Thriving Together: A Scoping Review of Interventions to Improve Refugee Social Capital and Health

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Wellesley Institute is a research and policy institute that works to improve health equity in the GTA through action on the social determinants of health.

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Introduction

In 2016, the recent influx of refugees into Canada has implications for health equity in the Greater Toronto Area (GTA). In the first quarter of 2016, 25,863 refugees were granted permanent residency in Canada—a number greater than the total number of refugees accepted in the entirety of 2014 (24,067 admitted) and more than half of the total refugee population in 2015 (32,110) (Citizenship and Immigration Canada, 2016). Statistics from Citizenship and Immigration Canada (CIC) (2016) also show that roughly half of the refugees from 2014 to 2016 have settled in Ontario. In 2016 approximately 45 percent of refugees coming to Canada settled in Ontario; in 2015 the numbers show 46 percent; and 49 percent in 2014. Historically, the City of Toronto welcomes most of the permanent residents in Ontario, including refugees, and in recent years this trend has not changed (City of Toronto, 2016).

This influx of refugees directly impacts health equity in the GTA; it has been reported that refugees are a population vulnerable to declining health (Toronto Public Health & Access Alliance Multicultural Health and Community Services [TPH &AAMHCS], 2011). For example, research from 2011 indicates that refugees are at risk of poor and deteriorating mental health status and that they self-report poorer health than other immigrant populations (TPH &AAMHCS, 2011).

Among the mental health challenges refugees in the GTA face, depleted social networks and social isolation have been associated with feelings of helplessness, loneliness and distress (Makwarimba et al., 2013; Hynie, Crooks, & Barragan, 2011). Furthermore, issues related to migration, such as leaving family members and communities behind, can increase vulnerability and may also result in emotional difficulties (Wilson, Murtaza, & Shakya, 2010). Improving the health outcomes of refugee populations would bring us one step closer to realizing health equity for communities across the GTA.

It is useful to consider how social capital impacts health challenges among refugees. Social capital is defined as the networks, trust, and norms that make up an individual's social world (McKenzie & Harpham, 2006). It has been shown that aspects of social capital, such as trust, social cohesion, family, and neighbourhood ties can have positive impacts on physical and mental health (Kawachi, 1999; Kawachi, Kennedy, Lochner, & Prothrow-Stith, 1997; Kawachi, Kennedy, & Glass; 1999; Almedom and Glandon, 2008; Kawachi, Subramanian &, Kim, 2008; Gilbert, Quinn, Goodman, Butler, & Wallace, 2013). The concept of social capital has also been identified as fundamental for successful refugee settlement and integration and it has also been shown to significantly affect their health (Ager & Strang, 2008; Strang & Queen, 2014; Hynie, Korn, & Tao, 2016).

The purpose of this scoping review is to identify interventions that have improved aspects of refugee social capital resulting in subsequent improved health amongst these populations. Implementing such interventions in the GTA could improve the health outcomes of refugee populations, and thus aid in the efforts to achieve health equity.

What is social capital and how is it related to refugee health?

Social capital is generally understood as the resources that an individual or a community can access through social networks (Turcotte, 2015). The term also encompasses trust and reciprocity as the main components of such networks. It is through these social relationships that individuals and communities

are able to access resources (Hawe & Shiell, 2000; Portes, 1998).

The concept of social capital originated in the field of sociology. The works of Pierre Bourdieu (1980) and James Coleman (1993) are usually cited as originating and advancing the concept. The work of political scientist Robert Putnam (1993, 1995) introduced social capital as a feature within communities or even nations (Portes, 2000). Despite different understandings of social capital, most definitions agree that it concerns networks, norms, and trust (McKenzie & Harpham, 2006).

It has been used in various disciplines such as the sociology of education, economic development, political sociology, or to understand group interactions (Fulkerson & Thompson, 2008). The concept has also been utilized within the public health field in recent decades (Kawachi et al, 2008). When used in a health context, the term has been useful for determining how different aspects of social capital can have positive effects on physical and mental health. For example, it has been found that people live longer when they engage socially and maintain frequent contact with friends and family (Nyqvist, Pape ,Pellfolk, Forsman & Wahlbeck ,2014). Furthermore, lack of social capital has been associated with mental illness (De Silva, McKenzie, Harpham, & Huttly, 2005). Trust in others and a sense of belonging has also been associated with mental well-being (Jones, Heim, Hunter, & Ellaway, 2014). Thus, the evidence suggests that an individual's social capital can positively impact their health.

The literature has also advanced to conceptualize different types of social capital (McKenzie & Harpham, 2006). In this paper, the concept of social capital is examined based in the following types: individual or ecological, cognitive or structural, bonding or bridging, and horizontal or vertical (McKenzie & Harpham, 2006; Ehsan & Silva, 2015). The categories are defined as such:

- The first two concepts (individual or ecological) refer to the level of attribution. Individual refers to the social capital attributed at the personal or individual level. It can be measured, for example, by the number of contacts a person has and the frequency of interactions between said individual and their contacts. Ecological refers to social capital at a community or neighbourhood level and can be measured, for example, by the number of membership groups in a specific neighbourhood or area.
- Cognitive social capital is exemplified by the quality of relations, whereas structural social capital relates roughly to the quantity or frequency of interactions to said relations.
- Bonding social capital describes relations between homogenous individuals—those who are similar to one another in terms of ethnicity, immigration status, socio-economic position, or other differentiating factors. Bridging social capital describes relationships among heterogonous groups or individuals with diverse characteristics.
- Horizontal social capital describes relations between persons in similar social strata, whereas vertical social capital refers to the links or relations with those in positions of power, such as public institutions or decision makers.

Depending on their characteristics, individual and ecological social capital can be described as cognitive or structural and also bonding, bridging, horizontal, or vertical. For example, individual capital can be classified as cognitive or structural. Cognitive individual capital refers to the quality of relationships a person has. Structural individual social capital refers to the quantity of relations and could be measured, for example, by how many formal or informal groups a person belongs to or how many contacts a person has with family and friends.

These classifications can also be described as bonding (if they concern people who are similar), or bridging (if they relate to those who showcase heterogeneous or diverse characteristics). Categories can

be further classified as horizontal (if they apply to people from similar social strata), or vertical if they describe relationships between those who are not perceived to be in power with those who are. For example, relationships between average citizens and those who can determine public policy, such as elected officials.

Likewise, ecological social capital can also be described as cognitive or structural, bonding or bridging, horizontal or vertical. Cognitive social capital refers to the quality of aggregated relations and can be measured, for example, by the level of general trust in a neighbourhood. Ecological structural social capital refers to the quantity of social capital at an ecological level and can be measured by indicators such as the quantity of membership groups that exist in a neighbourhood.

Social capital has been recognized as a determinant of refugee health (Strang & Queen, 2014). For example, refugees can lose the social networks they had at home, lose family members, or leave family members behind, thereby creating a disruption in their social networks that could detrimentally affect their health (Boateng, 2010; McMichael & Manderson, 2004). Once in their host countries, refugees might be at risk of becoming isolated or having limited social connections, putting them at risk of having detrimental health consequences (Lindercrona, Ekblad, & Hauff, 2008, Dow, 2011; Mosla et al., 2014; Hynie et al., 2011). Social capital has also been recognized as fundamental for refugee integration, as it affects other outcomes such as employment, housing, and education (Ager & Strang, 2008).

Based on the existing evidence, developing different types of social capital among refugee populations could improve their health outcomes and also facilitate their successful integration in their host countries.

Refugee Social Capital in Canada

In Canada refugees are granted refugee status through different categories. The most common categories are Government Assisted Refugees (GARs), Privately Sponsored Refugees (PSRs), and Refugees Landed in Canada (RLCs). A recent research synthesis of refugees in Canada found differential economic, housing, social, and health outcomes among the refugee categories (Hyndman, 2014). In addition, the study notes that all categories of refugees face challenges related to their social networks, such as feelings of depression, isolation, or dissemination of inaccurate information.

This evidence suggests that regardless of what avenues refugees access to enter Canada, the social capital of GARs, PSRs, and RLCs plays a role in their health. Finding and implementing interventions that modify social capital and improve refugee health outcomes can help to prevent and alleviate some of the existing challenges at the local level.

Methodology

This scoping review used the five-stage process proposed by Arksey and O'Malley (2005) as described below.

Identifying the research question

The research question was first identified. Specifically, what interventions improved the social capital and health outcomes of refugees in high-income countries? This research question was developed to fit with the objective of the review, which is to identify relevant interventions that could be implemented in the GTA.

Identifying relevant studies

In consultation with a librarian at the University of Toronto, a search strategy was developed. Relevant studies were identified by researching five databases (Medline, Embase, Pubmed, PsycInfo, Scopus), which were chosen for their focus on health and their interdisciplinary emphasis.

The search terms used were "refugee$ or asylum adj1 seek$ or forced adj1 migra$ or displaced adj1 person$" AND "social capital" OR network$ OR trust OR norm$". The terms networks, trust, and norms were used as key terms as each is recognized as a main element of social capital (McKenzie & Harpham, 2006). Other concepts that are similar to social capital, such as social cohesion or social inclusion, were not included as search terms. Ultimately, the search terms were selectively chosen to capture the essence of social capital.

The search was limited to the years 2000 to present and within the English language. The terms were then modified to fit the truncation and wild card criteria for each database.

A second search was conducted with the aim of exploring the literature further and expanding the number of articles reviewed. The search terms used for the second search were "refugee$ or asylum adj1 seek$ or forced adj1 migra$ or displaced adj1 person$ AND network$". The year limits for this search were from 1980 to 1999 and only included articles written in English.

Study selection

The articles for the primary and secondary searches were selected for inclusion based on the following criteria. All papers:

- Are peer-reviewed
- Contain a replicable description of an intervention
- Are directed to or have refugees as participants of the intervention
- Take place in a high income country as defined by the Organisation for Economic Co-operation and Development (OECD)
- Report on improvements in social capital among refugees and report health outcomes

For the purposes of this review health is understood as proposed by the World Health Organization (1948). More specifically, outcomes related to physical, mental, and social well-being were included.

In the instances in which more information was required for inclusion in this review, or if the article could not be accessed via the University of Toronto library, authors of articles were contacted directly. The main reviewer consulted with a second reviewer (WI staff) when a second opinion was needed to reach a final decision.

Charting the data

To chart the broad range of information covered by the selected studies a data extraction table is presented in the Appendix section. In an iterative process the following data was considered relevant, given the objective of the scoping review's study, location, refugee community targeted, participant gender, intervention description, intervention objective, social capital outcomes, health outcomes, social capital, and health interactions.

Collating, summarizing and reporting the results

This final report was written to summarize the results of the scoping review.

Search Results

The first search resulted in a total of 1427 articles. The abstracts and titles of the 1427 articles were reviewed for inclusion using the Cochrane recommended online-based platform for systematic reviews, known as Covidence (2015). Of those, 1286 were excluded from the title and abstract review. The remaining 141 were given a further abstract and title review, after which 74 reviews remained for full text review. Interventions were excluded based on the criteria outlined above. Reviews which did not provide a detailed description of the interventions or that did not measure health outcomes were then excluded. After full text review, four articles were finally included in the review. The main reviewer consulted with a second reviewer (WI staff) when a second opinion was needed to reach a final decision. A flowchart detailing this process is presented in the Appendix section, page 18.

The second search resulted in 299 articles. Of these, 172 were uploaded to the online software Covidence (2015) and were screened for title and abstract. 164 articles were excluded and 8 articles were selected for full text review. None of the articles were chosen for inclusion. This process is also documented in the Appendix section, page 18.

Findings

Table 1 provides a summary of the four interventions included in the report. A detailed description of each intervention can be found in the Appendix, page 18. The template for intervention description and replication (TIDier) (Hoffman et al., 2014) was used to extract detailed descriptions. Developed by international experts and stakeholders, this template is used to improve the completeness of reporting of interventions in order to facilitate replicability.

Table 1

Reference	Intervention Summary	Social Capital Outcomes	Health Outcomes
Siddiquee & Kagan, 2006	Community internet project aimed at improving the internet skills of refugee women Location: Manchester, United Kingdom Participants: female refugees from various countries of origin including Eritrea, Sudan, Zimbabwe, and Ethiopia Delivery: a non refugee female adult trainer provided internet skills training to refugee women	• Re-connect with social networks and support back home • Foster localised support networks, specifically with other participants of the program	Reduction in Isolation and anxieties through a recuperation of social support networks from country of origin and fostering of localized support networks

Wollersheim et al., 2013	Pilot project to explore how to use mobile phone based peer support, with the aim of improving the psychosocial health of refugee women and facilitation of their settlement Location: Melbourne, Australia Participants: Nuer (southern Sudanese) refugee women Delivery: Non-Nuer training facilitators trained Nuer women in peer support techniques. The women then practiced peer support techniques among themselves, in person, and through mobile phones	• Increased intimacy and trust	Greater confidence and empowerment as a result of positive changes in interactions with family, friends, and community Reflection of setbacks in a more positive light through peer support
Im & Rosenberg, 2015	Pilot peer-led community health workshop (CHW) Location: Greater Richmond Area of Virginia, United States Participants: Males and females from the Bhutanese community Delivery: Trained peer community members of the Bhutanese community delivered the CHW. Themes included healthy eating and nutrition, daily stressors of resettlement, healthy coping, etc.	• Expanding social networks within the community • Participation in solving community issues • Sense of community developed • Sense of unity among the participants	Participation in the peer group helped with daily stress management and increased emotional wellness

Stewart et al., 2012	Pilot to test a culturally congruent intervention to meet the support needs of refugees Location: Two Canadian urban centres, one in western Canada and one in Central Canada Participants: Male and female Somali and Sudanese refugees Delivery: Face to face support groups, matched by gender and ethnicity, were facilitated by trained professional and peers. Peers via the telephone provided supplementary one to one support	• Meeting new peers • Facilitating mutual exchange of support among group members • Accessing information through new networks	Increased social integration, decreased loneliness and expanded repertoire of coping strategies Feeling accepted as a group of peers

Descriptive Summary

The four studies included were all directed specifically towards refugees (Siddiquee & Kagan, 2006; Im & Rosenberg, 2015; Wollersheim, Koh, Walker, & Liamputton, 2013; Stewart, Simich, Shizha, Makumbe, & Makwarimba, 2012). Three studies were directed to specific refugee communities, namely Bhutanese (Im & Rosenberg, 2015), Somali and Sudanese (Stewart et al, 2012), and Southern Sudanese (Nuer) (Wollersheim et al., 2013). One was not directed to any specific group and included participants from various countries of origin, namely Eritrea, Sudan, Zimbabwe, and Ethiopia (Siddiquee & Kagan, 2006).

Two interventions were targeted towards women (Siddiquee & Kagan, 2006; Wollersheim et al., 2013) and one matched participants by gender (Stewart et al., 2012). Lastly, one included both men and women as participants (Im & Rosenberg, 2015).

Three of the interventions used trained peer community members as part of the intervention delivery (Im & Rosenberg, 2015; Stewart et al., 2012; Wollersheim et al., 2013).

Three studies used technology in their interventions, namely the use of computers with internet connection (Siddiquee & Kagan, 2006) and mobile phones (Wollersheim et al., 2013). One intervention used mobile telephones to provide supplementary peer support (Stewart et al., 2012).

All of the interventions were delivered in urban settings in high-income countries, as defined by the OECD.

Social capital outcomes

None of the interventions measured social capital quantitatively; however, all reported qualitatively on the effects of the intervention on social capital.

As reported, the interventions impacted different aspects of social capital. Three interventions described expanding the social networks of refugees. Specifically, refugees were able to meet with other refugees by participating in the interventions (Siddiquee & Kagan, 2006; Im & Rosenberg, 2015; Stewart et al., 2012). Two interventions reported creating a sense of belonging and community among the new networks created by participants (Im & Rosenberg, 2015; Stewart et al., 2012).

One intervention reported increasing the sense of intimacy and trust among participants who already knew each other (Wollersheim et al., 2013). Finally, one intervention reported allowing the refugees to access the social networks from their countries of origin (Siddiquee & Kagan, 2006).

Health outcomes

Similar to their measurement of social capital, all four of the interventions reported qualitatively on emotional health outcomes derived from social capital, although none of them reported quantitatively on the outcomes.

By building new social networks refugees were able to access the resources of those networks, including information and peer support, which resulted in increased emotional wellness, decreased stress, and less loneliness (Siddiquee & Kagan, 2006; Im & Rosenberg, 2015; Stewart et al., 2012).

Two of those interventions (Im & Rosenberg, 2015; Stewart et al., 2012) reported that by creating a sense of community, belonging, and unity among the new networks, refugees were able to feel more integrated and accepted as part of group.

Wollersheim et al. (2013) reported that the intervention improved trust and intimacy within participants who had existing relationships. These improved relationships prompted positive emotional health outcomes such as greater confidence and empowerment. Participants were also able to reflect on setbacks more positively. Siddiquee & Kagan (2006) found that refugee women engaged with technology, mostly via email, to recuperate and maintain networks in their countries of origin, including contact with family members. This communication resulted in a reduction of isolation and related anxiety.

Interpretation of Findings

As part of the scoping review, it is useful to create conceptual categories to map findings (Arksey & O'Malley, 2005). All four of the interventions reported modifications in social capital and corresponding improvements in emotional health and each one could be broadly categorized as either impacting new or existing social capital. In this section, the categories of social capital introduced earlier in the report are used to categorize the types of social capital reported within the interventions. This application allows a clear understanding of the effects of the interventions on social capital.

Existing social capital

Existing social capital was reported as improved within the studies in two ways:

a) Improved access to bonding social networks in the country of origin

Siddiquee & Kagan (2006) reported that participants who engaged with technology, specifically through email, were able to access their existing bonding social networks in their countries of origin. The result was reduced isolation and anxiety.

b) Improved cognitive aspects of existing bonding relationships at the local level

One intervention (Wollersheim et al., 2013) reported improved cognitive social capital of existing relationships at the local level. Trust and sense of intimacy within existing relationships was improved through this intervention, resulting in outcomes such as greater levels of confidence and reflecting on setbacks more positively.

New social capital

New social capital was reported as improved within the studies in two ways:

a)New bonding cognitive social capital at the local level

Two interventions reported building new cognitive social capital (Im & Rosenberg, 2015; Stewart et al., 2012). These studies reported creating a sense of belonging and community.

b) New bonding social networks at the local level

Three interventions reported creating new structural social capital (Siddiquee & Kagan, 2006; Im & Rosenberg, 2015; Stewart et al., 2012). These interventions reported increasing the social capital of refugees by facilitating introduction to new people and through the expansion of their social networks.

Common Interventions Features

Through charting the findings common intervention features were identified. These features could be used as a starting point when developing and implementing interventions targeted towards refugees.

Participatory approach

All the interventions (Siddiquee & Kagan, 2006; Im & Rosenberg, 2015; Wollersheim et al., 2013; Stewart et al., 2012) reported obtaining feedback from refugee communities during the intervention design process. Stewart et al. (2012) and Wollersheim et al. (2013) reported that refugee community leaders provided input into programs regarding details such as the scheduling and duration of the intervention or the topics to be discussed. Im & Rosenberg (2015) reported that refugees were actively involved in the adaptation of an existing curriculum from English to their native language. For example, to ensure cultural appropriateness they added culturally relevant examples and activities.

Peer participation and delivery

A common feature of the interventions was the use of peers to deliver the intervention itself and three of the studies used peer refugees as part of the intervention delivery (Im & Rosenberg, 2015; Wollersheim et al., 2013; Stewart et al., 2012). Peer facilitators helped, for example, to identify participants for the intervention and provide insights from lived experiences (Wollersheim et al., 2013; Stewart et al., 2012).

Language

All of the interventions mentioned language as an important factor of the interventions, either for delivery or as a facilitator for participant's interaction (Siddiquee & Kagan, 2006; Im & Rosenberg, 2015; Wollersheim et al., 2013; Stewart et al., 2012). Wollersheim et al. used interpreters to deliver the intervention (2013), Im and Rosenberg delivered the study in the language spoken by the refugees (2015), whereas Stewart et al. had all their materials, such as interviews guides, translated into the participant's first language (2012).

Siddiquee and Kagan (2006) reported that language was important for participants as it allowed refugees to communicate, mainly through e-mail, with their contacts located in their countries of origin.

Gender sensitivity

Two of the interventions only had women participants (Siddiquee & Kagan, 2006; Wollersheim et al., 2013) and one of them divided participants by gender (Stewart et al., 2012), as suggested by participants

during the intervention design.

The authors of these three studies rationalized that it was important to target women participants as female refugees face different challenges than male refugees; as stated, after immigrating women are usually more isolated and have fewer opportunities to participate in programs than males do (Siddiquee & Kagan, 2006; Wollersheim et al., 2013). Gender cultural differences were also identified as an important factor to deliver gender sensitive interventions. For example Stewart et al, 2012 delivered interventions to men and women separately, as gender segregation is traditionally exhibited in Sudanese and Somali societies.

Use of technologies

Three of the interventions used technology, specifically the internet (Siddiquee & Kagan, 2006) and mobile phones (Wollersheim et al., 2013). Stewart et al., (2012) used mobile phones in conjunction with face-to-face interactions.

The mobile phone based interventions were useful, as they allowed participants to access support more easily when needed and specifically to reach specific participants such as stay at home mothers (Stewart et al., 2012). Similarly, when using the internet participants were able to connect with social networks from their countries of origin as well as develop new networks through the internet (Siddiquee & Kagan, 2006).

Discussion

All of the interventions reported improvements in the participant's emotional health outcomes, attributing these improvements to aspects of increased social capital. The interventions showed that improving structural and cognitive social capital or, in other words, improving the quality and quantity of relationships in the new country, could improve health. The report also showed that improving access to the social capital in their countries of origin also helps to improve health outcomes. These findings suggest that there are various ways in which an intervention can impact the social capital of refugees, either locally or at their countries of origin, while also improving health. This data also provides a range of possibilities to improve health outcomes.

In addition, two interventions acted on existing social capital (Siddiquee & Kagan, 2006; Wollersheim et al., 2013). These two studies suggest that refugees can arrive in host countries with existing social resources that can be tapped into to improve health. These existing social channels can be found not only at the local level but also in their countries of origin. The importance of this finding is that interventions could aim to strengthen local and international social capital that are already in place.

A reader may be interested to note that all four of the interventions impacted bonding social capital. This type of social capital is classified as the relationships among people who are similar to one another—in this case, refugees with other refugees.

None of the interventions reported health outcomes resulting from increases in bridging or vertical social capital. This finding is significant because the broader literature suggests that bridging social capital can have positive effects on the health of populations (Mitchell & LaGory, 2002; Erickson, 2003). Bridging social capital has also been found to be important for refugee integration into new societies, as it provides links to the host society (Calhoun, 2010). Moreover, it has also been noted that a refugee's

sense of belonging to the host society can influence their well-being (Correa-Velez, Gifford, & Barnett, 2010). More specifically it was found that key indicators of belonging, such as perceived social status in the host community and feelings of discrimination, were strongly associated with well-being outcomes.

Research has also reported that refugees express willingness to create relationships to other groups within the host community (Strang and Quinn, 2014). This seems to be important for the GTA, as there is evidence that new immigrants and refugees rely mostly on co-ethnic networks, but that those networks might disseminate inaccurate information or create an over reliance on their limited resources (Lamba, 2003; Lai & Hynie, 2010; Hynie, Crooks, & Barragan, 2011). It will be important for future interventions to examine ways to develop relationships between refugees and host societies.

The interventions found in this scoping review present different possibilities regarding the bonding social capital of refugees. While this is a positive finding, in light of the evidence provided by the broader literature, it will also be important to find ways to improve other aspects of refugee social capital. This would expand knowledge of how social capital influences refugee health and also provide further interventions to be implemented.

Limitations

The methodologies employed in the interventions included in this report were not assessed. Typically quality assessment is not necessary in a scoping review methodology. Instead, the scoping review is intended to be broad in nature and lacks the comprehensiveness of a systematic review. Nevertheless, the interventions did show qualitative improvements to social capital that can lead to improved health outcomes. This finding is supported by the broader literature at it has asserted links between social capital and health.

Since this review focused on peer-reviewed studies, interventions in grey literature could have been missed.

Another limitation of this review is that the search was restricted to certain concepts and terms. It is understood that there are concepts and terms used in other disciplines that overlap with social capital. Nevertheless, the search terms used in this review—trust, networks, and norms—are accepted as the main components of social capital (McKenzie & Harpham, 2006).

Even though common features emerged among the interventions, the few number of interventions found do not allow for broad generalizations or recommendations as best practice guidelines. However, they could still be useful as guiding principles to consider when developing interventions aimed at improving the social capital of refugees.

The role of social capital for specific sub-groups, such as refugee children, youth, and elderly persons, was not examined in the interventions. In addition, there may be population sub-groups that warrant greater attention. For example, refugees with disabilities, single mothers with children, or refugees who identify as LGBTQ were not explored in this report. Therefore, the information presented in this report might not necessarily respond to the needs of those or other specific sub-groups.

All of the interventions reviewed focused on building individual bonding social capital for refugees. It has been argued that other types of social capital, such as bridging capital at the individual and ecological level, can influence health. Due to a lack of research produced, this review did not find existing interventions

aimed at improving those aspects of social capital among refugee populations.

Implications for Policy

Decision makers could consider the positive effects that social capital can have on refugee health and ensure that the necessary resources are in place to support efforts to increase refugee social capital.

They could focus, for example, on providing the necessary funding for organizations and researchers to implement, monitor, evaluate, and report on social capital interventions. This action could potentially improve the health of refugees. For example, with the necessary resources in place evidence based interventions can be scaled up or replicated.

Policy makers should also consider the broader impacts that improving social capital could have for refugee populations. It has been recognized that social capital is fundamental for refugee integration (Ager & Strang, 2008). Therefore, the benefits of a more connected and integrated refugee population extend beyond refugee communities, also encouraging social cohesion in the GTA and Canadian society more generally.

Implications for Practice

Despite the limited number of interventions reviewed, some implications could be of value for practice. For example, practitioners could create programs which are similar or contain the main features of the ones found on this report, namely participatory, peer-led approaches, gender and language sensitivity, and technology usage as part of their delivery and design.

Practitioners could recognize how interventions that apply the concept of social capital among refugees have the potential to result in beneficial health outcomes.

It would be useful for practitioners to consider how current programs could be facilitating or hindering the creation of social capital among refugees, as well as identifying which types of social capital are being facilitated. All of the interventions in this report impacted bonding social capital for refugee health. Thus, would be important to analyze whether the GTA exhibits a similar trend of focusing on the creation of co-ethnic relationships.

In addition, it might be necessary to facilitate the creation of vertical social capital, which connects refugees to decision makers who might be able to respond to the structural or ecological challenges that refugees face as a community. The participants of certain interventions (Im & Rosenberg, 2015; Stewart et al., 2012) showed the desire to connect to the wider community and also to bring community problems to public authorities, illustrating the importance of reflection on whether similar concerns are applicable within the GTA.

The role of a refugee's native language also seemed to play an important role in the delivery of the interventions. This finding should be considered with caution, given that the literature has highlighted that inability to communicate in the host country's official language could be isolating for refugees and immigrants (Nawyn, Gjokai, Lafa, Agbenyiga, & Grace, 2012). This finding points to the importance of developing host language skills in order to facilitate the development of bridging social capital.

The interventions considered in this review recognized the different needs of refugees based on gender. This is a practice that is recommended by the United Nations High Commissioner for Refugees (UNHCR),

expressly through its Age, Gender and Diversity Policy (2011). It is important to consider the needs of specific groups that the interventions included in this report did not address, such as children, the elderly, refugees with disabilities, those who identify as part of the LGBTQ communities, and other potentially vulnerable or disadvantaged groups. Specific interventions designed to respond to the specific needs of sub-groups could also be implemented.

The use of technology was important within the finding of the interventions considered herein, as it allowed refuges to access their existing networks from their home countries through the use of e-mail, as well as access support from local networks more easily via mobile phones. The broader literature has also found that interventions delivered via mobile phones could be effective in the delivery of necessary services (Seko, Kidd, Wiljer, & McKenzie, 2014). The use of technology should be taken into consideration in future research, as it holds potential to improve health outcomes.

Implications for Research

A main finding related to the existing research is the small number of articles found despite a search of a comprehensive section of the literature. This finding has implications for research, as it indicates a gap related to the number of interventions that are evaluated and reported from a social capital perspective. The author of this report encourages more interventions be conducted and evaluated in order to measure and explain the links between social capital and health outcomes.

None of the articles reported the relationships between vertical or bridging social capital and health. Researchers could pilot, or evaluate existing interventions that facilitate vertical or bridging social capital and measure social capital and health outcomes.

Future research should ensure the use of tools to measure social capital pre and post intervention, as well as specific health outcomes such as depression or physical activity. These inclusions could help us to more confidently clarify the links between social capital and health among refugee populations and the effectiveness of such interventions.

None of the research addressed the long-term implications of the interventions. It is important for future research to examine whether or not the interventions have longer-term health effects.

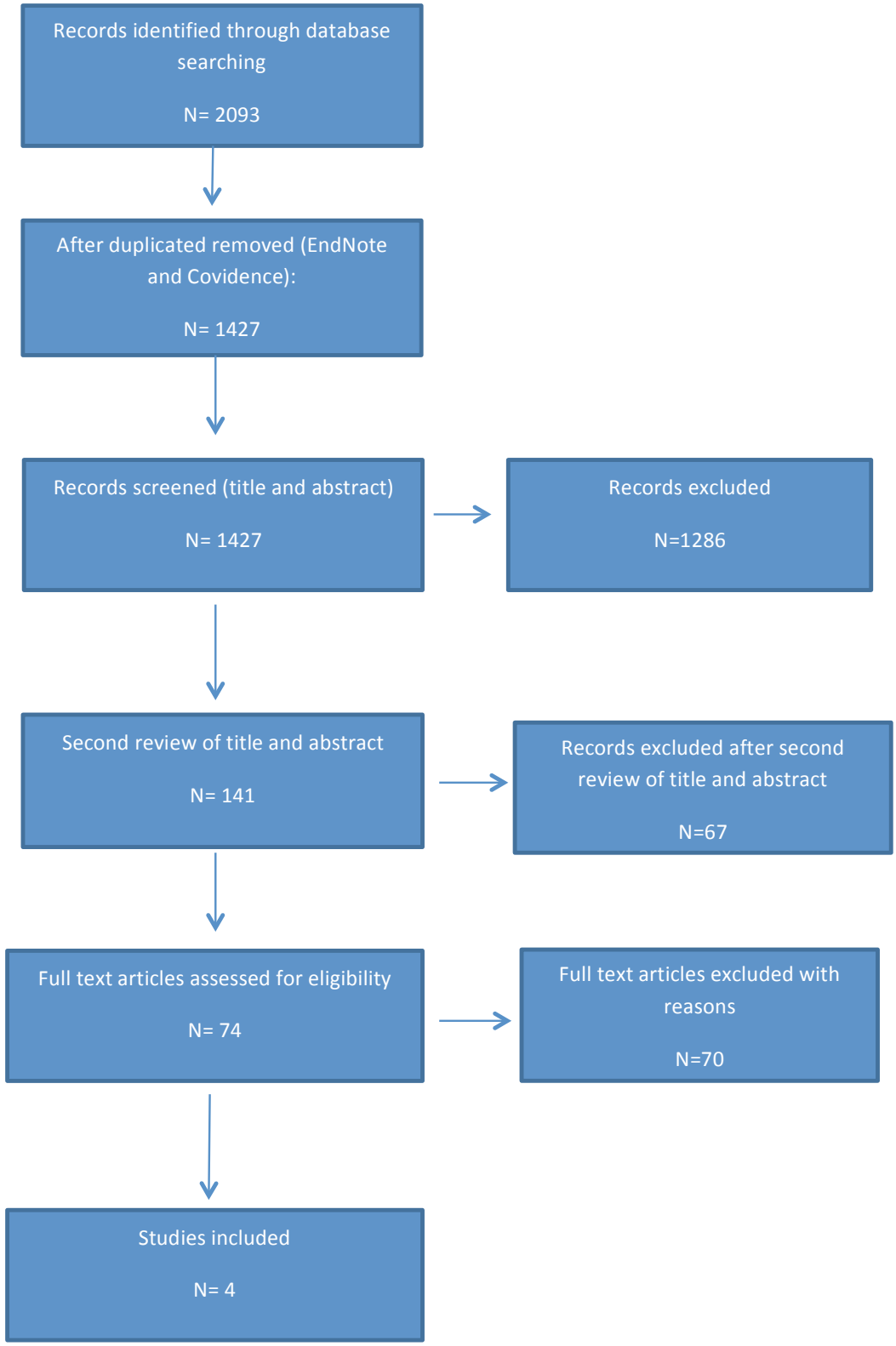
The literature has also recognized that social capital can have detrimental effects on health. Future research could address whether or not certain aspects of the interventions brought negative consequences, or were harmful towards short or long-term health. It has been argued, for example, that an excess of bonding social capital among immigrant and refugee populations could be detrimental to creating bridging relations, which are also linked to an improved sense of belonging and well-being (Portes, 1998; Deuchar,2011).

Conclusion

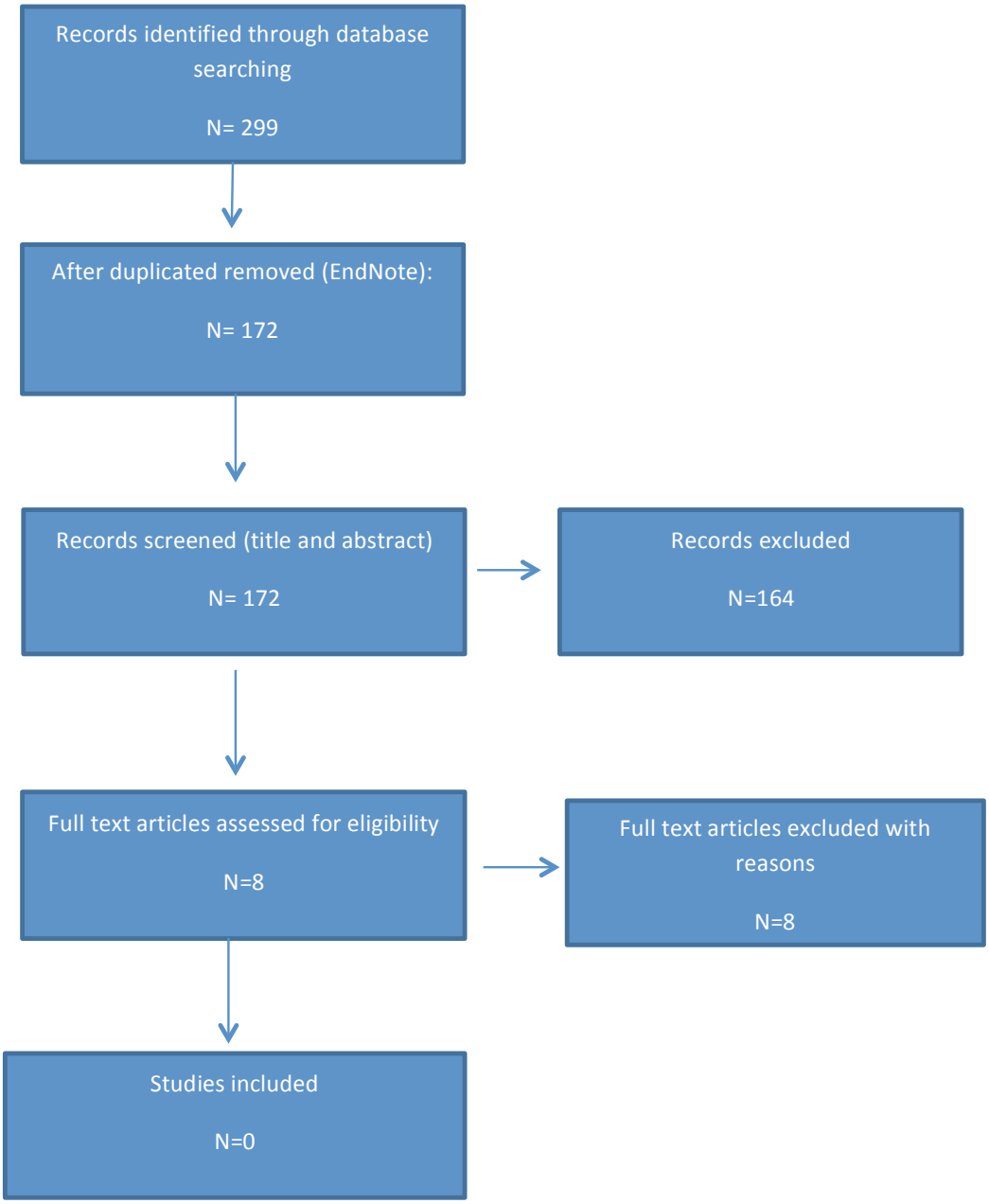
The interventions included in this report suggest that there are a range of possibilities to impact the social capital of refugees and improve health. They also focus on bonding social capital; however, a wider range of possibilities could be explored to create bridging and linking social capital. The findings of this report provide a starting point to advance the discussion; it shows that applying the concept of social capital to interventions has the potential to improve well-being amongst refugees. Governments, practitioners, and researchers could apply the lessons presented in this report to explore and improve refugee health

outcomes. Nevertheless, it would be useful to further consider how other concepts of social capital, such as bridging or vertical, can be impacted through interventions and how those interventions can impact the health outcomes of refugee populations.

Search decision flow chart (Search #1)



Search decision flow chart (Search #2)



Summary of the literature

Author/ Year	Study purpose	Research design	Participants on the intervention.	Location	Intervention	Social capital findings	Health findings
Asiya Siddiquee, Carolyn Kagan 2006	To examine the impact of refugee women's engagement with the internet on their empowerment and identity	Semi-structured interviews and non-participant observation	6 refugee women from Eritrea, Sudan, Zimbabwe and Ethiopia	Manchester, United Kingdom	The CIP was developed by the Manchester WEVH in conjunction with community partners (including local refugee groups, committees and local community centres) to support female refugees in using information and communication technologies	Internet literacy skills allowed the women to re-connect with their social networks and supports back home, or in some cases with those networks in their new countries but in other areas Email was utilised to foster localised support networks, particularly with other participants of the program	Reduction in Isolation and anxieties through a recuperation of social support networks, maintaining links with their country of origin, and fostering localised support networks
Hyojin Im, Rachel Rosenberg 2015	To explore the impact of a peer-led intervention on social capital for health promotion with the Bhutanese refugee community	Qualitative Focus group discussions embedded in the CHW meetings Post-intervention evaluation	Bhutanese Refugees: 22 participants consisting of 4 males and 18 females	Greater Richmond Area of Virginia, United States	The CHW intervention consisted of eight sessions relating to healthy eating and nutrition, daily stressors of resettlement, healthy coping, common psychological distress, and mental health issues facing the refugee community	The gatherings for the CHW in itself expanded their social networks within the community Sense of community developed. Strong unity was reported amongst the participants Participants were motivated to rebuild and strengthen the Bhutanese community Connections were made outside of the refugee community and was discussed among participants at various levels	The formation of peer groups helped participant's daily coping of stress and increased emotional wellness

Miriam Stewart, Laura Simich, Edward Shizha, Knox Makumbe, Edward Makwarimba Year of publication: 2012	To design and pilot test a culturally congruent intervention that meets the support needs and preferences of two ethno-culturally distinct refugee groups	Pre intervention: Individual in-depth interviews, to inform the design of the intervention Post Intervention: nine-item semi structured interview guide invited participants to describe their experience with the intervention	29 Participants: [Somali females =7; Somali males=6; Sudanese females=9 Sudanese males=7]	Urban Centres of two provinces, one in western Canada and one in Central Canada	Face-to face groups comprised of refugees, matched by gender and ethnicity, were created to enhance the depleted social networks of Somali and Sudanese refugees The ingredients of the support intervention reflected preferences articulated during pre-intervention interviews The features include: Intervention agents: i) peer facilitators and professional facilitators; ii) provision of information, affirmation and emotional support; iii) accessibility (e.g. childcare, transportation	Mutual exchanges of support were facilitated amongst group members Information was accessed through new networks Participants reported feeling accepted as part of a group of peers Participants helped one another by providing information and practical support and referring other refugees to services Meeting in groups provided opportunities to connect and share coping strategies Face-to-face group meetings provided opportunities to socialise for lonely and isolated refugees Refugees discussed strategies for improving relationships with the school system. They wanted to initiate dialogue with decision makers to address underlying reasons for high school dropout and high crime and drug use among newcomer adolescents and advocated community level interventions	This social support intervention resulted in increased social integration, decreased loneliness, and an expanded repertoire of coping strategies It was noted that participants “began to recognise that they were not the only ones facing particular challenges and received emotional support” According to participants, skills-oriented and entertaining support programmes give refugees something tangible to anticipate and relieves stress

Dennis Wollersheim, Lee Koh, Rae Walker, Prae Liamputtong Publication year: 2012	To study how to use mobile phone-based peer support to improve the psychosocial health and facilitate settlement in a group of nine Nuer refugee women in Melbourne, Australia	The end of each 5 week block consisted of a focus group program evaluation	9 Sudanese (Nuer) women	Melbourne, Australia	The purpose of this pilot program was to learn how to use mobile phone-assisted peer support with Nuer background refugee women The weekly program ran for two hours on a weekday evening The sessions taught the practice of peer support through a process of topical knowledge sharing via a peer support modality Each session had a single discussion topic and used a strength-based paradigm The women took turns being listener and talker Each participant was then invited to talk on the same topic during a discussion involving the entire group	Increases were noted in cognitive social capital, intimacy, trust, and the revelation that these relationships could be used for emotional healing Participants noted increased communication with community and family, as well as increased cognitive social capital Increased communication about participants and their families, sharing of ideas, good news, and problems led to greater trust and intimacy among the participants	The peer support network created a medium for the women to share their distress and gain new perspective Most participants reflected that mutual listening was a process of healing The participant narratives suggested that the use of Smiths (2006) strength-based paradigm helped to tap into peer-support and look at setbacks in a more positive way

APPENDIX: Detailed Description of Interventions

Name: Constant connections: piloting a mobile phone-based peer support program for Nuer (southern Sudanese) women.

Source: *Australian Journal of Primary Health* (2013).

Authors: Dennis Wollersheim, Lee Koh, Rae Walker, and Pranee Liamputtong

Why: To improve the psychosocial health of refugee women and facilitate their settlement.

Women were chosen because of their role as the social centre of their family and community. The was determined by their maintenance of day-to-day family matters and because of the more socially disadvantaged position of many women.

What: Peer support training was provided to nine refugee women participants.

The sessions taught the practice of peer support through a process of topical knowledge sharing via peer support modality.

Each session had a single discussion topic and used a strength-based paradigm (Smith, 2006).

Topics and order of topics discussed:

1. Introduction (ground rules, participant self-direction: what are your goals for this program? How do you want the program to run?)
2. Peer support skills taking turns
3. Life goals
4. Educational successes
5. Preliminary evaluation, review
6. Life successes
7. Goals for your family
8. Educational goals for your family
9. Goals for your community
10. Final evaluation, skills consolidation, and graduation ceremony

The women were paired based on a specific discussion topic, taking turns being listener and talker. Each participant was then invited to talk on the same topic during a discussion involving the entire group. In this way, the peer-support process guided the group process.

At the end of every second session the participants were each provided with 20-dollar mobile phone recharge vouchers and were assigned the homework of calling each other.

Who provided: Two non-Nuer facilitators, through a Nuer interpreter, facilitated each session. Both facilitators had more than 10 years of training experience in the peer support methodology.

How: Nine participants from Nuer background were recruited from the southeastern region of Melbourne. The Nuer women's leader selected the participants based on her judgement of who would be able to listen and provide peer support.

Where: Melbourne, Australia

When and how much: Once a week for two hours on a weekday evening for the duration of five weeks. At the end of five weeks, due to participants' requests, and in consultation with the leader, the program was extended for an additional five weeks.

Tailoring: Program details (discussion topics, daily session scheduling, duration, demographic and

focus group questions) were fleshed out in consultation with leaders from both the men's and women's Nuer community organisations. The participants also vetted discussion topics.

Name: Building Social Capital Through a Peer-Led Community Health Workshop: A Pilot with the Bhutanese Refugee Community.

Source: *Journal of Community Health*, 2015.

Authors: Hyojin Im and Rachel Rosenberg

Why: The current study is part of a community-based participatory research (CBPR) project to promote refugee wellness and healthy adaptation during resettlement. The overall project was comprised of community wellness partnership building, competency-based training of refugee leaders and service providers, and a subsequent community health workshop (CHW) fostering a peer-to-peer model. This description is the description of the CHW portion of the project.

The project was piloted with the Buthanese community since Bhutanese refugees were identified as one of the most vulnerable to health and mental health issues upon resettlement.

What: The CHW intervention consisted of eight sessions relating to healthy eating and nutrition, daily stressors of resettlement, healthy coping, common psychological distress and mental health issues facing the refugee community.

Each session, except for the first, started with a check-in that includes questions related to the lessons from the previous session contents. All eight sessions ended with a set of reflective questions, addressing issues such as main lessons, learned knowledge and skills, challenges and gaps, and future suggestions. These questions also included cultural topics and examples.

The last session included a closure ceremony followed by a post-intervention evaluation that included questions on the overall impact of the CHW as well as the group process.

Who provided: The first author (Im) developed and provided four days of training on mental health and psychosocial support to community leaders and active members from the Bhutanese refugee community.

Subsequently, trained peer facilitators from the Bhutanese community delivered the CHW. Peers were defined as people who share a common belief, ethnicity, religion, or other common factors. In this case they were members of the Bhutanese refugee community.

How: Six out of nine trainees, three males and three females, volunteered to provide community-based health workshops to their peer refugees after additional training on health education and group facilitation skills.

The Community health workshop curriculum was based on the psycho-educational modules by the first author (Im), adopting nutrition and healthy eating camponents of the Nutrition Outreach Toolkit by USCRI.

Since the curriculum was developed in English and yet delivered in the native language of the Bhutanese refugees (i.e Nepali), key terms of the intervention topics, such as stress, acculturation, mental health, nutrition, healthy lifestyle, and community were examined as a team in both languages. The peer facilitators had additional meetings prior to each session to go over the contents in Nepali.

These peer facilitators then identified 27 community members from the Bhutanese community, who were in need of health education and had difficulties accessing health care as well as social services due

to low educational levels and language barriers.

Where: Greater Richmond Area of Virginia, United States

When and how much: The CHW interventions consisted of eight sessions relating to healthy eating and nutrition, daily stressors of resettlement, healthy coping, common psychological distress, and mental health issues facing the refugee community.

Tailoring: In close collaboration with community stakeholders, including mental health service providers and refugee community leaders, the first author developed and provided four-day training on mental health and psychosocial support to community leaders and active members from the Bhutanese refugee community.

For a culturally sensitive and effective intervention, the trained refugee leaders were actively involved in the development and adaptation process by providing inputs and feedback on the topics and the contents and adding culturally relevant examples and activities to the curriculum (e.g.. Bhutanese proverbs regarding health, chanting for opening and closure, etc.).

Name: Supporting African refugees in Canada: insights from a support intervention

Source: *Health and Social Care in the Community* (2012)

Authors: Miriam Stewart, Laura Simich, Edward Shizha, Knox Makumbe and Edward Makwarimba

Why: The objective of this study was to design and pilot-test a culturally congruent intervention that meets the support needs and preferences of two ethno-culturally distinct refugee groups.

What: Face-to-face support groups comprised of refugees and matched by gender and ethnicity were created to enhance the depleted social networks of Somali and Sudanese refugees.

These support groups were co-facilitated by peers and professionals—a strategy that combined experiential and professional knowledge.

Peer facilitators delivered supplementary one-to-one support via the telephone between support group sessions.

Transportation and childcare costs were provided to counter known obstacles to group participation.

Individual support group participants initiated contact with peer facilitators via the telephone when they wanted additional support.

Who provided: Peer facilitators were Somali and Sudanese former refugees who had settled in Canada for more than 10 years and had first-hand experiential knowledge of refugee's experiences in coping with settlement challenges.

Professionals had service providers experience relevant to the challenges and support needs of refugees.

Peers and professionals were fluent in predominant languages spoken by the participants.

A total of 11 peer and professional facilitators were trained jointly by the research team within each site.

How: Somali and Sudanese refugees were recruited in the urban centres of two provinces, one in western Canada and another one in Central Canada. Participant recruitment was facilitated by referrals from immigrant and refugee-service agencies.

As both Somali and Sudanese societies exhibit traditional gender segregation, equal numbers of men and women from each ethnic group were sought, ultimately resulting in 53% male and 47% female participation.

Peer facilitators and refugee participants were matched in dyads according to ethnicity and gender and consistent with participant preferences.

Peer and professional facilitators were taught to monitor participant interactions to minimize negative social comparisons, identify people adjusting to immigration/integration challenges as positive role models, cultivate trusting relationships, and address challenges arising from interactions among peers from clans which perpetrated pre-migration atrocities.

During the intervening week between group sessions, peer facilitators called all participants to discuss the forthcoming meeting, ask for feedback, and provide support as needed.

Following the intervention, refugee participants were interviewed in groups and with peers, while professional facilitators were interviewed individually.

Regular communication between facilitators and research staff across sites reinforced the training, provided feedback, and allowed for the progress monitoring.

Where: Urban centres of two provinces, one in western Canada and another in Central Canada.

When and how much: Eight support groups took place in urban centres of two Canadian provinces. Each support group consisted of 5-12 participants and was facilitated by a peer and a professional. Support groups met bi-weekly for face-to-face sessions.

To maximize and sustain the effects of the support programme, and to ensure similar intervention 'dose' across participants, the support intervention (dyadic and group) was designed to last 12 weeks.

The duration of each face-to-face group session was approximately 60-90 minutes and dyadic telephone sessions ran for approximately 20 minutes.

Each participant made approximately four contacts during the intervention. An estimated total of 929 supplementary telephone contacts were made by peer facilitators and by participants during the intervention.

Tailoring: A participatory approach was employed. This involved collaboration and consultation with refugee-serving agencies and leaders from the two refugee communities.

Participants were initially consulted during pre-intervention assessment interviews about the desired type of intervention and subsequently during the initial support group session to determine the specific content topics and to provide input regarding timing of group sessions.

Name: The internet, empowerment, and identity: an exploration of participation by refugee women in a Community Internet Project (CIP) in the United Kingdom (UK)

Source: *Journal of Community & Applied Social Psychology* (2006).

Authors: Asiya Siddiquee and Corlyn Kagan

Why: The CIP was developed by the Manchester Women's Electronic Village Hall (WEHV) in conjunction with community partners (including local refugee groups, committees, and local community centres) to respond to the needs of women.

What: Community internet project to support female refugees in using Information and Communication Technologies (ICTs).

The CIP consisted of a minimum of 25 hours of training, transport costs were paid for, and crèche facilities were provided.

Who provided: The course tutor, who was an integral part of both organising and arranging the CIP, taught all of the CIP sessions and worked closely with the women in the course.

The tutor was a middle-aged white female, who had recently qualified as an adult trainer within the WEHV. Part of this training included dealing with the specific educational needs of adult females, and prior to the CIP; the tutor had attended training in working with refugees (including cultural awareness and sensitivity).

How: Trainee groups are kept small (approximately 10 women) to ensure full support is given. As part of the training women are offered personal development, counselling, and career guidance.

Where: Manchester Women's Electronic Village Hall (WEVH) hosted the CIP. The Manchester WEHV was established in 1992 as a centre run by women for women, providing ICT training and resources to meet community requirements.

The WEHV's ethos is rooted in the needs of women and all courses are organised around school hours and vacations.

When and how much: Including 25 hours of training, all courses are organised around school hours and vacations.

Tailoring: The CIP was developed by the Manchester WEVH in conjunction with community partners (including local refugee groups, committees, and local community centres) to support female refugees in using information and communication technologies.

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