

**Taking a New Collaborative Approach to
Refugee Health in Nova Scotia
June 2011**

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ISIS would like to thank Citizenship and Immigration Canada for making it possible to explore our vision for a refugee health clinic in Halifax. We believe this is an opportunity to both strengthen community partnerships and adequately meet the health needs of Nova Scotia's refugee population.

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Additional research contributors are named throughout the report in the sections corresponding to their work. Thank you for your support and hard work.

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EXECUTIVE SUMMARY

Background

The profile for the government assisted refugee population of Halifax has changed since the creation of the Immigrant and Refugee Protection Act (IRPA) in 2002. The IRPA has shifted the focus of selection to ensure the resettlement of convention refugees is based on most in need of protection. Government Assisted Refugees (GARs) resettling in Nova Scotia have lived in camp situations on average 17 years resulting in significant physical and mental health challenges.¹

The vision of ISIS is that of a community where all can belong and grow. In partnership, ISIS offers services and creates opportunities that enable immigrants to participate fully in Canadian life. Through the delivery of service programs for the social integration of Government Assisted Refugees (GARs), ISIS provides health literacy and access support to these new residents of Canada. The health services provided to GARs by ISIS include the provision of interpreters for primary care medical and dental appointments; hospital tours; orientation to the Canadian health care system; support in navigating and negotiating the health care system; referrals; the development of a health care plan or needs assessment; support and arrangement of medical appointments when needed; education and awareness training with service providers around refugee health needs and advocacy for access to needed health care services.

ISIS continues to advocate for the needs of Government Assisted Refugees with regard to accessing appropriate, comprehensive and cultural sensitive primary health care services. Despite years of advocacy and education by ISIS, numerous barriers remain in the provision of health care services to newcomers in Halifax. Interpretation is still not regularly provided in primary health, refugees are not receiving full health assessments to diagnosis conditions that are a result of pre-arrival conditions, immunization history is not being considered and updated, services provided under the Interim Federal Health Program are inadequate and many newcomers must wait months before finding a family physician willing to take them as patients. ISIS believes that now is the time to invest in a new strategy of primary health care provision to Government Assisted Refugees in the form of a targeted and collaborative health clinic.

The purpose of a refugee health clinic is to provide:

- Comprehensive health assessments, including public health screening within days of arriving in Halifax and necessary referrals
- catch-up immunization
- short term primary health care and additional support for complex cases
- follow-up for those requiring medical surveillance
- supported bridging to existing services for ongoing care, in particular, family physicians

The priority group for services will be Government Assisted Refugees during the first one-two years of resettlement. Services should be expanded to privately sponsored refugees during the first one-two years of resettlement and also to refugee claimants.

¹ Presse, D., & Thomson, J. (2007). The resettlement challenge: Integration of refugees from protracted refugee situations. *Refuge* 24(2), 48-53. Retrieved from <http://pi.library.yorku.ca/ojs/index.php/refuge/article/viewFile/21383/20053>

Needs Assessment

Each year between 180 and 200 Government Assisted Refugees are resettled in Nova Scotia. In addition there are approximately 25 refugee claimants and 20 privately sponsored refugees that make Halifax their home each year. Based on a two year service model, a refugee health clinic would provide primary health care service to approximately 500 refugees at any given time.

Current Refugee Profile for Nova Scotia

Refugee Category	Top Source Countries
Government Assisted Refugees	Bhutan Iraq Afghanistan Ethiopia Eretria Democratic Republic of the Congo
Privately Sponsored Refugees ²	Ethiopia Columbia Iraq
Refugee Claimants	Cuba Iran Sri Lanka

The most commonly reported health issues among newly arrived convention refugees to Canada include³:

- infectious diseases
- under immunization
- mental illness/distress
- parasitic infections
- nutritional deficiencies
- oral health and hearing loss

The complexity of refugee health is compounded by language, health literacy and cultural barriers that exist within primary health care services. The failure to provide interpretation and culturally competent practices inhibits access to service and ensures difficulty in navigating the health care system.

Current Service Arrangement

The North End Community Health Centre is currently serving 90 Bhutanese Government Assisted Refugees that arrived to Halifax between 2009 and 2011. The NECHC is committed to a multi-disciplinary primary care approach that includes the services of physicians, nurse practitioners, registered nurses, dietician, occupational therapist, shared care mental health, dental hygiene, dental partnership, foot care, blood work and diabetes clinic. The NECHC has worked very hard to provide comprehensive primary care to this population by providing full health assessments and developing immunization schedules. They have adapted services to meet the needs of large family groups and individuals with complicated health needs by extending appointment times and learning about the pre-arrival conditions of the Bhutanese refugee population.

² Nova Scotia Office of Immigration. (2010). *Nova Scotia immigration information and fact sheet: Refugees to Nova Scotia*. Retrieved from <http://novascotiaimmigration.com/immigration-statistics>

³ Morris, M. D., Popper, S. T., Rodwell, T. C., Brodine, S.K., & Brouwer, K.C. (2009). Healthcare barriers of refugees post-resettlement. *Community Health* 34, 529-538. Doi:10.1007/s10900-009-9175-3.

Those Government Assisted Refugees that are not currently patients of the NECHC are receiving primary health care from various family practice clinics within the HRM. These individuals are most often not receiving the comprehensive care required or provided by the NECHC model. Additionally, almost all interpretation services within primary care settings, including within the NECHC, is provided by ISIS. The ability to sustain this practice is contingent on continued funding from Citizenship and Immigration Canada (CIC). ISIS does not currently have the resources to provide health literacy training for interpreters and as a result many interpreters are not adequately trained for health settings.

Privately sponsored refugees and refugee claimants do not qualify for interpretation services through CIC and are reliant on volunteers or the hire of expensive professional interpretation services. As well, these individuals often share similar barriers to accessing primary health care settings including the inability to find a family physician willing to take them on as patients and the lack of culturally competent care available.

Key Service Issues

Key Issue	Description
Health assessment including screening & immunization catch-up	<ul style="list-style-type: none"> Besides the NECHC, most medical clinics do not have the capacity or resources to ensure that comprehensive health assessments and immunization catch-up is available to all refugees in Nova Scotia Failure to provide assessment and screening can increase the risk of serious conditions being missed or presenting late for treatment Long wait times for access to primary health care can contribute to complications in health conditions for newly arrived refugees
Language/interpretation	<ul style="list-style-type: none"> ISIS funding for interpretation services available to Government Assisted Refugees is contingent on commitment by CIC Interpreters used in primary care settings are often not trained for health interpretation The allotted time for primary care appointments is often inadequate to accommodate time needed for interpretation Privately sponsored refugees are not eligible for interpretation services from CIC resulting access barriers Refugee claimants do not have access to interpreters in primary care
Complexity of health needs	<ul style="list-style-type: none"> Family physician appointments do not provide adequate time to discuss the complexity of health needs resulting from extreme pre—arrival conditions or provide the necessary orientation Family physicians are often reluctant to take refugees as patients based on the perceived difficulty of providing care
Cultural Competency	<ul style="list-style-type: none"> Culturally competent care is currently not provided in all primary health care settings – the use of interpreters, gender matching, consideration for cultural and pre-arrival conditions Health professionals require resources, information, training and practical support such as clinical advice to best serve newly arrived refugees
Coordination	<ul style="list-style-type: none"> Currently there is limited coordination between primary health care professionals and ISIS settlement staff Improved coordination would result in better health as well as settlement outcomes

Refugee Health Clinic Service Model

In building primary health care services in Halifax that are both comprehensive and responsive to refugee health needs, ISIS believes a targeted clinic model with direction and dedicated to inclusion is the best approach. The ISIS vision for a refugee health clinic in Halifax includes the following components:

A. Partnerships and Sharing of Resources

The ability to provide comprehensive primary health care to refugees in a multidisciplinary team requires the formation of partnerships and the sharing of resources. The goal would be to provide primary health care with clinic partners for the first two years in Canada with the expectation of referral to other clinics once the individual is accustomed to the health care system and their health is stabilized. In all partnerships ISIS would remain as an active collaborator and advocate.

B. Cultural Competency

The willingness to adapt to the cultural and health literacy needs of the patient is essential to comprehensive and holistic primary health care provision. As the population of refugees resettling in Halifax is ever changing, it is vital that a clinic targeted to refugee health is willing to learn about and adapt to cultural diversity.

C. Inclusion of Internationally Educated Health Professionals

An interesting addition to a refugee health clinic that would be unique to Halifax is the inclusion of internationally educated health professionals in primary health care service delivery. Currently in Halifax there are two hundred and ninety eight internationally educated health professionals who are in the process of being re-certified to practice in Canada. The inclusion of these professionals could add expertise and capacity to the clinic that may otherwise be difficult to find and at the same time support them on their own journey to becoming licensed practitioners.

D. Inclusiveness of Service

It is extremely important to mention and include all categories of refugees residing in Nova Scotia, including privately sponsored and refugee claimants, in the discussion of targeted services for refugees. Barriers including the Interim Federal Health Program, interpretation services and the need for culturally competent care affect access to and quality of primary health care services for all refugees.

E. Supporting the Education of Future Health Professionals

A refugee health clinic in Halifax would not only be beneficial to the refugees receiving primary health care but the benefits could be expanded to the education of future health professionals including physicians, nurses, nurse practitioners, social workers, occupational therapists etc. The training of cultural competency could be included in University curricula and students could be provided the experience of working with refugees during practice placements.

The education of health professionals could expand beyond the classroom and into the area of family physician clinics and delivery of health orientation. Physicians working in the refugee health clinic as well as internationally educated health professionals could share their knowledge and skills of refugee health with family physicians. This mentoring system may encourage family physicians to willingly include refugees in their practice and provide the comprehensive and culturally competent care that is required.

F. Research

The area of education also allows for the prospect of and the opportunity to encourage academic research with regard to refugee health in Halifax. The inclusion of refugees in community based research will contribute to a better understanding of the needs of newcomers and provide suggestions for best practice in primary health care service delivery with regard to this population.

Objectives

1. Process

- Develop a strategy that would provide each refugee with a full health assessment in the initial post-arrival period in Canada
- Address health literacy issues
- Tailor medical appointments to allow time for interpretation and health needs to be adequately addressed
- Ensure for flexibility and adaptation to meet the needs of the continually changing refugee population arriving in Nova Scotia
- Secure sustainable access to required services such as interpretation and translation

2. Collaboration

- Create true collaboration between health care team and ISIS settlement staff to provide holistic primary care
- Nurture partnerships outside of clinic to ensure culturally competent and adequate specialized services are available and accessible to refugees
- Include internationally educated health professionals and medical graduates to support educational and accreditation endeavors as well as increase cultural competency in health care settings
- Support the education of future health professionals and encourage academic research regarding refugee health

3. Bridging

- Coordinate the bridging of refugee health care to mainstream family physicians following an initial 1-2 year settlement period
- Educate family physicians on the health care needs of refugees and newcomers on navigating the Canadian health care system

Implementation

ISIS is seeking the support of the federal government, the provincial government, primary health care clinics and other important community partners to ensure that the vision of a needs-based primary health care clinic for refugees can become a reality. In June 2011, a planning session will be held for key stakeholders. It is hoped that this will create a working group of interested partners willing to work together in creating a multi-disciplinary primary health care clinic for refugees in Halifax that is holistic, inclusive and sustainable.

PURPOSE OF THE REPORT

The health and wellness of refugees who have chosen Halifax as their new home is an area of concern that is contingent on many factors including the access to primary health care. Unfortunately refugees in Halifax continue to face challenges in accessing comprehensive and culturally competent primary health care services. This report evaluates relevant literature and reflects on the vision of Immigrant Settlement and Integration Services (ISIS) with the belief that it is now time to take a new approach to refugee health care through the formation of a Halifax refugee health clinic (or clinics if more community partners would like to share this initiative). The vision of ISIS is that of a community where all can belong and grow. In partnership, ISIS offers services and creates opportunities that enable immigrants to participate fully in Canadian life. Through the delivery of services programs for the social integration of Government Assisted Refugees (GARs), ISIS provides health literacy and access support to these new residents of Canada. The health services provided to Government Assisted Refugees by ISIS include the provision of interpreters for primary care medical and dental appointments; hospital orientation tours; support in navigating and negotiating the health care system; referrals; the development of a health care plan or needs assessment; support and arrangement of medical appointments when needed; education and awareness training with service providers around refugee health needs and advocacy for access to needed health care services.

ISIS continues to advocate for the needs of Government Assisted Refugees with regard to accessing appropriate, comprehensive and cultural sensitive primary health care services. Despite years of advocacy and education by ISIS, numerous barriers remain in the provision of health care services to newcomers in Halifax. Interpretation is still not regularly provided in primary health, Government Assisted Refugees arriving after numerous years in refugee camps are not receiving full health assessments to diagnosis acute and chronic conditions nor are they receiving necessary immunization. Further, ISIS staff is often forced to send newcomers to walk-in clinics or emergency departments as adequate primary health care appointments continue to be difficult to arrange. ISIS is concerned that these barriers to health care perpetuate inequities in the health care system and contribute to untreated health care conditions in the newcomer population. ISIS believes that now is the time to invest in a new strategy of primary health care provision to Government Assisted Refugees in the form of a targeted and collaborative health clinic. Community stakeholders including primary care professionals, nutritionists, pharmacists, dentists and others in front-line service delivery positions, have also expressed awareness of the issue and are in agreement for the need of targeted health care services for refugees. In providing a case for a new approach to refugee health care in Halifax, this report will provide a background of the refugee population with specific emphasis on their unique health needs, challenges and strengths. It will also provide a discussion of relevant initiatives undertaken by ISIS with community partners to raise awareness to the health needs of Halifax's refugees including the initial provision of targeted health care to a group of Bhutanese refugees by the North End Community Health Centre. In the exploration of a new approach to refugee health care, an overview of three Canadian and one international Refugee Health Clinics are explored. Finally, this report will provide a vision for a Refugee Health Clinic in Halifax with suggestions for moving forward.

PRIMARY HEALTH CARE

In the report *The Patient Journey Through Emergency Care in Nova Scotia, A Prescription for New Medicine* (October 2010 p. 82), Dr. John Ross provides the following definitions with regard to primary health care,

Primary care - health and disease care provided to individuals and families initially and in follow-up by primary care clinicians. Such clinicians may be family physicians, nurse practitioners, family practice nurses, physicians' assistants, or extended-role paramedics. General internists and general pediatricians, who provide an overlap of some primary but mostly secondary care, can support them. The focus is on service delivery. It involves health promotion, disease prevention, acute episodic care, ongoing care of chronic diseases, education and advocacy.

Primary health care – is the more holistic consideration of health, incorporating the 12 determinants of health: income and social status; employment; education; social environments; physical environments; healthy child development; personal health practices and coping skills; health services; social support networks; biology; genetic endowment; gender and culture.

In his report Dr. Ross discusses the need for all Nova Scotians to have access to high-quality, comprehensive, long term primary care that is able to accommodate unexpected illnesses and manage chronic illnesses in a timely manner. He suggests that this can be accomplished through the development of more clinics that deliver primary care and chronic disease management through open access (same-day or next-day appointments) and collaborative teams of doctors, nurses and allied health professionals. Although primary care is important for all Nova Scotians, this model of service provision would be extremely valuable in responding to the unique health needs of Government Assisted Refugees requiring a holistic, responsive and sensitive model of health care provision.

THE POPULATION

The United Nations High Commission for Refugees (UNHCR) established by the 1951 Geneva Convention defines a refugee to be a person, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country (UNHCR, 2011).

In keeping with our commitment to the 1951 Geneva Convention, Canada provides protection to thousands of convention refugees every year (CIC, 2011). Through the Resettlement Assistance Program (RAP), Canada sponsors approximately 7500 convention refugees, or Government Assisted Refugees, annually (UNHCR, 2011). These individuals and families are recognized overseas by the UNHCR as refugees and are selected for resettlement through a needs based model. The category of Government Assisted Refugees does not include privately sponsored refugees and refugee claimants.

Privately sponsored refugees are financially and socially supported by sponsorship individuals or groups within the community. Refugee claimants are not considered convention refugees and seek refugee status upon arrival in Canada. ISIS receives funding to provide settlement services, including health support, to Government Assisted Refugees, and as such this report will mainly focus on this population. The concentration of this report on Government Assisted Refugees does not ignore the fact that other refugees within Nova Scotia may face similar barriers as those observed by ISIS and experienced by our clients, as well as other barriers unique to their own situations. Intermittently throughout the report information regarding refugee claimants and privately sponsored refugees will be provided and the report concludes with a commitment to the inclusion of all refugees in the provision of targeted refugee health care services.

To understand the context for Government Assisted Refugees, it is important to distinguish between refugees and economic immigrants. Refugees differ from economic immigrants in that refugees do not actively seek to leave their country to settle in Canada (Kiss, 2010). Refugees enter Canada due to forced displacement and for the protection of themselves and their families (UNHCR, 2011). Individuals entering Canada for humanitarian and compassionate reasons have different patterns of migration and face unique difficulties and opportunities than those entering with economic objectives. As previously mentioned, each year the federal government sponsors 7500 convention refugees to resettle in Canada. Of this total, between 180 and 200 individuals are resettled in Nova Scotia. At present, the main source countries of refugees to Nova Scotia are Bhutan, Iraq, Afghanistan, Ethiopia, Eritrea and Democratic Republic of Congo. ISIS provides settlement services to all Government Assisted Refugees making Halifax their new home. In addition there are approximately 100 individuals in the categories of refugee claimant and privately sponsored refugees that make Halifax their home each year.

Upon arrival in Canada, convention refugees have the status of permanent residency. This status ensures that these individuals have access to services available to other permanent residents and Canadian citizens including provincial universal health care, such as Medical Services Insurance (MSI) in Nova Scotia. As well, for their first year in Canada, convention refugees are provided with additional coverage under a health benefit program provided by Citizen and Immigration Canada (CIC). This health benefit program is known as the Interim Federal Health Program (IFHP) and is currently administered by Medavie Blue Cross. Refugee claimants are also eligible for benefits under the IFHP.

According to the Medavie Blue Cross handbook, the purpose of the Interim Federal Health Program is to provide service in order to reduce risks to public health, ensure care for the refugee population and assist with the successful integration into Canadian society (2011). For Government Assisted Refugees the IFHP acts as a supplementary benefit program for items and services which may not be covered under provincial health care, including some prescriptions, mobility devices, hearing aids and eye glasses. For refugee claimants the IFHP provides their only access to health care services in Canada.

In January 2011, Medavie Blue Cross replaced Funds Administrative Service (FAS) in the administration of the Interim Federal Health Program. Initially it was unclear as to how this change would affect individuals accessing the program or the advocates, such as ISIS, assisting clients to receive benefits. In the short period of time since the change to administration has taken place, it has become clear that the role of advocacy, both by the client for themselves and by ISIS on behalf of the individual, has been diminished. Previous to the administration change, ISIS staff would often send requests of service for special cases directly to a representative within CIC for consideration. Medavie Blue Cross has altered this process and will no longer receive requests or pre-approvals from clients or advocates, nor will they provide explanations for service rejection to these individuals. The sharing of all information must be conducted between the medical professional with a service provider number (ex. dentists, optometrists, physicians etc.) and Medavie Blue Cross. This is extremely burdensome to the service providers who do not have the time or often the expertise in the advocacy work that ISIS was previously able to assist with. As highlighted in the following case example, this new process has already created access barriers for newcomers in receiving needed health services which can lead to poor health outcomes for these permanent residents of Canada.

Bishnu is an 80 year old woman who lived in a remote refugee camp for 17 years prior to her recent arrival in Canada. Due to the lack of primary health and dental services within the refugee camp, Bishnu arrived to Canada with multiple health conditions including the loss of her teeth which has resulted in extreme malnutrition. Both Bishnu's family physician and dentist wrote letters advising of her undeniable need for dentures. Bishnu's application for dentures through the Interim Federal Health Program was denied with no explanation given. There is no process for appeal nor is ISIS able to advocate on behalf of Bishnu with Medavie Blue Cross. At present the receptionist at the dentist's clinic is trying to speak to a representative at the IFHP with regard to the negative decision; however in trying to call, she has been put on hold on numerous occasions and has not been able to have the decision reviewed.

The above case provides an example of common access barriers to health care for newcomers. Not only are Government Assisted Refugees being refused services and treatments medical professionals deem to be necessary for their health and wellbeing; they are being denied these services without explanation or the ability to appeal the decision. This is not only potentially harmful to the client, but ISIS staff are also concerned about the extra work load placed on medical service providers in this new structure of the IFHP. Medical professionals and their staff are already extremely busy in day to day service provision and do not necessarily have the time or the ability to advocate for each government assisted refugee needing specialized care. This administrative burden can result in access barriers for refugees (Gagnon, 2002). The role of advocacy has previously been a significant contribution of the immigrant health program at ISIS to both assist clients to advocate for themselves as well as on their behalf. The loss of agency in this regard is extremely detrimental to empowerment, not to mention the health outcomes, of the Government Assisted Refugees new to Canada.

HEALTH CHALLENGES

Changes to the Canadian Immigrant and Refugee Protection Act (IPRA) in 2002 have resulted in a noticeable change in the government assisted refugee population selected for resettlement in Halifax. The IPRA has shifted the focus of selection to ensure the resettlement of convention refugees is based on those considered most in need of protection. As a result, newly arrived refugees are being recognized by service providers as needing much more support, having more complex health issues and utilizing more settlement services than those previously resettled in Canada (Public Works and Government Services Canada, 2002 cited in Kiss, 2010).

Many refugees seeking resettlement have been survivors of war, torture, rape and extreme prejudice (Kiss, 2010). They may have lived in refugees camps with poor and overcrowded living conditions and without access to proper nourishment (Kiss, 2010). The average duration in refugee camp situations for the world's convention refugee population, including those resettled in Canada, is seventeen years (Loescher & Milner cited in Presse & Thomson, 2007). Many refugees in camp situations have had little access to formal education or employment opportunities, and experience low levels of literacy as a result.

Densely populated camps, often with few services, including comprehensive medical care, also result in a significant portion of people with psychological and physical health concerns (Presse & Thomson, 2007). Acute and chronic diseases such as tuberculosis, malaria, hepatitis, intestinal parasites and natural deficiencies have been documented in resettled refugees and can persist upon resettlement (Morris et al., 2009). Other long-term health conditions found amongst resettled refugee populations include hypertension and diabetes, poor dental health and women's health concerns (pre/post natal care and implications of female genital cutting) (Morris et al., 2009). These clients often require immediate health care services upon arrival and on-going support during their first years in Canada.

Experiencing stressors pre and post resettlement not only affects the physical health of refugees but can also contribute to mental health concerns (Kiss, 2010). Traumatic incidents before migration result in increased levels of mental health disorders such as depression, anxiety, post-traumatic stress disorder (PTSD), dissociation and psychosis (Keyes, 2000 cited in Kiss, 2010). New and increased stressors experienced after relocation also affect the mental health and wellbeing of refugees (Keyes, 2000 cited in Kiss, 2010). Factors such as economic hardship, racial discrimination, isolation, unemployment, and language proficiency are all found to impact the mental health of newcomers to Canada (Kiss, 2010). The resulting effects of immigration policies such as family separations can also contribute to serious mental health concerns including psychological traumas, depression, family breakdown and integration difficulties (Lacroix, 2006). This can be especially relevant to refugee claimants, 80% of whom arrive in Canada without their immediate families (Bertot & Mekki-Berrada, 1999 cited in Lacroix, 2006).

To explore the health needs of refugees in Nova Scotia, the North End Community Health Centre (NECHC) in partnership with ISIS, collected data from health services provided to approximately ninety Bhutanese Government Assisted Refugees resettled in Halifax from 2009 to 2010 (NECHC, 2011). The goal of the data collection was to track the health care needs and status of newly arrived refugees.

The data collected by the NECHC is consistent with the literature regarding the complex physical health needs of refugees. Through the provision of health care to the Bhutanese refugees, the NECHC has identified numerous health challenges within the Halifax refugee population. The main health concerns identified within the population include active and inactive tuberculosis, G6PD deficiency, history of malaria, dyslipidemia and intestinal parasites (*D fragilis*, *Giardia*, hookworm, *B hominis*, *ascaris*, *strongloides*, *schistosomiasis*, *filariasis*), anemia and varying levels of nutritional health (NECHC, 2011). Further the clinic learned that none of the women or girls amongst this refugee population has received a pap test prior to arriving in Canada (NECHC, 2011). As a result, one woman was diagnosed with cervical cancer following testing (NEHC, 2011). See Appendix F for detailed information on the service provided to the Bhutanese Government Assisted Refugees by the NECHC.

In addition to the information provided by NECHC, Citizen and Immigration Canada indicate that within the government assisted refugee population there are a considerable number of individuals identified as “Special Needs Clients” currently resettling in Canada. A client may be considered to have special needs based on the existence of any one or more of the following factors: a physical impairment or other medical need not necessarily requiring institutional care; a history of having experienced trauma and/or torture; and/or long term displacement which is expected to hamper resettlement in Canada; and/or a family size or configuration which is expected to hamper resettlement in Canada. ISIS has identified that in 2010, over 30% of their government assisted refugee clients fit this category.

Both refugee health discourse and the data from the North End Community Health Centre indicate that as a result of persistent health needs and both historical and social factors, refugees may require special health care and treatment (Miedema et al., 2008). This may be especially important in the early stages of resettlement (Miedema et al., 2008). A targeted comprehensive health care program for refugees needs to be a holistic approach working from a multidisciplinary team built on partnerships and shared resources. Multidisciplinary approaches are vital to effective service provision to immigrant and refugee communities (Schmitz et al., 2003). Preventative and proactive services need to be provided in culturally competent settings that work to mitigate the need for long-term special care. Such a service design recognizes the legal, social, physical and mental health needs, as well as economic and cultural issues of newcomers (Schmitz et al., 2003). All these factors need to be considered in refugee program development and implementation (Schmitz et al., 2003).

It is important to mention that ISIS is committed to working from a strengths based perspective in service provision to our clients. Through this perspective it is imperative that service provision not only look at the needs of refugees but the unique capacities, talents, competencies, possibilities, visions, values and hopes of these individuals (Schmitz et al., 2003). Service provision in a strengths based culturally competent context involves learning new ways of thinking about global constructs and requires patience with self and others (Schmitz, 2003). The commitment of ISIS to this perspective provides opportunities for us to learn from the service users and adapt our services to incorporate their ideas, beliefs and practices into service provision.

CHALLENGES TO ACCESSING HEALTH CARE

Despite a universal health care system ensuring access to health care for all residents of Canada, health disparities remain for refugee populations (Kiss, 2010). Barriers including language, exclusive health programs, and cultural insensitivity all contribute to the inability of refugees to access appropriate and required health care services (Morris et al., 2009). Halifax's refugee population continues to face these similar challenges within the health care system. Language and interpretation services are not readily available in primary health care settings, access to holistic services that meet comprehensive needs is not accessible and culturally competent service provision is limited.

A. Language

Language and communication are consistently seen as major barriers to health care provision and access for refugee communities (Morris et al., 2009). This barrier includes the lack of language interpretation services, bilingual staff and translated health education materials in the health care system (Kiss, 2010). Language barriers can affect all stages of health care access from booking an appointment to filling a prescription (Morris et al., 2009).

Interpretation services are an essential element in the provision of health care to refugees. Not only is it essential that refugees are able to present health care providers with a detailed description of how they are feeling and what they may need, it is equally as important that patients receive adequate information and instructions to care for their own health. Instructions for health care can be provided through interpretation as well as in written materials provided in a patient's language. Misinterpretations and miscommunications can have serious consequences for both the patient and the health care provider (Morris, 2009). The use of medically trained interpreters in all health care settings, from hospitals to clinics to pharmacies, is an extremely important factor in determining newcomer access to care (Mayhew, personal communication, 2011).

Presently in Halifax the use of interpreters trained in health literacy are found in both the IWK and CDHA hospitals. These interpretation services are provided by Nova Scotia Interpretation Services. These services are only extended to primary health care settings when a service provider covers the costs. This seldom happens.

Currently ISIS is filling the interpretation gap for Government Assisted Refugees in primary health care through funding from CIC which offers limited language services for settlement purposes. Although crucial, these services are not secure or necessarily properly meeting the needs of newcomers to Halifax. These current interpretation services are not available for individuals that are not clients of ISIS and are contingent on funding from CIC. Also, the interpreters provided by ISIS for primary health care services have been trained as settlement interpreters and do not necessarily have interpretation training in health literacy. ISIS has continuously advocated for the expansion of interpretation services in all primary health care settings. To date, ISIS continues to advocate for these services and believes that a clearly defined and regulated interpretation process is necessary to provide culturally competent and holistic primary health care to Government Assisted Refugees in Halifax.

For privately sponsored refugees to Nova Scotia, the lack of access to interpretation services can be the most significant barrier to receiving adequate primary health care services. Individuals sponsored to Canada by community sponsorship groups are eligible for limited interpretation services provided by funding through CIC and offered through ISIS. As this service is limited, the private sponsorship community must often rely on volunteer interpreters, who may have limited or no interpretation training, or pay for very expensive professional services from the money fundraised and allocated to support the settlement of the sponsored family for one year. Paying for interpretation services for individuals with complex health needs can deplete the settlement fund very quickly. The inaccessibility and lack of interpretation offered in primary health care settings is an extremely challenging access barrier for privately sponsored refugees and their sponsors.

In addition to interpretation services, an investment in the translation of written health materials and the use of multilingual staff would be beneficial to assist newcomers with all aspects of health care access from making an appointment to understanding medical instructions. Written materials should incorporate an appreciation of the cultural norms of the community provided in an individual's first language (Alberta Health Services, 2008). Other mediums such as audio cassettes and videos could be used for communicating health information to refugees who may not be literate in their home languages (Alberta Health Services, 2008). Strategies for recruiting multilingual staff include retraining and utilizing the skills of internationally educated health professionals and the inclusion of ethno-culturally and linguistically diverse nursing and medical students into refugee health care (Alberta Health Services, 2008).

An increasingly diverse population in Nova Scotia requires service provision policies and practices to be innovative and responsive. An investment in resources for language skills is inevitably an investment in the future prosperity for Nova Scotia.

B. Exclusion and Inaccessibility

The Nova Scotia Department of Health and Wellness defines primary health care as focusing on health promotion, preventing illness, managing chronic diseases and treating people when they are sick (Province of Nova Scotia, 2011). The goal of primary health care in Nova Scotia is to improve access to services, while ensuring the appropriate use of resources in the delivery of care (Province of Nova Scotia, 2011). The objective of Canadian health policy as outlined in the Canada Health Act (CHA) is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers (Health Canada, 2008 cited in McGibbon & Etowa, 2009). The five principles of the CHA are: (1) public administration, (2) comprehensiveness, (3) universality, (4) portability and (5) accessibility (McGibbon & Etowa, 2009).

Despite the focus on access of services by both Health Canada and the Nova Scotia Department of Health and Wellness, Government Assisted Refugees continue to experience an inability to access comprehensive primary health care in Halifax. This inaccessibility to service exposes health inequities within the health care system. These health inequities can undeniably be contributed to power, oppression and systemic racism. In their book *Anti-Racist Health Care Practice*, McGibbon and Etowa highlight the contrast between the principles of the Canada Health Act such as universality and accessibility with longitudinal statistics revealing the inaccessibility of health care for racialized peoples resulting in poor health outcomes (2009). As evidence also shows that lack of education and poverty are disproportionately experienced by the non-white population, it is necessary to see the interconnectedness of racism, social exclusion, unemployment, underemployment, individual and family income and education (McGibbon and Etowa, 2009). These factors intersect with the social determinants of health and create extreme disadvantage, inaccessibility and poor health outcomes for marginalized peoples (McGibbon and Etowa, 2009).

Globally, the definition of health has been expanded over the last few decades to include many determining factors (McGibbon & Etowa, 2009). The World Health Organization (WHO) defines health to be, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (2003). In Canada the health of Canadians is determined by complex interactions between social and economic factors, the physical environment and individual behavior (PHAC, 2010). These factors are referred to as 'determinants of health' (PHAC, 2010). They do not exist in isolation from each other and the combined influences of these determinants of health define health status (PHAC, 2010).

In the discussion of the determinants of health it is important to note that Government Assisted Refugees arriving in Canada are vulnerable to be in such situations including poverty and social isolation which can lead, as highlighted above, to negative health outcomes. As previously described, refugees have been forced to flee their countries due to persecution and have often left everything behind to live for extended periods of time in refugee camps. In resettling in Canada, it is often very difficult for Government Assisted Refugees to find adequate employment due to cultural and language barriers, as well as credential recognition obstacles. These social and economic factors contribute to poverty, isolation and health inequity which in turn lead to negative health outcomes for this population.

Truly inclusive and responsive primary health care would take into consideration all the determining factors of health, including race, and seek to eliminate inequities not only in health care but in the broader social and economic realities of marginalized peoples. The compounding determinants of racism, poverty and social exclusion continue to contribute to the inaccessibility of adequate primary health care for Government Assisted Refugees in Halifax. This exclusion from essential and universal services results in poor health outcomes including preventative treatments and the under treatment of acute health conditions.

C. Cultural Competency

Culturally competent, ethnically sensitive services are anchored in an understanding of historical contexts and current policies (Schmizt et al., 2003) Therefore service within a cultural context must include knowledge of the experiences, perceptions and needs specific to a given immigrant or refugee community (Schmizt et al., 2003). Cultural competency in health care speaks to the capability of structures and systems to offer care to patients with diverse values, beliefs and behaviours (Betancourt et al., 2002 cited in Ryhmes & Brown, 2005). This competence includes building service provision to meet patients' social, cultural and linguistic needs (Betancourt et al., 2002 cited in Ryhmes & Brown, 2005). Lack of knowledge or skills to provide culturally competent and sensitive care may result in an underutilization of services or failure to use services by refugees (Kiss, 2010). This underutilization or failure to use services may result in long-term acute health problems (Kiss, 2010).

In tailoring culturally competent service delivery, it is important to remember that cultural characteristics cannot be universalized to all members of a cultural group and that although there may be shared values, programs need to be adaptable and flexible to provide sensitive services (McNaughton Dunn, 2002 cited in Ryhmes & Brown, 2005).

With respect to the local context it is important for primary health care providers to understand the historical situation of the individuals resettling in Halifax as well as have knowledge of particular cultural practices that influence health care decisions. Many refugees have not been accustomed to preventative care and wait to seek treatment when conditions are considered severe (Morris et al., 2003). As well, culturally competent care needs to consider the complexities of women's health including pre and post natal care and the sensitivity of gender matching in health care provision. Finally, it is important to understand the role of community elders in making community decisions including health care decisions. Recognizing such cultural considerations such as these can contribute to inclusive and holistic care for Halifax's refugee communities.

ISIS believes that the inclusion of internationally educated health professionals in primary care services for refugees can help to mitigate cultural barriers and foster communication and understanding between newcomers and health care providers. Not only would the health care system benefit from the valuable contribution of these individuals, but the experience could also benefit those professionals awaiting credential recognition.

a. Mental Health

Although all areas of primary health care to refugees require adherence to culturally competent practices, the assessment and treatment of mental health warrants specialized attention. This is in part due to the understanding that the acceptance of mental health amongst refugee populations can differ greatly from general Canadian beliefs and perceptions.

Mental health concerns related to the trauma of war and forced migration can be acute for refugees (Fennelly, 2006). Further, discrimination, cultural differences, unemployment and unfamiliarity with the health and social systems can contribute to the psychological vulnerability of refugees post-resettlement in Canada (Pyke et al., 2001). Unfortunately however, for those newcomers experiencing mental health difficulties, assessments are often inadequate and can be extremely culturally inappropriate (Fennelly, 2006). Further, newcomers' health seeking behaviours and attitudes are largely formed by the customs and practices prevailing in their country of origin (Lawrence & Kearns, 2005). As such these practices and norms can influence the stigmatization of mental health services or the practice of techniques such as "active forgetting" as a way to cope with traumatic experiences (Lawrence & Kearns, 2005). For these reasons it is important to find cultural competent practices that are able to adequately assess the mental health of a newcomer and provide treatment that is culturally sensitive and non-stigmatizing. Over the years ISIS has worked on numerous mental health services strategies with various community partners. Currently ISIS has a partnership with the Capital District Health Authority Community Mental Health Services, Bayers Road.

As a final consideration, it is important to speak to the diversity of experience within the refugee communities. Although mental health concerns including post traumatic stress disorder and depression can be acute amongst newly arrived refugees, not all individuals experience these conditions. This recognition of diversity within the communities again reinforces the imperative for culturally competent practices and policies within the health care system with respect to providing services to refugees.

SUGGESTIONS FOR CULTURALLY COMPETENT PRIMARY HEALTH CARE PRACTICES

In 2005 the Cultural Competence Guide for Primary Health Care Professionals in Nova Scotia produced by The Diversity and Social Inclusion Initiative of the Nova Scotia Department of Health, outlined eight steps to cultural competence for primary health care professionals. These eight steps are listed as follows:

1. Examine your values, behaviours, beliefs and assumptions.
2. Recognize racism and the institutions or behaviours that breed racism.
3. Engage in activities that help you to reframe your thinking, allowing you to hear and understand other world views and perspectives.
4. Familiarize yourself with core cultural elements of the communities you serve, including: physical and biological variations, concepts of time, space and physical contact, styles and patterns of communication, physical and social expectations, social structures and gender roles.
5. Engage clients and patients to share how their reality is similar to, or different from, what you have learned about their core cultural elements. Unique experiences and histories will result in differences in behaviours, values and needs.
6. Learn how different cultures define, name and understand disease and treatment. Engage your clients to share with you how they define, name and understand their ailments.
7. Develop a relationship of trust with clients and co-workers by interacting with openness, understanding, and a willingness to hear different perceptions.
8. Create a welcoming environment that reflects the diverse communities you serve.

These practices are to be implemented in all areas of service delivery including by primary health care professionals, management and frontline staff. The knowledge and sensitivity of frontline staff can be vital to the care received by refugees. Frontline staff can be seen as the gateway to care and those who can interact well in a diverse work environment will be better equipped to assist diverse clients.

LOCAL CONTEXT – WHAT ARE THE NEEDS?

A. Focus Groups with Government Assisted Refugees (2010)

Excerpts from: *Health Care Experiences in Canada: Focus Groups with Government Assisted Refugees* Prepared in part by: Stephanie Krauss, Dalhousie nursing student

In 2010/2011 ISIS conducted five focus groups with individuals within the four language groups currently most represented in the government assisted refugee population in Halifax: Nepali (Bhutanese), Roma, Farsi and Arabic. The purpose of the focus groups was to determine the primary health care experiences of Government Assisted Refugees within their first year in Canada. In particular, the intention was to compare the experiences of those individuals who received targeted refugee specific primary health care through the North End Community Health Centre versus those receiving primary health care in the general family practice system.

Method: Five focus groups were conducted from the September 2010 to March 2011. Participants were divided into focus groups based on language as well as having received targeted services or general services. Two groups were formed of Bhutanese individuals having received primary health care services through the NECHC; one for men and one for women. The remaining three focus groups were not gendered and were formed of individuals receiving primary health care services through general family practices. Participants were divided based on cultural identification; Roma, Iraqi, Afghani and Nepali. The questions were asked to stimulate group discussion surrounding healthcare experiences and the resulting emotions, actions and treatment. The topics discussed in the focus groups included health care resources available, health care providers, cultural respect, overall health care experience in Canada and the resulting emotions, actions and treatment.

Findings: Participants in most groups revealed that they most often rely on friends and neighbours for advice on what to do when they experience sickness. Others call on ISIS staff frequently for aid with booking appointments and for other health care advice. One participant responded,

Call to friend/neighbours to see what they think I should do, and then if they speak English, they can come [with] me to the doctor

Some participants indicated they most often go to the hospital emergency department when they are feeling ill and need assistance.

Usually go to Emerg and expect from them to give us help, just waiting, not much help, who can help, only God maybe

I always take my child to emergency because the family doctor never helps

In this way, the participants demonstrated active participation in seeking out health care services. However, seeking the advice of friends and neighbors may not provide adequate or correct information. As well, attendance at the emergency room is an expensive and time consuming alternative to responsive primary health care. Many individuals continue to require ISIS support for an extended period of time, as they are not certain how to navigate the health care system on their own nor do they have access to consistent and competent interpreters. Finally, ISIS does not have the capacity or the ability under Medavie Blue Cross, to continue to play such a large role in the health care advocacy and support of every individual.

When discussing their satisfaction with the primary health care services they were receiving, individuals attending for care in mainstream family physician clinics expressed deep concerns with both the quality and quantity of service provided,

I'm pissed off with my doctor because I requested afternoon appointments, but she always gives me morning appointments, so I can't see her

Doc shows up, gives needles, and leaves, no explanation

She didn't show up for the first appointment, then referred me to a blood clinic at the 2nd appointment, now 2 months later, I can't get an appointment until the new year

He calls for an appointment but when I arrive, he doesn't know why I am there

For these individuals, long wait times, short appointments, inadequate screening for illness and diseases (ex. particular parasites) and inadequate immunizations were named as the largest gaps in service. The most common concern expressed by these individuals was that physicians did not have enough time to look at all of the problems each person may be experiencing and patients were required to choose which problem they wished to discuss in the short fifteen minute appointment allotted to them.

To highlight this concern one participant indicated that when entering a clinic to see her family physician, she was experiencing both a headache and stomach pains. The physician responded by asking her which was worse and then treated one of her symptoms and told her to book another appointment for the second concern. All the participants in the focus group indicated they had experienced similar situations and one individual stated,

"You are only allowed one problem per visit ... if you have two things, too bad, you need to make another appointment."

In contrast to the negative experiences of individuals accessing care in mainstream general practitioner settings, participants who were attending the North End Community Health Centre for primary health care services were extremely content with the treatment they are receiving. One individual concluded,

...we are well treated at the North End Clinic and they are well acquainted with our needs.

Other participants echoed this response saying,

Yes, we feel comfortable to express our concerns and [they] include us in decisions making process regarding our healthcare.

Yes! My and my family's healthcare needs are being met this way. We believe it's in the more convenient way for us.

As highlighted, participants not receiving comprehensive primary health care assessments and treatment at the NEHC often leave their physicians' offices with unmet health needs. In order for their health needs to be met, these individuals are often forced to seek service at a walk-in clinic or in extreme cases the emergency department. The average walk-in clinic physician does not have access to the required information to best treat specialized patients such as Government Assisted Refugees. Many family physicians are unfamiliar with particular diseases and compounding health needs that are rare in the Canadian born population. This unfamiliarity can lead to both mistreatment and under treatment of acute and chronic health conditions.

When asked about the formation of a refugee health clinic in Halifax, the majority of participants agreed that services similar to those offered at the NEHC are necessary to adequately meet the needs of refugees. One participant stated,

It is a requirement for us!

Other participants discussed the services offered in a refugee health clinic that would improve their overall health and help bridge them to mainstream services,

Yes it would be good ... it would be wonderful if doctors who are there, who deal with all the special health issues to get fast treatment.

Refugee clinic could have a schedule to ensure we have all our vaccinations within a 2 year period before we have to move to another family doctor.

It is important to mention that some participants were concerned about separation from the mainstream Canadian population in a refugee health clinic based on fear of stigmatization. These participants indicated they felt safer receiving health care with “native Canadians” for fear of receiving an inadequate level of health care if singled out.

A final point of consideration is with regard to the issue of access to dental care for the newcomer population. The IFHP covers emergency dental care, however access to this care can be extremely difficult to receive. As well preventative care such as cleanings are not offered to refugees covered under IFHP. Participants reinforced this barrier,

everything has been taken care of except for the teeth

From this information it is recommended that an approach to comprehensive and holistic primary health care should also include access to preventative dental care services.

Conclusion

The findings of these focus groups indicate that the model of care which best meets the needs of the government assisted refugee population in Halifax is that of a non-stigmatizing tailored primary health care clinic. Government Assisted Refugees are a population with specialized health care needs and require to be treated as such. These findings support the establishment of a clinic specifically designed for refugees in the Halifax area. The clinic should be designed as a multidisciplinary and collaborative unit that provides refugees with health care related to their background, country of origin and culture. The clinic should be a place where individuals are specifically screened and tested for illnesses that are pertinent to their population. The establishment of such a clinic is required before the refugee population can be said to have equity in primary health care access. See Appendix A for focus group guide.

B. Dalhousie Dental School Pilot Project (2010)

Excerpts from abstract for the pilot project: *The Oral Health Status and Access to Oral Health Services of Recent Immigrants and Refugees in Nova Scotia*
Prepared by: E. Ghiabi

In 2010, Dalhousie Dental School undertook a pilot project in which ISIS assisted 40 Bhutanese Government Assisted Refugees to participate in. This pilot project demonstrated that communication with healthcare providers and access to healthcare are major challenges for immigrants and refugees.

Based on this pilot project and pending funding, Dalhousie Dental School is planning to conduct a more in depth

study regarding the oral health of newcomers. ISIS will also be involved in this comprehensive study.

C. Government Assisted Refugee Health Service Questionnaires (2009-2010)

Excerpts from: *A Review of Government Assisted Refugee Families and Immigrant Health Services at Immigrant Settlement & Integration Services (ISIS) in Halifax, Nova Scotia*, (2011)

Prepared by: Timothy Jason, MSc - Jason Research Consulting Services

The purpose of this exploratory study was to provide a summary report of GAR families who had received immigrant health services in 2008 and early 2009. The following issues were discussed in the study: the effectiveness of current service delivery, newcomer satisfaction with services at ISIS and in the community, and the cultural competence of services. This study offered important insights into the experience of government assisted refugee families who used ISIS immigrant health services. The analysis revealed that the support from ISIS staff was informative, supportive and helpful. The people surveyed had all been referred to health service provider and informed about various health services. The newcomers mainly expressed concerns about the care provided by health service providers due to short appointment times and service providers not understanding their health concerns and circumstances.

D. Service Provider Interviews

Health professionals working directly with newcomers are key informants able to provide a unique position on the needs of their clients and on experiences, systems and differential access to services that may affect health behaviour and outcomes (Fennelly, 2006). ISIS in partnership with Dalhousie University global health medical students conducted face to face interviews with health care service providers in the HRM with a history of service to Government Assisted Refugees. Interview topics discussed the health needs of their clients, barriers to accessing service, the use of cultural competency in primary health care and the need for targeted health care services for refugees.

Method: Data was collected during face to face interviews conducted during March and April 2011 with health care providers from the professional fields of family medicine, nurse practitioner, dentistry and pharmacy. Interviewers were Dalhousie University medical students participating in the school's global health program that were partnered with ISIS to conduct structured interviews with health care service providers.

Health Needs

There was a consensus among participants that the need for interpretation services is essential and distinguishes the refugee population from other patients. It was discussed that interpreters must be trained in health literacy to be able to properly interpret in health care settings. One dentist in speaking of interpreters expressed:

You can't work without them. You need a third party. Once somebody is there (to interpret) there is no problem.

It was explained by the service providers that refugees may require "catch-up" services that other Canadians have previously had access to, such as basic dental care and immunizations. As well, the medical doctors and nurse practitioners explained that the Government Assisted Refugees require specialized screening to identify latent infectious diseases. They expressed that due to the pre-arrival camp conditions as well as having little access to the medical history of the newcomers, meeting the health needs of these individuals may require more time. One participant explained:

While they have the same needs as Canadian patients, additional needs may be present because of exposure to endemic infections we do not have in Canada, uncertain vaccination status and the effects of poverty, war, refugee camps, on physical and mental health. Meeting their needs often requires more time because of the effects of the above noted on their health, and culture and language barriers.

Access to more preventative dental care was expressed as an important service inaccessible to the refugee population. Service providers raised concern that in the way the Interim Federal Health Program is fashioned, refugees are not able to access dental services until problems are acute. One dentist advised:

Sometimes people just need their teeth cleaned, it is not done, those teeth will need to be taken out eventually. They can't even get their teeth cleaned, GARS do not have this opportunity. They need to extend the program a little bit and give them the privilege of getting a few basic services done.

Participants expressed the value of preventative medicine, including dental care, for not only the treatment of disease but the positive effect of this treatment on the social determinants of health of the newcomer. Some dentists expressed the need for access to oral health, including dentures, to building confidence and assisting the patients overall wellbeing. One dentist expressed:

Dental health is part of the overall health, addressing the overall health issues, will only improve overall health, need to have confidence and get a job - overall well-being of the individual depends on oral health.

Finally service providers discussed the fact that although in some instances refugee health needs are similar to the general population, it is important to remember that these individuals are adjusting to a new culture and climate. This reality alone contributes to unique health needs and outcomes.

Systemic Barriers to Access

The concern was raised by service providers that although access to interpreters is essential, systemic language barriers remain in the primary health care system. Trained interpreters are not included in the services of family physician clinics and the use of family members for interpretation raises concerns of confidentiality for some providers. Some participants raised the issue of inadequately trained interpreters relied upon for health appointments. It was expressed that interpreters need to be trained specifically for health settings to ensure vital information is being communicated correctly for a better outcome of medical adherence. One participant expressed:

I find language to be a barrier at times. Translators are always an issue – some are good and some are bad. You are always unsure if the meaning of what you're saying is really translating appropriately ... Medical adherence can sometimes be an issue due to translation and the idea of chronic medications is a concept that is lost.

In addition to language difficulties, participants strongly articulated the debilitating barriers within the Interim Federal Health Program. One individual stated:

Currently most of the barriers are specific to drug coverage and reimbursement. The GAR program just changed in the middle of February and it is a bureaucratic nightmare.

Due to the restrictions and oversights within the IFHP and to insure the needs of the Government Assisted Refugees are being met, ISIS and community partners are required to find their own means to cover the costs of needed services. They are also required to spend valuable time advocating for change within the system designed to care for newcomers.

Some medications that are covered in pharmacare but are not currently listed with the GAR online program, so we are working with ISIS as well as professional affairs department to clean it up. In the interim no one has gone without at our pharmacy; we are giving out the medication and handling the administration and trying to get reimbursed from our end.

Other service providers, including dentists reiterated concerns with the IFHP and the limited capacity of refugees to access dental services:

I feel bad when someone comes in pain, you need a filling, and 1,2,3,4,5 things but you can only do one thing. We are restricted to the booklet.

Another participant expressed concern with the IFHP in restricting dental services to an acute emergencies rather than preventative care:

You should not have to wait until the pain prevents you from sleeping, eating, working etc. before you get treatment.

Participants also expressed their concern with the long wait times experienced by Government Assisted Refugees attempting to receive prior approval for services from the IFHP. One health care professional stated:

[I] Can only treat those emergency cases, if we want to do any other work we have to send letters to Ottawa etc to get permission, it takes a long time and there is a lot of paperwork and we may not be successful for approval.

Finally service providers raised concern that medication required for identified health needs within the current government assisted refugee population is often difficult to obtain and due to bureaucratic barriers, patients are often required to wait for needed treatment. A health professional emphasized:

Common meds for parasites are also difficult to get. The pharmacy is stuck because they have to wait a long time for the issues of coverage to be resolved. It seems there is a lot of federal bureaucracy involved and so things take a long time.

Many participants agreed that the Interim Federal Health Program needs to be expanded to allow for timely access to necessary oral care for both prevention and treatment. Further, access to required medication is essential and the barriers existing in the federal program need to be evaluated and adjusted. ISIS and many service providers are currently filling the gaps of service provision and coverage that is the responsibility of CIC under the IFHP. Unfortunately, for ISIS and community partners, this is not a sustainable solution to ensure access to care.

Importance of Cultural Competency

The importance of culturally competent primary health care was clearly identified by the service providers in their discussions of newcomer health needs and existing systemic barriers. Participants spoke of the need for both health professionals and the health care system to be striving to provide culturally competent care. One service provider expressed the importance of acknowledging different understandings of health care in day to day service provision:

Cultural competency is important in recognizing how to communicate with the particular client based on their background, we take it for granted that this is the way the health care works.

Another health professional reiterated the importance of understanding alternative definitions of health in culturally competent practice:

However, health is defined differently in different societies, for example teeth colours (preference for yellow versus white), health is defined differently so the dentists and doctors should be aware of some of the cultural differences.

In learning how to practice cultural competency, some service providers indicated they had received formal training through Capital District Health Authority, others admitted to having no formal training while a few participants advised that their own experience as immigrants informed their culturally competent practices.

Most providers indicated they incorporate cultural competency into their practice by using interpreters for health appointments and learning about patients' beliefs regarding health and what they wish for their treatment. One participant discussed the importance of being aware of refugees' cultural and historical context that may influence not only health status and outcomes but their beliefs and priorities in terms of health:

I find the Citizenship and Immigrant Canada book on Nepalese regarding their history, culture and the camps they came from was very informative for me. Gave me an awareness of what this population was dealing with.

All participants indicated that they were using various practices to enhance their ability to provide culturally competent practices. The use of interpreters was named as a common way in which to provide culturally competent service. Other participants suggested that service providers need to be aware of cultural beliefs and the impact of these in health care, for example gender matching between patient and health professional. Finally other participants advised that they were using unique communication tools to provide information to non-English speaking patients, for example one pharmacist is using clinical software that is able to print pictogram instructions for drug administration. These measures by the health professionals interviewed confirm their belief in the importance of providing culturally competent practice.

Targeted health care services

The need of a targeted primary health care approach for refugees in the HRM was agreed upon by all service providers interviewed. Some participants suggested that a multi-disciplinary team in a "one stop shop" type of clinic would be the best approach to meeting the needs of individuals and entire families. The service providers agreed that targeted health services would assist providers to become aware of refugee health needs and ensure responsive and adequate primary health care service.

An advantage would be that you would get very good at meeting the health needs of that population cause that's all you deal with.

Another health professional echoed the benefit of a targeted response to refugee health emphasizing the response to inaccessibility:

It would be a good thing, a central place where they could go and they can have their dental and health needs. At least they know they don't have to look for practitioners that are willing to take them.

The participants indicated the success of a refugee health clinic would depend on collaboration and inclusion. Many service providers suggested that a clinic would require the commitment of government, educational institutions and the NGO sector.

A clinic, the government needs to be involved because it requires some capital to get the clinic running ... It is possible if there is a serious effort on the part of government, Dalhousie could have a role, students from other countries, advanced students available to work in the clinic.

Providers indicated that the current coverage of services is inadequately in meeting the health needs of refugees and a clinic would benefit from expanding services to those currently excluded, such as preventative dental treatment.

Priority is to have a clinic that provide free care for basic care, extraction, filling, and cleaning of teeth, those are three things that would make a big difference.

In providing targeted refugee health services, service providers made suggestions to support both newcomer health and integration. Some providers suggested a need to include medical students and family practice residents in the delivery of primary health services in a targeted clinic to provide experience working with refugees. One participant spoke to the need for the inclusion internationally educated health professionals in service delivery.

I think it is very important to utilize people from that culture that have good language skills and a medical background.

Others suggested that an important aspect of a targeted health clinic for refugees would be the ability and willingness of the clinic to act as a bridge for refugees to mainstream services.

We eventually want these individuals to be able to look after their own primary health care within the Canadian context.

Conclusion

The service providers interviewed identified numerous barriers affecting access to care and the corresponding health outcomes for refugees. These health professionals spoke of the health needs of refugees, the importance of culturally competent practice and the benefit of targeted primary health services. In providing targeted services, participants suggested that a responsive approach to refugee health would provide holistic care in a multi-disciplinary environment with health professionals trained to identify and respond to the unique health requirements of this population.

See Appendix A for interview guide

ADDRESSING THE HEALTH CARE NEEDS OF GOVERNMENT ASSISTED REFUGEES?

As a support and advocate to Government Assisted Refugees, ISIS has been aware of the unmet health needs and the gaps in primary health services to newcomers for a very long time. In response to these barriers, ISIS has repeatedly acted as an advocate to reinforce the need for responsive and cultural competent primary health care services for newcomers to Canada. Despite ISIS participation in numerous committees and task forces, some of which are outlined below, Government Assisted Refugees continue to face barriers and gaps in the health care system. The following section summarizes some of the recent initiatives and partnerships ISIS has been involved in for the promotion of inclusive, responsive and culturally competent health care services to Halifax's refugee population. This journey of partnership and advocacy has lead ISIS to the belief that the primary health care needs of Government Assisted Refugees can best be met through a targeted and collaborative refugee health clinic model.

- A. **Keeping Canadian Values in Health Care: Inclusion, Diversity and Social Justice in Health: Newcomers from Kosovo** (Final report on Symposium held in Halifax, NS – December 1999)
Maritime Women's Centre of Excellence for Women's Health & Nova Scotia Council on Multicultural Health (1999)

In May 1999, over 5,000 Kosovo refugees were brought to Canada, half to Nova Scotia, in "Operation Parasol." Federal, provincial and local government departments and agencies, as well as non government organizations, including MISA (ISIS) collaborated to assist these newcomers. The goal of service provision by all of these organizations was to provide the displaced Kosovar people with food, shelter, health and social services and security.

Although many emergency and social services were provided during this period, the health services provided are pertinent to this report on primary health care service provision. Various levels of government cooperated to create and operate a medical clinic from May 14 to July 22, 1999. Services provided to the Kosovar population during this time included interpreters, pharmacy services, public health services, mental health services, diabetes clinic, dental clinic and optometry clinic.

Through the provision of these targeted services to these Government Assisted Refugees the importance of improving professional and public understanding of the physical, social and mental health needs of newcomers, and the need to provide culturally-appropriate services that meet all those needs was highlighted. The need for the recruitment and training of cultural health interpreters, as well as a collaborating network of stakeholders to plan and coordinate the allocation of resources was also emphasized. The following action plan was established to remove health care barriers for newcomers.

Removing Barriers: Action Plan

Short term

Initiate Team-Building, Networking and a Clear Strategy: Immediately develop and compose a vision or a policy statement regarding the medical and mental health service needs of new and acculturated immigrant communities.

Medium term

Services: Convince federal and provincial governments to expand the current provision of services to include culturally-responsive medical, social and psychological services to immigrant and refugee communities.

Education: Disseminate knowledge and increase awareness about the need for cultural sensitivity and responsive health programs at conferences, in political and academic arenas and through academic and training curricula.

Networking: It is important for stakeholders to be vocal about issues and to present a coordinated effort in lobbying to directly influence policy change, development, and implementation at the local and federal political level.

Long term

Social and Economic Inclusion: The social and economic inclusion of immigrant people in areas of employment and community life are key determinants of their overall health. Government should designate resources for the long-term process of helping newcomers and not only provide “crisis” aid.

The comprehensive health services provided to the Government Assisted Refugees from Kosovo upon arrival in Nova Scotia in 1999 offers an example of a collaborative and holistic approach to primary health care for refugees. Unfortunately this provision has not continued to date and is not extended to the Government Assisted Refugees currently arriving in Nova Scotia.

See Appendix B for a Summary of Service Provision to the Kosovar Community

B. A Blueprint for Action - Task Force Policy Goals – 2005 - With funding from Health Canada’s Population Health Fund, MISA (ISIS) facilitated the development of a Task Force to explore ways to enhance the responsiveness of the health and social service sectors for newcomers. Representatives from a broad range of sectors met over a two year period to share information discuss issues and identify policies that impact on newcomer’s health. From these consultations and from the experience and expertise of the Task Force members and advisors the Blueprint for Action was developed.

In April 2005, the Task Force organized a community forum called “Bridging the Gap: Bringing Together Culture and Health Care” to validate, by service users and the community, the recommendations outlined in the Blue Print for Action. From this forum seven points of action to guide policy makers in addressing the challenges of newcomers were finalized. The policy platform was framed around the following priority issues for newcomers: access to health information, development of health resources, access to health interpreters, access to culturally competent health care services, promotion of health and well being, support for the health and well-being of refugees and community capacity and involvement.

In the creation of targeted refugee primary health care in Halifax it is important to highlight the history of the ISIS vision expressed in the policy goals developed in 2005. For example, the 6th policy goal: **Additional Support for the Health and Well-being of Refugees** speaks to the creation of specialized public health support to assist immigrant sub-groups that are more likely to experience socio-economic disadvantages and associated health problems, namely refugees. It calls for a single-entry point for Government Assisted Refugees to be screened for health concerns within a specified time (e.g. 1-2 weeks after arrival). This policy goal is aligned with our current position which recognizes the need for targeted process to providing adequate primary care to refugees. As well an important point under the 2nd policy goal: **Development of Health Resources** recommends the support of internationally educated health professionals to work as “health brokers” in ensuring newcomers receive appropriate and sufficient health and social supports. This is also aligned with the ISIS vision for the inclusion of internationally educated health professionals in a refugee health clinic. See Appendix C for The Blue Print for Action Policy Goals

C. Development of a Culturally Competent Well Women’s Clinic - (Final Report, April 2010) - In March 2008 Cancer Care Nova Scotia in partnership with Capital Health, IWK Health Centre, North End Community Health Centre and MISA (ISIS) developed and piloted an enhanced screening program and services for women from the Arabic speaking communities of Halifax. Three well women’s sessions were held in a community based setting and were based on existing IWK Women’s Community Clinic models. The three sessions included an hour and a half long education module on a topic of interest identified by the target group and a one hour well-woman’s clinic visit provided by a nurse practitioner. Among various learnings, it is significant to mention that during visits to the

clinics, the women expressed interest in gaining more education on health issues for themselves and their family. See Appendix D for detailed information on the culturally competent well women's clinic

D. Partnership with North End Community Health Centre (2009-present) - The North End Community Health Centre has been providing primary health care services to newcomers in their catchment area for over twenty years and as such has a strong working relationship with ISIS. Since 2002, Nova Scotia has increasingly been receiving a significant number of Government Assisted Refugees with complex health needs. Barriers within the mainstream primary health system have prevented access to service for these newcomers resulting in many individuals receiving little to no care for the first crucial months following arrival in Canada. In response to this health care crisis, ISIS called on the support of our partner, the North End Community Health Centre in September 2009 to provide primary health care to approximately forty Bhutanese Government Assisted Refugees that were expected to arrive in the following months. The NECHC agreed to expand and adapt their programs to provide primary health care services to fifty other Bhutanese individuals that arrived in 2010.

Due to the collaborative and community based approach of NECHC, the newcomers at the community clinic are able to access the comprehensive services of medical doctors, nurse practitioners, registered nurses, a dietician, occupational therapy, physical therapy, mental health as well as dental hygienists and dentists (NECHC, 2011). Additional services available to the clients include blood work, foot-care, diabetes clinics, mobile outreach street health (MOSH) and community and individual outreach (NECHC, 2011). The NECHC also tailored service delivery to the Bhutanese by booking forty-five minute family appointments rather than the average individual fifteen minutes appointment time. This small detail is extremely important in refugee health care as these individuals may have compounding health needs and transportation difficulties among other concerns. The extension of appointment times also allows for adequate interpretation to be conducted. Encouraging patients to receive care for all their health care concerns in one large appointment rather than numerous short appointments better serves the needs of this population. The NECHC also developed their own screening/assessment plan and immunization schedule to ensure each patient is provided with the comprehensive primary health care they require.

Through their partnership with ISIS, the North End Community Health Centre recognized that the Canadian health system is not intuitive to the needs of refugees and that cultural competence is essential in the service provision of health care to these individuals (NECHC, 2011). They also learned that new refugees require assistance to learn how the health system functions and the basic ways of utilizing it. From their experience the NECHC advised that the provision of primary health care to newcomers is best accomplished through a culturally sensitive interdisciplinary team approach (2011). See Appendix F for detailed information

E. Invisible Women Concrete Barriers - (Conference Report prepared for: The Atlantic Centre of Excellence for Women's Health; Canadian Red Cross; Atlantic Council for International Cooperation; The Salvation Army ARIS Project; The Halifax Refugee Health Clinic / Update June 30th, 2010) - The Invisible Women Concrete Barriers is a partnership that has been formed to explore barriers for refugee claimant women. Through focus groups with refugee women in Halifax, health access barriers were identified as a very difficult challenge for refugees with refugee claimant women experiencing the most significant barriers. From a recommendation to educate Nova Scotia's health professionals about refugee claimant health needs, the planning committee prepared an article explaining the coverage afforded to refugee claimants under the Interim Federal Health program and the process for health professionals to seek reimbursement for services. The planning committee co-hosted a workshop with ISIS for health professionals on the topic of refugee health and improving services for the refugee community (Invisible Women, Concrete Barriers, 2010).

F. Working Together for the Health of Refugees in Nova Scotia 2011 - In January 2011, ISIS and the North End Community Health Centre initiated an information session with community stakeholders to explore the health needs of Halifax's refugee community and to open discussion regarding the creation of a targeted plan to meet the specific health needs of this population. The session included presentations from the Settlement and Community

Team Manager and Immigrant Health Coordinator of ISIS regarding the health needs of Halifax's refugee population, the Health Team Lead Manager and a family physician specializing in global health of the NECHC regarding their recent experiences of providing service to Bhutanese Government Assisted Refugees and from physician Dr. Maureen Mayhew of The Bridge Community Health Clinic who provided an overview of a successful refugee health clinic operating out of Vancouver. Following the presentations, a structured brainstorming discussion was held with the stakeholders to explore community resources and partnerships with intent of returning for a second session with a plan for action. A follow-up session with stakeholders will be held in June 2011. See Appendix E for detailed information from the key informant consultation 2011

REFUGEE HEALTH CLINIC

Learning from National and International Examples - In the discussions held with stakeholders in January 2011, ISIS presented the need for a primary health clinic for refugees in Halifax. To support this vision, ISIS included the Bridge Community Health Clinic in the presentation to provide information about the success of their refugee health clinic in Vancouver. The following organizations offering targeted refugee primary health services, including the Bridge Community Health Clinic, are examples in which the development of such service in Halifax could be modeled. Each example demonstrates the components of true collaboration including settlement services, the development of a refugee specific and early intervention process and the goal of bridging refugees from targeted services to mainstream family practice health care following an initial settlement period.

1. Regina Open Door Society Inc. & Regina Community Clinic – Regina, Saskatchewan

Summary

The Regina Open Door Society Inc. (RODS), a non-profit organization that provides settlement and integration services to refugees and immigrants in Regina, the Regina Community Clinic, a multi-disciplinary based primary health care centre and Public Health, formed a partnership for the purpose of providing comprehensive health care services to Government Assisted Refugees in their first two years in Canada. RODS helps to resettle approximately 200 Government Assisted Refugees each year. This partnership was formed as RODS identified the health needs of their clients were acute and were not being met without a targeted approach. Presently every government assisted refugee supported by RODS benefits from holistic and comprehensive health care including a full health assessment completed by the RCC. They also receive early and scheduled care by public health to ensure that individuals requiring emergency care are triaged for timely treatment and all clients are receiving up to date vaccinations. (Regina Open Door Society, Inc., personal communication, 2011). See Appendix G for detailed information

2. The Calgary Refugee Health Clinic – Calgary, Alberta

Summary

The Calgary Refugee Health Clinic operates through the Health and Wellness division of the Calgary Catholic Immigrant Society (CCIS). CCIS is a nonprofit volunteer organization which provides settlement and integration services to all immigrants and refugees in Southern Alberta (CCIS, 2011). The Health and Wellness division was launched as a community initiative aimed at overcoming the numerous barriers new refugees to Calgary face in accessing health services (CCIS, 2011).

The Health and Wellness division is host to a complete range of health-related programs and services, designed and delivered by a team of professionals dedicated to enhancing the health and well-being of newcomers (CCIS, 2011). In providing culturally appropriate and easily accessible services, the Calgary Refugee Health Clinic, has demonstrated that the provision of orientation to the Canadian health care system and the address of health problems during the first and second years of arrival significantly improve the quality and continuity of care to newcomers (CCIS, 2011). See Appendix H for detailed information

3. Bridge Community Health Clinic – Vancouver, British Columbia

Summary

The Bridge Community Health Clinic was formed in 1994 to both improve access to primary and preventative health services for refugees and new immigrants facing barriers to care and to provide a bridge for them to access available health services within the community. The clinic offers short-term health care with a multi-disciplinary team of professionals. Short-term care refers to the process of bridging patients into mainstream care after approximately one year of targeted care (Vancouver Coastal Health, 2005). The Bridge Clinic also provides opportunities for professionals and community members in training to receive culturally appropriate clinical experience which will enhance their professional practices in working with refugees (Vancouver Coastal Health, 2005). Additional roles of the Clinic include advocating for the population served, addressing issues of women's care, increasing public awareness, teaching students, conducting research and providing web-based support to family physicians (Mayhew, personal communication, 2011). See Appendix I for detailed information

4. Queensland Refugee Health Service – Queensland, Australia

Summary

In 2007 Queensland Health allocated funding to develop a state initiative known as the Queensland Refugee Health Program. The purposes of the Queensland Refugee Health Service are to provide standard health assessments, including public health screening and catch-up vaccinations, coordinate short term health management with additional support for complex cases and support referrals to existing services for ongoing care, in particular, to general practitioners. The priority groups for the service are newly arrived refugees (within the first six months of resettlement) and refugee claimants. (Queensland Government, 2008). See Appendix J for detailed information

BUILDING A REFUGEE HEALTH CLINIC IN HALIFAX

The previous section provided an overview of four refugee health clinic models currently in operation. Although each community is unique and provides services that specifically meet the needs of their own clients, all four clinics share the three following components. ISIS is interested in implementing these components in our own model for refugee health services in Halifax and believes services could be expanded to the refugee population throughout Nova Scotia using the technology of tele-medicine.

1. Collaboration

ISIS hopes to strengthen and further develop collaboration with our community partners in providing health care services to Government Assisted Refugees. ISIS believes that our own settlement and health literacy services need to be an active collaborator in the primary health care service delivery to Government Assisted Refugees. In many of the refugee health clinics currently operating throughout the world, settlement staff is not only a contributing partner of primary health care but are often located directly on the health clinic premise. This collaboration between primary health care providers and settlement staff contributes to holistic health care that most effectively meets the needs of Government Assisted Refugees resettling in Canada and address resourcing needs.

2. Process

In pursuing care through a refugee health clinic model ISIS is not only seeking collaboration in primary health care for Government Assisted Refugees but is also looking to develop a practical process which will ensure each individual is provided with adequate and timely medical services. For an example, as described in Appendix G, the collaboration between clinic and settlement agency in Regina ensures each government assisted refugee arriving in Regina receives an initial health needs assessment within their first week of arrival in Canada. Following this assessment each individual is then seen by a public health nurse and a primary health care physician for a full health assessment.

With regard to Halifax, ISIS believes that a process in which each government assisted refugee receives a health assessment within the first week in Canada would best meet the needs of our clients. An assessment would ensure that all aspects of refugee health would be taken into consideration and that health needs would be addressed in a timely manner. Assessing the health needs of each individual prior to moving them from their temporary accommodation would assist with long term planning for other services including finding accessible housing or adding mobility devices to a home prior to the move. A health assessment within the first week of arrival would assist ISIS and primary health care professionals to appropriately respond to and meet the health needs of our clients.

Another component of the process design which is essential in adequately meeting the health needs of Government Assisted Refugees is that of tailored medical appointments. This process may include longer appointments for each patient allowing time to address all health needs and concerns at a given appointment as well as accommodate the time required for interpretation. It may also include providing health care to families in blocked appointments rather than each individual separately on different days. This approach requires primary health care professionals to adapt service provision to best meet the needs of their patients.

A final consideration to the formation of process within a clinic is the need for flexibility and adjustment to the changing needs of the refugee population arriving in Halifax. The profile of refugees arriving in Canada is in a constant state of change. Each year the federal selection of refugees for resettlement is adjusted to target current international commitments. The change in demographic includes not only country of origin but age, health status, language and cultural context. For example, prior to 2009 ISIS received on average three seniors and eight expectant mothers annually. In the 2009- 2010 period, ISIS helped resettle eighteen seniors and only one expectant mother. Such demographic changes are sudden and unpredictable for the settling agency. As such health providers would need to learn about the health needs and pre-resettlement context of individuals arriving in their clinic and be willing to adjust their services accordingly to appropriately meet their health care needs.

3. Bridging

Following the lead of numerous refugee health clinics worldwide, ISIS not only seeks a process which tailors primary health care services to refugees but one that also offers bridging into mainstream primary health care. This design has the refugee health clinic providing primary health care to the newcomers for the first one- two years in Canada and assisting with their transition into mainstream family physician practices following this initial period. Successful bridging is best completed by supporting both the newcomer in the transition and also the family physician in their acceptance of these new patients.

Bridging Government Assisted Refugees to mainstream primary health care services following the initial settlement period is not only beneficial to assist with the integration of these newcomers into the community but also contributes to the sustainability of operating a refugee specific clinic. Due to many factors including the complexity of health needs, the use of interpreters, extended appointment times and the stress of compassion fatigue, the provision of tailored primary health services for refugees can be taxing on health care professionals and can affect staff retention (Lawrence & Kearns, 2005). ISIS believes that the transition of newcomers to mainstream health care services for the ongoing treatment of acute health care needs can mitigate the stress experienced by the refugee health clinic team and contribute to staff retention.

ISIS Vision

Multi-disciplinary refugee health clinics with expertise in global and refugee health have been established in various Canadian cities to address the unique health needs of the government assisted refugee population. There is currently no such clinic in Atlantic Canada. We believe that a clinic is a necessary endeavor in providing services for refugees that fit their circumstances and empower them to experience their life and environment in a way that makes meaning for them.

Our vision for a refugee health clinic in Halifax mirrors the discussion in Dr. Ross' 2010 report *The Patient Journey Through Emergency Care in Nova Scotia, A Prescription for New Medicine* which focuses on a multi-disciplinary and collaborative approach to primary health care service delivery. In this report, Dr. Ross indicates that a collaborative approach to primary health care could include, among other services, physicians, nurse practitioners, family practice nurses, dietitians, pharmacists, physiotherapist, occupational therapists and ongoing care coordinators.

The vision of ISIS would see a truly collaborative approach to multi-disciplinary health care provision to Government Assisted Refugees. In this approach, each of the following team members would be equally and actively involved in service provision.

Services

As indicated above, our vision for a target refugee health care in Halifax would be formed with both a detailed service delivery process and a bridging component. The process would ensure that each government assisted refugee would have access to prompt and complete primary health care upon arrival in Halifax. This process would include a health assessment prior to moving from their temporary accommodation, ideally within the first week in Canada. Such prompt primary care would enable ISIS and community partners to address specialized health needs in a timely manner as well as prepare preventive steps for successful settlement and integration.

The service process would also include tailored appointments to meet the needs of refugee individuals and families. ISIS has learned from the service user focus groups that Government Assisted Refugees require longer appointment times with health care professional allowing them to discuss the complexity of their health needs and receive adequate and timely care. This would require each appointment with a health professional to be extended from the current 10 to 15 minutes to a lengthier timeframe. This would also allow patients to discuss each health concern they are facing without having to return for another appointment.

Secure and appropriate interpretation services are also an essential component of a holistic approach to refugee health. A long-term strategy for the provision of interpretation services in all health care settings, including primary health care is a necessity. The process by which this service will be offered needs to be explored with current stakeholders including CIC and the Nova Scotia Department of Health and Wellness. As well, a sustainable interpretation strategy could also be explored with potential partners and future stakeholders, as was accomplished in the Regina Open Door Society Inc. and Regina Community Clinic refugee health strategy which secured interpretation funding through the Government of Saskatchewan Ministry of Advanced Education and Employment.

The bridging process is not only to prepare newcomers for a move to a family physician clinic after a one or two year period, but to support family physicians with the inclusion of newcomers to their practices. A successful bridge would ensure that all initial health care needs including assessments, vaccinations, referral to specialists etc. have been completed by the refugee health clinic and referral is for ongoing health care needs that are able to be addressed by family physicians. Further, to ensure successful bridging, ongoing education with physicians would provide information and support with regard to refugee health.

In building a vision for a refugee health clinic in Halifax, we have explored services in similar clinics currently in operation and have learned from the experience of the North End Community Health Centre's service provision to ninety Government Assisted Refugees. We believe a multi-disciplinary collaborative clinic model would include the following services accessible to all patients:

- Health history
- Complete health assessment
- Screening for infectious diseases and health conditions common in different refugee populations and in regions of the world
- Vaccinations
- Women's health
- Children's health
- Treatment and follow up
- Dental appointments
- Referrals to specialists
- Health literacy supports
- Special needs advocacy
- Interpretation services
- Bridging services

Built On

In building primary health care services in Halifax that are both comprehensive and responsive to refugee health needs, we believe a targeted clinic model with direction and dedicated to inclusion is the best approach. Our vision for a refugee health clinic in Halifax includes sharing resources through the building of partnerships; the use of culturally competent practices; the inclusion of internationally education medical professionals in practice; the provision of health care to all classes of refugees; supporting the education of medical professionals and engaging in research opportunities.

a. Partnerships and Sharing of Resources

The ability to provide comprehensive primary health care to refugees in a multidisciplinary team requires the formation of partnerships and the sharing of resources. Currently Halifax receives between 180 and 200 Government Assisted Refugees annually, each of whom is assisted by ISIS. In seeking partnerships in the development of a refugee health clinic, we understand that service provision may be shared by more than one clinic, each willing to take a portion of the newcomers as patients or in one clinic with the capacity to see all new Government Assisted Refugees arriving in Halifax. As demonstrated in the other clinics highlighted in this report, the goal would be to provide primary health care through the partnership for the first one-two years in Canada with the expectation of referral to other clinics once the individual is accustomed to the health care system and their health is stabilized. In all partnerships ISIS would remain as an active collaborator and advocate supporting the Government Assisted Refugees accessing primary health care services.

One clinic that have expressed interest in participating in a partnership with ISIS to provide primary health care to refugees is the North End Community Health Centre.

North End Community Health Centre - Since 2009, the North End Community Centre has partnered with ISIS to provide multidisciplinary primary health care services to approximately ninety Bhutanese with the use of the comprehensive patient care plan developed for refugee health clinics. As indicated in the focus groups of the Bhutanese Government Assisted Refugees receiving primary health care services at the NECHC, this partnership provided comprehensive health care that was both beneficial and agreeable to the newcomers.

Unfortunately, the NECHC does not currently have the capacity to provide services to new ISIS clients due to their large patient caseload. Presently NECHC is providing service to approximately one third of ISIS clients which leaves two thirds of Government Assisted Refugees with unmet primary health care needs and negative experiences as expressed in the focus group conducted by ISIS and detailed earlier in this report. ISIS will be receiving approximately 200 new Government Assisted Refugees in 2011 of whom NECHC does not have the capacity to include in their practice. Further, the majority of the Bhutanese refugees seen at the NECHC are not from the Centre's catchment area. There is concern that providing these services to individuals not residing in the north end, will take away from those individuals needing service within the catchment area.

b. Cultural Competency

The North End Community Centre's work with ISIS provides an excellent example with regard to a clinic's willingness and ability to learn about cultural competency in service delivery to refugees. The NECHC are not only able to teach the Bhutanese refugees that they are serving about the Canadian health care system and the Centre's system, but also tailor services to meet the cultural needs and expectations of these individuals. For example, the NECHC took an interest in understanding the patient/family culture of the Bhutanese group. This inquiry resulted in tailored approaches to health care delivery. The approaches include the team manager meeting with the head of the household prior to the initial centre visit. The manager explained the process of service delivery to the individual, who was then able to provide this information to their family members. Also, to accommodate the patients' preference of attending the NECHC in large family groups, service providers' schedules were blocked off to see more than one member of a family on the same day and with medical appointments scheduled for 45 minutes. Finally, the NECHC staff learned to welcome the Bhutanese community with Namaste, the greeting in their language of origin.

These gestures of accommodation and cultural awareness by the NECHC are welcomed in the continuation of service delivery to refugees through a refugee health clinic. The willingness to adapt to the cultural needs of the patients is essential to comprehensive and holistic primary health care provision. As the population of Government Assisted Refugees resettling in Halifax is ever changing, it is vital that a clinic targeted to refugee health is able to learn about and adapt to cultural diversity.

c. Inclusion of Internationally Educated Health Professions

An interesting addition to a refugee health clinic that would be unique to Halifax is the inclusion of internationally educated health professionals in primary health care service delivery. Currently in Halifax there are two hundred and ninety eight internationally educated health professionals who are in the process of being re-certified to practice in Canada. Included in this total are eighty physician/general practitioners, sixty-two physician specialists and thirty-eight registered nurses/ licensed practical nurses. The inclusion of these professionals could add expertise and capacity to the clinic that may otherwise be difficult to find and at the same time support them on their own journey to becoming licensed practitioners. The mentoring of these health professionals in the refugee health clinic could be an expansion of the partnership already offered through the North End Community Health Centre which provides job shadowing opportunities to those enrolled in the English for Internationally Educated - Healthcare Professionals class offered through ISIS.

d. Inclusiveness of Service – Privately Sponsored Refugees and Refugee Claimants

The principle elements of this report have focused on health care provision to Government Assisted Refugees. It is also extremely important to mention and include other categories of refugees residing in Halifax, including privately sponsored and refugee claimants, in the discussion of targeted services for refugees. Privately sponsored

refugees are selected overseas for resettlement with sponsorship and support provided by community groups. Refugee claimants seek refugee status upon entering Canada and wait for determination of their status within Canadian borders. In the primary health provision to newcomers, The Bridge Community Clinic operating in Vancouver, British Columbia, has experience working with refugees from all classes and within all statuses. They indicate that in their experience, convention refugees often have higher physical health needs than refugee claimants, due to extended periods of time spent living in refugee camps. Alternatively, they report that refugee claimants accessing their services often have higher mental health needs, which they attribute to the stress of waiting for a refugee decision in Canada, while separated from family and loved ones.

As mentioned previously in this report, refugee claimants do not have access to provincial health benefits nor are they eligible for provincial health cards. As a result, these individuals are reliant on the insufficient Interim Federal Health Program for access to health care. Due to the complexity of the program and the unwillingness of many health care providers to work with the IFHP, refugee claimants struggle to access primary health care services (Gagnon, 2002). The inclusion of refugee claimants in a health clinic that recognizes and understands the IFHP would significantly diminish access barriers for these individuals.

The privately sponsored refugee community in Halifax identifies similar health concerns as those experienced by Government Assisted Refugees. For many individuals arriving in Canada through private sponsorship, pre-arrival experiences of living in refugee camps and inaccessibility of health services is comparable to that of the government assisted refugee community. As previously highlighted, these conditions can result in multiple and complex health needs that are most often not easily treated by general primary health care providers. Further, the limited ability to access interpretation services was previously highlighted as a significant access barrier for privately sponsored refugees. The inclusion of privately sponsored refugees in a structured refugee health clinic, would not only more adequately serve these individuals, but could also aid the sponsorship community in the settlement support work they provide to the sponsored individuals and families.

A final consideration and as noted previously, the expansion of targeted refugee health services could be expanded from Halifax to the province of Nova Scotia through the use of tele-medicine. As many Regional Health Boards and service providers are already familiar with this service, it could be used to support the provision of comprehensive primary care to Nova Scotia's refugee population.

e. Supporting Education of Future Health Professionals

A refugee health clinic in Halifax would not only be beneficial to the refugees receiving primary health care but the benefits could be expanded to the education of future health professionals including physicians, nurses, nurse practitioners, social workers, occupational therapists etc. The training of cultural competency could be included in University curricula and students could be provided the experience of working with refugees during practice placements. The opportunity for medical and other health care students to work with refugees in the service provision of health care creates many opportunities for students including skills in communication and the ability to learn about other cultures while practicing basic health care skills (Griswold et al., 2006). Cultural competency has been described as a journey and is not learned "overnight" and thus early medical training exposure to cultural diversity among patients and families can lay a framework for later learning (Griswold et al., 2006). This fostering of cultural awareness in students could contribute to long-term ambitions of culturally competent service provision within all public medical services.

The education of health professionals could expand beyond the classroom and into the area of family physician clinics. In bridging Government Assisted Refugees to mainstream family physician clinics after a one-two year period, the continued education of family physicians is a necessity to ensure that the primary health care needs of these individuals continue to be met. Physicians working in the refugee health clinic as well as internationally educated health professionals could share their knowledge and skills of refugee health with family physicians. This mentoring system may encourage family physicians to willingly include refugees in their practice and provide the comprehensive and culturally competent care that is required.

f. Research

The area of education also allows for the prospects of and the opportunity to encourage academic research with regard to refugee health in Halifax. The inclusion of refugees in community based research will contribute to a better understanding of the needs of newcomers and provide suggestions for best practice in primary health care service delivery with regard to this population. In truly understanding the health care needs of refugees, we believe our community can grow and adapt to best serve and include these newest members.

CONCLUSION

Refugees arriving in Canada have experienced extreme pre-arrival situations which have negatively affected their health. Due to the seriousness of their health needs, many of these individuals arriving in Halifax are facing numerous challenges in accessing adequate primary health care and health information. After years of advocacy, ISIS believes Nova Scotia is ready to create a holistic response to the health needs of the refugee community in the creation of a refugee health clinic in Halifax. A multidisciplinary health clinic can best meet the health needs of refugees, while also building cultural competency within the health system through the inclusion of internationally educated health professionals and addressing health equity for marginalized populations. ISIS seeks the support of the federal government, the provincial government, primary health clinics and other community partners to ensure this vision can be made into a reality.

To follow the initial information session and discussion held with community stakeholders in January 2011, a second stage of planning will be held in June 2011 to determine the key partners involved and decide on the next steps to take in the creation of a refugee health clinic in Halifax. From this planning session, it is hoped that a round table of interested partners will be formed to work together in creating a primary health care approach for refugees that is both holistic and sustainable.

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APPENDIX A – Client Focus Group Guide / Service Provider Interview Guide

Client Focus Group Discussion Questions

Family/ Friends/Neighbours

When you or a member of your family is sick, what do you do? Who helps you if you do not know what to do? (ex. family members, friends, neighbour...)

Do you feel that you and your family's health care needs are being met this way? Or not? Why?

Health Care Providers

How long was it before you saw a family doctor in Halifax?

Were you satisfied with the visit to the doctor and the treatment that you received?

After you left the doctors office did you fully understand the instructions given to you about what to do next? (how to take medication, booking a follow up appointment, following a special diet and exercise plan...etc.)

Has your doctor sent you to any health specialists? (ex. Physiotherapy, social work, dentists, eye doctors)? (Looking for information in the frequency of referrals).

If you or a member of your family have been to a hospital in Halifax as a patient did you/they leave feeling better? Healthier? Clear about what was his or her problem and follow up at home?

Do you feel that you have control and are actively participating in your health care plan?

Cultural Respect

Do you feel that the health care providers are respectful and understanding of your culture? If so how? If not explain.

Do you feel comfortable to express your concerns? Do you feel that the health care providers hear what you are telling them and include you in decisions about your health care?

Health Care in Canada

What are your overall impressions of health care in Canada?

Positive (good), negative (bad)? Explain

What is the most important piece of information about health care in Canada that you wish someone had told you when you arrived in Halifax?

Challenges:

What is the biggest problem or challenge you have faced or are facing in getting the health care you need? (dental, long wait times, transportation etc.)

Clinic:

In other cities across Canada there are refugee health clinics where Government Assisted Refugees visit the clinic on the 3rd day after they arrive in Canada. Clients are able to access the clinic for their first 2 years after arrival and then they are referred to a local family doctor. The health care team at the clinic is cultural competent and specifically trained to screen for illness and concerns that pertain to refugee health.

Do you think that a health clinic for refugees in Halifax may be beneficial? Not beneficial? WHY, HOW? (what would your ideal clinic look like, what services/programs would you like provided, where would it be located...etc)

Evaluation question:

Do you think that this focus group has been helpful for you to talk about your concerns? WHY?

Is there anything that you would like to say that we have not addressed?

Service Provider Interview Guide

1. What has been your experience assisting Government Assisted Refugees (GARs) as patients?
2. In your experience, what are the needs of these clients? Do you their needs differ from other Canadian born patients? How?
3. Are the needs of GARs more complex than those of Canadian born patients? How?
4. In what ways are you able to meet the complex needs of GARs? In what ways are you unable to meet the needs? What barriers prevent you from meeting the needs? How do you prioritize the needs?
5. Do you feel that at times you are unable to provide service to GAR patients? What things prevent you or hinder your ability to provide service to GARs?
6. Do you believe cultural competency (sensitivity) is an important aspect in working with GARs? How are you able to incorporate cultural competency into your work?
7. How important is the use of interpreters in your work with GAR patients? What interpretation barriers do you encounter in your work with GARs?
8. Do you see gaps in medical services for GARs? What are these gaps?
9. What solutions can you envision that would help fill in the gaps in services for GARs? Do you believe that these solutions would improve the overall health of GAR patients?
10. In your opinion, would targeted medical services or a targeted approach be beneficial for service provision to GAR patients?

APPENDIX B – Summary Service Provision to the Kosavar Community (Source: MCEWH & NS on Multicultural Health, 1999)

Key Providers	Resources Available	Services Provided	Numbers Served	Challenges
Family Medicine Dept/QEII, VON, Northwood, Public Health, IWK Grace, NS Hospital, Health Canada	Medical Clinic Nurses (33 RNs, 6 LPNs) 21 physicians Lab techs, medics, support staff	Nursing Care: Nurses at the clinic all the time • provided care • access to community organizations Medical Care: Physicians on call 24 hours per day, 7 days per week	Medical Clinic Operated from May 14 to July 22, 1999 • 2,533 visits • 1,677 prescriptions • 52 obstetric visits • 36 gynecology exams • 25 hospital admissions • 10 pregnancies • 2 births	<ul style="list-style-type: none"> • Keeping families together • Sensitivity to Muslim customs for women
Public Health, Health Canada	Nurses	Surveillance & control of communicable disease • Assessment & screening (X-rays, skin tests) • Contact tracing • Treatment • Statistical Analysis	<ul style="list-style-type: none"> • Tuberculosis: 8 cases; 61 contacts traced & treated • Hepatitis B: 16 blood tests, no acute cases, 39 immunized • Intestinal Infection: 1 case 	<ul style="list-style-type: none"> • TB • Hepatitis B • Intestinal Infection • Health providers fears of infection • Public fears and need for reassurance • Interpretation: difficulty translating health issues
Dental School	<ul style="list-style-type: none"> • Dentists • Dental School 	<ul style="list-style-type: none"> • Dental examinations • Dental Care 	362 dental exams (90% of population)	
Optometrist Association	Optometrists	<ul style="list-style-type: none"> • Exams • Vision tests • Detection of eye problems 	322 eye tests	
Diabetic Clinic	Diabetes Nurse Dietician	<ul style="list-style-type: none"> • Care & Treatment • Education 	6 cases	

Key Providers	Resources Available	Services Provided	Numbers Served	Challenges
	Endocrinologist			
Key Providers	Resources Available	Services Provided	Numbers Served	Challenges
	<ul style="list-style-type: none"> Windsor Park, Aldershot, Greenwood, Gagetown Retired military personnel 	Administration: <ul style="list-style-type: none"> Data management system Office management Managed medical supplies 		<ul style="list-style-type: none"> Working with other professional cultures Shortage of interpreters and difficulty communicating
Metropolitan Immigrant Settlement Association	Settlement support staff	Orientation and Information: <ul style="list-style-type: none"> Basic needs, financial issues, medical concerns, immigration issues, starting life in Canada, geographic information 	574 people Group sessions: 60-70 people per session	<ul style="list-style-type: none"> Kosovars did not know where they were geographically Kosovars concerned about situation in home country Interpreters not trained
Canadian Red Cross Society	<ul style="list-style-type: none"> Multifaceted role 4,000 volunteers Advisory committees Humanitarian aid 	<ul style="list-style-type: none"> Social/recreation activities Liaison Transportation Managing donated goods Managing volunteers Coordinating NGOs 		<ul style="list-style-type: none"> Not enough vehicles Managing donated goods
		<ul style="list-style-type: none"> Identify personnel pool Create mechanisms for communication. 		<ul style="list-style-type: none"> Interpreters support staff
Department of National Defense	<ul style="list-style-type: none"> Infrastructure Equipment Skill set, "can-do" attitude 	<ul style="list-style-type: none"> Housing Clinic facilities 	403 people - Windsor	<ul style="list-style-type: none"> Crowding: 8-10 people per room Clinic space

APPENDIX C – A Blue Print for Action Policy Goals – 2005

1. Access to Health Information

Goal: Develop health information that takes difference into account (ie. difference in race, ethnicity, culture, language, gender, sexuality, religion, ability etc.)

- Provide newcomers with comprehensive, culturally inclusive, relevant and accessible health information (through an 'internet resource' and a 'people resource')
- Provide translated health information (print and web based) in different languages.
- Consult with communities and interpretive services to ensure health information is culturally appropriate.

2. Development of Health Resources

Goal: To make sufficient human and fiscal resources available to provide culturally competent health care services, information and social supports to newcomers.

- Create a greater network of communication amongst community organizations, health care providers, District Health Authorities and government (i.e. what services are out there? Who does what? What are the best practices?).
- Offer sustained funding for programs and practices that work (supported by example and research).
- Capital District Health Authority, IWK, long-term care facilities, community health clinics, governing bodies etc., adopt a policy of mandatory cultural competency training for staff and volunteers.
- Provide support for internationally trained health professionals to work as "health brokers" to help facilitate communication and understanding between the newcomers and service providers, and to ensure newcomers are receiving appropriate and sufficient health and social supports.

3. Access to Health Interpreters

Goal: Develop, endorse and enact policy commitments to providing competent health interpretation services in the primary health care setting.

- Provide training to health professionals on working with health interpreters.
- Lobby government – regarding the need for paid health interpreting services.
- Create protocols to guide the practice of health interpreters in the health care setting.
- Create and implement standardized training programs or a certification procedure for health interpreters

4. Access to Culturally Competent Health Care Services

Goal: Ensure health care services address the cultural specific health needs, knowledge, beliefs and perspectives of the client.

- Engage in a collaborative process so that health service providers are aware of and can readily partner with existing services for newcomers (i.e. interpretation services, settlement services, ethnocultural organizations and associations).
- Provide appropriate remuneration for health care providers so they may conduct comprehensive assessments of newcomer clients while accessing health care services.
- Support the planning and implementation of the Nova Scotia Department of Health's Diversity and Social Inclusion Initiative in Primary Care.
- Match up health care providers with mentors from diverse cultural communities (i.e. health brokers).

5. Promotion of Health and Well-Being

Goal: Provide policies, programs and services that ensure the continued good health of new immigrants by addressing all of the determinants of health

- Target newcomers as population sub-groups in health promotion and prevention programs.
- Create an advisory group with the provincial Office of Immigration to encourage them to address the barriers many newcomers are facing.
- Increase the awareness of the impact of migration on health (especially mental health).
- Incorporate mental health awareness into ESL (English as a Second Language) programs.

6. Additional Support for the Health and Well-Being of Refugees

Goal: Provide specialized public health support to assist immigrant sub-groups that are more likely to experience socio-economic disadvantages and associated health problems, namely refugees

- Create a single-entry access point for Government Assisted Refugees to be screened for health concerns within a specified time (e.g. 1-2 weeks after arrival).
- Create an IFP (Inter-mode family physicians) program whereby there would be designated clinics, physicians and pharmacies that would accept newcomers on an inter-mode basis.
- Ensure newcomers at higher risk of health issues receive appropriate treatment and follow-up, and are educated on ways to keep healthy.
- Work with Public Health Agency of Canada to include measures that support community agencies in assisting newcomers with prevention, compliance, monitoring and reporting of communicable/infectious diseases.

7. Community Capacity and Involvement

Goal: Strengthen community-based resources and build immigrant communities capacity to address health issues.

- Support programs and policies that empower immigrant groups to develop and maintain their own ethno-specific institutions and health promoting practices.
- Provide funding for multicultural groups and committees to engage in formal collaborative activities.
- Build capacities of newcomers to deal with mental health issues (i.e. encourage the development of support groups).
- Engage immigrants and ensure representation in public health policy consultation (i.e. interpreting services are available as needed, creating a comfortable, non-threatening environment for discussion etc.)

APPENDIX D – Development of a Culturally Competent Well Women’s Clinic

- March 2008 - \$50,000 funding awarded to Cancer Care Nova Scotia among partnership group including Capital Health, IWK Health Centre, North End Community Health Centre and MISA (ISIS).
- Partnership formed to develop and pilot an enhanced screening program and services for women from marginalized communities
- Focus group – women who spoke Arabic and practiced the Muslim faith

Pilot Model

- Three well women’s sessions were held in a community based setting. The clinics were built on existing IWK Women’s Community Clinics models. The three sessions included an hour and a half long education module on a topic of interest identified by the target group and a one hour well-woman’s clinic visit provided by a nurse practitioner. The importance of social atmosphere was recognized through the provision of refreshments and a “greeter” to welcome women to the clinic.
- Booking for the clinics – a message in Arabic instructed women to leave their name and telephone number and advising them their call would be returned within 24 hours
- Flyers for the clinic were provided in both Arabic and English
- Interpretation services were provided for the education session and the clinic visits.
- Health providers were trained in culturally competent practices.
- The inclusion of Muslim practices were included into the sessions (ie. identified prayer space, agenda accommodated for prayer times and food chosen to reflect cultural requirements)
- Education materials were collected and/or revised into Arabic or easily understood English

Learnings

- The Arabic community is large and diverse. Need a plan to reach all leaders and sub-groups to be included.
- Important to focus on specific cultural needs of Muslim women within the Arabic speaking population.
- Title of education sessions need to be carefully chosen as it can be interpreted differently than intended
- Time must be built into education sessions for discussion and validation of traditional practices
- Adult education principles must be applied to the development of the sessions
- More exploration needed to assess the needs for a well woman’s clinic
- Women very interested in more education on health issues for themselves and their family

APPENDIX E – Working Together for the Health of Refugees in Nova Scotia – 2011

In January 2011, ISIS and the North End Community Health Centre initiated an information session with community stakeholders to explore the health needs of Halifax's refugee community and to open discussion regarding the creation of a targeted plan to meet the specific health needs of this population.. Attendants from the following organizations participated in the session:

- IWK
- NS Ministry of Health and Wellness
- Dalhousie University
- NS Office of Immigration
- Dalhousie Dental
- Citizenship & Immigration Canada
- North End Community Health Clinic
- Capital District Health Authority
- Dalhousie Family Medicine
- Public Health
- ISIS

The main objective of the session was to provide information regarding the health needs of Government Assisted Refugees in Canada and highlight the gaps in Halifax's primary health care services that are unable to adequately meet these needs. The three presentations provided an understanding of the unique health care needs of Government Assisted Refugees, the vulnerability of these individuals due to post and pre arrival contexts that can increase primary health care needs and the local communities' inability to affectively absorb these individuals into the present primary health care services. The presentations created an increased awareness for the need of targeted primary health care services to appropriately meet the needs of Government Assisted Refugees in Halifax. A targeted service could be based on the collaborative model of the Vancouver based Bridge Community Health Clinic (see Appendix I for detailed information on this clinic).

Following the presentations, discussions with key consultants focused on building capacity to move forward in meeting the health care needs of Government Assisted Refugees in Halifax. These discussions produced the following four main themes: funding, partnerships, inclusiveness and cultural competency. Below is a brief summary of each theme.

Funding

1. Advocate for government support and seek funding options
Complete a cost/benefit analysis to emphasize the cost reduction in preventative primary health care against expensive use of emergency services
2. Aim for sustainability

Partnerships

1. Learn and understand the roles that each health care professional brings in working together to share and work collaboratively towards the same goal
2. Plan together with a "big picture" view which can help to uncover hidden resources
3. Develop bridging programs for health care professionals including Internationally Educated Health Professionals

Inclusiveness

1. Capacity building should embrace health care for all refugees including those privately sponsored and refugee claimants
2. Focus thinking on determinants of health and health inequities
3. Involve all interested participants in working toward the goal including public, private and individual sectors

Cultural Competency

1. Enhance educational efforts related to inequities of health and health services including recognizing racism as an integral component to the health inequities for refugees
2. Build greater capacity in language materials
3. Provide education and incentive for primary health care professionals to increase cultural competency

APPENDIX F – North End Community Health Centre & ISIS – A Partnership (2009- present) (NECHC, 2011)

Description

The North End Community Health Centre takes a collaborative and community based approach to provide primary health care in a culturally sensitive and aware environment. It was brought to the attention of the NECHC that ISIS was experiencing challenges in accessing urgent and ongoing primary health care to refugees. The NECHC agreed to partner with ISIS for the provision of health care to newly arrived Nepali speaking Bhutanese refugees. The patients seen were a mix of females and males ranging in age from 35 weeks to 76 years old.

September 2009 - 8 families / 37 patients ; October 2010 – 13 families / 86 (+) patients; January 2011 – 2 families / 6 patients

Services

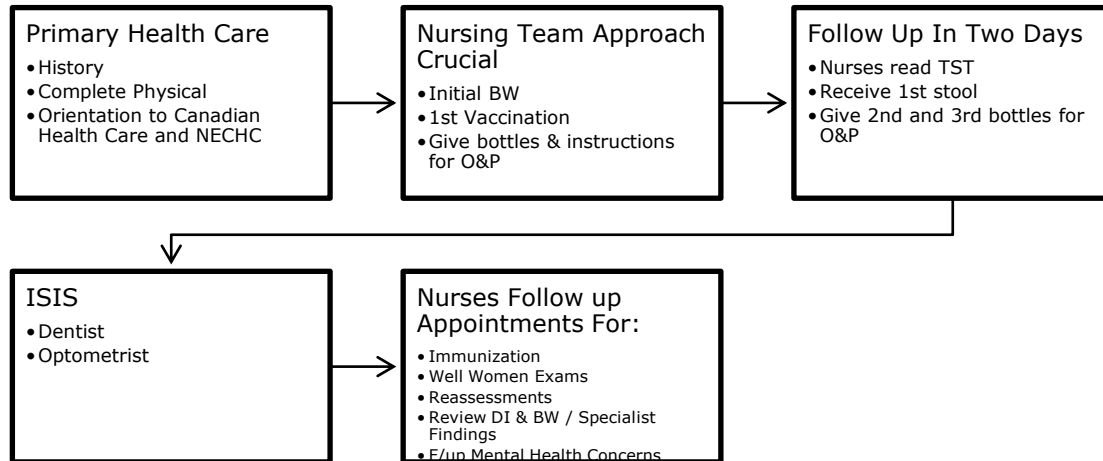
Within the centre, there is a physician with expertise in tropical medicine (Dr. Campbell). The majority of service are provided by this physician and a nurse practitioner however the following services are all available to the Bhutanese patients seen at the NECHC:

- Medical Doctors
- Nurse Practitioners
- Registered Nurses
- Dietitian
- Occupational Therapist
- Physical Therapist
- Shared Care Mental Health
- Dental Hygiene
- Dentistry Partnership
- Blood work
- Foot-care
- Diabetes clinics
- MOSH
- Community and individual outreach

With regard to specific services, a complete medical assessment including the gathering of medical history was completed on each individual. This assessment included:

- Current Concerns
- PMHx (Malaria, Hepatitis, Parasites, anemia)
- TB history: personal and family
- Immunizations
- Pregnancy and pap history
- Injuries, Surgeries, Allergies
- Medications
- S/Sx of Infectious Disease (Fever, cough, diarrhea, rash, weight loss, night sweats, HA, rhino)
- Social: smoking, alcohol, occupation, education, housing (there and here), refugee camp and route to Canada (countries in transit)
- Physical: general appearance, height and weight, blood pressure and heart rate, visual acuity and fundi, H&N, chest, abdomen and skin
- Microbiology lab: stool, sputum, blood

The following chart is the NECHC's process for providing comprehensive health care to the refugee patients:



Partnerships/Financial Support

- ISIS & Public Health
 - Translations
 - Access to dental and optometry
 - Coordination of patients
- TST
- Vaccines

Learnings / Outcomes

In General

- New refugees require assistance to learn how the system functions and basic ways to utilize it
- Interdisciplinary team is necessary to provide care
- Cultural competence is essential in the service provision of refugee health
- Nurses provide the **link** to all the wonderful resources available

Crucial Link: ISIS – NECHC

- Working relationship between Nursing and ISIS Immigrant Health Coordinator
 - Most appointments require translator and escort
 - Arranging initial assessment appointments
 - Scheduling follow up appointments for immunizations and specimen collection
 - Contacting Pts for urgent follow up based on results

Link: Public Health – NECHC

- Unique schedule to childhood and school based immunization programs
- Ordering vaccines (PH very responsive)
 - Tetanus, MMR, IPV, Men C, Pneum 23, TB, Varicella, Hep B
- Hep B – if they are still in school; and they may not be the usual Canadian ages

Process Lessons

- Service provider schedules protected to receive large family groups at one time
- All assessments followed a structured guide developed by Dr. Kevin Pottie from the University of Ottawa
- Courteous to notify the lab on days initial assessments are being completed as there will be a large number of stool, sputum and blood samples at once
- Important to form partnerships (ISIS & Public Health)
- Essential screenings – BW, TB
- Completion of pap tests – none of the women attending the clinic had ever had a pap test
 - Explanation for the purpose of pap tests required
- Vaccinations may be up to date or may not
 - Considerations: vaccine quality, coverage, lack of records
- Instructions need to be provided in written languages other than English
- Interpreters and translated instructions need for stool O&P
 - Bottles need to be given one per week otherwise samples are provided all at once
- Mental Health needs to be assessed
- Interim Federal Health Plan – limitations to medication coverage

The Future

- Create Pamphlets translated into first language of patients to:
 - Explain what will happen during appointments and what is needed
 - Explain special procedures ie. CXR, PV exam etc.
- Continue to establish and learn from other Canadian Clinics who are well functioning

APPENDIX G – Regina Open Door Inc. & Regina Community Clinic

Description

In 2005 The Regina Open Door Society Inc. (RODS) formed a strong relationship with the Regina Community Clinic and Public Health to provide health assessments and culturally sensitive and appropriate health care to newcomers. The Regina Community Clinic (RCC) is Regina's only health care co-operative which is committed to providing primary health service through a multi-disciplinary team of health professionals. RODS and Public Health compliment and extend the services offered to clients through the RCC.

Services

Step 1

- Within the first week of arrive the client is receives a needs assessment by the Health Service Facilitator (HSF) (trained LPN on staff at RODS).
- Needs assessment is used to meet the client's needs and for prioritizing purposes
- Clients with identified medical problem can see the doctor within 2 days

Step 2

- Clients are referred by the HSF to the Public Health Nurse (fulltime staff onsite at RODS)
- The PHN complies client's health history, explains health assessment process and conducts immunizations
- All clients will be seen by PHN within the first month of arrival

Step 3

- Clients are referred by PHN to the Regina Community Clinic
- Clients receive a full health assessment

Step 4

- Clients are referred by RCC to external health services including specialists, mental health, optometrists, dentists, infectious diseases

Partnerships/Financial Support

- Citizen and Immigration Canada – funding for Health Service Facilitator position (RODS)
- Public Health – funding for Public Health Nurse (RODS)
- Ministry of Health – funding for nurse practitioner / doctor (RCC)
- Ministry of Advance Education and Employment – funding for interpreters and translators
- Regina Community Clinic

Learnings / Outcomes

Between April 2005 – April 2006

- Health assessments and services provided to 144 refugees
- 88/144 clients were referred to specialists

Between June 2005 – April 2006

- 50 Mantoux tests completed (to identify tuberculosis)
- 21/50 clients referred to Infectious Diseases
- 165 children immunized
- 75% children seen by Public Health were sent to the dentist

Through the partnerships a high numbers of medical conditions were identified including:

- Parasites
- Hepatitis A, B, C
- HIV
- Tuberculosis
- Malnutrition
- Sick cell anemia
- Anemia
- Syphilis
- Hypertension
- Diabetes
- Seizures
- Liver Problems
- Developmental delays
- Renal problems
- Squamous Lesion
- Hearing problems
- Vision loss

Additional Positive Outcomes

- Decrease in emergency room visits by GARs
- Decrease in hospital stays by GARs
- Improved client health
- Settlement workers spend less time in doctor offices
- Better coordinated services for GARs
- Large saving for health system
- Increased ability to meet the needs of special need clients

APPENDIX H – The Calgary Refugee Health Clinic

Description

The Calgary Refugee Health Clinic is one of two main components of the Health and Wellness division of the Calgary Catholic Immigration Society. This division was launched as a community initiative aimed at overcoming the numerous barriers new refugees to Calgary face. A range of health-related programs and services are delivered by a team of professionals.

The two main components of the Health and Wellness Division include:

The Calgary Refugee Health Clinic - A full-time primary care practice, providing initial assessments and on-going health care

Complimentary health programs and services – external referral service, specialty clinics, and activities focusing on health promotion and community engagement.

Services

- Calgary Refugee Health Clinic (primary care for refugees)
- Specialty Clinics
 - Pediatrics
 - Obstetrics/Gynecology
 - Psychiatry
 - Tuberculosis
 - Hepatitis
 - Chronic Disease
- Mental Health
- Audiology
- Immunization
- Optical Health
- Nutrition
- Women's Health
 - Post-partum sessions
 - Pre-Natal clinic and classes
- Oral (Dental) Health

Partnerships/ Financial Support

Partnerships include a wide variety of Calgary's health and community service providers both public and private. Including:

- Alberta Health Services
- Alberta Health and Wellness
- Alberta Medical Association
- Citizenship and Immigration Canada

Outcome Goals

The main focus is to provide culturally appropriate, easily accessible services to individuals unfamiliar with the Canadian health care system. Clinicians with special expertise in international health, as well as coordinative staff who can bridge the numerous gaps are brought together in one location. The focus is achieved through interpretation, community outreach and culturally sensitive program delivery. The provision of orientation to the Canadian health care system and the address of health problems during the first and second years of arrival have been shown to significantly improve quality and continuity of care to newcomers.

APPENDIX I – The Bridge Community Clinic (Vancouver Coastal Health) - (Vancouver Coastal Health, 2005 & Mayhew, 2011)

Description

Since 1994 Bridge Community Health Clinic has provided access to primary and preventative service for refugees and new immigrants. All refugees, refugee claimants or recently arrived immigrants who lack medical coverage may access health care services at Bridge Clinic. The Bridge Clinic strives to provide integrated, comprehensive, culturally and language appropriate care for the target population and their families during their initial adaption period and integration in the Vancouver area.

The Bridge Clinic also provides opportunities for professionals and community members in training (eg. Psychology, social work, nursing, dentistry, medicine, occupational & physical therapies, counseling psychology, interpretation, etc.) to receive culturally appropriate clinical and health promotion training, which will enhance their professional practices to work more effectively with the diverse needs of the targeted population.

The Bridge Clinic has a capacity of 3000 patients and has 2000 new patients arriving each year. The three most frequently represented countries include Myanmar (Burma), Iran and Iraq.

The Bridge Clinic aims to provide short-term primary and preventive health services. This short-term period is approximately for one year before transferring patients to “mainstream” health services.

Services

- Primary health care
- Screening for infectious and/or chronic diseases
- Immunization
- Chronic disease management
- Pediatric consultation
- Outreach/health education
- Immigration medical examinations
- Mental health services
- Settlement services
- Prenatal services
- Newcomer Pediatric Health Clinic
- Nutritionist
- Physiotherapist
- Respiratory therapist
- Speech language pathologist

The clinic has an interdisciplinary health team. Important team members include the community liaison worker and a counselor. The Bridge Clinic has formed many links with others who address issues particularly related to the determinants of health.

Additional roles of the clinic include advocating for the population served, addressing issues of women’s care, increasing public awareness, teaching students, conducting research and providing web-based information support to GPs (translated documents, links to services, etc.)

Partnerships/ Financial Support

- BC Children’s Hospital
- BC Women’s Hospital and Health Centre
- Providence Health Care
- Immigrant Society of BC
- BC Multicultural Health Services Society

Funding is from the Ministry of Health; physicians receive session fees except for the pediatrician and intern who are paid fee-for-service. Some funding is through the RFA for trauma; additional funds are from private and public sector.

Observed Learnings

- Early health issues are related to infectious / communicable diseases
- Later issues are related to chronic illness and limited treatment of physical injuries in home countries as well as lack of preventable interventions
- Almost all patients have lived with some form of mental illness
- Accompanying health information is limited and may be written in patient's first language
- Many issues related to stress emerge as health issues several years after arrival in Canada

APPENDIX J – Queensland Refugee Health Service Plan (Queensland Government Australia) (Queensland Government, 2008)

Description

In 2007 Queensland Health allocated funding to develop a Queensland Refugee Health Service. \$1.08 million* was allocated in 2007/08 for the establishment of the service and \$1.2 million was allocated recurrently from 2008/09. The Service Plan is a four year plan, covering the establishment of the service in 2007/08, service implementation 2008/09 to 2010/11 and review during 2010/11. *Australian Dollars

The Service Model is a “hub and spoke” model. The “hub” has a small statewide team to do planning, coordination, education, support and quality monitoring, as well as conduct the Brisbane South Refugee Health Clinic. The “spoke” services provide direct clinical care services to the client group in the local area and are supported by the hub. (Queensland Government, 2010). Detailed funding information can be found in the Service Plan – Executive Summary Part 2 found at:
http://www.health.qld.gov.au/multicultural/health_workers/refugee_hlth.asp

Service Goals

- Develop and implement a coordinated statewide health service for refugees and refugee claimants
- Provide standardized health assessments
- Public health screening
- Catch-up vaccinations
- Coordination of short-term health management
- Additional support for complex cases
- Supported referral to existing services for ongoing care, in particular, general practitioners

Objectives

- To establish and implement an appropriate governance structure to oversee and guide the implementation of the Queensland Refugee Health Service
- To coordinate and support the spoke services to conduct standardized health assessments for refugees and refugee claimants
- To provide early health assessments to refugees and refugee claimants
- To coordinate transition of health care to mainstream care providers (general practitioners)
- To provide complex health case coordination to refugees with complex health needs requiring multiple referrals
- To review service data for ongoing service development and to build capacity for effective service response

APPENDIX K - Sample of Current Refugee Health Clinics

Name and location	Partnerships	Service providers	For whom	Serviced delivered
<p>Access Alliance, Toronto</p> <p>www.accessalliance.ca/services/health.com</p> <p>About 800 government –assisted refugees</p>	<p>Ontario Ministry of Health</p> <p>COSTI Settlement agency</p>	<p>Certified Diabetes Educators</p> <p>Parent and Family Support Workers</p> <p>Community Health Nurses</p> <p>Interpreters</p> <p>Medical Secretaries</p> <p>Nurse Practitioners</p> <p>Physicians</p> <p>Psychiatrist (through the Toronto Urban Health Alliance)</p> <p>Registered Dietitians</p> <p>Registered Practical Nurses</p> <p>Social Workers</p>	<p>Disadvantaged immigrant and refugees</p>	<p>Preventative health care – screening, teaching and education</p> <p>Routine physical exams</p> <p>Immunization for children and adults</p> <p>Assessment and treatment of acute episodic stress</p> <p>Ongoing management of chronic disease</p> <p>Pre- and post-natal care and well-baby care</p> <p>Triage service for urgent client problems</p> <p>Therapeutic counselling for individuals and families</p> <p>Mental Health services</p> <p>Nutrition assessment and counselling</p> <p>Health education – healthy lifestyle, diabetes management</p> <p>sexual health care and family planning counselling, well mom and baby, breastfeeding support</p> <p>After hours phone consultation</p> <p>Information, advocacy, service referral and practical support</p>
<p>Auckland Regional Public Health Services refugee health Clinic, Mangere Refugee Resettlement Centre (MRRC), Auckland New Zealand</p> <p>The national health screening centre in New Zealand</p> <p>www.arphs.govt.nz</p>	<p>Partnership between health services, refugee communities, government agencies and NGO organizations</p>	<p>Range of service providers</p>	<p>Government-assisted refugees and asylum seekers</p>	<p>Screening and healthcare, assessment, immunization, medical treatment and facilitating access/referrals to special health services</p> <p>Building community capacity and partnerships and improve accessibility</p>

Boston Center for Refugee and Human Rights, Boston Medical Center in Boston www.bccrrhr.org/pro/pro_indexhtml . 300 refugees per year	Collaboration between Boston Medical Center (Dept. of psychiatry, medicine, Family Medicine, Pediatrics, social work and interpreter services), Boston University (schools of Medicine, Public Health, dentistry, Law), Global Lawyers, Physicians and the National Center for Post-Traumatic Stress Disorder.		Refugees	Comprehensive medical, mental and dental health coordinated with legal and social services and interpreter services. In addition: educate service providers, advocate to conduct clinical, epidemiological and legal research
Bridge Community Health Clinic, Vancouver 800-900 per year www.welcomebc.ca/shared/docs/community_health.pdf .	Providence Health Care Society, Vancouver Coastal Health Authority and Immigrant Services Society of BC	Multi-disciplinary team including physicians, nurses, interpreters, settlement worker, nutritionist, physiotherapist, respiratory therapist, speech language pathologist, psychologist and psychiatrist	Refugee, refugee claimants and immigrants without access to health care services	Primary health care, screening, for infectious and/or chronic diseases, immunization, chronic disease management, pediatric consultations, outreach/health education, immigration medical examination, mental health services and settlement services
Bruey're Immigrant Health Clinic For up to two years	Institute of population health, University of Ottawa, Immigrant health Visiting Friends and Relatives Program	Multi-disciplinary team incl. physicians, nurses practitioners, nurses, interpreters, pharmacist and social worker	Refugees and immigrants from developing countries	Comprehensive health assessments and care, immunization, psycho-social assessment, health assessments and health promotions
Calgary Refugee Health Program, Margaret Chisholm Resettlement Centre, Calgary 1200 refugees per year www.ccic-calgary.ab.ca	Calgary catholic Immigrant Society, Calgary Health Region and individual health service providers	Multi-disciplinary team	Government assisted, privately sponsored refugees and immigrants in refugee like situations	Address initial refugee health, enhance capacity of individual refugees to improve their health and raise awareness about refugee health issues Services include: psychiatry, paediatrics, gynaecology/obstetrics, infectious disease, vaccinations, health promotion programs, interpreter services

North Hamilton Community Health Centre (NTCHC), Hamilton 500 new patients per year www.inform.hamilton.ca/record/HAM0656 .	Funded by Ontario Ministry of Health Partnering with local University, hospital departments and community organizations	Community health worker, social worker, clinical psychologist, family physician	All immigrant and refugees	Comprehensive and accessible primary care, address social issues of new immigrants and refugees. Health care integrated with settlement and language supports: Asthma program Children's Community Breakfast Club Children's Gardening Club Chiropody (including Diabetes foot care) Community Advisory Committee Community Health Programs Diabetes Education Program (also provided in Spanish) Health Promotion Programs HIV care Immigrant/Refugee services Keep fit Club Nutrition Counselling Physiotherapy Smoking Cessation Program Social Work Sunny Strollers Club Twinning Program for Newcomers Volunteer Program
Queensland Refugee Health Services, Australia Clinics/services in Seven cities/locations http://www.health.qld.gov.au/multicultural/health_workers/refugee_hlth.asp	Range of partners depending on number of new arrivals in the area. Each location have access to centralized services and expertise	See website for details	Government-assisted refugees and refugee claimants	Range of services varies

Regina Open Door Society Inc. (RODS) & Regina Community Clinic (RCC), Regina SK www.rods.sk.ca www.reginacommunityclinic.ca 150 GARs per year	RODS, RCC, Public Health, CIC, Ministry of Health, Ministry of Advanced Education and Employment	Health Service Facilitator / LPN Public Health Nurse Multi-disciplinary team (physicians and nurse practitioners)	Government Assisted Refugees	Needs assessment : within one week – Health Service Facilitator Vaccinations/immunizations, explanation of health system, collection of health history : within one month – Public Health Nurse Full health assessment / referral to specialists, mental health, optometrists, dentists and infectious disease – multi-disciplinary team
Hauora o Puketapapa/Roskill Union and Community Health Clinic (HoP) http://www.healthpoint.co.nz/default_105137.sm	Partnerships with Government and NGO sectors	General practitioners Refugee Health Co-ordinator Pharmacist Physiotherapist	Low-income groups – large population of immigrant and refugees	Primary health care services Community Development Refugee Support Programs Maternity Support Interpreter services