

Caring for Refugees, New Immigrants, and Uninsured Women: Social Responsibility and Access to Healthcare



Ethical Issues in Women's Healthcare: Practice and Policy

Edited by Lori d'Agincourt-Canning and Carolyn Ells

Publisher: Oxford University Press Print Publication Date: Apr 2019

Print ISBN-13: 9780190851361 Published online: Apr 2019

DOI: 10.1093/med/

9780190851361.001.0001

Caring for Refugees, New Immigrants, and Uninsured Women: Social Responsibility and Access to Healthcare

Chapter:

Caring for Refugees, New Immigrants, and Uninsured Women: Social Responsibility and Access to Healthcare

Author(s): Paul Caulford, and Sumathy Rahunathan

DOI: 10.1093/med/9780190851361.003.0003

... the protection of refugees is not only the responsibility of neighbouring States of a crisis; it is a collective responsibility of the international community.

—ANTONIO GUTERRES, *UN Secretary General*

Introduction



It is well established that refugees are one of the most vulnerable populations. Many have left home because of conflict or hopeless poverty and have had no access to healthcare. Others fleeing war and persecution are making arduous journeys in poor living conditions where overcrowding and lack of basic sanitation, water, and food cause a myriad of health problems. Compounding their difficulties is the fact that many refugees are not granted public health insurance in the countries that receive them, so they are left with no means to pay for needed healthcare

Caring for Refugees, New Immigrants, and Uninsured Women: Social Responsibility and Access to Healthcare

after relocation.¹ The complex vulnerability of these groups is largely absent from the health ethics literature, despite the growth in asylum seekers and migrant numbers globally. In this chapter, we discuss ethical concerns related to caring for refugees, new immigrants, and uninsured immigrant women in Canada. Case examples from our clinic illustrate systemic barriers many refugees and uninsured immigrant women face when attempting to access healthcare. We show how systemic barriers to healthcare result in delayed diagnosis, underdiagnosis, and inappropriate use of emergency services by refugees and undocumented immigrants. We also reflect on the moral obligations of host countries and healthcare providers to refugee and uninsured women and their families. We begin our discussion, however, with an overview of the broader context shaping migration and refugee patterns today.

World Numbers: Unprecedented



Since earliest times, people have moved around. Some people move to search for new economic opportunities and to build better lives. "Others move to escape armed conflict, poverty, food insecurity, persecution, terrorism, or human rights violations and abuses. Still others do so in response to the adverse effects of climate change, natural disasters (some of which may be linked to climate change), or other environmental factors. Many move, indeed, for a combination of these reasons."²

Yet, according to the United Nations, more people than ever before live in a country other than the one in which they were born. Migrants are present in all countries in the world. During the period from 2000 to 2017, the total number of international migrants increased from 173 to 258 million persons, an increase of 85 million (49%).³ Most concerning, however, is that within this population are roughly 65 million forcibly displaced persons, including over 21 million refugees, 3 million asylum seekers, and over 40 million internally displaced persons.

The terms *migrant*, *refugee*, *displaced person*, and *undocumented immigrant* are often used interchangeably. For the purpose of this chapter, we use the following definitions summarized from the United Nations³ and the International Organization for Migration.⁴ Host countries accepting new arrivals may create additional categories as well.

Migrants: People who move from their home country to another with a view to being employed and/or achieving a better life for themselves and their families. Movement is in keeping with the laws and regulations governing exit of the country of origin and travel, transit, and entry into the destination or host country.

Refugees: Persons who have left their country of origin and crossed an international border for fear of persecution due to race, religion, nationality, membership of a particular social group, or political opinions. Refugees may also include people who have been compelled to leave their country owing to conflict, generalized violence, or other

Caring for Refugees, New Immigrants, and Uninsured Women: Social Responsibility and Access to Healthcare

circumstances that have seriously disturbed public order and who, as a result, require international protection.

Internally displaced people (IDPs): Persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights, or natural or human-made disasters, and who have not crossed an internationally recognized state border.

Undocumented immigrants: Persons who have traveled to a host country outside the regulatory norms of the sending, transit, and receiving countries. From the perspective of destination countries, it is entry, stay, or work in a country without the necessary authorization or documents required under immigration regulations.

Asylum seekers: Persons who seek safety from persecution or serious harm in a country other than their own and await a decision on the application for refugee status under relevant international and national laws. In case of a negative decision, the person must leave the country and may be expelled, as may any non-national in an irregular or unlawful situation, unless permission to stay is provided on humanitarian or other related grounds.

In 2017 the United Nations High Commission for Refugees (UNHCR) reported that 65.6 million individuals were forcibly displaced worldwide as a result of persecution, conflict, violence, or human rights violations.^{5,6} That was an increase of 300,000 people over the previous year, and the world's forcibly displaced population is at a record high. The majority of forced displacement has been driven by the conflict in Syria: 12 million people at the end of 2016, which included 5.5 million refugees, 6.3 million IDPs, and nearly 185,000 asylum seekers. Crises in sub-Saharan Africa (Burundi, the Central African Republic, Democratic Republic of the Congo, South Sudan, and Sudan) have contributed as well. Tragically, there has also been a significant rise in unaccompanied youth. In 2016, 75,000 unaccompanied or separated children lodged asylum applications in 70 countries, but the figure is assumed to be an underestimate.⁵ There are also 10 million stateless people (not considered a national by any state) who have been denied a nationality and access to basic rights such as education, healthcare, employment, and freedom of movement.⁶

Where Do Refugees Go?



The vast majority of refugees go to low-income developing countries, particularly those that are proximate to their countries of origin. According to the UNHCR,⁵ countries that have the fewest resources are among the greatest affected. In 2016, a small number of developing nations hosted 84% of the world's UNHCR refugees and 66% of the overall forcibly displaced migrants. More than 5.9 million refugees under UNHCR's mandate reside in countries where the GDP per capita is below \$5,000 (USD).⁷ Turkey recorded the largest refugee population, hosting some approximately 3.1 million refugees and asylum seekers. In

Caring for Refugees, New Immigrants, and Uninsured Women: Social Responsibility and Access to Healthcare

2016, the second largest country of asylum was Jordan, hosting around 2.9 million refugees, followed by Palestine (2.2 million), Lebanon (1.6 million), and Pakistan (1.4 million).³

Women as Migrants and Refugees



In 2016 the UNHCR reported that women and girls constitute almost half of the refugee population, and the proportion who are under age 18 is 51%.⁵ The number of migrant women has also been increasing steadily, reaching 52% of all immigrants in the developed world and approximately 44% of all migrants in developing regions.⁸ The flow of migrating women is the result of their significant economic contribution to their families and communities. It is becoming increasingly evident that many women enter migration as the main economic providers for their families.⁹

Yet, women migrants encounter gender-based barriers and challenges.^{9,10} For one, gender roles in most cultures create the expectation that women should be the direct caregivers for their children. This means that most mothers who migrate still face the direct pressure of caring for their children. These women are under enormous pressure to settle quickly so that they can bring their children to the host country. Further, women who migrate from low-income countries often do not leave their children with their fathers, but rather in the care of other family members. This creates additional pressure to get their children to join them.¹⁰

Women who are displaced because of conflict or war usually move with their children. Because they are the primary caregivers, they bear the responsibility of getting their children food and other necessary resources, even though they may have no means of earning an income.¹⁰

Trafficking and Violence Against Women



Another dimension of migration is human trafficking and forced labor. In the Global Report on Trafficking in Persons, sexual exploitation was noted as by far the most commonly identified form of human trafficking (79%), followed by forced labor (18%).¹¹ Women make up the vast majority of the detected victims who are trafficked for sexual exploitation. Some women become victims because of financial desperation or lax and complicit policing, while others are deceived and then transported to other countries and forced to work to stay alive.¹⁰

Stress and poverty in camps appreciably increases female partner violence, with 80% of women reporting being beaten by their husbands.^{12,13,14} Low availability of access to protection, counseling, and mental health supports and the reluctance of women to step forward after abuse contribute to declines in mental and physical health status.

Lakshmi Puri, UN Assistant Secretary-General and Deputy Executive Director of UN Women, underscores the gender-based accumulation of vulnerabilities:

Caring for Refugees, New Immigrants, and Uninsured Women: Social Responsibility and Access to Healthcare

As both migrants and refugees, women have specific needs and vulnerabilities. They are often forced to move by root causes such as conflict, poverty and inequality, and face a series of challenges, which include psycho-social stress and trauma, health complications, physical harm and risk of exploitation. They often become separated from their families, and refugee women and adolescent girls can find themselves unexpectedly as head of a household.

Displaced and migrant women and girls are commonly subject to multiple and intersecting forms of discrimination. On top of gender-based discrimination, they may be targeted on additional grounds such as race, disability or belonging to a minority group. This discrimination limits women's access to basic services and to decision-making processes, affecting their interactions within their households or communities, in the labor market, as well as their mobility—within and outside their countries of origin. Their voice and participation are frequently constrained and the risk of sexual and gender-based violence, an ever-present reality for all women worldwide, significantly increases.¹⁵

LGBTQ Migrants



Lesbian, gay, bisexual, transgendered, and queer (LGBTQ) persons face targeted persecution and violence in many countries worldwide and significant disparities to healthcare access.¹⁶ Asylum-seeking journeys generate additional gender-based health risks. Ninety-eight percent of asylum-seeking lesbian, gay, and bisexual survivors report experiencing persecution due to their sexual orientation. Eighty percent experienced torture. Many report efforts against them to change their sexual orientation, often through forced marriage. Women were more likely to be forced to move from place to place and to experience rape/sexual assault and threats. Men were more likely to be publicly persecuted. All report depression and anxiety.¹⁶

LGBTQ persons are appearing within forced migration populations in increasing numbers. New anti-LGBTQ legislation, torture, and the spread of terrorist networks have forced LGBTQ persons to flee to Eastern Europe.¹⁷ Inadequate healthcare access and culturally non-competent healthcare are described by LGBTQ migrants crossing into the United States from Central America.¹⁸

In our Toronto clinics, LGBTQ government-assisted refugees began appearing for care in growing numbers, particularly since February 2017 when Canada formally developed policies for adjudicating LGBTQ refugee claims. We were surprised when gender-based social isolation and shunning was directed toward the arriving LGBTQ migrants by Syrian refugees cohabitating at the Toronto shelter. LGBTQ migrants reported that this exacerbated preexisting posttraumatic stress disorder symptoms

Caring for Refugees, New Immigrants, and Uninsured Women: Social Responsibility and Access to Healthcare

of fear, anxiety, chronic pain, insomnia stemming from prior torture, lashings, beatings, imprisonment, and state-sponsored murders in their home countries.

Systemic Challenges



Against this background, it is no surprise that refugees have poorer health status than those of other immigrant groups.¹⁹ Refugee women and girls are among the most negatively impacted. Access to public health is sporadic or nonexistent in camps. Deficiencies in reproductive, maternal and newborn care, communicable and noncommunicable diseases, and cancer screening and treatment are commonly reported.^{5,10,20,21} Health status also deteriorates from neglected treatment of chronic diseases such as diabetes and hypertension.²² Gender-based violence and sexual human trafficking adds to the health deficits. Syrian and other refugees arriving to our refugee clinics showed advanced oral decay.

Yet, as Graetz and colleagues observe—and our experience confirms—one of the biggest challenges refugees, undocumented immigrants, and new immigrants face in their host countries is the access to health services. “Although the human right to health has been set out in the 1948 Constitution of the World Health Organization (WHO), as well as in subsequent international legal documents, in practice migrants often face formal and informal barriers in accessing health services.”^{23(p6)}

Haya’s story helps illustrate challenges faced by those lacking insurance. We saw her at the Canadian Centre for Refugee and Immigrant Health Care (CCRIHC) in Scarborough, Toronto. Started in 1999, the CCRIHC provides health and dental care to refugee claimants and uninsured persons through volunteers offering multidisciplinary clinics.

Haya is 74. She arrived at our clinic with chest pain that made it difficult to look after her grandchildren while her children worked. Haya’s journey began 3 years ago in Syria. Her house was blown up in the war, killing her husband. Her children brought her to Canada. Her refugee claim in 2014 was rejected. This made Haya an undocumented 74-year-old forced migrant fleeing war with no status in her receiving country, and no access to public healthcare.

Despite Canada’s universal healthcare system, many who reside here struggle to acquire public health insurance and accordingly needed healthcare. A recent study by Mahon and colleagues²⁴ reported that migrants from all immigrant categories face barriers accessing care in Canada; however, refugees and asylum seekers experience even greater

Caring for Refugees, New Immigrants, and Uninsured Women: Social Responsibility and Access to Healthcare

difficulties. Systemic challenges may be differentiated into (1) legal-policy barriers and (2) social/cultural barriers.²⁵ We will explore each in turn.

Legal-Policy Barriers

McKeary and Newbold summarize the barriers related to Canadian policy succinctly: “Health care access is affected by the complexities and challenges of health insurance for refugees, which reflects a bureaucracy that impacts on health access as various levels of government are responsible for different components.”^{25(p535)} In Canada, some refugees may be eligible for provincial health insurance plans, based on their refugee status and (typically) on a minimum residency period in the province of up to 90 days. Refugee claimants may also be eligible for healthcare under a federal program called the Interim Federal Health (IFHP) insurance program. However, while the IFHP provides limited, temporary coverage of healthcare benefits, enrollment is not automatic; each refugee must file an application with the appropriate provincial authorities. The mix of government levels, programs, and eligibility requirements is confusing for refugees. Delays in receiving coverage are common, dangerous, and expensive. Further issues including fear, mistrust, and abject poverty mean that many new refugees may fall through the gaps.

In 2016, for example, a new and totally unexpected population began seeking care at the CCRIHC. African refugees, almost exclusively women and children, undertook dangerous crossings smuggled in the back of trucks in winter from the United States into Canada. All had originally fled life-threatening conditions in Africa and first made asylum claims in the United States, but then feared deportation under the Trump administration. After crossing, many were abandoned in snowy fields in the early hours of the morning. Oma’s story is typical.

Immigration and Customs Enforcement (ICE) agents in Texas were coming to medical clinics looking for pregnant immigrant women seeking healthcare. It got too dangerous to go for my pregnancy visits. I knew other women who were deported. Going back to Nigeria was no option. They wanted to cut my daughter.

So I paid a smuggler. We climbed into the back of his unheated truck. There were five other men inside. Three days later the driver made the others get out after we crossed at Buffalo (New York). An hour later the truck stopped again. The man forced us out in a field. It was 4 a.m. No one was around. He told us to wait for another man. It was very cold. My children cried. Our clothes were not warm. The truck drove away. We waited. No one came. I never knew about cold like that. We started walking. A stranger driving by saw us and put us in his car. He bought us warm soup. Then he took us to a shelter. He saved

Caring for Refugees, New Immigrants, and Uninsured Women: Social Responsibility and Access to Healthcare

our lives. I love Canada. Our fingers were painful and turned black.

Those with frostbite hid their injuries by wearing gloves at the shelter. They feared Canada would send them back to the United States if they sought health care. Delayed public health coverage access led to delays in seeking vital limb-saving care. Some of these women had fled to Italy first, but gangs forced them and other women into sexual trafficking. Oma showed us her scars from the machete wounds she suffered when she tried to escape. Other women told us of similar experiences. One told us, “The gangs are here now, doctor!”

While care was ultimately provided, this quote highlights why confusing administrative policies would pose a major obstacle to traumatized refugees and undocumented migrants needing healthcare. According to Newbold and McKeary,¹⁹ insurance is included as a systemic barrier, but it is ultimately the complexity, cost, burdensome paperwork, and unclear eligibility rules that create obstacles for refugees.

Persons who are denied refugee status have a choice to either alter their application pathway (e.g., humanitarian) or seek legal support and appeal the refugee status rejection. If this in turn fails and the person receives a written notification of his or her removal date, the person then faces the choice of (a) leaving the country, (b) going into hiding, or (c) seeking legal support in an attempt to overturn the order removal.²⁶ The “choices” refugee claimants and others face occur typically in a context of poverty.

Sociocultural Barriers

Sociocultural factors frequently pose another barrier to accessing care. These include poor healthcare literacy (meaning inadequate knowledge of local healthcare systems), language and insufficient interpreter support, lack of access to transportation, confusion about entitlement to services among service providers, and cultural insensitivity among front-line health workers.^{27,28} “In other words, learning how to navigate a complex system in a new country where service providers and patients do not share fluency in the same language or cultural customs likely makes it hard for patients to access that system.”^{27(p704)} At our CCRIHC clinics most refugees have never experienced an organized, primary care-based healthcare system. They express trepidation when confronting Canada’s complex and daunting health system after gaining healthcare coverage. “What is a drugstore?” one young Syrian mother asked when we provided her a prescription for her daughter’s earache. “How do I find a drugstore? Is it a woman who I talk to?” Beliefs about the need for healthcare or health services, based on the person’s country of origin, may also affect access.²²

Caring for Refugees, New Immigrants, and Uninsured Women: Social Responsibility and Access to Healthcare

Calls for more culturally competent care have been on the rise.²⁹ There is growing awareness of the need to educate health providers and help them to reflect on their own and others' cultural attitudes, beliefs, behavior, and communication strategies and to promote practice that fosters quality, nondiscriminatory care.³⁰ Currently, many health services are alienating to individuals who do not hold Western values.^{4,29}

Systemic Barriers: Poorer Health Outcomes

Given systemic barriers, evidence shows—and our experience confirms—that refugees and uninsured immigrants avoid or delay seeking care until the situation is urgent.²⁹ A review of emergency visits in Ontario shows that while the uninsured are sicker than the insured, they are less likely to be admitted, more likely to leave without treatment, and more likely to die than those with insurance.³¹ A case from our clinic highlights how intersecting vulnerabilities and lack of healthcare lead to significant harm.

Aisha, aged 18 years, from Grenada, was entering college when she experienced another in a series of sickle cell crises and sought medical care. Her condition was beyond primary care. We referred her to the hospital emergency department. At first, she refused to go, having experienced previous requests for upfront payment before receiving care. The doctor reassured Aisha that this would not happen. This was an emergency, we told her, providing her with a referral letter and calling ahead to the emergency department.

At the emergency department Aisha was told she had to pay \$350 before they would provide care. She was told her current condition was not an emergency. Not having the money, Aisha explained that her sickle cell crisis would soon leave her unconscious; it had before. Emergency department admitting staff told her that if she became unconscious, they would take her in and treat her without demanding payment first. Aisha seated herself near the triage station in full view of the nurses and waited. When she collapsed, she was taken in. After 3 days in the hospital she received a bill for more than \$5,000.

Aisha was a sponsored youth in Canada, sent for by her father and stepmother at age 12. Her parents later separated and left Canada. Her sponsorship lapsed. Aisha was left to fend for herself without health insurance. She managed to get a part-time job, find a room to rent, complete high school, and enter college in Scarborough. Her hospital bill ended her education.

Caring for Refugees, New Immigrants, and Uninsured Women: Social Responsibility and Access to Healthcare

Aisha's care experience seemed more like torture and assault than competent medical care. Being born in a developed country with a national health service should not be akin to winning a healthcare lottery.

Research also shows differences in pregnancy care and perinatal outcomes for uninsured immigrants and refugee claimants new to Canada compared to insured women.^{32,33} For example, uninsured mothers experienced a higher percentage of cesarean sections due to abnormal fetal heart rates and required more neonatal resuscitations.³² In our clinics 80% of undocumented migrants and failed refugee claimants report either absent or incomplete antenatal care.

In 2018 Jen arrived at our clinic for her first prenatal visit because of severe headaches. She was 37 years old and 34 weeks pregnant. Her symptoms were from a life-threatening obstetrical emergency. Jen immigrated to Canada 8 years ago as a foreign domestic worker. She had been steadily employed for 7 years, but last year Jen lost her job. Her pregnancy made gaining new employment difficult. Unemployed, her public health insurance was canceled. The gynecologist required \$2,000 before providing pregnancy care. Immigration officials told her she should go home. We admitted her to the hospital. Jen left with a \$4,000 hospital bill.

When does a migrant become "Canadian enough" to be granted access to maternal care? Jen could not access any antenatal care. Her obstetrical emergency could have been prevented, preventing an expensive hospital bill and harm to her and her unborn child.

Many pregnant women attending our CCRIHC clinics report similar experiences. In 2017, at shelters for both newly arrived undocumented refugee claimants and government-assisted refugees with health coverage, women initially hid their pregnancies from our medical staff. They avoided attending health clinics for both pregnancy and other needs, confiding later they feared deportation if their pregnancy was discovered.

In our clinic, where free healthcare is provided to all immigrants and refugees without health insurance, the majority of attendees (66%) have been female; 19% of all patients sought maternity care. We found that 80% of pregnant women who have come to our clinic had deficiencies in prior antenatal care ranging from having lacked adequate provider contact, pelvic examination, screening for diabetes, or counseling about the use of folic acid. Mean gestational age at presentation is 23 weeks. Patients who present near term are delivered by midwives and obstetricians chosen according to the mother's risk factors.

Caring for Refugees, New Immigrants, and Uninsured Women: Social Responsibility and Access to Healthcare

Policy Failure, Social Responsibility, and Access to Healthcare in Receiving Nations



Every refugee's journey is treacherous. Over 1,200 new migrations begin every hour, with the refugees fending for themselves, crossing the sea, the desert, through no fault of their own. How well is the world doing to create access to much-needed healthcare on their journeys and in receiving countries? What is our responsibility to this staggering apocalyptic refugee crisis?

Policy-driven access barriers to essential health services for forced migrants and refugees have persisted in wealthier receiving nations with advanced public health plans.²³ As numbers grow and rising levels of medical needs appear, fear, xenophobic attacks, the erection of walls and fences, and restrictions to healthcare for asylum seekers take hold. Unwelcoming efforts often drive refugees into the hands of smugglers and traffickers.

In North America, yesterday's pioneers were refugees and immigrants who built the foundations of today's strongest economies. Yet in today's world migration crisis, their descendants have replaced altruism with harsh national populace policies, including travel bans, exclusion, protectionism, fear, and rejection. The United States imposed severe immigration restrictions in 2016, but it is not alone. Many European nations have laid down their own nationalist-driven unwelcome mats. In 1956 the world opened its arms to Hungarian refugees; today Hungary erects fences to keep refugees out.

In response to actions taken by the United States, Canada's prime minister sent out a welcoming tweet to the world's refugees on January 28, 2017:

To those fleeing persecution, terror & war,

Canadians will welcome you, regardless of your faith.

Diversity is our strength.

Nearly 50,000 people claimed asylum in Canada in 2017, including 20,600 who crossed the US border, mostly in Quebec.³⁴ Originally fleeing unsafe nations, they took Canada's welcome at face value, crossing a dangerous frozen northern border on foot or hidden in trucks. Yet Canadian government policy subsequently accepted only 63% of these refugee claims.³⁵ In 2017-18 only 7% of refugee claims by Haitians have been accepted. Access to public healthcare was delayed for months for many we treated. Uninsured pregnant mothers went without antenatal care. Children with asthma found it harder to breathe. Rejected refugee claimants became medically uninsured undocumented immigrants.

Caring for Refugees, New Immigrants, and Uninsured Women: Social Responsibility and Access to Healthcare

Government policy obstructing healthcare access for forced migration populations in Western nations is being used for immigration enforcement purposes. This is a direct challenge to the moral foundations of medical care and the social responsibility of physicians to access equity.

In 2002 the Medical Professionalism Project authors were moved to emphasize this threat to physician altruism, social responsibility, and health care equity in the *Charter on Medical Professionalism in a New Millennium*.³⁶ The charter asserts that changes to healthcare delivery systems in countries throughout the industrialized world threaten the foundations of medical professionalism:

The conditions of medical practice are tempting physicians to abandon their commitment to the primacy of patient welfare . . . the objective of all healthcare systems is the availability of uniform, equitable access. Physicians must individually and collectively strive to eliminate discrimination barriers to equitable healthcare access whether based on race, gender, socioeconomic status, ethnicity, religion, or any other social category. Altruism contributes to the trust that is central to the physician–patient relationship. Market forces, societal pressures, and administrative exigencies must not compromise this principle.^{36(pp243–246)}

This is becoming harder to do. The macro level of policymaking where corporate pressures trump ethical healthcare values cannot be trusted to make medically and socially responsible healthcare access decisions. It is too disconnected from the reality of the micro level, where endless lived realities of being undocumented and medically uninsured meet disease, disability, and death head on. Being in the room with a migrant 3-year-old refugee girl struggling to breathe for want of a \$10 asthma inhaler is as compellingly and shamefully grotesque an argument as can be made for affirmative social responsibility action.

Withholding basic healthcare access through an immigration-health policy matrix is not prudent for Western nations to take. Pushing healthcare costs down the line, letting diseases worsen, and harming an essential human labor force is arguably counterproductive and expensive. Public health and public safety research demonstrates the risks to societies of leaving infectious diseases untreated, persons unimmunized, and patients with serious mental health problems unmanaged. In 2003, with severe acute respiratory syndrome (SARS) and again in 2014 with the Ebola virus, asylum seekers without access to health insurance were arriving at our center from endemic geographies but were unable to afford community clinics and hospital screening.

Arguably, physicians hold their medical skills in trust for the society they serve—all its residents. When physicians are neutral on healthcare denial and inequity, they have chosen to side with those who create unjust policies. Threats to their careers, jobs, and remuneration can ensue for taking a stand. Sadly, medical ethics are not enforceable when

Caring for Refugees, New Immigrants, and Uninsured Women: Social Responsibility and Access to Healthcare

governments are complicit in access and social responsibility violations through their policies.

The current stance of European countries makes a farce of the UN conventions that they have all ratified, which include guaranteeing the right to health care for undocumented migrants. All member states should detach health care from immigration control and take the necessary measures to ensure that access to health care for undocumented migrants is uniformly implemented by national and local authorities.³⁷

Conclusion



In this chapter, we examined systemic barriers to healthcare for refugees and undocumented immigrants based on our experience at the CCRIHC. Although we focused on the Canadian healthcare system, our experiences can be generalized elsewhere. A 2012 review showed that only 5 of 27 European states were fully meeting their internationally agreed-to responsibilities for access to healthcare set down in United Nations and European Union agreements for undocumented migrants, including recently failed refugee claimants.²⁰ While we recognize some of the information may be out of date, in all cases government policies were responsible for restricting access.

Migration is a major issue facing the world today; the plight of refugees and undocumented immigrants is only expected to get worse.

Today, as yesterday, a nation is judged by its attitude towards refugees.

—Elie Wiesel, Nobel Laureate and human rights leader

References

1. Caulford P, Vali Y. Providing health care to medically uninsured immigrants and refugees. *Can Med Assoc J*. 2006;174(9):1253–1254. doi: 10.1503/cmaj.051206
2. United Nations. *New York Declaration for Refugees and Migrants. Resolution A/71/L.1*. New York; 2016.
3. United Nations. *International Migration Report 2017*. New York; 2017.
4. International Organization for Migration (IOM). *Migration Terms*. <https://www.iom.int/key-migration-terms>.
5. United Nations High Commission for Refugees. *Global Trends: Forced Displacement in 2016*. 2017. www.unhcr.org/statistics. Accessed March 15, 2018.

Caring for Refugees, New Immigrants, and Uninsured Women: Social Responsibility and Access to Healthcare

-
6. United Nations High Commission for Refugees. *Figures at a Glance*. 2017. unhcr.org. Accessed March 15, 2018.
 7. United Nations High Commission for Refugees. *UNHCR Global Trends: Forced Displacement in 2014*. 2015. www.unhcr.org.
 8. United Nations. *Population Facts*. Department of Economic and Social Affairs, Population Division. www.unpopulation.org.
 9. de Leon Siantz ML. Feminization of migration: a global health challenge. *Glob Adv Health Med*. 2013;2(5):12-14. doi:10.7453/gahmj.2013.065
 10. Adanu RMK, Johnson TRB. Migration and women's health. *Int J Gynaecol* 2009;106(2):179-181. doi:10.1016/j.ijgo.2009.03.036
 11. United Nations Office of Drugs and Crime. *Global Report on Trafficking in Persons*; 2014.
 12. Jewkes R. Intimate partner violence: causes and prevention. *Lancet*. 2002;359(9315):1423-1429. doi:10.1016/S0140-6736(02)08357-5
 13. Blitz B, d'Angelo A, Kofman E, Montagna N. Health challenges in refugee reception: dateline Europe 2016. *Int J Environ Res Public Health*. 2017;14(12):1484. doi:10.3390/ijerph14121484
 14. Keygnaert I, Dialmy A, Manço A, et al. Sexual violence and sub-Saharan migrants in Morocco: a community-based participatory assessment using respondent driven sampling. *Glob Health*. 2014;10(1):32. doi:10.1186/1744-8603-10-32
 15. Puri L. Op-ed: Empowering women and girl migrants and refugees. September 2016. <http://www.unwomen.org/en/news/stories/2016/9/op-ed-empowering-women-and-girl-migrants-and-refugees>.
 16. Piwowarczyk L, Fernandez P, Sharma A. Seeking asylum: challenges faced by the LGB Community. *J Immigr Minor Health*. 2017;19(3):723-732. doi:10.1007/s10903-016-0363-9
 17. Equal Rights Coalition. Statement on Situation in Chechnya, April 26, 2017. http://international.gc.ca/world-monde/issues_developpement-enjeux_developpement/human_rights-droits_homme/eqr-ced.aspx?lang=eng.
 18. Chávez KR. Identifying the needs of LGBTQ immigrants and refugees in southern Arizona. *J Homosex*. 2011;58(2):189-218. doi:10.1080/00918369.2011.540175
 19. Newbold KB, McKeary M. Journey to health: (re) contextualizing the health of Canada's refugee population. *J Refug Stud*, published March 3, 2018. doi:10.1093/jrs/fey009

Caring for Refugees, New Immigrants, and Uninsured Women: Social Responsibility and Access to Healthcare

20. Cuadra CB. Right of access to health care for undocumented migrants in EU: a comparative study of national policies. *Eur J Public Health*. 2012;22(2):267–271. doi:10.1093/eurpub/ckr049

21. Moris D, Kousoulis A. Refugee crisis in Greece: healthcare and integration as current challenges. *Perspect Public Health*. 2017;137(6):309–310. doi:10.1177/1757913917726019

22. World Health Organization. *Migration and Health: Key Issues*. Office for Europe euro.who.int. Accessed March 15, 2018.

23. Graetz V, Rechel B, Groot W, Norredam M, Pavlova M. Utilization of health care services by migrants in Europe—a systematic literature review. *Br Med Bull*. 2017;121(1):5–18. doi:10.1093/bmb/ldw057

24. Mahon A, Merry L, Lu O, Gagnon AJ. Postpartum pain in the community among migrant and non-migrant women in Canada. *J Immigr Minor Health*. 2017;19(2):407–414. doi:10.1007/s10903-016-0364-8

25. McKeary M, Newbold B. Barriers to care: the challenges for Canadian refugees and their health care providers. *J Refug Stud*. 2010;23(4):523–545. doi:10.1093/jrs/feq038

26. Campbell RM, Klei AG, Hodges BD, Fisman D, Kitto S. A comparison of health access between permanent residents, undocumented immigrants and refugee claimants in Toronto, Canada. *J Immigr Minor Health*. 2014;16(1):165–176. doi:10.1007/s10903-012-9740-1

27. Kalich A, Heinemann L, Ghahari S. A scoping review of immigrant experience of health care access barriers in Canada. *J Immigr Minor Health*. 2016;18(3):697–709. doi:10.1007/s10903-015-0237-6

28. Ahmed S, Shommu NS, Rumana N, Barron GRS, Wicklum S, Turin TC. Barriers to access of primary healthcare by immigrant populations in Canada: a literature review. *J Immigr Minor Health*. 2016;18(6):1522–1540. doi:10.1007/s10903-015-0276-z

29. Gagnon AJ, Dougherty G, Wahoush O, et al. International migration to Canada: the post-birth health of mothers and infants by immigration class. *Soc Sci Med*. 2013;76:197–207. doi:10.1016/j.socscimed.2012.11.001

30. Guilfoyle J, Kelly L, St Pierre-Hansen N. Prejudice in medicine: our role in creating health care disparities. *Can Fam Physician*. 2008;54(11):1511–1513, 1518–1520.

31. Hynie M, Ardern CI, Robertson A. Emergency room visits by uninsured child and adult residents in Ontario, Canada: what diagnoses, severity and visit disposition reveal about the impact of being uninsured. *J Immigr Minor Health*. 2016;18(5):948–956. doi:10.1007/s10903-016-0351-0

Caring for Refugees, New Immigrants, and Uninsured Women: Social Responsibility and Access to Healthcare

32. Wilson-Mitchell K, Rummens J. Perinatal outcomes of uninsured immigrant, refugee and migrant mothers and newborns living in Toronto, Canada. *Int J Environ Res Public Health*. 2013;10(6):2198–2213. doi: 10.3390/ijerph10062198
33. Shah RR, Ray JG, Taback N, Meffe F, Glazier RH. Adverse pregnancy outcomes among foreign-born Canadians. *J Obstet Gynaecol Can* 2011;33(3):207–215.
34. Siegfried K. *The Refugee Brief-22 March 2018*. United Nations High Commission for Refugees; 2018.
35. Immigration and Refugee Board of Canada. Refugee Protection Claims by Country of Alleged Persecution-2017. www.irb-cisr.gc.ca. Accessed March 15, 2018.
36. ABIM Foundation. American Board of Internal Medicine, ACP-ASIM Foundation. American College of Physicians-American Society of Internal Medicine, European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med*. 2002;136(3):243–246.
37. Access to health care for undocumented migrants in Europe. *Lancet*. 2007;370(9605):2070. doi:10.1016/S0140-6736(07)61872-8