Rising Up to the Challenge: Strategies to Improve Health Care Delivery for Resettled Syrian Refugees in Canada

Alvi A. Rahman, BHSc, MSc(c)[1]

[1]School of Epidemiology, Public Health, and Preventive Medicine, University of Ottawa

The haunting image of three-year-old Alan Kurdi lying dead on a Turkish beach struck a chord across the world and brought the urgency of the Syrian refugee crisis to light. Notably, it ignited fervor in the Canadian political landscape following the revelation that the boy's family was trying to eventually reach Canada. In response, the newly elected Liberal government pledged to welcome 25,000 government-assisted Syrian refugees into Canada by the end of 2015.[1] Following the Paris terror attacks of November 2015, however, the government revised their target by committing to resettle 25,000 government-assisted refugees by the end of 2016, citing an intensified screening process as the cause for delay.[2] By the end of March 2016, over twenty-six thousand Syrian refugees had arrived in Canada, with approximately 15,000 classified as government-assisted.[3] As Canada continues to strive towards its commitment to resettle Syrian refugees, profound implications exist for the health care system with respect to its ability to meet refugees' specific health necessities. Health needs for refugees often differ as a result of their distinct environmental exposures, living conditions, and family histories of disease.[4] To fulfill these necessities, the quality of primary health care delivered to refugees needs to be significantly improved by promoting access to health services, mitigating language barriers, and stimulating health literacy.

Newly arrived immigrants and refugees frequently report having limited access to health care due to factors such as a lack of understanding of the health care system, language and cultural barriers, or discrimination.[5] These problems persist despite the implementation of policies to promote access to health services among refugees. The Interim Federal Health Program (IFHP) was introduced by the federal government to provide refugee newcomers with temporary coverage of health-care benefits as they await acceptance into a provincial health insurance plan.[6] At present, the IFHP provides resettled refugees with full health-care coverage that includes basic health-care services (i.e. physician and hospital care), supplemental services (i.e. limited vision and dental care, allied health services, and assistive devices), and prescription drug coverage.[6] Under the IFHP, refugees moving to Canada should have immediate access to both basic and supplemental health coverage. However, they still face difficulties in accessing these services. Statements from Resettlement Assistant Program workers, who assist government-sponsored refugees, indicate that primary care physicians frequently do not acknowledge the IFHP certificate.[7] This reluctance to treat refugees is usually due to unfamiliarity with the IFHP or an unwillingness to engage in the long administrative process required to be reimbursed for services provided.[7] In some cases, when the reimbursement process is slow, refugee patients have been approached by their primary care provider for payment for services.[7] These patients ultimately visit emergency rooms for non-urgent conditions.[7] Since hospitals have distinct departments to address billing issues, they accept IFHP certificates more readily, but this increases waiting times in the emergency room.[7] Moreover, reports indicate that refugee mothers with IFHP coverage who are refused care are often unable to locate an alternative provider, potentially resulting in adverse implications for their child's health.[8] Another barrier that limits refugee patients' access to health services is discrimination in health-care settings. Although overt forms of discrimination, such as racial slurs or stereotyping, have been documented, most discrimination in Canada today is subtle.[9] This may include rude or unfair treatment, exclusion, or being dismissed.[9] Documented incidences include health service providers becoming frustrated when asked to respect religious or cultural beliefs or pretending to not understand the patient.[8,9] The occurrence of these incidents is concerning due to the adverse effects associated with discrimination in health-care settings, which include poor physical health, mental health, and risky lifestyle behaviours.[9]

In order to tackle these issues, better training and mentorship services should be administered to medical students and primary care providers. As medical students graduate,

Corresponding Author:
Alvi A Rahman
arahm098@uottawa.ca

they will be faced with a rapidly changing population with a diverse set of values and beliefs, and they will need to be culturally competent to deliver effective, patient-centered care. Students and physicians can gain vital exposure to these populations by working in specialty clinics that serve refugees. Studies indicate that medical students who have had the opportunity to care for refugee patients developed an increased awareness of their cultural background, which included an acknowledgement of the role of religion and spirituality in health care, identification of family structure and relations, and understanding of gender roles and relations.[10] Additionally, students also learned key lessons about cultural humility, enabling them to appreciate their own privileged background, meet the emotional needs of refugees through empathy, and demonstrate a willingness to integrate refugees into their community.[10] In Canada, medical students at the Memorial University of Newfoundland initiated a program that successfully connected resettled refugees with the health care system and offered medical students the opportunity to engage in clinical training with refugee populations and to practice cross-cultural care.[11] For primary care physicians, these types of services can be supplemented within the curriculum of professional development workshops.[12] Providing medical students and primary care providers with specific training will familiarize them with policies regarding the delivery of health services to refugees and enable the development of cultural competence when approaching refugee patients. Ultimately, this will enhance refugees' experience and improve their access when seeking healthcare.

There are several facets of health services that determine the quality of care being delivered to patients. For recently resettled refugees, proper communication of health information is paramount. Language barriers represent a serious obstacle to receiving a satisfactory level of health care and contribute to deficiencies in health literacy.[13] Not only do language barriers affect patients' ability to communicate with their primary care providers, but they also impact subsequent appointments with specialists and understanding of instructions associated with follow-up or prescriptions.[14] Canadian health care practitioners (HCPs) prioritized language interpretative services and communication support as the most important practice strategy needed to enhance the quality of primary health care for vulnerable populations.[12] Approaches to implement this recommendation include matching patients with primary HCPs who speak the same language or administering interpretive services using staff interpreters or contracting qualified interpreters.[12] Furthermore, the recent emergence of mobile technologies has led to the development of applications that can be used by physicians to surpass language barriers and effectively communicate with patients. *MediBabble Translator* is an excellent tool that allows physicians to take patient histories and make diagnoses. The program performs these functions in a number of widely spoken languages.[15] A less specialized mobile application that can be used is *Google Translate*, which can allow HCPs to easily translate English phrases into a language of their choice.[16] Along with traditional interpretive services, modern technologies can be effective in facilitating transparent communication between Syrian refugees and their health care providers.

Community-level interventions have also been identified as a strategy to improve health service delivery to vulnerable migrants.[12] Community health workers (CHWs), which possess advanced knowledge of social determinants of health, play an integral role in implementing these strategies.[17] CHWs understand the difficulties faced by marginalized communities in accessing health and social services, and help members of these communities achieve better states of health through health education, community development, and advocacy.[17] Specifically in Syrian refugees, mental health conditions such as depression, posttraumatic stress disorder, and anxiety disorders are prevalent, owing to the effects of violence, displacement, travel, or family separation.[18] CHWs can act as facilitators to help refugees navigate the health care system and can link them with the necessary services through linguistically and culturally-appropriate support.[17] However, Canada currently lacks an organizing body to regulate the quality of community outreach programs.[17] Collaboration between community and governmental organizations in the development and evaluation of outreach programs is essential to encourage their growth. Proficient community outreach programs have strong potential to promote the adaptation, settlement, and integration of Syrian refugees into Canadian society.

The aforementioned strategies provide guidance to enhance the quality of primary health care services to meet the oncoming challenges posed by Canada's laudable initiative to resettle Syrian refugees. The health care system needs to adapt by providing specific training and mentorship of medical students and primary HCPs on current health policies related to refugees, implementing adequate language translation services, and fostering collaboration between governmental and community organizations to develop strong outreach programs.

References

1. 5 things to know about Canada's Syrian refugee program. Toronto: The Canadian Press; 2015. Available: http://www.cbc.ca/news/politics/syrian-refugees-by-the-numbers-1.3469080 (accessed 2016 Mar. 25).
2. How response to Syrian refugee crisis went from 10k in three years to months. Toronto: The Canadian Press; 2016. Available: http://www.torontosun.com/2016/01/01/how-response-to-syrian-refugee-crisis-went-from-10k-in-three-years-to-months (accessed 2016 Mar 25).
3. Welcome refugees: key figures. Ottawa (ON): Citizenship and Immigration Canada; 2016. Available: http://www.cic.gc.ca/english/refugees/welcome/milestones.asp (accessed 2016 Mar. 25).

4. Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. Can Med Assoc J 2011;183:E824-E925.
5. Setia MS, Vallee-Quesnel A, Abrahamowicz M, et al. Access to health-care in Canadian immigrants: a longitudinal study of the national population health survey. Health Soc Care Community 2011;19: 70-9.
6. Interim federal health program: summary of coverage. Ottawa (ON): Citizenship and Immigration Canada; 2016. Available: http://www.cic.gc.ca/english/refugees/outside/summary-ifhp.asp (accessed 2016 Oct. 21).
7. Miedema B, Hamilton R, Easley J. Climbing the walls: structural barriers to accessing primary care for refugee newcomers in Canada. Can Fam Phys 2008;54:335-6.
8. Wahoush EO. Equitable health-care access: the experiences of refugee and refugee claimant mothers with an ill preschooler. Can J Nurs Res 2009;41:186-206
9. Edge S, Newbold B. Discrimination and the health of immigrants and refugees: exploring Canada's evidence base and directions for future research in newcomer receiving countries. J Immigr Minor Health 2013;15:141-8.
10. Griswold K, Zaya LE, Kernan JB, et al. Cultural awareness through medical student and refugee patient encounters. J Immigrant Health 2007;9:55-60.
11. Duke P, Brunger F. The MUN med getaway project: marrying medical education and social accountability. Can Fam Phys 2015;61:e81-7.
12. Pottie K, Batista R, Mayhew M, et al. Improving delivery of primary care for vulnerable migrants: Delphi consensus to prioritize innovative practice strategies. Can Fam Phys 2014;60:e32-40.
13. Rootman I, Ronson B. Literacy and health research in Canada: where have we been and where should we go? Can J Public Health 2005;96 Suppl 2:S62-77.
14. McKeary M, Newbold B. Barriers to care: the challenges for Canadian refugees and their health care providers. J Refugee Studies 2010;23:523-45.
15. O'Hagan E. Getting started with medical apps: apps you should know about. J Hosp Librarianship 2012;12:162-70.
16. Brown S. Mobile apps: which ones really matter to the information professional? Business Information Review 2012;29:231-7.
17. Torres S, Spitzer DL, Labonté R, et al. Community health workers in Canada: innovative approaches to health promotion outreach and community development among immigrant and refugee populations. J Ambul Care Manage 2013;36:305-18.
18. Pottie K, Greenaway C, Hassan G, et al. Caring for a newly arrived Syrian refugee family. Can Med Assoc J 2016;188:207-11.