



Primary Health Care: Provider Perspectives on their Services for Preschool Children in Refugee & Refugee Claimant Families

Olive Wahoush*

McMaster University, Canada

Abstract

This paper presents service provider perspectives about primary health care services for refugee and refugee claimant mothers when their preschool child had an acute and minor illness. Information was collected from primary health care providers in Hamilton Ontario between August 2004 and February 2006 as part of a larger study about the health of children in recently arrived refugee and refugee claimant families. Primary health care providers in this study represented the full array of primary health care services available at the time. Information included details of services available and preparation of staff to work with a diverse population including immigrants in general and refugees in particular. The main finding was that primary health care providers and staff had little or no training and preparation for working with refugee or refugee claimant families and had little understanding about health insurance or their entitlement to health care. Services were significantly reduced in number and variety after 5pm and during nights or weekends; most providers reported that they would accept refugees and fewer reported that they would accept refugee claimants as clients. The conclusion of this study was that primary health care providers need training for working with culturally diverse populations and in particular clear information about health insurance for refugee and refugee claimant families. Disparities in health care have been associated with limited cultural sensitivity, lack of knowledge or awareness of support systems including health insurance for refugees and refugee claimants and failures in understanding. These factors limit access to needed health care services and diminish the effectiveness of services provided. Recent changes to health insurance eligibility for refugees and refugee claimants are concerning as entitlements to health insurance have been reduced or eliminated.

Keywords: Primary health care; Refugee health; Cultural training; Health insurance; Interim federal health Program

Introduction

There is little information about primary health care provider perspectives on primary health care access or health services for preschool children in refugee or refugee claimant families. This paper presents results from a PhD study, which explored primary health care access for pre-school children in refugee or refugee claimant families resettling in Ontario, Canada. Fifty five mothers who were refugees or refugee claimants and nineteen primary health care providers participated [1]. Information describing features of the primary health care system was also collected. Specifically, this paper presents information about primary health care services available for participant families and health service provider perspectives on primary service delivery for refugee and refugee claimant families with pre-school children resettling in Hamilton Ontario. Hamilton is a large city with a population of more than 500,000 people and is a receiving centre for refugee resettlement.

Significance of this study

Primary health care providers are the most common first contact for those needing health care. Health insurance is important for health service access and the health care experience influences future contacts with health care providers. Preparation and training of service providers to work with multicultural populations has been shown to support equitable treatment of diverse populations [2-4]. Results from this study found barriers including limited health insurance coverage for refugee and refugee claimant families who needed to access health care for their preschool children. Since this study was completed there have been significant changes to health insurance coverage with significant reductions for refugee families and loss of coverage for refugee claimants [5]. This means that health care access is likely even more limited today.

Background

Immigration is an important part of population growth in Canada

with approximately 250,000 arriving annually. Refugees comprise 9 -11% of all immigrants to Canada [6]. The refugee class includes refugees from abroad and successful refugee claimants. Refugee claimants arrive to Canada and make a claim for refugee status after they arrive in Canada. There are important distinctions between refugees and refugee claimants which affect their access to health insurance and to health care. Refugees receive government funded supports on and after arrival, they have provincial health insurance and at the time of this study also had insurance coverage from the Interim Federal Health Program (IFHP) usually for up to one year after arrival in Canada.

Refugee claimants do not have access to the same supports as refugees until their claim has been reviewed and accepted. They may arrive from the same countries as those with convention refugee status and/or have similar histories. Approximately one half of all refugees reported by Citizenship and Immigration Canada begin life in Canada as refugee claimants [6]. Many of these individuals and families have survived trauma, uncertainty and endured significant hardship prior their arrival in Canada. At the time of this study refugee claimants had access to health insurance from the IFHP if they did not have resources to provide their own health insurance.

Ontario is home to the largest proportion (40%) of all permanent migrants including refugees and 60% of refugee claimants [6]. Resettlement in Canada has changed over the last decade as the

*Corresponding author: Olive Wahoush, Rm HSC 2J34a, McMaster University, 1280 Main Street West, Hamilton Ont L8S 4K1, Canada, Tel: 905 525 9140, ext 22802; Fax: 905 525 1963; E-mail: wahousho@mcmaster.ca

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Ministry of Citizenship and Immigration has successfully promoted resettling in cities other than Toronto, Montreal and Vancouver. This was an important change with refugees resettling in urban and other communities with little experience of welcoming and supporting newcomers. In addition the needs of refugees are complex and relate to their forced migration experience [3,7].

Although primary health care providers are the most common first contact for those needing health care there is little information in the literature about health care provider perspectives on working with refugee families resettling in a receiving country. Knowledge of cultural differences, customs and beliefs are known to be important for professionals especially nurses working with different populations or ethno-racially different groups within a population [8-10]. Professional associations in Canada have developed guidelines and standards of practice to promote good quality practice and client centred care through culturally appropriate care [11-14]. Training programs and workshops can help clinicians become culturally competent [4,10]. A limitation of these guidelines and programs is an absence of information about considerations which might be important when working with refugees and others such as indigenous populations who have experienced a history of colonization [15].

Preparation in cultural competency while helpful maybe insufficient for health professionals working with refugees especially with those who arrive as claimants [16,17]. Studies in other refugee receiving countries highlight the challenging issues and needs that refugees have which may not be considered by inexperienced professionals and staff [7,18-20]. In addition to language, issues affecting refugees may include post traumatic stress disorder [21], lack of knowledge about body function [22] and lack of knowledge about the health care system [1,23]. For care providers, ethnocentric approaches to care [24] and gaps in knowledge about refugee experiences [16] and family roles [25] are examples of issues which if not addressed may pose risks of causing further harm [26]. In addition experiences during health care encounters influence subsequent health seeking behavior which may result in negative consequences for future health.

At the time of the study refugees from abroad were entitled to provincial health insurance in Ontario on arrival and were also supported with additional coverage through the Interim Federal Health Insurance Program (IFHP). Refugee claimants were supported by the IFHP when they made their claim for refugee status in Canada. Coverage from IFHP included essential dental, emergency care, primary health care visits, medications, ambulance, prosthetic devices, laboratory and diagnostic services [27]. Since June 2012, IFHP for refugees is withdrawn when provincial insurance is in place and refugee claimants will only have insurance coverage for urgent or essential care, eligible services include medications and vaccines for diseases that present a risk to the public [28]. Changes to IFHP has resulted in confusion for primary health care providers and more refugees and claimants being denied access to services [29,30].

Design & Methods

This qualitative descriptive study was completed in Hamilton Ontario, a large city close to three main entry points for immigrants coming to resettle in Canada. This choice of setting was also relevant as refugees were encouraged to settle in areas other than the three main centres of immigration settlement, Toronto, Montreal and Vancouver, [31].

Primary health care provider agencies were identified using multiple sources of information such as reports from participating mothers, city directories, websites, telephone book and network recruitment.

Representatives (n=19) of thirteen agencies participated in interviews (Table 1); they included doctors (n=6), clinical managers (n=2) nurses (n=6) and registration/clerical staff (n=5). Respondents for each agency were identified by the manager/director initially contacted and all respondents provided direct care or support to their agency's clientele. Primary health care provider agencies represented the full range of primary care services from emergency departments in large hospitals to single practice family physicians. Representatives from Emergency Departments (n=3), Community Health Centres (n=4), Walk in clinics (n=2), Family Physician practices (n=3) and an alternative health care provider (n=1) were interviewed about their health services and experiences of providing health services to pre-school children of refugee families.

Data was collected using semi-structured interviews with open ended questions asking for details of health services provided by each agency, provider perceptions of difficulties mothers encountered, benefits of working with refugee families, preparation for working with ethnically diverse clientele and for a recommendation that would improve services for refugee families with preschool children. Interviews were completed in 30 - 45 minutes, audio recorded with permission and transcribed verbatim. Field notes were recorded about each interview with details about each setting for example, information on bulletin boards, materials in languages other than English. Ethics approval was obtained from the University of Toronto.

Analysis of transcripts was completed using word tables and detailed personal review of transcripts by the author and an assistant working with the study. Confirmability of the analysis was achieved through an independent analysis of two transcripts by a researcher with expertise in qualitative methods and migrant health research. Results were then compared for similarities and points of difference, differences were minor and related to choice of phrasing for themes, these were agreed upon through discussion.

Results

Most agencies (n=12) provided primary health care services to the general population including refugees. Collectively these agencies provided services from a wide array of health professionals (Table 2). Only one agency had service hours that were limited to business hours (9-5pm), all others reported that they offered some after hours and/or on call services and the three emergency departments provide services on a 24 hour daily basis. More than half did not accept refugee claimants as clients because they were closed to any new clients (n=4) or because of the billing problems associated with the time required to process reimbursement for services (n=3). One respondent reported serving only refugee claimants as new clients, because she understood that they are the most marginalized in access to health care. Issues identified about health insurance coverage for claimants included frustration with treatment delays caused by the pre-approval process required from IFHP often required before treatment commenced. Information from mothers in the study confirmed this finding [1]. Services varied in their

Agencies	Frequency	Respondents
PHCP-ER	3	7
PHCP-CHC	4	5
PHCP-Doctor Practice	3	3
PHCP-Walk in Clinic	2	3
PHCP-Alternative health care provider	1	1
Total	13	19

Table 1: Participating Primary Health Care Agencies.

Health Professionals on site	Agencies
Physician	11
Nurse	10
Social Worker	7
Mental Health	4
Alternative	2
Chiroprody	2
Physiotherapy	3
Dentist	3
Nutritionist	3
Optometrist	1
Early Child Development	1

Table 2: Health Professionals at Primary Health Care Agencies.

ability to accept clients who were not registered with them, emergency departments were universally accepting but required payment when there was no proof of health insurance and physician services only accepted appointments with registered clients. Community health centres and walks in clinics varied in accepting clients without being registered.

Observations in waiting rooms and clinical settings found that staff was welcoming and that they attended to clients promptly. Notice boards were crowded with information almost always in English with very few items in French and only one space had a notice in other languages. This multilingual poster invited readers to report spousal abuse. Community based agencies also offered services directed at supporting parents in their parenting, promoting child health & well-being, child clothing banks and day care programs. Most areas were equipped with some toys, puzzles, books and magazines. Space was limited for families with more than one child present.

Provider perceptions and experience

Participants were asked about difficulties they experienced when working with refugee and refugee claimant families when their preschool child was sick, and about changes they would recommend to better support refugees and refugee claimants. Responses about difficulties staff experienced were reported by 75% of respondents and were clustered into two themes: cultural differences and failures of understanding.

A summary of provider reports of difficulties experienced by mothers is presented in (Table 3). Providers identified different challenges for these mothers in their daily life and when accessing health care. Differing cultural norms and values were noted to create problems for clients because of the negative provider perceptions of different eating patterns and sleeping arrangements for young children in refugee and refugee claimant families. Providers also reported that mothers did not understand the health care system for example the importance of appointment times. They reported that mothers sometimes missed specialist appointments and did not realize the inability to get another specialist appointment quickly. Three providers, a doctor and two nurses each in a different agency, reported witnessing or being aware of racist behaviour experienced by mothers when accessing health care. They also stated that they did not act on these events as they did not know what to do when the incidents occurred or were reported to them.

Respondents reported that they believed mothers were concerned about the costs of health care. Almost 50% of provider agencies charged fees for service when the child was not covered by health insurance. Fees charged direct to clients for service ranged widely from \$20 to \$325

Themes: Day to day living	Rank Order
Language	1
Socio-economic	2
Culture	3
Fear	4
None or unaware	5
Lack of knowledge for local systems and community	6
Themes: In accessing Health Care:	Rank
Lack of understanding by mothers	1
Communication	2
Socioeconomic issues of mothers	3
Health Insurance coverage	4
Stress	5
Racism	6
Available doctors	7

Table 3: Provider reports of difficulties experienced by Refugee and Refugee Claimant mothers. In their day to day living Total responses = 79.

depending on the type of service agency. Less than half of PHCPs (n=6) reported they did not charge fees for service, four were Community Health Centres (CHCs) and two were independent clinicians who reported that they were able to determine their own billing practice for the uninsured and each reported that they specifically did not charge fees for refugees or refugee claimants. Rates of fees at other agencies varied with no standard rate of fees reported. Emergency departments reported the highest fees \$250 - \$325, and there were differences in what was included in the fees, e.g. tests, x-rays. In each of the remaining agencies where clients were billed, fees did not include any investigative tests. Walk in clinics were much less expensive at \$28 - \$40 per visit and family physicians were least expensive at the lower end of this range and they were also the least available.

Reported benefits of working with refugee and refugee claimant families were clustered into three main themes; benefits were the same as for the general population (n=5), working with this population was personally gratifying in some way (n=5), giving to and helping others was important (n=8). Two examples of the experience with refugee and refugee claimant mothers adding value to the provider are captured in the following comments; "Gratitude from clients when you help them gives me a professional satisfaction and I also learn a bit about different cultures" (RN in a Community Health Centre). Increasing provider appreciation for the benefits of living in Canada was noted by five respondents, one person commented "I realize where people are coming from and I feel lucky to be in the Canadian system, born in this system" (Receptionist in a Family Doctor office).

Nurses, physicians and staff reported worry about causing offence to their clients and expressed frustration about lateness and missed appointments which they believed was due to cultural differences. Mothers in this study also expressed concern about difficulties attending appointments they reported significant challenges with child minding and transportation to attend appointments.

Providers had very little knowledge about who among their respective clients were refugees and almost all reported that they had no training or preparation to work with culturally diverse populations. No-one had any preparation to work with refugees. Some participants seemed to see specific preparation as not really necessary. For example, an emergency physician stated, "We have no specific preparation and treat everyone the same, we have questions and protocols which help". These findings are important as refugees often have specific needs based on their migration history; needs which are difficult to meet when they

remain anonymous in the general patient population. In addition, cultural values may be different and influence a clients' willingness to share information or ability to act on instructions from their health care professional.

Recommended changes to improve the system for refugee and refugee claimant mothers were quite diverse and were grouped into four themes: improving language access for mothers, educating mothers about the importance of the health card, educating mothers how to use the system efficiently, and increasing services for this target group. One respondent explained, *"I wish we had an education system for all new comers patients and clients, so that they can learn English to better understand the system, what is available and how to get a family doctor. I know all our signs are in English and that is not helpful. I try to help families as I know they are worried about having to pay for things and they have very little money to do that. I have a list of walk in clinics and CHCs which I use to help families understand there are other choices than the emergency department, especially when they have Interim Federal Health Program or cannot show proof that they are insured"* (RN in an Emergency Department).

Most responses were about helping mothers accommodate to the Canadian system; there were only a few suggestions of changing the system to offer better service to these mothers. One provider suggested government funding of social workers in all agencies working with refugees and refugee claimants, another identified the need for the IFHP to remove the requirement of pre-approval before providing some treatments. No-one mentioned need to understand health insurance, IFHP or rights and entitlements of refugees and refugee claimants.

Individual stories indicated that providers try to meet the needs of the refugee or refugee claimant family at the time of contact. However provider responses also indicated that health care system responses fail to meet the specific needs of refugee or refugee claimants. For example, few agencies prepared their staff to work with ethnically diverse populations (n=3) and none had preparation for working with refugees and refugee claimants.

Participants from an agency which self identified as an Immigration designated facility reported that they had no specific preparation for their staff and that they relied on the training of health care professionals and personal experience. Furthermore, although language barriers, were the most commonly reported difficulty identified by providers, most relied on informal interpreters, staff or family members (n=4) few agencies provided professional interpreter support (n=3). The remaining six agencies relied on families to address their interpreter needs.

Discussion

Although the health system in Hamilton had a wide array of primary health care provider services, there was evidence of a shortage of family doctors in the city. Primary health care services at night and weekends were provided by each of the four emergency rooms. There was also evidence that some services were not known among participating families and provider respondents in this study did not identify services such as Tele-health or a community health bus as possible options for their clients. Tele-health provides health advice by phone in multiple languages. The health bus provides primary health services such as immunizations, health screening and some dental services in different locations across the city on a predetermined monthly schedule. Proof of health insurance is not required for either service.

Primary health care providers were unable to identify refugees or refugee claimants among their clients. This may indicate that

their refugee clients are treated equitably, or, that providers may not be meeting special or specific needs of this group if they have needs related to their immigration trajectory or status in Canada. An example of not understanding the trajectory of refugee claimants was the lack of awareness of fear caused by detailed documentation of personal information at each health visit and the removal of important immigration papers for photocopying (refugee claimants). The inability to identify refugees among their client population was also a feature of emergency room responses and may be related to the volume of clients and the lack of continuity in the provider client relationship. The lack of continuity of care may also be problematic when emergency departments are the main health care provider for a child or other family members.

Primary health care providers reported general concerns they had about failing to meet the needs of refugee families. They expressed concern about failing to meet client expectations as they were unsure about client expectations about privacy, delays in appointments; they expressed concern about miscommunication and being misunderstood. Limited preparation to work with ethnically diverse populations may have added to this concern. Although training was often limited to general social skills training or was nonexistent in primary health care agencies it was rarely identified as a concern. This suggests providers may underestimate the importance of their interactions with this population. In contrast, mothers accessing these services for their preschoolers recalled staff attitudes and behaviours in detail and explained that positive behaviours of welcome and warmth encouraged their comfort and trust in the intentions of providers. Refugee and refugee mothers ranked provider attitudes higher than language barriers in importance [1]. Two agencies with annual anti-racism training for their staff were mentioned in reports from mothers. Mothers reported that they remained with these agencies as their preferred provider even when they had relocated some distance away and had to travel up to 1.5 hours each way.

In general, children of refugee claimant mothers had less choice of health care provider; this finding was confirmed by providers who said they would refer these families to other agencies. Recent changes to IFHP [28] have further reduced access to health services for both refugees and refugee claimants in Canada [29-32]. Collectively, these reports highlight some of the risks of such cuts to the health of refugee children, pregnant women and others, there are also negative consequences for the health care system with increased costs related to delayed health checks and treatments. Problems also exist when the type of health insurance and the right to have it are not well understood, individuals have declined to seek care when needed [30] and others have been refused medical care because the provider did not understand that health insurance was in place [29].

Reports from Australia [33,34], the United States [35] and the United Kingdom [36] suggest that such cuts will result in significant hardship and risk for refugee and refugee claimant families and that costs for the Canadian health care system are likely to rise when health care needs are under or never served.

Implications

Findings in this study have implications for practice and policy. Primary health care service providers need training and preparation for working with diverse populations such as immigrants and refugees. Training must include information about the likely impact of migration history on the health of refugees, their rights to health care and information about IFHP and provincial health insurance. Reports of

racist behaviours indicate anti-racism preparation and training is also needed.

These families may have experienced considerable hardship related to their migration path and have limited resources to comply with treatment recommendations. Providers also need to be attentive to how they are perceived by refugee and refugee claimants. Mothers reported that they were more likely to remember details of instructions that providers gave in person as they were able to ask questions for clarity. Explanations of expectations about attendance for appointments and the triage process in emergency departments were rare in this study and this gap in information created frustration for mothers and was interpreted as evidence of racism.

Providers need to promote the sharing of accurate and current information about their services and expertise with settlement support and primary health care services. In this study, when providers knew about other services, they were able to use this information to inform mothers. There were also examples of mothers being sent to other agencies for services which could not be provided. These problems could be eliminated with better sharing of information. In addition details of services such as Tele-health and the community health bus need to be known by this community.

Policy changes in recent years have lifted medical restrictions for refugees coming to resettle in Canada; changes to the IFHP (2012), have limited health insurance coverage to refugees when they have provincial health insurance and removed entitlement to health insurance for almost all refugee claimants. Current trends in refugee movements show increases in the number of refugees arriving with chronic conditions such as type 2 diabetes, cardiovascular disease and cancer [37]. The impact of the recent changes to health insurance coverage for refugees and refugee claimants needs to be studied urgently and health insurance coverage revisited as a right and as an investment in health and reduced health care costs in the long term [38].

Limitations and Strengths

Findings from this study have limited generalizability as the study was completed in one city. However nurses and physicians came from many different educational programs and collectively they represented the full range of available primary health care services. The study was located in a city within 70 kilometers of several immigration entry points and is a receiving centre for refugee resettlement. At the time of this study, the city had an integrated model of public health services focused on social determinants of health and working in partnership with settlement agencies; this model remains in place today. The integrated model may have resulted in improved access for this population in particular refugee families who were attached to settlement agencies. Results from this study represent a best or better case than is likely today given the recent changes to health insurance provision to both refugee and refugee claimant families.

Conclusion

Inequitable access to health care is present when factors other than need or demographics are associated with variation in health care access [39]. Findings in this study raise questions about equity of primary health care access between these two groups of mothers and across different PHCP agencies. The recent changes to health insurance entitlement (IFHP) will sharpen these differences with significant reductions affecting refugee claimant families in particular. Primary health care professionals such as nurses and physicians need support to develop their abilities to work confidently with culturally diverse

populations in particular where they can anticipate working with refugees. Recommendations include more research to determine, 1) the effects of recent changes to IFHP on refugee and refugee claimant adults and children and 2) the most efficient and effective way to prepare health professionals for working with diverse populations including refugees and others.

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