

Calculated Kindness? The Voices of Women Refugee Claimants: Accessing Pre- and Postnatal Health Care Services in Toronto, Ontario

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Résumé de l'article

Au Canada, les demandeurs d'asile reçoivent un statut d'immigration temporaire, ce qui rend difficile l'accès aux services de santé. Alors que le gouvernement fédéral détermine les droits accordés aux demandeurs d'asile, les provinces sont responsables de la prestation des services de soins de santé. Dans le cadre de cette étude qualitative, des entretiens semi-structurés approfondis ont été menés auprès de huit personnes ayant demandé le statut de réfugié et de six prestataires de services à Toronto, en Ontario. Un cadre théorique intersectionnel a été employé pour examiner les expériences des femmes demandant le statut de réfugié et leur accès difficile et souvent incomplet aux services de soins de santé prénataux et postnataux. Les résultats ont démontré que la prestation des services de soins de santé en Ontario engendrait des obstacles à l'accès et une sous-utilisation des services résultant de l'intersection entre la couverture médicale, le statut migratoire, le genre, la classe sociale et la discrimination.

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Calculated Kindness? The Voices of Women Refugee Claimants: Accessing Pre- and Postnatal Health Care Services in Toronto, Ontario

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ABSTRACT

In Canada, refugee claimants are given temporary immigration status, making access to health care services challenging. While the federal government determines the entitlements granted to refugee claimants, provinces are responsible for delivering health care services. This qualitative study conducted in-depth semi-structured interviews with eight refugee claimants and six service providers in Toronto, Ontario. An intersectional theoretical framework was employed to examine the experiences of women refugee claimants and their complicated and often incomplete access to prenatal and postnatal health care services. Findings revealed that delivery of health care services in Ontario created barriers to access and under-utilization of services resulting from intersections of health coverage, immigration status, gender, class, and discrimination.

KEYWORDS

women refugee claimants; prenatal care; postnatal care; health care access

RÉSUMÉ

Au Canada, les demandeurs d'asile reçoivent un statut d'immigration temporaire, ce qui rend difficile l'accès aux services de santé. Alors que le gouvernement fédéral détermine les droits accordés aux demandeurs d'asile, les provinces sont responsables de la prestation des services de soins de santé. Dans le cadre de cette étude qualitative, des entretiens semi-structurés approfondis ont été menés auprès de huit personnes ayant demandé le statut de réfugié et de six prestataires de services à Toronto, en Ontario. Un cadre théorique intersectionnel a été employé pour examiner les expériences des femmes demandant le statut de réfugié et leur accès difficile et souvent incomplet aux services de soins de santé prénataux et postnataux. Les résultats ont démontré que la prestation des services de soins de santé en Ontario engendrait des obstacles à l'accès et une sous-utilisation des services résultant de l'intersection entre la couverture médicale, le statut migratoire, le genre, la classe sociale et la discrimination.

INTRODUCTION

In Canada, asylum seekers pursuing in-land claims for refugee status have increased due to global conflicts and the inability to address these conflicts (Balintec, 2023). Some of the asylum seekers are women of childbearing age who arrive while pregnant or experience pregnancy during their resettlement period (Khanlou et al., 2017; Zivot et al.,

2020). Seeking asylum and claiming refugee status is a long, arduous journey documented in numerous studies (e.g., Brun & Fabos, 2015; Dempsey, 2022; Stavropoulou, 2019). However, undergoing this journey while pregnant adds further complexities that are less explored. A close study of women refugees in this situation reveals much about gendered access to health care in a large urban setting in Canada.

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Refugee access to health care has always been a contentious issue. We often hear in the media about refugee claimants who are not eligible for health care in Canada (CBC News, 2012, 2013; CTVNews.ca Staff, 2013). The issue was memorably illustrated in the protests following the 2012 government cuts to refugee health care, which led to the subsequent reinstatement of services in 2014. Although the story of refugees being denied access to health care is nothing new, the health care delivery landscape post-COVID-19 pandemic has added urgency to the situation.

PURPOSE OF THE STUDY

This article draws on the author's dissertation (Gateri, 2019), which examined the access barriers to reproductive health care experienced by refugee women claimants in Toronto. The main objective of this study is to continue this work by exploring the complex intersecting barriers to service access from the perspectives of eight women refugee claimants and six service providers.

This study contributes to refugee and social work scholarship by providing unique insights into the impacts of structural inequities in Canada's health care system.

LITERATURE REVIEW

Previous Canadian studies have documented that refugee claimants and resettled refugees experience systemic barriers to health care access (Campbell et al., 2014; Kuile et al., 2007; McKeary & Newbold, 2010; Merry et al., 2011). Despite the well-documented medical and psychosocial needs of people in these groups (Beiser et al., 2001), studies by McKeary and Newbold (2010) and Merry et al. (2011) found that some health care providers are unwilling to accept refugees even when they are accepting new patients. Refugee claimants are seen as "challenging due to

complex health needs, linguistic barriers, and complicated insurance coverage that can delay payment for services delivered" (McKeary & Newbold, 2010, p. 535). McKeary and Newbold noted that the Interim Federal Health Program (IFHP) is challenging to navigate, and many general practitioners turn refugee claimants away to avoid dealing with bureaucracy, payment delays, pre-approval processes for some procedures, and lower financial compensation. This can be seen as institutionally reinforced discrimination as health care providers are deterred from serving patients who may incur extra costs in terms of time and labour.

Similar studies in Canada (Merry et al., 2011; Simich et al., 2007) found that health care providers are often confused about IFHP coverage and reimbursement, leading eligible refugee claimants to be refused care or charged fees. Studies in Britain and the Netherlands demonstrated that women refugees tend to present very late in their pregnancies for prenatal care due to fears that their uncertain immigration status and legal restrictions will affect access to health care. This is particularly true for failed refugee claimants without health insurance coverage (Ascoly et al., 2001; Gaudion et al., 2006). Other Canadian studies (Khanlou et al., 2017; Wilson-Mitchell & Rummens, 2013) found that many asylum-seeking women receive less than adequate or no prenatal care at all because they do not have health insurance.

Studies have shown that refugee women avoid reproductive health care services due to experiencing prejudice and racial stereotyping by health care workers:

In a Canadian study with 432 Somali women refugees (individuals who had applied for temporary residence) and immigrants (individuals who had received permanent residence), 87.5% reported hurtful comments made ... related to their having undergone female genital mutilation. ... They reported verbal expressions of shock and disgust

by healthcare providers, which they perceived as a lack of respect. In some instances, colleagues were invited by providers to look at the women's private parts without first seeking their permission, which was perceived as a lack of respect for the woman and [her privacy].

(Chalmers & Hashi, 2000, p. 232)

Similar studies conducted in the UK also found that refugee women often associate mainstream maternity services with racism, racial stereotyping, and a lack of sympathy, which impacted their participation in pre- and postnatal services (Bulman & McCourt, 2002; McLeish, 2002). These studies demonstrate some barriers women refugees face to equitable health care access.

A study conducted by Spitzer (2004) in Canada with South Asian and Vietnamese immigrants and refugee women explored the broader systemic and institutional factors that shape the views and behaviours of health care providers. The study showed that health care reform and cutbacks, stemming from Canada's public services' adaptation to neoliberal market forces, have resulted in increased workloads and staff and supply shortages, which in turn have led to a tendency in nurses to ignore patients assumed to be problematic and costlier in terms of time and energy. Patients who were visible minorities were seen as problematic due to linguistic and cultural barriers (Spitzer, 2004). Thus, health care restructuring may have particularly adverse effects on women refugees and refugee claimants, especially those without health care coverage.

The studies reviewed tended to combine immigrant and refugee populations, failing to distinguish between the two groups; however, given the complex intersecting barriers to health care access during settlement and the differences in health care provision through the IFHP, refugee claimants are a different population from immigrants. Therefore, this study contributes to refugee

and social work scholarship by providing unique insights into the impacts of structural inequities in the context of Canada's health care system. It could also inform health professionals who care for pregnant refugee claimant women. This information is timely, given Canada's ongoing influx of refugee claimants.

THEORETICAL UNDERPINNING

This study draws on an intersectional conceptual framework to explore how social identities of race, class, gender, and immigration intersect and complicate the health care access experiences of women refugee claimants. Crenshaw (1989) coined the term **intersectionality** to investigate systems of oppression and the social constructions of race, class, and gender (Collins, 1990). This understanding of intersectionality helped to better integrate gender, race, class, and other identities into this research, as these social identities are socially constructed in the lives of women refugee claimants. This study showed that when participants' multiple intersecting social identities at the micro level (e.g., race, gender, refugee status) intersected with macro-level structural factors (e.g., policies, class, racism), their access to health care services was impacted.

Furthermore, women refugee claimants' experiences with pre- and postnatal health care services were captured in this study by considering the interlocking nature of oppressive systems and the intersections of gender, class, immigration and health policies, and discrimination. This is rooted in the work of Hankivsky and Christoffersen (2008), who asserted that this practice provides an understanding of

what is created and experienced at the intersection of two or more axes of oppression [e.g., immigration status, class, gender, and race] on the basis that it is precisely at the intersection that a

new status is more than simply the sum of its parts.
(p. 275)

Additionally, economic opportunities and resources (i.e., employment, income) affected women refugee claimants' engagement with health care services—particularly those women without health coverage and financial or family support to pay for their medical bills. This study provides the impetus for investigating the experiences of women refugee claimants and their access to pre- and postnatal health services at the intersections of these multiple statuses.

METHODS

Guiding Questions

To understand the experiences of women refugee claimants and their access to pre- and postnatal services in Canada's health care system, the following questions guided the study:

1. How do women refugee claimants engage with pre- and postnatal care?
2. What factors influence these women's use of pre- and postnatal care services?
3. What are these women's experiences with the health care system in general, and how does this relate to their different identities based on gender, class, and immigration status?

Study Design and Setting

This qualitative study was designed to situate women refugee claimants' experiences with health care access in their everyday lives as shaped by their immigration status and the processes of relocation and settlement. Purposive and snowball sampling was used to recruit participants in two community health centres (CHCs) and refugee shelters that provide services to refugee populations. These CHCs and refugee shelters are located in Toronto, Ontario; I cannot disclose their

names to protect the participants and retain anonymity for the organizations. I started recruiting service providers from CHCs and refugee shelters in January 2017 because of their familiarity and trust with women refugee claimants. These providers helped with recruiting the women who participated in the study. All participants were asked to suggest other potential participants to reduce bias and expand the study's reach. The interviews were conducted from March to July 2017. The Research Ethics Board of York University granted ethics approval.

Study Participants: Women Refugee Claimants

The study sample included eight women refugee claimants and six service providers. The women refugee claimants were from diverse countries of origin and household sizes and had differing migration statuses. Each participant had a Canadian-born child between one and two years old; one was pregnant with her second child. All the women participated in both pre- and postnatal care. Five women had failed their refugee claim hearing with the Immigration and Refugee Board (IRB) and were appealing. [Table 1](#) provides the women refugee claimants' demographic characteristics. Also see [Appendix A](#) for interview questions asked of women refugee claimants.

Study Participants: Service Providers

The service providers interviewed were selected because they had frontline professional experience working with women refugees and refugee claimants. The providers who participated in the study included two nurses, three social workers, and one administrative assistant for the prenatal and postnatal program in a CHC. All providers were women and had between 2 and 18 years of professional experience working

Table 1*Demographic Characteristics of Participants: Women Refugee Claimants*

Participant identifier	Age range	Country of origin	Immigration status	Number of Canadian-born children
R1	26–30	Nigeria	Appealing	1
R2	26–30	Nigeria	Refugee claimant	1
R3	26–30	Nigeria	Refugee claimant	2
R4	31–35	Cameroon	Appealing	1
R5	21–25	St. Vincent	Appealing	1
R6	21–25	Nigeria	Refugee claimant	2
R7	41–45	Antigua	Appealing	1
R8	31–35	Nigeria	Appealing	1

with refugee populations. Two spoke a second language, and the others spoke only English. [Table 2](#) shows the demographic characteristics of the service providers. Also see [Appendix B](#) for interview questions asked of service providers.

Data Collection

All interviews were conducted at a place chosen by the participant. Before the interviews, I emailed all the participants the interview question guide and consent form. I obtained signed consent and protected participants' anonymity by assigning an alphanumeric identifier (R1 for the first interview with female refugee claimants and SP1 for the first interview with service providers, etc.). The semi-structured interview guide mainly used open-ended questions to generate ideas and understand the women refugee claimants' social reality in their own words and from the service providers' perspectives. Interview questions were developed under two broad themes related to pre- and postnatal care: (a) health care access and use or lack of health care services and (b) immigration.

The health care providers I interviewed were very well informed about access to health care and the general barriers that women refugee claimants encounter during

their settlement in Canada. They provided detailed responses to the questions in the interview guide. The interviews lasted an average of 1.5 hours each and were audio-recorded with participants' permission; four participants refused to be recorded. Participants who refused to be recorded were given the choice to ask me to stop taking notes at any point during our conversation if they felt the need to do so.

Data Analysis

Thematic analysis was used to analyze data, following [Braun and Clarke's \(2006, p. 87\)](#) approach: (a) familiarization of the data through transcribing, reading, and rereading; (b) producing initial codes; (c) searching for the themes in the codes; (d) reviewing and making any adaptations to themes and related data; (e) naming and defining themes into easily understood concepts; and (f) reporting data. I coded the data manually and with NVivo software, initially using a deductive approach to identify data relevant to the research questions. This step was followed by an inductive, latent theme identification approach to explore participants' experiences with the health care system, and it related to the refugees' identities, such as gender, class, and immigration status. This

Table 2

Demographic Characteristics of Participants: Service Providers

Number of participants	Professional background	Years of experience	Type of organization	Racial identity
1	SP1: Nurse	8	Community health centre	White
1	SP2: Nurse	7	Community health centre	Spanish
1	SP3: Social worker	18	Refugee shelter	Black (African)
1	SP4: Social worker	2	Refugee shelter	White
1	SP5: Administrative assistant	5	Community health centre	White
1	SP6: Social Worker	6	Community health centre	Black (Canadian)

approach allowed me to form themes and consider triangulation between the two participant groups (women refugees and service providers).

Rigour and Trustworthiness

Lincoln and Guba's (1985) criteria were used for data collection, analysis, and findings to ensure and establish rigour of data. For transparency, the study results are demonstrated via rich example quotations from raw data that reflected the participants' experiences (Lincoln & Guba, 1985, p. 290). The credibility criteria were met by audio recording during data collection, followed by verbatim transcription to avoid any bias. Furthermore, when I conducted the interviews, I wrote my field notes and checked with the interview guide if additional probing questions arose.

The confirmability criterion was completed by checking the codes with a colleague during the development stage. As a researcher who identifies as a Black woman and an immigrant with lived and work experience in health care settings in Toronto, I coded all the interviews while a colleague reviewed the codes. As suggested by Lincoln and Guba (1985), "transferability was established by thick, vivid explanations that captured the [participants'] experiences" (p. 316). However, I shared the concern raised by Kirsch

(1999), "can researchers understand and represent the experiences of others without misrepresenting, misappropriating, or distorting their realities?" (p. 10), because I maintained the sole power of representing and mapping the research design and analyses, as well as of writing this paper. My personal and social locations have shaped the analyses, research objectives and questions, and relevant theories and literature. However, I have endeavoured to bring the women's and service providers' experiences to the centre of the analysis and ground the analyses in their diverse perspectives and voices. I have also presented the research participants' diverse perspectives, experiences, and voices by maximizing the use of examples, quotations, and excerpts from their narratives in the paper.

To assure data adequacy, I sought the participants' input on their interviews. When I finished transcribing the interviews, I contacted all the women who participated in the study and asked if they would like a copy of their transcript and an opportunity to provide corrections or other feedback. One participant responded; I emailed her a copy of her transcript. She read the transcript and provided input. I also emailed transcripts to the service providers and asked them to provide their input. I did not receive any service

providers' input. Participants were not asked to collaborate on data analysis or provide any input or feedback on interpreting the data because it did not seem feasible given time and other constraints.

Steps were also taken to ensure ethical conduct of the study, which is critical in qualitative research (Haverkamp, 2005, as cited in Okoro et al., 2022). Adequate attention was given to privacy and confidentiality, informed consent, potential for harm, and competence. All interviews were conducted in spaces that afforded privacy for participants. Informed consent was duly attained from each participant. All audio recordings and transcripts were stored in a secure device, which was only accessible by the researcher with a password. All transcripts were de-identified prior to data analysis, and only the researcher had access to them. The interview guides also reflected inquiry that aimed for balance with questions that sought to elicit responses from women refugees and service providers (Appendices A and B).

RESULTS

Thematic analysis of participants' interview data identified the following themes pertinent to the research questions:

1. Lack of health coverage
2. Discrimination in the following areas:
 - Staff acting as gatekeepers
 - Refusal of care
 - IFHP confusion

Lack of Health Coverage

When participants were asked about their experiences with the health care system in general and with pre- and postnatal services in particular, many spoke about how some women without health coverage presented late for care, neglected care, and had trouble

accessing care. Service provider SP1, who worked in a CHC, shared the following:

Some women refugee claimants we serve tend to present late for pregnancy care. We see women coming for care in their third trimester or just about to give birth. It is challenging for us to get all the blood work and tests done before delivery. Finding an obstetrician-gynecologist to see them and hospitals where they will deliver is also challenging.

Additionally, lack of health coverage due to immigration status meant some of the women missed screening opportunities, including genetic and ultrasound screening and postnatal group programs for health promotion. R3 described her health condition and delivery without prenatal care:

When I arrived in Canada, I lived in the community. I was pregnant and did not access prenatal care. I thought I could not because I did not have health care coverage. I went to a program provided by public health in the community because I was not feeling well, and I was 34 weeks pregnant. I spoke to the nurse about my condition, and she advised me to go to a walk-in clinic. The doctor told me my blood pressure was high and I should go to the hospital for an emergency. When I arrived at the hospital, I received diligent care, although I had to sign so many papers because I did not have health coverage. The health care providers were [supportive]. They tried to lower my blood pressure, but the solution was to deliver my baby through a C-section.

This participant's baby was born at 34 weeks, prior to a full-term pregnancy. Furthermore, as reported in the participant's narrative, she did not access prenatal care at all due to not having health coverage.

At the time of this study, the in-land refugee claims process was long and complicated. It required applicants to complete their claim application forms, gather relevant documents, and then take this paperwork in person to an Immigration, Refugees and Citizenship Canada (IRCC) office. Then, they would attend an eligibility interview with an immigration officer to assess whether

their refugee claim was eligible for referral to the Refugee Protection Division of the Immigration and Refugee Board. This process could take between 30 and 45 days or even longer, and refugee claimants were without health coverage during this waiting period. During the interview, one participant (R2) who arrived in Canada four months pregnant shared her experiences:

[If] we have not gone for our claim hearing, then we do not have status and the refugee identity. We cannot go to the hospital. We have submitted everything; we are waiting for the IRB hearing. It is very serious when you do not have status if your health condition gets worse.

This participant was in the midst of the screening process and consequently did not have access to health care. The time it takes for a refugee claimant's status to be established impacts women refugee claimants who arrive in Canada pregnant and in need of prenatal care. Furthermore, refugee claimants remain in limbo until the IRB determines their hearing.

Two service providers working in a refugee shelter explained that they refer pregnant refugee women without health coverage to CHCs; however, sometimes the CHCs cannot meet the needs of the refugee population, particularly in situations where they need emergency services. It also becomes challenging when pregnant women without health coverage access hospitals for emergency services. SP4 reported:

I find CHCs can provide services to our clients without health coverage, especially to pregnant women. However, we have had some issues with the hospital emergency visits when our clients waiting for their eligibility interview receive services. The hospital bills them for these services. We have had clients who could not pay their bills because of the lack of finances. So, this is very serious for clients without financial support.

CHCs provide primary health care to refugees free of cost; however, the centres do

not have emergency services. Based on my experience as a service provider in a CHC, in cases where clients needed emergency services, providers advocate by calling the hospital and negotiating for their emergency visit bill to be covered once the IFHP is issued. Sometimes these negotiations fail, and clients are billed for their hospital visits even when service providers have advocated on their behalf. This may disproportionately affect pregnant refugee women, who are more likely to need immediate health care services upon arrival in Canada.

Further, refugee claimants without health coverage are required to pay for their hospital stay and other services that CHCs do not cover. For example, pregnant refugee claimants without health coverage are expected to pay for their hospital stay during delivery; fees can range from \$1,100 to \$2,500 per night. R6 was hospitalized when she was pregnant, and she shared her experiences:

When I arrived in Canada, I was referred to a CHC, where I received my first prenatal care. Then I was told I was pregnant with twins. I was also given weekly appointments since I was almost seven months pregnant, and I needed follow-up with my medical tests. However, one night, I was unwell and reported to the shelter staff; she told me I needed to go to the hospital emergency. She called a taxicab that drove me to St. Joseph's Hospital since I had seen an obstetrician-gynecologist there. I am glad my babies were delivered safely. However, I was asked to sign some papers related to the payment of my hospital stay and services. When I was discharged from the hospital, bills were mailed to me in the shelter where I was living.

Health care access for this group of refugees can be very costly; some pregnant women delay getting care they need because of the financial burden involved.

Discrimination

When participants were asked if they had experienced unpleasantness or challenges

with access to health care or with health care providers, 9 of 14 participants (5 women refugee claimants and 4 service providers) replied they had experienced or supported friends or clients who had faced discrimination when accessing health care services. The reported incidents were categorized as follows: staff acting as gatekeepers, refusal of care, and IFHP confusion.

Staff as Gatekeepers

The current study found that incidents of discrimination were sometimes exacerbated by administrative staff acting as gatekeepers to the system. Participants who had accessed emergency services at a hospital when pregnant described being asked for their health coverage up front even though they were unwell. They felt that the hospital administrative staff discriminated against them based on their health coverage or ability to pay. Staff were more concerned about whether the participants had health coverage or could make payments than about their health. The initial screening question posed by the staff—"Can I have your health card?"—determined whether they could see a doctor. Participants felt that the screening process could endanger the life of a pregnant woman or her baby because it could delay access to urgent health care services. Participants also noted other forms of discriminatory treatment by administrative staff. R7, for example, spoke about the discriminatory actions she had experienced accessing care:

I go to a CHC, and sometimes the shouting from the front reception staff is embarrassing. I am constantly asked, "Can I have your health card?" Sometimes, they are very rude; they ask this question in the reception area, and people waiting can hear them shouting at me. It is not very comfortable, especially when you have children.

She felt that these incidents also made her children uncomfortable. She further said that she moved here to make a better life for her-

self and her family, and although she did not have health coverage, she did not deserve to be discriminated against. However, she mentioned that other health care providers were accommodating and respectful of her needs. She accessed the services and programs at the CHC (e.g., counselling and health care) without discrimination.

Refusal of Care

The study found that women who were covered by IFHP or did not have any coverage were dismissed or neglected and had trouble accessing care. R1, a refugee claimant, noted,

I have noticed that when we refugee women visit the hospital when we are not well, or our babies [are not well], the health care providers dismiss our concerns as if they are not expected. It is as if they wait for our conditions to get worse for treatment to be provided.

When I asked R1 if the hospital or health care providers had dismissed her, she said this had not happened to her; however, her friend, a refugee claimant, was dismissed by a health care provider at the hospital when her baby was sick. My participant had been with her friend when the incident happened:

When we arrived at the hospital, the nurse assessed the baby and asked my friend to go home and observe the baby for a few days. If he does not get well, she should bring him back. My friend was distraught since her baby had been sick for four days, and she was noticing he was getting worse. She started crying and explained to the nurse that her baby's health condition was getting worse. When the health care providers saw she was crying, the baby was attended to immediately by a nurse and the doctor, and the IV was administered because he was dehydrated.

She thought the initial dismissal occurred because health care providers and hospitals did not want to deal with refugees' health coverage. Other service providers working in CHCs reported that some refugee claimants had been denied care or neglected because

they did not have IFHP or OHIP (Ontario Health Insurance Plan) coverage. SP6, a social worker in a CHC, shared her experiences:

Some refugee claimants had been denied care or neglected because they did not have OHIP. Due to the lack of proper communication between the hospital administrative staff (specifically the uninsured patients' liaison) and CHCs, CHCs provide letters to all uninsured and refugee claimant patients to facilitate access to services outside the centre.

Sometimes, clients who had unpaid hospital bills after delivery were told they could only receive services once the bills were paid. However, once social workers were involved, they advocated for their clients to work on a payment plan with the hospital's finance department so the client could receive services.

Interestingly, service providers working in CHCs agreed with SP3, who commented that access to health care for refugee claimants can be complex and sometimes confusing. The service providers noted other ways that women refugee claimants had been denied care that could be viewed as discriminatory practices against pregnant refugee claimants at the hospital during labour. For example, SP1, SP2, and SP6, all service providers in a CHC, shared the following concerns:

There have been occasions when financial staff walked into the labour ward and prevented a client giving birth from receiving the care that she needed because of an unpaid bill. Service providers also expressed concern that hospitals were sending clients' bills to collection agencies immediately instead of contacting the CHC or other providers to work out a payment plan with the client.

Refugee claimants being refused health care services because of the type or lack of coverage was viewed by the service providers in the study as discriminatory and a significant obstacle to health care access outside the CHCs, which sometimes compromised the women's health.

IFHP Confusion

According to Winn et al. (2018),

the refugee landscape in Canada has undergone changes over the last several years, which has resulted in additional [strain] on the health-care system, magnifying existing problems and requiring care providers to go to exceptional lengths to ensure the quality of care. (p. 2)

All service providers in the study noted that IFHP cuts to refugee health care were confusing in regard to what should be charged and to whom:

The confusion may have been caused by some health care providers' lack of understanding of the refugee health coverage under the IFHP and the billing process. Because of changes made to the IFHP in 2012, many health care providers are often uncertain about what is covered and how to complete paperwork related to IFHP billing. Some health care providers are not familiar with the IFHP and may refuse to accept these women as their patients.

These funding cuts also led to refugee claimants with health coverage being billed by hospitals. R8, a pregnant refugee claimant, explained that she was asked to pay for services despite having health coverage:

The staff did not understand my IFHP health coverage; they insisted I should pay for blood work. I was embarrassed when asked for payment because I was in line with others who heard the conversation when I was asked to pay for services.

During this period, service providers working in CHCs described challenges in understanding the ongoing policy changes around health care coverage for refugees as they found it complicated and confusing. In addition, neither government agencies nor the online federal health care portal were updated when policies changed.

DISCUSSION

The results of this study provide valuable insights into pre- and postnatal health care ser-

vices in Toronto, Canada, and how they affect the well-being of women refugee claimants. In particular, they highlight how the intersection of systemic barriers affects this group of women regarding their access to health care services and their overall well-being. The results corroborate many findings from past literature while adding novel contributions to the evidence base in the Canadian context and critical recommendations for improved pre- and postnatal health care for this population.

Health Coverage and Migration Status

A key finding of this study is that health coverage intersected with migration status for women refugees and affected their access to pre- and postnatal health care services. Some study participants described arriving in Canada while pregnant and finding that they were unable to receive adequate pre- and postnatal services because of the lack of health coverage. Access to health care services was further delayed by the in-land refugee process, which requires screening to determine the eligibility of their claims. During this process, refugee claimants did not have health coverage, illustrated by two participants who consequently did not have access to health care. The lack of health coverage often resulted in refugee claimants being neglected and denied access to health care services. Furthermore, women with failed asylum claims were afraid to access health services because of their immigration status. These findings are consistent with those of previous studies in Canada (Khanlou et al., 2017; Mumtaz et al., 2014; Wilson-Mitchell & Rummens, 2013) that have shown that many asylum-seeking women receive less than adequate prenatal care or no prenatal care at all because they do not have health coverage, which increases

complications and poor birth outcomes. The study findings confirm that nothing has improved in the health care delivery in Canada to help pregnant refugee claimants access quality health care.

Gender

The study findings also indicate that when gender intersected with refugee identity and migration status, health care became limited for pregnant claimants. Intersectionality scholars [Samuels and Ross-Sheriff \(2008\)](#) “understand that each woman’s experience is unique and affected by changes in the context that shift the meaning of various social identities to give rise to new ones” (p. 6). This is particularly relevant to pregnant women refugee claimants since their health appeared to be compromised not only by their gender but also by their new identities—of refugee claimants and pregnant persons. Research has shown that the impositions of these identities acted as pathways by which systems of inequalities place women “at a disadvantage and, in turn, influence their health outcomes” ([Weber & Parra-Medina, 2003](#), p. 204). Women who were both pregnant and refugee claimants were significantly impacted by the barriers that limited access to health care services. This example is illustrated in the work of [Heslehurst and colleagues \(2018\)](#), who connected adverse pregnancy outcomes in women refugees to their migration status.

Class

The study findings further suggest that class intersected with a lack of health coverage and migration status. Women refugee participants had a lower socio-economic status because they were unemployed; however, they were still required to pay hospital fees. The study participants’ narratives describe situations where they were denied access or

required to pay for health care services. These narratives reflect the results of [McKeary and Newbold \(2010\)](#), who demonstrated the complexities and challenges of health coverage for refugees and the impacts on their access to health care and outcomes. According to the participants' narratives, some women were not covered by the IFHP since they had yet to complete the screening process. Therefore, they were expected to pay out of pocket for health care services. The lack of health coverage during the application process created a vicious circle during which some refugees used emergency services for primary care and then were unable to pay the resulting bills. In 2017, this gap was finally addressed as the IRCC changed the IFHP ([Young, 2017](#)).

Discrimination

In addition, study findings demonstrate that refugee women experience discrimination when accessing health care. [Willey et al. \(2022\)](#) asserted that people seeking asylum experience discriminatory attitudes, behaviours, and policies in the health care system, all of which can contribute to poor health outcomes and health inequities. The study participants reported discrimination when accessing health care services; this included staff acting as gatekeepers, refusal of care, and IFHP confusion. These acts of discrimination intersected with lack of health coverage and migration status; however, they may also have been influenced by the refugees' racial identities. An intersectional lens recognizes the subtle forms of discrimination that Black women are subjected to, which include microaggressions and exclusion due to the intersection of race, ethnicity, and gender; furthermore, this discrimination can be both interpersonal and systemic ([Rosenthal & Lobel, 2020](#)). Access to health care was further complicated by structural

discrimination. The intersections of structural discrimination were evident when service providers disrespected women refugee claimants because of their immigration status, as well as in the form of refusal of care based on the type or lack of health coverage. Structural discrimination also intersected with IFHP cuts, which maintained barriers to health care access for women refugee claimants.

Individual racist attitudes and discriminatory policies can have profound implications for pregnant women refugee claimants who may use insufficient health care services or be at risk for inappropriate treatment and complications. [Harris and Zuberi \(2015\)](#), among others, suggested cuts to IFHP funding led pregnant women and children to become more at risk. Others flagged the way funding cuts led to confusion among health care professionals and increased difficulties in navigating the system ([Ruiz-Casares et al., 2016](#); [Webster, 2015](#)). Despite the Liberal Party changes in policy that restored the IFHP after winning the federal election in 2015, the rapidly increasing number of refugees in Canada has only increased strains on the health care system. [Raphael \(2011\)](#) suggested that the Canadian approach to health care provision for this group

is consistent with other Liberal welfare states (e.g., Australia and the United Kingdom) in that the government is outwardly committed to providing the fundamental prerequisites for health. [However, it] fails to match that commitment fully with actual policy and budgetary support. (p. 99)

Raphael further suggested that "to ensure equity in health care for all ... support for vulnerable groups must be made available" (p. 109)—in Canada, this includes support for refugees.

It is essential to acknowledge that the service providers in this study are in positions of power compared with the refugee claimants and work as part of systems (e.g., CHCs and

shelters). However, based on the participants' narratives, these service providers were not involved in acts of discrimination towards women refugee claimants. In some cases, they acted as advocates (especially those working in CHCs) for their refugee clients to ensure they had access to hospital health care services. Furthermore, the participants (social workers) working in refugee shelters provided information to asylum seekers and sometimes directly advocated on behalf of their clients to help them access health care services. These service providers also worked with institutions (CHCs and refugee shelters) trusted by the refugee populations.

Limitations

The small sample size is a limitation of this study that affects interpretation of the findings. However, the study participants were quite diverse regarding age, immigration status, and number of Canadian-born children. There were also commonalities as all were Black women: two women from the Caribbean and six women from Africa (one from Cameroon and five from Nigeria). The significant number of Nigerians in the sample can be explained by statistics demonstrating that Nigeria has been among the top five countries with the highest number of asylum claimants ([Statistics Canada, 2019](#)). This fact may have affected participation numbers in the sample. The over-representation of African women does not reflect the experiences of all refugee claimants or all African women but only those who participated in this study.

Locating women needing help accessing services in CHCs or settlement agencies was also challenging. Another limitation of the study was that it did not include a diverse sample of English-speaking women and those who did not speak English. This discrepancy was due to the lack of funds to pay

interpreters to help in the interviewing and transcribing stages.

Recommendations

With the study participants, we developed the following recommendations to improve health care access for refugees in Canada in the areas of practice, policy, and research.

Practice

Women refugee claimants' access to pre- and postnatal services was related to their overall access to health care, especially to the quality of primary care they received. Participants unanimously suggested the need to open clinics in refugee shelters to make health care services accessible to female refugee claimants and to provide information about pre- and postnatal care in different languages. They also recommended that primary care providers inform and educate women, especially newly arrived refugee claimants, about the importance of these services. In the study, women often received this information only if they accessed a CHC, where they were provided with a wide range of supports, including settlement, health information, primary health care, and referrals to health care providers at hospitals. Having access to primary health care can also be a significant source of support for women refugee claimants who have limited knowledge about reproductive health care and other health care services in Canada.

Participants also suggested that there is a need for providers in the health care system to understand refugee claimants' IFHP health coverage. This need could be met by educating health care providers and administrative staff who work in hospitals and CHCs about the refugee determination process and the eligibility to apply for provincial health care coverage. This information may improve claimants' access to appropriate

care and minimize financial stress when they do not yet have coverage and are sometimes required to pay for health care services.

Policy

This study emphasizes the importance of promptly communicating policy changes. Disseminating health policy changes to service providers and updating websites could reduce widespread confusion or outdated information about health care eligibility under the IFHP. It could also prevent situations where eligible refugees are mistakenly denied care. These initiatives would make the system more accessible to service providers and the refugee population. Second, streamlining IRB administrative processes to determine eligibility could increase the number of providers who provide timely prenatal care to refugee women. Third, expediting reimbursement to physicians could reduce the number of pregnant refugee claimants who are required to pay upfront costs for clinics and hospital services, which is prohibitive for women refugees with low socio-economic status.

Research

Future research studies need to include a more diverse group of women refugees and refugee claimants. Moreover, efforts could be made to investigate the experiences of women accessing health care services in other Canadian provinces to determine whether the issues in this study occur nationally. Finally, including a broader range of service providers and administrative staff in health care settings will be essential to creating effective changes in the IFHP program that policy-makers and health care providers can readily implement.

CONCLUSION

This study contributes to the body of knowledge on refugee health care equity, specifically among women refugee claimants with limited health coverage. This study demonstrates that women refugee claimants' participation in pre- and postnatal services can be shaped by lack of health coverage due to immigration status and acts of discrimination (staff acting as gatekeepers, refusal of care, and confusion about the IFHP), all of which can adversely impact their access to health care services. These barriers pose significant challenges to many women refugee claimants, especially women who arrive in Canada pregnant. Therefore, improving access to pre- and postnatal care for refugee claimant women requires an understanding of the broader context of their everyday lives. The findings also demonstrate that pregnant refugees are a distinct and vulnerable population due to the time-sensitive nature of perinatal care. Proper pregnancy care can be compromised by the multitude of barriers that health care professionals and women refugee patients face, potentially impacting pregnancy and birth outcomes (Winn et al., 2018). Finally, service providers who work with this population should be equipped with the skills needed to meet their clients' needs and up-to-date information about policies and health care eligibility.

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APPENDIX A

INTERVIEW QUESTIONS FOR WOMEN REFUGEE CLAIMANTS

1. Personal and demographic information
 - a. How do you identify yourself? (Please circle all that apply.)
Refugee/refugee claimant/immigrant/woman of colour/other
 - b. Age
 - c.
 - i. Country of birth
 - ii. Last country of residence prior to arriving in Canada
 - iii. Other
 - d. Length of stay in Canada
 - e. Immigration status
 - f. Are you employed? If yes, what is your monthly income?
If no, how are you supporting yourself and family?
2. Experiences with and access to health care system: Pre- and postnatal care
 - a. After moving to Canada, how did you first find out about the Canadian health care system? (e.g., doctors, nurses, health care services, clinic, midwifery care, hospitals)
 - b. Where do you usually go to seek treatment for pre- and postnatal care or any other health needs?
 - c. What are the problems/challenges you usually face seeking pre- and postnatal care or any other health care service?
 - d. What is your most pleasant or unpleasant experience with your health care provider or the Canadian health care system?
 - e. What changes would you recommend to the health care system in general, and in particular pre- and postnatal care, to make it more accessible to you or to provide better care for you?
 - f. Is there anything else you would like to share with me? Do you have any questions for me?

APPENDIX B

INTERVIEW QUESTIONS FOR SERVICE PROVIDERS

1. Personal and demographic information
 - a. How do you identify yourself?
 - b. Professional background/education
RN [Registered Nurse]
NP [Nurse Practitioner]
Physician
Social Worker
Other
 - c. Years of experience working with refugees, refugee claimants, and women?
What percentage of your clients are women refugees?
What percentage of your clients are refugee claimants?
2. Pre- and postnatal care

- a. How do women refugees and refugee claimants in need of pre- and postnatal care find out about your services and/or the Canadian health care system?
- b. What reproductive health care services and general services are available to them?
- c. What are the problems/challenges they experience seeking pre- and postnatal care or other health care services?
- d. Are there any challenges you have experienced/experience providing pre- and postnatal reproductive care or working with women refugees and refugee claimants?
- e. What would you recommend be changed about the Canadian health care system in general, and pre- and postnatal care in particular, to make it more accessible to women refugees and refugee claimants or to provide better care to these women?
- f. Is there is anything else you would like to add or any question you would like to ask?