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Résumé

L'égalité d'accès aux services de santé : l'expérience des réfugiées et des demandeuses d'asile qui s'occupent d'un enfant d'âge préscolaire malade

Ellen Olive Wahoush

On sait peu de choses sur l'accès aux services de santé des enfants d'âge préscolaire issus de familles de réfugiés ou qui ont présenté une demande d'asile au Canada. Dans le cadre de cette étude fondée sur une approche à méthodes mixtes, nous avons recueilli des données auprès d'un échantillon choisi à dessein constitué de 55 mères habitant dans une ville de deuxième rang de la province de l'Ontario. Ces données soulèvent des questions sur l'accès de ces familles aux soins primaires. Des facteurs autres que les besoins déterminent si une mère accédera ou non à des soins pour son enfant. Même si tous les enfants avaient vu un médecin au cours de l'année précédente et que 78 % disposaient d'un prestataire de soins attitré, leurs mères avaient éprouvé des difficultés à obtenir des soins lorsque le besoin se présentait. Ces difficultés sont liées au faible revenu, aux problèmes relatifs à l'assurance-maladie, à la méconnaissance des services offerts, à la peur d'être jugée en tant que parent et à la discrimination perçue. Ces observations comportent des implications pour les prestataires de soins, dont les personnes qui travaillent dans les services d'établissement, la protection de l'enfance et la santé publique.

Mots clés : accès aux soins de santé, réfugiés

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Equitable Health-Care Access: The Experiences of Refugee and Refugee Claimant Mothers With an Ill Preschooler

Ellen Olive Wahoush

Little is known about access to health services for preschool children in refugee or refugee claimant families living in Canada. This mixed-methods study collected information from a purposive sample of 55 mothers living in a second-tier city in the province of Ontario. The findings raise questions about equitable access to primary health care for these families. Factors other than need determined whether a mother was able to access care for her child. Although all the children had been seen by a doctor during the preceding year and 78% had a regular care provider, mothers faced difficulties accessing care when needed. These difficulties were related to low income, problems with health insurance, lack of knowledge about available services, fear of being judged as a parent, and perceived discrimination. The findings have implications for care providers, including those working in settlement services, child protection, and public health.

Keywords: health-care disparities, health-care access, child health, refugee, asylum seeker

The number of immigrants entering Canada in the past 10 years has been estimated at close to 2.4 million, far more than in any decade since 1931 and accounting for two thirds of the country's population growth. Accompanying this increase in the number of immigrants is a dramatic shift in source countries — from the United Kingdom, the United States, and Europe to Africa, Southeast Asia, and South America. The Canadian health-care system must now address the health needs of new arrivals from a host of cultures and speaking an array of languages.

Refugees are an important subgroup of immigrants, comprising 11% to 13.9% of the annual total (25,120 to 32,686) (Citizenship and Immigration Canada, 2005). Refugees are either "Convention" refugees — those who meet the United Nations definition of "refugee" and come to Canada sponsored by the government, their families, or community groups; or refugee claimants — those who arrive in Canada and then seek refugee status. Approximately 50% of all refugees in Canada arrive as refugee claimants, and almost all become Canadian citizens.

Experiencing very high levels of disadvantage in income, housing, and access to employment, refugees face many challenges as they settle into

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Canadian communities (Chui, 2003; Jenson, 2000; Papillon, 2003; Picot & Hou, 2003). These challenges should raise concerns about their health, health behaviour, and access to care, particularly in relation to their preschool children, who constitute 5% of all refugees. However, there is almost no research literature on the health practices of refugee families (Hyman, 2001; Mulvihill, Mailloux, & Atkin, 2001). Indeed, empirical evidence on the health practices of parents on behalf of their young children is extremely limited in Canada.

This article describes a mixed-methods study of health behaviours of refugee mothers responding to an acute minor illness in their eldest child under 4 years of age. A total of 55 mothers who were Convention refugees (n = 27) or refugee claimants (n = 28) participated in either a focus group (n = 22) or a semi-structured interview (n =33). At the time of the study, which was conducted between August 2004 and May 2005, all participants lived in Hamilton, Ontario.

The objective was to generate evidence about equity and access to health services for preschool children in refugee families. Three research questions informed the objective: 1. *How do refugee and refugee claimant mothers respond when their preschool child has an acute minor illness?* 2. *What factors influence mothers' choices and actions in helping their child to recover?* 3. *What problems or barriers do mothers encounter in seeking access to health services for their child?*

The selection of concepts for study was guided by the Andersen Model of Health Behaviour, a socio-ecological model widely used in health research with vulnerable populations (Andersen et al., 2002; Beiser, Dion, Gotowiec, Hyman, & Vu, 2002; Brown et al., 2004; Gelberg, Andersen, & Leake, 2000). In brief, this all-encompassing model outlines a relationship between four broad concepts: environment, population characteristics, health behaviour, and outcomes. Three aspects of population characteristics have been shown to predict most health behaviours. These are predisposing characteristics such as age and gender; enabling factors such as health insurance, transportation, and having a regular health-care provider; and perceived need (Andersen et al., 2002). In this study, enabling factors and the health behaviours of the mothers were the prime areas of interest. Selected concepts included socio-economic factors; enablers such as health insurance; having a regular health-care provider; and health behaviours.

Literature Review

Convention refugees are sponsored by government, family members, or community groups, have access to provincial health insurance and support services to facilitate their settlement in Canada, and are rarely able to return to their homeland. Refugee claimants apply for refugee status upon or after their arrival in Canada. They must prove that they meet the United Nations definition of "refugee" while remaining in Canada, a process that can take years. Refugee claimants have no access to settlement support services but may obtain health insurance through the Interim Federal Health Program (IFHP), which offers more limited coverage than provincial plans. Refugee claimants were included in this study, as almost half of all claimants make successful claims and become permanent residents. Convention refugees and refugee claimants are a vulnerable population in Canada and their numbers are increasing.

Refugees are under-researched in Canada (Gagnon, 2002; Hyman, 2001). Most research on refugees has focused on settlement issues related to housing, income (Picot & Hou, 2003), and access to employment (Friesen et al., 2002; Frisken & Wallace, 2002; Kilbride, 2001). Research on the health of refugees has concentrated on the mental health of adults (Rios et al., 2000; Yuan, Rootman, & Tayeh, 2000), seniors, and adolescents (Beiser, Shik, & Curyk, 1999; Beiser et al., 2002) or on reproductive health (Gagnon et al., 2007). There have been few studies examining health-care access for young children, and little is known about health-care access for refugee children in Canada.

Studies of immigrant health fall into two categories: secondary analyses of large surveys, and small studies with specific ethno-racial groups. Large-scale surveys such as the Canadian Community Health Survey focus on older adolescents and adults (Statistics Canada, 2002, 2003a). The National Longitudinal Survey of Children and Youth focuses on children but does not identify refugees (Statistics Canada, 2005) and the Longitudinal Survey of Immigrants to Canada (Chui, 2003) is restricted to Convention refugees and does not include children. Findings from studies with specific ethno-racial groups are so narrowly focused that they reveal little that is applicable to refugees in general or the response of the health-care system to their needs (Robertson et al., 2006; Simich, 2004; Spencer & Le, 2006). In view of the fact that, in the general population, primary health care is used more frequently by younger children than by older children, the dearth of research on use of health services represents a gap in the literature (Brownell et al., 2002; Casanova & Starfield, 2003; Polivka et al., 2000).

In summary, evidence concerning health-care access by children is limited. Effective and appropriate care of common acute minor illnesses is important for maintaining child health. This article presents results from a study of refugee mothers' attempts to meet the needs of their preschool children during an acute minor illness. The study was intended to address the lack of empirical evidence on the use of primary health care by refugee mothers in Canada and the response of the health-care system to their needs (Hyman, 2001).

Methods

This mixed-methods study employed a retrospective cross-sectional semi-structured interview design supplemented with three focus groups. Purposive sampling was used to promote the inclusion of the most informative participants, refugee and refugee claimant mothers of a preschool child. A network recruitment approach using multiple start points was selected, to achieve a maximally diverse sample of mothers, to minimize the risk of ethnocentric and researcher bias, and to reach mothers who might not use conventional health care. To accommodate their preferences and facilitate recruitment, mothers were offered a choice: they could either attend a focus group meeting or have a personal interview.

The interviews were audiotaped to enable cross-checking of handwritten notes for completeness and accuracy. Three interpreters were trained by the principal investigator to ensure that mothers understood the questions and had an opportunity to respond in their own "voice." The principal investigator conducted those interviews and focus groups where interpretation was not needed. When an interpreter was needed, the principal investigator attended, took field notes, and was available to answer questions. Ten interviews and two focus groups required interpreter assistance in one of six languages.

Qualitative data were transcribed verbatim. The principal investigator and two research associates identified key concepts by means of content analysis. These concepts were grouped thematically using an inductive approach described by Miles and Huberman (1994). Three interview transcriptions were independently analyzed by an expert nurse researcher. Differences were resolved through a review of field notes, discussion, and consensus. Potential risks to rigour and trustworthiness associated with the use of interpreters were addressed through the inclusion of cross-checking elements in the interview guides, the training of interpreters in the use of standard methods, and attendance by the principal investigator at each interview for the purpose of recording detailed field notes for post-interview clarification. Quantitative analysis was performed using SPSS version 12 to generate the descriptive information presented in the study.

To be eligible, mothers had to be living in Hamilton, to meet the criteria for status as Convention refugees or refugee claimants, and to be able to communicate in English or one of the six languages for which interpreter support was available (Arabic, Farsi, French, Somali, Spanish, and Tigrinya). Explanations were provided in the mother's language or in

English. Informed consent was requested of all participants at the time of the interview. Ethical approval was obtained from the University of Toronto Research Ethics Board. For families with more than one preschool child, mothers were asked to respond in relation to the older (or oldest) child.

Findings

Fifty-five mothers participated in one of three focus groups (*n* = 22) or in a semi-structured interview (*n* = 33). Refugee mothers were evenly divided between interviews and focus groups (14 vs. 13), whereas refugee claimants were more represented in interviews (*n* = 19) than in focus groups (*n* = 9).

Collectively, mothers represented all immigrant source regions. Roughly half were Convention refugees. A majority had settled in Hamilton upon arrival (56%). Among those who had moved to Hamilton from another location in Canada (secondary migrants) (44%), most had come from Toronto (Table 1). Almost half of the children in the study had been born in Canada. More than half of all mothers did not know anyone in Canada when they first arrived and many were lone parents. More than half of the mothers had college or university education and one quarter had less than high school or no formal education. Approximately two thirds of mothers had Ontario provincial health insurance (OHIP), while the remainder had IFHP insurance. Over 90% of the mothers lived below the poverty line.

Mothers' Responses to Their Child's Acute Minor Illness

In rank order, the most common illnesses that mothers attempted to treat on their own, at least initially, were fever, coughs and colds, diarrhea, rashes, sore throat, and earache. There was no difference in the types of illness that led to a consultation with a health-care provider. The key factors that led mothers to consult a provider were duration of the illness, perceived severity of the illness, and perceived threat associated with the illness.

Mothers used an array of strategies in response to the illness. These can be placed in two broad categories: personal health practices, and health-services access (Figure 1). Personal health practices, which were common during the initial phase of the illness, comprised three main roles. The role of interventionist included seeking advice and providing therapies to restore the child's health. The role of monitor had mothers checking the child's well-being, watching the child, and waiting for the child to recover. Finally, in the role of comforter the mothers attended to the child's need for rest or for special attention.

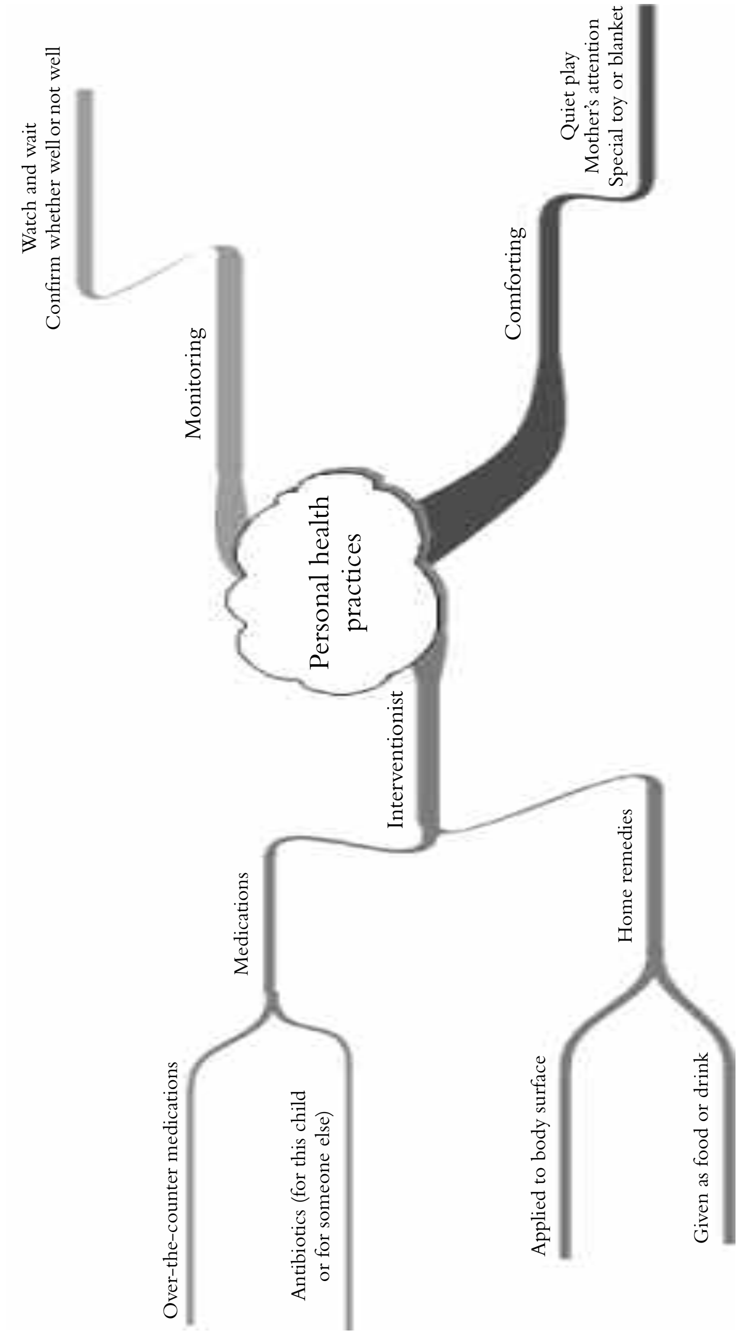
Table 1 *Sociodemographic Data*

Source Region of Mothers	**Convention Refugees** *n* **= 27 (%)**	**Refugee Claimants** *n* **= 28 (%)**	**Total** *N* **= 55 (%)**	**Survey of Refugees**[a] *n* **= 9,800 (%)**
Africa	91.5%	39.3%	33 60.0	23.6
Asia and Middle East	18.5%	28.6%	13 23.6	52.0
Europe	0	14.3%	4 7.3	17.2
Pacific	0	3.6%	1 1.8	n/a
South and Central America	0	14.3%	4 7.3	n/a
Social Contacts in Canada				
Knew no one pre-arrival	14 51.9	16 57.1	30 54.5	24.6
Lone parent	15 55.6	11 39.3	26 47.3	24.8
First Location in Canada				
Hamilton	20 74.0	11 39.3	31 56.4	
Toronto	4 14.8	12 42.9	16 29.0	
Other	3 11.1	5 17.8	8 14.6	
Child's Place of Birth				
Canada	13 48.1	16 48.5	29 52.7	
Not Canadian-born	14 51.9	12 42.9	26 47.3	

Education							
None or less than high school					14	25.5	37.8
High school					12	21.8	28.3
College					18	32.7	22.2
University					11	20.0	11.5
Time in Canada							
Less than 24 months	20	74.0	9	32.1	29	52.7	
Between 25 and 48 months	5	18.5	16	57.1	21	75.0	
More than 48 months	2	7.4	3	10.7	5	17.9	
Health Insurance[b]	***n* = 14**		***n* = 19**		***N* = 33**		
Mother IFHP	4	28.6	8	42.1	12	36.4	n/a
OHIP	10	71.4	11	57.9	21	63.6	
Child IFHP	3	21.4	5	26.3	8	24.2	n/a
OHIP	11	78.6	14	73.7	25	75.8	
Household Income[b]							
< $20,000	11	78.6	14	87.5			
> $20,001	3	21.4	2	12.5			
Below LICO (low income cut-off)	13	92.9	18	94.7[c]	31	93.9	52.4

[a] Information from Longitudinal Survey of Immigrants to Canada 2001 (Chui, 2003).
[b] Information from mothers who were interviewed (*n* = 33).
[c] Excludes three mothers who said they did not know; if included as income above LICO, the percentage below LICO is 84.8.

Figure 1 ***Personal Health Practices of Mothers***



The following example of a mother seeking advice while waiting to see if her child would recover or would need to see a doctor illustrates the value placed on experience:

> *I've been just calling the women from church, some of whom are grandmothers. They have been a good group I can always rely on. I am not . . . a person that runs straight . . . to the doctor. My mom never did that. . . . I would ask women first, before I rush to the doctor, you know. Sometimes that is good, sometimes that is bad. I really don't have the expertise. It could be something major and I don't know.* (refugee claimant; mother of 3-year-old girl)

This mother had no relatives in Canada. For the majority of mothers, their first source of advice was a health professional, a friend, or a family member. Health professionals were most often a family doctor, a public health nurse, or a nurse practitioner at a community health centre. For almost one third of the mothers, the Internet and Telehealth Ontario were important sources of information. Telehealth Ontario is a 24-hour telephone service that connects Ontario residents to a registered nurse for information or advice. All mothers in the study had access to a telephone.

The mothers all described similar therapies (Table 2), which included fluids, over-the-counter medications, rest, and special foods made at home. Home remedies were described by all the mothers. Remedies such as herbal teas, massages, specially prepared foods, and substances applied to the skin were common interventions as mothers watched and waited to see if their child showed signs of recovery or needed to see a doctor:

> *I give honey mixed with* bareqa *(poppy seed oil) to sweeten it. Honey and garlic and* geet *oil. I can get it at [name of local pharmacy]. I give this to her to drink before eating, rub olive oil on chest. If diarrhea, I give Pedialyte and yogurt. Home medicines work well.* (refugee; mother of 3-year-old girl)

Mothers used a variety of interventions before deciding to consult a doctor. Some worried about being judged negatively if they delayed too long, while others worried about being seen as "not coping" if they acted too soon. Some women expressed concern that their child would be "taken away."

Mothers seeking health care most often visited a doctor; few used community health centres (see Table 2). More than half the mothers were able to visit or otherwise access a health professional for advice immediately (the same day).

Table 2 ***Health Behaviour of Mothers***

Actions at Home	**Convention Refugees *n* = 14 (%)**		**Refugee Claimants *n* = 19 (%)**		**Total *N* = 33**
Advice from family outside Canada	6	42.9	6	31.6	12
Fluids/fluids only (2)	11	78.6	11	57.9	22
Over-the-counter medications	8	57.1	16	84.2	18
Comfort measures (bath/massage)	11	78.6	13	68.4	24
Rest	8	57.1	14	73.7	22
Special food	6	42.9	9	47.4	15
None; always see doctor	2	14.3	1	5.3	3
Total Responses	**46**		**64**		**110**
Medications at Home					
None	3		1		4
1 to 2	5		11		16
3	1		5		6
4	5		2		7
Total Respondents	**14**		**19**		**33**
Health-Care Provider Consulted					
Family doctor	12		10		22
Walk-in clinic	4		10		14
Emergency department	4		8		12
Community health clinic	2		4		6
Urgent care	1		0		1
Nurse clinic	0		1		1
Father, sister, friends	0		1		1
Total Responses	**23**		**34**		**57**
Health-care needs unmet	2		6		8
Total Respondents	**14**		**19**		**33**

When describing what they did to help their child recover, mothers included details that highlight the impact of living in poverty, social networks, and awareness of available services.

Factors Influencing Mothers' Choices and Actions in Helping Their Child to Recover

Enabling factors in the Andersen model include personal, family, and community-based factors. Personal enabling factors are perceived need, awareness of available health services, and the means to access health services. More than 90% of the participants rated their child's health status as good to excellent, indicating a low level of perceived need (Table 3). Few mothers were aware of the full range of services available. The health-care sources most consistently identified were family doctors and emergency departments. Much less frequently mentioned were community health centres and walk-in clinics. For most participants, social supports were limited, at least initially, as few of the mothers knew anyone in Canada before they arrived and almost 50% were lone parents.

Most mothers reported the following as enabling factors: living in the same city (since arriving in Canada), community-based factors such as public transit, and the help or advice of friends. The most frequently reported transportation choice was buses. Some health services were more available than others. Excluding emergency departments, walk-in clinics had the most after-hours availability, while most other providers had some evening and weekend hours. There was no difference between refugees and refugee claimants in the proportion of children with a regular health-service provider, and all mothers had consulted a health professional, usually a doctor, about their child during the preceding year.

Mothers identified a number of features as important in a health-service provider. These included language ability (five doctors) or interpreter support (at community health clinics); the ability to be seen without an appointment; health-care provider acceptance of IFHP; comprehensiveness of services; "knows us"; and proximity to home.

Problems or Barriers Encountered by Mothers Seeking Access to Health Services

The absence of enabling features, perceived high cost, and negative prior experiences with providers were barriers to care for mothers looking after an ill child. Eight mothers, mostly refugee claimants (*n* = 6, 31.6%, vs. *n* = 2, 14.3%), were unable to obtain health care for their child when they believed it was needed because they had no interpreter support (*n* = 2), no means of transport (*n* = 2), or insurance problems (*n* = 2). Mothers reported being turned away by providers because they had

Table 3 *Health and Health Care of Preschool Children*

	Convention Refugees ***n*** **= 27 (%)**	**Refugee Claimants** ***n*** **= 28 (%)**	**Total** ***N*** **= 55 (%)**	**Refugees (LSIC)[a] (%)**	**General Population[b] (%)**
Mother's Rating of Child's Health (*n* = 55)					
Excellent/very good	14 51.9	19 67.9	33 60.0	78.0	58.6
Good	11 40.7	7 25.0	18 32.7	19.0	28.8
Poor/fair	2 7.4	2 7.1	4 7.3	3.0	12.4
Interviewed Mothers	***n*** **= 14**	***n*** **= 19**	***N*** **= 33**		
Regular provider	11 78.6	15 78.9	26 78.8[c]		91.2
Interpreter Support					
Needed	9 64.3	8 42.1	17 51.5		
Offered	3 33.0	2 25.0	5 29.4		
Transportation					
Own car			11 33.0		
Bus			13 39.4		
Walk			9 27.6		

Missed Meals								
Once or twice/week	2	14.3	3	15.8	5	15.1		
Once or twice/month	3	21.4	10	52.6	13	39.4		
Never	9	64.3	6	31.6	15	45.5		90.0
Sources of Advice								
Doctor	14	100.0	19	100.0	33	100.0	80.8	81.8
Nurse	7	50.0	13	68.4	20	63.6		
Pharmacy staff	8	57.1	11	57.8	19	57.6		
Friend	9	64.3	12	63.1	20	63.6		
Family	4	28.6	11	57.8	15	45.5		
Internet	2	25.0	7	36.8	10	30.3		
Telehealth Ontario	3	21.4	5	26.3	8	24.2		12.8

[a] Longitudinal Survey of Immigrants to Canada 2001 (Chui, 2003).
[b] Statistics Canada (2003), Cycle 2.1.
[c] Includes three emergency departments as regular providers; if excluded, 69.7% of children had regular health-service providers.

IFHP insurance only. The following mother was unaware of available no-fee health and dental services close by:

> *She had a toothache. I could not afford a dentist and I did not know where to go or that dental service is possible without a fee. I tried to distract her, make her comfortable, and gave pain medication until the tooth stopped hurting — 3 days. . . . It was a baby tooth and temporary.* (refugee claimant; mother of 3-year-old girl)

This mother had no relatives in Canada and few people available to advise her.

Mothers encountered two problems when helping their child to get better: cost, and negative experiences during health-service encounters.

Cost was a significant barrier for many mothers, in particular refugee claimants. Five refugee claimants reported having to pay a fee to be seen by a doctor. Fees ranged from $25 at a walk-in clinic to more than $200 at an emergency department. Emergency departments were the only health service available after 10 p.m. and on weekends. The cost of over-the-counter medications such as Tylenol or cough syrup had a significant impact. For up to 50% of the mothers, this cost resulted in missed meals on a monthly basis. Mothers also reported that their partner and older children missed meals so that younger children would not go hungry (Table 3).

Negative experiences reported by more than one third of mothers included witnessing or being the object of racism and discrimination in the health-care system. "They pretend they do not understand me," said one refugee claimant, who was aware of her accented English. Two mothers identified prolonged waiting in an emergency department as evidence of racism. All other reports of racism concerned the attitude of health-service providers. More refugee claimants than Convention refugees reported such incidents.

Discussion

In general, the participants appeared to have acted similarly to most mothers of a preschool child with an acute minor illness (Janicke, Finney, & Riley, 2001; Yearwood, 2007). However, detailed analysis revealed differences relating primarily to refugee status. Health insurance, though important, was not sufficient to ensure access to health services. Even mothers of children who were born in Canada and were covered by OHIP had little or no information on health services available to them. As a consequence, they engaged in extensive problem-solving to manage their child's illness.

Equitable health care means that services are accessible based on need (Andersen, 1995). This study found that factors other than need determined whether a mother was able to access health care for her child. All mothers faced challenges related to income and awareness of the range of health-service providers available.

All mothers described personal health practices they used to help their child recover, and all had contacted a doctor for their child at least once during the preceding year. This is higher than the proportion reported for the general population or in previous immigrant surveys (Chui, 2003; Statistics Canada, 2003a) and suggests that access to health care was not a problem for mothers in the study. However, this finding may reflect increased need due to the age of the child (Brownell et al., 2002; Casanova & Starfield, 2003) or may suggest that the needs of refugees and refugee claimants are greater than those reported for the general population.

Although all the children had health insurance, both OHIP and IFHP are limited in terms of the services they cover. Furthermore, for the participants in this study, policy guidelines were not always followed in the granting of insurance coverage. Some Convention refugee mothers were still insured by IFHP when they should have been covered by OHIP. The 90-day wait for OHIP coverage was eliminated for Convention refugees in May 2004 (Ministry of Health and Long Term Care Ontario, 2005). Yet mothers reported that they had been told they were not eligible for OHIP. This finding is supported by the literature (Gagnon, 2004; Wayland, 2006). OHIP coverage had one important advantage: It was accepted by all health-service providers. All children born in Canada had OHIP coverage but differences in health insurance among members of the same family were common.

Approximately 75% of the children had a regular health-care provider. This is a lower percentage than that reported for the general population. It may reflect the fact that the mothers of these children were new to the community, or it may indicate reluctance on the part of health-service providers to accept refugee or refugee claimant families as patients.

Poverty among mothers in this study was much greater than reported for recent Convention refugees in the Longitudinal Survey of Immigrants to Canada (Chui, 2003) and almost four times the rate for the general population of young children in Hamilton (Statistics Canada, 2003b). The impact of poverty on access to health care is compounded by limited access to employment that offers health insurance benefits (Tolley, 2003). Consequences of low income were dire when mothers had little or no health insurance and little awareness of available services. However, Convention refugees are provided settlement and integration services for at least their first year in Canada (Ministry of Citizenship, 2002; Simich, Beiser, Stewart, & Mwakarimba, 2005) and most of the mothers in this study had been in the country less than 2 years.

In addition, most mothers lacked information about potentially useful health resources. The exclusion of refugee claimants from settlement support services prevents them from connecting with important sources of support and information or with other people in similar circumstances. The refugee claimant mothers in this study developed small social support networks consisting of women they met at a clinic or shelter or through their church. These informal networks were similar to those reported by Simich (2004).

In spite of the fact that only refugee claimants were charged for health services, more women in this group than in the Convention refugee group reported visiting an emergency department, even during daytime hours when other, less expensive options were available. This could be due to lack of information about community health centres and walk-in clinics, or it may suggest that these mothers did not know how to access such services (Hatton & Bacic, 2001). These health behaviours may also reflect a desire to be seen as a "good" parent or as "not greedy or needy" (Harney, 2003).

In addition to factors that may have inhibited access to health services for all of the mothers, individuals with IFHP face provider refusal to accept the fee offered by the plan. Having to wait to be seen in the emergency department, or being turned away because of inadequate insurance coverage, led to dissatisfaction and was perceived by a few mothers as evidence of racism. Participants stated that they would seek a different provider next time; this example of outcomes influencing future health-service use supports the Andersen (1995) model.

The findings of this study have implications for care providers, including those working with settlement services or in child protection or public health settings. Refugee mothers are not fully aware of the health services available to them at little or no cost and of their entitlements to health insurance. Also, they are fearful of child protection services in Canada, largely due to misconceptions about the role of these organizations. Care providers are well positioned to address the informational needs of refugee mothers. In addition, health practitioners should be informed about the impact of health-service experiences on the willingness of mothers to seek care for their children. When mothers with IFHP coverage are refused care, they are unlikely to return and may be unable to locate an alternative provider, compromising their child's health. Health-care staff need to be trained in working with refugee and other immigrant groups. In addition, sensitive explanation of expected delays and wait times may help prevent these being interpreted as racist or discriminatory.

This study may be the first to focus on the health of preschool children in refugee and refugee claimant families. Locating the study in a second-tier city is consistent with immigration policy, which is now promoting the dispersal of refugees to smaller, more welcoming communities. However, the findings have limited transferability due to the small size of the sample, the restriction of the study to a single urban setting, and the fact that policies on immigrant and refugee health care are undergoing rapid change. In addition, reform measures recently instituted in Ontario include the introduction of a new multidisciplinary team for primary health care (Meuser, Bean, Goldman, & Reeves, 2006), which has the potential to improve access for vulnerable families. Future research could include other settings and examine the impact of primary health care reform on the refugee and refugee claimant population.

The findings of this study raise questions about equity of access to primary health care for refugees compared to other immigrants and the general population. When health insurance was adequate, the needs of most of the children were met during a medical visit. The health-care needs of the children in this study were similar to those of children generally. However, the responses of their mothers were affected by immigration policy and health-care policy. Despite these and other challenges, the participants exhibited strong coping skills in looking after their children.

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