Refugee Claimant Women and Barriers to Health and Social Services Post-birth

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ABSTRACT

Objectives: Access to services for international migrants living in Canada is especially important during the postpartum period when additional health services and support are key to maternal and infant health. Recent studies found refugee claimant women to have a high number of postpartum health and social concerns that were not being addressed by the Canadian health care system. The current project aimed to gain greater understanding of the barriers these vulnerable migrant women face in accessing health and social services postpartum.

Methods: Qualitative text data on services that claimant women received post-birth and notes (recorded by research nurses) about their experiences in accessing and receiving services were examined. Thematic analysis was conducted to identify common themes related to access barriers.

Results: Of particular concern were the refusal of care for infants of mothers covered under IFHP, maternal isolation and difficulty for public health nurses to reach women postpartum. Also problematic was the lack of assessment, support and referrals for psychosocial concerns.

Conclusions: Better screening and referral for high-risk claimant women and education of health care providers on claimants' coverage and eligibility for services may improve the addressing of health and social concerns. Expansion of claimants' health benefits to include psychotherapy without prior approval by Citizenship and Immigration Canada is also recommended. Interventions aimed at social determinants underlying health care access issues among childbearing refugee claimants should also be explored. These might include providing access to subsidized language courses, social housing and government-sponsored benefits for parents, which currently have restrictive eligibility that limits or excludes claimants' access.

Key words: Emigration and immigration; postpartum women; access to health care; refugees

La traduction du résumé se trouve à la fin de l'article. *Can J Public Health* 2011;102(4):286-90.

Many who flee their country and seek refugee protection in another country, i.e., asylum seekers/refugee claimants, have suffered abuse and other traumatic experiences. Women are particularly vulnerable and may have been victims of sex and gender-based violence.[1] Once in a new country, their precarious status (not knowing if their application to stay in the country will be accepted), limited or no fluency in official language(s), separation from family members, and unfamiliarity with the country's systems and laws add further stress.[2] In Canada, claimants are covered for emergency and essential health care under the Interim Federal Health Program (IFHP).[3] Benefits covered include prenatal, contraception and obstetrical care; essential prescription medications; emergency dental treatments; and treatment and prevention of serious medical conditions. Other services such as counseling or psychotherapy, diagnostic procedures, ambulance services (unless for emergency) and eyewear are also covered but require pre-approval from Citizenship and Immigration Canada (CIC).[3]

Access to services among vulnerable migrants living in Canada is a major concern.[4] The postpartum period is a time when additional health services and support are needed. Our research to date examining the health and service needs of childbearing migrants has shown that refugee claimant women have a higher number of postpartum health and social concerns not being addressed by the health care system compared to Canadian-born women.[5,6] The current project aimed to gain greater understanding of the barriers refugee claimant women face in accessing health and social services in the post-birth period in Montreal and Toronto, the two Canadian cities that receive the highest number of claimants.[7] Guiding our work is the health capability framework proposed by JP Ruger[8] which suggests it is socially unjust for *any* individuals to be deprived of capabilities to be healthy as a result of suboptimal health care, inhibited health agency (i.e., ability to engage with and navigate the health care system to prevent mortality and morbidity and to meet health needs) and oppressive social norms.

METHODS

This study was a qualitative subproject of a larger four-year multisite prospective cohort study entitled "The Childbearing Health and Related Service Needs of Newcomers" (CHARSNN).[9] Ethical

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approval was obtained for CHARSNN from all participating universities and hospitals. For participation in the CHARSNN study, Canadian-born women and migrant women (≤5 years in Canada, speaking any of the 13 study languages) were recruited from among 12 postpartum units in Montreal, Toronto and Vancouver. All women giving birth during the recruitment period were screened for eligibility (N=58,342 women). Once a refugee or a refugee claimant woman was identified, an immigrant or Canadian-born woman matched by closest date and time of birth was recruited (immigrant and Canadian matches were alternated). All consenting participants were visited by a research nurse at 2 weeks and at 4 months post-birth to assess maternal and infant physical and psychosocial health and to record services received. These data were then independently reviewed by a nurse expert blinded to the research questions, city of residence and immigration status of the participants to determine whether the professionally-identified concerns (determined through the use of screening tools and objective criteria based on standards of care,[10]) were addressed by the health care system. For the current project, CHARSNN records of refugee claimant women in Montreal with ≥5 'unaddressed' concerns at either 2 weeks or 4 months post-birth and in Toronto women with ≥3 unaddressed concerns were qualitatively analyzed. Selection criteria differed by city in order to yield a comparable number of records for review. Vancouver was excluded due to too few refugee claimant participants at that site.

The data analyzed mainly included ad hoc notes recorded by the nurses during telephone and home contacts. These were not part of the planned CHARSNN data collection but provided insight regarding women's experiences in accessing and receiving (or not receiving) services. 'Care diaries' (maternal reports of care received between birth and 4 months postpartum and reason for care) provided information on services accessed. An in-depth analysis of these texts was conducted to identify themes related to access barriers.[11,12] A framework for categorizing the data was devised based on the research objective and an initial reading of the records. Ten to fifteen records were then reviewed to test and refine the categories (i.e., main themes) and to ensure consistency in how they were applied. All records were reviewed and text in the form of passages, quotations or single words was extracted and transcribed into a table containing all of the theme headings. The majority of records were coded by NK, the primary coder; the second coder LM reviewed records with French text and also reviewed and recoded a subsample (5-10% from each city) of records coded by NK to test reliability of the analysis. Discrepancies were resolved by discussions between the two coders. Once the coding was complete, the coders jointly reread the text segments within the context of the categories under which they were classified in order to identify patterns and subthemes that best summarized the main themes.

RESULTS

A total of 112 records were reviewed (51 Montreal; 61 Toronto). Background characteristics of the participants are detailed in Table 1. Montreal participants were mainly from Nigeria, Mexico and India; Toronto participants were from Nigeria, Mexico, Colombia and St. Vincent. Women were similar in age to the Canadian average age of women giving birth.[13] Most of the women had low levels of education, were living in poverty and were living without the father of their baby.

Table 1. Background Characteristics

	Montreal (n=51)	Toronto (n=61)
Demographic Variables		
Age (years), mean (SD)	29.2, (6.0)	28.5, (5.5)
Income (CDN $)		
<$10,000/yr	25	26
≥$10,000/yr	26	35
Level of education completed		
≤12 yrs	29	34
>12 yrs	22	27
Living with father of the baby		
Yes	32	31
No	19	30
Migration variables		
UN region of birth		
Africa	14	14
Asia	10	10
Europe	1	2
Latin America	26	35
Came from an area of armed conflict*		
Yes	16	19
No	34	37
Unknown	0	2
Spent time in Canadian immigration detention centre*		
Yes	6	6
No	44	50
Unknown	0	2
Length of time in Canada		
<2 yrs	45	39
≥2 yrs	6	22
Spoke English or French at 4 months post-birth* (could communicate well/fluently)		
Yes	25	33
No	25	25
Father of baby (living with mother and baby) spoke English or French when first arrived in Canada*	(n=31)	(n=29)
Fluently/Well in one or the other	17	18
With difficulty/Not at all in both languages	14	11
Health variables		
Parity		
Primipara	17	24
Multipara	34	37
Type of birth		
Spontaneous vaginal	29	32
Vaginal operative	1	6
Cesarean	21	23

* Data collected at 4-month home visit not available for 1 Montreal and 3 Toronto participants (women withdrew after the first home visit).

Six main themes emerged from the data: isolation; difficulties reaching mothers postpartum; language barriers; low health literacy; lacking psychosocial assessments, support and referrals; and IFHP being limited and confusing.

Isolation

The majority of women were new to Canada, having arrived less than two years prior to their baby's birth. Women reported being separated from family and friends and having no access to child care. They therefore felt isolated; they didn't know where to get services, had difficulty getting to services and overall felt they had "no one to help".

One research nurse in Toronto wrote:

"She is here as a refugee. She came alone and left her husband and 2 yr old child in China. She only speaks Mandarin. Mother is living in a small apartment with 4 other families she does not know - Mom claims none of them are her friends and they do not help her. No help, not enough food and not aware of social resources."

(24 y.o., China, 1 yr 4 mos in Canada)

Difficulties reaching mothers postpartum

A number of women were living in a shelter or had other temporary accommodation. Women moved frequently and were not eas-

ily reachable by phone. Some had no phone or it was out of service or their number had changed. Often women simply did not respond to calls. In other cases, their husband had the cell phone, or their phone was turned off or out of credits.

A research nurse in Toronto describes her experience in trying to contact one mother:

"I called several times. She was unavailable. It was difficult to locate her. A worker states she has left the shelter. 'Jessica', a person who lived at the shelter, knows the client and gave me her phone number."
(35 y.o., Nigeria, 7 mos in Canada)

Language barriers

At four months post-birth, many women could not communicate well in English or French. For women living with the father of the baby, most of the fathers also did not speak English or French well/fluently. Women had difficulty accessing language classes because they had no transportation or child care, did not know where courses were offered or could not afford to attend. Women therefore had communication difficulties when trying to access services. Interpreters were not available and women could not easily express their concerns or understand teaching and information given. Women also reported hesitating to call 911 in the case of an emergency for fear of not being able to communicate.

The research nurses reported:

"Mother wanted to learn French but needs money for bus pass."
(28 y.o., Nigeria, 5 mos in Canada, Montreal)

"The woman claims the social worker told her she has to research [English] classes on the internet herself. The woman paid someone to interpret at her [prenatal] visits. Public health nurse called to check on mom and baby but there was no interpreter so they were not able to communicate."
(26 y.o., Mexico, 8 mos in Canada, Toronto)

"She's been able to access services for learning French and she went but was told she could not go with her baby."
(30 y.o., Nigeria, 10 mos in Canada, Montreal)

Low health literacy

Thirty to forty percent of the mothers were primipara and close to half had experienced a cesarean or operative vaginal birth. As both new mothers and new to the country, women lacked knowledge about self-care and baby care, and due to the language barriers, teaching was poorly understood or not provided.

A Montreal research nurse explains in the following:

"Mother has had no nurse [visit] yet. She is a new mother who has very little info, intensive teaching had to be done... breastfeeding…mother does not know why she has to give vitamin D."
(25 y.o., Mexico, 1 yr in Canada)

"Mother doesn't know about 911. She said she would call neighbour or go to hospital.… She also said if there is no time she will pray to God for help…."
(25 y.o., Pakistan, 6 mos in Canada),

Due to their precarious migration status, women were also hesitant to seek care, especially for themselves. One Toronto research nurse describes two women's experiences:

"Mom will not pursue counseling regarding PTSD until she knows the results of the [refugee claim] hearing … Her symptoms are stronger than usual due to pending hearing and having to relate stories of her traumatic experiences."
(30 y.o., Colombia, 1 yr in Canada)

"Mom took baby to children's hospital due to respiratory distress. Mom is also sick but was not treated. She did not go to hospital for herself. She was told at the children's hospital that she will be sent a bill for $42 for baby visit. She was unable to find a physician to examine her. Mom said she was afraid to go to the children's hospital but went anyway as she was very worried about baby's health."
(27 y.o., China, 13 mos in Canada)

Lacking psychosocial assessments, support and referrals

Of the 50 participants in Montreal who received a 4-month home visit, 26 women had symptoms of postpartum depression (PPD) and 16 reported skipping meals due to lack of resources. In Toronto, 27 of the 58 women visited at 4 months had symptoms of PPD and 11 reported skipping meals. Many had also experienced abuse within the past year (10 of 36 and 12 of 54 who completed the screen in Montreal and Toronto, respectively). A number of women came from areas of armed conflict and slightly more than 10% had spent time in a Canadian detention centre. Despite their migration histories, rate of psychosocial concerns and low SES, very few of these women were being followed by support programs that exist in Montreal and Toronto and are meant to care for high-risk mothers.[14-16]

The lack of psychosocial assessment and support was clearly noted by the research nurses:

"She did not mention it [skipping meals] because the [nurse] had not asked."
(33 y.o., Congo, 1.5 yrs in Canada, Montreal)

"She [the mother] was unaware that there are health professionals who deal specifically with this type of abuse. She has never had any counselling."
(25 y.o., Mexico, 11 mos in Canada, Toronto)

"The [family] was told that since they are on welfare then they cannot receive anymore assistance…they cannot receive any more [food]coupons."
(21 y.o., India, 1 yr 4 mos in Canada, Montreal)

"She was told she would no longer receive milk and egg coupons, they are only for during pregnancy."
(38 y.o., Haiti, 1 yr in Canada, Montreal)

IFHP is limited and confusing

It was unclear to women and health care professionals which services were covered under IFHP and women and their infants were consequently refused care and/or charged fees.

The following research nurse excerpts illustrate these challenges:

"The doctor sent her [mother] for blood tests and did not tell her that they are not covered by insurance…"
(35 y.o., Nigeria, 7 mos in Canada, Toronto)

"The family practitioner charged her $50 for baby visit even though she had the form from hospital showing it was the health card for baby."
(32 y.o., India, 4 yrs 8 mos in Canada, Toronto)

"Mom has lost her documentation [IFHP]. Her social worker is helping her to get it replaced, but have not been successful. Mom is concerned she may not have access to healthcare for herself at present…"
(30 y.o., Nigeria, 10 mos in Canada, Toronto)

"Paediatrician refused to see baby because she had no medicare. One month later the paediatrician gave her an appointment but when mother said she still had no medicare then he cancelled it."
(36 y.o., Mexico, 6 mos in Canada, Montreal)

DISCUSSION

Refusal of care for infants of mothers with IFHP is alarming. Health care providers lacking knowledge of or willingness to accept IFHP is a known issue,[17,18] however the extension of refusal to infants of refugee claimants has not been brought to light. Isolation of new mothers and difficulty for public health nurses to reach women in the postpartum period are also important concerns for this population. Language barriers, hesitance to seek care and confusion related to IFHP[17,18] are similar to what many migrants generally have reported. This includes inaccessibility of interpreter services and not seeking services due to confusion regarding IFHP coverage or for fear it could affect their status. In the postpartum context, hesitance to seek care might also be due to mistrust or cultural inappropriateness of services for certain concerns such as depression or abuse.[19]

Implications for health care therefore include better postpartum screening to identify and refer high-risk mothers, such as women who arrived recently to Canada, those with limited language skills and/or not living with the father of the baby. Requesting additional phone numbers prior to hospital discharge, repeated calls and/or 'drop-in' home visits to women not easily reachable by phone are also recommended.

At the institutional and policy levels, strategies are needed to facilitate the use of interpreters and to educate clinicians on claimants' coverage and eligibility for services. Better teaching of emergency numbers and assessment and support for psychosocial concerns (PPD, abuse and food insecurity) according to maternal-child health best practices[10,20] are also needed. Recommended health literacy approaches for immigrants (e.g., plain language and pictograms) should also be applied in teaching to enhance usability of health information and services by refugee claimant women.[21]

On the immigration side, the addition of psychological services to the benefits covered for refugee claimants without prior approval by CIC could help streamline access to mental health services. Interventions aimed at social determinants (income, housing, social support) underlying health care access issues among childbearing refugee claimants should also be explored. These might include providing access to language courses, social housing and government-sponsored benefits for parents such as subsidized daycare, tax benefits and other child-related subsidies which currently have restrictive eligibility that limit or exclude claimants' access.[22-27]

The main limitation of this study is that it is a subproject of a larger study whose objective did not include understanding health care access barriers. Analysis was therefore limited to maternal reports of services received and ad hoc notes recorded by the nurses; access issues could not be explored in-depth with the women directly. The strength of this study is that it provides further evidence to the growing literature on health care access disparities and highlights concerns specific to childbearing refugee claimant women.

REFERENCES

1. Gagnon AJ, Merry L, Robinson C. A systematic review of refugee women's reproductive health. *Refuge* 2002;21:6-17.
2. Thomas TN. Acculturative stress in the adjustment of immigrant families. *J Social Distress and the Homeless* 1995;4:131-42.
3. Citizenship and Immigration Canada. *Interim Federal Health Program, Information Handbook for Health-Care Providers*. Edmonton, AB: FAS Benefit Administrators Ltd., 2006.
4. Rousseau C, ter Kuile S, Munoz M, Nadeau L, Ouimet MJ, Kirmayer L, et al. Health care access for refugees and immigrants with precarious status: Public health and human right challenges. *Can J Public Health* 2008;99:290-92.
5. Gagnon AJ, Dougherty G, Platt R, Wahoush O, George A, Stanger E, et al. Refugee and refugee claimant women and infants post-birth: Migration histories as a predictor of Canadian health system response to needs. *Can J Public Health* 2007;98(4):287-91.
6. Gagnon AJ. Childbearing Health and Service Needs of Migrants [oral presentation given at the CPHA 2010 conference: Public Health in Canada: Shaping the Future Together]. Archive of the CPHA Centennial Conference, 2010. Available at: http://resources.cpha.ca/CPHA/Conf/Code/Presentations.php?y=2010&l=E&t=1&p=1&name=gagnon (Accessed May 1, 2011).
7. Citizenship and Immigration Canada. *Facts and Figures 2008: Immigration Overview - Permanent and Temporary Residents*. Ottawa, ON: Minister of Public Works and Government Services Canada, 2009.
8. Ruger JP. Rethinking equal access: Agency, quality, and norms. *Global Public Health* 2007;2(1):78-96.
9. Gagnon AJ, Wahoush O, Dougherty G, Saucier JF, Dennis CL, Merry L, et al. The Childbearing Health and Related Service Needs of Newcomers (CHARSNN) study protocol. *BMC Pregnancy and Childbirth* 2006;6(31). Available at: http://www.biomedcentral.com/1471-2393/6/31 (Accessed May 1, 2011).
10. Health Canada. *Family-centred Maternity and Newborn Care: National Guidelines*. Ottawa: Minister of Public Works and Government Services, 2000.
11. Aronson J. A pragmatic view of thematic analysis. *The Qualitative Report* 1994;2:1-3. Available at: http://www.nova.edu/ssss/QR/BackIssues/QR2-1/aronson.html (Accessed May 1, 2011).
12. Attride-Stirling J. Thematic networks: An analytic tool for qualitative research. *Qualitative Research* 2001;1(3):385-405.
13. Statistics Canada. Mother's Day... by the numbers. 2006. Available at: http://www42.statcan.gc.ca/smr08/2006/smr08_047_2006-eng.htm (Accessed May 1, 2011).
14. La Direction des communications du ministère de la Santé et des Services sociaux. *Services intégrés en périnatalité et pour la petite enfance à l'intention des familles vivant en contexte de vulnérabilité, Cadre de référence*. Québec, QC: Bibliothèque nationale du Québec, 2004.
15. La Maison Bleue. 2010. Available at: http://www.maisonbleue.info/ (Accessed May 1, 2011).
16. City of Toronto. Healthy Babies, Healthy Children. 2010. Available at: http://www.toronto.ca/health/healthybabieshealthychildren/index.htm (Accessed May 1, 2011).
17. ter Kuile S, Rousseau C, Munoz M, Nadeau L, Ouimet MJ. The universality of the Canadian health care system in question: Barriers to services for immigrants and refugees. *Int J Migration, Health and Social Care* 2007;3:15-26.
18. Simich L, Wu F, Nerad S. Status and health security: An exploratory study of irregular immigrants in Toronto. *Can J Public Health* 2007;98:369-73.
19. Gagnon AJ, Carnevale FA, Saucier JF, Clausen C, Jeannotte J, Oxman-Martinez J. Do referrals work? Responses of childbearing newcomers to referrals for care. *J Immigrant and Minority Health* 2010;12:559-68.
20. Registered Nurses' Association of Ontario (RNAO). *Interventions for Postpartum Depression*. Toronto, ON: RNAO Nursing Best Practice Guidelines Program, 2005.
21. Simich L. *Health Literacy and Immigrant Populations*. Ottawa: Policy brief prepared at the request of the Public Health Agency of Canada, submitted to the Public Health Agency and Metropolis Canada, 2009.
22. Canada Revenue Agency. Employment Insurance (EI) and Workers and/or Residents Outside Canada. 2010. Available at: http://www.servicecanada.gc.ca/eng/ei/information/outside_canada.shtml (Accessed May 31, 2011).
23. Gouvernement du Québec. L.R.Q., chapitre A-29.011, Loi sur l'assurance parentale, 2005. Available at: http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/A_29_011/A29_011.html (Accessed May 31, 2011).
24. Canadian Council for Refugees. Children's rights, Access to services - Summary by province. L'accès aux services au Québec. 2008. Available at: http://www.ccrweb.ca/en/content/quebec (Accessed May 31, 2011).

25. Canadian Council for Refugees. Children's rights, Access to services - Summary by province. Accessibility of Services in Ontario. 2008. Available at: http://www.ccrweb.ca/en/content/ontario [serial online] (Accessed May 31, 2011).
26. Canada Revenue Agency. CCTB: Application and Eligibility. 2010. Available at: http://www.cra-arc.gc.ca/bnfts/cctb/fq_qlfyng-eng.html (Accessed May 1, 2011).
27. Canada Revenue Agency. UCCB - Application and eligibility. 2009. Available at: http://www.cra-arc.gc.ca/bnfts/uccb-puge/pplctn-eng.html (Accessed May 31, 2011).

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RÉSUMÉ

Objectifs : L'accès des immigrantes aux services de santé et aux services sociaux est particulièrement important après l'accouchement, quand des soins de santé et du soutien additionnels sont nécessaires au bien-être de la mère et du nouveau-né. Des études récentes ont révélé que les demandeuses d'asile ont un grand nombre de problèmes médico-sociaux non abordés par le système de santé canadien durant la période postpartum. L'étude en cours avait pour but de mieux comprendre les obstacles auxquels font face ces femmes vulnérables devant l'accès au système de santé.

Méthode : Des données qualitatives provenant des notes prises par des infirmières-chercheures sur les services reçus par les demandeuses d'asile durant la période postpartum et les expériences de ces femmes en essayant d'accéder aux services ont été analysées. Une analyse thématique à été faite pour dégager des thèmes communs concernant les obstacles à l'accès aux soins.

Résultats : Le refus des soins aux nouveau-nés dont les mères sont couvertes par le Programme fédéral de santé intérimaire (PFSI), l'isolement des nouvelles mères ainsi que la difficulté pour les infirmières de joindre ces femmes durant la période postpartum étaient particulièrement inquiétants. Nous avons aussi observé d'importantes lacunes dans l'évaluation, le soutien et l'aiguillage des femmes ayant des problèmes psychosociaux.

Conclusions : Une amélioration du triage et de l'aiguillage des demandeuses d'asile à risque élevé pourrait peut-être réduire le nombre de problèmes de santé non abordés par le système, tout comme la sensibilisation des professionnels de la santé à la couverture des demandeuses et à leur admissibilité aux services. L'inclusion de la psychothérapie sans approbation préalable par Immigration et Citoyenneté Canada dans les services de santé assurés améliorerait l'accès aux soins psychologiques. Des interventions visant les déterminants sociaux à l'origine des problèmes d'accès aux soins devraient aussi être envisagées. Il pourrait s'agir d'offrir aux demandeuses d'asile enceintes un accès à des cours de langues subventionnés, à des logements sociaux et aux prestations gouvernementales accordées aux parents, des services qui excluent ou limitent actuellement l'admissibilité des demandeurs d'asile.

Mots clés : émigration et immigration; réfugiés; femmes postpartum; accès aux soins de santé

Prendre soin

de vous et de votre bébé

Le livret *Prendre soin de vous et de votre bébé* est un guide pratique dont le but est d'aider les nouvelles mères à s'occuper de leurs bébés à partir de leur naissance jusqu'à ce qu'ils commencent à marcher. Il présente de l'information qui peut vous aider, vous et votre bébé, à rester heureux et en santé. Ce guide a été rédigé par des spécialistes de la santé publique qui se sont concentrés sur ce qu'il faut faire pour élever des bébés en santé et les protéger contre les blessures et les maladies.

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