

**THE ROLE OF NGOs IN HEALTH CARE  
SERVICES  
FOR IMMIGRANTS AND REFUGEES**

**PROCEEDINGS OF THE WORKSHOP  
FOURTH INTERNATIONAL METROPOLIS  
CONFERENCE  
WASHINGTON D.C., DECEMBER 7-11, 1999**

CANADIAN COUNCIL FOR REFUGEES AND CITY OF TORONTO PUBLIC HEALTH

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**ORGANIZERS**

The workshop was organized jointly by Wendy Kwong of the Partnership Advisory Council, Joint Centre of Excellence in Research on Immigration & Settlement (CERIS) and of Toronto Public Health, and by Janet Dench of the Canadian Council for Refugees (CCR).

**PROCEEDINGS**

These proceedings present the summaries of the papers presented as well some notes on the workshop discussion. The complete papers of the presentations by Dr Michael Chan, Tim Haines, Joyce Riungu, Dr Garry Aslanyan and Bernarda Lo Wong are also available on request from the co-organizers.

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**1.0 BACKGROUND**

Adequate health care services are essential for the health of communities. To meet basic needs they must be able to respond to all parts of society, including those who have arrived as immigrants and refugees. Newcomers' past life experiences, their cultural realities and their experiences since arrival in their new country may all be pertinent to the form of health care services they need. Non-governmental organizations play a particular role in hearing cultural minorities' needs, interpreting them to other players, including health care institutions, and in delivering services. A greater appreciation of NGOs' particular current and potential roles can help to contribute to the provision of appropriate health care services to people who have an experience as refugees or immigrants.

**2.0 GOALS OF THE WORKSHOP**

1. To promote health care services that are responsive to the diversity of the population and users' cultural and linguistic identity and their life histories.
2. To promote more equitable and effective access to health care services among marginalized sections of the population, particularly those who came as immigrants or refugees (whether recently or not).
3. To promote a greater appreciation of the role NGOs can and do play in the health care system, particularly with respect to marginalized sections of the population, in the identification of health care needs, cultural interpretation, access, facilitation of institutional adaptation and delivery of services.

**3.0 OVERVIEW OF WORKSHOP**

The workshop was planned with a view to bringing together representatives from three key sectors: researchers, policy makers and non-governmental organizations, all of whom play a significant role in determining the health care services available to newcomers.

Through eight presentations and discussion from workshop participants, the workshop examined issues relating to:

1. Health issues for refugees and immigrants, with a special focus on TB, mental health, dental and oral health and women's health.
2. The needs, benefits and challenges of collaboration and partnership among NGOs, policy-makers and researchers.
3. Issues related to access and equity in the community health care system.
4. The challenges of cultural interpretation in health care delivery among an immigrant and refugee population.

#### **4.0 METROPOLIS**

Metropolis is a cooperative national and international forum for policy-related research on the effects of immigration and settlement on urban centres. It has as a fundamental goal to incorporate findings, drawn from national and international comparative research, into decision-making. As it matures, the Project will increasingly seek to develop the policy and program options that are urgently needed by countries/cities to meet the challenges posed by migration and to take advantage of related opportunities. The Metropolis Project is a federally funded Project.

#### **5.0 FOURTH INTERNATIONAL METROPOLIS CONFERENCE**

The Fourth International Metropolis Conference was held in Washington D.C. from December 8-11,1999 at Georgetown University's Conference Centre. The themes of the Conference were :

- Building Community : Civil Society and Citizenship
- Neighbourhood Development : Housing and Labour Markets
- Governments and NGOs in Partnership

The conference was sponsored by the Carnegie Endowment for International Peace in collaboration with the Metropolis International Secretariat at Citizenship and Immigration Canada in Ottawa. Building on the experiences of the first three conferences in Milan (1996), Copenhagen (1997) and Israel (1998), this conference aimed to further intensify discussions amongst NGOs, senior policy-makers and leading academics in the field of immigrants through their participation in interactive plenary sessions and highly-focused, results-oriented workshops.

#### **6.0 CANADIAN COUNCIL FOR REFUGEES**

The CCR is an umbrella organization of some 150 Canadian non-governmental organizations concerned for refugees and for newcomer settlement.

## **7.0 TORONTO PUBLIC HEALTH**

Toronto Public Health is the largest health unit in Canada and the fifth largest in North America. Its challenge is to promote and protect the health of Toronto's 2.4 million people.

## **8.0 JOINT CENTRE OF EXCELLENCE FOR RESEARCH ON IMMIGRATION AND SETTLEMENT (CERIS) - TORONTO**

CERIS is one of the four Canadian university-based research centres established in 1996, as part of the International Metropolis Project.

## **9.0 SUMMARIES OF PRESENTATIONS**

### **9.1 Canada's Immigration Medical Examination - Non-Governmental Organization Involvement**

Dr Neil Heywood, Director, Selection Branch, Immigration Health Policy Division, Citizenship and Immigration Canada

In keeping with most migrant receiving countries, Canada requires that all immigrants and certain visitors undergo an immigration medical examination. The Canadian *Immigration Act* requires that applicants are assessed with regard to their likelihood of posing a threat to public health or safety and whether they may create excessive demands on Canada's publicly funded health and social services.

In view of the global source and large number of applicants, compared to a limited number of medical officers employed by Citizen and Immigration Canada (CIC), the medical examination is conducted by local physicians. These local physicians are appointed by CIC and are called Designated Medical Practitioners (DMPs). Such DMPs not only bring local knowledge, which may impact on the health evaluation of the applicant, but also are selected on the basis of their language skills, among other factors.

The DMP is required to review the past medical history provided by the applicant and then undertake a physical and mental examination, as well as arrange for three age related routine tests - urinalysis, chest x-ray and syphilis blood test at 5, 11 and 15 years and over respectively. The DMP then provides an opinion of the applicant's health status and forwards the written report to CIC, together with the laboratory tests result reports and the chest x-ray film.

A CIC medical officer then reviews the documentation, including the chest x-ray, to undertake an immigration medical assessment of risk to public health and safety, and excessive demands. Should the information be insufficient to arrive at an assessment result, the medical officer may request further information. Applicants identified with infectious tuberculosis are denied entry to Canada until they have received appropriate anti-tuberculosis treatment and have been demonstrated to be no longer infectious. Such individuals, together with applicants identified as having evidence of inactive, non-infectious tuberculosis may then be granted entry to Canada but are required to report to the public health authority of the province/territory of destination. This process is known as medical surveillance.

Applications may be made for permanent residence, refugee status or an extension of visitor status by individuals already in Canada. With the exception of certain visitors, there is a requirement for an IME as has already been described. In this instance, individuals who are determined to be Convention refugees are exempt from the excessive demands assessment. Where an in-Canada applicant is identified as having infectious tuberculosis he/she is treated until rendered non-infectious. Applicants identified with inactive, non-infectious tuberculosis are placed under medical surveillance.

While most CIC operations staff, who interface with applicants, are proficient in the two official languages of Canada (English and French), the very large range of languages spoken by

applicants for entry to Canada may pose a challenge for both applicants and CIC officials. It is appreciated that non-government organizations (NGOs) may be of great assistance both in terms of assisting with providing information concerning the Canadian immigration medical examination and medical surveillance processes, but also in terms of entrants' integration into Canadian society. Recent examples of NGO activities include the Canadian Red Cross involvement with the Kosovar refugee movement to Canada and the Tibetan Association in connection with the Tibetan refugee movement.

In-Canada refugee claimants are one of the few groups of migrants who are permitted to enter Canada without having undergone prior IME. As a co-signatory to the Geneva Convention on Refugees, Canada is obligated to provide safe haven for such persons until a refugee hearing can be undertaken. There would appear to be increasing scientific evidence that the stress associated with the fear of persecution may well impact upon the individual's resistance to infections such as tuberculosis. Under the right circumstances, this may result in primary tuberculosis infection, or in the reactivation of previous tuberculosis infection. The importance of an early IME after entry to Canada is self evident. The participation of NGOs in providing both information and support in undergoing the IME could well prove invaluable in achieving the desired high compliance.

Canada's medical surveillance program requires that entrants placed under surveillance report to a public health authority within thirty (30) days of entry to Canada. This process is potentially beneficial to both the entrant as well as Canadian residents. For entrants who speak neither of Canada's official languages this can pose quite a challenge. The involvement of NGOs is seen as a possible way of making this process easier for the entrant as well as ensuring high compliance.

## 9.2 Chinese Immigrants and Refugees in Chicago

Bernarda Wong, Executive Director of the Chinese American Service League, Chicago, United States

According to a 1990 community health report, language, money, and cultural factors are the key barriers stopping Chinese immigrants from receiving health services. Immigrants without English language ability most likely do not understand the health system in the United States and lack knowledge of local resources. Those with limited English are fearful that they will be unable to explain their medical problems and receive proper care.

Almost all Chicago hospitals are deficient in bilingual staff or translators for the Asian languages. Interpreters when provided are sometimes a technician or a maintenance worker "borrowed" from another department. Therefore Asian clients refuse to seek out health services because of fear and frustration of not being able to communicate their health needs. Family members accompanying the client, while they provide a sense of comfort, may themselves speak minimal English, leading to misinterpretations, and sometimes imposing emotional stress on the young family member forced into the role of translator.

Immigrants and refugees unable to read or speak English often experience the health care institution as unfriendly and foreign. As a result they are reluctant to attend follow up visits even if it means preventing future health concerns.

Ethnic Chinese may be reluctant to submit to "Western" medical treatment and prefer traditional remedies. Western health professionals often do not understand the cultural differences in how patients receive home treatments in their home country, which can result in serious consequences. For example, a dying cancer patient, who was dehydrating, refused to drink cold water because it is believed in China that cold water worsens the illness.

Additional challenges include logistical barriers, medical expenses, and few specialty doctors. Many immigrants lack transportation and are reluctant to leave the community for services. The price of prescriptions is beyond the means of many seniors. In specialty fields, mental health doctors who speak Chinese are almost nonexistent. This means that a limited English individual with disorders like dementia and depression may have no choice but to seek help from general practitioners who may misdiagnose and treat the disorder inappropriately.

Like other NGOs across the country, the Chinese American Service League (CASL) helps immigrants overcome barriers to health care by providing cultural and linguistic appropriate facts and services. CASL is a comprehensive community-based social service agency serving 12,000 clients annually, mostly immigrants from China, Hong Kong, and Southeast Asia ranging from infants to elderly. There are four departments: Child Education Development Services, Family and Community Services, Employment and Training Programs, and Elderly Services, with a health outreach program cutting across all programs. Every client is potentially targeted for health outreach and education.

CASL educates the Chinese community about social and health resources through mass

communication (e.g fliers, brochures, posters). Bilingual health workshops are conducted regularly in different Chinese dialects, some geared towards the elderly, some to parents etc. Memoranda and bilingual flashcards are used to by-pass the communication barrier in setting up appointments and translating pertinent information needed by and for the physician. CASL's goal is to guide individuals to be independent productive members of society

CASL also provides and assists clients in direct services, translating materials into Chinese, helping set up appointments, interpreting clients' inquiries of the service providers on the phone, and providing transportation and escort services. Often, counseling is offered on the spot during visits to clinics and hospitals. This service includes follow-up and referral to further options if necessary.

Partnership is an important aspect of CASL's health outreach program. CASL recruits service providers, educating them on the population's needs, and developing an on-going network with community health professionals. For 20 consecutive years CASL has brought together the Chicago Department of Health (CDH), local hospitals, neighborhood doctors, and dentists for an annual health screening, which has proven to be an exceptional outreach in the Chinese community. For some, the screenings have provided a first encounter with health providers in the US. Another program, the Peer Education project on "Breast Cancer Education and Screening" disseminates information on breast cancer and self-examination techniques.

Advocacy is recognized an important part of the health outreach program. CASL advocates at two levels: it advocates for individual cases and targets the system as well. The health care system itself has challenges such as the process of referrals, lack of translators, insensitivity to cultural differences, and untrained professional staff. On a case basis, Chinese clients who experience service problems are supported through meeting with staff of the institutions.

CASL runs a number of Illinois-contracted programs that focus on elderly and children's health, through the Community Care Program (CCP) which provides Homemaker service, Adult Day Care, and KidCare. The CCP maintains, strengthens, and safeguards the functioning of individuals in their homes in accordance with a structured system of care. This program demonstrates a close working relationship between NGOs and government in health.

Many NGOs like CASL are acknowledged and respected, but there is more work to be done both locally and nationally, to keep health programs running effectively and efficiently. Let me offer several recommendations. First, there is a need for clearer language and role clarification for agencies receiving federal and state funds in providing services to Limited English speaking Persons (LEP). Second, the Commission on Civil Rights should seek assurance that any health care reform will not promote discrimination based on national origin either against consumers or medical practitioners. Third, the government should provide more money and Technical Assistance to community based social service NGOs so that services can be planned and received in more appropriate bilingual/bicultural approaches and settings. Fourth, more funding should be set aside for the establishment of culturally and linguistically effective community based primary care health facilities. Lastly, government and health organizations should identify more best practices in the area of health services for limited English immigrant populations and make those information readily available and easily understood by all NGOs across countries.

### **9.3 Access & Equity in the Community Health Service System**

Dr Michael Chan, Chair of the Afiya Trust, visiting Professor in Ethnic Health at the University of Liverpool.

New immigrants and refugees in the United Kingdom (UK) need to be registered with the National Health Service (NHS) in order to gain access to all health care. The NHS is funded by central government from general taxation and provides health care services free-of-charge at the point of need for all *bona fide* immigrants and refugees.

Community health care in the NHS includes primary care, community antenatal and postnatal care, home visits for the care of mothers and babies, follow up of day surgery patients, mental health services and specialist clinics for diabetes and hypertension in primary health centres.

Issues facing new immigrants and refugees include language barrier, information about the NHS knowledge of social welfare benefits, specific health needs such as sickle cell disease, thalassaemia, hypertension and HIV/AIDS, and support in the community. The role of NGOs in community health care in Britain is supportive and is directed to the incorporation of these services in the mainstream of the NHS and local authority services. Language support is crucial but its funding is usually short-term and inadequate to meet the needs of clients. Government is committed to tackling health inequalities and this policy must include the needs of new immigrants and refugees.

#### **NEW ENTRANTS TO BRITAIN AND TUBERCULOSIS**

People coming from countries at high risk of tuberculosis are likely to be referred to the port medical inspectors (PMI) for examination. PMIs are appointed by the Secretary of State for Health and tend to be public health physicians who are consultants in Communicable Disease Control. Referral rates to PMIs at the three main international airports in England (London Heathrow, Gatwick and Manchester) are more than 40 per 10,000 visitors per annum. Everyone from countries with a high prevalence of tuberculosis is invited to attend a BCG immunisation clinic for skin testing. Those who have a reaction to the skin test are referred to the Chest Clinic where they are put on chemoprophylaxis usually isoniazid.

If NGOs are well organized and adequately funded to employ staff and pay for volunteers' travel costs, they could be enlisted to contact new immigrants requiring a visit to the BCG clinic. Any follow-up of immigrants should be seen as part of an integrated plan to help improve the health of ethnic communities in the UK. Tuberculosis control would be better served by being incorporated into primary health care.

#### **9.4 Community Tuberculosis Education and Prevention Program (COTESAPP)**

Dr Francesca Gany, Director, New York Task Force on Immigration Health, New York University School of Medicine, United States

The five-year old Community Tuberculosis Education and Prevention Program (COTESAPP) is run by the New York Task Force on Immigrant Health (NYTFIH) with ACDP, African Services Committee, CAMBA, Haitian Women's Program.

NYTFIH is housed fiscally at NYU School of Medicine, and physically at Bellevue Hospital Center. An interinstitutional program, it serves as a bridge between foreign-born communities and the health care system, forming a network of community members, practitioners, administrators, health care facilities and policy makers. Its mission is to increase access to appropriate care for New York's large foreign-born communities. It is involved in research, education and training, information dissemination, and program and policy development.

Its largest program areas are in tuberculosis; language access to care; cultural competence; insurance, managed care, medicaid and CHIP; technology and immigrant access; medical education and smoking prevention. Funders are the Fan Fox and Leslie Samuels Foundation, the New York City Department of Health, with funds from the Centre for Disease Control, the Stony Wold Herbert Foundation and the Edna McConnell Clark Foundation.

Tuberculosis rates are on the decline in all US populations except the foreign-born. In New York City (NYC), the foreign-born account for almost half of the cases of TB, out of proportion to population size. The highest TB case rates are found in diverse groups and in people from China, Ecuador, Dominican Republic, West African countries, including Senegal and India.

Reasons for the high TB rates in the foreign-born include high rates in sending countries, stress of migration, inadequate screening at the borders, living conditions in the United States and lack of adequate access to screening, prevention, and treatment in the United States.

Barriers to TB care in the US include linguistic barriers (interpretation and translation), cultural barriers (education, media, health care systems, stigma, trust), economic barriers, legal barriers (real and perceived) and structural barriers (hours of operation, distance).

COTESAPP depends on a true partnership with community-based organizations. An advisory Board was formed, with representation from community health care facilities, practitioners, state and city departments of health and social scientists.

Research was conducted on which groups to target, doing needs assessments, using focus groups. These looked at knowledge, attitudes and beliefs about TB, health care seeking behaviour, community social structure and health education information channels (media (spoken and written), family and friends, music, health care providers (allopathic and non-allopathic), written materials).

In a second phase, materials (written materials, translations, back-translations, videotapes) were

developed and tested through the focus groups.

The community based organizations are critical partners, because they have the trust of the community; they know the language and culture of community; they are flexible and tireless.

Community outreach workers were given two month initial training and then receive weekly supervision and monthly reviews. They are trained in TB knowledge; educational techniques; role plays and evaluation; TST placement, reading, storage and safe practices; referrals and case management.

A wide variety of outreach venues are used, including ESL classes, hair braiding salons, barber shops/domino parlors, soccer clubs, churches and other religious institutions and job training programs. The community based organizations do individual case follow up and use incentives such as tokens, food coupons and movie passes (for adolescents).

As a new initiative they are working with community healers (the first step is to build trust).

Physicians within the community are not necessarily supportive and in some cases have been giving out misinformation.

30,000 people have been educated through the program (over a little more than 4 years). INH completion rate is 90%.

They have identified the high risk population as recent arrivals (many undocumented), no health insurance, no prior contact with health care system, non-English-speaking, communities with high TB incidence, adolescents.

Active TB case finding: 400/100,000

Next steps:

- further evaluation
- model expansion (new communities, new modalities, new venues)
- model dissemination (nationwide, internationally, in writing)

## 9.5 STTARS & Refugee Resettlement in South Australia

Timothy K Haines, Executive Director, Survivors of Torture and Trauma Assistance and Rehabilitation Service, Australia

**Overview & Environment** South Australia is a largely metropolitan State with a total population of 1.4 million. Most migrants and refugees, like most of the population, live in the capital, Adelaide. About 20% of South Australians are foreign-born, of whom a fairly high percentage are refugees.

The Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS) is a non-government organization in South Australia and a member of a loose national coalition of torture/trauma agencies, which comprise the National Forum of Services to Survivors of Torture and Trauma. The National Forum has fought successfully for recognition of torture/trauma by the Commonwealth Government as a significant factor in the mental health of refugees and STTARS is funded by the government through the National Forum.

STTARS is the sole NGO and the only service in South Australia specializing in the treatment of refugee survivors of torture and trauma. The State Government's Migrant Health Service is in charge of primary health care to refugees, as to other migrants in the State, and refers survivors of torture and trauma on to STTARS where appropriate. The State Government funds STTARS, as a State-based service, for important infrastructural needs.

### **Organizational Involvement in Refugee Settlement in SA**

A number of government agencies (of the commonwealth and state governments) as well as non-governmental organizations are involved in refugee settlement. The principal roles of Government is to establish policy and provide funding.

Whilst government funding is highly sought after and highly competitive, it comes with some disadvantages. An assumption of "ownership" threatens NGOs' ability to advocate on behalf of their clients, sometimes against the interests of government. Government funding is often project-specific, which is limiting. Thirdly, the credibility of NGOs in the eyes of their clients can inhere in their perceived independence from Government influence. A solution is to diversify in funding sources to the degree that dependence on one individual provider is diminished. STTARS has already achieved this to some degree in its government funding, which is drawn from three separate portfolios. But the challenge is to diversify beyond government.

### **The Issues Surrounding Refugee Settlement**

Refugees in the settlement problem face economic as well as other problems. When there are economic problems inherent in society, refugees may be virtually unemployable. Government policy seems to be to deny that there is a cost to refugee settlement and to apologize for such costs as prove unavoidable, promising that they will be kept brief and minimal. Where possible the government seems eager to "mainstream" services. J. Jupp has argued that language difficulties are not necessarily at the core of settlement problems and promotes specialized labour programs for refugees. Jupp maintains that refugees should be isolated in policy terms as

a distinct recipient of government attention and their needs not conflated with those of migrants. STTARS supports these points, but recognizes the need to ensure accurate communication with clients in the context of torture and trauma treatment. STTARS works to involve clients in the direction of the agency and promotes the use of adequate, professional interpreting services.

### **Model for Language Communication between Service Provider and Client**

It is often assumed that among language-based strategies, the optimum would be the bilingual/bicultural practitioner. However, the bilingual worker may be of a different class or gender, be perceived as being of high status within the community or be of a different sub-ethnicity.

STTARS promotes the model of a sensitive, experienced practitioner using a qualified interpreter who is (or becomes) familiar with the client. The value of regular use of the interpreter is that trust and rapport can also be established between the interpreter and the client (as well as between the worker and the interpreter), so that there may in effect be a triangular support network established (while always recognising the professional “distance” of the interpreter).

### **Challenges in the delivery of mental health care services to a diverse population**

The answer to some of the challenges seems to lie in strategic alliances between NGOs and between NGOs and government. Success should be viewed in terms of client outcomes.

**Partnership No 1 - GP Network:** STTARS developed a flexible network with the Adelaide Western Division of General Practice, with whom STTARS co-authored a manual for GPs in 1998. This led to the establishment of a viable two-way referral channels with GPs for clients, and GPs have begun to be more aware of the unique needs of torture/trauma survivors.

**Partnership No 2: NESBWEB: Transcultural Mental Health Network SA:** In SA , NESBWEB is an alliance of NGOs and government providers in all fields of mental health service delivery. Through monthly meetings and discussion, all service providers in the mental health arena exchange and compare positions and assistance.

**Partnership No 3 - Case Coordination:** This system was first established to cater for newly-arrived refugees, initially to respond to the imminent arrival of refugees from Bosnia in January 1996. As a hastily cobbled-together amalgam of agencies involved in the early reception and treatment of refugees, it worked well and effectively. STTARS was not included in the initial partnership. Housing quickly became a major issue, at the expense of other concerns.

**Partnership No 4 Operation Kosovo Safe Haven:** Counsellors from both STTARS and the State Government joined forces in addressing some of the psychological needs of the Kosovars. The effectiveness of the intervention is questionable given that the refugees had neither a secure present nor security for the future, necessary preconditions for traditional intervention

**Conclusion** Context determines the needs of our clients (including language, housing, employment but also more fundamental issues of the past, present and future) and context therefore in large measure should drive the response to those needs. Thus any partnership must pay strict attention to the context of its clients and their needs if it is to be successful in meeting

those needs, which will entail involving the clients themselves in the process; and must be clear on and respectful of the role and integrity of any partners in the process.

## **9.6 Challenges in the Delivery of Mental Health Care Services to a Diverse Population**

Dr Harry Minas, Director, Centre for Cultural Studies in Health, University of Melbourne, Australia

Australia has a very diverse population: in various cities the foreign-born make up 20-25% of the population. 40% of residents of Melbourne are foreign-born or have at least one parent that is foreign-born.

### **Services**

- should be determined by the needs of the population
- needs should be jointly determined by users and providers
- community should be involved in all aspects (planning, management, evaluation)
- users (and non-users) should know what services exist, how they can gain access, feel that services are appropriate, and have access to the full range of services.
- external outcome indicators should meet goals of both users and providers.

Studies have shown an enormous range in the rate of use of inpatient and outpatient services. Australian and British-born made the greatest use. Among other populations there is shown to be a substantial and sustained underutilization. There is a need to respond locally, regionally and nationally.

### **Mental health**

Australia as a federal state has division of powers. Until recently mental health was exclusively a state responsibility. In the early 1990s, however, a National Mental Health Strategy was developed. The first plan began in 1992, the second covers 1998-2003 and contains three planks:

1) prevention and promotion; 2) development and fostering of partnership in service reform; 3) quality and effectiveness.

The strategy has made possible a national approach to transcultural health.

The Australian Transcultural Mental Health Network brings together local networks from each state.

### **Collaboration**

Successful collaboration depends on recognizing that everyone has interests — not all of them identical. This cannot be obscured by talking about partnership. The focus should be on what the interests are, the extent to which there is commonality, the means to pursue interests, and recognition of each party's freedom to pursue their own and contradictory interests.

Collaboration involves shifts in power, trust and priority being given to the common goal.

## **9.7 Promotion for Refugee Women's Health in Kenya Camps**

Joyce Riungu, Refugee Services Desk Coordinator, National Council of Churches of Kenya

There are over 200,000 refugees in the Kakuma and Dadaab camps in northern Kenya. Most of these refugees crossed the border between 1991 and 1992. There are about 40,000 urban refugees (mostly pre-1991 arrivals and mostly with full status).

Dadaab has a local community of 10,000 people but houses about 122,000 refugees (92% Somalis, also Ethiopians, Eritreans, Sudanese, Ugandans and Congolese). 49% of the population is female.

Kakuma has a local population of about 20,000 people and houses 81,000 refugees (71% Sudanese, 24% Somalis, and the rest Ethiopians, Eritreans, Ugandans, Rwandans and Burundians).

Services in the camps are provided by a number of agencies. The fragmentation of services is a major challenge as each NGO may have its own policy and agenda (verticalization without integration). This may leave gaps or cause duplication of services.

UNHCR and host government need to set policies related to coordination right from the start. Kenya is only now presenting a 7<sup>th</sup> refugee draft bill to parliament, despite the fact that there have been refugees in Kenya for nearly 30 years.

Coordination is achieved through monthly agency meetings, weekly situation reports and security meetings at camp level. There is a monthly health and nutrition committee/task force which meets centrally. Although there are continuous attempts to coordinate, they seem to work best during disasters.

### **REFUGEE WOMEN'S HEALTH**

Health is one of the first items on the list in emergency situations and continues throughout the period of the refugees' stay in the country of refuge. Issues considered are emergency interventions for the wounded, makeshift delivery services and rehydration and feeding programs. Concerns in relation to reproductive health: immunization services not put in place; STDs treated as any other illnesses (no special services); HIV/AIDS not even thought of; counselling and STD support not available; services for rape victims absent; services for adolescent girls and boys not in place.

Through a special reproductive health project (funded by World Council of Churches) information and education in anatomy and functions of the female and male reproductive organs; dangers of female genital mutilation; prevention and management of STDs and HIV/AIDS; family planning and birth spacing; logistical supports (provision of drugs, family planning methods and laboratory reagents for HIV/STD test (all centred on community involvement and participation).

Reproductive health is defined as the complete state of well-being, physically, mentally and

socially - and not mere absence of disease or infirmity in all matters relating to reproductive system, its functions and process.

The implication is that an individual should be able to have a satisfactory and safe sex life and that they are capable of reproducing, freedom to decide when, where and how often to do so. This involves an ability to enjoy each other's company and also the birth and growth of their children. The woman is the major stakeholder in the matter and needs to be given extra support and chances to enjoy the love and partnership of their spouse during the process of reproduction. Health services provided should therefore pay special attention to women.

To improve women's health in refugee situations, we should focus on the following main areas.

**Safe motherhood** - sex education; antenatal, delivery and postnatal services; child welfare services; post abortal care; family planning education and child spacing services; referral system for obstetric and gynaecological emergencies; provision of emergency post abortal care.

**Sexual and gender-based violence** - education on gender equality and access to health; harmful cultural beliefs and practices and how best they can be changed to support women's health; community involved in gender sensitization and support; formation of anti-violence/anti-rape community groups; use of the law of the land policies to protect women from violence be it sexual, physical or otherwise; counselling and social support services for female victims of violence; provision of emergency contraceptive pills for rape victims.

**Family planning and child spacing** - information and education on the issues; provision of methods of child spacing; provision of affordable and accessible family planning services; protection of both born and unborn children; training and availing of femal health workers.

**STDs and HIV/STD infections** - education and information on the disease presentation and modes of infection transmission; diagnosis and management of STDs; provision of services curative and preventive; provision and free distribution of condoms; education for acceptance and support of people people with AIDS; education for management of PWA (home-based care).

**Economic standards of women** - education for both genders to support the family (sharing of available resources); income generating projects for both men and women (women are often targeted for these, thus increasing their workload); employment and income-generating projects should be encouraged more for men than for women.

**Environmental factors** (most rapes happen outside camps while collecting firewood or water) - provision of security for women when collecting food, water and firewood; protection for women to have free movement which can be through the community groups or the host country security forces; firm measures taken against those causing insecurity; food security should be accorded to women who are most vulnerable but not at the expense of their health.

## **9.8 Community Oral and Dental Health Care Services for Immigrants and Refugees**

Dr. Garry Aslanyan, Department of Social Medicine, Health Policy and Management  
Yerevan State Medical University, Armenia

Dental health is an essential part of general health. The providers of community health care services for immigrant and refugee populations often neglect this fact. These populations are less likely to get required dental care than their native counterparts. After arrival, they have limited access to care because of cultural and language barriers, low awareness of the health system, and lack of financial resources. Policy-makers of governmental and non-governmental sectors should recognize the essential need for oral health services along with screening for tuberculosis, administration of immunizations and provision of mental health services.

The scientific literature contains a number of studies which have addressed the dental health of immigrants and refugees in developed countries such as Canada, the United States, the United Kingdom, Italy, Sweden, Norway, and Denmark. These studies reported on the assessment and analysis of oral health status, caries and periodontal disease prevalence, treatment needs and utilization of dental services. Comparisons were made in some studies between different groups of immigrant and refugee populations as well as with the native population. It was found that many immigrants and refugees originate from countries without immediate access to proper dental care, preventive services, fluoridated water supplies or other sources of fluoride. The results of these investigations demonstrated high caries prevalence, poor oral hygiene and periodontal health, unmet needs for dental treatment and low utilization of dental services.

When compared to native population groups of a similar age, immigrants and refugees had markedly poorer oral status. Also, a correlation was found between better oral health status and time since immigration. Because of increased immigration, developed countries become more multicultural. Refugee populations are no longer homogenous since they come from diverse cultural backgrounds, including the Former Yugoslavia, Poland, Chile, Iran, Vietnam, Pakistan, India, Iraq, Somalia, and Bangladesh and other countries. Studies have shown a significant difference in prevalence of dental diseases, oral health beliefs, determinants of perceived importance and perceived seriousness of oral health and their effect on oral health and frequency of dental visits between different cultural groups.

Large numbers of refugees are a concern for both established and developing economies. Countries of Eastern Europe and the Newly Independent States have been also facing this problem. Increased risk of violence in areas of conflicts leads to the massive exodus of people to other countries. According to UNHCR estimates, refugees in the Caucasus represented 8% of the total population. The movement for reunification of Nagorno-Karabakh with Armenia led to subsequent massacres of Armenians in Azerbaijan. As a result, at least 350,000 Armenians fled Azerbaijan in two years. These people had great difficulty adapting to life because they lost their homes, possessions, and Armenia was ill prepared to accept them. In conditions of socio-economic crisis, the Armenian health care system has a very limited capacity to meet the priority needs of its refugee population. In such circumstances aid from international NGOs is crucial.

Such assistance should be steered into priority programs defined by the government, such as improving access to primary health care services, including primary dental care.

A systematic and comprehensive implementation of oral health promotion and education programs and treatment facilities for these groups is a priority need. A key to success is to make the services culturally acceptable and accessible. This could have an important function in bridging cultural, linguistic and situational barriers, and could be particularly effective in multicultural societies. Special outreach programs conducted by dental health personnel may be an effective means of introducing immigrants to the host country's dental care system. Dental examination of newly arrived refugees may also be recommended. The NGOs providing community health services to these populations should be aware of these factors in order to achieve effective use of resources.

## 10.0 DISCUSSION POINTS

The following are some of the points made in discussion during the workshop:

The role of NGOs in the health field is not always readily accepted by all players. Participants mentioned barriers to be overcome, for example, doctors undermining a TB sensitization program with contradictory advice or what appears to be a protectionist approach from the health care system, reflecting fears that NGOs want to “take over”. Yet, often people at high risk come to NGOs rather than to hospitals.

Funding issues are critical and complex. Without adequate financial support, NGOs are limited in how effectively they can carry out their role. On the other hand, funding also brings challenges to NGOs’ independence and they risk losing their advocacy role.

Often newcomer communities have health professionals, who are qualified in the home country but are denied the right to practise in the new country, because of barriers to access to trades and professions. Some of these professionals end up working as interpreters, which is a waste of their skills. There is always a time lag before a new community begins to have health professionals, as the younger generation goes through school: this is obviously too slow to help with new arrivals. Programs to encourage members of underrepresented communities to train does not necessarily lead to them working within the community.

Interpreting was generally understood to require more than literal translation: cultural interpretation is needed, requiring cultural as well as linguistic skills. Health care providers need training too, beginning with learning to understand their own culture. “Cultural broker” is a term preferred in Edmonton and used in the context of a community-based program for pre- and post-natal care.

High rates of diagnosis of mental health problems raise questions: is it the result of the stress of migration or is there a cultural or political explanation? Schizophrenia for example is diagnosed in the non-Canadian born at significantly higher rates than among the Canadian-born. There may be problems of language, cultural misunderstanding and/or racism.

Collaboration and partnership could be a topic for a further discussion.

## **11.0 PRESENTERS:**

### **Dr. Michael Chan**

#### **Chairperson – Afiya Trust, UK**

Dr Michael Chan is the Chairperson for the Afiya Trust, an NGO dedicated to the study of health care for ethno-racial groups and refugees. It is the only NGO that has a remit for ethno-cultural health and is run by ethno-racial professionals. Dr Chan is a visiting Professor in Ethnic Health at the University of Liverpool. He was Director of the NHS Ethnic Health Unit 1994-97.

### **Timothy K. Haines, Executive Director**

#### **Survivors of Torture & Trauma Assistance and Rehabilitation Services (STTARS), Australia**

Tim Haines is the Executive Director of Survivors of Torture & Trauma Assistance and Rehabilitation Services (STTARS), a member of Australia's National Forum for Services to Survivors of Torture and Trauma.

### **Dr Neil Heywood**

#### **Director - Selection Branch, Immigration Health Policy Division, Canada**

Dr Neil Heywood is a senior policy maker for the Canadian government. He has both a national and international perspective on community health care services especially related to immigrant and refugee issues.

### **Joyce N. Riungu**

#### **Refugees Desk Co-ordinator - The National Council of Churches of Kenya**

Joyce N. Riungu works at the Refugee Desk of the National Council of Churches of Kenya, in which capacity she is involved in health issues affecting refugees in Kenya, with a special focus on the health needs of refugee women.

### **Dr Garry Aslanyan**

#### **Assistant Professor - Department of Social Medicine, Health Policy and Management, Yerevan State Medical University**

Dr Garry Aslanyan is a dentist and has a Master's degree in Public Health. The topic of his Master's thesis was an evaluation of a health education program for pregnant women in Armenia, including oral and dental health education. He is currently working on his Ph.D. dissertation that is focussing on health policy reforms in transitional economies of Central and Eastern Europe and their impact on health care services.

### **Dr. Francesca Gany**

#### **Director - New York Task Force on Immigration Health, New York University School of Medicine**

The New York Task Force on Immigration Health (NYTFIH) bridges immigrant and refugee communities and the health care system. NYTFIH is a network of health care providers, health care administrators, social scientists, researchers, and community members which facilitates the delivery of epidemiologically informed and culturally and linguistically sensitive health services.

**Associate Professor Harry Minas**

**Director, Centre for Cultural Studies in Health, University of Melbourne**

The main area of Professor Harry Minas' work is in mental health of immigrants and mental health services for immigrants.

**Bernarda Lo Wong, Executive Director**

**Chinese American Service League, Inc., Chicago, USA**

Chinese American Services League (CASL) is an NGO that provides a variety of culturally and linguistically appropriate community services for Chinese immigrants and refugees in Chicago. Bernada Lo Wong is a founder and the Executive Director of CASL. She is also an active participant in community and public affairs.

**Discussant**

Laurel Borisenko, Executive Director

Mennonite Centre for Newcomers and Vice-President, Canadian Council for Refugees  
Edmonton, Alberta, Canada

**Co-organizers:**

Wendy Kwong

Partnership Advisory Council

Joint Centre of Excellence in Research on Immigration & Settlement (CERIS)

Toronto Public Health, Planning and Policy Section

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Janet Dench, Executive Director

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