a signed copy with my information to you for your records.

After I receive this, I will follow up with you to schedule your interview.

Should you have any questions, please do not hesitate to contact me.

With thanks and kind regards,

Meera

If willing to participate, proceed:

Dear [insert name of participant],

Thank you for agreeing to take part in this research study, and for completing the informed consent form, I truly appreciate your participation. A copy of the fully signed consent form is attached to this email for your records.

[Answer any questions posed by potential participant] Please let me know your preference for conducting the interview: would you prefer to do it: by phone, or by Zoom?

My schedule is generally flexible, please provide some dates/times in the next little while when you are available to take part in the interview while last approximately an hour.

Thank you once again for agreeing to participate and I look forward to talking to you soon.

Kind regards,

Meera Karunakaran

Third email:

Dear [insert name of participant],

Make arrangements to schedule the interview according to the person's preference and confirm time. If via Zoom, provide person with Zoom link and any additional information. If one phone, determine confirm phone number and time and date.

If NOT willing to participate, proceed:

Dear [insert name of participant],

Thank you for considering participating in the research study and thank you for following up to let me know that you have decided not to participate.

Kind regards,

Meera Karunakaran

APPENDIX D: TELEPHONE RECRUITMENT SCRIPT

Note: These scripts may be adapted in minor ways, as needed/dictated by participant comments/questions in order to communicate effectively about the study.

First call:

Hello, may I please speak with [name of participant]

Hello, my name is Meera Karunakaran. I am a student in the Global Health Master's program at McMaster University. I'm calling you about a research study. Is now a convenient time to talk?

Thank you so much for showing interest in my research study and reaching out to me. I'm calling today to provide you with a bit more information about the research study and answer any questions you might have.

The research study I am leading is on understanding the experiences of Tamil Canadians in accessing healthcare in the Greater Toronto Areas of Canada. I am looking to interview around 8-12 Tamils in the area about this. You must be within the ages of 55 to 75 years old, live in the Greater Toronto Areas and be comfortable in speaking in English and or Tamil.

So, participation in this research study would involve taking part in an one-on-one interview by myself and will last approximately an hour. These interviews would either take place via a telephone call or Zoom, depending on your preference.

I will digitally record these interviews to analyze them for key patterns and themes over the following months. The results of this research study will be shared with you to make sure that I have captured your experiences correctly.

Do you think you might be interested in participating in this research study? If so, I would like to provide you with an e-mail copy of the informed consent form for the research study, which contains more detailed information about the research study. May I please have your email address?

After you have had a chance to review this form, please let me know if you have any questions. I am more than happy to discuss any questions or concerns via email or by phone, my contact information is provided on the consent form, and I can always share this information with you at the end of this call.

After reviewing the consent form, if you don't have any questions and would like to participate in the research study, please sign the consent form and email it back to me. If you would require any help with this, please let me know. After receiving your consent form, I will send a signed copy with my signature to you for your records.

After I receive this, I will follow up with you to schedule your interview.

Do you have any questions for me at this time? *Answer any questions posed by potential participant.*

Provide contact information (email and phone number)

Thank you for taking the time out of your day to speak with me, and I look forward to hearing back from you.

If willing to participate, proceed:

Hello, may I please speak with [name of participant]

Hello, my name is Meera Karunakaran. I am a student in the Global Health Master's program at McMaster University. I'm calling you about a research study. Is now a convenient time to talk?

I received a copy of the consent form you completed, thank you so much for agreeing to take part in this research study, I truly appreciate your participation.

Did you have any questions for me regarding the research study?

Answer any questions posed by potential participant.

When it comes to the interviews, would you prefer to do the interviews: by phone, or by Zoom?

My schedule is generally flexible, would you be able to provide some dates/times in the next little while when you are available.

Schedule interview.

Great, your first interview is scheduled for [date/time].

If interview will take place by phone:

I will give you a call at the following number [insert number] on [date/time].

If interview will take place via Zoom:

I will send you an email containing the link to attend the Zoom meeting and some instructions for joining the meeting. On the day of the interview, you just click on that link and follow the prompts to connect to join the interview. If you have any technical difficulties just give me a call [insert phone number]

Thank you so much, I look forward to speaking with you.

If NOT willing to participate, proceed:

Hi,

May I please speak with [name of participant]

Thank you for considering participating in the research study and thank you for following up to let me know that you have decided not to participate.

APPENDIX E: INFORMED CONSENT FORM

LETTER OF INFORMATION / CONSENT

Study Title: Changes in Experiences of Accessing Healthcare: Perspectives of Sri Lankan Tamil Canadians

Investigators:

Local Principal Investigators:
Dr. Lydia Kapiriri
Department of Health Aging & Society
McMaster University
Hamilton, ON, Canada
(905) 525-9140 ext. 27203
E-mail: kapirir@mcmcaster.ca

Student Investigator:
Meera Karunakaran
Department of Global Health
McMaster University
Hamilton, ON, Canada
(416) 875- 5323
E-mail: karunm@mcmaster.ca

Dr. Amanda Sim
Department of Psychiatry and
Behavioural Neurosciences
McMaster University
Hamilton, ON, Canada
Email: siml3@mcmaster.ca

What am I trying to discover?

You are invited to take part in this study on exploring the Tamil Canadian's experiences of accessing healthcare in the Greater Toronto Areas of Canada. I want to look at how Tamil refugees and immigrants, aged 55-75 years old accessed healthcare resources upon their initial arrival to Canada in the late 1980s and how their experiences have changed in the present day. I am hoping to learn about the barriers that Tamil Canadians may have faced while trying to navigate the healthcare system. This research is being completed for my Master's thesis.

What will happen during the study?

If you are interested in this study and would like to participate, you will be interviewed one-on-one with me on a telephone call or online through Zoom for an hour. I am looking to interview 8-12 participants. You will be allowed to pick any time for this interview that is convenient for you based on your personal schedule. With your permission, the interview will be digitally recorded (audio only).

In the interview, I will first ask you some questions about yourself. These questions include your age, gender, when you moved to Canada, what your residency status was in Canada when you first moved, and what your current residency status is. Next, I will ask you to share information on your experiences in accessing healthcare when you first arrived in Canada. Following this, I will ask you to share information

on your current experiences in accessing healthcare. When the study is completed, I may contact you again, to make sure that I have captured your experiences correctly, if you are comfortable in verifying my study findings.

Are there any risks to doing this study?

There are minimal risks involved in participating in this study. You may potentially feel uncomfortable with reflecting on your past experiences on arriving to Canada and in your experiences accessing healthcare. You do not need to answer questions that you do not want to answer or that makes you feel uncomfortable. You are also allowed to take a break at any time during the interview. You can stop taking part at any time or withdraw consent at any point in the study.

Are there any benefits to doing this study?

The research will not benefit you directly. We hope to learn more about how the experiences of accessing healthcare in Canada has changed for the Tamil population. This could help us understand any barriers or challenges in accessing healthcare resources and could help improve refugee and immigrant agencies and or resettlement policies.

Reimbursement

As a token of appreciation, you will receive $10.00 electronic gift card.

Confidentiality

You are participating in this study confidentially. I will not use your name or any information that would allow you to be identified. No one but me will know whether you participated unless you choose to tell them. Every effort will be made to protect your confidentiality and privacy. I will not use your name or any information that would allow you to be identified. You are participating in this research anonymously. If you choose to identify names of places during your interview, I will change these names to keep their privacy. If I am using quotes from your interview in the results of the study, your name will not be used. The audio interview file will be kept on a computer that will be protected with a password. Only I will have access to it. The interview will be transcribed by me, and these documents will be kept on a computer that will be protected with a password, in a file separate from your consent form. The data collected from this research study will be stored on our secure One Drive at McMaster University. Only the research team will have access to the information and all the team members are committed to protecting your privacy and confidentiality. Once the study is complete, an archive of the data, without identifying information will be kept for 10 years. You are also allowed to participate if you are enrolled in other research during the time of this study. Additionally, by participating in this study, you do not waive any rights to which you may be entitled under the law.

This study will take place through a telephone call, if preferred, which will be recorded with a digital recorder. The study could also take place through Zoom, if preferred. If you choose to participate through Zoom, this study will use the Zoom platform to collect data, which is an externally hosted cloud-based service. A link to their privacy policy is available here: https://explore.zoom.us/en/privacy/. While the Hamilton Integrated Research Ethics Board has approved using the platform to collect data for this study, there is a small risk of a privacy breach for data collected on external servers.

If you are concerned about this, I would be happy to conduct the interview via telephone. Please talk to the student investigator, Meera Karunakaran, if you have any concerns.

Lastly, for the purposes of ensuring the proper monitoring of the research study, it is possible that a member of the Hamilton Integrated Research Ethics Board may consult your research data. By signing this form, you would authorize such access.

What if I change my mind about being in the study?

Your participation in this study is voluntary and confidential. It is your choice to be part of the study or not. If you decide to be part of the study, you can decide to stop, at any time, ever after signing the consent form or part-way through the study. If you decide to withdraw, there will be no consequences to you. If you want to remove your interview data that has already been collected, you can contact Meera Karunakaran at the email and phone number provided above before August 31st, 2022.

How do I find out what was learned in this study?

I expect to have this study completed by approximately September 2022. If you would like a brief summary of the results, please let me know how you would like it sent to you.

Questions about the Study

If you have questions or need more information about the study itself, please contact me Meera Karunakaran at (416) 875-5323 or karunm@mcmaster.ca. Additionally, you can contact Dr. Lydia Kapiriri at kapirir@mcmaster.ca or Dr. Amanda Sim at siml3@mcmaster.ca.

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HiREB). The HiREB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call the Office of the Chair, HiREB, at 905.521.2100 x 42013.

CONSENT

- I have read the information presented in the information letter about a study being conducted by Meera Karunakaran of McMaster University.

- I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.

- I understand that if I agree to participate in this study, I may withdraw from the study at any time. I will be given a signed copy of this form. I agree to participate in the study.

- I consent to be audio recorded during my interview.

- I agree to be contacted again at the end of the study, to ensure that my experiences have been captured correctly.

_____	_____	_____
Name of Participant (Printed)	Signature	Date

Consent form explained by:

_____	_____	_____
Name and Role (Printed)	Signature	Date

APPENDIX F: RESOURCE LIST

Resource List

RESOURCE	CONTACT INFORMATION
Crisis Line Scarborough/Rouge Hospital	**https://www.shn.ca/mental-health/crisis-support/** 416 495-2891 for 24/7 telephone crisis support.
York Region Crisis Response Service	**https://yssn.ca/crisis-response-services/** 1-855-310-2673 or (TTY) 1-866-323-7785
Durham Distress Centre	**https://distresscentredurham.com/** 905-430-2522 or 1-800-452-0688
Vasantham Wellness Centre	**https://www.vasantham.ca/** 2600 Eglinton Avenue East, Scarborough, ON M1K 2S3, Canada 416-847-4172 info@vasantham.ca
TESOC Multicultural Settlement Services/Tamil Eelam Society of Canada	**https://tesoc.org/** 1160 Birchmount Road, Unit 1A, Toronto, ON M1P 2B8, Canada 416-757-6043 info@tesoc.org
Canadian Tamil Medical Association: CTMA	**https://www.ctmacharity.com/** 385 Silver Star Boulevard, Suite 205, Toronto ON M1V 0E3, Canada ctmacharity@gmail.com
Scarborough Centre for Healthy Communities	**https://www.schcontario.ca/** 416-642-9445 info@schontario.ca
Community Matters Toronto	**http://communitymatterstoronto.org/** 260 Wellesley Street East – Unit 102 416-944-9697 info@communitymatterstoronto.org