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Barriers to and facilitators of health services utilisation by refugees in resettlement countries: an overview of systematic reviews

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Abstract

Objective. The aim of this study was to provide an overview of the previously reviewed research literature to identify barriers and facilitators to health service utilisation by refugees in resettlement countries.

Methods. An overview of systematic reviews was conducted. Seven electronic databases (Medline, Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsycINFO, ProQuest Central, Scopus, EBSCO and Google Scholar) were searched for systematic reviews of barriers and facilitators to health-seeking behaviour and utilisation of health services by refugees following resettlement. The two authors independently undertook data selection, data extraction and quality assessment using a validated tool.

Results. Nine systematic reviews covered a range of study areas and refugee populations. Barriers to health service utilisation fell into three broad areas: (1) issues related to refugees, including refugee characteristics, sociocultural factors and the effects of previous experiences; (2) issues related to health services, including practice issues and the knowledge and skills of health professionals; and (3) issues related to the resettlement context, including policies and practical issues. Few facilitators were identified or evaluated, but these included approaches to care, health service responses and behaviours of health professionals.

Conclusions. Barriers to accessing health care include refugee characteristics, practice issues in health services, including the knowledge and skills of health professionals, and the resettlement context. Health services need to identify barriers to culturally sensitive care. Improvements in service delivery are needed that meet the needs of refugees. More research is needed to evaluate facilitators to improving health care accessibility for these vulnerable groups.

What is known about the topic? Refugee health after resettlement is poor, yet health service use is low.
What does this paper add? Barriers to accessing health services in resettlement countries are related not only to refugees, but also to issues regarding health service practices and health professionals' knowledge and skill, as well as the context of resettlement. Few facilitators to improving refugee access to health services have been identified.
What are the implications for practitioners? The barriers associated with health professionals and health services have been linked to trust building, and these need to be addressed to improve accessibility of care for refugees.

Additional keywords: access to care, developed countries, health-seeking behaviour, service access.

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Introduction

The current forced global displacement of people is unprecedented and accelerating. The displacement grew 40% in just over 3 years from 42.4 million people in 2011 to 59.5 million in 2014.[1] By the end of 2015, the United Nations High Commissioner for Refugees (UNHCR) estimated that 65.3 million people had been forcibly displaced; of these, 21.3 million people were designated as refugees and 3.2 million were designated as asylum seekers, whose status as refugees is yet to be assessed.[2] The future of these people is uncertain, with many living for protracted periods in refugee camps in poor conditions.[3] When return to their home country is not possible, the goal for many refugees is resettlement in a high-income country.[4]

However, resettlement in a high-income country is not the end of a refugee's story. Often health remains poor, yet health service use is low. Globally, the use of health services by

refugee groups in high-income countries after resettlement is lower than host populations, despite the poorer health status of refugees. For example, among refugees settling in Australia, common health issues include communicable diseases, poor states of nutrition, poorly managed chronic, dental and/or optical health and the physical consequences of torture and trauma.[5] Such health issues can be exacerbated if access to and utilisation of health services is restricted or not taken up.[6]

Health service use is an important issue for resettlement. Prearrival health checks for a limited range of conditions are routine for refugees before departure from transit countries to countries of resettlement. However, some conditions are not appropriately screened for due to difficult conditions in transit countries,[7,8] such as anaemia, schistosomiasis and vitamin D deficiencies, which respond well to early detection and treatment, and are not universally included in prearrival checks. Further, prearrival health checks do not include many of the chronic and infectious diseases that are relatively common in refugee populations. This means that on arrival some refugees can have immediate health needs that are treatable and warrant medical care.[9] Without timely treatment, many conditions worsen, subsequently requiring more expensive interventions.[10,11]

Those healthcare professionals responsible for refugees after resettlement face several obstacles in meeting the needs of many refugees in a culturally appropriate way despite long recognition of these needs and challenges. Several reasons have been suggested as to why problems persist in this area, including lack of familiarity with health issues that are specific to country of origin or transit countries[12] and deferral of health assessments by the refugees themselves after their arrival in resettlement countries, which delays diagnosis.[13]

Several systematic reviews have explored possible reasons explaining the phenomenon of poor health service use by refugees following resettlement.[11,14–16] These reviews have covered a range of resettlement countries and have focused on different population groups,[14] health issues[15,17,18] and types of health services.[15,16,19] To better understand common barriers and facilitators to the access of health services by refugees in resettlement countries, we undertook an overview of systematic reviews that have explored these issues with the goal of developing a conceptual map that could be used to help plan services and identify gaps in the research.

Methods

Search strategy

With the help of a senior university librarian at La Trobe University, a search strategy was devised based on the STARLITE acronym[20] to identify systematic reviews that reported barriers and facilitators to health-seeking behaviour and utilisation of health services by refugees following resettlement. Search terms were determined on the basis of the PICO acronym (population, intervention, comparison and outcome). The approach is detailed in Table 1.

Seven electronic databases were searched for any review article published in English (Medline, Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsycINFO, ProQuest Central, Scopus, EBSCO and Google Scholar). No date limit was set and specific search strategies were used for each database with keywords based on the inclusion criteria (see Table 1). The final searches were conducted on 13 March 2018. In addition to the electronic database searches, the reference lists of included articles were scanned and examination of forward citations conducted using Google Scholar.

Table 1. STARLITE approach used in the literature search
CINAHL, Cumulative Index to Nursing and Allied Health Literature

Sampling strategy
Comprehensive: attempts to identify all relevant studies on the topic
Type of studies
Systematic reviews or literature reviews with a clear search strategy
Approaches
Six electronic databases; hand searching (reference lists and forward citations)
Range of years
No date limits
Limits
English language, developed country
Inclusions and exclusions
Inclusions
• Refugee and/or asylum seeker population
• Barriers to health service use, access or service provision identified
• Facilitators to health service use, access or service provision identified
• High-income countries
• Search strategy described
Exclusion
• Empirical research
• Refugee camps and transit countries
Terms used
Refugee*, Asylum seekers* AND health-seeking behaviour*, service use, access to health services, health service utilisation, access to care, resettled countries, high-income countries*
Electronic sources
Medline, CINAHL, PsycINFO, ProQuest Central, Scopus, EBSCO, Google Scholar

Data extraction and management

The Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) guidelines were followed for data extraction to enhance transparency.[21]

All search results were imported into EndNote X8 (Clarivate Analytics (Australia) Pty Ltd, Sydney, NSW, Australia) and duplicates removed. Titles and abstracts were screened for potential inclusion, with all potentially relevant full-text articles retrieved for full-text review. The inclusion criteria were applied independently by the two authors to assess eligibility, with discrepancies resolved by discussion. The following data were extracted from the studies included and tabulated: study name and year of publication, review objectives, databases searched, years searched, inclusion and exclusion criteria, number and types of studies and key findings. Directed content analysis was used to categorise findings from each review as either identified barriers and/or facilitators to health service use.[22]

The quality of each review was independently assessed by the two authors using the Assessment of Multiple Systematic Reviews (AMSTAR) tool.[23] The quality of the reviews was classified as high (AMSTAR score 9–11), medium (6–8) or low (0–5). Any disagreements were resolved through discussion.

Results

The search strategy resulted in the identification of 125 potentially relevant titles. After duplicates had been removed, 102 records were screened and 39 full-text articles were retrieved and assessed for inclusion. Of these, nine review articles[6,11,15–19,24,25] met the inclusion criteria for eligibility and were included for the overview (Fig. 1). Table 2 provides a summary of the systematic reviews included in this study and their quality rating.

Characteristics of reviews included in this study

The key characteristics of the nine reviews included in this study are given in Table 2. One review focused on pharmacy-related issues,[24] six were focused on general issues of settlement, including problems with disability, physical health issues and women's health,[6,11,16,17,19,25] and two reviews focused on mental health.[15,18]

Populations identified in the reviews included refugees, asylum seekers and healthcare professionals (nurses, midwives, pharmacists and general practitioners (GPs)). The number of papers included in the systematic reviews ranged from eight to 32, with between three and 12 databases searched. The most commonly searched databases were CINAHL (eight of nine reviews), Medline (seven of nine reviews) and PsycINFO (seven of nine reviews). All reviews included in this analysis were published between 2010 and 2017, with a total of 95 reported papers reviewed, however it was not possible to determine the extent of overlap because three reviews did not list the studies they included.[18,19,25] In the six reviews that listed the studies included, 95 individual papers were listed, with only four studies reported in more than one review.[6,11,15–17,24]

Methodological quality

Based on AMSTAR ratings,[23] two reviews were judged to be of high quality, two were considered to be of medium quality and five were considered to be of low quality (Table 2). Ratings of poor quality were due to the lack of a list of included and excluded studies, cross-checking of data extraction and differences due to study methodology. Other factors affecting quality ratings included lack of information about publication bias or how findings were analysed.

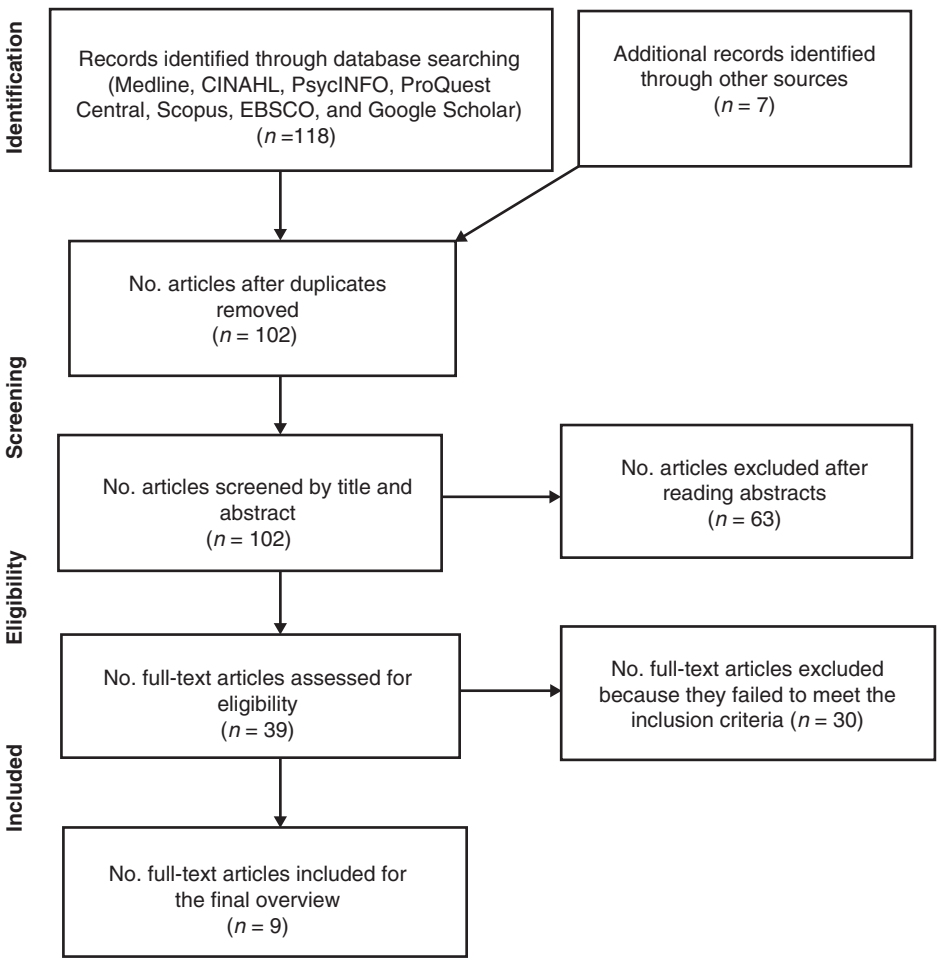

Fig. 1. Flowchart of search results and study selection. CINAHL, Cumulative Index to Nursing and Allied Health Literature.

Table 2. Summary of systematic reviews included in overview

AMSTAR, Assessment of Multiple Systematic Reviews; ERIC, Education Resources Information Center; GP, general practitioner; IBSS, International Bibliography of the Social Sciences; MM, mixed-methods study; Qual, qualitative study; Quant, quantitative study; SocioAbs, Sociological Abstracts; SWA, Social Work Abstracts; WHO, World Health Organization

Study	Objectives	Databases searched (years of search; date of search) and other searches	Inclusion and exclusion criteria	No. studies included	Participants	Main findings: barriers and facilitators to health seeking	AMSTAR quality rating
Bellamy *et al.*[24]	To explore barriers and/or facilitators to accessing medication and pharmacy services for resettled refugees	Scopus, ProQuest, Sociological Abstracts, PubMed, EMBASE and APAIS Health (1990–2014; March 2014) Other searches: government websites, TROVE and refugee organisation websites, The Grey Literature Report, OAIster, Open Grey, Mednar, WHO, Google Scholar	Inclusion: refugees accessing medication and pharmacy services Exclusion: non-English language, refugee camps, migrants and immigrants, and major focus on asylum seekers	9 (5 Qual, 4 Quant)	793 refugees, most from South-east Asia (at least 573) One study included a mix of refugees from African and Asian countries ($n=36$) Refugee origin not reported in one study ($n=184$)	Refugees: difficulties with language and navigating Western healthcare system, cultural barriers and discordant illness beliefs, use of traditional medicines, effects of family, peers and communities on health behaviour and adherence, illness beliefs affecting health-seeking behaviours and understanding, low levels of education and literacy Health services: inconsistent use of interpreter services, lack of information about local services Context: Western medication considered 'too strong', stigma associated with disease, role of preventive care	Low
Cheng *et al.*[19]	To explore the experiences of refugees and asylum seekers using general practice services in resettlement countries	Embase, Ovid MEDLINE, PsycINFO, CSA SocioAbs, and CINAHL (1990 and 2013; date of search not reported)	Inclusion: primary data describing individual refugees or asylum seekers' personal experiences of GP services Exclusion: experiences of mixed populations beyond refugee and asylum seekers	23 papers (13 focusing on refugees, 3 focusing on asylum seekers, 7 focusing on both; all Qual)	864 refugees and asylum seekers in 11 countries	Refugees: language barriers, poor doctor–patient relationships, problems with cultural acceptability of medical care, lack of knowledge of health system, including role of GPs and how to make appointments and access after-hours care Health services: lack of available interpreter services, inadequate cultural competency, high cost of medical care	Low

Colucci *et al.*[15]	To summarise issues with the use of mental health services by children and young people with refugee backgrounds, and to identify obstructions to service users and facilitators of access and engagement	PsycINFO, PubMed, Medline, CINAHL, SocioAbs, IBSS, ISI: Web of Science (from inception: 1966 for Medline, 1960 for PsycINFO; May 2011)	Inclusion: original research published in scientific journal or book with data relating to access or use of mental health services where data on refugees could be extracted (or if aggregated data for refugees and asylum seekers only reported) Exclusion: only asylum seekers included)	11 papers reporting 10 studies (8 Quant, 1 Qual, 1 MM)	At least 2193 participants (998 unaccompanied refugee minors, 105 refugee children (source country not reported); 537 refugee adolescents or young adults (from Middle East and Africa); 304 Sudanese (age not reported); 249 Palestinian refugee families)	Refugees: poor knowledge of mental health, low priority for mental health care, stigma and tendency to hide problems, lack of trust, lack of confidence to seek help, cultural factors including previous traumatic experiences Health services: lack of experience and confidence among staff, issues with training and/or time to recognise and manage complex needs and problems among refugees, language difficulties including translation or interpreter issues, gender issues, issues with appointments (e.g. booking systems, missed appointments, schedules, waiting periods, transport difficulties) Context: absence of partnerships or collaboration between agencies and service providers (effects continuity of care), high geographical mobility of refugees	Low
Hadkiss and Renzaho[6]	To assess physical health problems of asylum seekers and their issues with to access health services during settlement	MEDLINE, PsycINFO, Embase, CINAHL (2002–October 2012; date of search not reported)	Inclusion: adult asylum seekers residing in the community of high-income countries, published in peer-reviewed journal in English Exclusion: studies focusing on mental health or assessing burden of disease	32 papers for 30 studies (21 Quant, 9 Qual)	>20 000 asylum seekers settled in high-income countries	Asylum seekers: inability to pay for medical consultations, unable to navigate healthcare system, inadequate knowledge of availability and eligibility for health services, language and cultural factors Health services: long waiting times for all types of services and lack of continuity of care, mistrust over degree of confidentiality and security	High

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Table 2. (*continued*)

Study	Objectives	Databases searched (years of search; date of search) and other searches	Inclusion and exclusion criteria	No. studies included	Participants	Main findings: barriers and facilitators to health seeking	AMSTAR quality rating
						for health information, discrimination and poor attitudes among health professionals	
Hoffman and Robertson[17]	To provide a comprehensive perspective of documented physical and mental health issues of Karen refugees from Burma	Medline, PsycINFO, SWA, Scopus, and CINAHL (from 1966 for Medline, from 1978 for PsycINFO, from 1986 for SWA, from 1823 for Scopus and from 1937 for CINAHL; 2014)	Inclusion: Qualitative studies exploring experiences of Karen refugees on resettlement or quantitative studies of Karen refugee health and migration experiences Exclusion: if focus did not extend to after resettlement or if mental, physical or psychosocial health not included	18 papers (12 Qual, 6 Quant)	>3000 resettled refugees from Burma	Refugees: inadequate shelter, inaccessible education, unemployment, health care, communication issues, cultural factors, lack of education, gender norms, language problems, sense of powerlessness and disillusionment Health services: programs and services not targeted to meet specific health needs of Karen community	Medium
O'Mahony and Donnelly[18]	To gain an understanding of the mental health needs of immigrant and refugee women during the postpartum period	CINAHL, PsycINFO, MEDLINE (Ovid), EBM Reviews, Cochrane Database of Systematic Reviews (years of search not reported; date of search not reported]	Not reported	Not reported	Not reported	Refugees: language difficulties, unfamiliarity with accessing healthcare services, childcare issues, cultural factors leading to fear of stigma, lack of awareness of postpartum depression, disproportionate domestic work for women Health services: lack of social support, transportation difficulties, financial cost, lack of information about healthcare services	Low
Robertshaw *et al.*[16]	To explore challenges and facilitators for health professionals providing primary health care for refugees and asylum seekers in high-income countries	MEDLINE, EMBASE, PsycINFO, CINAHL, Web of Science (years of search not reported; March 2016)	Inclusion: qualitative studies involving GPs, nurses, pharmacists and midwives working with refugees in developed countries	26 papers reporting 21 primary studies (19 Qual, 2 MM)	469 healthcare professionals (including GPs, nurses, pharmacists, midwives)	Refugees: lack of trust in relationships, communication difficulties, poor health and social conditions, suspicion of authorities, unique physical health problems (including communicable diseases,	Medium

						female genital mutilation, injuries and psychological trauma from torture, abuse, social difficulties, somatisation) Health services: lack of training or guidance, time constraints, deficiency of professional support (supporting traumatised patients without support), isolation, referral difficulties Context: transience of refugees or asylum seekers, cultural values, health and social conditions, lack of language-specific resources Facilitators: continuity of care, assistance with wider needs, interest in refugee issues, compassion and empathy, explanation of roles of health professionals, using professionally trained interpreters, using visual aids, awareness of cultural values and body language, training and professional support, appropriate referral pathways, collaboration with other services, codelivery of services, service provision through multiagency teams	
			Exclusion: studies with mental health professionals, studies reporting service users as migrants or illegal migrants, studies published in languages other than English				
Szajna and Ward[25]	To determine access to healthcare services by the resettled refugee population using dimensional analysis	CINAHL, Scopus, and PsycINFO (2002–2011; date of search not reported)	Inclusion: studies on resettled refugees in English-speaking countries Exclusion: general migrants, illegal migrants	20 articles (types not reported)	Resettled refugees in English-speaking countries	Refugees: culture (including spirituality and religion), language, fear of discrimination and stigmatisation, and logistical concerns Healthcare providers: uncertainty over the cultural appropriateness of examination and feelings of apprehension when explaining reproductive procedures such as Pap	Low

(*continued next page*)

Table 2. (*continued*)

Study	Objectives	Databases searched (years of search; date of search) and other searches	Inclusion and exclusion criteria	No. studies included	Participants	Main findings: barriers and facilitators to health seeking	AMSTAR quality rating
						smears, gender-related issues when counselling refugees on birth control and consent for treatments	
Taylor and Lamaro Haintz[11]	To study the effects of social determinants of health on refugees in accessing healthcare services in Australia	EBSCO, MEDLINE Complete, Health Policy Reference Center, SocINDEX, CINAHL Complete, Global Health, PsycINFO, ERIC (from 2006; date of search not reported)	Inclusion: studies published in English, specific to refugees, based in Australia, peer-reviewed studies, at least one measurement relating to refugee healthcare access Exclusion: international studies, studies focused on migrants, asylum seekers or mixed groups	8 studies (6 Qual cross-sectional studies, 1 MM cohort study, 1 systematic review)	Participants from refugee backgrounds	Refugees: language difficulties (verbal and written), low health literacy, low trust in healthcare providers, transport difficulties, cost of healthcare services, poor navigation of healthcare systems, low literacy levels Health service: long waiting times, poor use of professional interpreter services, lack of culturally appropriate health information and communication, lack of cultural understanding, lack of knowledge about the refugee experiences	High

Table 3. Summary of key findings
GPs, general practitioners

Barriers			Facilitators/recommendations
Refugee and asylum seekers issues	Health services or systemic issues	Context of resettlement	
Characteristics	Practice issues	Policy issues	Approaches to care
• Communication or language difficulties	• Working with interpreters, including inconsistency in their use	• Design of health system including different layers of service provision	• Community-based approach
• Types of health issues	• Time constraints to address communication issues with patients	• Funding limits	• Family-centred and strength-based approach
• Low health literacy	• Complexity of paperwork and administrative processes	• Lack of refugee-specific resources	• Flexible primary healthcare system
• Lack of confidence to access services	• Referral difficulties, including geographical location and relationships with refugee organisations	Practical issues	Health service responses
• Financial constraints and employment status	• Lack of professional support in supporting traumatised patients	• Location of services	• Cultural competency training
• Unfamiliarity or poor knowledge of available services	• Lack of collaboration between agencies and service providers for continuity of care	• Availability of transport	• Support for GPs and refugee families
Social/cultural	Knowledge	• Connections between service organisations	• Universal access to health services
• Influence of family and peers	• Lack of cultural competency or cultural understanding	• Transience of refugee and asylum seekers	• Flexible appointment times
• Health beliefs and stigma	• Lack of knowledge about refugee health issues and experiences	• Different cultural values	• Explain roles of health professionals
• Cultural acceptability	• Lack of training on how to manage complex needs		• Colocated services: English classes, GP practices, pathology, pharmacy and specialist care
• Gender norms	• Lack of proper information system for refugees		• Refugee mentor programs
Effects of previous experiences			Health professional behaviours
• Distrust in services and service providers			• Use of effective communication, resources and techniques
• Fear of judgment and discrimination			• Use of demonstration to ensure understanding
• Previous exposure, torture or trauma			• Avoid refugee stereotypes and value individuals, focusing on their needs
• Pessimism and sense of powerlessness			• Develop personal qualities of sensitivity, empathy and cultural humility

Barriers and facilitators to health service access and utilisation

The barriers to accessing health services for refugees after resettlement fell into three broad domains: (1) refugee issues; (2) health service issues; and (3) the context of resettlement. Refugee issues related to the specific characteristics of the refugees, social or cultural factors and the effects of previous experiences. Health service issues focused on practice issues and the knowledge base of health providers. The context of resettlement could be grouped into policy or practice issues (Table 3). Only one study[16] looked at facilitators, and these included approaches to care, types of health service responses and behaviours of health professionals.

Discussion

This overview provides a synthesis of the current evidence of the barriers and facilitators to health service access by refugees following resettlement. The overview included nine systematic reviews, of which six comprised more than 90 unique studies covering a broad range of settings and population groups. In this body of literature, many more barriers to accessing healthcare services by refugees were identified than facilitators. A clear finding of the overview is that more attention has been given to describing problems with refugee health services than in finding solutions in this area. Only one systematic review identified interventions designed to improve refugee access to health services after resettlement,[16] although other studies recommended different strategies.[6,11,14,15,17–19,24–27]

Barriers to health care access fell into three distinct domains, namely refugee characteristics, health service or systemic issues and the context of resettlement, and these are interlinked. The most commonly reported barriers related to communication and cultural understanding and involved both refugees and those providing care. Refugees experienced language difficulties,[1,18–20,25,26] whereas health professionals used interpreters inconsistently and/or inappropriately in their

practice[11,15,18,19,24,27] and lacked the knowledge needed to provide culturally competent care.[6,11,15,19,25,27]

Despite the diversity of study settings, factors affecting access to health care were common across the systematic reviews. For example, refugees were described as lacking the capacity and/or confidence to navigate health services,[6,11,15,18,24–26] which was attributed to characteristics of the refugees, including communication difficulties due to language barriers,[11,14,16–19,24,25,27] low health literacy[6,11,19,24,26] and lack of knowledge and/or unfamiliarity with the services available.[6,11,17–19,24,26]

The issues related to healthcare providers and services were less frequently directly identified as barriers to health care access, but were acknowledged as key to developing trusting relationships with refugee groups in several reviews.[6,11,16,19,24–27] Factors associated with trust in these reviews included lack of cultural competency,[16,25,27] inadequate training or guidance,[16,27] lack of professional support,[14–16,24] poor communication between services[24] and insufficient time to address complex and sensitive issues.[15,18,19,27]

The resettlement of refugees to different countries, where different health systems and policies apply, means that some barriers to and facilitators of health care accessibility will necessarily be contextual.[27] The type and quality of resources available to refugees will be variable,[16] as will the level of support and political goodwill.[15]

Possible facilitators for improving refugee access to health care services were identified by Robertshaw *et al*.[16] and can be categorised as approaches to care and the response and behaviours of individual healthcare providers. Similar strategies to improving access to care were included as recommendations in other reviews[16,25,27] and appear to be based on the application of simple human principles, such as taking interest in refugees as individuals, showing compassion and empathy, explaining professional roles and asking and assisting refugees with their needs beyond their presenting health condition. Other recommendations to facilitate access to health care for refugees included in the reviews are the provision of ongoing social support, building capacity and confidence among refugees, establishing community networks and the appropriate use of interpreters.[19,24,25]

Support for integration of health and other services was a strong theme across the systematic reviews.[6,19,24,26] Other studies outside this overview have also proposed that indicators of integration, such as language acquisition,[28] access to labour markets[29] and the use of health and education systems over time,[30] are effective pathways to the better utilisation of services generally. Similar findings are found in systematic reviews that focus on immigrant populations.[16,25,27] The findings of the present overview highlight the need to support and build capacity in healthcare providers and health services, as well as in the refugees themselves.

Study limitations

This overview has several limitations. First, it was reliant on the quality and content of the systematic reviews included in the analysis. A minority of the reviews included were rated as high quality and the reviews covered a broad area of practice. Few reviews addressed facilitators for improving access to health care, and there was little evaluation of strategies that would make a difference. Nevertheless, the overview offers a useful picture of the topic and shows that these barriers are common across a broad range of areas and groups.

Conclusion

Appropriate access to health services is an important issue for refugees after resettlement. This overview shows that the barriers to accessing care involve more than issues associated with the refugees themselves and include practice issues in health services, the knowledge and skills of health professionals and the policies and systems of the resettlement country. Improvements in refugee health following resettlement will need strategies that address this broad spectrum of issues. Health services need to identify barriers within their control and consider how to implement culturally sensitive care for this vulnerable population. Improvements in service delivery that meet the needs of refugees are also likely to improve care for others from culturally and linguistically diverse backgrounds. Health professionals also need to consider how they may overcome their own practice and knowledge shortcomings to better meet the needs of their clients. More research is needed on evaluating the effectiveness of different facilitators to improving health care accessibility for refugees.

Competing interests

The authors declare that they have no competing interests.

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