# Reaching a hard-to-reach population such as asylum seekers and resettled refugees in Canada

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Global migration of people, whether voluntary or forced, means health-care professionals and staff need to communicate effectively as they care for progressively more diverse communities, often with specific needs, varied language abilities and literacy. Refugees and asylum seekers are forced migrants. They may have health needs related to their refugee status and may not have the language abilities or skills common among other types of migrants.[1] Although the proportion of refugees who resettle in developed nations under the United Nations convention is relatively small, most become citizens in their host country.[2] The challenge for health professionals in resettlement communities is how to reach these newcomers, in particular refugees and asylum seekers who may be isolated by language or lack of knowledge about the local health-care system.

An important way to influence the health of populations is through building relationships; for this, effective communication is essential. Clear communication enables trust and mutual understanding about expectations regarding health behaviour, needs and services.[3]

Communication in health care is important for three reasons: (i) exchanging important information about health; (ii) promoting ongoing care to restore health after treatment for illness; and (iii) relationship building for ongoing health maintenance. Effective communication approaches for providing public health information are particularly important for "hard-to-reach" populations such as forced migrants as their usual sources of information and family support are often fractured.[4]

In many resettlement countries, an industry in cultural competency/sensitivity training has evolved, in part to improve the way health workers meet the needs of their increasingly diverse populations.[5,6] These initiatives aim to reduce health disparities related to race and ethnicity. Communication skills (both verbal and non-verbal) are at the centre of cultural competency training, which is now part of many medical and nursing education curricula. In addition, standards or guidelines for practice have been introduced by many professional associations since the mid-1990s. The importance of these skills must not be underestimated. Health professionals educated before these changes may be inadequately prepared to work with diverse populations.

Newcomers who are unfamiliar with the health-care system may interpret relatively innocent events as evidence of discrimination or racism if they are not clearly explained by health providers. For example, waiting in an emergency department to be seen by a relatively junior physician may be interpreted negatively as discrimination (EO Wahoush, unpublished data, 2009). Negative experiences may result in subsequent avoidance of seeking health care. On the other hand, if verbal communication is difficult because of language barriers, patients can interpret non-verbal cues and so understand the intent of the health-care professional.

New approaches are needed for public health communication to reach newcomers and other hard-to-reach populations. In Canada, the ethnic media is underused as a vehicle for health information even though this media is a direct link into potentially isolated newcomer communities. In addition, health information and advice systems such as Telehealth Ontario are not well known among newcomers in general although this free telephone service provides advice from a health professional in more than 100 languages. New targeted marketing approaches using different communication vehicles may improve reach into newcomer communities as preferences for specific types of communication media differ among cultural groups and migration status.[7]

Cultural competency or sensitivity training may be helpful as long as stereotypes are not promoted and participants develop knowledge of the potential range of values and beliefs that influence diet, perceptions of illness, recognition of need for care and preference for type of health worker. The challenge remains how to help health professionals to be open to the differing views and expectations about health among their diverse clientele while avoiding stereotypes which may blind them to the individuality of their patients and communities. A renewed focus on communication skills and approaches for health-care professionals and public health information might provide better outcomes than cultural competency training alone. ■

## References


1. *Global refugee trends: overview of refugee populations, new arrivals, durable solutions, asylum seekers, stateless and other persons of concern to UNHCR*. Geneva: United Nations High Commission for Refugees;2005.
2. *Facts and figures 2007: Immigration overview permanent and temporary residents*. Ottawa: Citizenship and Immigration Canada; 2008.
3. Murphy ST, Censullo M, Cameron DD, Baigis JA. Improving cross-cultural communication in health professions education. *J Nurs Educ* 2007;46:367-72. PMID:17727000
4. Ward C. Migrant mothers and the role of social support when child rearing. *Contemp Nurse* 2003;16:74-82. PMID:14994898
5. Sirio CA. Educating medical students for cultural competence: What do we know? *CME Report* 2006;11:246-61.
6. Bryant R. *Regulation, roles and competency development*. Geneva: International Council of Nurses; 2005.
7. Viswanath K, Bond K. Social determinants and nutrition: reflections on the role of communication. *J Nutr Educ Behav* 2007;39 Suppl;S20-4. PMID:17336801 doi:10.1016/j.jneb.2006.07.008


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