MARITIME CENTRE of EXCELLENCE for WOMEN'S HEALTH

Promoting social change through policy-based research in women's health

Keeping Canadian Values in Health Care

Inclusion, Diversity and Social Justice in Health: Newcomers from Kosovo

The final report on a Symposium held in Halifax, Nova Scotia, by the Nova Scotia Council on Multicultural Health
December 1999

DALHOUSIE University

IWK Health Centre

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Executive Summary

A symposium was organized by the Nova Scotia Council on Multicultural Health (NSCMH) to bring together those who helped as part of a relief project to bring Kosovar refugees to Nova Scotia. The project was named "Operation Parasol". Non-government organizations as well as federal, provincial and local government departments and agencies collaborated to assist the Kosovar newcomers. These included Citizenship and Immigration Canada (Nova Scotia office), the Department of National Defense, Health Canada, the Nova Scotia Department of Health, the Nova Scotia Department of Community Services, the Canadian Red Cross Society, the Metropolitan Immigrant Settlement Association, Dalhousie University's School of Dentistry, the Nova Scotia Association of Optometrists, local hospitals and clinics, as well as interpreters and hundreds of community volunteers. The goal of the service providers was to provide the displaced Kosovar people with food, shelter, medical care and security.

The goals of the symposium were to:

- Share experience and knowledge related to the health and well-being of the resettled refugees.
- Discuss issues and lessons learned from the Kosovo experience.
- Identify barriers to inclusion, diversity and social justice in health care services for newcomers.
- Discuss the development of multicultural health policy based on a broad understanding of diversity and inclusion.

Several organizations and departments partnered with the NSCMH to provide the symposium. They included the Canadian Council on Multicultural Health, the Canadian Mental Health Association (Nova Scotia Division), the Maritime Center of Excellence for Women's Health, the Metropolitan Immigrant Settlement Association, and the Nova Scotia Department of Health. Presenters at the symposium included Dr Tom Ward (Deputy Minister of Health for Nova Scotia), Dr Fred Archibald (Family Medicine Physician at Windsor Park) and representatives of other agencies and departments that were involved with Operation Parasol. Audience members were invited to participate in the discussions. Key words and issues were noted and used to summarize suggestions for solving problems, as well as recommendations for helping communities to deal with similar issues in the future. Policy implications were described that pertain to federal and provincial governments, as well as to key organizations and agencies involved in newcomer resettlement.

Barriers to Health Service Provision for Newcomers

- Interpretation Challenges: Too few interpreters, interpreters not trained, and overworked.
- Inadequate preparation: too little time, not knowing what to expect because of the novelty of the situation.
- Newcomer community had a different cultural understanding of mental health and mental health services.
- Needing to meet the mental health needs of providers and interpreters who worked with the refugees.

- Need to meet the education needs of health professionals about the diverse physical, social and mental health needs of newcomers.
- Provider and public fears about contracting communicable diseases from refugees.
- Conflicting professional cultures.

Recommendations for Removing Barriers

Service Provision

- Provide culturally-appropriate health services to meet the diverse physical, social and mental health needs of newcomers.
- Link with groups or agencies with expertise in compassion fatigue and the other mental health needs of those who respond to crises.

Establish Coordinating Network or Advisory Committee

- Initiate team-building, networking and a clear strategy for meeting the diverse health needs of newcomers.
- Establish a coordinating network or advisory council that links resettlement programs, health and social services, educators, and newcomers
- Engage the coordinating network to collaborate in planning integrated or seamless care delivery, ensure appropriate resource designation in crisis and non-crisis situations, and serve as a bridge between multicultural policy development and health care services.

Education

- Recruit and train interpreters in medical terminology as well as cultural and linguistic translation.
- Integrate multicultural issues in education curricula and continuing education programs for health and social service providers and volunteers.
- Educate providers and the public about communicable diseases and cultural sensitivity.

Policy Development

- Formulate a vision or policy statement regarding the medical, social and mental health service needs of newcomers.
- Assess next steps towards the development and implementation of multicultural health policy.
- Establish a coordinating advisory council to monitor the removal of barriers to access, and plan the integration of services and the appropriate designation of resources.
- Lobby for the development of multicultural health policies. The Canada Health Act needs to be amended and provincial multicultural health policy needs to be developed to accommodate expansion of services to ensure that the mental, physical and social health needs of culturally diverse newcomers are addressed. Continuous funding is needed for the provision of programs that meet the needs of newcomers during non-crisis situations.
- Develop legislation that is sensitive to the culture, gender and age considerations of newcomers.
- Develop provincial standards for training and practice of cultural health interpreters.

Research

- Directly involve newcomers in community-based research about their diverse health needs.
- Determine the health service needs of women, elders, and children using a cultural, age and gender based analysis. Conduct culturally-relevant community-based research to shape policy, professional education, and service delivery.
- Conduct culturally-relevant, community-based research to help in the development of a knowledge base about the diverse health needs of newcomers.
- Develop a resource library with a database of information that can be used to educate providers about the needs of specific communities, their backgrounds, and the availability of resources.
- Use community-based research to convince federal and provincial governments to expand the current provision of services to include culturally responsive medical, social and mental health services for newcomers.
- Use community-based research about the diverse health needs of newcomers to shape practice, and inform the education of health professionals.

Keeping Canadian Values in Health Care
Inclusion, Diversity and Social Justice in Health: Newcomers from Kosovo

1.0 Summary of the Project

During April 1999, roughly 350,000 people from Kosovo fled their homes in an attempt to find safety (Currie, 1999). Canada responded to a United Nations High Commission for Refugees (UNHCR) call to evacuate Kosovar people and provide them with temporary shelter and permanent residence. Women with children and no husbands were prioritized, as were at-risk women and children, seniors, and people who were vulnerable because of experiences of trauma. The UNHCR stipulated that families would not be separated, even if it meant accommodating extended family members. By May 26 1999, 5,051 displaced Kosovar people had been airlifted to Canada as part of a relief operation that was code-named "Operation Parasol" (Currie, 1999). Careful coordination and hard work was required to provide for their needs. This was a massive endeavor that called on the sustained efforts of countless volunteers, federal and provincial governmental departments, and international and non-government organizations. They responded to the challenge with commitment and dedication, collectively pooling their strengths and expertise to provide a warm welcome to the refugees. Following the June 10 peace agreement, some Kosovars chose to return home. The first repatriation flight began on July 7, 1999 (Currie, 1999).

A symposium was organized by the Nova Scotia Council on Multicultural Health (NSCMH) to discuss the experiences of those who helped with Operation Parasol in Nova Scotia, lessons learned, and barriers and recommendations for improving health care services for newcomers. Presenters included Dr Tom Ward (Deputy Minister of Health for Nova Scotia), Dr Fred Archibald (Family Medicine Physician at Windsor Park) and representatives of other agencies and departments that were involved with Operation Parasol. Key words and issues were noted and used to summarize suggestions for solving problems, as well as recommendations for helping communities to deal with similar issues in the future. Policy implications were described that pertain to federal and provincial governments, as well as to key organizations and agencies involved in newcomer resettlement.

1.1 Symposium Goals

- To share experience and knowledge related to the health and well-being of resettled refugees.
- To discuss issues and lessons learned from the Kosovo experience.
- To identify barriers to inclusion, diversity and social justice in health.
- To discuss the development of policy based on a broad understanding of diversity and inclusion.

1.2 Service Provision

Non-government organizations as well as federal, provincial and local government agencies collaborated to assist the Kosovar newcomers. These included Citizenship and Immigration Canada (Nova Scotia office), the Department of National Defense, Health Canada, the Department of Health, Department of Community Services, the Canadian Red Cross Society, the

Metropolitan Immigrant Settlement Association, local hospitals and clinics, Dalhousie University's School of Dentistry, the Nova Scotia Association of Optometrists, as well as interpreters and hundreds of community volunteers (Appendix A). The goal of the service providers was to provide food, shelter, medical care and security. Soon after they landed at the military base at Greenwood Nova Scotia, the newcomers received clothing, meals, medical examinations and vaccinations. From Greenwood, people were transferred to sustainment sites in Halifax (Windsor Park) and Aldershot which offered shelter, medical clinics, dining and laundry facilities, recreation and child care facilities, and shops for basic supplies. There was consensus among conference participants that the various groups and agencies worked together with a spirit of cooperation and goodwill. The community was not passive. During Operation Parasol, the Kosovar community took control of organizational duties and responsibilities. People were mobilized within the community to address their sanitation needs. They also established a political structure which included a mayor. An Albanian newsletter was distributed. The experience of working with the Kosovo community was both personally and professionally rewarding for those involved.

Citizenship and Immigration Canada (CIC)

Staff at the CIC office had a month to prepare for the arrival of the Kosovar refugees. They had questions about what was needed and how they were going to meet the needs of the Kosovar people. Staff felt that they were not adequately prepared and that the reality of the situation was different than they had expected. Nevertheless, "everything came together" because of interagency cooperation. Sponsors were recruited to help the refugees stay in Canada. The sponsors had the opportunity to meet the refugees before they went into the community. It was an emotional time for everyone because of the relationship between the sponsors and refugees. Of the 403 Kosovar people who stayed at Windsor Park, 299 decided to stay in Canada, 102 returned to Kosovo, and one went to Switzerland. The department felt that their most valuable lesson was that many people come together with a spirit of cooperation during a crisis.

Department of National Defense

The military provided resources, infrastructure, equipment and personnel. The Canadian Forces had a number of briefings about Kosovar culture, language, religion and customs. The military contributed a unique skill set and found it challenging at times to work with other professional cultures. It is believed that they are in a much better position now that they have been through this once.

The Canadian Red Cross Society

The Canadian Red Cross was invited by CIC to provide a humanitarian touch in helping to meet the basic needs of the Kosovo refugees. One challenge was to manage the volunteers from the community and coordinate NGO contributions. In Nova Scotia, the Red Cross coordinated the efforts of over 4,000 volunteers. Another task was to match volunteers to activities. The advisory committees provided information to the volunteers. Another duty was managing the generosity of the donations received by coordinating and storing large amounts of items.

The Red Cross volunteers provided humanitarian assistance from the time the refugees arrived. From the time they got off the plane, individuals were escorted by Red Cross volunteers. Red Cross volunteers also worked as a liaison between the medical clinic and the people. They also assisted by providing social activities and play areas for the children. They had some difficulties with transportation, as there were too few vehicles for transporting large groups of people. The Red Cross did not want to impose activities on the people and wanted them to choose their activities. They set up an advisory committee which met on a regular basis to assess the community's needs. The Kosovar community helped to decide which recreation programs were provided.

Metropolitan Immigrant Settlement Association (MISA)

MISA was primarily involved at Camp Aldershot. Education modules were prepared and group sessions were offered which provided information about how to start a new life in Canada. About 60 to 70 people attended each session. Many asked basic questions about where they were and whether or not they could stay in Halifax. Many had concerns about events in Kosovo. The informative sessions were mostly attended by men, some of whom used them as a political forum.

Community and Housing

Housing was set up in Aldershot and Windsor Park. The latter was quickly transformed to provide a fully functional medical clinic and housing for 403 people. There were problems with the military barracks that were resolved by the refugee community themselves. The more important issues related to crowding. They included privacy, screening, hygiene, and public health concerns. There were 8 to 10 people per room. Amidst concerns about sanitary conditions related to crowding, public health inspectors and military personnel conducted an inspection. By the next day the community had taken responsibility for the issue, formed a committee, and had people in place to look after sanitation. Within two days, the refugee community had dealt with the hygiene issues. The community was very involved in resolving their problems. In Windsor Park the community had a mayor and a self-governance structure. They had a newsletter in the Albanian language and a Mosque was set-up. Meetings were held with the local Muslim community. High praise was given to this community for their help and their offer to help with any crises that might arise (e.g., a death; fortunately there were no deaths).

1.3 Health Services

1.3.1 The Medical Clinic

Various levels of government cooperated to help establish and operate the clinic from May 14 to July 22, 1999. There were 2,533 visits to the clinic. Most medical problems were not serious and related to chronic cardiovascular and pulmonary conditions and diabetes. There were 10 pregnancies, two births and 25 hospital admissions. Family support services were provided to 574 people. One of the most important challenges was keeping families together. The staff were aware of cultural and religious factors, such as providing female physicians for the women.

The clinic provided rooms for physicians, nurses and other health workers. The health providers were described as flexible and committed to helping the community. Health personnel were concerned about the Kosovar people being anxious or afraid, or having questions about the staff and the health care services that were provided. Administration in the clinic was provided by retired military personnel who volunteered as office managers. They provided immediate assistance and set up a data system to track people who required follow-up care. Nurses were at the clinic all the time and were described as the mainstay of the service providers. Nursing personnel included 33 registered nurses and 6 licenced practical nurses. The VON provided access to community organizations. Public health nurses and a nurse from Health Canada conducted contact tracing and statistical analysis. Medical care was provided by 21 physicians. Some were on-call at all times. Hospitals went out of their way to meet the needs of the people. Specialized health services included those provided by interpreters, pharmacists, public health nurses, mental health and family support workers, and staff of the dental, diabetic and optometry clinics:

1.3.1.1 Interpreters

Interpreters were described as providing the most important service. Contributors to the symposium agreed that they could not have functioned without them. The operation utilized the services of Albanian-speaking interpreters from all parts of Canada; some traveled from as far away as British Colombia to work in Nova Scotia. About 45 interpreters were needed at each base. Windsor Park had about 45 interpreters who were required to work at the medical clinic, hospitals, dental clinic, optometrists, public health, housing block, MISA, Red Cross, CIC offices, and with sponsors. Translation services were augmented with list s of phrases and body parts and a tri-dictionary. Interpretation services worked well for some providers, but the majority of service providers reported challenges related to the provision of interpretation services:

- One of the interpreters who provided interpretation in the mental health department described how Kosovo did not have mental health services, and that people were not familiar with what mental health providers did.
- One of the greatest challenges was that there were no interpreters who had been trained as health interpreters. This made it difficult for the service providers to impart the information they were trying to communicate. The translators tried hard, but they had been pulled from their daily lives and were inclined to interpret their own ideas.
- At times, there were no interpreters. Where there were no interpreters, the service providers were unable to communicate with the refugees.
- The interpreters had heavy work demands. They were needed in all areas. They worked 12 to 16 hour shifts including nights and weekends. One of their greatest challenges was working with the mental health department because there were so many cases.
- Some interpreters came from the Kosovo refugee group and had their own mental health issues. It was difficult for them as they were trying to deal with their own situations. It was important that the interpreters received mental health support.

1.3.1.2 Pharmacy Services

Pharmacy services were provided on site. A drug store was designated to provide and deliver supplies and medication as required. A total of 1,677 prescriptions were filled.

1.3.1.3 Public Health Services

The main role of public health personnel was surveillance and control of communicable diseases. Several medical and public health issues were identified. Sixteen people had Hepatitis B, but none were acute cases. One case of intestinal infection was found. All people who entered Canada over the age of 11 years had x-rays and skin tests. In Windsor Park there were eight cases of Tuberculosis (TB). In Greenwood there were five people with TB. Contact tracing was an extensive process and was conducted by the Public Health Department. They identified 61 contacts, a large number of whom were started on medication. Of these, only three people were identified as having TB through contact tracing.

Tuberculosis received prominence in the news media. Both health care providers and the public were worried about being infected through involvement with the refugees. Public health staff learned that one of their primary roles was to inform the public and other health professionals that there was an ongoing surveillance system in place to detect and prevent transmission of communicable disease.

1.3.1.4 Mental Health Services

There were concerns that many of the refugees had been traumatized by their experiences. They were troubled by memories of what had happened and many reported having nightmares. Mental health support was provided to those who wanted to talk. The refugees were described as trying to live normally. A symposium participant asked about military uniforms being threatening to the refugees. It was suggested that the Kosovar people had been helped by soldiers at refugee camps and that they may have become accustomed to uniforms. Nevertheless, many of the military personnel did not wear uniforms.

The Department of Community Services helped to coordinate a response to the psychosocial needs of the Kosovo refugees through a network that had been established during the response to the Swiss Air 111 disaster. Professionals from the network were contacted and a steering committee was established to select psychiatric mental health professionals who had at least ten years of experience.

1.3.1.5 Coordination of Psychosocial Response

- Identify goals and responsibilities.
- Identify support network and coordinate agencies in charge
- Establish a health steering committee
- Identify pool of available personnel.
- Identify how long emergency will occur and be flexible.
- Create a line of communication.

A mental health social worker and a mental health registered nurse were the first responders. Family support workers were also involved in the initial care of the newcomers. The network included local hospitals and mental health services in Greenwood. Staff were recruited from existing facilities (QEII Health Sciences Centre, IWK Grace Health Centre, NS Hospital) and worked on a rotation basis. At Windsor Park, mental health services were provided from the medical clinic. The staff wanted both medical and mental health services together in one area because of overlapping concerns that could be dealt with more efficiently and effectively if services were together. Mental health services were available for health providers, workers and interpreters.

Forms were developed to evaluate the need for mental health services. A comprehensive medical filing system was set up in Greenwood. The mental health status of individuals was indicated by color-coded forms that included recommendations for follow-up care. These color-coded forms facilitated the rapid identification of people who needed services once they arrived at Aldershot or Windsor Park. A document prepared by Ray Lafond (*Providing Emotional Support for Kosovo Refugees and Newcomers – A Guide to Responses and Caregivers*) was forwarded with their medical files.

1.3.1.6 Diabetes Clinic

The local Diabetic Clinic was contacted to provide care and education. A nurse, dietician and endocrinologist provided assistance to six individuals who required treatment.

1.3.1.7 Dental Clinic

The dentists of the Dental School at Dalhousie University volunteered their services and provided 362 of the 403 (90%) Kosovars with a dental examination. Those that needed further dental care were treated at the dental school.

1.3.1.8 Optometry Clinic

The Optometry Association in Halifax was contacted and jumped to the challenge. They conducted vision tests and examinations with 322 of the 403 refugees.

1.3.2 Summary

Symposium participants identified several challenges and barriers related to health service provision. These highlighted the importance of improving professional and public understanding of the physical, social and mental health needs of newcomers, and the need to provide culturally-appropriate services that meet all those needs. They also emphasized the need for recruitment and training of cultural health interpreters, as well as a coordinating network of key stakeholders to plan and coordinate the allocation of resources. These barriers reflect those encountered by other newcomers to Nova Scotia and highlight the need for collaborative, culturally-appropriate service delivery during both crisis and non-crisis situations.

1.3.3 Barriers and Challenges to Health Service Provision

- Community's health needs: Pre-existing illness; concerns about situation in Kosovo.
- Living conditions in housing block: Crowding and sanitation.
- Newcomer community had a different cultural understanding of mental health.
- Provider and public fears about contracting communicable diseases from refugees.
- Need to meet the education needs of providers about needs of newcomers.
- Inadequate preparation by providers: too little time, novelty of situation.
- Conflicting professional cultures.
- Interpretation Challenges: Too few interpreters, interpreters not trained, and overworked.
- Needing to meet the mental health needs of providers and interpreters.

1.4 Removing Barriers: Recommendations for Change

1.4.1 Service Provision

Newcomers vary considerably in terms of their backgrounds and needs. Services and treatment need to be delivered according to the short and long-term priorities of newcomers and service providers. Cultural sensitivity and responsiveness needs to be taught to health care providers, and culturally-relevant services need to be delivered to community members. For example, western models of psychiatric-mental health services emphasize individualism and talking. This may be inappropriate for those from cultures in which people have a collective identity and are uncomfortable about talking about themselves as individuals. Furthermore, in many cultures, people only disclose deep anguish with a few trusted individuals, such as spiritual leaders or close friends and family. Professional psychiatric services may be reserved for treating only the most serious mental illnesses. Some languages may not even have words for "psychiatrist" or "psychologist". Consequently newcomers may be guarded or withdrawn in their response to providers and it may take a long time to develop trust. The community members' need for autonomy needs to be assured in identifying priorities and deciding how to respond. People may prefer basic practical help that enables them to deal with their needs. Symposium attendees agreed that follow-up care is important as newcomers try to rebuild a >normal' life. Some individuals may have endured extreme trauma. Follow-up is especially important for preventing, detecting, or treating serious long-term problems such as post-traumatic stress disorder.

Recommendations

- Provide culturally-appropriate health services to meet the diverse health needs of newcomers.

1.4.2 Network or Coordinating Mechanism

Key Stakeholders

- Immigrant and non-immigrant communities.
- Local, provincial, regional and federal non-profit groups and government departments.
- Multicultural groups and advocates.
- Educators who provide basic and continuing education for health providers.

Symposium participants suggested forming a coordinating network or advisory committee composed of key organizations, service providers, and newcomers. Their role would be to plan continuity of services and the appropriate designation of resources in both crisis and non-crisis situations. Early access to culturally appropriate health services is critical for helping people to deal with the challenge of adjusting to a new life in Canada. Providers often work in isolation in their fields. Access to services is dependent on the effective integration and cooperation of existing resettlement support programs and health services.

Mainstream providers seldom tailor their programs for culturally-diverse populations. Currently there are no programs specifically targeted towards meeting the medical and mental health needs of newcomers in Nova Scotia. Some programs may address newcomer needs at the local level, but many newcomers do not receive services at all. There is a need for coherent, province-wide coordination of newcomer services with existing health services and support networks. Links between resettlement programs and health service providers, as well as education, housing, and social services can benefit newcomers by ensuring that their needs are detected and that they are referred to the appropriate providers. Any network or coordinating group must:

- result from a joint initiative between interested parties,
- seek financial support from a variety of sources,
- be a relatively permanent body,
- have a sustainable framework and,
- serve as a 'bridge' between policy development and multicultural health.

Recommendations

- Establish Coordinating Network or Advisory Committee
- Initiate team-building, networking and strategy for meeting diverse health needs of newcomers.
- Establish a coordinating network or advisory council that links key stakeholders.
- Engage the coordinating network in planning seamless care delivery, appropriate resource designation, and serving as a bridge between policy development and health care services.

1.4.3 Education

The provision of culturally-appropriate health services needs to be dependable and continuous. There is a need to educate health professionals at all levels about the importance of being culturally sensitive and responsive. This means encouraging the integration of multicultural health issues in education curricula of nurses, physicians, social workers, psychologists, NGO workers, and volunteers.

Trained interpreters are essential in crisis and non-crisis settings, including hospitals, physician offices, and other health care delivery environments. Lack of access or a shortage of trained interpreters can lead to critical misunderstandings or mistranslations which in turn result in misdiagnoses or inappropriate services. The symposium revealed that interpreters at the Kosovo refugee camps were mentally and physically over-worked. It is important that interpreters are

recruited and that they receive training in translating medical terminology and in providing cultural as well as linguistic translation.

Recommendations

- Recruit and train interpreters in medical terminology as well as cultural and linguistic translation..
- Integrate multicultural issues in education curricula and continuing education programs
- Educate providers and the public about communicable diseases and cultural sensitivity.

1.4.4 Policy Development

Policy Audiences

- Local and provincial health authorities: Departments of Health and Community Services
- Federal departments: Citizenship and Immigration Canada, Health Canada
- International organizations: United Nations High Commission for Refugees, NGOs

Two policy arenas that need to be targeted for change are the development of a Multicultural Health Policy for Nova Scotia, and changes to the Canada Health Act. We need to work together to lobby for the development of policies that advance culturally-appropriate health promotion, network development, provider education and licensing, and research:

- It is important to assess our next steps towards the development and implementation of multicultural health policy. It is important to build on other provinces' models (NSCMH, 1996).
- The Canada Health Act and provincial multicultural health policy need to accommodate the expansion of services to ensure that the mental, medical and social health needs of multicultural communities are addressed. Continuous funding is needed for the provision of programs that meet the needs of newcomers in non-crisis situations.
- A coordinating advisory council needs to be established to monitor the removal of barriers to access, develop plans for the integration of services and the appropriate designation of resources.
- Multicultural health policy needs to facilitate the development of provincial standards and training for cultural health interpreters, as well as basic and continuing education of health providers.
- Recruitment, retention and licensing issues: There is a need for health professionals who are immigrants themselves to have easier access to professional licensing upon immigration.

Recommendations

- Formulate vision or policy statement regarding health service needs of newcomers.
- Lobby for development of multicultural health policies and continuous funding for non-crisis care.
- Establish an advisory council to facilitate improved access to care by newcomers.
- Develop provincial standards for training and practice of cultural health interpreters.

- Develop legislation that is sensitive to the culture, gender and age considerations of newcomers.

1.4.5 Research

Newcomers need to be directly involved in culturally-relevant, community-based research about their health needs. An age and gender-based analysis would be helpful in determining the mental health issues of concern to women, elders, and children. This will have the benefit of facilitating community empowerment or capacity building and can help to:

- Shape health service provision. A resource library with a database of information can be used to educate providers about the needs of specific communities, their backgrounds, and the resources available throughout the province. It is important that the information is not used to stereotype people with specific cultures.
- Guide the development of federal and provincial multicultural health policy that promotes the expansion of current service provision to include culturally responsive physical, social and mental health services for newcomers. Legislation should be sensitive to gender and age considerations of newcomers.

Recommendations

- Conduct culturally-relevant, community-based research about health needs of newcomers.
- Determine health service needs of newcomers.
- Develop resource library to shape practice and educate providers
- Use research to convince federal and provincial governments to develop multicultural health policy.

1.5 Removing Barriers: Action Plan

1.5.1 Short term

Initiate Team-Building, Networking and a Clear Strategy: Immediately develop and compose a vision or a policy statement regarding the medical and mental health service needs of new and acculturated immigrant communities.

1.5.2 Medium term

Services: Convince federal and provincial governments to expand the current provision of services to include culturally-responsive medical, social and psychological services to immigrant and refugee communities.

Education: Disseminate knowledge and increase awareness about the need for cultural sensitivity and responsive health programs at conferences, in political and academic arenas, and through academic and training curricula.

Networking: It is important for stakeholders to be vocal about issues and to present a coordinated effort in lobbying to directly influence policy change, development, and implementation at the local and federal political level

1.5.3 Long term

Social and Economic Inclusion: The social and economic inclusion of immigrant people in areas of employment and community life are key determinants of their overall health. Government should designate resources for the long-term process of helping newcomers and not only provide 'crisis' aid.

2.0 Conclusion

Multicultural health care is an important issue that needs to be addressed by health care policy, education, and delivery. About 200,000 newcomers arrive in Canada every year, about 50,000 of whom are children. We need to be concerned about how their needs are met. Operation Parasol provided an opportunity to examine the delivery of multicultural health services in Nova Scotia. From the experience of helping the Kosovar people lessons were learned about the commitment and cooperation of key stakeholders as old linkages were strengthened and new linkages were forged towards a common purpose, namely helping the newcomers to recover from their experiences and adapt to life in Nova Scotia. Other lessons were learned too. Several barriers were encountered in the delivery of services to the Kosovars. These barriers reflect those encountered by other newcomers to Nova Scotia. Recommendations and an action plan were suggested for overcoming the barriers and building on the experience of helping the Kosovar refugees. They include steps toward meeting the need for culturally-appropriate service delivery, the need for education of interpreters and providers, the need for multicultural health policy, and the need to establish a network or coordinating mechanism to plan the seamless delivery of culturally-responsive services to newcomers.

The NSCMH organized this symposium in the belief that the concerns identified by providers who responded to the needs of the Kosovar community are part of a systemic problem. Commitment from key decision makers is required to address the need for health care that is accessible, appropriate and relevant to culturally diverse newcomers. This project reiterates the outcomes of previous projects in which participants have identified similar concerns about the need for culturally responsive health programs and services (NSCMH, 1996, 1997). It is our hope that the federal and provincial health departments, community health boards, and health service agencies will consider the results and recommendations of this project and take action. The NSCMH continues to advocate for a culturally responsive health system and we trust the results of this project will serve as a catalyst for change.

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Appendix A: Summary of Service Provision to the Kosovar Community

Key Providers	Resources Available	Services Provided	Numbers Served	Challenges
Family Medicine Dept/QEII, VON, Northwood, Public Health, IWK Grace, NS Hospital, Health Canada	**Medical Clinic** Nurses (33 RNs, 6 LPNs) 21 physicians Lab techs, medics, support staff	**Nursing Care**: Nurses at the clinic all the time • provided care • access to community organizations **Medical Care**: Physicians on call 24 hours per day, 7 days per week	**Medical Clinic** Operated from May 14 to July 22, 1999 • 2,533 visits • 1,677 prescriptions • 52 obstretric visits • 36 gynecology exams • 25 hospital admissions • 10 pregnancies • 2 births	• Keeping families together • Sensitivity to Muslim customs for women
Public Health, Health Canada	Nurses	Surveillance & control of communicable disease • Assessment & screening (X-rays, skin tests) • Contact tracing • Treatment • Statistical Analysis	• Tuberculosis: 8 cases; 61contacts traced & treated • Hepatitis B: 16 blood tests, no acute cases, 39 immunized • Intestinal Infection: 1 case	• TB • Hepatitis B • Intestinal Infection • Health providers fears of infection • Public fears and need for reassurance • Interpretation: difficulty translating health issues
Dental School	• Dentists • Dental School	• Dental examinations • Dental Care	362 dental exams (90% of population)	
Optometrist Association	Optometrists	• Exams • Vision tests • Detection of eye problems	322 eye tests	
Diabetic Clinic	Diabetes Nurse Dietician	• Care & Treatment • Education	6 cases	

Key Providers	Resources Available	Services Provided	Numbers Served	Challenges
	Endocrinologist			
Drug Store	Medications	Delivery and provision of medications	1,677 prescriptions filled	
Interpreters	45 Albanian interpreters at Windsor Park	Interpretation for hospitals, medical clinic, dental clinic, optometrists, public health, housing block, MISA, Red Cross, CIC offices, sponsors		• Hard work • Workload in mental health dept. • Long hours: 12 hour shifts • Personal mental health issues • Some came from Western Canada
Citizenship and Immigration Canada		• Recruited sponsors • Met refugees • Helped with settlement in Canada	• 299/403 stayed in Canada • 102 returned to Kosovo • remainder to Switzerland	• One month preparation • Most refugees wanted to go home • Too few interpreters
Department of Community Services	Professional network	Coordinate psychosocial response: • Develop goals and responsibilities • Identify support network • Establish health steering committee • Identify personnel pool • Create mechanisms for communication.		Providing support to interpreters: • Developing goals & responsibilities Mental Health Services to: • health care providers • interpreters • support staff
Department of National Defense	• Infrastructure • Equipment • Skill set, “can-do” attitude	• Housing • Clinic facilities	403 people - Windsor	• Crowding: 8-10 people per room • Clinic space

Key Providers	Resources Available	Services Provided	Numbers Served	Challenges
	• Windsor Park, Aldershot, Greenwood, Gagetown • Retired military personnel	**Administration**: • Data management system • Office management • Managed medical supplies		• Working with other professional cultures • Shortage of interpreters and difficulty communicating
Metropolitan Immigrant Settlement Association	Settlement support staff	Orientation and Information: • Basic needs, financial issues, medical concerns, immigration issues, starting life in Canada, geographic information	574 people Group sessions: 60-70 people per session	• Kosovars did not know where they were geographically • Kosovars concerned about situation in home country • Interpreters not trained
Canadian Red Cross Society	• Multifaceted role • 4,000 volunteers • Advisory committees • Humanitarian aid	• Social/recreation activities • Liaison • Transportation • Managing donated goods • Managing volunteers • Coordinating NGOs		• Not enough vehicles • Managing donated goods

Appendix B: Policy Fact Sheet

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1. Needing to provide seamless care to meet the physical, social and mental health needs of newcomers in culturally appropriate ways.	• Provide culturally-appropriate health services to meet the diverse mental, physical and social health needs of newcomers. • Lobby for the development of multicultural health policies and continuous program funding to ensure that the needs of newcomers are addressed during non-crisis situations. • Establish a coordinating network that links resettlement programs, health and social services, educators, and newcomers to collaborate in planning seamless care delivery, ensure appropriate resource designation for crisis and non-crisis situations, and serve as a bridge between multicultural policy development and health care services.
2. Needing to meet the mental health needs of providers and interpreters who worked with the refugees.	• Link with groups or agencies with expertise in compassion fatigue and the other mental health needs of those who respond to crises.
3. Inadequate preparation, not knowing what to expect and conflicting professional cultures.	• Initiate team-building, networking and a clear strategy for meeting the diverse health needs of newcomers. • Establish a coordinating network or advisory council to plan continuity of services and the appropriate designation of resources. • Formulate a vision or policy statement regarding the physical, social and mental health service needs of newcomers.
4. Interpretation Challenges: Too few interpreters, interpreters not trained, and overworked.	• Develop provincial standards for training and practice of cultural health interpreters. • Recruit and train interpreters in medical terminology as well as cultural and linguistic translation.
5. Need for dependability and continuity of culturally responsive services.	• Integrate multicultural issues in education curricula and continuing education programs for health and social service providers and volunteers.
6. Provider and public fears about contracting diseases from newcomers.	• Educate providers and the public about communicable diseases and cultural sensitivity.

Appendix C: Future Research Fact Sheet

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1. Need to provide care that is sensitive to cultural, religious, gender, and age-related health needs of newcomers.	• Determine the health service needs of women, elders, and children using a cultural, age and gender based analysis. Conduct culturally-relevant community-based research to shape policy, professional education, and service delivery. • Use community-based research to convince federal and provincial governments to expand the current provision of services to include culturally responsive medical, social and mental health services for newcomers. • Develop legislation that is sensitive to the culture, gender and age considerations of newcomers.
2. Different cultural understandings of mental health and mental health services	• Directly involve newcomers in community-based research about their diverse health needs. • Use community-based research about the diverse health needs of newcomers to shape practice, inform the education of health professionals, and guide policy development.
3. Need to meet the education and training needs of health professionals about the diverse mental, physical, and social health needs of newcomers.	• Conduct culturally-relevant, community-based research to help in the development of a knowledge base about the diverse health needs of newcomers. • Develop a resource library with a database of information that can be used to educate providers about the needs of specific communities, their backgrounds, and the availability of resources.