

## CASE 1

# Mobilizing Knowledge into Action: Best Practices in Responding to Urgent Refugee Health and Resettlement Service Needs

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Zola Faraji leaned back in her chair and let out a momentous sigh. Zola and her colleagues were wrapping up a data analysis meeting in relation to one of their research projects – the *Best Practices in Refugee Health and Resettlement Services* project. It had been eight months since the launch of the project within the community-based research department at Access for Health and Settlement Centre (AHSC).

Looking outside the boardroom window on that late April morning, Zola noticed that the clouds were shifting unpredictably as they often did in Toronto this time of year. Sitting next to her was Jamila Ahmed, a young project coordinator, who was re-reading meeting notes at the table. Zola glanced over at Jamila and recognized an expression of curiosity on her face. This was the same curiosity that brought Zola to pursue a career in public health research.

The day was full of reflection and nostalgia, as it marked 11 years since Zola started working at AHSC. She held a role as a senior scientist at the organization, leading multiple research projects within the community-based research department. Zola knew that this particular project had captured her efforts and attention as early as the ideation stage over 14 months ago in a way that no other project had done so before. She glanced back at the shifting weather, recognizing that it was a reflection of the context from which the project arose.

The *Best Practices in Refugee Health and Resettlement Services* research project stemmed in reaction to the movement of thousands of refugees from Syria to Canada between 2015 and 2017, following the Syrian Civil War that began in 2011. As an unprecedented number of refugees entered the country, government and other cross-sector agencies were required to mobilize efforts to facilitate the resettlement process and provide accessible, equitable, and culturally-relevant health care within an environment of haste and chaos. There was a need for a fast and coordinated response within the health care sector, in collaboration with various other sectors.

As part of the community-based research department at AHSC, a community health centre that primarily services new Canadians, Zola and her team have access to colleagues from other parts of the organization. These individuals include service providers and senior-level management, who were active leaders in the establishment of a cross-sector response during the Syrian refugee crisis. This had put Zola in an ideal position to utilize her expertise and cross-sector relationships to document the response. Documentation of the response was meant to shed light on what worked and what did not when multiple agencies came together to

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coordinate and establish systems that serviced a large cohort of refugees within an extremely short period of time.

Zola could envision how lessons learned from this response could greatly influence the implementation of systems that could better serve future cohorts of refugees. What barriers could have been avoided? What strengths could be further reinforced? What resources, collaborations, or communications were missing? These were all important questions that Zola and her team posed – all of which presented interesting findings.

Jamila finally looked up from her meeting notes and said, “most of the interviewed participants are concerned about seeing how their successes and failures may transcend this specific response. They are thinking about the impact these findings can have on how our systems react to future mass cohorts of refugees who may arrive in Canada.” Jamila’s academic background in public health and her personal interest in refugee health fueled her passion for this project. “You make a really interesting point, Jamila. We need to talk more about how we are going to enable our systems to use and implement these findings. Yes, we may have been able to capitalize on our positioning to document the response, but what good will it do if we aren’t able to showcase the potential impacts of our results? How can we create cross-sector understanding and incentive *to act* on these findings?” Zola replied.

Zola flipped through her papers until she found the knowledge mobilization plan that the team developed at the beginning of the research project. Zola made a point to never forget to bring knowledge mobilization plans to her research meetings. She understood the importance of exploring and answering impactful questions, but she made sure to never forget that answers can only make an impact when they are mobilized and implemented into subsequent action.

### BACKGROUND

#### The Humanitarian Crisis

As the senior scientist at AHSC, Zola was aware of the social determinants of health that affect new Canadians throughout their migration journey—such as the social and political factors that often lead to displacement. However, she also knew that the Syrian refugee crisis was unique due to its evolution into a large-scale humanitarian crisis. This crisis had unfolded under complex international political and social contexts that witnessed wildly contrasting civic and media engagement.

Throughout the research project, Zola often found herself reflecting on a statement made by the UN Human Rights Commissioner, Zied Ra’ad Al Hussein: he described the crisis as “the worst [human-made] disaster the world has seen since World War II” (United Nations News Services, 2017). The Syrian Civil War had displaced 6.5 million people within Syria (UNHCR, 2016), and led 5 million to flee the country and live as refugees in Turkey, Egypt, Iraq, Jordan, Lebanon, and North African countries (UNHCR, 2017b). Additionally, it had forced almost 1 million Syrians to request asylum in European countries (UNHCR, 2017a).

In 2015, the Canadian government and its citizens stepped in with a nationwide commitment to resettle 25,000 Syrian refugees. This ambitious commitment had a deadline of late 2015, which was later extended to the early spring of 2016. As the resettlement process was undertaken, advocacy groups and community agencies rallied the Canadian government to increase Syrian resettlement numbers, leading to the expansion of the commitment to a total of 40,000 Syrian refugees by mid-2017 (Government of Canada, 2017a).

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### Sectors Involved in the Response

Within Ontario, 16,000 Syrian refugees were resettled, one third (5,345) of whom were located in the City of Toronto (Access Alliance Multicultural Health and Community Services, 2017b). These arrivals included government-assisted, privately-sponsored, and blended visa-office-referred refugees. Refugees are categorized based on the method of their sponsorship and support. For example, government-assisted refugees must be initially registered as refugees with the United Nations High Commissioner for Refugees (UNHCR), which then refers refugees to Canada. This resettlement is fully supported by the Government of Canada or the province of Quebec for up to one year (Government of Canada, 2016). Privately-sponsored refugees are supported in their resettlement by groups of Canadian volunteers who help refugees financially, socially, and emotionally for a minimum of one year (Government of Canada, 2017c). Meanwhile, blended visa-office-referred refugees are UNHCR-identified refugees who are matched with private sponsors. Blended visa-office-referred refugees receive social and emotional support from private sponsors for a minimum of one year, and combined financial support from the Government of Canada for six months and from private sponsors for another six months (Government of Canada, 2017b).

With such staggering numbers of refugees resettling in the province in a short period of time, governments and cross-sector agencies mobilized in response (Access Alliance Multicultural Health and Community Services, 2017b). Fifteen different sectors were involved in the response, including settlement, community and non-profit, housing, education, language, employment, food assistance, research, primary health care, and community health care (Exhibit 1). However, due to the urgent and frantic nature of the situation, there were many hurdles to meeting the health and resettlement needs of refugees, with additional limitations on capacity to evaluate effectiveness of services.

AHSC was one of the many primary and community health care organizations that participated in the resettlement efforts within the City of Toronto. Zola's colleagues at AHSC, including primary health care providers, social workers, health promoters, system navigators, and interpreters, all played a key role in working collaboratively to provide needed services.

Upon the government's announcement to resettle Syrian refugees in Canada in such large numbers, AHSC was among a long list of organizations that were not prepared to coordinate a response. However, the government did develop plans in response to immediate needs, activating a Ministry Emergency Operations Centre (MEOC) to share information and manage collaborations across levels of government and with regional partners. The province also mobilized the *Ontario Health System Action Plan* for Syrian refugees (Exhibit 2). The first three phases of the plan (*Phase 1: Identifying Syrian refugees to come to Canada*, *Phase 2: Processing Syrian refugees overseas*, and *Phase 3: Transportation to Canada*) were primarily undertaken by government agencies. Meanwhile, *Phase 4: Welcoming in Canada* and *Phase 5: Settlement and community integration* were key phases that providers and agencies, such as AHSC, became involved in (Access Alliance Multicultural Health and Community Services, 2017b).

### Access for Health and Settlement Centre and Its Role

Having worked at AHSC for 11 years, Zola knew that as soon as Canada made a commitment to resettle 40,000 Syrian refugees, AHSC would be at the frontline providing its services and resources. Up to this point, AHSC had exhibited a great commitment to providing client-centered care that is equitable, accessible, and inclusive to the most vulnerable newcomer populations. AHSC functions under an anti-oppressive and anti-racist framework that made this commitment and emphasis on health equity and the social determinants of health possible.

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AHSC provides services such as primary care, illness prevention, health promotion, community capacity building, service integration, and community-based research. This marked AHSC as a respected leader in refugee health within the City of Toronto. The organization's vision and commitment was undoubtedly translated into passionate leadership to service Syrian refugees upon their arrival (Access Alliance Multicultural Health and Community Services, 2017a). In fact, AHSC applied its tradition of providing integrated and interdisciplinary leadership to support the Syrian refugees in the City of Toronto. In collaboration with numerous other community health centres in the City of Toronto, a model of care for a systematic response to the needs of the population was developed with two main care initiatives (CACHC, 2016).

The first initiative began as a collaboration with Crossroads Clinic, St. Michael's Hospital, and Queen West-Central Toronto Community Health Centre, forming a Primary Care Planning Committee. The committee, on which Zola's colleagues sat, eventually grew to 30 primary health care agencies, consisting of a large number of community health centres. This collaborative effort placed great emphasis on ensuring that a series of clinics would provide full health assessments to arriving refugees. Providing this access to primary care would act as a gateway to all other health care services (CACHC, 2016).

As a result, refugees staying in temporary accommodation sites, such as hotels, were connected with one of the 30 primary health care organizations for their full initial health assessment. Some of the temporary accommodation sites provided these health assessments via on-site, primary care clinics. However, in order not to overwhelm these on-site clinics, the Red Cross provided transportation between temporary accommodation sites and the 30 primary health care organizations committed to providing initial health assessments. Additionally, each of the 30 organizations provided refugees with a minimum of three months of follow-up care while they were connected to ongoing primary care practices (CACHC, 2016).

The second initiative was a collaborative effort with COSTI Immigrant Services. The initiative ran across accommodation sites and was meant to develop a primary care service model that addressed refugees' limited access to immediate care for acute and episodic medical concerns. This model was accomplished in partnership with Community Health Centre (CHC) partners. Refugees based in temporary accommodation sites had access to a triage assessment through which immediate health concerns were met by doctors and nurse practitioners from local CHCs, allowing for care and follow-up both on-site and in nearby centers. However, on-site care was not limited to primary health care (CACHC, 2016). Through a collaboration with Toronto Public Health, AHSC arranged additional on-site care, such as flu vaccinations and urgent dental assessments, as well as access to urgent dental care at affiliated off-site locations. Organizations representing sectors such as housing, education, language, employment, and food assistance also utilized these accommodation sites as hubs through which services and resources were provided (CACHC, 2016).

### **Post-Response**

Transitioning from a state of unpreparedness, to an integrated, collaborative, and interdisciplinary response that aimed to meet health and resettlement needs was a path full of challenges. It was also a path full of successful feats and opportunities for improvement. As the immediate response phase came to an end, Zola and her team saw that it was time to document the experience through a cross-sector perspective. The evaluation stage of any public health program or service is vital to its success, providing important insights on the achievements and challenges experienced to better serve the population at hand. Ideally, ongoing evaluations occur as programs or services run, enabling real-time planning,

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coordination, and implementation improvements. However, in the case of the Syrian refugee response, there were too many moving pieces involved to coordinate an ongoing evaluation.

This limitation did not stop Zola and her team from working with colleagues across organizations and sectors to collect and share information regarding the response. With funding from United Way Toronto and United Way York Region, the objective of the research study was to document the response to the arrival of thousands of Syrian refugees within a short period of time and to identify evidence-based best practices that could inform future responses. Emphasis was placed on understanding the nature of cross-sector collaborations, system navigation supports, and the institutional factors that enabled these collaborations and successes. Additionally, attention focused on documenting the challenges faced, how agencies responded to those challenges, and providing a comparative context on how regional differences in Ontario contributed to variations in service planning (focusing on the City of Toronto, Region of Peel, and Region of Waterloo) (Access Alliance Multicultural Health and Community Services, 2017b). Findings would have an impact on both future waves of refugees and the Syrian refugee population.

The research study that Zola and her team designed encompassed lived experience perspectives through the engagement, recruitment, and training of two recently arrived Syrian Canadians in leadership capacities as “peer researchers”. Mona Sameh and Sami Aman participated in this community-based research study at each step of the research cycle, including research design, data collection, analysis, writing, and knowledge mobilization activities. Their perspectives as privately-sponsored and government-assisted refugees, respectively, were integral to the success of the research project. The team also ensured representation from a diversity of involved sectors and regions, interviewing 22 key informants who played direct and active roles in the Syrian refugee response. Key informants were senior-level leaders and frontline service providers, as well as key players in various roles across settlement, government, community development, and faith and non-faith-based organizations and groups. From these interviews, emergent themes were captured and analyzed – a process that Zola and her team had just concluded (Access Alliance Multicultural Health and Community Services, 2017b).

### **Study Results**

The *Best Practices in Refugee Health and Resettlement Services* research project revealed themes related to the successes and challenges that were experienced across sectors and organizations, leading to the development of recommendations for best practices. The following is a summary of successes and failures uncovered:

#### **Successes:**

Cross-sector Collaborations and Innovation	Innovative models of cross-sector collaborations enabled timely and integrated services for Syrian refugees. Dozens of collaborative working groups were created, taking on different shared responsibilities.
Temporary Accommodation Sites	Temporary accommodation sites became service hubs for innovative collaborations and services to meet needs. This included health, resettlement, and community services.

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Humanitarianism and Goodwill	Humanitarianism and goodwill were exhibited by members of the public, service providers, and volunteers. This commitment allowed for immediate resettlement needs to be addressed in a timely and personalized manner.
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Source: Access Alliance Multicultural Health and Community Services, 2017b.

### Challenges:

Communication gap	A lack of sufficient data about the arrivals of Syrian refugees led to confusion and limitations on service preparations. This uncertainty negatively affected the planning of services.
Funding	Smaller agencies that were involved in the response were fiscally neglected. There were also funding gaps for specific kinds of services and supports, such as hiring interpreters, service coordinators, and additional staff.
Burnout	Service providers and volunteers were working very long hours. Staff felt overwhelmed and shocked, experiencing mental and physical exhaustion, as well as burnout and isolation.
Fairness and equity	Unequal amounts and types of services were available between different cohorts of Syrian refugees, and between Syrian refugees and refugees from other countries.
Poor coordination	It was difficult for agencies to put different response elements together because there was poor initial coordination between agencies and a lack of a central coordinating group. This lack of unity meant that some agencies took on a significant load of work while others were underutilized.
Meeting community-specific needs	Meeting needs related to larger family sizes, conflict-inflicted complex health issues, and preferred settlement locations close to Syrian or Arab populations in the Greater Toronto Area was challenging.
Navigating the health system while meeting complex needs	Refugees exhibiting complex or specific health needs experienced difficulty navigating the health system during the initial response, and they were not being seen by service providers fast enough.
Interpretation barriers	Interpretation is already an existing structural barrier within the Canadian health care system, and it was a key challenge during the response, making it more difficult to navigate the health system.
Access to pregnancy and reproductive care	There was a lack of information on the number of pregnant women arriving in Canada and the related urgency of care that was needed. Minimal preparation was made to meet the sexual and reproductive health needs of this population, including birth control.

Source: Access Alliance Multicultural Health and Community Services, 2017b.

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### KNOWLEDGE MOBILIZATION: FROM EVIDENCE TO ACTION

Sitting in the AHSC boardroom, Zola shifts her focus from findings to knowledge mobilization. She begins to examine the knowledge mobilization plan developed by her team at the beginning of the project. Zola's experience over the years has taught her the importance of integrated knowledge mobilization as part of the research cycle. Integrated knowledge mobilization goes beyond the documentation of research results through reports and publications, a process commonly known as end-of-grant knowledge mobilization (CIHR, 2012). Integrated knowledge mobilization encompasses knowledge producers and users (such as policy makers, health professionals, and individuals with lived experience) in the synthesis, adaptation, and dissemination of evidence into co-produced products, tools, and events (CIHR, 2012; Powell, Davies, & Nutley, 2016; Phipps et al., 2016). The goal of integrated knowledge mobilization is to bridge the gap between evidence, and practice and/or policy change. The integration of knowledge producers and users within the knowledge mobilization process ensures that developed resources are more relevant and useful (CIHR, 2012). For example, research questions that are formulated and explored in collaboration with physicians are more likely to uncover findings that are relevant to physicians' perspectives. Additionally, when findings are adapted into a resource or event through co-production, physicians are most likely to be reached and engaged in the content and its application.

Ultimately, research is conducted to learn about public health issues with the goal of improving the systems that function to positively impact the health and lives of populations that are serviced. To enable findings to have more meaningful population-level impacts, active efforts need to be made in moving findings forward as action-based recommendations through various channels, reaching identified individuals or organizations who can guide, influence, and alter relevant practice or policy (Access Alliance Multicultural Health and Community Services, 2011).

In fact, through the incorporation of integrated knowledge mobilization, the research agenda is broadened, allowing for more interactive dialogues to develop surrounding research questions of interest and enabling greater perspectives and impacts to arise (Access Alliance Multicultural Health and Community Services, 2011). Potential impacts move beyond project end dates. At AHSC, integrated knowledge mobilization can take on many forms, including:

- The development of community capacity for understanding evidence
- The creation of materials and tools that help knowledge users utilize evidence to influence and enact practice and policy change
- The development of relationships to influence and enact practice and policy change
- The facilitation of workshops and events that engage community, service providers, and policymakers in constructive partnerships that mobilize collaborative reflection and subsequent action
- The development of capacity for stakeholders to lead and participate in knowledge mobilization (Access Alliance Multicultural Health and Community Services, 2011)

All in all, integrated knowledge mobilization not only leads to knowledge uptake, but it influences practice and/or policy-based action — thus completing the knowledge-to-action cycle that research initially aims to enact (Access Alliance Multicultural Health and Community Services, 2011).

Zola and her colleagues develop knowledge mobilization plans at the beginning of research projects, updating them throughout the lifespan of projects. Dissemination does not have to begin at the end of a research project. It should be planned at the beginning and executed throughout the research cycle, increasing access and control of knowledge. Sharing information

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about the development of the research question, the process of establishing the research design, and the frameworks utilized to analyze data is valuable (Access Alliance Multicultural Health and Community Services, 2011; Powell, Davies, & Nutley, 2016; Phipps et al., 2016).

Dissemination requires deliberate planning, resources, and time. Knowledge mobilization plans identify the who, what, where, when, why, and how of sharing information (Access Alliance Multicultural Health and Community Services, 2011). Essentially, knowledge mobilization attempts to meet people where they are at, aiming to carry them to a frontier of action.

Why	Plans must identify key objectives and prioritize them, thus setting the framework for all subsequent strategizing and action – what information needs to be shared?
Who	Key audiences must be distinguished based on goals and scans for potential vital partnerships must be conducted – who needs to learn about findings, who can help guide influence change, and what kind of change must be mobilized (i.e. grassroots-level, agency-level, policy-level, or more than one level)?
What	Facilitators and barriers to knowledge uptake and use must be examined – what factors stand in the way of turning research into action (i.e. political landscapes, organizational contexts, lack of motivation, incentive, funding, contextual understanding, accountability, time, or understanding on how to incorporate findings into practice or policy concretely)?  How do these facilitators and barriers influence dissemination priorities and goals, message framing, the list of intended audiences, and timelines?
How	Effective, relevant, and innovative channels must be assessed – how will identified audiences be reached, and how can various traditional and innovative mediums be utilized to maximize the impact of reach (i.e. mass media, magazines, websites, blogs, conferences, brown bag lunches, community events, workshops, symposiums, infographics, animations, video screenings, development of action-focused toolkits, etc.)?
When and Where	Where can we find our audience, and when is the best time to reach them?

### NEXT STEPS

The knowledge mobilization plan in Zola’s hands defined the who, what, where, when, why, and how of the team’s knowledge mobilization strategy. It was clear to the team why this work was important, and they developed a good sense of which sectors and stakeholders to engage. The team also distinguished a steady timeline of when and where activities could be implemented.

Zola looked up at Jaden Butler, the newest addition to the team who filled a new highly anticipated role within the department – knowledge broker. “Jaden, what can we do to mobilize this new knowledge that we possess? How can we make sure our stakeholders are able to use it? How can this plan guide us to enable and empower stakeholders to implement our recommendations across sectors?”

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### EXHIBIT 1

Sectors involved in the Syrian refugee response, organized by degree of involvement.

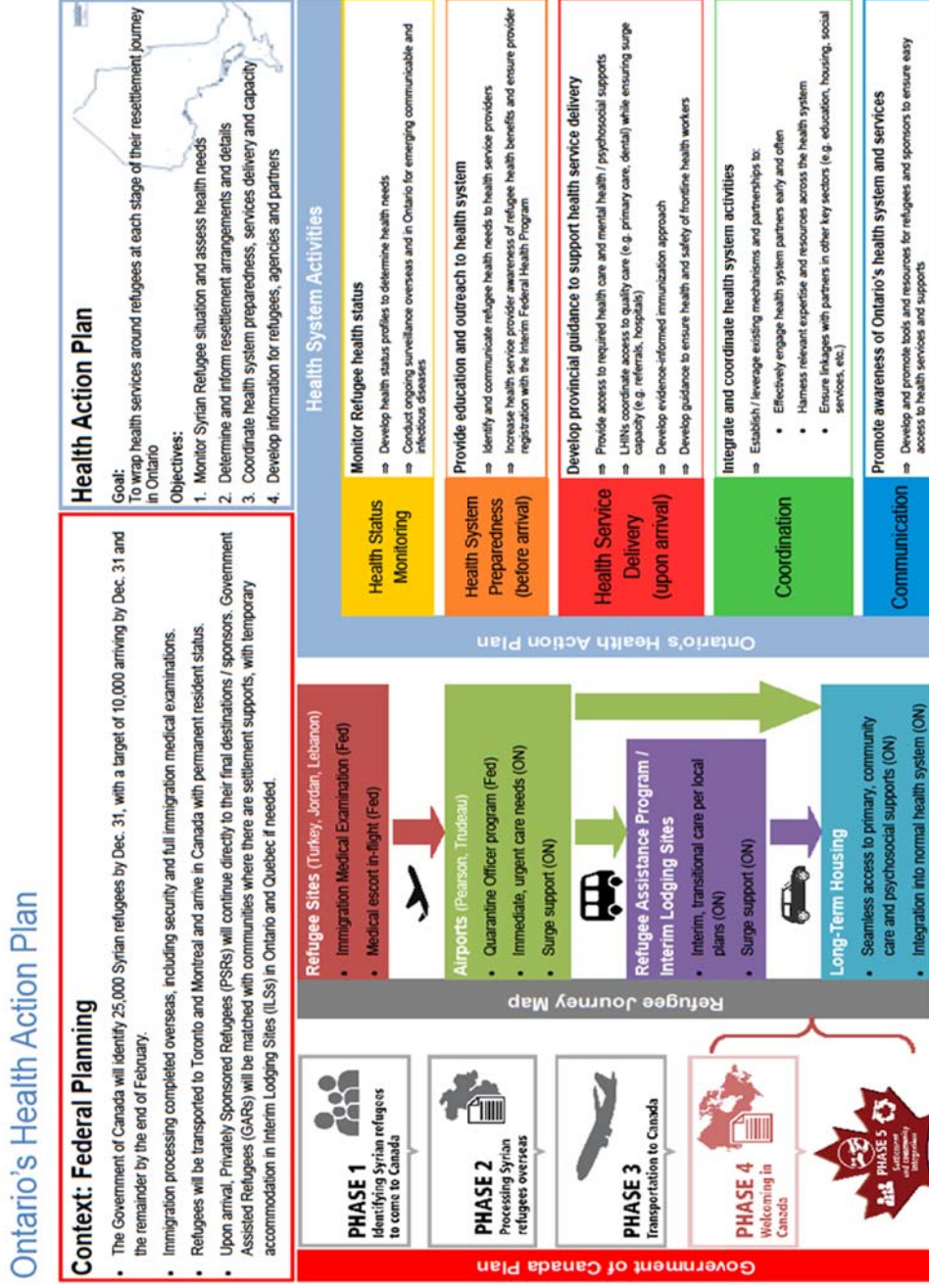


Source: Access Alliance Multicultural Health and Community Services, 2017b.

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## EXHIBIT 2

### Ontario's Health Action Plan in response to the Syrian refugee resettlement effort.



Source: Ministry of Health and Long-Term Care, 2015.

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## INSTRUCTOR GUIDANCE

### Mobilizing Knowledge into Action: Best Practices in Responding to Urgent Refugee Health and Resettlement Service Needs

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#### BACKGROUND

The Syrian Civil War has displaced 6.5 million people internally within Syria (UNHCR, 2016) and has led 5 million to flee the country and live as refugees in Turkey, Egypt, Iraq, Jordan, Lebanon, and other North African countries (UNHCR, 2017). In 2015, the Canadian government and Canadian citizens stepped in with a nationwide commitment to resettle 25,000 Syrian refugees. Due to community-based rallying, the commitment expanded to a total of 40,000 Syrian refugees by mid-2017 (Government of Canada, 2017). In response to this urgent and unprecedented arrival of refugees, hundreds of community agencies and many community groups across Canada banded together to provide services and supports to Syrian families (Hansen & Huston, 2016; Access Alliance Multicultural Health and Community Services, 2017).

Various sectors were represented in this effort: healthcare, settlement, community and non-profit, housing, education, government, language, sponsor groups, children's services, community and civic participation, police and safety, faith-based organizations, research, employment, and food assistance. Among organizations that represented these sectors, Access for Health and Settlement Centre was a community health centre that situated itself in a temporary accommodation site, serving primary health care, interpretation, and other community services (Access Alliance Multicultural Health and Community Services, 2017).

Through this effort, Dr. Zola Faraji, a senior scientist at Access for Health and Settlement Centre, and his community-based research team began to recognize the importance of documenting the manner in which the response was unfolding around them within the Greater Toronto Area (GTA). Zola knew that upon the government's announcement to resettle so many Syrian refugees in Canada, none of the sectors and agencies who were to participate were adequately prepared to coordinate a response that matched the urgency of the situation. However, the response had been a remarkable one but not without its successes and challenges. Therefore, Zola conducted an environmental scan to document how service provider agencies within the GTA planned and delivered health, settlement, and other services for a large number of refugee families within a short period of time through a cross-sector perspective (Access Alliance Multicultural Health and Community Services, 2017). The study findings captured key successes and challenges that informed the development of best practices for refugee health and resettlement services, particularly in relation to future large-scale arrivals of refugees.

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Now, Zola and her team are at a crossroad. They possess vital research findings and must develop recommendations as well as relationships with key players across various involved sectors. The team is developing a knowledge translation strategy. How can Zola and her team develop and implement a strategy that ensures that knowledge is not only shared but implemented into action? How can this research be utilized in a knowledge-to-action framework to benefit these vulnerable populations in the future?

### **OBJECTIVES**

1. Understand the importance of evaluating services to identify gaps, leading to the development of, or investigation for, evidence-based recommendations to implement improvements.
2. Demonstrate the importance of sharing knowledge and research – internally and/or externally – to facilitate the process of best-practice implementation within an organization, within a sector, or cross-sectorally.
3. Design innovative tools and strategies through which knowledge translation goes beyond sharing information but rather builds capacity for action.
4. Coordinate important collaborations and relationship-building opportunities in the process of implementing successful knowledge-to-action initiatives.
5. Evaluate public health's current limitations and responsibilities to mobilize organization and system-level changes through knowledge translation and to protect and promote the health of vulnerable populations.

### **DISCUSSION QUESTIONS**

1. Why was it important for Access for Health and Settlement Centre to launch a research project to uncover lessons learned in relation to the Syrian refugee response?
2. What were some of the incentives for Zola and her team at Access for Health and Settlement Centre to collect and share information beyond their organization?
3. What avenues did Access for Health and Settlement Centre consider in terms of knowledge and information sharing? What other innovative avenues should they consider?
4. What is the difference between simply sharing knowledge and sharing knowledge for the purpose of action or change? What is the significance in the difference?
5. How should Access for Health and Settlement Centre use their recent research and relationships to build capacity and enable systems-level change to be implemented cross-sectorally—for example, what are some of ingredients that have to be considered to do this successfully?
6. What are some of public health organizations limitations when it comes implementing effective knowledge translation initiatives?
7. How do public health professionals become advocates and build interest in knowledge translation and mobilization? How do public health professionals build competencies in knowledge translation and mobilization?
8. Is it public health's responsibility to translate research into tools or methods that facilitate positive changes to services, the healthcare system, and society at large? What role does public health need to take?
9. What are some of the potential impacts of a best practice knowledge-to-action model on for future refugee surges? How can such a model aid the coordination of services within the healthcare sector and other related sectors?

### **KEYWORDS**

Refugee health; refugee settlement; knowledge translation; knowledge mobilization; knowledge exchange; integrated knowledge mobilization; implementation science; Syrian refugee response; best practices; evidence-based; managing health services.