



Winnipeg Regional
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Part Two: Developing an Evidence-Informed Response

Understanding the Health and Health Issues of Immigrant and Refugee Populations

**in Winnipeg, Manitoba and Canada
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Introduction to Part Two

Purpose

The purpose of this section of the report is to summarize available evidence on the health status and health issues of immigrants and refugees in order to provide guidance for evidence-informed health planning and service responses.

How Part Two is Organized

Part Two is organized into four main sections.

1. Health status of immigrants and refugees
2. Health issues of immigrants and refugees
3. Priority immigrant and refugee health service needs and populations
4. Implications for system planning

Data and Data Sources

While Part One focused on the demographic data of immigrants arriving in Winnipeg and Manitoba specifically, Part Two summarizes data from a number of sources: the national and international research on migrant health (including analysis of Canadian health surveys); local consultation and research activities; and, the broader literature on health disparities and culturally responsive care.

Challenges

There are a number of challenges in researching the health of immigrants and refugees in Canada.

- First, unlike the health data reported in some countries such as the United States, Canada's health data does not routinely incorporate ethnicity indicators (including indicators of immigration status, country of origin or time of arrival in Canada). The lack of ethnicity indicators creates challenges in monitoring the population of Canada's immigrants and refugees' health status, access, and prescribed treatment or health outcomes. It also limits exploration of immigration-related impacts. However, it should be noted that some reportable disease monitoring and cancer screening programs by province do collect ethnicity indicators.
- Second, while there is a growing research literature on disparities among various ethno cultural groups in Canada, there is inconsistency, and sometimes lack of clarity, around the variables used to define ethnicity. Should ethnicity be based on

- Third, much of the literature on disparities focuses only on one or more specific immigrant sub-populations. Findings for one population cannot be assumed to apply to others. Further, it may be difficult to interpret the findings in isolation from findings for the general Canadian population. Little Canadian research routinely analyses results by immigration status.
- Fourth, the interaction of many immigration-related factors creates challenges in research design and interpretation. For example, cross sectional studies of immigrants often are affected by the cohort effect; that is, recent arrivals may have better or worse health than their counterparts who arrived at an earlier time. Also, changes in countries of origin over time will have significant impacts on reported behaviours such as smoking. Changes in legislation around qualifications for entry can also confound research design and interpretation of the health of immigrants and refugees.
- Fifth, much of the data generated by research relies on self report, the validity of which is questioned given that health rating differs significantly among ethnic/cultural groups and is affected by language fluency (Evans, 2007; Flaskerud, 1988; Menec et al., 2007).

Data from Canadian Health Surveys

There are three national surveys which provide data that can be analyzed to provide insight into immigrant health; some of the research informing this report was based on these surveys.

- **The Canadian Community Health Survey (CCHS).** The CCHS is a *cross-sectional* survey that collects information related to health status, health care utilization and health determinants for the Canadian population. It relies upon a large sample of respondents and is designed to provide reliable estimates at the health region level.

It includes a number of questions related to immigration status (e.g. *In what country were you born? Were you born a Canadian citizen? In what year did you first come to Canada to live?*), race and ethnicity (e.g., *To which ethnic or cultural group did your ancestors belong? People living in Canada come from many different cultural and racial backgrounds. Are you ...?*), and language (*In what languages can you conduct a conversation? What languages do you speak most often at home? What is the language that you first learned at home in childhood and can still understand?*)

However, it is important to note that as the CCHS is a cross-sectional survey, it is difficult to disentangle cohort effects. Also, the sample size is not sufficient in size to allow analysis of regional level data according to time of arrival, world area of origin, or immigration status.

- **The National Population Health Survey (NPHS).** Launched in 1994/95, the National Population Health Survey is a *longitudinal* survey that collects information on health status and the factors influencing health from a sample of persons living in Canada. Questions related to immigration status, ethnicity and language are similar to those of the CCHS.

Although there are advantages to a longitudinal study, many limitations remain: there are risks to drawing conclusions due to cohort effects^a; there is limited information on immigrant subgroups; linguistic and cultural barriers may affect response rates; and use of proxy informants may affect reporting of health problems.
- **The Longitudinal Survey of Immigrants to Canada (LSIC).** The Longitudinal survey of Immigrants to Canada is designed to examine the first four years of a person's settlement in Canada--a time when newcomers establish economic, social and cultural ties to Canadian society. The LSIC has two objectives: to study how new immigrants adjust to life in Canada over time; and, to provide information on the factors that can facilitate or hinder this adjustment. Topics covered in the survey include language proficiency, housing, education, foreign credential recognition, employment, health, values and attitudes, the development and use of social networks, income, and perceptions of settlement in Canada. This survey also asks specifically about immigration category, and month and year of arrival.

The LSIC survey was administered in ten languages spoken, including English and French. The NPHS and the CCHS were administered in English and French only – in a few situations, family members assisted in translating for the respondent. The limitations of surveys in general, and the impacts of excluding those who do not speak a language in which the survey is conducted must be kept in mind when using the above survey data.

Despite these three specialized data sources, significant knowledge gaps in the area of immigrant health remain—particularly around health outcomes; preventable conditions and chronic disease outcomes; and, differences between various immigrant populations (Hyman, 2004). One recent development which attempts to address some of these knowledge gaps is the linking of immigration and health administrative data bases for research purposes (DesMeules, et al., 2004). It can be anticipated, therefore, that our knowledge in the area of immigrant health and health status will continue to expand over the coming years.

^a **Cohort effect** -- When people who immigrated at about the same time, such as during a given year or a particular decade, share various characteristics **as a group** (e.g., cigarette smoking) they are said to represent a 'cohort'. The 'effect' of the cohort comes into play when, for example, the per capita consumption of smoking in immigrants has declined, partly because the cohort of people over 50 years of age, who tend to smoke less, has proportionately increased.

Section 1

The Health Status of Immigrants and Refugees

Approximately one in five Canadians is foreign born and many others are Canadian born to foreign born parents. Considerable diversity exists within these populations. Perhaps the most important factor to consider in planning for immigrant and refugee populations is “time since arrival” in Canada, as the focus of immigrant service development is the newcomer population. However, other factors continue to affect health of these populations over time: immigration experience (e.g., voluntary immigrant vs. refugee); country/world area of origin; and English language proficiency. All of these factors interact with the broader determinants of health such as education, employment, social support and income, creating a complex context for health systems and service providers. Indeed, very few conclusions can be drawn about the health of ‘immigrants and refugees’ in general (Beiser 2005).

A. The Health Status of Immigrants and Refugees

Health status is essentially an indicator of the health of a person, group or population. There are various ways of measuring and assessing health status, including analysis of indicators of health status, such as traditional measures of mortality and morbidity (e.g., chronic diseases) and subjective assessments of people’s own health (e.g., self-reported health). As few indicators of immigrant status and ethnicity are tracked within the Canadian healthcare system, the main source of data on immigrant and refugee health is self-report.

1. Health Status of Immigrants and Refugees on Arrival

There is strong evidence that immigrants to Canada, in general, have higher health status on arrival than the general Canadian population (Ng et al., 2005). This so-called *healthy immigrant effect* has often been attributed to self-selection effects (healthier people are more likely to migrate) and government screening programs that favour newcomers who are young, healthy, and well-educated.

While these are the general patterns of health status of new arrivals, there are important differences between subgroups of new arrivals. It is important to consider diversity within the immigrant groups arriving (e.g., source country and other characteristics) and to distinguish immigrants by immigration category, as the research indicates important differences by year of arrival, country or world area of origin (source), and immigration status.

The healthy immigrant effect is generally not evident among refugees. Refugees to Canada often have much lower health status on arrival than that of voluntary immigrants, which may impact their health over the long term. They often arrive with additional health problems resulting from trauma, malnutrition and infectious disease

(Kinnon, 1999). Also, other immigrants (e.g., many family class immigrants) originate from countries with refugee-like conditions (e.g., war-affected countries).

There are special health issues affecting those who have non-official status in Canada (e.g., those who have not been accepted as permanent residents, or have a valid visa for temporary stay in Canada), as they do not have the same health care access as immigrants and refugees accepted to Canada. Although the number of refugee claimants (i.e., those who arrive in Canada asking to be accepted as refugees; not to be confused with the vast majority of refugees who arrive in Manitoba and are accepted as permanent residents) in Manitoba is quite small (only 6% of the total refugee population), Canadian research indicates that this population is of particular risk for both physical and psychological illnesses such as depression stemming from chronic stress, insecurity and often family separation (Simich et al., 2009). There is also evidence of higher rates of illnesses and conditions arising from trauma and infectious disease; increasing concern of excess morbidity; and, even wrongful death, arising from delayed access to care (Rousseau et al., 2008, ter Kuile et al., 2007).

Temporary foreign workers may also differ in initial health status from economic immigrants. Most are from countries where economic and political instability is creating the conditions which motivate their exodus to temporary employment; many are separated from family and, are working in stressful and sometimes dangerous occupations (Elgersma, 2007).

2. Changing Health Status of Immigrants and Refugees over time

In spite of their initial health advantage, over time the health of immigrants declines and converges with that of the native-born. Recent research indicates that this deterioration is noticeable relatively soon after arrival (Newbold, 2009; Ng et al., 2005).

Newbold (2009), for instance, found that the proportion of new arrivals reporting fair or poor health tripled over the four year period following arrival, while the proportion reporting excellent health declined from 37% to 19%. Significant declines in self-reported health were observed in the first two years after arrival. Further, in the time period between 6 months to 2 years after arrival, the proportion of arrivals reporting new emotional or mental health problems increased six-fold to over 28% of the population--refugees were the most likely to report such problems. The author also shows that recent arrivals may have more dramatic declines in health than immigrants who arrived in earlier cohorts—likely a reflection of increasing immigration from non-European countries.

These patterns of deterioration are complex, varying between economic migrants, family class immigrants and refugees. Economic arrivals tend to report better health on arrival than either family class or refugees, and are less likely to transition to poor health. In other words, not only do refugees arrive in poorer health, their health is also more likely to decline after arrival. Visible minority arrivals, in all immigration classes, are less likely to report excellent health than non-visible minority immigrants. Those

immigrants arriving from non-European countries are also twice as likely to report deterioration in health (Ng et al., 2005).

3. Explanations for the Decline in Immigrant and Refugee Health Status over time

In spite of increasing evidence of the deterioration in immigrant health over time, the reasons underlying this decline are still poorly understood. Several explanations have been proposed:

- a. *Environmental effects*, that is, the adoption by new arrivals of less healthy behaviours and exposure to the same environmental risks as those born in Canada. While this has been the dominant explanation to date, it is not likely that lifestyle choices could result in poorer health in the short time frame identified by recent research, nor is it supported by research on lifestyle factors (e.g., lower rates of smoking among non-European immigrants) (Beiser, 2005).
- b. *Linguistic and cultural barriers to health promotion and preventative and primary health care services* that place immigrants and refugees at greater risk of decreased health status over time. This notion is supported by immigrant health research that identifies: lower participation in screening programs (Latif, 2009; Lothers et al., 2007); later diagnoses of diseases such as cancer (Ashing-Giwa et al., 2004; Fitch et al., 1997); and links between language proficiency and self-reported health, particularly in women (Pottie et al., 2008).
- c. *The effects of stress* experienced by immigrants around adaptation to Canadian society, as well as status incongruity, discrimination and racism (Karlsen and Nazroo, 2002; Krieger, 2000; Stuber et al., 2008; Williams and Mohammed, 2009). The identified relationship between decline in health status and non-European country of origin supports this explanation.
- d. *The process of acculturation and familiarization with the health care system* has been used to explain the increased likelihood that immigrants will be diagnosed with a chronic condition over time (McDonald and Kennedy, 2004). As immigrants become better able to navigate the health system, they are more likely to interact with health care practitioners and thus the likelihood of illness diagnoses increases (e.g., the initial observed rates are in treatment prevalence, not true prevalence). Related to this idea is the theory that immigrants may under-report health concerns in the immigration application process, and may 'learn' to assess their health status in ways more similar to Canadian born residents (i.e., show less cultural variation in self assessment). However, there is as yet little evidence for this latter theory.

B. Factors Influencing Immigrant and Refugee Health Status

On arrival, immigrants and refugees move from one set of health risks, behaviours and constraints, to an environment that potentially includes a very different mix of risks with probable adverse impacts upon health. The following outlines several of the factors or determinants of health that influence immigrant and refugee health status after arrival.

1. Immigration Experience

The importance of the immigration experience to health is so significant that it has been proposed that the immigration experience itself should be considered a determinant of health for all immigrants (Gagnon, 2002). A number of factors affecting immigrant health status prior to, during, and post migration interact with other determinants of health in complex and diverse ways.

- a. *Experiences prior to migration.* Individual immigrants, even from the same country, come with different education levels, employment history, early childhood experience, levels of social support, and experience with the health care system. These factors can significantly impact their health and well-being both upon arrival and in the long term. For example, socio-economic status (SES) in the country of origin may affect nutritional status, access to and quality of medical and dental care, or risk of exposure to infectious diseases (e.g., HIV/AIDS, tuberculosis [TB] and parasitic infections). These individual level factors may vary significantly among those arriving from the same country.
- b. *The migration experience.* The circumstances surrounding departure from country and culture of origin can deeply impact health status (Kinnon, 1999). There are often great differences in experiences of migration between immigrants and refugees, and between groups of immigrants, depending on immigration class, country of origin, and period of migration. Refugees, who are forced to leave their country, may have been directly exposed to war, violence or other trauma. Others, both immigrants and refugees, migrate because of instability or economic insecurity in their country of origin. These factors often create both immediate and longer lasting health conditions.

There is also considerable individual variation in the length of time and conditions of migration. While most immigrants and some refugees come to Canada directly from their country of origin, others do not. Some are forced to spend months or even years in flight and migration, living in refugee camps or in intermediary countries; also, they are sometimes exposed to both physiological and psychological risks such as infectious disease, sexual violence, ongoing inter-ethnic violence (Adams et al., 2004).

- c. *Post-migration experience.* Post-immigration experiences, particularly the response from the receiving society (e.g., social supports and settlement services) also have significant implications for health and well-being. Post migration experience will vary depending on country of origin, year of arrival, and location of Canadian

The process of adaptation and acculturation, that is, the length of time required to become confident participants in Canadian society and institutions varies among both individuals and newcomer groups. Factors affecting this adaptation include age on arrival (and aging processes), education, official language proficiency, gender, employment status and opportunity, access to English/French language training, trauma experienced, reception by the receiving community, and individual coping strategies. While all immigrants go through phases of adjustment, “the permanent, forced nature of the refugee migration experience often makes...integration into society more difficult” (Gagnon, 2002).

2. **Income and Social Status**

Many new arrivals experience a decline in status, occupational level and income on arrival, leading to a situation termed ‘status incongruity.’ Status incongruity is a conceptual term from anthropology describing the impact of culture change on individuals’ well-being. Specifically, status incongruity describes the quantitative associations between exposure to nontraditional, Western ways of living—through migration or local change—and self-reported symptoms of physical and emotional distress or physiological measures of stress.(Graves & Graves, 1985; Pollard et al., 2000)

Recently arrived immigrants are disproportionately poorer than the general population (Galarneau & Morissette, 2004). It has always been the case that, on average, new arrivals earned less than the Canadian born, but until recently, their earnings slowly caught up with, and sometimes surpassed earnings of the Canadian born (Frenette & Morissette, 2003). However, over the past 25 years there has been a steady deterioration in the economic outcomes of new arrivals. The earnings gap between immigrants and the Canadian born continues to increase, in spite of rising educational attainment of immigrants (Picot et al., 2007). Several potential explanations exist for this trend:

- a. *Change in world regions from which the majority of immigrants are arriving.* The majority of immigrants are now arriving from non-European countries. As a consequence, there are often greater challenges: achieving English language proficiency, schooling inequivalency, and greater potential of discrimination.
- b. *Declining ‘economic returns’ from previous work experience.* Even immigrants who are well educated may end up being underemployed and fall into a low income category. It is noted that most entering immigrants realize virtually no economic benefit from

- c. *Deterioration of conditions for labour market entrants as a whole*, especially changes in demand for IT professionals.

These poorer economic outcomes are observed in spite of a dramatic increase in the educational attainment of recently arrived immigrants and the increased proportion of skilled economic class immigrants.

About 65% of entering immigrants have low income status at some time during the first ten years in Canada and, of these, two thirds are at this status during the first year after arrival. The “five-year” chronic low-income rate (i.e., the rate of low income four of the first five years in Canada) is approximately 19%—or 2.5 times that of the Canadian born and established immigrant population (Picot et al., 2007).

As is the case with health status, there are important differences in income between subpopulations (e.g., country/world area or origin, immigration category). Refugees are more likely to experience chronic low income (defined as being in a low income strata at least four of the first five years in Canada) than other classes (Picot et al., 2007, p.33). For example, in the cohort of immigrants arriving in 2000, after controlling for demographic differences, the chronic low income rate was 27% for refugees, compared to 13% in the family class, and 16% in the skilled economic class. Older immigrants and single parents, as expected, were more likely to be low income. (Picot et al., 2007).

Likewise, chronic low income varies by world area of origin. After controlling for other demographic differences among source of immigration regions, a low prevalence of chronic low income is found among immigrants from North America and Europe—approximately 8% in 2000—whereas, immigrants from Africa and East Asia had the highest rates of chronic low income—19% to 24% (Picot et al., 2007).

Picot et al. (2007) also found that:

- There is little difference between university degree holders and those with only a high school education in the likelihood of becoming low income over time. Over 40% of the chronically poor in the 2000 cohort had a university degree. (p. 32).
- Immigrants in the skilled economic class were *more* likely to enter low income than those in the family class—possibly because the family class immigrants often enter an already economically established family (p. 7).

These findings challenge two common perceptions about low income immigrants – i.e, that they have low levels of education and that they tend to be of the family immigrant class.

Another important factor affecting income is where the immigrant or refugee settles. For example, immigrants and refugees settling in rural or small towns appear to fare better economically than those settling in larger urban centres. Refugees in very large urban areas earn on average 43% less than the Canadian-born. In large and mid-sized urban areas, refugees generally earn lower incomes. However, in smaller areas, the gap is not as wide (Beshiri, 2004)

The important message from these findings is that poverty is a potential confounder of any relationship between immigration and health, and may contribute to the decline in immigrant health status after arrival in Canada.

3. Social Support Networks

By definition, immigrants and refugees are cut off from their established social support networks of extended family, friends, community, and work colleagues. A major task of 'settlement' in a new country is to establish new networks of social support. As for other social determinants of health, the challenges and time required to accomplish this vary, reflecting both individual and community factors.

Individual factors include factors related to migration experience, presence of family/friends in Canada, official language capability and personal coping skills. Community level factors include the reception by the receiving community, the size of the established immigrant/refugee population in Canada, and the health of this community. Ethno cultural "communities" affected by war, for example, are often not experienced as safe and supportive by new arrivals, as all 'sides' of a conflict may be resettled in the same location (Bowen, 1999).

4. Education and Literacy

Even though the average educational level of immigrants is higher than that of the Canadian born, this educational attainment does not bring the protective effect it would have in the immigrant's country of origin. First, as earlier indicated, educational achievements and credentials are often not recognized in Canada, leading both to lower income, and to stress effects (Dean & Wilson, 2009). Well educated immigrants may also have greater difficulties in adapting to life in Canada (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988; Bowen, 1999). Second, higher education does not necessarily translate into English language literacy. Many new arrivals lack official language fluency, leading not only to barriers to employment and adaptation, but to specific health literacy challenges (Baker et al., 1999; Gazmararian et al., 2003).

5. Employment and Working Conditions

As earlier described, even well educated immigrants may experience difficulty in finding employment for which they are qualified, leading to lower income, stress, and dissatisfaction (Bowen & Simbandumwe, 1998; Dean & Wilson, 2009). Language barriers place many new arrivals at particular risk of work injury (Premji et al., 2008; Smith & Mustard, 2009). This is exacerbated by the fact that many new arrivals are employed in sectors that are "dirty and dangerous," and are often provided with little

workplace orientation. Temporary foreign workers face additional challenges and are at risk of abuse within the workplace (Alberta Federation of Labour, 2007; Elgersma, 2007).

6. **Social and Physical Environments**

Some immigrants, and most refugees, often find themselves living in substandard housing and unsafe neighbourhoods. Winnipeg research has documented the extent of these living conditions and highlighted the challenges of these factors to successful adaptation (Carter et al., 2008). One study showed that one quarter of the study's refugee households did not feel safe in their neighbourhood in their first year; the same proportion also felt their housing was unsafe (Carter et al., 2008). This study also found that refugee families were highly mobile, further challenging successful integration. For example, in the first year after arrival, 93% of families had lived in more than one place; 25% had lived in more than three. Over one-half wanted to move to another location (60%) and the average length of tenure in the new location was just twelve weeks (Carter et al., 2008).

Some newcomer families are large, creating additional housing challenges and increasing risks due to overcrowding. Overcrowding and poorly maintained housing increases health risks—e.g., risk of injury and transmission of infectious disease. Crowded living conditions combined with stress may also contribute to reactivation of tuberculosis (Reitmanova, 2008).

7. **Health Services and Health System Organization**

While the health system itself is not the major determinant of health status, health service delivery has the potential to affect future health, particularly at times of individual vulnerability. Health systems that fail to provide equitable care have the potential to exacerbate social disparities and contribute to lower health status (Bowen, 2001).

Immigrants to Manitoba are fortunate in that all classes of immigrants (including refugees and family class immigrants) are eligible for Manitoba Health coverage immediately on arrival. However, those who do not have official status are not covered under Manitoba Health, but are covered for critical services under the Federal Interim Health Program. This coverage does not prevent new arrivals from being disadvantaged by health system organization.

- a. ***Quality of communication.*** Barriers to effective communication (e.g., lack of health literacy) present some of the greatest risks to immigrant and refugee health. It is also important to note that the risks of using family, friends or other untrained helpers are often as great as the risks of no interpreter at all because privacy rights can be violated (Bowen, 2004; Office of Minority Health, 1999).
- b. ***Access to health promotion and prevention information.*** The greatest negative impact results from barriers to health promotion/prevention and primary care information

and services. Cultural sensitivity remains a significant issue for Canadian immigrants. Consider that cultural practices that prohibit females from being attended by a male physician or health professional further limits the access of newcomers to health promotion/prevention and primary care services. For example, immigrant women are less likely to participate in cervical cancer screening (Latif, 2009; Lofters et al., 2007). Barriers to prevention and primary care can have enormous impacts on long-term health.

- c. ***Lack of cultural proficiency within health care.*** Stereotyping and discrimination may affect health and well-being in many ways, either through the actions of individual health providers or through institutional practices that have the effect of preventing barriers to service or inequitable care (Bowen, 2008). Providers are not well prepared to meet the needs of a culturally diverse population (Azad et al., 2002; Flores et al., 2000) and Canadian health care services are designed around the needs and understanding of the established Canadian-born community (Bowen, 2001). Providers may lack expertise with diseases, conditions and experiences of their newcomer patients, affecting both quality and appropriateness of care.
- d. ***Availability of specialized services.*** A small proportion of immigrants and refugees require specialized services rarely needed by those born in Canada and for which professional expertise may not be readily available. These services include expertise in tropical disease diagnosis and treatment and specialized mental health services for torture survivors.
- e. ***Other factors*** include lack of orientation services, lack of full health coverage for refugee claimants (and administrative and informational barriers to the services they are eligible for), and non-financial barriers to care such as lack of knowledge of services or language barriers (Doyle R, Visano L. *A time for action: Access to health services for members of diverse cultural and racial groups.* Toronto: Social Planning Council of Toronto, 1987).

8. Other Factors (Health Determinants)

- a. ***Gender.*** Gender is an important factor that may interact with immigrant/refugee status and with other social determinants of health. Men and women may have different experiences (both pre- and post-migration) in terms of poverty, housing, un/employment, social networks and support, and discrimination; they may also differ in their health behaviours and use of services (Llacer et al., 2007). The relationship between self rated health and language proficiency is particularly significant for women (Pottie et al., 2008). Changing gender roles may create both challenges and opportunities. However, these factors vary both among immigrant subpopulations, and among individuals within the same population (Beiser, 2005). And, while the vulnerability of women during migration and resettlement has been emphasized in the literature, there is some evidence that women may have adaptation advantages, particularly in some communities (Bowen, 1999).

- b. **Personal health practices and coping skills.** Practices and skills are often focused on traditional health practices—these have received significant attention in the area of refugee health. While it is important for health professionals to be aware of the variation in health beliefs and practices *across* countries of origin, it is also important to be aware that beliefs and practices vary *within* countries of origin according to region, education, religion and other factors among subpopulations within the same country. Many traditional practices support both psychosocial and physiological health, and many immigrant populations have a lower rate of unhealthy behaviours such as smoking (Ng et al., 2005). Strategies for supporting traditionally healthy practices (e.g., diet, family cohesion) should be explored.

- c. **Healthy child development.** The major risk for children of immigrants is the risk of living in poverty. In spite of the challenges of adaptation, there is some evidence that, in general, immigrant children do better emotionally, and may be less likely to adopt unhealthy lifestyle habits than the Canadian born. One study, based on the National Longitudinal Survey of Children and Youth found that although they are twice as likely to live in poverty, immigrant children had lower levels of emotional and behavioural problems (Beiser et al., 2002). However, there is great variation among the immigrant population and, therefore, the child population and its needs. Furthermore, unaccompanied minors and refugee children who have experienced trauma or torture bring additional needs (Crockett, 2005). The Canadian Centre for Victims of Torture (CCVT) in Toronto reports that, of clients served in 2004-2005, 24% were children or youth (CCVT, 2004).

In terms of income, the economic disadvantage experienced by immigrants does not, in general, disadvantage their children; children born in Canada to immigrant parents are more likely to stay in school and achieve higher levels of education. And, while males in some (particularly visible minority) populations continue at an earnings disadvantage, female children are more likely to earn more (Palameta, 2007).

- d. **Biology and genetic endowment.** There is an increasing, although controversial, trend within medicine to tailor assessment and treatment to the genetic/racial background of individual patients (Brooks & King, 2008; Lee, 2009). Certain diseases and conditions are found more commonly in certain populations, although there is evidence that many differences relate to environment (risk/benefit often approaches that of the host population after immigration). However, prevalence of some conditions and response to some treatments (e.g., pharmaceuticals) does vary by population groups (Kurian, 2010; Cardarelli, 2007; Creatore, 2010; Jarvis, 2002). The challenge for medicine is to provide individualized care while avoiding simplistic and often dangerous stereotyping.

C. Implications for Planning

The health status of new arrivals, while generally higher than that of the Canadian born, begins to deteriorate after arrival.

There are disparities among immigrant subgroups both in initial health status on arrival and likelihood of transitioning to poorer health status following settlement in Canada. Refugees are more likely than economic immigrants to report poor health. Non-European immigrants are also more likely to transition to poor health than those of European background.

As the decline in health status occurs very soon after arrival, it is important to address health and social needs of newcomers immediately upon arrival. Opportunities to prevent this decline in immigrant health, and to avoid the costs of more intensive health services, are missed if planners only focus on the reported 'high' health status of immigrants without considering the rapid decline experienced soon after arrival.

Effective responses must be based on an understanding of the complex inter-relationship of immigration experience with other determinants of health, and recognition that an individual's immigrant status and experience is but one of that individual's many cultural identities. It is essential that any response recognize the diversity of experience both among communities and among individuals from the same newcomer communities.

Health and preventive services must take into account the specific health issues and health risks related to specific subpopulations. As will be discussed in the next section, **health issues vary significantly among individual immigrants and specific immigrant subpopulations.**

Section 2

Priority Health Issues of Immigrants and Refugees

There are a number of health issues of priority to new arrivals. Some of these health issues are simply the result of being recently arrived in a new country, others are related to the country or world area of origin, or to the circumstances related to immigration. In order to facilitate planning, Section 2 is organized according to the following headings, “Health Status Related to”:

- Newcomer Status
- Country or World Area of Origin
- Immigration Experience
- Language and Cultural Barriers

A. Health Issues related to Newcomer Status

1. Issues on Arrival

Newcomers to Winnipeg face a number of barriers simply due to their status as new arrivals. Most lack familiarity with the Canadian health care system. The challenges of learning to navigate the system can be more acute for those from non-European countries (the source of most current immigration) where alternate understandings of health, disease or health maintenance may be common, and where the roles, rights and responsibilities of both patients and providers may be significantly different than those in Canada.

Newcomers may be unsure about what health services are provided through the public system or, how best to access care. Expectations about roles, communication, wait times, and/or care schedules (e.g., immunization schedules) may vary significantly. While all Canadians currently face challenges in finding a primary care provider, this challenge is more acute for new arrivals who not only lack the family or friendship contacts that often provide referrals but who may arrive with existing health problems. New arrivals also do not have established care relationships with other health providers such as dentists and pharmacists.

Some new arrivals may also be naïve about local health risks. For example, consultations with Winnipeg new arrivals found that some new arrivals had been told in their country of origin that Canada was a ‘clean’ country and, therefore, need not worry about sexually transmitted infections (Bowen, 2004).

Orienting new arrivals to the health system traditionally has been left to settlement organizations that are not resourced to undertake this activity. Winnipeg-based research which included community consultations found that many of the settlement staff responsible for such orientation is not knowledgeable about the health system (Bowen, 2004).

2. Longer Term Implications

Unaddressed need for orientation to the health care system may have long lasting effects on both health outcomes (e.g., lack of participation in cancer screening programs) and patterns of health utilization (e.g., reliance on emergency rooms [ER] or walk in clinics for ongoing care). Of particular concern are the barriers to prevention, promotion and screening services as Canadian research indicates that new arrivals are less likely to have a regular source of care and are less likely to participate in cancer screening programs (Latif, 2009).

B. Issues related to Country or World Area of Origin or Transit

Many of the best known issues related to immigrant/refugee health are related to immigrant source and/or transit countries where there is greater risk of exposure to certain diseases and conditions. Some of these health issues may also be experienced by Canadians living abroad. It is important to keep in mind that many of these issues are related to risk exposure related to residency in a certain area – not to immigrant/refugee status.

1. Infectious disease

The *Immigration and Refugee Protection Act (IRPA)*^b, excludes potential immigrants from coming to Canada if their health condition is likely to pose a threat to public health and safety or if their condition would place an “excessive burden on Public Health Services.” Accordingly, all applicants must undergo an Immigration Medical Exam which includes a chest x-ray, test for syphilis and, from 2002 onwards, an HIV test. However, refugees cannot be denied access to Canada based on the excessive-cost clause of the Act.

With the shift in source countries away from the northern to the southern hemisphere, there has been an increase in the rates of some infectious diseases and introduction of ‘tropical’ diseases little known in Canada. This has led to increased health system and public concern about the public health implications (Johnston & Conly, 2008; Tam, 2009). These concerns have tended to dominate the discussion around new arrivals’ health status.

- a. ***Tuberculosis (TB)*** There has been a dramatic increase in foreign-born cases of tuberculosis in Canada over the past 20 years, reflecting both changes in source countries of immigration and the passage of the Immigration and Refugee Protection Act. In 2007, 66% of Canada’s TB cases were found among foreign-born persons (Public Health Agency of Canada 2008). A recent study of 112 adult government assisted refugees seen in an immigrant friendly medicine centre in Ottawa within six months of arrival, showed that nearly half had latent TB (Pottie et al., 2007).

^b The Immigrant and Refugee Protection Act Immigration and Refugee Protection Act (IRPA) governs matters concerning immigration and refugee protection in Canada, including much of the work of the Immigration and Refugee Board of Canada (IRB). The Act came into force on June 28, 2002, replacing the previous Immigration Act. Retrieved from <http://www.cisr-irb.gc.ca/eng/brdcom/publications/oveape/Pages/index.aspx>

In Manitoba in 2008, a total of 141 new active and re-treatment cases were reported for an incidence rate of 11.7 per 100,000. Rates (per 100,000) varied as follows: Canadian-born Manitobans – 1.2, foreign-born Manitobans – 20.4 and Canadian-born Aboriginal Manitobans – 51.2 (Public Health Agency of Canada, 2008). However, it is important to recognize that the rates among foreign born varied significantly by world area of origin, highlighting the importance of screening by world area rather than by immigrant status. In addition, the strains of tuberculosis vary by region. For example, many TB positive immigrants from some regions test positive for the Beijing/W type strain of *Mycobacterium tuberculosis* (e.g., Beijing strains represent about 50% of strains in east Asia and at least 13% of strains worldwide) (Parwati et al., 2010; Bifani et al., 2002). It is also important to keep in mind that contributing to the spread of TB is overcrowding and stress are risks faced by some immigrant subpopulations, particularly those living in poverty (Reitmanova, 2008).

- b. **HIV/AIDS.** Since the Immigrant and Refugee Protection Act (IRPA, 2001) came into effect, there has been an increase in the proportion of those living in Canada infected with HIV that originated from endemic countries with AIDS. Additionally, persons from these countries continue to be over-represented among Canada's HIV/AIDS population. The Public Health Agency of Canada (PHAC), for example, estimates the infection rate among individuals from HIV/AIDS-endemic countries to be at least 13 times higher than among other Canadians (PHAC, 2007). Alongside this estimate, PHAC notes that currently available data do not allow for differentiation between infections acquired abroad from those acquired in Canada.

The Canadian immigrant and refugee population, especially from Sub-Saharan Africa, is diagnosed at a later stage in their HIV infection and has lower CD4 counts, a larger percentage of females, different HIV subtypes, and an array of co-morbidities (such as tuberculosis and toxoplasmosis) previously rare for Canada and requiring more intense clinical and laboratory services (Krentz & Gill, 2008). Some of these cases are pediatric (MacPherson et al., 2006). While Economic Class immigrants testing positive for HIV/AIDS may be denied access to Canada under the excessive-cost clause of IRPA, Family Class Immigrants and Refugees cannot be denied on this basis.

While immigrants and refugees from HIV/AIDS-endemic countries and countries with an established prevalence of HIV/AIDS tend to arrive in Canada with basic knowledge about transmission and outcomes of HIV/AIDS, they may not be aware of the risks of contracting HIV in Canada because they see little information about the prevention of infection directed to the general public or to their communities. Lack of access to information and absence of first language resources may contribute to ongoing vulnerability to HIV in Canada (Foster & McPherson, 2007).

- c. **Hepatitis.** Hepatitis B is endemic in Africa and Southeast Asia. It is estimated that 5-15% of immigrants and refugees from high-risk endemic areas have been shown to be active carriers of hepatitis B virus. Hepatitis B infection is highly endemic in all of

Increased use of HBV vaccine has reduced the incidence of acute hepatitis B in all age groups in recent years; however, immigration continues to introduce additional HBV-infected individuals to Canada (Sherman et al., 2007). Immigrants, particularly those from geographic regions with high endemic rates of HBV such as Asia, constitute the largest group of hepatitis B virus (HBV) carriers in the country (Sherman et al., 2007).

Approximately 20% of reported hepatitis C infections in Canada occur in the immigrant population (Manitoba Communicable Disease Control Branch, 2009). Hence, screening for Hepatitis C is recommended for patients from world areas with a high prevalence of infection, as well as those who have undergone blood transfusion, ritual genital surgery, or a surgical procedure (Adams, 2004). According to WHO, “HCV infections are common worldwide. It is estimated that about 3% of the world’s population have HCV. There are about 4 million carriers in Europe alone” (WHO, 2002a). Chronically infected with Hepatitis C leads to cirrhosis of the liver.

Hepatitis may go undetected for up to ten years following migration (Ford-Jones et al., 2000). Screening for Hepatitis B and C is not part of the mandatory Immigration Medical Examination (IME) for newcomers. Enhanced health assessments—for instance, screening for Hepatitis C among refugees from African and South East Asian and among those who have had a previous blood transfusion, ritual female genital surgery (FGM), or surgical procedure—have been recommended during routine visits to physicians by newcomers (Adams et al., 2004).

- d. **Syphilis.** Syphilis screening has been a routine component of the Immigration Medical Exam for decades in immigration-receiving nations, such as Canada. Screening of refugee claimants indicates that they have an elevated risk of syphilis infection (MacPherson & Gushulak, 2008).

2. Tropical Diseases

Immigrants often arrive with diseases which are largely unknown in Canada. Some, such as malaria, are wide-spread and found in many continents. Others, such as Chagas’ disease (caused by infection with the protozoan agent *Trypanosoma cruzi*) can also have long lasting health implications, but are limited to specific regions, and appear to affect smaller numbers of immigrants (Steele et al., 2007).

- a. **Parasites.** Intestinal and tissue parasites may also be a concern for immigrants from some countries (Walker & Jaranson, 1999). “Infection with parasites can lead to such complications as blood loss, iron deficiency anemia, malnutrition, growth retardation and death” (Libich, 2007, page 10).
- a. **Malaria.** Malaria is more common in African than Asian immigrants. Africa accounts for 90% of the world’s annual deaths due to malaria (World Health

3. Vaccine Preventable Illnesses

Some immigrant and, in particular, refugee groups may be vulnerable to measles, mumps, and rubella. One study found that 36% (range, 22% to 54%) of the study population was non-immune to at least one of the three diseases. This proportion varied by age, sex, and region of origin (Greenaway et al., 2007).

4. Longer Term Implications

Unlike health status (where risks of poor health increase in the years following immigration), most immigrants with infectious diseases experience improvements in health status over time. However, the largest number of TB cases among immigrants appear to be reactivation of a previous infection—a situation that may be exacerbated by a decline in overall health status and other risk factors.

Lack of appropriate orientation and language and cultural barriers also contribute to the ongoing risk new arrivals may have of contracting new infectious diseases. Lack of orientation and language barriers prevent many new arrivals from benefiting from public health messages on a range of topics, such as communicable disease risks (e.g., localized syphilis outbreaks) and influenza preparedness.

In addition, immigrants visiting friends and relatives (VFR) abroad experience excessive rates of travel-related morbidity and mortality. High-risk illnesses in VFR travelers include childhood vaccine-preventable illnesses, hepatitis A and B, tuberculosis, malaria, HIV, and typhoid fever (Angell & Cetron, 2005; Bacaner et al., 2004; Sherrard & McCarthy, 2009). Higher risk for infectious disease among VFR travelers is likely due to a lack of pre-travel care (perhaps due to language barriers and a lack of awareness of available travel medicine services), assumptions that they have 'immunity' to high-risk illnesses, lack of childhood vaccinations, and patterns of travel that likely include visits to areas of risk and for longer periods of time.

5. Implications for Service Providers

There is a need for immediate assessment and screening of immigrants from some world areas to identify key endemic infectious diseases. Guidelines for such screening have been developed and should be reviewed for applicability to the Manitoba context and then implemented. Similarly, immunization assessment should be undertaken according to identified guidelines (Public Health Agency of Canada, 2006). Effective treatment also depends on effective language interpretation and translation of materials, and reduction in other barriers to appropriate care.

Ongoing attention to health promotion activities is needed to prevent new arrivals from being more vulnerable to communicable diseases common in Canada and to the risks related to return travel as VFRs. However, the need for infectious disease screening and treatment for some groups of immigrants should not detract from the larger health related needs of immigrants to Canada--with appropriate intervention and treatment, communicable disease risk is generally quickly resolved.

6. Other Health Issues related to World Area of Origin or Transit

- a. ***Non-communicable diseases.*** In addition to a finding of higher prevalence of communicable diseases among immigrants and refugees according to country or world area of origin, the same rates of higher prevalence of non-communicable diseases is also found. The factors affecting rates of non-communicable diseases such as diabetes, various cancers and cardiovascular disease are complex and reflect an interaction of genetic, lifestyle, environmental and health system factors (Lee, 2009). Awareness that one sees a higher prevalence of certain non-communicable diseases amongst immigrants and refugees may assist health care professionals provide quality care.
- b. ***Other conditions.*** Conditions such as iron-deficiency anemia and vitamin-D deficiency may also be related to country or world area of origin, creating an increased need for provider training and resources for screening for other conditions by world area.

C. Issues Related to Refugee Experience

Although there is considerable diversity in refugee experiences, it is possible to identify health issues associated with the experience of refugee-like conditions. These issues may affect physical or mental health, and may be short-term or long-term in nature.

The term “refugees” will be used in this section for simplicity; “refugees” will mean persons who have experienced unsafe conditions and or/persecution in their home country, regardless of the class under which they came to Canada. For example, someone who comes to Canada as a refugee may then sponsor family members, who would not be considered refugees even though they have experienced the same conditions and may have similar health issues as their sponsor. Therefore, it is more helpful to define these issues by the experience of refugee-like conditions in the source country, rather than by immigrant status.

1. Issues on Arrival:

Immediate and short term issues affecting many refugees include the physical and psychological effects of trauma, and in some cases torture, malnutrition, reproductive health issues, dental health concerns and infectious disease.

- a. **Malnutrition.** Refugees who have been living in areas with food insecurity (unavailability of food such that households live with hunger or fear of starvation) have high rates of nutritional deficiencies (Woodruff et al., 2006). Some common examples include anaemia (Benoist 2008a), iodine (Benoist 2008b), folate and vitamin B12 deficiencies, vitamin A deficiency (WHO 2009), and inadequate caloric intake (Benoist et al., 2008a; WHO 2009).
- b. **Sexuality and reproductive health.** Refugees leave their country following conditions of oppression and war. Sexual violence is common against the general population and rape and sexual torture is practiced in many countries against both men and women. Women refugees have special health concerns. Displaced women face high maternal mortality, unmet needs for family planning, complications following unsafe abortion, and gender based violence (Austin et al., 2008). They are also at greater risk of contracting sexually transmitted diseases and HIV/AIDS (UNHCR/WHO/UNFPA, 2010; WHO 2008).
- c. **Dental health.** Refugees often experience oral health issues due to conditions in their home countries and in refugee camps (e.g., little access to dental services within camps). Refugees have been found to have higher rates of early childhood tooth decay, untreated dental conditions and fewer permanent teeth (Davidson et al., 2006). Refugee-like conditions that affect oral health include shortage of dental services and tooth care products (e.g., tooth brushes), poor nutrition, and lack of water fluoridation. Torture may also result in dental injuries (New South Wales Refugee Health Service, 2005).
- d. **Infectious disease.** Refugees and, in particular, refugee claimants are, on arrival, at higher risk of infectious diseases as described earlier (Adams et al., 2004; Krentz & Gill, 2008; Pottie, 2007; Public Health Agency of Canada, 2008).
- e. **Injury and mental health issues resulting from torture and other forms of violence.** Refugees may have been victims of violence resulting from war, incarceration, torture and rape. These experiences may result in the need for immediate treatment for traumatic injuries or counseling. Torture is described by Amnesty International as 'epidemic;' in 2004, torture was reported as common in more than 132 countries.

Prevalence of torture among refugees is unknown; studies report the rate at 5-30% depending on country of origin (Baker R., 2002). Survivors of torture may have experienced: beatings; electric shock; cold water, chemical and/or hot water torture; burns caused by cigarettes; sexual abuse; rape; deprivation of sleep and/or food; and the breaking of bones. Psychological torture can take several different forms including isolating the victim, exposing the victim to mock executions, forcing the victim to witness family members and/or friends being abused, tortured or killed.

- **Traumatic injury.** Traumatic injury can result in: neurological problems; ear damage; broken or poorly healed bones; teeth and gum disease; damage to heart, kidneys, lungs, spine, ears, or eyes; gynecological and urologic problems; chronic pain; and localized disorders.

- **Mental health issues.** Psychological consequences may include anxiety, depression, survivor guilt, sleep disturbances and nightmares, impaired use or loss of memory, concentration difficulties, hyperarousal, hypersensitivity, suspiciousness, fear of authority and paranoia. (Canadian Centre for Victims of Torture, 2004).

Refugee claimants (e.g., asylum seekers) may be particularly vulnerable to mental health issues. A study in Montreal found that almost 60% of claimants received a psychiatric diagnosis—mainly depression and post-traumatic stress disorder (Ouimet et al., 2008). However, access to many services is limited for refugee claimants due to their uncertain status.

The mental health consequences of exposure to political violence are not limited to those with refugee status. With changes in source countries of immigration, many immigrants are arriving from repressive or totalitarian societies. For example, one Quebec study found that while refugees reported the highest percentage of personal and family exposure to political violence, 48% of economic class immigrants and 42% of family class immigrants also reported such exposure (Rousseau & Drapeau, 2004).

- **Mental health issues related to migration and adaptation.** Even those who have not directly experienced trauma have often witnessed atrocities or lost family members. All refugees suffer the trauma of being forced to leave their home, friends and families. Many immigrants have left family members in their home country, which causes them significant anxiety and can impact the physical and economic wellbeing of their families. Local evidence shows that prolonged separation from family can also cause depression and feelings of isolation (Arango et al., 2006).

The process of acculturation once in Canada is a time when many immigrants and refugees face significant mental health challenges. The stress of adapting to life in Canada is often exacerbated by the lack of proficiency in an official language, and experiences of discrimination and racism from Canadian society, as well as loss of culture and family supports, difficulties securing employment (Blum & Heinonen, 2007) and safe and affordable housing (Hakim & Angom, 1999; Simbandumwe, 2007). These struggles have been documented by organizations and communities for years but they continue to be a challenge (Kinnon, 1999).

2. Longer Term Impacts

The major longer term impacts of the migration experience are largely in the area of mental health as refugees often experience serious mental health consequences, and it may take several years before the full impact is known (Beiser, 2005; Government of Canada, 2006; Magoon, 2005). There is evidence that many issues do not surface until many months or even years after initial settlement.

There is also evidence of longer term physiological impacts, including reproductive health effects, pain syndromes, and other long term symptoms of torture and sexual violence (Canadian Centre for Victims of Torture, 2004).

3. Implications for Community Health

An overlooked, longer term impact of related violence and trauma is the health of refugee communities. As Martin-Baro et al. (1995) observed, gross violations of human rights are "experiences that affect a whole population, not only as individuals but as social beings in a social context" (Martin-Baro et al. 1995, page 124). It should be no surprise then that there are important community health issues within some refugee communities. There may be profound divisions within groups of new arrivals arriving from refugee-producing countries. In addition to political, ethnic, religious, socio-economic and regional differences, there may be a climate of distrust and fear within communities that creates both challenges in service provision and ongoing issues affecting the health of these communities (Bowen, 2006; Simbandumwe, 2007).

4. Implications for Service Providers

In addition to the culturally responsive mental health services that are needed by all Canadians, some immigrants to Canada require specialized treatment, in both the immediate and longer term, for mental health and physiological issues resulting from trauma and torture, or from exposure to political violence. Individuals arriving from countries with a history of political violence often report multiple traumatic experiences, regardless of immigration status (Fortuna et al., 2008). Such experiences may be exacerbated by the immigration and acculturation experience (e.g., experiencing discrimination in Canada or by living, as new arrivals, in neighbourhoods with high levels of poverty and violence.)

There is no evidence, apart from refugees and those arriving from war affected countries that mental health needs are greater than that of the general population. However, linguistic and cultural barriers often result in significant underutilization of mental health services compared to the general population. For example, one study found significantly lower rates of use of health care services for psychological distress among immigrants than non-immigrants (6% compared with 15%)—differences that could not be explained by SES, somatic or psychological symptoms, length of stay in Canada, or use of alternative sources of help (Kirmayer et al., 2007). Another study found significantly lower utilization between South Asian, Southeast Asian, and Chinese immigrants and "whites" (both immigrant and Canadian born) (Tiwari & Wang, 2008).

Communities report absence of needed specialized services, lack of cultural proficiency of providers, distrust, lack of knowledge of services, and language barriers as major obstacles to health service utilization. Treatment approaches that medicalize what many survivors consider normal response to pathological situations (e.g., diagnoses of post-traumatic stress disorder or PTSD) often alienate those seeking help (Millet, 1994; Desjarlais et al., 1995). Development of culturally and linguistically

responsive services developed in collaboration with affected communities is required (Simich et al., 2005).

D. Issues related to Language and Cultural Differences

Issues related to language and cultural differences between health care providers and patients are emerging as increasingly important given the shift in source areas of immigration to Canada.

1. Language Barriers

A comprehensive review of the research literature identified compelling evidence that lack of language access services presents barriers to first contact for most health services (Bowen, 2004). Language barriers have been demonstrated to decrease participation in health promotion, prevention and screening programs and delay presentation for care. Access to almost every type of health program and service appears affected, for example: prenatal education, first aid courses, pharmacy education services, and support services for caregivers of the elderly. Language barriers are also associated with greater risks of misdiagnosis, poorer patient understanding of his/her condition and adherence to prescribed treatment, lower satisfaction and confidence, and differences in prescribed treatment. There is also less likelihood of appropriate pain management. Greater risks are found in health areas, such as mental health and sexuality/reproductive health that rely more on interpersonal aspects of care. Concerns about confidentiality due to unavailability of trained interpreters may result in patients concealing or omitting relevant information.

Language barriers are also associated with differences in health outcomes. Some of these differences may be related to delayed presentation for care; others are related to delayed treatment because of misdiagnosis or poor patient understanding of recommended treatment. Language barriers are associated with less effective management of chronic diseases such as diabetes and asthma. Patients with unaddressed communication barriers are less satisfied with care, less confident in their providers, and are often prevented from providing informed consent. Language barriers often result in the organization failing to protect the privacy and confidentiality of patient information.

Language barriers have been demonstrated to have perverse effects on health service utilization; they decrease utilization of preventive and screening services, and can increase use of more costly services (such as diagnostic testing, hospital admission, and length of hospital stay). This contributes to decreased health system efficiency, including longer waiting lists. Two factors within the health encounter account for increased service utilization. First, the provider may exercise greater caution in the face of language barriers. This “up-triaging” results in greater likelihood of increased diagnostic testing, specialist referral, hospital admission, or repeat visits. Second, if greater caution is not exercised, language barriers increase the risks of misdiagnosis due to incomplete or inaccurate assessment, and of complications resulting from less appropriate treatment and poorer patient comprehension (Bowen, 2004).

It may take many years for an individual to gain sufficient English language fluency to effectively manage complex health care interactions. Furthermore, there is ongoing concern regarding availability and comprehensiveness of English language training for new arrivals. In addition to access to language training, factors affecting learning of an additional language include: age, experience of trauma, and education. The aging process may also affect language fluency.

Recent research has been able to disentangle the influence of culture and language on health behaviour. The key finding is that language barriers, not cultural beliefs, have the greatest influence on interaction and satisfaction with the health system, and that many observed “differences” among cultural groups (from attendance at follow-up appointments, to participation in breast screening programs, to compliance with medication regimes) can be attributed not to cultural beliefs, but to language barriers (Bowen 2008).

2. Differences in Systems of Care

Not all countries base their medical systems on western medical beliefs. Newcomers from China or Southeast Asia, for example, may have very different views about how the body works, how organs are related to each other, what causes disease, and how to maintain good health.

The structure of the health care system also varies among countries, and often the experience of health care is related directly to socio-economic position. Some countries provide high standards of western health care to those who can afford to pay; those who are less well off have little access and care, the standards of which may be questionable. These differences in previous experience, even among those from the same country, affect expectations and satisfaction with care in Canada.

The types of health services provided, the structure of the system, and schedule of services (e.g., immunization, prenatal care) may vary significantly even among those from developed countries, as will availability and practice of a range of health related services (e.g., dental care, home care). Differences in the legal system related to key issues (e.g., quarantine, domestic violence, abortion) also affect expectations and patterns of care. There are also variations in expectations of the role of provider, patient rights and responsibilities, and appropriate communication.

3. Religious Tradition and Practice

In the earlier parts of the 20th century the overwhelming majority of immigrants arriving in Canada were of Judeo-Christian backgrounds. With the shift in world areas of origin of current Canadian immigrants, there have been increases in the number of Canadians declaring other religions. Based on the 2001 census, those identifying as Muslim recorded the largest increase in number, doubling in size to 579,000 in ten years. This represented 2% of the total population. In the same census year, those identifying as Hindu increased by 89%, Sikh by 89%, and Buddhist by 84%. Of the 1.8 million new immigrants who arrived during the 1990s, Muslims accounted for 15%, Hindus almost

7% and Buddhists and Sikhs each about 5%. The population of each of these religion-based immigrant groups was relatively young: compared to the national median of 37 years for the overall population, the median age of Muslims was 28 years, Sikhs 30, and Hindus 32 (Statistics Canada, 2003). These trends of increasing religious diversity can be expected to continue.

Religion has important implications for both health and health service provision. Many lifestyle choices (e.g. diet, use of alcohol and tobacco) are affected by religious belief. Beliefs regarding female modesty, death and dying, reproductive health, hygiene, use of blood products and other issues have important implications for many areas of health care provision. The increasing religious diversity of Canada strengthens the imperative for health organizations to develop responsive practice. It is important for providers to be aware of key areas affected by religious belief and practice in order to provide culturally responsive care. At the same time, caution is needed to avoid stereotyping an individual patient. There is great diversity, not only within each of the world's religions, but also in individual faith and commitment to practice.

4. Traditional Health-related Practice

Individuals may bring with them varying beliefs about disease causation and health maintenance, and appropriate practice around sexuality, reproductive health, mental health, and death and dying.

While it is important to recognize that foreign born patients may ascribe to alternate formal medical belief systems (e.g., Chinese medicine) and/or have traditional health practices that affect care, this is not the area perceived as most important to newcomers themselves (Bowen, 1999; Bowen, 1993). Nor is it feasible or necessary for providers to have an encyclopedic knowledge of the specific cultures in order to provide culturally responsive care (Carpenter-Song et al., 2007). It would be impossible to list all possible beliefs and practices that affect health. Even if it were possible, it would be dangerous to assume that any client could be understood in terms of commonly accepted characteristics associated with a particular world area (Gregg & Saha, 2006; Kleinman & Benson, 2006). These assumptions might prevent the individualized assessment that is essential to quality, safe care. Hence, assumptions about cultural preferences may lead to lower quality care. For example, while lower rates of participation by immigrant women in breast screening are often attributed to "cultural" differences, these rates can be more appropriately explained by barriers to preventive information from the failure of physicians to discuss options when interacting with immigrant patients (Choudry et al., 1998).

Two important areas where broad cultural practice affects use and appropriateness of health care are mental health and reproductive health and sexuality.

- a. ***Mental Health.*** Mental health is particularly sensitive to cultural and linguistic barriers, as assessment and treatment is largely dependent on communication. That these barriers prevent access is demonstrated by the significantly lower utilization of both specialty and general medical services for emotional and mental distress by

- b. ***Female Genital Mutilation (FGM)***. Also known as “female circumcision”, it is one example of a sexuality related practice with important health implications. The non-therapeutic partial or complete removal or injury of each of the external female genitals (also known as female genital mutilation, or female genital cutting) is common in many parts of the world. The World Health Organization estimates that 100 to 140 million women worldwide, in 30 countries, have had some version of the procedure performed. The majority of these have been in Africa (World Health Organization Regional Office for Europe, 2008; Yoder & Khan 2008). Prevalence varies from an estimated 98% of Somalia women ages 18–49 to a low of 0.6% of women in Uganda. Although often assumed to be associated with Islam, FGM is a cultural, not a religious practice, and is found among groups of different religious backgrounds. However, with the shift in areas of immigration increasing numbers of women and girls who have undergone these procedures are arriving in Canada, presenting challenges to healthcare professionals.

There are many forms of FGM, with varying implications for reproductive health and sexuality. Immediate physical consequences may include: bleeding, wound infection, sepsis, shock, micturition (urination) problems and fractures. Longer term consequences commonly include anaemia, urinary tract infections, incontinence, infertility, pain, menstruation problems and dyspareunia (painful sexual intercourse) and increased risk of HIV. Some forms of FGM also present additional risks in pregnancy and childbirth, including prolonged delivery, excessive blood lost, tearing and infection (Utz-Billing and Kentenich, 2008). Although FGM is against the law in Canada, health care providers are reporting cases where girls have been sent back to their home country to have it performed (Magoon, 2005).

E. Implications for Service Providers

Not every person from the same country shares the same culture. Many countries encompass those of diverse ethnicities, languages and religions. Even when a country is relatively homogenous in terms of ethnicity, socio-economic, political, urban/rural or regional differences may result in significant diversity affecting every aspect of health. For this reason, individual patient must be individually assessed regarding traditional beliefs and practices. Such assessment requires development of skills in intercultural communication. “Recipe book” approaches to assessment of patients from certain countries or of certain religions are not appropriate and pose risks to quality and safety of care.

While addressing differences in culture between health care providers and patients is key to addressing the health status and health issues of immigrants and refugees, so too are language barriers as they have the greatest influence on interaction and satisfaction with health system.

Section 3

Identifying Priority Health Services Needs for Immigrants and Refugees

The previous section summarized the research evidence for specific health issues facing immigrants and refugees. In order to identify priority health-services needs, it is also essential to build on evidence about the different *types* of health services (e.g., service design—acute, subacute, primary care and health need) that may be required and the *subgroups* that are in greatest need for specialized services.

A. Priority Health Service Needs

It is important to distinguish health needs as requiring a short-term response (e.g., infectious/tropical disease screening), a specialized response (e.g., treatment of victims of torture) or a system re-design/change to meet the ongoing needs of a diverse population. It has often been the case that decision makers and providers focus on urgent or emergent needs (particularly when a language barrier is present), or on conditions presenting an immediate public health concern (e.g., parasitic diseases, tuberculosis). While these are significant issues to address, there is also a need to identify other, often more complex, but less apparent health needs of immigrants and refugees upon arrival, and in the longer term. Many of these relate to health promotion, prevention and primary health care services.

1. Specialized Immigrant and Refugee Services

Many of the health issues faced by new arrivals to Canada are short term in nature. It is important to note that if these issues are not addressed in the earlier stages of settlement, they will result in poorer health outcomes, requiring more specialized resources and engendering poorer health in the long term. Services needed to address these issues include:

- a. **Orientation services.** The emerging research identifying the early decline in health status of new arrivals, particularly in more vulnerable groups, highlights the need for early orientation and assistance as follows:
 - **Orientation to the Canadian health system and Winnipeg health services,** with an emphasis on service availability, prevention, promotion and screening programs, appropriate service use, how to access services, expectations of roles and communication among patients and providers, and rights to service. Specific orientation is also needed for mental health services, and cultural expectations and assumptions
 - **Active assistance in finding a primary care provider,** and learning how to access services.

- e. *A centralized point of access for information and referral regarding immigrant health issues.* Through this centralized point of access, which would not necessarily provide direct health services (though may be integrated with newcomer screening services), provider and client needs can be addressed.

2. Enhanced Service Responses in Key Areas

- a. *Culturally responsive and specialized mental health services.* Unlike needs in other areas, mental health concerns do not necessarily improve with time, may be long lasting, and in some situations may worsen over time. Mental health service provision poses a number of unique challenges: assessment and treatment is often language-based; there are cultural differences in expression of distress, acceptability of mental illness, and in patient/provider communication that can present significant challenges in diagnosis and treatment; patients may fear breakdown of confidentiality; and patients affected by war trauma and torture often require specialized services. Given the evidence of the relationship between mental health concerns and increased health service utilization (Martens et al., 2004), attention to mental health concerns presents opportunities for avoiding other costs to the health system, as well as to the general community. In addition to the specialized services required to provide assessment and treatment for individuals who are suffering the psychological effects of trauma and torture, expertise in cross cultural mental health/counseling services becomes an increasing priority as our society continues to diversify.
- b. *Enhanced infectious disease capacity for diagnosis and treatment.* While the infectious diseases identified on arrival are most often easily treatable, ongoing immigration trends, combined with the implications of increasing international travel, require enhanced infectious/tropical disease diagnosis and treatment capacity. Because of the risks of new infections to which immigrants visiting relatives and friends in their home country are exposed, in many cities services for infectious/tropical disease are integrated with Travel Medicine services.
- c. *Sexuality and reproductive health services.* Sexuality and reproductive health services are also priority areas for care due to the following circumstances:
- A higher proportion of immigrants are in their child-bearing years (e.g., 46% of recent immigrants, compared to 31% of the general population, are in the 25-44 age range)
 - Information shared about sexual and reproductive health practice is sensitive, based on cultural beliefs and values, and may be emotionally laden. Language and cultural differences may contribute to avoidance of care and reluctance to disclose information that may be embarrassing or stigmatising.
 - Confidentiality is extremely important.
 - Assessment depends heavily on history, cultural expression, and/or subjective experiences of the patient.
 - Conditions may involve concepts that are less likely to be understood by laypersons (e.g., HIV, pregnancy complications).

- There are often special needs related to STI/HIV exposure and pregnancies relating from rape.

Childbirth is a significant event in the life of the family; experiences with health care related to childbirth may affect confidence and appropriate utilization of health services for many years. Further, newcomer mothers are at higher risk for postpartum depression and less likely to have social support (Stewart et al., 2008); they are also more likely to have unmet health concerns (Gagnon et al., 2007).

- d. ***Culturally and linguistically appropriate health promotion and prevention strategies.***
There is strong evidence that the greatest barriers facing new arrivals are access to preventive and health promotion services (Bowen, 2005). Combined with emerging research on the speed of health decline of newcomer health status highlights the importance of ensuring these strategies are accessible.

B. Identifying Priority Populations

As previous sections have outlined, not all immigrants have the same health needs or face the same challenges in obtaining appropriate health services. For this reason it is important to clarify which new arrivals within the larger immigrant group (i.e., the 20% of the population born outside of the country) are of particular concern, and for what reason. Evidence of disparities within groups is critical in identifying populations in greatest need of specialized services.

It is not possible to identify *specific* immigrant communities that are a priority, as, over time, changing world conditions continue to create new patterns of international migration and ‘waves’ of refugees. However, evidence reviewed here suggests that the health needs of newly arrived refugees and those of immigrants facing linguistic and cultural barriers (particularly those from non-European countries) should be prioritized. In addition, in the short term, recently arrived newcomers coming from world areas with diseases and conditions less common to Canada require special attention (e.g., infectious/tropical disease services). Among newly arrived refugee and immigrants facing linguistic/cultural barriers, certain characteristics have been identified as creating higher need. These include:

- High percentage of new arrivals lacking English language fluency.
- High proportion of refugees within the community
- Significant differences between health care systems or practices between country of origin and Canada.
- Increased prevalence of infectious diseases and other conditions.
- Proportion of community at risk due to other determinants of health (Bowen Stevens, 1993).

Within certain populations, youth, particularly unaccompanied minors (Gagnon, 2002; Gagnon et al., 2007) and women may also be particularly vulnerable. Those at risk

because of other determinants of health (e.g., lack of education, employment) are also of concern.

Some groups of immigrants and refugees may continue to need specialized services such as health interpreter services and specialized mental health services for many years; consideration should also be given to the effects of the aging process on immigrant and refugee health. The aging process may result in the re-emergence of needs requiring special attention, even after decades of successful adaptation (e.g., loss of English language proficiency or intrusive memories due to dementia). This is an increasing concern in caring for Manitoba's older European immigrants.

Section 4

Implications for Health System Planning: Designing a Health System Response

In order to develop an effective and equitable service response to immigrant and refugee health needs, three forms of evidence are required:

- Research evidence on health issues affecting immigrants and refugees, their incidence, prevalence and resulting health burden
- Evidence related to community experience and preferences
- Evidence related to the context of service design.

While the earlier sections of this report have focused on the Canadian research evidence on immigrant and refugee health status and health issues, this section will consider both the evidence of community experience, and the Winnipeg and Manitoba context in which services are to be delivered (Arango, D., 2006; Blum, 2007; Bowen, 1999; Libich, W., 2007; Magoon, J., 2005; Simbandumwe, 2009).

A. Community Perspectives

Over the past decades, there have been several community consultation and assessment activities to explore the needs of newcomer communities in Winnipeg (see, for example, Bowen, 2005; Bowen, 1993; Libich, 2007; Magoon, 2005). The priorities for service response have been consistently communicated by newcomer communities throughout these activities. It should also be noted that, in recent consultations, newcomers have communicated frustration around ongoing consultations that result in little action.

The priorities for newcomer service response expressed by community members themselves are as follows:

1. Access to the full range of health services as other Canadians.

The majority of newcomers welcome the opportunity to participate in Canadian health services (including health promotion and prevention activities) along with other Canadians; there is little support for separate or parallel services. Health services are generally held in high regard. While some would prefer to see a provider of their own background, others would prefer to receive services outside of their own, often small, community. For example, in the area of reproductive health, one Winnipeg program found that most women preferred seeing a Canadian provider with interpretation support, rather than a provider from their own community (Bowen, 1993).

There is, however, a lack of information on service availability, how to access services, or what can be expected from service providers. Because of the international reputation of

Canada's publicly funded system, some immigrants may bring unrealistic expectations of care. For example, lack of understanding of the challenges that *all* Canadians face with respect to waiting for access to such things as special programs, primary health care providers, specialists, and surgery may result in immigrants interpreting that they are being discriminated against if they experience waits.

2. Trained, confidential health interpretation services.

The major barrier to participation in Canada's health services, experienced by new arrivals, is language. There are two strategies for addressing language barriers within health care: 1) ensure language congruent interaction (i.e., patient and provider speak the same language) or 2) provide interpretation services. The goal of "English as an Additional Language (EAL)" training is to achieve the goal of fluency in the country's official language. However, such fluency takes many years. New arrivals face the challenges of learning a new language as an adult and learning while under the stress of acculturation, trauma recovery, and employment and family demands; sometimes access to EAL training is limited. Interpreter services, therefore, may be required for many years. Community members share stories related to misdiagnosis, inappropriate treatment, breach of confidentiality, and avoidance of care related to lack of access to trained interpreters.

3. Cultural responsiveness of the health care system and individual providers.

Many new arrivals experience the health care they receive as culturally unresponsive, and even discriminatory, resulting in calls for more culturally responsive care. Examples of unresponsive care are as follows: dietary needs may not be considered in advice; health assessment may not take into account the refugee experience, exposure to tropical diseases or traditional practice; expectations regarding protection of female modesty may not be met; religious practice may not be accommodated; and specialized care (e.g., obstetrical care of women who have undergone FGM) may not be available. Newcomers want providers to be aware of important cultural issues affecting care, and of specialized health concerns. At the same time, like other Canadians, they want individualized, non-judgmental care – assessment of their concerns that are not based on stereotypes.

4. Specialized services in key areas.

Members of some newcomer communities also express needs for specialized services, particularly in the area of mental health. Many families and communities struggle with mental health issues related to treatment of torture, trauma and loss. Culturally responsive counseling related to acculturation issues is also needed. The other areas where gaps are experienced is in infectious and tropical diseases.

5. Recognition of the broad definition of health

Many immigration related factors affect health, including trauma, acculturation stress, loss, and discrimination. For many immigrants, these experiences have a direct impact on health and effective interventions must reflect this.

B. Contextual Considerations for Service Design

Service responses for Manitoba residents should be guided by the principles of equity in health and community engagement and empowerment. In addition, given the current pressures within the health care system on both financial and human resources, any response to immigrant and refugee needs should:

- target the health issues of greatest concern and where interventions would be most effective
- combine research, community and contextual evidence to inform the specific service response
- avoid duplication of resources within the health system
- minimize costs

Winnipeg and Manitoba face some unique challenges in designing services for immigrants and refugees. First, there are small numbers of individuals from many different language and cultural communities within a very small provincial population base of just over one million. Many newcomer language/cultural communities may have no licensed health care providers; language/cultural congruency in specialist care is very rare in a province of this size. Another challenge is the historical absence of a coordinated health system based response for immigrants and refugees; having one would require thoughtful development. And finally, like the health systems in other jurisdictions, response to the health needs of immigrant and refugee communities must be considered within the larger context of providing equitable care to all residents, some of whom face barriers to equitable care for reasons other than immigrant or refugee status.

At the same time, the Winnipeg Regional Health Authority health region has already undertaken a number of collaborative initiatives to promote more culturally appropriate service provision. There is an opportunity to build on these initiatives.

1. Immigrant and Refugee Working Group.

The Immigrant and Refugee Working Group is providing leadership in development of recommendations for provision of integrated, coordinated, and comprehensive services to respond to the immigrant and refugee health needs within the Winnipeg Regional Health Authority (WRHA). In partnership with funded agencies and Manitoba's Department of Labour and Immigration, the group has agreed upon a set of principles for service planning and for the support and creation of culturally responsive health services organizations (Bowen, 2006).

2. Language Access Service.

The WRHA was the first Canadian health region to strategically develop and implement an evidence-informed regional health interpreter service, incorporating a coordinated approach for all four language constituencies: Aboriginal languages, official language minorities, immigrant languages and sign language. As of May 2010, 89 trained health interpreters are available for 31 immigrant languages. While implementation is still

proceeding, this region-wide service is designed to “follow the patient,” providing services in whatever health related setting they are needed.

3. Diversity Framework.

The WRHA has recently adopted, in principle, an approach that provides an overarching framework for responding to the diversity of our populations and that emphasizes: use of evidence of health disparities; access; quality of care; outcomes to set priorities; and the need for organizational level responses to address the needs of a diverse population (Bowen, 2007). Work is underway to develop a framework to guide further development of cultural proficiency across the Winnipeg health region.

4. Regional Language and Ethnicity Indicators (RLEI) Data Collection.

In April 2006, WRHA Senior Management supported the introduction of Regional Language and Ethnicity Indicators (RLEI) data collection. This is a way of proactively shaping new IT systems to capture data to enable health planners to monitor any disparities in access, process of care, or health outcomes. Language indicators have been integrated into data collection at the test site, and an evaluation has been completed (Gibbens & Bowen, 2009). Further work is planned as the WRHA considers the evaluation findings and moves towards implementation in the collection of these data.

5. Refugee Health Services (BridgeCare Clinic)

In November 2010, the WRHA opened the BridgeCare Clinic to provide:

- Immediate and short term physician services
- Assistance in locating a permanent primary care provider
- Orientation services to refugees with respect to the Canadian health care system
- Screening and assessment services
- Mental health services
- Access to language interpreter services
- Outreach services including health care service navigation
- Collaboration with Labour and Immigration Settlement Services

C. An Integrated Service Response

With the exception of some specific, specialized and short term services described above, planning for immigrant and refugee health should be integrated with overall health planning. An integrated response reflects both the preferences of most newcomers and the realities of addressing a variety of preventive, primary care and acute/specialized care needs for a relatively small population.

An integrated service model requires a focus on organizational diversification and includes a range of initiatives across the continuum of care:

- 1. Integrating immigrant and refugee health into health system planning.**
Evidence on priority immigrant and refugee populations, their health needs priorities, and most appropriate service design should be integrated into regional planning; effective strategies for doing so must be identified. This will include designated responsibility for immigrant/refugee health within the health region.
- 2. Identifying a responsibility centre for addressing immigrant refugee health needs.**
The literature on organizational cultural responsiveness stresses the importance of designating high level organizational accountability for diversity initiatives (Office of Minority Health, 2001; Bowen, 2004). Winnipeg newcomer communities, and their advocates, have long been frustrated by the fact that there is no one person or program responsible for immigrant and refugee health. This creates barriers to community organization engagement.
- 3. Improving the cultural proficiency of the health care organization as a whole.**
It is important to distinguish an approach that targets change within the organizational culture from one that focuses on training individuals to be more “culturally sensitive” (Bowen, 2004). Organizational diversification is essential for designing services to address needs of diverse populations; standards and guidelines for such development have been established (Bowen, 2004; Office of Minority Health, 2001). An example of an organizational change initiative to support cultural proficiency would involve the development of strategies that increase community participation in priority setting and planning.
- 4. Promoting evidence-informed intercultural training for healthcare providers.**
Although evidence indicates that the training of healthcare providers is not the most important component of a response to immigrant and refugee health needs, appropriate training has a role in a comprehensive immigrant and refugee health strategy. Federal culture approaches, that avoid the risks of stereotyping, and emphasize intercultural communication skill development are required. There is an emerging research literature that identifies important components of effective training initiatives. Such training must recognize the cultures of all individuals, and the diversity within any population group (Bowen, 2008).
- 5. Developing partnerships to address immigrant refugee issues.**
The issues impacting the health of immigrants and refugees are broad, complex and intertwined. Participation of affected communities in planning and priority setting is essential. In addition, collaborative, inter-sectoral partnerships across multiple sectors are required to address health needs and to improve the overall health and well-being of immigrants and refugees. Healthcare responses, important as they are, cannot single-handedly address health disparities. Nevertheless, the health system *is* in a position to assume leadership in addressing complex issues contributing to the health of disadvantaged groups, including developing inter-sectoral partnerships to shape policy and structural interventions that address the social determinants of health. Over the past few years, the WRHA has established productive partnerships with Manitoba Labour and Immigration; such partnerships should be expanded and strengthened.

6. Key areas for service enhancement

The integrated service response will require enhanced services in the following key areas:

- a. ***Infectious diseases, particularly tuberculosis (TB) and HIV/AIDS.*** Shifts in source countries of immigration have resulted in increased prevalence of TB and HIV/AIDS in the immigrant and, in particular, refugee populations, requiring a focus on providing culturally and linguistically appropriate and accessible services to this population. However, new arrivals are not the only populations significantly affected by such diseases, suggesting that service specific (e.g., TB services), rather than population specific (e.g., refugee TB services) are most appropriate.
- b. ***Culturally responsive mental health and counseling services.*** These services, including provision of addictions and family violence services are critical to an integrated service response.
- c. ***Culturally responsive sexuality and reproductive health services.*** The sensitivity of language and cultural barriers in these areas has been previously outlined.
- d. ***Culturally responsive health promotion services.*** This service area is often neglected because the impacts on health are not immediately apparent, and many activities fall outside of the individual clinician/patient interaction. However, if the personal, social, and health system costs are to be avoided in the long term, attention must be given to this area.

D. The Role of Bridging Services

An integrated response also includes provision of what are sometimes called 'bridging' services – services that allow and facilitate clients to appropriately access and use services. Necessary components of an integrated plan include:

1. Language access services.

Trained health interpreters are a critical component of culturally responsive health services. By allowing a patient to speak for her/himself, through trained health interpreters, facilitates individualized care, and minimize the risks of provider stereotyping. Appropriate (written) translation services are also required in key areas: health promotion messages, and after care instructions.

2. Appropriate orientation services.

These services include assistance in connecting with a regular primary care provider and trained health interpreter services as needed.

3. A newcomer orientation, screening and assessment service

Reflecting the principles of an integrated service response, the development of an “immigrant health clinic” is not recommended. However, some specialized services related to newcomer status are still required. It is not feasible in a small city the size of Winnipeg to provide the specialized services required to offer these services in multiple locations. For an integrated model to be effective, a centralized approach to orientation, screening and assessment is needed. Ongoing planning is underway in Winnipeg for a BridgeCare Clinic that reflects the principles of an integrated service response. The clinic will be open during the Fall of 2010, and will reflect the following:

- A single point of access for both the immigrant and refugee communities and professionals
- Provision of only specialized newcomer orientation, screening and assessment services with the goal of assisting clients to access the health services available to all residents, and supporting professionals to provide quality care to a diverse society. In order to achieve this, practical assistance needs to be provided to clients, in finding appropriate ongoing care, and to professionals in accessing the specialized consultation they require must be integral to service design.
- Integrated with, or effective links to, a comprehensive newcomer information and referral service (e.g., education, housing)
- Location of the service must reflect both health system responsibility and community patterns of service use. There must be a convenient physical location for first access to these services as new arrivals are often not confident in telephone access and have limited ability in negotiating around the city.

E. Development of Specialized Services

There are a few service gaps where new service development is needed – gaps that cannot be addressed by adapting existing services to make them culturally and linguistically appropriate. Areas where there are currently gaps in service include: newcomer assessment; screening and orientation capacity; specialized mental health services for survivors of political violence; expertise in treating tropical diseases; and sensitive reproductive health and obstetrical care of women who have undergone female genital mutilation (FGM).

For specialized services that serve relatively small numbers, it is generally not feasible – and certainly not cost-effective – to develop system-wide capacity. These services are generally best provided through points of care associated with the associated discipline (e.g., FGM care – women’s health/obstetrics; treatment for torture victims – mental health; tropical disease – travel medicine).

With the exception of a newcomer health assessment, screening and orientation, the other specialized needs appear to have a clear link with an existing program area. Following a focused effort to address the service gaps, services can then be integrated into overall service provision. The challenge will be to ensure that the overall service plan identifies and evaluates strategies for effective referral to these specialized services once developed.

Section 5

Summary and Conclusion

This report has: summarized data on immigration to Winnipeg and Manitoba in the context of national immigration trends; outlined the key health issues affecting immigrants and refugees; and has identified priorities and key principles for development of services responses in the Winnipeg region.

The primary objective of Canadian health policy is to protect, promote and restore the physical and mental well being of residents of Canada, while facilitating access to health services without financial or other barriers (Canada Health Act, 1985). However, there is growing evidence that some populations do not experience equitable access or treatment, either from publicly insured or extended health services. Some newcomer populations to Canada are among these underserved populations.

Many factors contribute to the health (or, as recent research indicates, the declining health) of Canada's immigrants; the health system is but one determinant. However, health services (and access barriers to them) function as important determinants of health. Health systems that fail to provide equitable care have the potential to exacerbate social disparities and contribute to lower health status (Bowen, 2001; McGibbon et al., 2008).

Recent research has highlighted how quickly after arrival in Canada the health of some immigrant and refugee groups declines (Newbold, B., 2009). It has also shown the relationship between increasing poverty in immigrants and refugees, decline in health status, and non-European country of origin. The health system has a critical role to play in maintaining immigrant and refugee health – through organizational diversification strategies that respond to the increasing diversity of our society, and provision of services to meet the specialized needs of some new arrivals. There is also a role for the health system to promote public policy in the area of immigration and settlement, and to work in partnership with other sectors in addressing the broader determinants of health.

Addressing identified gaps will require resources. However, failure to address needs on arrival will contribute to both declining health and additional challenges for adaptation by new immigrants, and additional costs to the health system in the future. Unaddressed barriers result in increased risk of preventable illnesses and conditions, exacerbation of underlying problems, inappropriate use of health services, and ultimately, higher health care utilization. The overall strategy suggested by this review of the evidence minimizes costs to address current needs, as it:

- minimizes duplication through a single point of access, and avoids development of a parallel service structure
- focuses on issues where both the research and community evidence indicate priority needs and service responses, and
- focuses resources “upstream” with the intent of minimizing utilization of higher intensity services.

Immigration will continue to increase; there is no other alternative for societies, such as Canada’s, that are facing an aging population along with low fertility rates. The majority of immigrants (who also play a vital role in health service provision) will be arriving from countries of the developing world--increasing the likelihood of differences in language, culture, religion and life experience between patients and their providers. Therefore, the challenges currently experienced by both newcomer communities and the providers caring for them can be expected to increase.

Winnipeg had experienced, until recently, lower rates of international migration than many other major Canadian centres. As a consequence, it has lagged behind many other cities in responding to the needs of newcomers. This lag is apparent in the absence of newcomer orientation, screening and assessment services, as well as needed specialized services in the areas of mental health, reproductive health and infectious disease. At the same time, Winnipeg has: lead the country in provision of trained health interpreter services across the continuum of care; approved a framework for responding to our diverse society; initiated a coordinated, evidence-informed response to planning for immigrant and refugee health services; and, developed productive partnerships with Manitoba Labour and Immigration as well as numerous community agencies. These initiatives will position the region to respond to current and future needs in immigrant and refugee health.

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