

The Global City: Newcomer Health in Toronto

November 2011



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About the Project Partners

Toronto Public Health reduces health inequalities and improves the health of the whole population. Its services are funded by the City of Toronto, the Province of Ontario and are governed by the Toronto Board of Health. Toronto Public Health strives to make its services accessible and equitable for all residents of Toronto.

Access Alliance Multicultural Health and Community Services improves health outcomes for the most vulnerable immigrants, refugees and their communities in Toronto. It does this by facilitating access to services and working to address systemic inequities. Access Alliance receives funding from the Ontario Ministry of Health and Long-Term Care via the Toronto Central Local Health Integration Network, Citizenship and Immigration Canada, the United Way of Greater Toronto and the City of Toronto. Access Alliance is a registered charitable organization and a United Way member agency.

Foreword

Newcomers to Toronto bring many strengths and assets that make our city vibrant and prosperous. These include good health, education, professional experience and skills, cultural diversity and new and innovative perspectives. However, many newcomers face challenges to their health as they establish themselves in Toronto and embark on their journey towards successful integration into Canadian society. *The Global City: Newcomer Health in Toronto* describes the “health advantage” that most newcomers bring to Toronto, the decline in their health over time and the need to re-examine and strengthen our efforts to support newcomers, especially those whose health risks are compounded by their income level, gender, immigration status, ethno-racial background, sexual orientation or other factors.

Toronto Public Health and Access Alliance share a commitment to working collaboratively across sectors to improve outcomes for newcomers and to build a healthy city for all. *The Global City: Newcomer Health in Toronto* brings together new data analyses with the complementary knowledge of our staff and the perspectives of a wide range of local stakeholders, including front-line service providers and newcomers. It is the first comprehensive report that focuses on the health of newcomers in Toronto.

We hope that this report and the initiatives it generates will help to reduce health inequities faced by newcomers, lead to improved health for all residents, and lay a strong foundation for the future prosperity of our global city.

Dr. David McKeown
Medical Officer of Health
City of Toronto

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Overall, newcomers bring many strengths and assets to Toronto but their "health advantage" often declines over time.

Above: Newcomers and other new parents attend the *Nobody's Perfect* program (Albion Library, in partnership with Braeburn Neighbourhood Place).

EXECUTIVE SUMMARY

Newcomers to Toronto bring many strengths and assets that enrich the city. These include high levels of education, professional experience and skills, cultural diversity and new and innovative perspectives. These assets help make Toronto a vibrant and prosperous place to live. An additional and very important asset that newcomersⁱ bring is their good health. After their arrival, however, there are many aspects of life in Toronto that threaten their physical health, mental health, and well-being.

In order to effectively promote and sustain the health and well-being of newcomers in Toronto, planners, policy makers and service providers need timely and relevant information on the health status, health needs and determinants of health for this population. This report brings together new and existing evidence related to newcomer health. Findings presented here draw from recent academic and local community-based studies, insights from focus groups with local service providers and newcomers who use health services, and analyses of existing health and socio-demographic data. This report is intended to be a useful resource for policy makers, health planners, service providers and others interested in making Toronto a healthier and more equitable place to live for newcomers and all residents.

The following is a summary of key findings from each of the report's main sections.

SOCIO-DEMOGRAPHICS

Largely as a result of immigration, the ethno-racial, cultural and linguistic composition of Toronto is continuously changing, as illustrated by the following statistics from the 2006 census and other sources:

- As of 2006, half of Toronto's residents were born outside of Canada.
- Half a million immigrants and refugees settled in the city between 2000 and 2009.¹
- Many others arrive each year as temporary residents or live in Toronto without recognized immigration status.
- 81% of newcomers (arrived 2001–2006) identify themselves as members of a racialized group (visible minority); with 27% identifying as South Asian and 20% identifying as Chinese.
- While 90% of newcomers speak English or French, most newcomers speak a language other than English and French most often at home.
- Immigrants are, on average, younger and have more children than the Canadian-born population. A high proportion of births in Toronto is found among recent and longer-term immigrants. While immigrants make up 50% of Toronto's population, 66% of all births in Toronto in 2006 were to immigrants.²

Since the 1970s, the principal source region for immigrants to the city has shifted from Europe to Asia. More than half of all newcomers to Toronto between 2001 and 2006 have come from Asian countries. Between 2001 and 2006, the top source countries for permanent residents to Toronto during this period were China, India, Philippines, Pakistan and Sri Lanka. Significant numbers of immigrants and refugees also come to Toronto from Africa, the Middle East, Eastern Europe, and South and Central America. These demographic changes have

ⁱ In this report the term “newcomer” is used to refer to someone who was born outside of Canada and who came here within the past ten years, including refugees and individuals who are temporary residents or living without documented status. The existing literature suggests that the first five years after migration is a critical period in terms of settlement and access to services. However, transitioning and adapting to a new country may take much longer, and many health issues may not be apparent until later in the settlement process.

important policy and program implications for the health sector in terms of the kinds of health services that are needed and the ways in which these services are delivered.

In order to assess newcomers' health assets and risks, more than just immigration status and place of origin must be considered. In this report, findings are presented about the health of newcomers based on factors such as age, gender, ethno-racial background, socio-economic status, immigration status, language proficiency and sexual orientation. Health status and needs often vary based on one or more of these factors.

HEALTH STATUS AND NEEDS

National and provincial research points to the idea that newcomers are healthier, overall, than Canadian-born residents. For example, newcomers experience lower rates of heart disease mortality, cancers and mental health problems. This health advantage is often referred to as the “healthy immigrant effect”. But a large body of research has shown that, after settling in Canada, immigrants lose this advantage over time. The rates of some health issues among immigrants increase until they equal or exceed rates seen in the Canadian-born population.

In Toronto, evidence supports the existence of a newcomer health advantage and subsequent decline. The findings in this report suggest, however, that there are many differences among sub-populations of immigrants, and this trend does not apply to all areas of health. There are important exceptions to the health advantage, and the health of some groups of immigrants declines more quickly than others. The diversity of newcomers who settle in Toronto leads to a complex picture of the health status of this population.

The following are some key findings related to the health status of newcomers to Toronto:

Self-reported health status:

- Toronto data from the Canadian Community Health Survey (CCHS) show that newcomers report similar levels of health to Canadian-born residents, and that longer-term immigrants (more than 10 years since arrival) report poorer health.
- Some national and provincial research shows better self-reported health among newcomers,^{3,4,5} while other research points to no difference between newcomers and Canadian-born residents.⁶
- Toronto data from the Longitudinal Survey of Immigrants to Canada also shows that newcomers' self-reported health declines over time, and that certain sub-populations of newcomers are more likely to report poorer or worsening health, including women, older immigrants, low-income immigrants and refugees.

Risk factors for chronic disease:

- Toronto data from the CCHS as well as provincial and national data show that newcomers are less likely to have several key risk factors for chronic disease, such as being overweight or obese or drinking heavily.^{7,8,9,10} Newcomer women are also much less likely than Canadian-born women to smoke.
- However, Toronto newcomers are less likely to be physically active in leisure time based on CCHS data, and have some dietary risk factors that are similar to Canadian-born residents. Nutrition and healthy eating have been identified by local stakeholders as important health issues affecting newcomer men and women of all ages.

Chronic diseases:

- Toronto CCHS data show that newcomers are similar to Canadian-born residents in their likelihood of having one or more chronic diseases, and that longer-term immigrants are more likely to have one or more chronic diseases than their Canadian-born counterparts.
- According to national data, newcomers are less likely than Canadian-born residents to have or to die from some specific chronic diseases, including cancer, heart disease, and respiratory disease.^{7,4,6,11,12} Research has also shown that rates of chronic diseases are higher among long-term immigrants compared to recent immigrants.
- However, the prevalence of some chronic health conditions, for example, diabetes, is higher among specific newcomer sub-populations than among Canadian-born residents.¹³ Local and provincial analysis of data from the Ontario Diabetes Database shows that immigrants from South Asia, the Caribbean, Latin America and Sub-Saharan Africa are at particularly high risk.

Communicable diseases:

- Newcomers are more likely than Canadian-born residents to suffer from some communicable diseases, particularly TB and HIV/AIDS.
- More than a third of TB cases in Toronto are among newcomers who have arrived in Canada within the past 5 years.¹⁴ This reflects the high rates of TB in the countries of origin.
- HIV/AIDS also affects immigrants in Toronto and across Canada disproportionately, with an increasing proportion of HIV cases among immigrants from regions with high rates of HIV, particularly Sub-Saharan Africa and the Caribbean.^{15,16} Immigrants from these regions may acquire HIV infection before or after arrival.

Maternal and infant health:

- Toronto research findings show that compared with longer-term immigrants and Canadian-born residents, newcomer women are less likely to give birth to a premature baby and are more likely to breastfeed for up to 6 months. However, newcomer women are less likely to exclusively breast feed their babies and are more likely to have a low birth weight baby.¹⁷
- Much Canadian and international research has found that birth outcomes are better among newcomers compared to longer-term immigrants and Canadian-born residents, but certain sub-populations of newcomers have a higher risk of some negative outcomes.

Mental health and addictions:

- Local researchers and newcomers in the community identify high levels of stress and mental and emotional health as priority health issues for newcomers in Toronto.
- However, recent Canadian research indicates that immigrants, particularly newcomers, have better self-reported mental health status than those born in Canada. Newcomers also report lower rates of several self-reported mental health and addiction issues including depression, mood and anxiety disorders, suicidal thoughts and alcohol dependence.^{18,7,19}
- Certain newcomer sub-populations are at higher risk for specific mental health issues, including women, low-income newcomers, some racialized newcomers and refugees.^{20,21,22}

Oral health:

- Oral health is frequently identified by local stakeholders and published research as an important area of need for Toronto immigrants and sub-populations.
- Local research suggests that newcomer youth have worse oral health and access to dental care compared to their Canadian-born counterparts.²³

ACCESS TO HEALTH SERVICES

Access to quality primary and preventive care is important for maintaining good health. In this report, several findings show that newcomers are less likely to use primary and preventive care, and that some services are difficult for newcomers to access:

- Toronto-based findings show that health services are often not culturally and linguistically accessible, and some newcomers report experiences of discrimination while accessing services. Local and national evidence suggests that some newcomers have difficulty accessing primary care and have concerns about the quality and continuity of care.
- Toronto CCHS data shows that newcomers are less likely than longer-term immigrants to have a regular family doctor, with newcomer men being less likely than their female counterparts to have one.
- Certain sub-populations of newcomers are less likely to access primary and preventive care, for example, those who experience language barriers, older men and women, those without health insurance, and those without immigration status.
- Toronto CCHS data show that newcomer women are less likely to access cervical and breast cancer screening than Canadian-born women. These data are consistent with local, provincial and national research.

The findings highlight other specific newcomer health service needs that are not being met:

- **mental health care** and services, including access to specialists, counselling and therapy, and education and prevention programs;
- **perinatal care**, including health care, information and supports through pregnancy, childbirth, and post-birth;
- **dental care**, including preventive care and treatment;
- **services and care not covered by the Ontario Health Insurance Plan (OHIP)**, including prescription medication, vision care, medical supplies, such as blood sugar testing equipment, and assistive devices, such as glasses, hearing aids and wheelchairs;
- **sexual health services**, including health promotion and education, counselling, testing and treatment, particularly for newcomer youth; and
- **nutrition and recreation programs** for newcomers of all ages.

In addition, local stakeholders identified a number of specific barriers to accessing health services faced by newcomers, including:

- cost and eligibility, particularly with respect to health services not covered by OHIP;
- lack of awareness of services and difficulties navigating the health care system;
- inadequate language interpretation and lack of cultural competency among service providers;
- long wait times;
- stigma related to issues such as mental health and HIV/AIDS; and
- transportation difficulties.

In some cases, these barriers may lead newcomers to forgo or delay care, which can lead to more serious health problems and increased future costs to the health system.

Obtaining health care is especially difficult for newcomers who are not eligible for OHIP coverage or for the Interim Federal Health Program (IFHP). Permanent residents in Ontario must wait three months before they are eligible for OHIP; local stakeholders have frequently identified this waiting period as a significant and unfair

barrier. Newcomers without status also lack OHIP coverage and they also face many other barriers to accessing health care as a result of their precarious situation, fear of deportation and the possibility of being denied services.

SOCIAL DETERMINANTS OF HEALTH

A wide range of social, economic and political factors influence the health of Toronto's newest residents. Among the top issues facing newcomers are those related to income and employment. After arriving in Canada, many newcomers experience systemic barriers to employment and income security that impact their health and also hinder their access to services. In spite of the fact that newcomers are highly educated overall, many are under-employed or working in jobs that are unrelated to their experience and qualifications. Newcomers face a particular set of barriers to finding secure and stable jobs, including lack of what is often referred to as "Canadian experience", non-recognition of foreign credentials and discrimination.

While newcomers make a crucial contribution to Toronto's economic prosperity, many struggle to realize their full economic potential. They are much more likely to live in low-income households and to be unemployed compared to longer-term immigrants and the Canadian-born population:

- 2006 census data show that 46% of newcomers (less than 5 years since arrival) in Toronto were living in low income households in 2005, compared to 23.2% of more established immigrants and 19.5% of the Canadian-born population.
- While newcomers made up 10.8% of Toronto's population in 2006, they represented 36.0% of low-income households.
- By 2009, the unemployment rate for newcomers (less than 5 years since arrival) in the Greater Toronto Area was 19%, compared with 9% unemployment for the total city. This newcomer unemployment rate is higher than the 12% rate in 2006.²⁴
- Levels of poverty and unemployment tend to be greater for certain sub-populations of newcomers, including some racialized individuals, women and refugees. For example, newcomer women are more likely to be unemployed than newcomer men.

In addition to experiences in Canada after arrival, the health of newcomers may be affected by experiences before coming to Canada (e.g., socio-economic status, socio-cultural norms) and experiences during migration (e.g., displacement or family separation). Other important determinants of newcomer health discussed in the report are race-based discrimination, education, language proficiency, transportation, and family and social support.

KEY THEMES AND IMPLICATIONS

Immigration has been a key source of talent and new growth in Toronto. Newcomers arrive with a wealth of education, skills, experience, and usually, good health; however, their health advantage is often lost over time. Reversing this decline and improving the health of all residents are key to a prosperous and healthy city.

Several overarching themes have emerged from the evidence reviewed and from discussions with local stakeholders:

- **Most newcomers arrive in good health.** Research has shown that, on average, newcomers are in better health than Canadian-born residents, particularly with respect to many chronic diseases and related risk factors. Medical screening prior to arrival as a part of the immigration process and the relative young age of newcomers contribute to this health advantage. However, this advantage was not found for all health outcomes or for all groups of newcomers.

- **Overall, newcomers lose their health advantage and their health declines over time.** There is strong evidence showing that, over time, the health of immigrants to Canada gets worse in terms of overall health status, chronic disease, mental health and other areas. This is true for newcomers who arrive with good health and for those who arrive with pre-existing health issues. The health of some groups of newcomers declines more quickly than others and is directly affected by social and economic factors that increase health risks and create barriers to preventive care and treatment.
- **Newcomers have diverse health needs.** Findings show that some health needs are broadly applicable to many newcomers, while others are unique to certain sub-populations based on their age, gender, sexual orientation, ethno-racial identity, migration experiences, income level, education and other factors. Health service providers need to strengthen their capacity to provide equitable, culturally sensitive preventive and primary care to diverse groups of newcomers with varied health status, health risks and health needs.
- **Settlement is a health issue.** Newcomer health needs are different, in many ways, from those of the Canadian-born population. The health of newcomers is clearly affected by the processes of migration, settlement and adaptation. The challenge and opportunity, therefore, is to provide the necessary conditions and supports that will enable newcomers to stay healthy and fulfil their potential. This will require a coordinated and integrated approach to providing health and settlement services in Toronto.
- **Social and economic exclusion have a major impact on the health of newcomers.** Newcomers begin to experience marginalization almost immediately after arrival. High rates of unemployment, precarious types of employment and work environments, income insecurity, discrimination, social isolation, housing insecurity, and barriers to health and other services often result in declining health among newcomers. The findings underscore the need to expand and coordinate efforts across the health, settlement and other sectors to advocate for policy changes that promote the social and economic inclusion of newcomers.
- **Newcomers experience multiple barriers to accessing necessary services.** Key barriers relate to cost and eligibility, socio-cultural and linguistic barriers, lack of cultural competence among service providers and poor awareness of services. Failure to address these barriers may lead newcomers to forgo or delay care, which can lead to more serious health problems and greater health care costs.
- **Newcomers' health knowledge and positive behaviours should be acknowledged and promoted.** Newcomers bring considerable health knowledge as well as healthy behaviours such as significantly lower rates of smoking, alcohol use, substance use and risk factors that lead to obesity and higher rates of breastfeeding. These help lower risks for certain illnesses for newcomers and can result in major savings to the healthcare system.
- **Research on immigrant and refugee health in Canada yields vital data.** Continuing research on the health and well-being of immigrants in Canada is vital to our understanding of this population and to responding adequately to their diverse health needs. Although there is a substantial and growing body of evidence related to newcomer health, local and Canadian data are limited with respect to certain health topics and newcomer sub-populations. Ongoing surveillance and population health assessment, particularly longitudinal studies, are also needed to measure health disparities over time.

In conclusion, the wide range of evidence presented in this report shows that the health needs of newcomers are different from those of Canadian-born populations and that migration and settlement experiences may significantly impact health. To capitalize on the health advantage that newcomers bring, health and settlement services need to coordinate with each other to meet the diverse needs of today's newcomers. In short, settlement is a health issue, and health is a settlement issue. Toronto Public Health, Access Alliance Multicultural Health and Community Services and other local organizations are working to improve service access and quality for newcomers and longer-term immigrants. However, more work remains to be done in order to meet the health needs of newcomers in Toronto and to provide the necessary conditions and supports that will enable newcomers to stay healthy and to fulfil their potential.



An improved understanding of newcomer health can help to ensure that policies, programs and services will make Toronto a healthier and more equitable city.

Above: A newcomer mother receives a home visit as a part of Toronto Public Health's *Healthy Babies, Healthy Children* program.

1. INTRODUCTION

Toronto is a destination for people from all over the world. Half of the city's residents were born outside Canada, and nearly a half million newcomers settled here between 2000 and 2009. Health is an important asset that this population brings with them to Toronto, along with their education, work experience, diverse cultures and languages.

While most newcomers are healthy upon arrival to Canada, they often experience life changes during the settlement process that have a significant impact on their mental and physical health and well-being. And while the city is greatly enriched by newcomers' contributions, many of them encounter barriers to accessing health services and to social and economic inclusion.

In order to effectively promote and sustain the health and well-being of newcomers, health planners, policy makers and service providers need timely and relevant information on the health status and related determinants of newcomer health and the key health needs of this population. It is also important to consider the complex and interrelated factors that affect the health of this population and of specific sub-groups of newcomers. An improved understanding of newcomer health can help to ensure that policies, programs and services are planned and delivered in ways that will make Toronto a healthier and more equitable city.

1.1 - OBJECTIVES

This report is based on the findings of several research activities which shared the overall goal of improving the understanding of the physical and mental health status, health needs and health determinants of newcomers in Toronto. This work was undertaken as part of the Toronto Newcomer Initiative, which is led by the City of Toronto and funded by Citizenship and Immigration Canada.

The specific objectives of this initiative are as follows:

- **consolidate existing knowledge** related to newcomer health (with an emphasis on local and Canadian data) by:
 - creating a demographic profile
 - assessing current health status and related determinants of health
 - identifying health service needs, gaps and barriers to access;
- **identify knowledge gaps** and corresponding research needs and opportunities;
- broadly **distribute findings** through clear and accessible documents;
- **inform service planning, policy development** and **further research** at Toronto Public Health, Access Alliance and other local organizations with an interest in newcomer health; and
- **build on** and **complement Toronto Public Health's existing work** on health inequalities.

1.2 - RESEARCH QUESTIONS

The following questions guided the data collection activities for this report:

- What are the socio-demographic characteristics of newcomers in Toronto that may have implications for health service planning?
- What is known about the health status and related health needs of newcomers in Toronto?

- What are the differences between newcomers, longer-term immigrants and Canadian-born residents in health status and needs?
- Which sub-populations of newcomers have unique health needs? Example: groups at high risk for certain chronic diseases or mental illness.
- What barriers to accessing health services (including primary health care, preventive health care and community health promotion programs) do newcomers in Toronto experience?
- What are the key determinants of health for newcomers in Toronto?
- What are the key health determinants that intersect with newcomer status and with each other?
- What are the key knowledge and information gaps related to the health of newcomers in Toronto?

1.3 - KEY DEFINITIONS

Various terms related to immigration and health are used throughout the report. Below, some of the key ones are defined:

Newcomer

For the purposes of this report, “newcomer” is defined as someone who was born outside Canada and who migrated here within the last ten years, except where otherwise noted. The existing literature on newcomer health suggests that the first two to five years after migration is a critical period in terms of settlement and access to services, but that many health issues may not be apparent until later in the settlement process. This definition also recognizes that the process of integration and settlement may take ten years or longer for many newcomers.

According to the 2006 census, there were 465,815 newcomers in Toronto, which accounts for 18.4% of the city’s total population. Of this number, 267,855 or 10.8% of all residents had been in Canada for five years or less.

Longer-Term Immigrant

In this report, “longer-term immigrant” is used to refer to individuals who were born in another country but have been in Canada for more than 10 years (unless otherwise indicated).

Immigrant

The term ‘immigrant’ is used in this report is used to refer to both newcomers and longer-term immigrants.

Immigrants (Born outside Canada)	
Newcomers (Lived in Canada 10 years or less)	Longer-Term Immigrants (Lived in Canada more than 10 years)

The definitions of “newcomer”, “longer-term immigrant” and “immigrant” used in this report are inclusive of all immigration categories, including refugees, temporary residents and those who are living without status, though most local research data pertains to permanent residents. This definition helped to focus data collection activities. It also allowed flexibility. Research applicable to newcomers in Toronto but that did not match the definition exactly could still be incorporated. For example, in published census data, “recent immigrants” are typically defined as those who arrived in Canada within the previous five years (i.e., 2001–2006 for the 2006 census).

Racialized groups

Throughout this report there are references to individuals that belonging to a “racialized group”. According to the Ontario Human Rights Commission, a community that faces racism is racialized. “Racialization” refers to social processes and systems that label some groups and treat them differently and unequally compared to members of the dominant group.^{25,26} Many local service providers, advocates and researchers working on issues related to race and racism use terms like “racialized individuals” and “racialized group” rather than terms that refer to a person's skin colour or race, like “visible minority” or “non-White”. Referring to individuals as racialized recognizes that society creates and uses racial categories to identify and treat some individuals differently than others.

Because 81% of newcomers to Toronto identify as a member of one or more racialized groups, considerations of race and ethnicity contribute to the understanding of the health status and needs of this population. Due to the complex nature of inequalities, health issues facing newcomers can be compounded by the fact that they may also belong to racialized communities.²⁷ Conversely, members of racialized communities may face continued inequalities, despite being born in Canada or having lived in Canada for many years. Therefore, in some sections data emerging from research and consultations with racialized groups are reported, even though members of these groups may or may not be newcomers to Canada.

1.4 - ABOUT THE PARTNERS

This report is the result of a collaborative effort between Toronto Public Health (TPH) and Access Alliance Multicultural Health and Community Services (Access Alliance). These organizations jointly planned, coordinated and conducted the key research activities.

TPH selected Access Alliance as a collaborator through a request for proposals process. In addition, some specific activities (as described in section 1.5) were contributed by or sub-contracted to external individuals with expertise in particular topics and/or methodologies.

Within TPH, a steering committee was established to guide the project. The steering committee consisted of middle and senior level management, and the project coordinators. The members of this committee also helped to synthesize the diverse findings, identify key implications and formulate recommendations. A reference group was also established to provide advice and assistance. The reference group consisted of staff from various TPH program areas. Both groups met several times over the course of the project.

A number of external stakeholders were also consulted at various stages. Most notably, a round table was organized early on which brought together local experts and stakeholders in the area of newcomer health. Participants helped to establish the context for this report and to identify other key stakeholders and sources of data related to immigrant health in Toronto. These and other participants were subsequently invited to attend a knowledge integration meeting (as described in section 1.5), where they helped to identify key messages and implications, based on the preliminary findings.

1.5 - RESEARCH ACTIVITIES

Several different research activities were undertaken to collect and synthesize the data that are reported in the sections that follow. These activities are briefly described below and summarized in Figure 1.1. Detailed descriptions of each of the major data collection activities are included in Appendix A.

Literature review

A detailed review of published academic literature was completed by Ilene Hymanⁱⁱ. The review was based on a search of published literature using multiple databases, including Medline, Scopus and CINAHL. Findings drawn from the literature search were supplemented with findings from other recent reviews. The review focused on three main topics related to newcomer health: health status, determinants of health and access to health services. The review focused on research conducted in Toronto, Ontario and other Canadian cities. More than 500 published articles and reports, mostly from peer-reviewed journals, were referenced.

Environmental scan

Staff at Access Alliance conducted a scan of local reports and publications, including:

- community-based research reports, planning documents, government reports, fact sheets, briefing notes and web-based information;
- research findings from community and government initiatives that may not be published, such as evaluations and needs assessments; and
- information about research projects currently underway.

Researchers collected documents from various sources identified by TPH and Access Alliance staff and also by external stakeholders. The environmental scan also identified and summarized other selected publications related to newcomer health in Canada (e.g., policy reports, synthesis documents, tools and resources).

Analysis and review of existing health and socio-demographic data

A number of data analysis activities were conducted by TPH and Access Alliance staff, as well as by external contributors. Data were extracted and analyzed from several existing data sets that contain information on newcomer health status, health determinants, access to health care and socio-demographics. These activities included the following:

- TPH conducted an analysis of self-reported data on health status, risk factors and access to health care among immigrants and Canadian-born residents in Toronto from the Canadian Community Health Survey (CCHS);
- Bruce Newboldⁱⁱⁱ contributed analysis of data from the Longitudinal Survey of Immigrants to Canada (LSIC); the data capture self-reported health among newcomers in Toronto, measured at specific points in time during their first four years in Canada.
- Maria Isabella Creatore^{iv} contributed analysis of data on diabetes prevalence among immigrants in Toronto, which was generated by linking data from the Canadian Landed Immigrant Database (LIDS), containing Citizenship and Immigration Canada data on immigrants landing in Canada, to the Ontario Diabetes Database (a data registry created from health care system data, such as hospital records and doctors' billing claims);
- Staff at Access Alliance and TPH compiled socio-demographic information about newcomers, using Citizenship and Immigration Canada (CIC) data on recent landings and 2006 census data on the Toronto population published as tables by Statistics Canada. These data include information on a range of social, demographic and economic characteristics, such as newcomers' top countries of origin, ethno-racial identity, age, income and education.

ⁱⁱ independent research consultant

ⁱⁱⁱ School of Geography & Earth Sciences, McMaster University

^{iv} Centre for Research on Inner City Health, the Keenan Research Centre in the Li Ka Shing Knowledge Institute of St. Michael's Hospital; the Institute for Medical Sciences, University of Toronto; and the Institute for Clinical Evaluative Sciences

Stakeholder focus groups

Access Alliance and TPH conducted a series of seven semi-structured focus groups with local stakeholders in order to gather additional insights regarding newcomer health status and health needs. Focus groups were organized with several distinct groups of stakeholders in order to capture a variety of perspectives. The groups included:

- newcomer users of health services in Toronto (2 groups);
- settlement workers;
- health care providers;
- outreach workers that serve specific newcomer communities in Toronto (employed by Access Alliance); and
- service providers and other staff at TPH (2 groups).

A total of 75 individuals with expertise and knowledge of and/or experience with newcomer health issues and local immigrant health services participated in the focus groups.

One additional focus group was held with local academic and community-based researchers who have investigated a range of newcomer health issues, including social determinants of health. A key goal of the researcher focus group was to identify gaps in data and knowledge regarding newcomer health status and health needs, and how these gaps might be addressed by future research and other activities.

Analysis and integration

The final phase of the project involved analyzing and integrating data from the various sources. After the initial findings from each of the data collection activities were compiled, two “knowledge integration” (KI) meetings were organized, one with local service providers and researchers that are familiar with newcomer health issues, and another with TPH staff members. The objectives of these meetings were to:

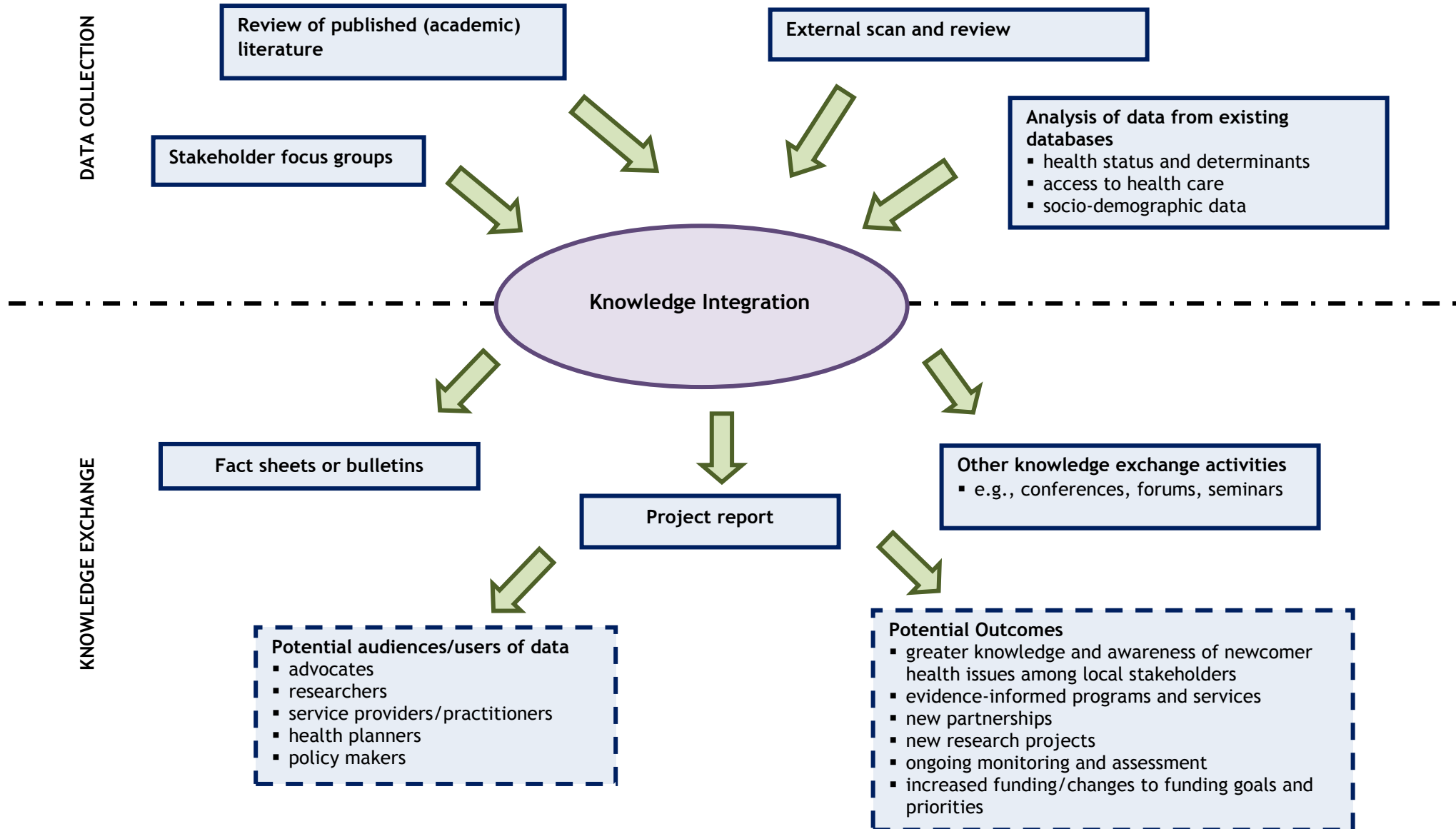
- share preliminary research findings from the project; and
- identify and prioritize key issues and themes.

Drawing upon input from KI meeting participants, the project coordinators then consolidated and prioritized key findings from the various research activities. The integration process prioritized local data when they were available and incorporated a mix of both academic and non-academic research and evidence. For some topics where limited data were available, it was not possible to be as selective about what research evidence was used and reported.

This report was written collaboratively by the project coordinators, with significant input from other staff members at Access Alliance and TPH, including members of the steering committee. Marguerite Pigeon was contracted to provide editorial advice at several stages of the writing process.

In addition to this report, the key findings from the research activities will be disseminated to a broad audience through bulletins written in 'popular' style and fact sheets speaking to specific newcomer health issues. Where the opportunities arise, the findings will also be presented at conferences, forums, and seminars focussing on health, immigration and other related topics.

Figure 1.1: Summary of Project Activities



1.6 - ABOUT THIS REPORT

This report provides a summary and synthesis of new and existing evidence from the various data collection activities described above. It is intended to serve as a reference to help readers to better understand newcomer health in the context of the City of Toronto. The report has been written for a broad audience that includes health planners, policy makers, service providers in the health sector, students and researchers. It will also be of interest to those who work with newcomers in immigration, settlement and other sectors.

The focus of this endeavour has been on bringing together what is known about newcomers. In order to identify which health issues are especially relevant for this population, some of the findings reported here compare their health status and needs to those of immigrants that have lived in Toronto for a longer period of time and to residents born in Canada. Recognition of the heterogeneity and diversity of newcomers in Toronto is strived for throughout the report. Where sufficient data are available, findings are organized by specific sub-groups, as determined by gender, age, ethno-racial identity and indicators of socio-economic status (typically income). In many sections, the voices of those who took part the stakeholder focus groups are included.

The report is organized as follows:

- Section 2 offers a brief socio-demographic profile of newcomers in the City of Toronto.
- Section 3 summarizes current evidence on the health status and needs of newcomers in Toronto.
- Section 4 examines access to health care services among newcomers and identifies key access barriers.
- Section 5 provides an overview of the key determinants of health and well-being for newcomers (i.e., those factors that directly and indirectly affect their health).
- Section 6 highlights knowledge and information gaps with respect to the health of newcomers.
- Section 7 identifies several overarching themes from the findings and discusses some of the implications of these themes for the health sector.
- Appendix A provides supplemental information on the research methods used for this report.
- Appendix B provides some statistics for Toronto neighbourhoods with the largest numbers of newcomers (as of 2006).



Toronto is one of the world's most ethno-racially diverse cities, and this diversity has increased in the past decade as the city continues to welcome newcomers from all over the world.

Above: Newcomers participate in culturally appropriate nutrition education as a part of Toronto Public Health's *Peer Nutrition* program (Jane/Finch Community and Family Centre).

2. SOCIO-DEMOGRAPHIC PROFILE OF IMMIGRANTS IN TORONTO

Toronto is one of the world's most ethno-racially diverse cities, and this diversity has increased in the past decade as the city continues to welcome immigrants from all over the world. Data from the 2006 census show that half of Toronto's residents were born outside of Canada. At that time, there were 465,815 newcomers (10 years or less since arrival) in Toronto, which accounts for 18.4% of the city's total population. Of this number, 267,855 or 10.8% of all residents had been in Canada for five years or less. In addition, there were 54,610 non-permanent residents living in Toronto in 2006. The Toronto census metropolitan area (CMA) ranks higher than any other metropolitan area in North America in terms of immigrants as a percentage of the total population.²⁸

Though they are all “newcomers”, the individuals who move to Toronto actually differ from one another in many ways. They may be refugee claimants, temporary workers, permanent residents or living without status. They are students, workers, caregivers and dependents. They may identify as lesbian, gay, bisexual, transgendered or queer. They may or may not identify as being part of a religious/faith community. Each of these factors corresponds with particular health assets or risks and may affect access to services. The changing ethno-racial, cultural, linguistic and socio-economic composition of the newcomer population has important implications for the health sector. For example, the composition of residents may affect access to and use of existing health services while also increasing the need for services that are responsive to cultural and linguistic diversity. At the same time, newer and emerging communities may have unique health issues and needs.

2.1 - IMMIGRATION CATEGORIES

Immigrants to Canada are accepted as either permanent residents (PRs) or temporary residents (TRs). Permanent residents, sometimes referred to as landed immigrants, are persons granted the right to live permanently in Canada. PRs may have come to Canada as immigrants or refugees. Temporary residents are those who have permission to remain in Canada for only a limited period of time. In this section, the main subcategories of immigrants are defined.

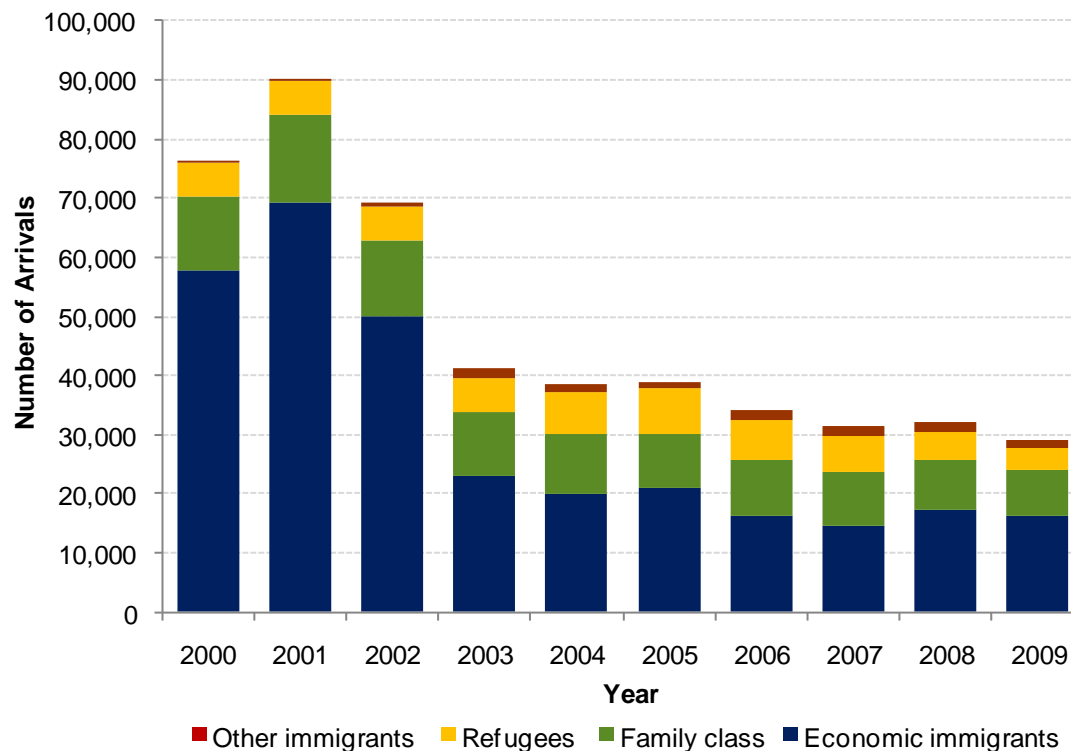
Migrants without status are those who have not been given permission to stay in the country or who have stayed in Canada after their visa has expired.²⁹ They are sometimes referred to as “undocumented”, as they generally lack any sort of official documentation, such as a permanent resident card, student visa or work permit.

A notable trend in immigration to Toronto is that the total number of permanent resident (PRs) arriving each year has decreased significantly since 2001, while the number of temporary resident (TR) arrivals increased each year between 2005-2009. As a result, the annual number of TR arrivals is now higher than the number of PR arrivals. The implications of this trend in terms of health and other social service needs are not yet clear but should be carefully considered.

Permanent residents

An average of 48,100 new PRs arrived in the City of Toronto each year between 2000 and 2009. This represents 20% of all PRs arriving in Canada during this period. Of these, 63% were economic immigrants and their dependents, 22% were family class immigrants and 12% were refugees and their dependents.¹ Figure 2.1 shows the number of permanent resident arrivals by immigration category.

Figure 2.1 Number of Permanent Residents Arriving in the City of Toronto, by Category, 2000 to 2009



Data Source: Citizenship and Immigration Canada, 2010

Permanent Resident Categories

Permanent residents are persons who have been granted the right to live permanently in Canada. Permanent residents must live in Canada for at least two years within a five-year period or risk losing their status. They may apply for Canadian citizenship after living in Canada for at least three of the last four years (not applicable to children). Those who become citizens are no longer permanent residents.

The *Immigration and Refugee Protection Act* defines three basic classes of permanent residents immigrating to Canada:

- **Economic class immigrants** are selected for their skills and ability to contribute to Canada's economy. The majority of immigrants in this category come as "skilled workers". This category includes the Principal Applicant and, where applicable, the accompanying spouse and/or dependants.
- **Family class immigrants** are sponsored by a Canadian citizen or permanent resident living in Canada and include spouses, partners, parents, grandparents and certain other relatives.
- **Refugees (also referred to as "protected persons")** are accepted as permanent residents under Canada's Refugee and Humanitarian Resettlement Program. This category includes:
 - **government assisted refugees**, who are selected abroad for resettlement to Canada and receive initial resettlement assistance from the federal government;
 - **privately sponsored refugees**, who are selected abroad for resettlement to Canada and are privately sponsored by organizations, individuals or groups of individuals;
 - **refugees landed in Canada**, who have had their refugee claims accepted and who subsequently applied for and were granted permanent resident status in Canada (the application may include family members in Canada and abroad).

Source: Citizenship and Immigration Canada, 2010

The annual number of *economic immigrants* to the city has decreased dramatically from a peak of nearly 70,000 in 2001 to 16,165 in 2009. The number of refugees and family class immigrants has also decreased, though more modestly, in the same period.

It is notable that 22% of all PRs to Canada initially settle in communities that surround the City of Toronto, such as Brampton, Mississauga, Vaughan, Richmond Hill and Markham. Many of these communities have experienced significant growth in terms in their foreign-born populations. For example, Brampton's foreign-born population increased by 59.5% from 2001 to 2006, and Markham's by 34.1%. Ajax, Aurora and Vaughan also saw increases of more than 40% in the foreign-born population.²⁸ The increasing number of newcomers settling in these communities appears to be part of a national shift in immigrant settlement patterns away from urban core areas to suburban communities and smaller municipalities.³⁰

Temporary residents

In 2006, there were nearly 55,000 temporary residents living in the City of Toronto, representing 2.2% of the city's population. Immigrant landing statistics show that more than 450,000 temporary residents came to Toronto between 2000 and 2009. In recent years, the number of TR arrivals in Toronto exceeds the number of PR arrivals on an annual basis. The total number and main categories of temporary resident arrivals to the city between 2000 and 2009 are shown in Figure 2.2.

The largest category of temporary residents is temporary foreign workers, representing one third (33.9%) of all temporary resident arrivals between 2000 and 2009 (15,535 per year on average). Many of these workers fill low-skilled jobs, and they have few of the supports and protections available to permanent residents.^v Toronto also attracts many students from abroad, receiving an average of nearly 12,000 foreign students each year, which represents one quarter (25.4%) of all TR arrivals. Refugee claimants made up 14% of TR arrivals in Toronto between 2000 and 2009 (approximately 6,400 per year on average). Refugee claimants remain temporary residents while their claims are being reviewed, a process that can take several years.

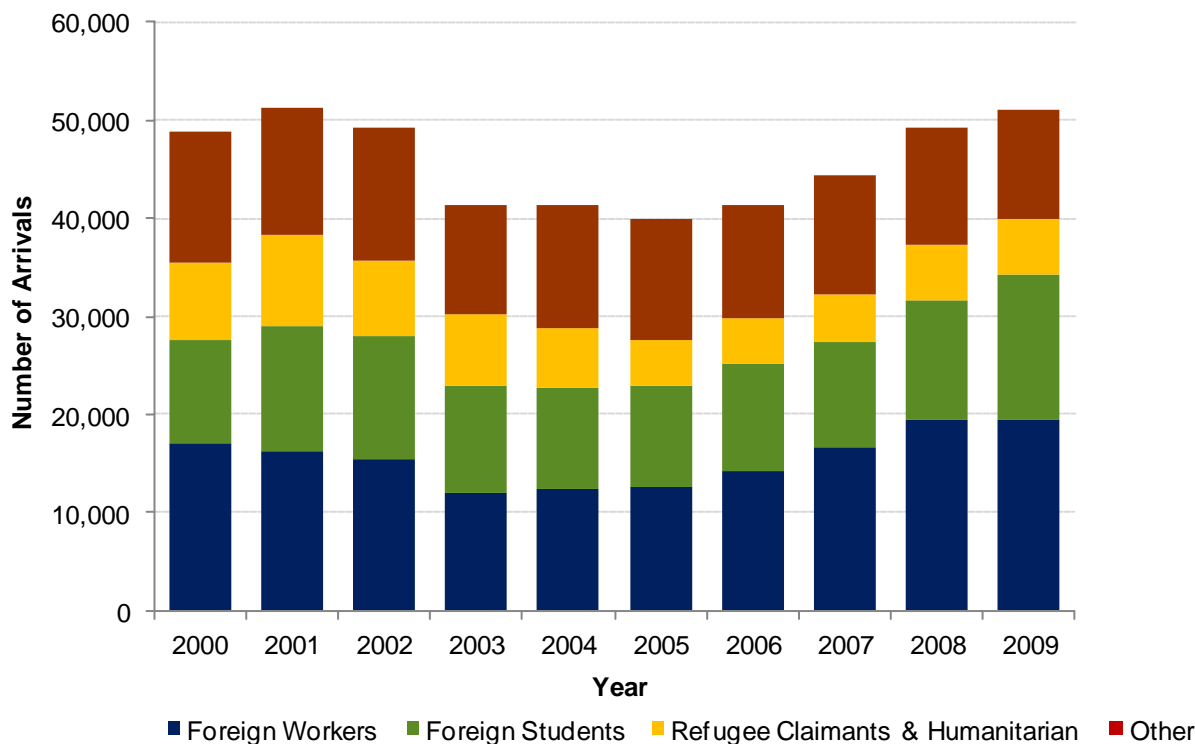
Migrants without status (undocumented migrants)

The number of migrants living without status in Toronto is unknown. Given that most of these individuals are "undocumented", they are not captured in immigration statistics or counted in the national census. Anecdotal evidence from advocates and service providers working with non-status individuals suggests that their numbers are considerable. Although estimates vary greatly, it has been suggested there are between 200,000 and 500,000 individuals living in Canada without status,³¹ with the majority living in major urban centres, including Toronto.

^v Effective April 2011, the federal government made several changes to the Temporary Foreign Worker program. These changes include the introduction of a more rigorous assessment of job offers and a limit on the length of time that the worker may stay in Canada before returning home. For more information on these changes, refer to:

<http://www.cic.gc.ca/english/work/changes.asp>.

Figure 2.2 Number of Temporary Resident Entries* in the City of Toronto, by Category, 2000 to 2009



* Entries include both initial entries and re-entries.

Temporary Residents are grouped according to the principal reason for residing in Canada during the calendar year.

Data Source: Citizenship and Immigration Canada. 2010

Temporary Resident Categories

Temporary residents are persons who have been granted permission to remain in Canada only for a limited period of time.

The *Immigration and Refugee Protection Act* defines three main classes of temporary residents immigrating to Canada:

- **Temporary Foreign workers** are those who have been issued a work permit by Citizenship and Immigration Canada. This permit allows the person to be here for as long as the permit is valid. Canada offers a number of temporary foreign worker programs, including the Seasonal Agricultural Worker Program, the Live-In Caregiver Program and the Temporary Foreign Worker Program.
- **Foreign Students** are in Canada principally to study and have been issued a study permit. This category excludes temporary residents who have been issued a study permit but who entered Canada principally for reasons other than study.
- **Refugees Claimants** are those who request refugee protection upon or after arrival in Canada. A refugee claimant whose claim is accepted may make an application in Canada for permanent residence. Unsuccessful refugee claimants are required to leave the country.

Source: Citizenship and Immigration Canada, 2010

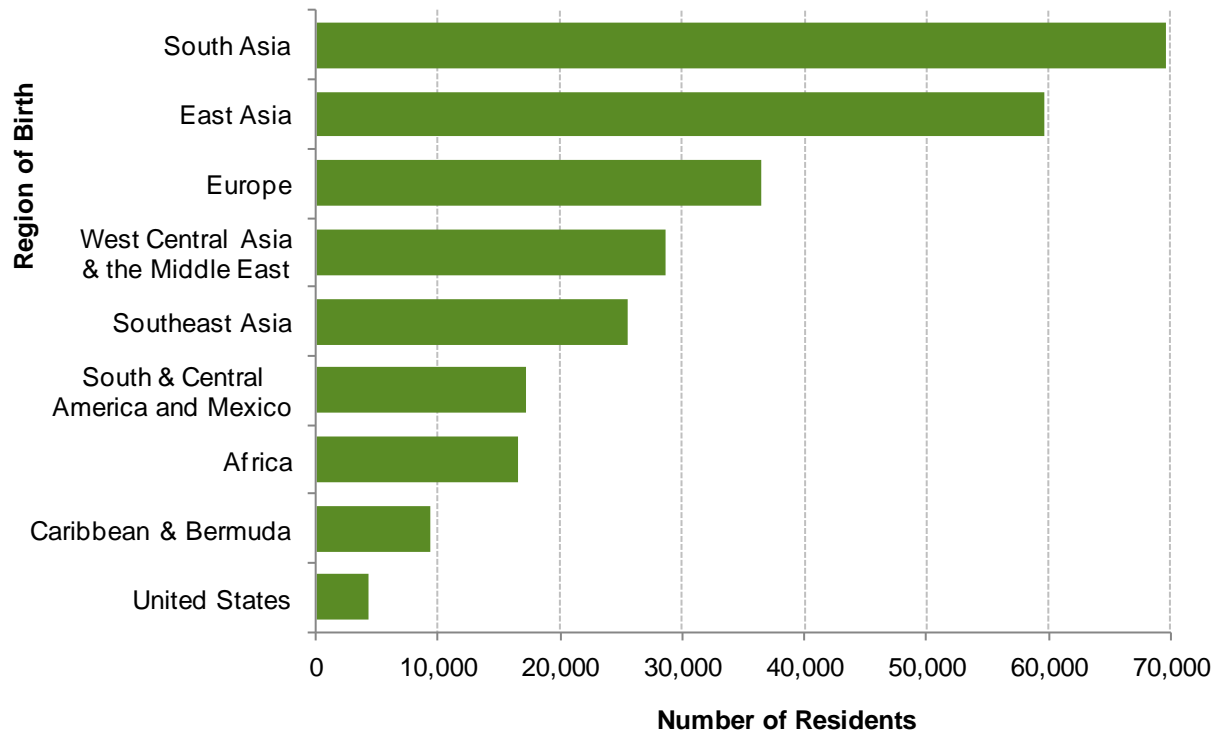
2.2 - PLACES OF BIRTH AND SOURCE COUNTRIES

Prior to the early 1970s, most newcomers to Canada came from the United Kingdom, Europe and the United States.³² The source regions of immigration have shifted significantly since that time as a result of changing political and social forces in Canada and globally, including changes in immigration policy. In recent years, more than half of all immigrants to Toronto come from Asia, but with significant numbers also migrating from Africa, the Middle East and Central and South America.

The top regions of birth for newcomers, arriving between 2001 and 2006 (excluding temporary residents), are shown in Figure 2.3. Data from the 2006 census show that immigrants from Asia represented 56% of all newcomers in Toronto, while 14% came from Europe. The top regions of origin for immigrants settling in Toronto between 2001 and 2006 were:

- South Asia (26%);
- East Asia (20%, most from China);
- Europe (14%, most from Eastern European countries);
- Middle East and West Central Asia (11%);
- Caribbean, Central and South America and Mexico (10%);
- South East Asia (10%, predominantly Philippines at 8%); and
- Africa (6%).

Figure 2.3 Number of Newcomers by Region of Birth, Toronto, 2006

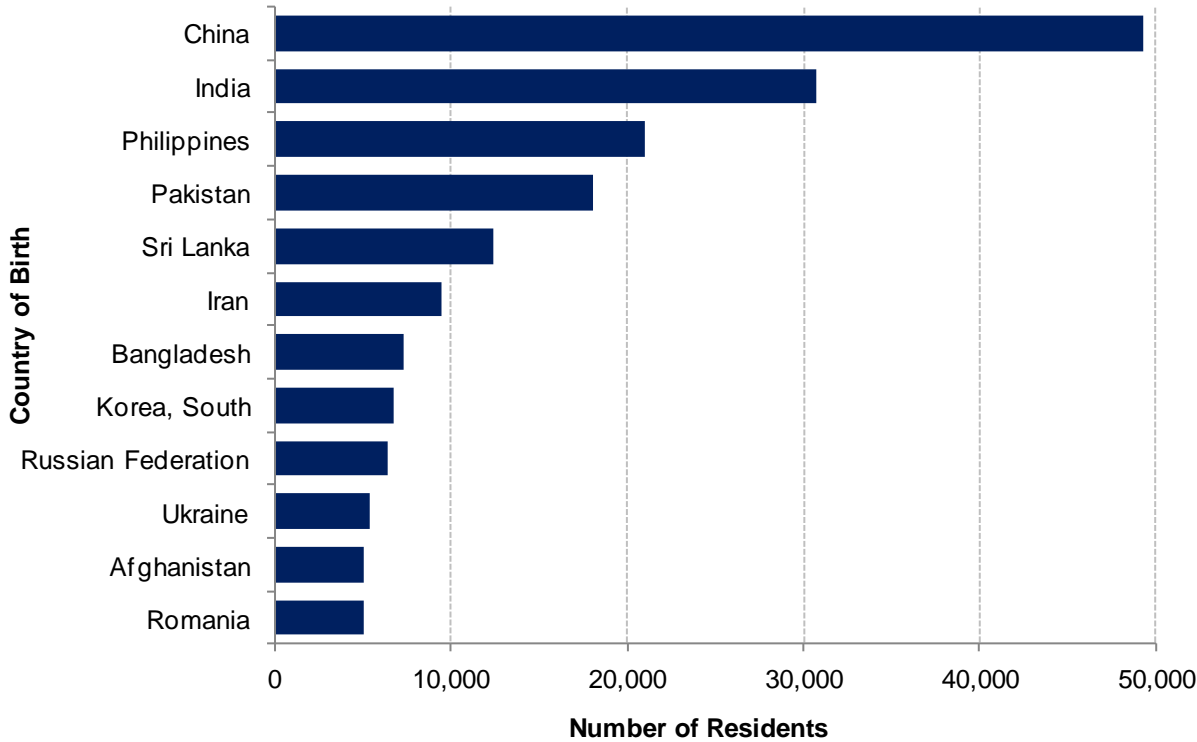


Data Source: Statistics Canada, 2006 Census of Canada, Custom Cross-Tabulations

The top countries of birth for newcomers (arrived between 2001 and 2006) and established immigrants to the City of Toronto in 2006 are shown in Figure 2.4. Five countries accounted for nearly half of all immigrants to Toronto arriving between 2001 and 2006:

- China (18.4%)
- India (11.5%)
- Philippines (7.9%)
- Pakistan (6.7%)
- Sri Lanka (4.6%).

Figure 2.4 Number of Newcomers by Country of Birth, Toronto, 2006



Data Source: Statistics Canada, 2006 Census of Canada, Custom Cross-Tabulations

Census data include newcomer PRs and TRs, but do not include specific immigration categories such as refugees. Drawing from more recent Citizenship and Immigration (CIC) data, the top source countries for newcomers arriving in the City of Toronto between 2005 and 2009 are shown in Table 2.1.

In addition to the major source countries, there are a number of newer and emerging^{vi} immigrant communities in Toronto. Some of newer and emerging source countries for newcomers (arrived between 2001 and 2006) are shown in Table 2.2. Newer and smaller immigrant communities are notable because, compared to more established immigrant communities, they may have less access to social support networks and to linguistically and culturally appropriate services.

^{vi} Newer and emerging communities were identified based on: (i) the high percentage of total immigrants from that country that are newcomers to the City of Toronto as of 2006; and (ii) the absolute number of immigrants from that country that came to the City of Toronto in recent years.

Table 2.1: Top Source Countries^{vii} for Arrivals/Entries by Immigration Status, City of Toronto, 2005-2009

All Permanent Resident Arrivals	Refugee Arrivals ^{viii}	Temporary Resident Entries
1. China	1. China	1. United States of America
2. India	2. Colombia	2. China
3. Philippines	3. Afghanistan	3. Korea (South)
4. Pakistan	4. Iraq	4. Mexico
5. United States	5. Sri Lanka	5. India
6. Iran	6. Pakistan	6. Japan
7. Bangladesh	7. Ethiopia	7. United Kingdom
8. Sri Lanka	8. Turkey	8. Philippines
9. Russia	9. India	9. Germany
10. United Arab Emirates	10. Mexico	10. Australia

Data Source: Citizenship and Immigration Canada, Landings Data, 2010

Table 2.2: Newer and Emerging Communities in the City of Toronto

Country	Newcomers <i>birth country</i> (arrived between 2001 and 2006)	Total immigrant population (2006)	Newcomers as % of local pop. (2006)	Permanent resident arrivals <i>source country</i> (2005 to 2009)
Bangladesh	5,990	15,160	39.5%	4,683
Colombia	2,875	6,425	44.7%	2,746
Albania	2,460	5,610	43.9%	1,626
Iraq	2,240	6,775	33.1%	1,722
Nigeria	1,920	4,815	39.9%	1,695
Mexico	1,670	4,180	40.0%	1,943
Bulgaria	1,595	4,350	36.7%	1,087
Cuba	830	2,000	41.5%	1,135
Zimbabwe	810	1,450	55.9%	462
Kazakhstan	730	1,590	45.9%	532

Data Source: Statistics Canada, 2006 Census, Target Group Profiles; Citizenship and Immigration Canada, 2010

^{vii} Source country is defined as the principal country of last permanent residence for all permanent residents and temporary residents; in some cases it is different from country of birth.¹

^{viii} This includes permanent residents only. Refugee claimants are classified as temporary residents while their claim is under review.

2.3 - AGE AND GENDER

The overall age distribution of newcomers is quite different from that of the rest of the city's residents (see Table 2.3). Given that the immigration process favours younger and skilled workers, it is not surprising that nearly half (48.7%) of newcomers to Toronto in 2006 (arrived between 2001 and 2006) were adults between the ages of 25 and 44.³³ By comparison, 29.2% of Canadian-born residents fell into this age group.

Children under 15 years old accounted for 18.1% of newcomers (arrived between 2001 and 2006) compared to 29.2% of those born in Canada (note that some of the Canadian-born children may have parents who are newcomers). At the other end of the age spectrum, 3.5% of newcomers (2001-2006) were 65 or older, compared to 22.6% of longer-term immigrants (pre-2001) and 9% of Toronto residents born in Canada.³³

Table 2.3: Population by Period of Immigration, Sex and Age, City of Toronto, 2006

Sex/Age Group	Total City Population	Newcomers (arrived between 2001 and 2006)	Longer-Term Immigrants (pre-2001)	Canadian-Born
Both sexes	2,476,565	267,855	969,865	1,184,235
Males	48.2%	47.5%	46.6%	49.5%
Females	51.8%	52.5%	53.4%	50.5%
<15	16.5%	18.1%	2.2%	28.2%
15-24	12.8%	16.0%	8.5%	15.1%
25-44	32.2%	48.7%	30.2%	29.2%
45-64	24.9%	13.7%	36.5%	18.4%
65 or older	13.5%	3.5%	22.6%	9.0%

Data Source: Statistics Canada, 2006 Census of Canada, Target Group Profiles

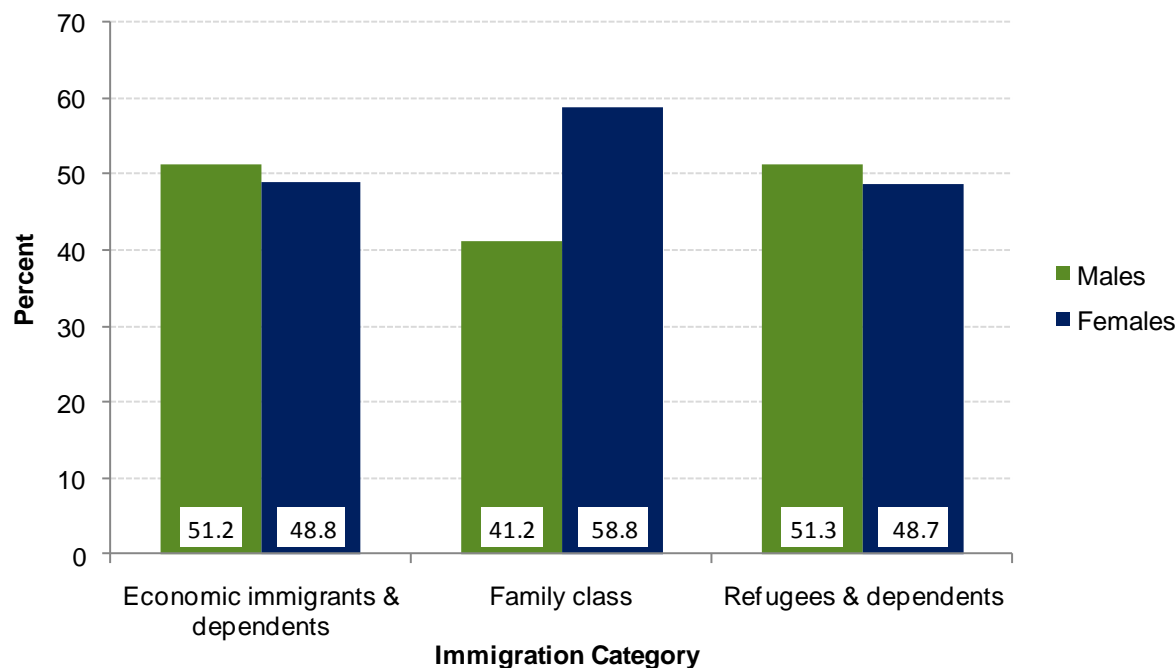
Slightly more than half of newcomers (52.5% of those who had arrived between 2001 and 2006) were women or girls, which is very similar to the city population as a whole (51.8%). However, immigrant landing data show differences in the immigration categories of men and women who migrate to Toronto, including:

- men are more likely to arrive as skilled workers and as refugees; and
- women are more likely to arrive as family class immigrants and through the live-in caregiver program.^{ix,1}

Figure 2.5 shows the number of arrivals to Toronto for selected categories of permanent residents, by gender.

^{ix} Live-in caregivers initially arrive as temporary residents. However, they may apply for permanent residence after 24 months or 3,900 hours of authorized full-time employment acquired within four years after arrival (see: <http://www.cic.gc.ca/english/work/caregiver/extend-stay.asp>).

Figure 2.5 Percent Males and Females in Each Immigration Category, Permanent Residents Arriving in the City of Toronto, 2005-2009



Data Source: Citizenship and Immigration Canada, Landings Data, 2010

2.4 - FAMILY AND HOUSEHOLD COMPOSITION

Table 2.4 shows that the composition of newcomer households (arrived between 2001 and 2006) differs somewhat from that of the rest of the city's residents. Newcomers were more likely to be part of a census family^x. In other words, they are husbands, wives, common-law partners, lone parents or children. Newcomers are much less likely to live alone than other residents of Toronto.

Table 2.4: Family/household Composition of Newcomers, City of Toronto, 2006

	Newcomers (arrived between 2001 and 2006)		Total City Population	
	#	%	#	%
Total number of persons in private households	267,445	100%	2,467,165	100%
In census families ^x	230,495	86.2%	1,987,540	80.6%
Not in census families	36,950	13.8%	479,625	19.4%
Living with relatives	10,450	3.9%	75,145	3.0%
Living with non-relatives only	14,835	5.6%	108,960	4.4%
Living alone	11,665	4.4%	295,520	12.0%

Data Source: Statistics Canada, 2006 Census of Canada, Target Group Profiles

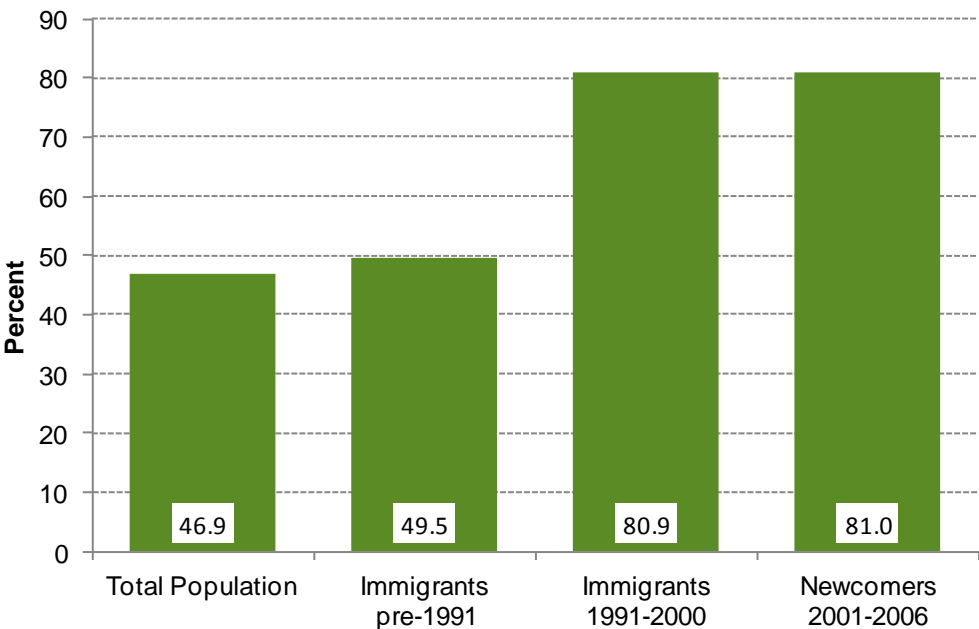
^x A census family is defined by Statistics Canada as a married couple and the children, if any, of either or both spouses; a couple living common law and the children, if any, of either or both partners; or, a lone parent of any marital status with at least one child living in the same dwelling and that child or those children. All members of a particular census family live in the same dwelling (for a full definition, refer to: <http://www.statcan.gc.ca/concepts/definitions/cfamily-rfamille-eng.htm>).

2.5 - ETHNO-RACIAL IDENTITY

The percentage of all City of Toronto residents that identify as a racialized group member increased from 42.8% in 2001 to 47.0% in 2006, and this percentage is projected to increase even more in the future given current immigration trends. From 2001 to 2006, the fastest growing racialized groups were Latin Americans (up 19.3%), Filipinos (up 18.6%) and South Asians (up 17.5%). The proportion of newcomers of European origin fell from 47.0% in 1996 to 17% by 2001 and 16.7% in 2006.

In 2006, 81% of newcomers (2001–2006) in Toronto identified themselves as a member of a visible minority (racialized group), compared to 28.0% of those born in Canada and 47.0% of all Torontonians. Figure 2.6 shows the proportion of racialized groups by period of immigration and for the total city population. Among newcomers (arriving 2001-2006), nearly half identified as South Asian (27.3%) or Chinese (20.1%) at that time.³³ Visible minority (racialized) populations, as defined by Statistics Canada, are summarized in Table 2.5.

Figure 2.6 Percent Visible Minority (Racialized Group) by Period of Immigration, Toronto, 2006



Data Source: Statistics Canada, 2006 Census of Canada, Custom Cross-Tabulations

Table 2.5: Population by Period of Immigration and Visible Minority status, City of Toronto, 2006

Visible Minority (Racialized Group)	% Total City Population	% of Newcomers (arrived between 2001 and 2006)	% of Immigrants (pre-2001)	% of Canadian- born
All Visible Minorities	46.9%	81.0%	61.7%	28.0%
South Asian	12.0%	27.3%	15.2%	6.3%
Chinese	11.4%	20.1%	16.6%	5.6%
Black	8.4%	7.7%	10.0%	7.4%
Filipino	4.1%	7.7%	5.8%	2.1%
Arab or West Asian	2.6%	7.4%	3.4%	0.9%
Latin American	2.6%	4.1%	3.5%	1.6%
Korean	1.4%	2.6%	1.8%	0.8%
Southeast Asian	1.5%	1.5%	2.3%	0.9%
Japanese	0.5%	0.3%	0.3%	0.7%
Multiple visible minority	1.3%	1.0%	1.4%	1.2%
Other	1.0%	1.3%	1.4%	0.6%
Not a visible minority	53.1%	19.0%	38.3%	72.0%

Data Source: Statistics Canada, 2006 Census of Canada, Target Group Profiles

2.6 - LANGUAGES

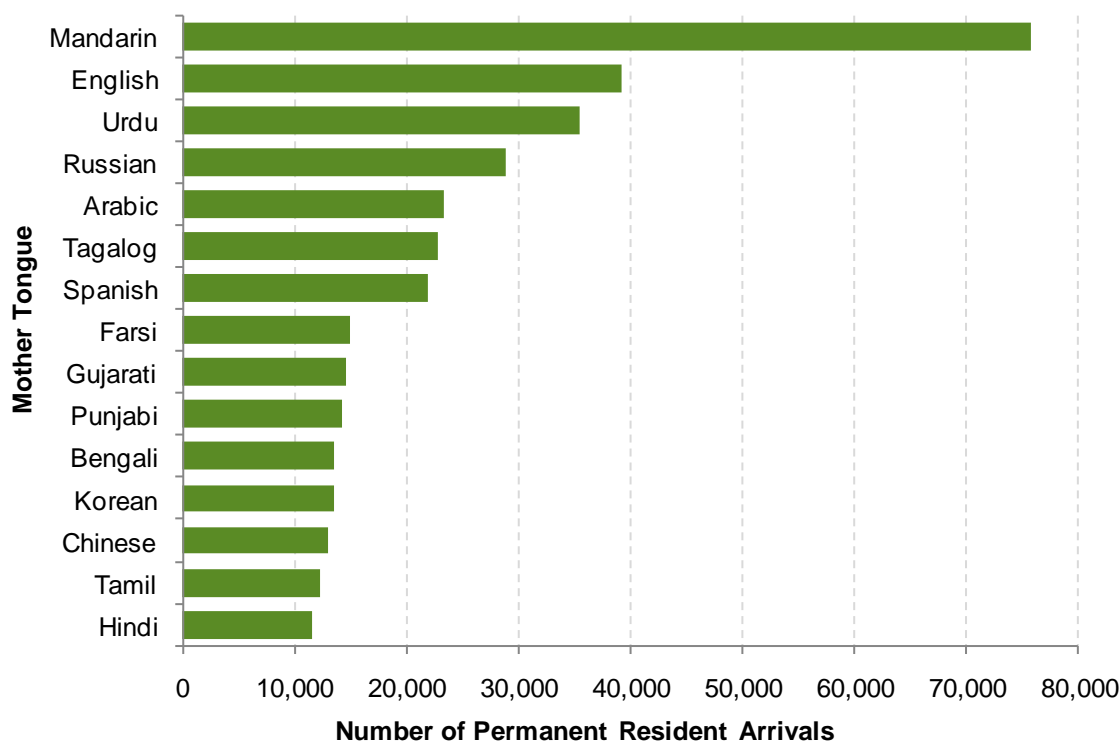
Toronto remains a mosaic of many languages. As of 2006, 47.0% of the city's total population had a mother tongue^{xi} other than English or French, and 31.2% of residents reported speaking only a non-official language most often at home. A smaller percentage, 5.3% of all Toronto residents, reported no knowledge of English or French.³³

The majority of newcomers arrive with the ability to converse in English and/or French. Among those who arrived in Toronto between 2001–2006, only 10.1% had no knowledge of English or French.³³ Census data from the greater Toronto region (CMA) show that a higher proportion of newcomer women (11.8%) than men (8.1%) did not speak an official language in 2006.³³ Among newcomers, 84.0% had a mother tongue other than English or French, and 68.1% spoke a non-official language most often at home.

The top mother tongue languages for new Permanent Residents arriving in the City of Toronto between 2000 and 2009 are shown in Figure 2.7. Figure 2.8 illustrates the top home languages for newcomers (arriving 2001–2006) to Toronto in 2006.

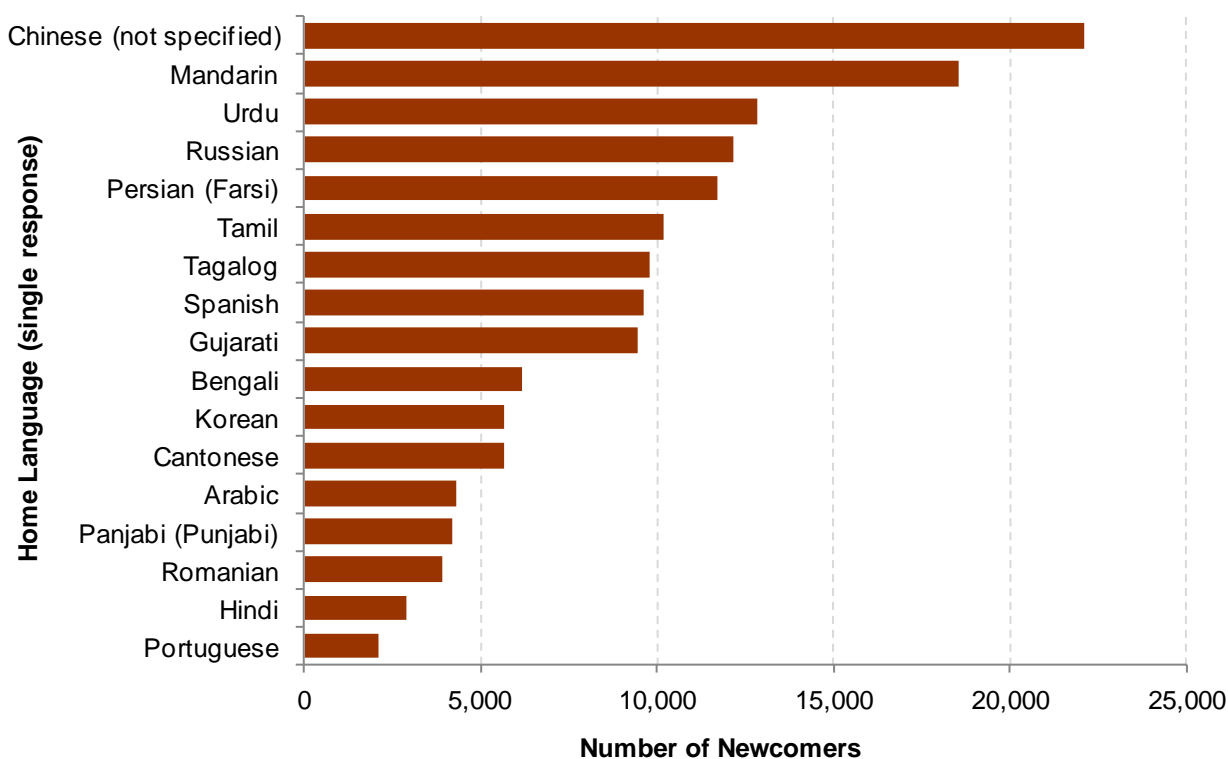
^{xi} Statistics Canada defines mother tongue as the first language learned at home in childhood and still understood by the individual at the time of the census.²³

Figure 2.7 Top Mother Tongue Languages for New Permanent Residents Arriving in Toronto, 2000 to 2009 Combined



Data Source: Citizenship and Immigration Canada, Landings Data, 2010

Figure 2.8 Top Non-Official Home Languages for Newcomers to Toronto, 2001-2006



Data Source: Statistics Canada. 2006 Census of Canada. Custom Cross-Tabulations

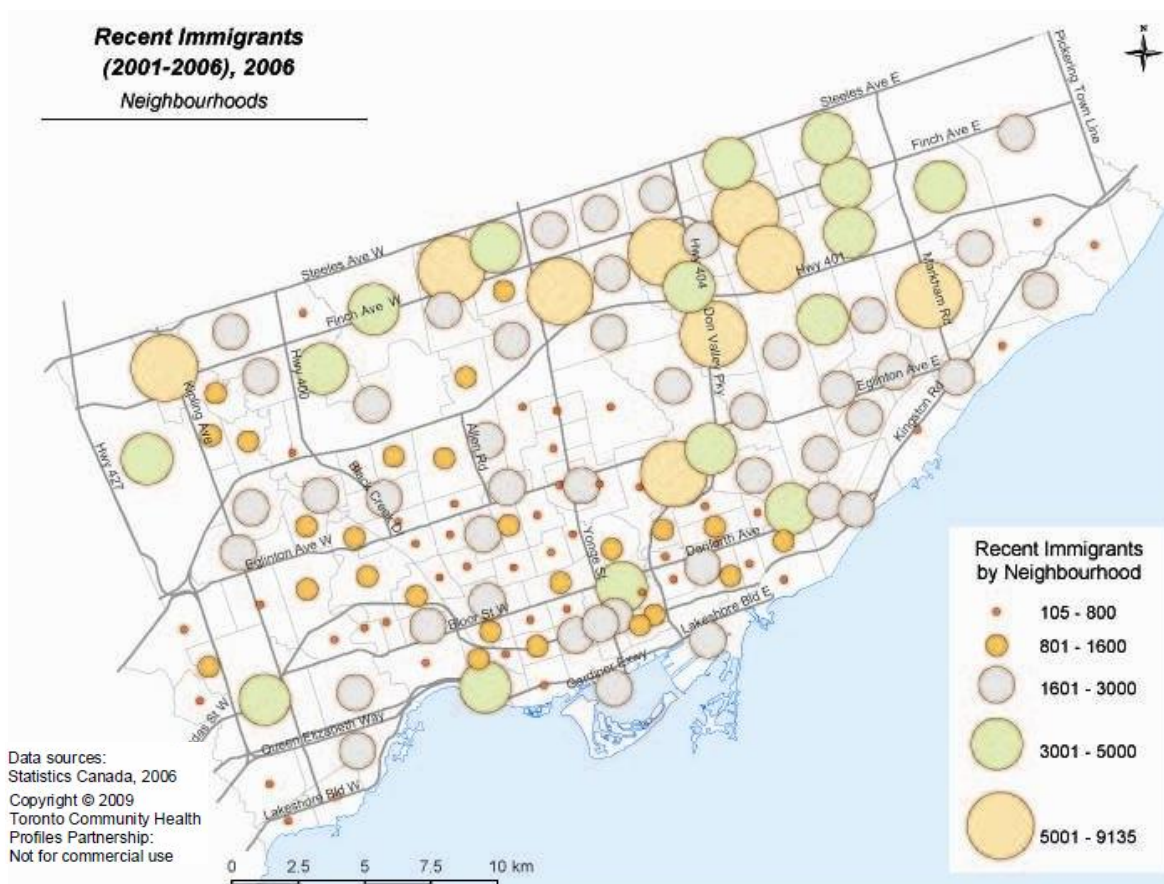
2.7 - SEXUAL ORIENTATION AND GENDER IDENTITY

No statistics are available on the sexual orientation of newcomers to Toronto, nor are there statistics on the number/proportion of transgendered newcomers. In spite of this data gap, many Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) newcomers in Toronto have important health needs, some of which are discussed in sections 3.5, 3.10 and 3.11, and in section 5.12 of this report.

2.8 - NEIGHBOURHOOD

The majority of newcomers settle in the northern and eastern parts of Toronto (formerly North York and Scarborough). Figure 2.9 shows the distribution of newcomers (arriving between 2001 and 2006) across Toronto neighbourhoods in 2006. The neighbourhoods^{xii} with the highest number of newcomers (2001 to 2006) were Woburn (9,135), L'Amoreaux (7,890) and Mt. Olive-Silverstone-Jamestown (7,125). Some statistics for Toronto neighbourhoods that have relatively high numbers of recent immigrants were also compiled for this report; these are listed in Appendix B.

Figure 2.9 Number of Newcomers (arrived between 2001 and 2006) in Toronto by Neighbourhood, 2006

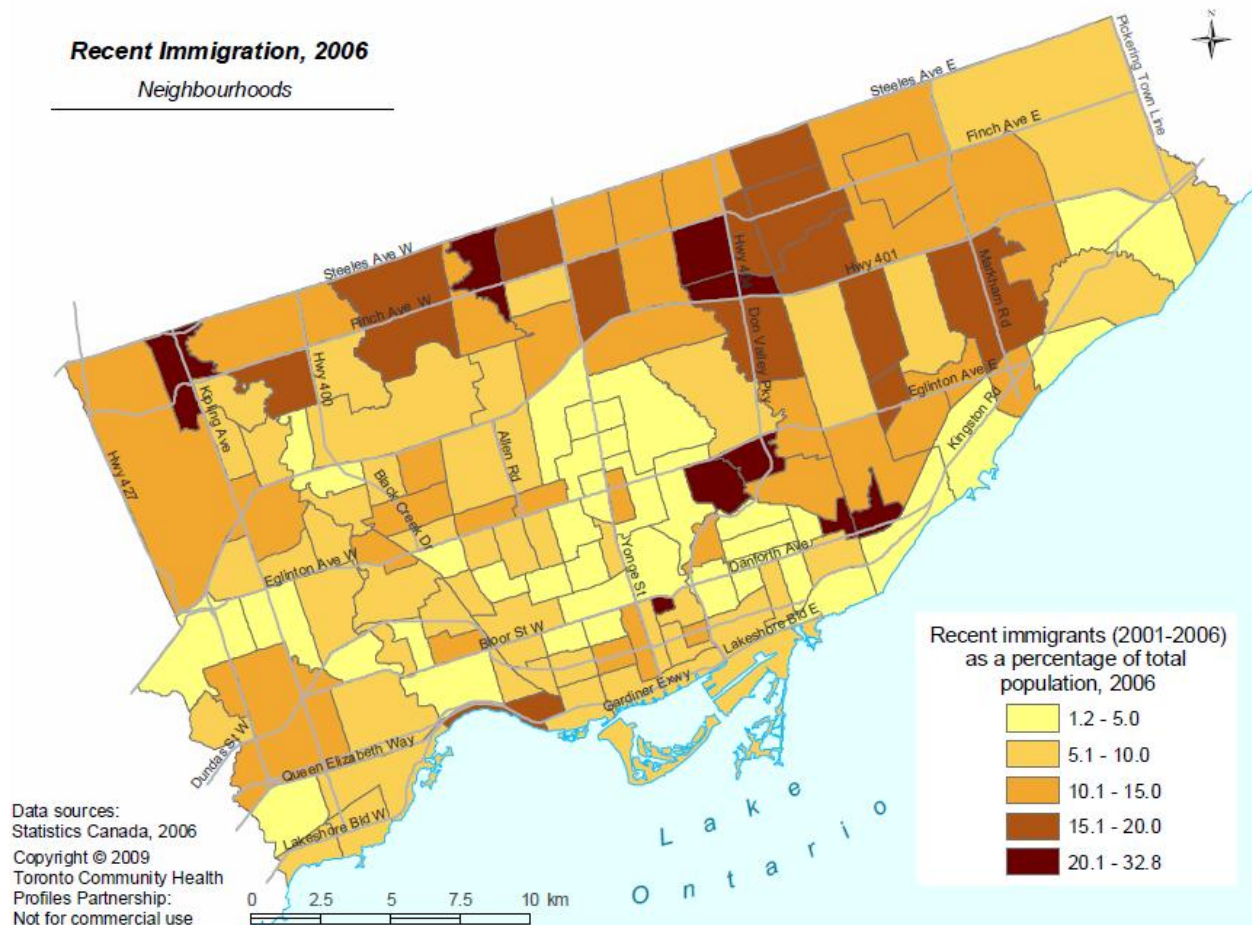


^{xii} For information for all Toronto neighbourhoods see http://www.toronto.ca/demographics/profiles_map_and_index.htm

While in 2006 10.8% of all Toronto residents were newcomers (arrived within five years), they made up a much higher proportion of residents in some neighbourhoods. Areas with the highest percentage of newcomers (2001–2006) were Henry Farm (32.8%), Thorncliffe Park (31.1%) and Don Valley Village (26.4%). Figure 2.10 is a map of Toronto neighbourhoods that shows newcomers as a percentage of the total population. Darker colours indicate a higher proportion of newcomers.

Neighbourhood factors that affect the health of newcomers to Toronto are discussed in section 5.6 of this report.

Figure 2.10, Newcomers (2001-2006) as a Percentage of Total Population by Neighbourhood, 2006





Research has shown that newcomers enjoy better health than Canadian-born residents overall. However, immigrants also experience a disproportionate burden of certain health problems, and some sub-populations of immigrants face substantially higher risks than others for particular health issues.

Above: A youngster participates in Access Alliance's Green Access project.

3. THE HEALTH STATUS OF IMMIGRANTS IN TORONTO

This section describes the health status of immigrants in Toronto and provides information on the health issues and risks faced by specific sub-populations where possible. Information is provided on general health, physical health conditions, risk factors for poor health, and mental health and well-being.

While much research has shown that newcomers enjoy better health than Canadian-born residents overall, immigrants also experience a disproportionate burden of some health problems. The newcomer population in Toronto is also highly diverse, and some sub-populations of immigrants face substantially higher risks than others for certain health issues.

3.1 - NEWCOMER HEALTH ADVANTAGE

The majority of newcomers come to Canada in good health. Research has shown that, on average, newcomers are in better health than Canadian-born residents. This health advantage, often referred to as “the healthy immigrant effect”, is believed to exist for two main reasons. First, there is a self-selection process by which people who are more healthy and motivated tend to be more likely to immigrate to Canada than those who are sick or disabled. Second, Canada’s immigration process screens out many immigrants with serious health issues and selects younger and more highly educated immigrants with better language abilities and job skills.³⁴

Despite the assets that newcomers arrive with, much research has also shown that after settling in Canada, some begin to lose their health advantage. Rates for several health problems among immigrants have been found to increase over time until they eventually reach those seen in the Canadian-born population. For other conditions, immigrants’ health status deteriorates to worse levels than those of Canadian-born residents.

However, when the Toronto evidence is examined, important exceptions to both the health advantage and the post-settlement health decline of newcomers are seen. These exceptions include

- mixed or unclear research findings on some health indicators;
- health conditions where the newcomer health advantage and subsequent health decline trends do not apply;
- sub-populations of newcomers who experience different health advantages or disadvantages; and
- areas of health where evidence about Toronto’s immigrants differs from national research findings.

Below are summaries of local, provincial, and national findings that **support** or **contradict** a) the health advantage and b) the subsequent decline in health status among newcomers. Sections 3.2 to 3.16 present more detailed information on specific newcomer health issues.

The health advantage among newcomers

Self-reported health:

- Survey-based data analyzed for this report show that the percent who report 'fair' or 'poor' health is similar among newcomers and Canadian-born residents in Toronto. Some provincial and national research also shows no advantage among newcomers.^{35,4,9}
- However, other Canadian and Ontario research shows better self-reported health among newcomers.^{3,5}

Risk Factors for Chronic Disease:

- Analysis conducted for this report shows that newcomers are much less likely to be overweight or obese, to drink heavily, or to smoke.
- The same analysis, however, showed that newcomers are equally as likely as Canadian-born residents to eat sufficient amounts of vegetables and fruit, and that they are less likely to be physically active in leisure time.

Chronic Disease:

- Research on chronic disease in Toronto conducted for this report shows that newcomers and Canadian-born residents have a similar likelihood of reporting that they have one or more chronic disease.
- However, research across Canada has shown that newcomers have lower rates of chronic disease overall.^{7,6,12} and have lower overall mortality rates.^{36,37}
- Provincial and national prevalence and mortality rates for type 2 diabetes and some cancers, including liver, nasopharynx and cervical cancer, have been found to be higher among immigrants and specific immigrant sub-populations than among Canadian-born residents.^{37,13}
- Toronto findings for diabetes based on analysis conducted for this report are consistent with national research showing that immigrants are more likely to have diabetes, and that immigrants from South Asia, the Caribbean, Latin America and Sub-Saharan Africa are at particularly high risk.

Communicable Disease:

- Generally, the newcomer health advantage does not apply to communicable disease. Newcomers to Canada tend to have higher prevalence and mortality rates for several communicable diseases, including tuberculosis (TB) and hepatitis B.^{37,12} The vast majority of TB cases in Toronto (92%) are among immigrants, many of whom are newcomers.^{14,38}
- In Toronto and across Canada, HIV and AIDS disproportionately affect immigrants compared to non-immigrants. An increasing proportion of HIV cases have been identified among immigrants from regions with high rates of HIV.^{15,16}

Mental Health:

- Recent Canadian research has shown that immigrants, particularly newcomers, have better self-reported mental health status and experience lower rates of some self-reported mental health problems, including depression and its symptoms, mood disorders, anxiety disorders, suicidal feelings and alcohol dependence, compared to the rest of the population.^{18,7,19,39,40}
- International and national research has shown that immigrants are at higher risk of experiencing some mental health conditions, including psychosis, schizophrenia and post-traumatic stress disorder (PTSD).
- Canadian and local mental health research has identified many newcomer sub-populations who are at higher risk for poorer or deteriorating mental health status, including women, low-income immigrants, immigrants from some racialized groups and refugees.

Decline in health status among newcomers

Self-Reported Health:

- Analysis of changes in self-reported health status over time in Toronto conducted for this report shows that newcomers' health deteriorates in the first few years after arrival in Canada, particularly for some sub-populations, including women, older immigrants, low-income immigrants and refugees.

- Additional research looking at changes in self-reported health status over time has found declines in self-rated health for all immigrants, with dramatic and rapid declines among newcomers and some sub-populations.^{42,41,43}
- In another analysis conducted for this report, longer-term immigrants rated their health more poorly than those born in Canada, whereas newcomers were no different from Canadian-born residents.
- Some national and provincial research has also reported that longer-term immigrants rate their health as worse than Canadian-born residents.^{34,4,9}

Risk Factors for Chronic Disease:

- Analysis conducted for this report shows that longer-term immigrants are more likely than newcomers to be overweight or obese and to drink heavily.
- Longer-term immigrant women are also more likely to smoke than newcomer women.
- However, longer-term immigrants are more likely than newcomers to be physically active in leisure time.

Chronic Disease:

- Analysis conducted for this report shows that longer-term immigrants in Toronto are more likely to have a chronic disease than their Canadian-born counterparts, whereas newcomers are not more likely.
- Several research studies have shown that rates of chronic disease and mortality are higher among immigrants who have lived in Canada for a longer period of time compared to newcomers.^{7,37,6,12}

Mental Health:

- Several studies have shown that self-reported mental health is worse among immigrants who have lived in Canada for longer periods of time compared to newcomers,^{18,7,19,39,40} and that newcomers experience a deterioration of their self-reported mental health within their first few years in Canada.^{41 42}

The newcomer health advantage differs for sub-populations of immigrants

- Immigration category and status are important factors that can shape health. Refugees make up a small proportion (approximately 12%) of new Permanent Residents arriving in Toronto each year, but they are a unique sub-population who differ from other newcomers in important ways. Many refugees have experienced significant stresses and traumas that may have an impact on their health. Although refugees enjoy some of the same health advantages as other newcomers, such as lower overall mortality rates, they also have some health disadvantages, such as higher rates of infectious disease.⁴⁴
- Socio-demographic factors and social determinants of health overlap and intersect to shape health advantage and disadvantage, as outlined in section 5. For example, research has shown that low-income newcomer women are four times as likely to experience depression compared with low-income newcomer men.⁴⁵

Important considerations when examining the newcomer health advantage and decline

- *Study design may impact findings:* There are two general approaches to studying the newcomer health advantage: (i) analysis of longitudinal data that follows the same group of immigrants over time, and (ii) analysis of cross-sectional data that compares newcomers with longer-term immigrants at one point in time.^{41,42,44} Among studies using data from one group of immigrants over time, some have found declines in immigrants' self-reported health.^{41,42,46} However, much of the evidence used to consider the newcomer health advantage and post-settlement health decline is cross-sectional; it compares groups of people that may be quite different from each other at that point in time.^{41,44} Therefore, findings that use cross-sectional data to demonstrate the newcomer health advantage should be interpreted with some caution.
- *As migration patterns shift, so does health status:* Immigration patterns in Toronto and across Canada have changed substantially over the past 40 years. Longer-term immigrants who arrived 20 or more years ago are

more likely to be White and from Europe or North America, while more recent newcomers are more likely to be from a racialized group and from Asia or Africa. Recent newcomers are also more likely to be highly educated and from a higher socio-economic background. These factors suggest that today's newcomers are more likely to be healthy than previous generations of immigrants—not due to length of stay in Canada, but because of differences in the socio-demographic characteristics and social determinants that influence their health.

In sum, there is much evidence that when newcomers arrive in Canada they have better health than longer-term immigrants and Canadian-born residents, but that this health advantage tends to decrease over time. Understanding who is healthier and who may be at risk for declining health status can lead to more targeted efforts to promote health and prevent health declines. However, a closer look at the evidence reveals a complex picture. There are many exceptions to this pattern, including for specific health conditions and among newcomer sub-populations. The evidence on immigrant health and changes in health over time is complex and evolving, and the factors influencing immigrant health are multi-faceted and include socio-demographic factors, social and economic determinants of health, genetic predisposition, experiences before migration, and stressors from the settlement process. Given the diversity of the newcomer population and the complexities of newcomer health status, it appears that focusing on the promotion, maintenance and improvement of the health of all newcomers can lead to better health outcomes.

3.2 - SELF-REPORTED HEALTH STATUS

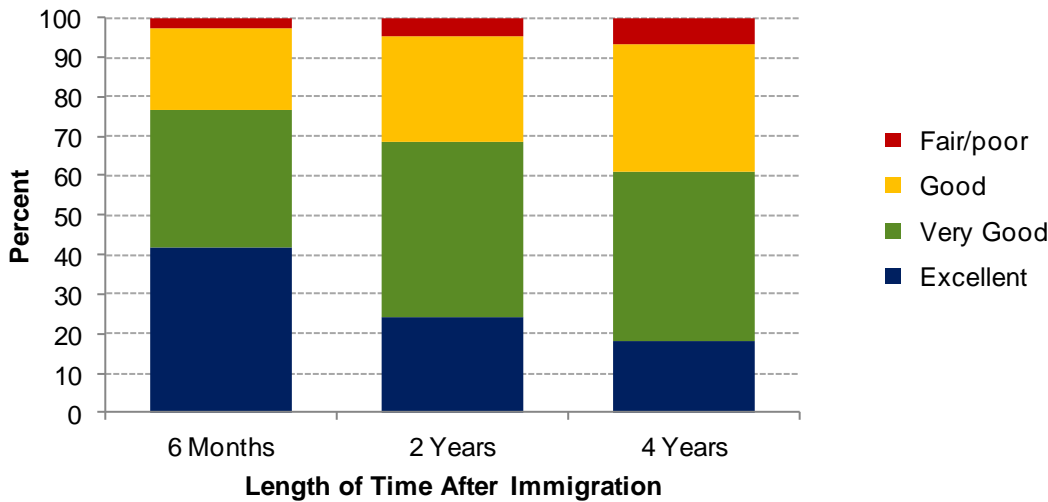
Many health surveys ask respondents to rate their general health as either “excellent”, “very good”, “good”, “fair” or “poor”. Self-reported health status is considered to be an important indicator of overall health and well-being. Studies have shown that self-reported health status is a good predictor of actual health status, including for mortality, morbidity and health care utilization.^{47,48}

➤ *Self-reported health status among immigrants in Toronto*

Analysis of data from the Longitudinal Survey of Immigrants in Canada (LSIC) conducted for this report provides a window into changes in newcomer health over time. The LSIC looked at self-reported health among newcomers aged 15–64 who had immigrated to Canada in 2000 and 2001, at 6 months, 2 years and 4 years after arrival in Canada. The LSIC analysis shows that among all Toronto immigrants in the study, the likelihood of reporting “excellent” health decreased with time after immigration, while the likelihood of reporting “good”, “fair” or “poor” health increased. Newcomers were less likely to rate their health as “excellent” at 2 years (compared with 6 months) after immigration, and again at 4 years (compared with 2 years) after immigration (see Figure 3.1).

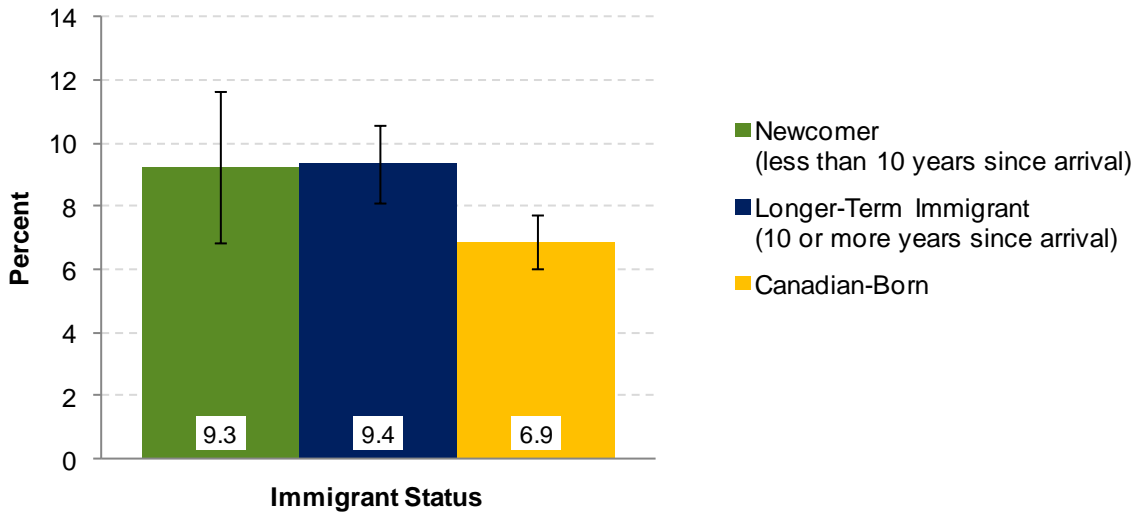
An analysis of the cross-sectional Canadian Community Health Survey (CCHS) data from Toronto conducted for this report shows that, overall, there was no significant difference in self-reported health between newcomers (at the time they were surveyed) and longer-term immigrants or Canadian-born residents. Longer-term immigrants, however, are more likely than Canadian-born residents to rate their health as fair or poor (see Figure 3.2).

Figure 3.1 Self-Reported Health Status among Newcomers Arriving in 2000 and 2001 at Six Months, Two Years, and Four Years after Immigration, Toronto



Data: Newbold, K.B. (2011). Unpublished data and analysis. Data source: Longitudinal Survey of Immigrants in Canada (Statistics Canada, 2001-2005)

Figure 3.2 “Fair” or “Poor” Self-Reported Health Status among Newcomers, Longer-Term Immigrants, and Canadian-born residents, Toronto, 2001 to 2008 Combined[†]



Error bars denote 95% confidence intervals

[†] - Data age standardized to the 1991 Canadian Population

Data Source: Canadian Community Health Survey, 2001, 2003, 2005, 2007 and 2008. Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario Ministry of Health and Long-Term Care

These findings do not support a newcomer health advantage, and they differ from some other analyses that have looked at self-reported health among newcomers and longer-term immigrants in Ontario, which have found that newcomers have better self-reported health outcomes than Canadian-born residents and longer-term immigrants (see 'The provincial and national context' on page 34 for more details).

As can be seen in Figure 3.1, there can be a quick decline in self-reported health status, with substantial declines evident as early as four years after immigration. It is possible that the definition of newcomer used here (less than ten years since arrival) includes too long a period of time after immigration, and thus fails to capture the initial health advantage that newcomers may have in their first few years. When this analysis, using the same definition, was conducted on Ontario-wide data, there were also no significant differences between newcomers and Canadian-born residents in the proportion that reported fair or poor health.

The analysis of CCHS data provides insights into how health status and needs may have varied between different immigrant groups and Canadian-born residents at the time the survey was conducted. However, there are some limitations of the survey, including under-representativeness of newcomers. It is possible that the newcomers reached by this survey do not represent the diverse profile that can be seen in Toronto's newcomers (see Appendix A for more information).

➤ *Self-reported health status among newcomer sub-populations in Toronto*

Analyses of LSIC data on sub-populations of newcomers aged 15–64 in Toronto have been conducted for this report, including:

- a logistic regression analysis to identify factors associated with “fair” or “poor” self-reported health status at 6 months after immigration; and
- a survival analysis to identify factors associated with transitioning from “excellent”, “very good” or “good” to “fair” or “poor” health between 6 months and 4 years after immigration.

The analysis of Toronto CCHS data includes an examination of differences among certain sub-populations, as determined by factors such as gender, age, and region of origin.

Gender

The analysis of newcomers (four years since arrival) using LSIC data shows that **women** are more likely than men to experience declines in self-reported health over time. CCHS data show that longer-term immigrant women that have been in Canada ten or more years are significantly more likely than Canadian-born women to report “fair” or “poor” health.

Age

As might be expected, the analysis on newcomers using LSIC data shows that **older adults** (aged 40–64) are more likely to report worse health and to experience declines in self-reported health over time than their younger counterparts (aged 15–39). Similarly, the CCHS analysis shows that among newcomers and longer-term immigrants, older adults are significantly more likely than younger adults to report “fair” or “poor” health.

In addition, the CCHS analysis finds that among older adults (40–64), both newcomers and longer-term immigrants, are more likely to report “fair” or “poor” health than Canadian-born adults of the same age.

Income and housing status

The analysis using LSIC data shows that, consistent with other research linking income and health, newcomers with **lower income** (in the case of this analysis, \$20,000 per year or less) are more likely to report “fair” or “poor” health than those with income over \$20,000. In addition, **newcomer homeowners** are less likely to report “fair” or “poor” health and less likely to experience declines in health than residents who do not own a home. The analysis of CCHS data shows that, longer-term immigrants living with low incomes^{xiii} are significantly more likely to report “fair” or “poor” health status than their counterparts with medium high or high incomes.

^{xiii} Based on Statistics Canada’s low-income cutoff; see Appendix A, Research Methods.

Education and language proficiency

CCHS data demonstrate that newcomers and longer-term immigrants with a post-secondary degree or diploma are significantly more likely than Canadian-born residents with this level of education to report “fair” or “poor” health status. In addition, longer-term immigrants without a post-secondary degree or diploma are significantly more likely to report “fair” or “poor” health than their counterparts with a degree or diploma, a finding that is consistent with other research linking education and health. In the analysis of newcomers using LSIC data, proficiency in the English language was associated with a lower likelihood of reporting “fair” or “poor” health.

Immigration category

The analysis of newcomers using LSIC data shows that **refugees** are more likely than economic and family class immigrants to experience declines to “fair” or “poor” self-reported health between 6 months to 4 years after arrival. A survey of adult clients of a Toronto community health centre serving immigrants and refugees found that **refugee claimants and refugees** are more likely to report poor health status than economic and family class immigrants.⁴⁹

Other sub-population categories

Newcomers who are **married**, have Ontario Health Insurance Plan (**OHIP**) **coverage**, and are **satisfied with the immigration experience** are less likely to report “fair” or “poor” health, according to the analysis of LSIC data. However, married residents are more likely than non-married residents to report health declines over time.

Key findings on newcomer sub-populations at risk

The current research has found that the following sub-populations of newcomers are at risk for either worse self-reported health, declining self-reported health over time, or both:

At risk of poorer self-reported health

- older adults (40–64 years)
- individuals with lower incomes
- those who don’t own a home
- those without English language proficiency
- those without OHIP coverage
- those unsatisfied with the immigration experience

At risk of declining self-reported health

- women
- older adults (40–64)
- those who don’t own a home
- refugees and refugee claimants

➤ ***The provincial and national context***

Findings on self-reported health among newcomers in Toronto emerging from analysis for this report differ from some provincial and national findings. Some analyses of Ontario^{3,4} and Canadian^{5,6} data on self-reported health from the CCHS and Primary Care Access Survey have shown that immigrants, particularly newcomers, have better self-reported health than Canadian-born residents. However, findings of a self-reported health advantage among newcomers have not been consistent and, in some cases, have been weak.⁶ An analysis of 2005–2008 CCHS data for Ontario found that immigrants are significantly less likely to report very good or excellent health than those born in Canada.⁹

The analysis of Toronto data conducted for this report shows that newcomers in Toronto have similar levels of self-reported health as longer-term immigrants or Canadian-born residents. However, the analysis conducted for this report showed that longer-term immigrants in Toronto have worse self-reported health than their Canadian-born counterparts. This finding is consistent with some provincial and national studies that have also found worse self-reported health among longer-term immigrants compared with those born in Canada.^{4,35}

The finding that self-reported health declines among Toronto newcomers over time is consistent with national research looking at the National Population Health Survey and the LSIC, which shows a deterioration in self-reported health for all immigrants with length of stay, and dramatic and rapid declines for newcomers.^{41,42,43}

Newcomer sub-populations identified as being at higher risk for worse and/or deteriorating self-reported health in national research include women, seniors, low-income immigrants, members of some racialized groups, those with poor language proficiency in English or French (particularly women), those with low education, and refugees.^{41,50,51,42,46,11,52} For the most part, the findings on immigrant sub-populations emerging from the present analyses are thus consistent with this Canadian research.

➤ *Notes about the data*

There are some limitations related to how people rate their own health. Some researchers assert that self-reported chronic disease is a more reliable measure of health status than self-reported overall health. In addition, diverse cultural interpretations and varying levels of language proficiency may complicate reporting of one's health status. Meanwhile, some research has found that self-reported health status is not comparable among different ethno-racial groups, though other studies have validated the measure across groups.

An important consideration for the analysis of self-reported health based on Toronto LSIC data is that reported declines in self-reported health may reflect increased comfort with the health care system. With increased time in Canada, newcomers may be more likely to interact with health care practitioners and to vocalize their concerns and problems, which might lead to worse self-assessed health that reflects perceived, rather than actual, changes in health.^{6,43} In addition, there is no comparable data looking at the health declines of Canadian-born residents. Some part of these declines can likely be explained by aging and the passage of time, but without a non-immigrant group for comparison purposes it is difficult to know how much.

3.3 - RISK FACTORS FOR CHRONIC DISEASE AND POOR HEALTH

Health researchers have identified several factors that can put people at higher risk for developing chronic diseases. These include health conditions such as high blood pressure and obesity, as well as behaviours and practices such as physical activity, healthy eating and substance use. In addition to affecting a person's risk of chronic disease, some of these factors may also affect other areas of health and well-being, including risk of communicable disease, risk to mental and emotional health and to general health and well-being.

Some studies have explored whether declining health among immigrants who have lived in Canada for a longer time can be explained by the adoption of risky health behaviours after arriving in Canada, like smoking, heavy drinking and eating high-fat foods. However, research shows that immigrants do not consistently adopt these unhealthy behaviours, and that a decline in health may occur despite avoidance of these risk factors. For example, one study found that after adjusting for socio-demographic factors, differences in health behaviour did not explain differences in health status between groups of immigrants and Canadian-born residents.¹² This evidence underscores that behaviours and practices are only one set of factors that influence people's health status. Social

and demographic factors such as income, education, race and gender also play an important role in shaping health. These factors are discussed in section 5 (Social Determinants of Health for Immigrants in Toronto).

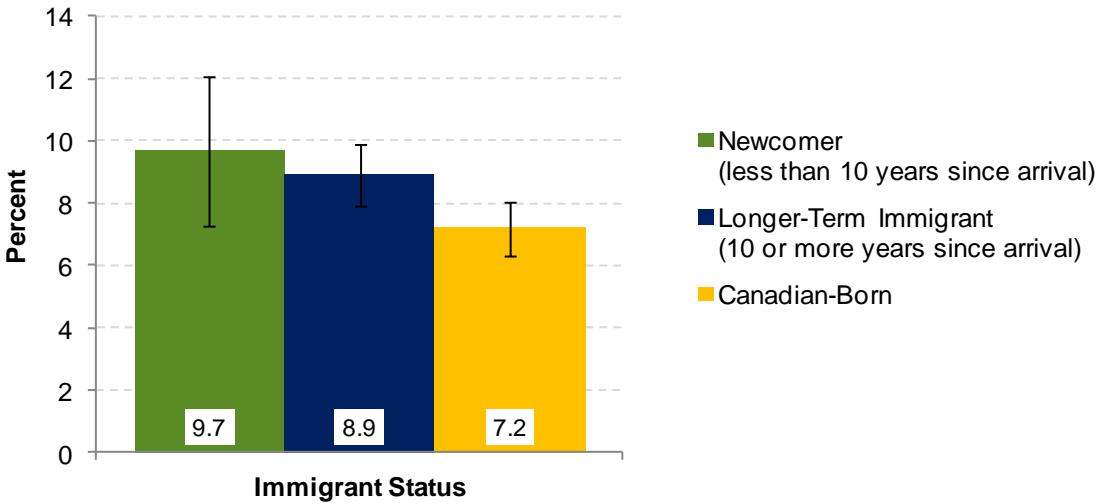
High Blood Pressure

High blood pressure (or hypertension) is an important cardiovascular health issue and is a risk factor for developing heart disease and stroke.

➤ **High blood pressure among Newcomers in Toronto**

The analysis of Toronto Canadian Community Health Survey (CCHS) data conducted for this report shows that, overall, there are no significant differences in self-reported rates of high blood pressure among newcomers, longer-term immigrants and Canadian-born residents (see Figure 3.3).

Figure 3.3 High Blood Pressure among Newcomers, Longer-Term Immigrants, and Canadian-born residents, Toronto, 2001 to 2008 Combined†



Error bars denote 95% confidence intervals

† - Data age standardized to the 1991 Canadian Population

Data Source: Canadian Community Health Survey, 2001, 2003, 2005, 2007 and 2008. Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario Ministry of Health and Long-Term Care

➤ **Newcomer sub-populations in Toronto at greater risk of having high blood pressure**

The analysis of CCHS data as well as the literature review conducted for this report have identified some differences in high blood pressure prevalence among sub-populations of newcomers based on the following factors:

Gender

Although the CCHS data show no differences between newcomers and Canadian-born residents, longer-term immigrant women are significantly more likely to have high blood pressure than Canadian-born women, pointing to possible future health risks for newcomer women.

Age

Among younger residents (aged 15–39), newcomers are significantly more likely than longer-term immigrants and Canadian-born residents to have high blood pressure, according to the analysis of CCHS data, indicating that

newcomers may face higher risk of high blood pressure at a younger age. The analysis also finds that among older residents (aged 40–64), longer-term immigrants are significantly more likely to have high blood pressure than their Canadian-born counterparts.

Ethno-racial identity

Ethno-racial background and gender are important factors in risk for high blood pressure among immigrants and Canadian-born residents. Provincial and national research has shown that high blood pressure varies substantially by ethno-racial background. For example:

- Research conducted on specific ethno-racial groups in Canada has found that **South Asians**, particularly women, experience higher rates of high blood pressure with increased length of time in Canada.⁵³
- Research examining high blood pressure among ethno-racial groups in Ontario has found that residents from **Black** and **South Asian ethno-racial backgrounds** are significantly more likely to have high blood pressure.^{54,55}

➤ *The national and provincial Context*

Analyses of CCHS data at the national and provincial levels have produced mixed findings and have found differences between immigrant groups and Canadian-born residents that are not seen in the Toronto data produced by the current analysis. One analysis of CCHS data at the national level shows that newcomers (5 years or less since arrival) are significantly less likely than longer-term immigrants (more than 5 years since arrival) and Canadian-born residents to report having high blood pressure; however no significant differences in high blood pressure rates have been found between longer-term immigrants and Canadian-born residents.⁷ In contrast, an analysis of 2005–2008 CCHS data for Ontario finds that immigrants are significantly more likely to report having high blood pressure than Canadian-born residents.⁹

➤ *About the data*

A limitation of the analysis of CCHS data for high blood pressure is that self-reports may lead to an underestimate of its true prevalence. However, self-reported high blood pressure data is useful for comparing rates among groups and sub-populations.

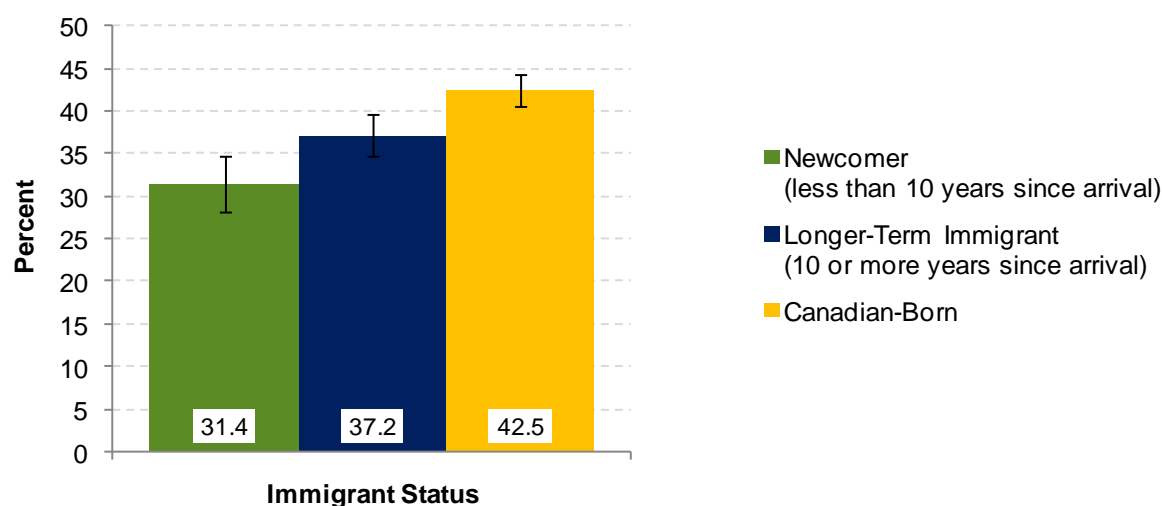
Overweight and Obesity

Being overweight or obese increases a person's risk for diabetes, cardiovascular disease, high blood pressure, osteoarthritis, some cancers and gall bladder disease. Mental and emotional health issues, functional limitations and disabilities are also associated with being overweight or obese. Being overweight puts people at increased risk for these health issues, and being obese puts people at a high to extremely high risk.

➤ *Overweight and obesity among immigrants in Toronto*

The analysis of Toronto data from the CCHS finds that, overall, newcomers are significantly less likely than longer-term immigrants and Canadian-born residents to be overweight or obese. This newcomer health advantage appears to decline with time; however, longer-term immigrants are also less likely than Canadian-born residents to be overweight or obese (see Figure 3.4).

Figure 3.4 Overweight and Obesity among Newcomers, Longer-Term Immigrants, and Canadian-born residents, Toronto, 2001-2008 Combined[†]



Error bars denote 95% confidence intervals

[†] - Data age standardized to the 1991 Canadian Population

Data Source: Canadian Community Health Survey, 2001, 2003, 2005, 2007 and 2008. Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario Ministry of Health and Long-Term Care.

➤ *Newcomer sub-populations in Toronto at greater risk of being overweight or obese*

The analysis of CCHS data as well as the literature review conducted for this report have identified some differences in chronic disease overall among newcomers. These differences point to sub-populations of newcomers, as determined by the following factors, who may be at higher risk for chronic disease now or in the future:

Gender

Among newcomers and longer-term immigrants, **men** are significantly more likely to be overweight or obese than women.

Age

Older newcomers (aged 40–64) and longer-term immigrants are more likely than their younger (aged 15–39) counterparts to be overweight or obese, according to the analysis.

Education

Although there are no significant differences by education level among newcomers, longer-term immigrants with no post-secondary degree or diploma are more likely than their counterparts with a post-secondary degree or diploma to be overweight or obese, which suggests that newcomers with low education may face future risks.

Ethno-racial identity

In the Greater Toronto Area (GTA),^{xiv} Immigrants of **East and Southeast Asian ethno-racial background** are less likely to be overweight or obese than immigrants of other ethno-racial backgrounds. The analysis also shows that for residents of Black ethno-racial background, longer-term immigrants are significantly more likely to be

^{xiv} Data from the GTA were used in this case because the sample size for the City of Toronto was too small to allow for an analysis of differences among different ethno-racial groups.

overweight or obese than their Canadian-born counterparts, indicating a future risk for newcomers in this ethno-racial group.

➤ *The national and provincial context*

The findings emerging from the present analysis are consistent with Canadian and Ontario research, which has also shown that immigrants, specifically newcomers, are less likely to be obese than their Canadian-born counterparts. Some of this research has also shown that immigrants tend to lose this health advantage and experience weight gain with increased length of time in Canada.^{7,8,9,56} National and provincial research on ethno-racial differences has found that South Asian immigrants and Black women are more likely to be obese,^{53,54} and that obesity may increase among non-European immigrants after a longer time in Canada.

One Canadian study found that ethnic social networks are associated with likelihood of overweight or obesity. For example, immigrants from ethno-racial backgrounds with low rates of overweight and obesity who also live in neighbourhoods with large populations from the same ethnic background are less likely to become overweight or obese.⁵⁶

➤ *Notes about the data*

Overweight and obesity are based on Body Mass Index (BMI), a measure that is calculated using a person's self-reported height and weight. For the present analysis, overweight and obesity were defined as having a BMI of 25 or higher. Limitations of CCHS data for overweight and obesity reported here are:

- Some evidence has shown that the health risks associated with overweight and obesity correspond to different BMI levels for different ethno-racial groups, particularly Asian residents, who may be at higher risk at a lower BMI. However, the BMI levels used for the present analysis are the levels currently recommended by the World Health Organization.
- Some research has shown that self-reported height and weight underestimate people's true BMI. This underestimation could differ for different groups in the analysis.

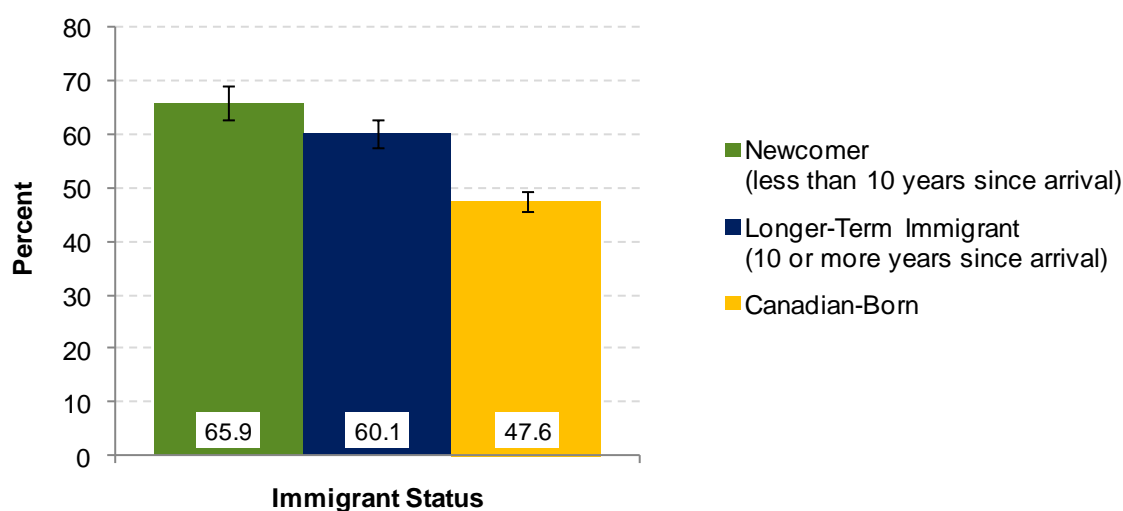
Physical Activity

Being physically active can lower a person's risk for cardiovascular disease, diabetes, colon cancer, osteoporosis, and overweight and obesity.

➤ *Physical activity among immigrants in Toronto*

An analysis of CCHS data from Toronto on "leisure time physical activity" was conducted. This measure looks at the amount of time a person spends doing physical activity for leisure and not for work, housework or transportation. As people's lifestyles become less active due to desk jobs, to transportation by car, and to recreational television and computer use, it becomes more important to participate in physical activity during leisure time. The analysis showed that, overall, both newcomers and longer-term immigrants are significantly less likely to be physically active during leisure time (see Figure 3.5). Although newcomers do not appear to have a health advantage in terms of leisure-time physical activity, evidence to examine exercise that is done as a part of active jobs, commuting, or domestic work is currently unavailable.

Figure 3.5 Leisure Time Physical Inactivity among Newcomers, Longer-Term Immigrants, and Canadian-born residents, Toronto, 2001 to 2008 Combined[†]



Error bars denote 95% confidence intervals

[†] - Data age standardized to the 1991 Canadian Population

Data Source: Canadian Community Health Survey, 2001, 2003, 2005, 2007 and 2008. Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario Ministry of Health and Long-Term Care.

➤ ***Newcomer sub-populations in Toronto at greater risk for physical inactivity***

The analysis of CCHS data as well as the literature review and focus groups conducted for this report have identified some differences in leisure-time physical activity among different newcomers. These differences point to sub-populations of newcomers, as determined by the following factors, that may be at higher risk for the adverse health effects of physical inactivity:

Gender

Although there are no differences between males and females among newcomers, the analysis of CCHS data finds that longer-term immigrant women are significantly less likely to be physically active in leisure time than their male counterparts. These findings suggest that newcomer women are at high risk for physical inactivity, an issue that was also raised in the focus groups.

Age

Although there are no differences between older and younger residents among newcomers, older longer-term immigrants (aged 40–64) are significantly less likely to be physically active in leisure time than their younger counterparts (aged 15–39), according to the analysis, pointing to possible risks for inactivity faced by newcomers as they get older.

As well, physical inactivity among **newcomer children and youth** in school and at home was cited as an important issue by service providers and newcomer participants in the focus groups.

“Back home, everybody is your parent. So, the kids come back from school and go out playing for 4-5 hours. Here everybody sits in a tall building. Parents are afraid for their children’s safety. They sit in front of the TV.” (participant, service provider focus group)

Education

The analysis finds that **newcomers with no post-secondary degree or diploma** are less likely to be physically active in leisure time than their counterparts with a post-secondary degree or diploma. This was also true for longer-term immigrants.

Income

The analysis also shows that **low-income newcomers** are significantly less likely to be physically active in leisure time than newcomers with high incomes.

Ethno-racial identity and region of origin

- In the analysis by ethno-racial identity, newcomers in Toronto of **South Asian, West Asian and Arab**, as well as **East and Southeast Asian ethno-racial backgrounds** are significantly less likely to be physically active than White newcomers.
- **South Asian, West Asian, and Arab** as well as **Black immigrants** are less likely to be physically active in leisure time compared to their Canadian-born counterparts.
- In the analysis by region of origin, **newcomers and longer-term immigrants from Asia** and longer-term immigrants from the Americas (excluding the U.S. and Canada) have lower rates of physical activity than those from Europe (excluding the U.K.) and Africa.
- In the East African Health Study in Toronto (EAST), which surveyed 456 residents from five **East African communities**, 98% of whom were immigrants who had been in Canada an average of 10 years, “lack of exercise” was cited by 51% of respondents as a major problem in the East African community in Toronto.⁵⁷
- A study of **Colombian newcomers** in London, Ontario found that 73% of study participants reported being less active than they were before immigrating to Canada, and that rates of physical inactivity were higher for women than for men.⁵⁸

➤ *The national and provincial context*

The findings emerging from the present analysis are consistent with national and provincial research, which has also found that immigrants, and specifically newcomers, are less likely to be physically active than the Canadian-born population.^{9,56,11,59} National and provincial research on ethno-racial differences has found that women from Black, South Asian and Chinese ethno-racial backgrounds are less likely to be physically active⁵⁴ and that physical activity may decrease among non-European immigrants after a longer time in Canada.¹¹

➤ *About the data*

A limitation of the analysis of CCHS data for physical activity is that it only measures the amount of time a person spends doing physical activity for leisure and does not capture physical activity done for work, as housework or for transportation. All physical activity reduces the risk of health problems, so it may not be necessary for people to engage in leisure time physical activity if they do enough physical activity elsewhere.

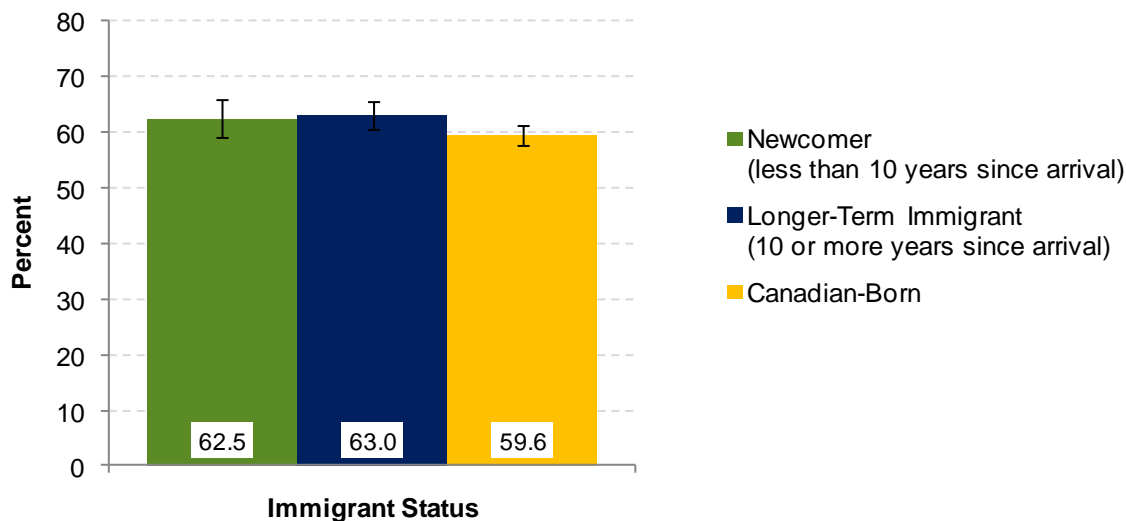
Nutrition and Healthy Eating

Healthy eating includes eating enough servings of vegetables and fruit every day. Vegetables and fruit have important nutrients, including vitamins, minerals and fibre, and are usually low in fat and calories. A healthy diet that is rich in vegetables and fruit can help reduce the risk of cardiovascular disease and some types of cancer. Low vegetable and fruit consumption may increase the risk of health issues, including overweight, obesity and diabetes.

➤ Nutrition and healthy eating among newcomers in Toronto

An analysis of CCHS data from Toronto on eating vegetables and fruit less than 5 times a day was conducted for this report. Eating vegetables and fruit 5 or more times a day is used as a proxy for the amount of vegetable and fruit recommended for a person's diet. Consuming vegetables and fruit less than 5 times a day is considered to be a risk factor for poor health. The analysis showed that, overall, there are no differences between newcomers, longer-term immigrants and Canadian-born residents in the likelihood of eating vegetables and fruit less than 5 times a day (see Figure 3.6).

Figure 3.6 Eating Vegetables and Fruit Less than Five Times per Day among Newcomers, Longer-Term Immigrants, and Canadian-born residents, Toronto, 2001-2008 Combined[†]



Error bars denote 95% confidence intervals

[†] - Data age standardized to the 1991 Canadian Population

Data Source: Canadian Community Health Survey, 2001, 2003, 2005, 2007 and 2008. Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario Ministry of Health and Long-Term Care.

Although this analysis has not found that newcomers or longer-term immigrants are at greater risk than Canadian-born residents for low vegetable and fruit consumption, it is important to note that this analysis indicates that a large proportion (approximately 63%) of Toronto immigrants are not eating adequate amounts of vegetables and fruit. Nutrition and healthy eating were also identified frequently as important health issues affecting newcomer men and women of all ages in focus groups conducted for this report and in local research reports reviewed. Service providers and newcomers in the focus groups suggested that many newcomers are not familiar with Canadian nutrition guidelines and may prefer to eat traditional foods, some of which may be unhealthy.

“Some of my clients, back home [they] have pasta, rice, something green and beans. Coming here it’s not easy for them to follow health Canada’s guidelines because they cannot afford to buy for the family, three times a day. So they still feed [their families] the same thing. So there’s a lot [of nutrients] missing.” (participant – outreach worker focus group)

As discussed in section 5.8, food security is an important issue related to nutrition and healthy eating, as people experiencing food insecurity are not able to get enough nutritious food to address their hunger and nutrition needs on a regular basis. A study of Toronto food bank users found that 47% of users were immigrants. Of all immigrant food bank users, 37% had been in Canada less than 5 years and 14% had been in Canada 5–9 years, indicating a

high level of food insecurity among newcomers in Toronto.⁶⁰ Other local research has found that newcomer families may have difficulty making healthy eating a priority because they have limited financial resources and time.^{61,62} Focus group participants identified changing eating habits and lack of ability to maintain a diet similar to diets back home (including eating enough fruits and vegetables) as important issues for newcomers, that are related to poor access and lack of affordability. In some cases, neighbourhoods where immigrants settle (in Toronto's inner suburbs) may have relatively poor access to healthy and affordable food.

“According to some of my clients, junk is cheaper than buying healthy food but sometimes I doubt that statement. I think there is just so much of it. At school there are pizza parlours and fried chicken places so that is what they have access to at lunch...The accessibility to healthy food isn't there in neighbourhoods where a lot of immigrants live...they want to eat Doritos, chips, candy bars and pop or juice drinks that are not actual juice.” (participant – outreach worker focus group)

Vitamin D deficiency is a health issue that is related to nutrition and that can lead to rickets, a serious health issue. International research has identified being a newcomer as an important risk factor for rickets due to vitamin D deficiency, along with having darker skin and breastfeeding. Breastfeeding is a risk factor because breast milk contains low levels of vitamin D. It is therefore recommended to give vitamin D supplements to breastfed infants. A national study of Canadian cases of rickets due to vitamin D deficiency from 2002–2004 among children under 18 years showed that, of the 104 cases in this time period, approximately 55% were in Ontario, 24% of those had immigrant parents, 89% had “intermediate” or “darker” skin, and 94% had been breastfed (none of the breastfed infants had received vitamin D supplements). The study identified infants with darker skin who are breastfed without appropriate vitamin D supplementation as being at higher risk for vitamin D deficiency rickets.⁶³

➤ ***Newcomer sub-populations in Toronto at greater risk of having poor nutrition***

The analysis of CCHS data as well as the literature review and focus groups conducted for this report identified some differences in healthy eating among different newcomers. These differences point to sub-populations of newcomers, as defined by the following factors, who may be at higher risk for poor nutrition now or in the future:

Gender

Service providers and newcomers in the focus groups identified nutrition as an important health concern for **women**, particularly pregnant women. As one service provider stated, “80% of at-risk pregnant women in [our] prenatal nutrition program are new immigrants.”

Age

Children were identified by focus group participants as being at particularly high risk for poor nutrition. Newcomers and service providers said that many newcomer children and youth in Toronto do not get proper nutrition, and that their newcomer mothers are often unaware of what they should pack in their children's lunch boxes because traditional foods are often ridiculed in schools. The adoption of unhealthy eating habits after arriving in Canada was also raised as a health issue of importance for newcomer children in local reports reviewed for this report.⁶⁴

As well, the analysis of CCHS data found that **older newcomers** (aged 40–64) are significantly less likely than their Canadian-born counterparts to eat vegetables and fruit five or more times a day, suggesting that older newcomers may be at higher risk for poor nutrition.

Education

Although there are no significant differences by education level among newcomers, longer-term immigrants with no post-secondary degree or diploma are significantly less likely to eat the recommended amount of vegetables and fruit than longer-term immigrants with higher education levels, according to the present analysis, which suggests that newcomers with low education may be at future risk.

Ethno-racial identity

The analysis by ethno-racial identity found that **East and Southeast Asian newcomers** and longer-term immigrants are at higher risk for low vegetable and fruit consumption than their White counterparts.

Immigration category

Service providers in the focus groups identified nutritional deficiencies as a significant health issue among **refugee** clients.

➤ *The national and provincial context*

Some national research has found that immigrants are less likely to eat recommended amounts of vegetables and fruits than Canadian-born residents.¹⁰ An analysis of 2005–2008 CCHS data for Ontario, however, is consistent with the present findings and shows that immigrants are as likely as Canadian-born residents to eat recommended amounts of vegetables and fruits.⁹ Canadian research on dietary changes after immigration has yielded mixed findings, with some research reporting that immigrants' diets change significantly after migration, and other studies finding no significant dietary changes.

Meanwhile, analysis of CCHS data at the national level has also found high levels of food insecurity among newcomer households.⁶⁵

➤ *About the data*

A limitation of the analysis of CCHS data for vegetable and fruit consumption is that there may be cultural variations in terms of how people estimate how often they eat vegetables and fruits. The measure used here captures the number of times vegetables and fruit are eaten per day, but does not capture the serving size of vegetables and fruits eaten each time. This measure may lead people with different eating habits to over- or underestimate the number of vegetables and fruit servings they eat each day.

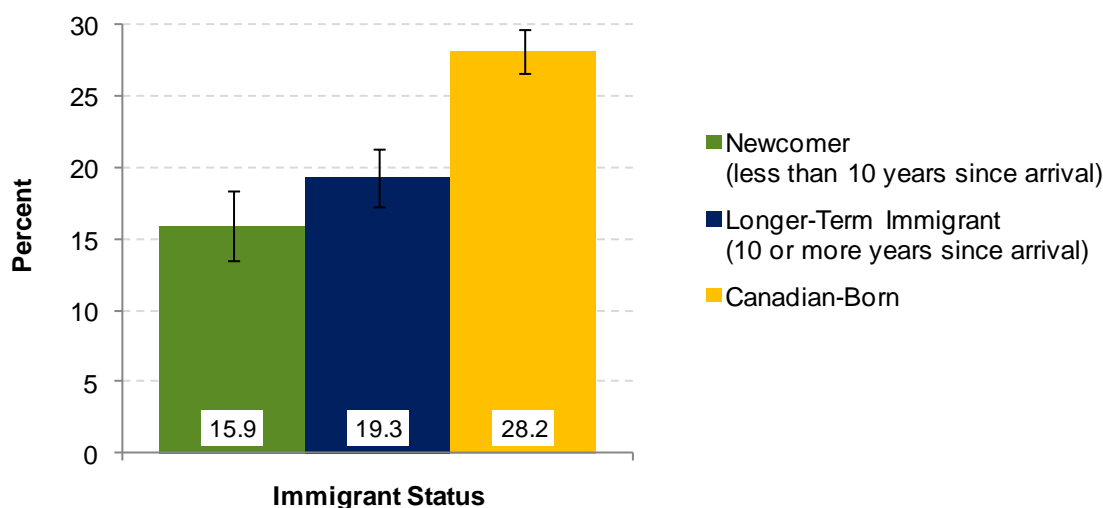
Smoking

Cigarette smoking is the leading cause of preventable death in Canada. Smoking can increase a person's risk of developing several types of cancer, cardiovascular disease and respiratory disease. Although smoking every day puts people at higher risk for health problems, people who smoke occasionally are also at risk.

➤ *Smoking among immigrants in Toronto*

An analysis of Toronto CCHS data conducted for this report shows that, overall, both newcomers and longer-term immigrants are significantly less likely than Canadian-born residents to smoke either daily or occasionally (see Figure 3.7). However, this difference only applies to women. When smoking among men only is considered, immigrant men are shown to be just as likely to smoke as Canadian-born men.

Figure 3.7 Smoking among Newcomers, Long-Term Immigrants, and Canadian-born residents, Toronto, 2001-2008 Combined[†]



Error bars denote 95% confidence intervals

[†] - Data age standardized to the 1991 Canadian Population

Data Source: Canadian Community Health Survey, 2001, 2003, 2005, 2007 and 2008. Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario Ministry of Health and Long-Term Care.

➤ *Newcomer sub-populations in Toronto with a greater risk of smoking*

The analysis of CCHS data as well as the literature review have identified some differences in smoking among different newcomers. These differences point to sub-populations of newcomers, as determined by the following factors, who may be more likely to smoke now or in the future:

Gender

Newcomer women are significantly less likely to smoke than longer-term immigrants and Canadian-born women. This health advantage and possible decline, however, only applies to women. There are no significant differences in smoking levels between immigrant and Canadian-born men.

Age

See “The national and provincial context” below for findings related to age.

Ethno-racial identity

Based on the analysis by ethno-racial identity, **newcomers from racialized groups** in the Greater Toronto Area (GTA)^{xv} are significantly less likely to smoke than White immigrants. This is also true for longer-term immigrants. This finding builds on other local findings, including studies that show that high school youth who identify their ethnicity as "Canadian" or as European are more likely to smoke than youth who identify with other ethnicities.^{66,67} However, smoking remains a concern for many racialized groups:

- In the East African Health Study in Toronto (EAST), which surveyed 456 residents from five **East African communities**, 98% of whom were immigrants who had been in Canada an average of 10 years, smoking was cited by 44% of respondents as a major problem in the East African community in Toronto.

^{xv} Data from the GTA were used in this case because the sample size for the City of Toronto was too small to allow for an analysis of differences between White and racialized respondents.

The study also found that Somalis are more likely to smoke than residents from the Ethiopian, Kenyan, Ugandan and Tanzanian communities.⁵⁷

- Research on smoking among **Ethiopian immigrants** in Toronto has found that although smoking rates are twice as high among men compared with women, twice as many women reported that they started smoking after immigrating to Canada. This suggests that Ethiopian newcomer men and women are at risk for smoking, with women being at particularly high risk for starting to smoke.⁶⁸

Region of origin

The analysis also shows that **newcomers from Europe** (excluding U.K.) in the GTA are significantly more likely to smoke than those from the U.S., U.K. and Oceania, the Americas (excluding the U.S. and Canada), Africa and Asia.

➤ *The national and provincial context*

The findings are consistent with national and provincial research, which has also found that immigrants are less likely to smoke than Canadian-born residents,⁹ particularly women and immigrants from non-European and non-English-speaking countries. This research also shows that smoking rates are higher among longer-term immigrants, particularly for immigrant men from English-speaking and European countries, with immigrants from Europe and the U.S. who have been in Canada for 10–20 years as likely to smoke as their White Canadian-born counterparts.^{10,12}

Research on smoking among youth in Ontario has found that immigrant youth are significantly less likely to smoke than Canadian-born youth, despite living with a low income.^{69,70} National research on immigrant children and youth has found that less than 5% of newcomer youth aged 11–13 report ever trying smoking.⁷¹

Consistent with the present Toronto analysis, provincial research has found that Ontario residents from Black, South Asian and Chinese ethno-racial backgrounds are less likely to smoke than White residents.⁵⁴

➤ *About the data*

Although the findings show a significant difference in smoking rates between immigrants and Canadian-born residents, this difference is mostly due to differences among women. When smoking among men only is examined, immigrant men are shown to be as likely as Canadian-born men to smoke. Therefore, it is possible that some of the other findings related to smoking rates among newcomer sub-populations also vary by gender.

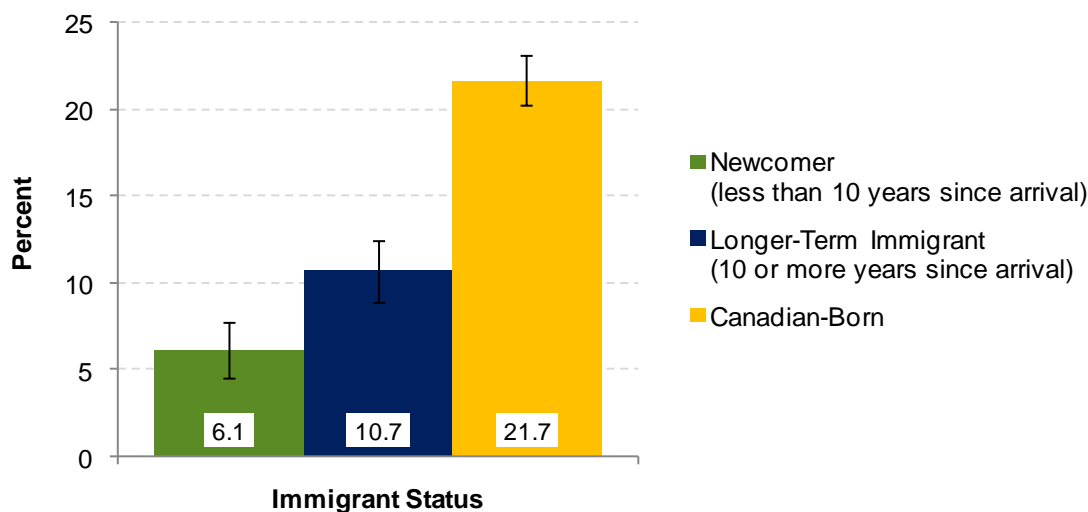
Alcohol Use

Drinking large amounts of alcohol increases a person's risk for illness and death from liver disease; liver, throat, breast and other cancers; and high blood pressure, stroke and other health issues. Excessive alcohol use is also associated with risk for suicide, and people who binge drink are at higher risk for intoxication-related injuries, such as driving accidents, unintentional injuries and violent incidents.

➤ *Alcohol use among immigrants in Toronto*

An analysis of CCHS data from Toronto on “frequent heavy drinking episodes” was conducted for this report. These episodes are defined as having five or more alcoholic drinks on one occasion, at least once per month. The analysis shows that, overall, newcomers have a health advantage in terms of this risk factor, as they are significantly less likely than longer-term immigrants and Canadian-born residents to have frequent heavy drinking episodes. Longer-term immigrants are also less likely to have these episodes than Canadian-born residents (see Figure 3.8).

Figure 3.8 Frequent Heavy Drinking Episodes among Newcomers, Long-Term Immigrants, and Canadian-born residents, Toronto, 2001-2008 Combined[†]



Error bars denote 95% confidence intervals

[†] - Data age standardized to the 1991 Canadian Population

Data Source: Canadian Community Health Survey, 2001, 2003, 2005, 2007 and 2008. Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario Ministry of Health and Long-Term Care.

➤ *Newcomer sub-populations in Toronto at risk for unhealthy alcohol use*

The analysis of CCHS data as well as the literature review have identified some differences in alcohol use among different newcomers. These differences point to sub-populations of newcomers, as determined by the following factors, who may be at higher risk for the adverse health effects of heavy alcohol use now or in the future:

Gender

Recent immigrant women are significantly less likely to have frequent heavy drinking episodes than their male counterparts, according to the analysis. This is also true for longer-term immigrants.

Age

Although there are no significant differences by age group among newcomers, younger longer-term immigrants (aged 15–39) are significantly more likely to have frequent heavy drinking episodes than older longer-term immigrants (aged 40–64), suggesting that younger newcomers may be at future risk.

In focus groups with Russian immigrants in the GTA, youth identified alcohol use as a serious issue among **Russian immigrant youth**.⁷²

Ethno-racial identity and region of origin

In the analysis of CCHS data by ethno-racial identity, **newcomers from racialized groups** in the GTA^{xvi} are significantly less likely to have frequent heavy drinking episodes than their non-racialized counterparts. This is also true for longer-term immigrants. However, in the survey of local reports conducted for this report, drinking was shown to be a concern among some ethno-racial groups in the city, though less so for others:

- In focus groups with **Pakistani** immigrants in the Greater Toronto Area, community members identified alcohol use as a concern, particularly among Pakistani men.⁷²
- In the East African Health Study in Toronto (EAST), which surveyed 456 residents from five **East African communities**, 98% of whom were immigrants who had been in Canada an average of 10 years, the majority of East Africans (81%) reported drinking alcohol less than 2-3 times a month or never, with fewer Somalis and Ugandans reporting ever drinking. East African immigrant women drank less often and less heavily than men.⁵⁷

➤ *The national and provincial context*

The present findings are consistent with national and provincial research, which has also found that immigrants are generally less likely to drink alcohol, to drink heavily and to binge drink than Canadian-born residents, particularly immigrants from non-European and non-English speaking countries.^{9,10,12} This research has also found that for immigrant men from English-speaking and European countries, rates of alcohol use are higher among longer-term immigrants, with men from Europe and the U.S. who have been in Canada for 10–20 years being as likely to drink alcohol as their White Canadian-born counterparts.¹⁰

Research on Ontario youth in grades 7–12 has found that immigrant youth are significantly less likely to drink alcohol, binge drink and to have a hazardous drinking problem than Canadian-born youth.⁶⁹ Similarly, national research on immigrant children and youth indicates that less than 5% of immigrant youth (aged 11–13) report ever having had an alcoholic drink without parental knowledge.⁷¹

➤ *About the data*

One limitation to the findings based on CCHS data for heavy drinking episodes is that heavy drinkers are generally more difficult to reach in surveys. Therefore, the proportion of residents with one or more heavy drinking episodes per month might be underestimated. As well, survey respondents may not respond accurately to questions about drinking alcohol because they may be concerned about the social acceptability of their drinking behaviour. Finally, survey data on drinking behaviour do not capture differences in the health effects of heavy drinking, which may vary based on sex, body size and other factors.

Other Substance Use

Some research exists on the use of other substances by immigrants and immigrant sub-populations in Canada. However, data sources do not allow analysis of use among Toronto immigrants.

➤ *Other substance use among immigrants in Canada*

National research on youth and adults (aged 15–54) has found that immigrants are significantly less likely than their Canadian-born counterparts to use illicit drugs, with those who do not speak English or French at home even less likely to do so. These differences remain after controlling for socio-demographic factors, religiousness,

^{xvi} Data from the GTA were used in this case because the sample size for the City of Toronto was too small to allow for an analysis of differences between white and racialized respondents.

friends' use of substances and participation in social activities. This research has also found rates of substance use to be higher among longer-term immigrants, with rates rising the longer immigrants have been in Canada.⁷³

➤ *Other substance use among immigrant sub-populations in Canada, Ontario and Toronto*

Age

- National research on **immigrant children and youth** has found that less than 5% of newcomer youth (aged 11–13) report ever having taken drugs.⁷¹
- Research on Ontario youth in grades 7–12 has found that **immigrant youth** are significantly less likely to use illicit drugs than their Canadian-born counterparts. When looking at specific drugs, immigrant youth are less likely to report using cannabis, hallucinogens and Ritalin for non-medical purposes than Canadian-born youth, but are more likely to report using solvents.⁶⁹

Ethno-racial identity and region of origin

- In focus groups with **Afghan, Pakistani and Russian immigrants in the GTA**, participants identified marijuana use as an issue of concern for immigrant and refugee youth in all of these communities.⁷²
- In focus groups with **Afghan** immigrants in Toronto, community members identified the use of hashish as a health concern in the Afghan community.⁷²
- In the East African Health Study in Toronto (EAST), a quarter of **Ethiopian, Kenyan, Somali, Ugandan and Tanzanian immigrants** reported using illicit drugs at some point in the past; of these half reported using illicit drugs in the past year, and 5% reported using drugs on a weekly basis. The most commonly reported drugs used by participants were marijuana and “khat”, leaves from the catha edulis shrub that contain cathinone and are highly addictive. No injection drug use was reported. Fewer East African immigrant women reported ever using drugs than men.⁵⁷

3.4 - CHRONIC DISEASE

Chronic diseases are the major cause of illness and death in Canada, making chronic disease an important focus for health promotion, education, prevention and care.

➤ *Chronic disease overall among immigrants in Toronto*

An analysis of chronic disease overall was conducted for this report by looking at the proportion of residents in Toronto Canadian Community Health Survey (CCHS) data who reported having at least one of the following chronic diseases: high blood pressure, diabetes, heart disease, cancer, stroke (suffering from the effects of stroke) or respiratory disease (emphysema or chronic obstructive pulmonary disease (COPD)). The analysis showed that, overall, there was no significant difference in self-reported chronic disease between newcomers and their longer-term immigrant or Canadian-born counterparts. Longer-term immigrants, however, were more likely than Canadian-born residents to report having at least one of these chronic diseases.

These Toronto data do not support the notion that newcomers have a health advantage in terms of chronic disease, which can be seen in national and provincial research (discussed below). However, estimates based on self-reports of having one or more chronic diseases have a number of limitations. Firstly, self-reported data on chronic diseases are known to under-capture the prevalence of some chronic diseases. For example, estimates of diabetes prevalence based on self-reports are far lower than those based on healthcare system data, as was seen in analyses for this report. It is possible that this under-capture is more prominent in some immigrant status groups over others. Secondly, as this measure does not distinguish between chronic diseases, it obscures patterns in specific

diseases. Some diseases, such as diabetes (discussed below), may be more prevalent among newcomers, whereas others may be less prevalent, such as cancer, heart disease, and respiratory disease (also discussed below).

In addition, when the same analysis was conducted on Ontario data, there were no differences between newcomers, longer-term immigrants, and Canadian-born residents in the likelihood of having one or more chronic disease. This indicates that the methodology and representativeness of this survey are possible reasons why the health advantage is not evident (See appendix A for more details on the CCHS).

➤ *The provincial and national context*

National and provincial research has generally found that levels of self-reported chronic disease overall are lower among immigrants than Canadian-born residents, but that this advantage decreases with length of time spent in Canada.^{7,4,6,11,12} As mentioned, the findings for newcomers in Toronto emerging from the analysis conducted for this report are inconsistent with this literature. However, the finding in this report's analysis, that longer-term immigrants are more likely to report having a chronic disease than their Canadian-born counterparts, is somewhat consistent with national and provincial research showing that self-reported chronic disease levels are higher among immigrants who have been in Canada longer.

Canadian research has shown that immigrant sub-populations at higher risk for chronic disease include seniors (aged 65 and over), women, low-income immigrants, and non-European immigrants,^{74,11,43,46} which is also supported by the Toronto findings.

➤ *About the data*

For this analysis of chronic disease overall, seven chronic diseases were grouped together to look at the prevalence of having at least one of them. As a result, the analysis does not address the possible risk factors and health service responses for any one specific chronic disease. Evidence related to specific chronic diseases is discussed below.

Cancer

Existing data sources do not allow analysis of cancer prevalence and mortality among newcomers and newcomer sub-populations in the City of Toronto. However, much research has been conducted on cancer at the national level, which can provide insight into this issue and related needs for Toronto newcomers.

➤ *Cancer among immigrants and immigrant sub-populations in Canada*

Overall, Canadian research has found that cancer risk is lower among immigrants than in the Canadian-born population,^{7,75,13} with the exception of some types of cancer, including liver, nasopharyngeal and cervical cancers.¹³ Cancer prevalence and mortality rates tend to increase among immigrants who have lived in Canada for a longer time.^{76,7,77,37,11} Specifically, this research has shown that Hodgkin's lymphoma, prostate, colon and breast cancer rates increase among immigrants who have been in Canada longer. Some Canadian research has also found that immigrants' Canadian-born children experience cancer rates that are higher than cancer rates among their parents' generation, though still lower than in the general Canadian population. For example, colon, lung and breast cancer rates among the children of Italian immigrants were found to be about halfway between the rates of Italian immigrants and the Canadian-born population.⁷⁶

➤ *Immigrant sub-populations in Ontario and Canada at greater risk for cancer*

National, provincial and local research reviewed for this report provides some insight into sub-populations of immigrants in Toronto that may be at higher risk for cancer, based on the following factors:

Gender

In a report based on a literature review and focus groups in Toronto, breast and gynaecological cancers were identified as an area of need among **older immigrant women**. The authors conclude that improved resources and services are required for this sub-population.⁷⁸ Meanwhile, immigrant **men** in Canada have been found to have higher liver and nasopharyngeal cancer mortality rates compared with the general Canadian population.³⁷

Ethno-racial identity and region of origin

- Research on immigrants in Canada has found that, compared to the general Canadian population, **Southeast Asian immigrants** are at higher risk for liver cancer; **Northeast Asian immigrants** are at higher risk for liver and nasopharyngeal cancers;¹³ and **Chinese immigrants** are at higher risk for liver, nasopharyngeal and esophageal cancers.⁷⁹ Although **Chinese immigrants** have been found to have lower rates of Hodgkin's lymphoma, prostate and breast cancers than their Canadian-born counterparts, rates of these cancers have been shown to be higher among Chinese immigrants than among Chinese people living in China and Hong Kong^{80,79} pointing to a potential area of risk for newcomers from China.
- A study in British Columbia found cervical cancer rates to be 2–4 times higher among women of **Chinese** ethno-racial background than among White women.⁸¹

Immigration category

National research has found that **refugees** have higher liver cancer mortality rates than other immigrants.³⁷

Heart Disease and Stroke

Existing data on heart disease and stroke do not allow heart disease and stroke prevalence for Toronto's immigrant population to be ascertained. However, at the national and provincial levels ample evidence exists to help form insights that are applicable to local newcomers.

➤ *Heart disease and stroke among newcomers in Ontario and Canada*

Canadian research has shown that newcomers have lower rates of heart disease mortality, heart disease and stroke.^{82,83,84} Studies using health care system data to compare heart disease and stroke among newcomers (less than 5 years since arrival) and longer-term residents (including longer-term immigrants and Canadian-born residents) in Ontario have found:

- **a 33% lower risk of heart attack** (acute myocardial infarction) among newcomers compared to longer-term residents;⁸³ and
- **a 30% lower risk of premature stroke** for adult newcomers aged 16–65 compared to longer-term residents.⁸⁴

In contrast, an analysis of 2005–2008 CCHS data for Ontario found that immigrants are significantly more likely to report having heart disease than Canadian-born residents.⁹ National research studies have shown that heart disease rates and risk factors among immigrants tend to increase and may surpass those seen in the native-born population after many years in Canada.^{12,59}

➤ *Immigrant sub-populations in Ontario and Canada at greater risk for heart disease and stroke*

National, provincial and local research into sub-populations at risk for heart disease and stroke provides some important insights into immigrant sub-populations, based on the following factors, who may be at higher risk for heart disease and stroke:

Gender

A national study has found that **Southeast Asian refugee women** experience higher stroke mortality rates than the general Canadian population.³⁷

Ethno-racial identity and region of origin

Ethno-racial background may be more important than region of origin in determining heart disease and stroke risk among newcomers and Canadian-born residents. National and international research has demonstrated that cardiovascular disease risk varies substantially by ethno-racial background, and that risk is greater among newcomers from some ethno-racial groups than their counterparts living in their countries of origin, suggesting that a complex mix of genetic and environmental factors influence cardiovascular health. Examples include:

- Research conducted on specific ethno-racial groups in Canada has found that **South Asians**, and particularly South Asian women, are at higher risk for heart disease and stroke, and that stroke may occur at an earlier age among South Asian women.^{53,54,85} These findings suggest that South Asian newcomers, and particularly women, may be at increased risk for heart disease now or in the future.
- Provincial research on ethno-racial groups found that **Black residents** have a less favourable cardiovascular risk profile than other ethno-racial groups; however Black residents have relatively low rates of heart disease.⁵⁴
- Through focus groups conducted with **Chinese community members** and service providers working with this community in the Greater Toronto Area and other parts of Ontario, The Ontario Heart and Stroke Foundation identified low awareness of risk factors for heart disease and stroke as an issue for members of Ontario's Chinese community.⁸⁶

Immigration category

One Canadian research study showed that mortality rates for stroke were higher among **refugee men** than in the general Canadian population.³⁷

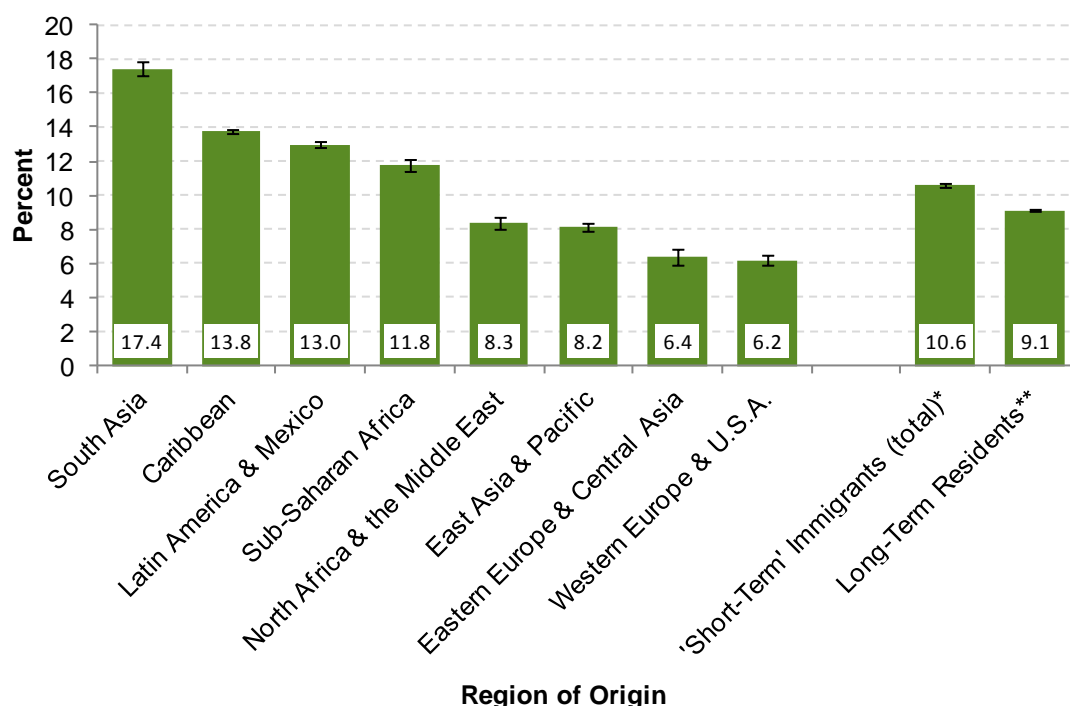
Diabetes

An analysis was conducted for this report on the prevalence of type 2 diabetes mellitus among Toronto immigrants and non-immigrants using the Ontario Diabetes Database (ODD), which is drawn from health care system data, such as hospital records and doctors' billing claims. This information on diabetes was linked to Canadian immigration data on immigrants arriving between 1985 and 2000, which made it possible to examine diabetes prevalence in this group of immigrants. Unfortunately, it was not possible to look at diabetes prevalence among more recent immigrants.

➤ *Diabetes among immigrants in Toronto*

The analysis, as shown in Figure 3.9, finds that diabetes is more common among 'short-term' immigrants who arrived in Canada 8–23 years before 2008 (between 1985–2000) than among longer-term residents, including Canadian-born residents and immigrants who arrived prior to 1985. This is especially true for immigrants from some regions of origin (discussed below).

Figure 3.9 Diabetes among 'Short-Term' Immigrants* Aged 20 and Older by Region of Origin, Toronto, 2008[†]



Error bars denote 95% confidence intervals

[†] - Data age standardized to the 1991 Canadian Population

* 'Short-Term' immigrants are defined here as people who immigrated to Ontario between 1985 and 2000 and had therefore been in Canada for between 8 and 23 years

** Long-term residents are defined here as people who were born in Canada or immigrated to Ontario before 1985 and had therefore been in Canada for 24 years or more

Source: Creatore, M.I. (2011). Unpublished data from PhD dissertation in preparation.

Data sources: Landed Immigrant Database (Citizenship and Immigration Canada, 1985-2000); Ontario Diabetes Database (Institute for Clinical Evaluative Sciences, 2010)

In addition, service providers and newcomer community members in the focus groups conducted for this report frequently identified diabetes as an issue of concern and need among newcomers in Toronto.

➤ **Immigrant sub-populations in Toronto at greater risk for diabetes**

The analysis of ODD data as well as the literature review and focus groups have identified some differences in diabetes prevalence and among different sub-populations of immigrants. These differences point to sub-populations of newcomers, as determined by the following factors, who may be at higher risk for diabetes now or in the future:

Age

Among **older men** (65 and older), and particularly those aged 75 and older who are 'short-term' immigrants, rates of diabetes are quite similar across all regions of origin. Meanwhile, focus group participants identified **newcomer children and youth**, particularly in the Somali community, as being at risk for diabetes. One service provider noted, “*Back home diabetes and high cholesterol were called the disease of rich people. Now most people from my community have diabetes and high cholesterol. We have Somali kids, 12 years old, with diabetes and high blood pressure.*”

Region of origin

- As shown in Figure 3.9, 'short-term' immigrants who arrived 8–23 years before 2008 from **South Asia** have been shown to experience the highest rates of diabetes and have significantly higher rates of diabetes compared to immigrants from other regions and compared to other residents (Canadian-born and immigrants who had lived in Canada 24 or more years).
- 'Short-term' immigrants from the **Caribbean, Latin America and Mexico, and from Sub-Saharan Africa** also experience significantly higher rates of diabetes than 'short-term' immigrants from other regions and longer-term residents.
- Rates of diabetes are similar among older women (aged 65 and older) who are 'short-term' immigrants from **South Asia, the Caribbean, Latin America and Mexico**. These rates are significantly higher than for older women from the other five regions of origin.
- Rates of diabetes are particularly high among **South Asian 'short-term' immigrant men** aged 35–64 compared with 'short-term' immigrant men of the same age group from other regions.
- Toronto researchers in the focus groups conducted for this report noted that another immigrant sub-population at high risk for diabetes is made up of first- and second-generation **immigrants from North Africa and the Middle East**.
- The East African Health Study in Toronto (EAST), which surveyed 456 residents from five East African communities, 98% of whom were immigrants who had been in Canada an average of 10 years, found that **East African immigrant women** were more likely than men to report having diabetes, and that diabetes was most commonly reported among **Somali immigrants**, followed by Ethiopians and Kenyans, with many fewer Tanzanians and Ugandans reporting having the disease.⁵⁷

Ethno-racial identity

Although the analysis of Toronto ODD data shows differences in diabetes rates by region of origin, ethno-racial background may be a more important factor in determining rates of diabetes among immigrants and Canadian-born residents. Much research from the U.S. and U.K. has demonstrated that diabetes risk is significantly higher among some racialized groups, and that immigrants from these racialized groups are at higher risk than their counterparts in their countries of origin, indicating that a complex mix of genetic and environmental factors related to immigration may play an important role.^{87,54,88}

Provincial research examining diabetes rates by ethno-racial background has found that **Black and South Asian residents** in Ontario have a prevalence of diabetes that is approximately double that of other ethno-racial groups,⁵⁴ indicating that newcomers from these ethno-racial backgrounds may be at increased risk for diabetes now or in the future.

Immigration category

A study of 200 patients at the Volunteer Clinic for the Medically Uninsured in Scarborough, Toronto, found that diabetes was prevalent and often poorly managed among clinic patients, who had been in Canada an average of 2 years and the majority of whom were **newcomer women from the Caribbean, South Asia and East Asia**.⁸⁹

➤ *The provincial and national context*

Canadian research suggests that type 2 diabetes is increasing among Canadian immigrants⁹⁰ and that immigrants are 20% more likely to report having diabetes than their Canadian-born counterparts, with longer-term immigrants (defined here as more than 5 years since arrival) being 70% more likely to have diabetes than newcomers (5 or less years since arrival).⁷ An analysis of 2005–2008 CCHS data for Ontario also found that immigrants were significantly more likely to report having diabetes than Canadian-born residents.⁹

National and provincial research on specific sub-populations is also generally consistent with research findings for Toronto. Findings include:

- Nationally, immigrants from South Asia, the Caribbean, Latin America and Sub-Saharan Africa are twice to four times more likely to develop diabetes than immigrants from other regions, and this higher risk begins at an early age (35–49 years).⁹¹
- Immigrant men in Canada from the Caribbean have higher diabetes mortality rates.³⁷
- Provincial research has shown that diabetes risk is the same or higher for immigrant women compared with immigrant men, that immigrants with lower income and women immigrants with lower education are at higher risk, and that diabetes risk is higher among longer-term immigrants who have lived in Canada for 15 years or more.⁹¹
- International, national and provincial research has also found that ethno-racial background is associated with diabetes risk, showing that residents from non-White ethno-racial backgrounds, including South Asian and Black residents, are at higher risk for diabetes.

Respiratory Disease

Relatively little research exists on respiratory disease among immigrants and immigrant sub-populations in Canada, and data sources do not allow analysis of this data for Toronto immigrants.

➤ *Respiratory disease among immigrants in Canada*

Analysis of Canadian survey data shows that immigrants are 50% less likely to report having chronic obstructive pulmonary disease (COPD) or asthma than their Canadian-born counterparts.⁷ Other Canadian research has also found that immigrants, particularly newcomers, are significantly less likely to have asthma than their Canadian-born counterparts, but that rates of asthma are closer to Canadian-born rates among longer-term immigrants.^{92,93} An analysis of 2005–2008 CCHS data for Ontario also found that immigrants are significantly less likely to report having COPD or asthma than Canadian-born residents.⁹

➤ *Respiratory disease among immigrant sub-populations in Canada*

One Canadian study examined the prevalence of respiratory disease among adolescents aged 12–15 of Chinese ethno-racial background who were either immigrants to Canada, born in Canada or living in China and Hong Kong. This study found that asthma prevalence and symptoms were higher among Chinese adolescent immigrants living in Canada than those living in China and Hong Kong; that asthma symptoms were more common among Chinese adolescent immigrants who had lived in Canada longer; and that Canadian-born adolescents of Chinese immigrant families had the highest rates of asthma and symptoms. These findings suggest that environmental factors and length of exposure to these factors play a role in determining asthma prevalence.⁹⁴

3.5 - COMMUNICABLE DISEASE

“Most of my clients come from refugee camps so they have experience of parasites and infectious diseases. Some of my clients were born in refugee camps. They have been in the camp for 21 years. They come skinny and weak. Although I know the UN screens them for health issues...some of them when they came here they still had tuberculosis, arthritis... and they are young.” (participant – service provider focus group)

Newcomers do not experience a health advantage in terms of communicable disease. Although the numbers of affected individuals are small compared to chronic disease, newcomers are disproportionately affected by some communicable diseases, including HIV and tuberculosis (TB). This is related to several factors, including:

- *Country of origin:* newcomers sometimes arrive from countries with high rates of HIV, TB and other communicable diseases, or that have an incidence of infectious diseases that are rare in Canada.
- *Immunization:* lack of comprehensive vaccination programs in immigrants' countries of origin now and in the past means that some newcomers and longer-term immigrants are not immune to diseases uncommon in Canada (e.g., measles, mumps and rubella).
- *Pre-migration experiences:* immigrants who lived in settings such as refugee camps and war-torn areas before coming to Canada are often at higher risk for communicable disease because of conditions there, which may have included overcrowding, poor sanitation, poor nutrition and lack of quality health care.
- *Barriers to care:* newcomers face significant barriers to accessing health services after arriving in Canada (see section 4).

With access to appropriate health services in Canada, including appropriate communicable disease prevention, screening and treatment, many communicable diseases may decline and others may be better managed among immigrants who have been in Canada for a longer period of time.

➤ *Communicable disease among newcomers in Toronto, Ontario and Canada*

In addition to HIV and TB, which are discussed in more detail below, research at the local, provincial and national levels has identified several communicable diseases that are important health issues for immigrants.

- The Canadian Collaboration for Immigrant and Refugee Health Guidelines has conducted a series of 21 systematic evidence reviews in collaboration with immigrant health experts to identify key issues for immigrant and refugee health services, and to develop primary care recommendations for these health issues. In addition to HIV and TB, communicable diseases they have addressed are: **malaria, intestinal parasites, hepatitis B, hepatitis C, chicken pox** (varicella), and **MMR/TDP** (measles, mumps, rubella and tetanus, diphtheria, polio).⁴²
- National research has found mortality rates for **infectious and parasitic diseases** to be higher among refugee women than in the general Canadian population.³⁷ National and local research on groups of refugee patients in Toronto and Ottawa found that parasitic infections occurred in 29% of Canadian travellers, the majority of whom were travelling for immigration reasons;⁹⁵ were highly prevalent among Karen refugees (from Myanmar) in Toronto;⁹⁶ and were seen in 13.6% of government assisted refugee patients seen at the Ottawa Immigrant Health Clinic.⁹⁷
- **Malaria** is a major cause of illness and death internationally. In 1996, more than 400 cases of malaria were reported in Ontario, and 1,029 cases were reported across Canada in 1997.⁹⁸
- National research has found that immigrants, particularly refugees, have higher **hepatitis** mortality rates than the general Canadian population.³⁷ Research on refugee patients in Ottawa found that 5.4% of government assisted refugee patients seen at the Ottawa Immigrant Health Clinic had hepatitis B.⁹⁷

Local research on **rubella** and **hepatitis B** among immigrant and refugee women who were pregnant or had recently given birth found lower rates of rubella immunity and higher rates of hepatitis B and rubella among immigrant and refugee women than their Canadian-born counterparts.^{99,100}

HIV and AIDS

Immigrants from HIV-endemic regions, specifically the Caribbean and Sub-Saharan Africa, account for an increasing proportion of HIV cases in Canada. Existing data on HIV make it difficult to determine how many immigrants from HIV-endemic regions acquire HIV infections before arriving in Canada and how many become

HIV-positive after immigrating, but one study has estimated that 20–60% of new HIV infections among immigrants from HIV-endemic areas to Ontario happen after arriving in Canada.¹⁰¹

➤ *HIV among immigrants in Toronto and Ontario*

In 2010, the rate of newly diagnosed HIV cases reported in Toronto was 18.7 cases per 100,000 residents, compared to a slightly higher 21.6 per 100,000, the five-year average from 2005–2009.¹⁴ Eleven percent of the diagnosed cases of HIV in Toronto in 2010 were among residents from an HIV-endemic country. Information on when these residents arrived in Canada is unavailable, and thus no statements about newcomers versus longer-term immigrants can be offered.

In 2008, an estimated 1.4% of residents in Toronto from HIV-endemic regions (2,860 people) had HIV infections, accounting for 17% of all residents living with HIV in the city. The 2008 estimates also show that among women living with HIV in Toronto, 48% (1,180 cases) were from HIV-endemic regions, while among men with HIV, 12% (1,680 cases) were from HIV-endemic areas.¹⁶

Immigrants from HIV-endemic regions make up an increasing proportion of Ontario HIV cases. The prevalence of HIV in Ontario among residents from HIV-endemic regions has increased by 62% between 2003 and 2008. In 2008, there were an estimated 4,878 cases of HIV among immigrants from HIV-endemic areas provincially. This represents 18% of all HIV cases in Ontario, while residents from HIV-endemic countries account for only 3.5% of the population.

➤ *Immigrant sub-populations in Toronto and Ontario at greater risk for HIV and AIDS*

Local and provincial research as well as participants in the focus groups conducted for this report have identified sub-populations of immigrants who are at increased risk for HIV. Although existing research does not examine how risk might be associated with length of time in Canada, this information provides important insight into sub-populations of immigrants who are at higher risk for HIV.

Gender

Immigrant women from HIV-endemic regions are at particularly high risk, as 55% of female HIV cases in Toronto were among women from these areas in 2010.¹⁶ However, women from HIV-endemic regions comprised less than 8% of total male and female HIV cases in Toronto in 2008.

Sexual orientation

Service providers in the focus groups identified **LGBTQ newcomers** to Toronto as a group for whom HIV is an important health concern.

Region of origin

- Immigrants from HIV-endemic regions, specifically the **Caribbean and Sub-Saharan Africa**, make up an increasing proportion of HIV cases in Ontario and are a high risk group, as discussed above.¹⁰¹
- In Ontario in 2006, immigrants from **Sub-Saharan Africa** experienced the highest rates of HIV-related deaths among men and women.¹⁰²
- Immigrants to Ontario from specific countries in the Caribbean are more likely to have HIV than others from the region. Of the estimated 1,366 HIV-infected persons in Ontario from the Caribbean, four countries accounted for 86% of infections in 2002: **Jamaica, Guyana, Trinidad and Haiti**.¹⁰¹
- Immigrants to Ontario from specific countries in Africa are more likely to have HIV than others from the continent. Of the estimated 1,261 HIV-infected persons in Ontario from Africa, five countries accounted for 66% of infections in 2002: **Ethiopia, Somalia, South Africa, Uganda and Kenya**.¹⁰¹

- In the East African Health Study in Toronto (EAST), which surveyed 456 residents from five **East African communities**, 98% of whom were immigrants who had been in Canada an average of 10 years, two thirds of participants felt that HIV/AIDS was either a minor or major problem in their community in Toronto, with 41% of participants citing it as a major problem ⁵⁷

➤ *The national context*

National research on HIV among immigrants is consistent with findings for Toronto and Ontario. Canadian research has shown that immigrants from HIV-endemic regions (the Caribbean and Sub-Saharan Africa), and particularly women from these regions, make up an increasing proportion of HIV cases in Canada.¹⁵ National research has also found higher HIV/AIDS mortality rates among immigrants from the Caribbean and among immigrant women than in the general Canadian population.³⁷

Tuberculosis (TB)

Tuberculosis (TB) can be active or latent (inactive); people with active pulmonary TB are symptomatic and can spread the disease, while people with latent TB do not have symptoms and are not contagious. However, people with latent TB may develop active TB at some point in the future. Treatment courses can cure both forms of the disease. The number of active TB cases in Canada has decreased over the past 20 years. However, as TB rates among Canadian-born residents have fallen, TB has increasingly become an illness of immigrants, who now make up two-thirds of all cases in Canada. Over the past 10 years, 80% of immigrants coming to Canada came from countries with high rates of TB. It is estimated that as many as half of these newcomers may have latent (inactive) TB and/or be at risk for active TB.¹⁰³

Immigrants are screened for active TB before entering Canada, and those who have active TB are required to successfully complete TB treatment before entering Canada. Experts in Canada generally agree that the majority of active TB cases among immigrants are due to latent TB infections being reactivated, and that a much smaller proportion are due to new infections happening just before or after immigration. Social, economic and environmental factors such as stress, overcrowded and poor living conditions, poor nutrition and poverty may all contribute to immigrants contracting active TB. Several studies have found that newcomers are most at risk for developing TB within the first 5 years after arrival.¹⁰⁴

➤ *TB among immigrants in Toronto*

In 2010, the rate of active TB cases across Toronto was 11.1 per 100,000 residents, and an average rate of 12.0 per 100,000 active TB cases was reported each year in the city from 2005–2009. In 2010, 92% of the 298 TB cases reported in Toronto were among immigrants.¹⁴ Over one third of Toronto TB cases were among newcomers who have arrived in Canada within the past 5 years. Of the new active TB cases diagnosed among immigrants from 2006 to 2010:

- 24% were among newcomers who had arrived in Canada up to 2 years before;
- 18% were among newcomers who had been in Canada between 2 and under 5 years;
- 15% were among newcomers who had been in Canada between 5 and under 10 years;
- 42% were among immigrants who had been in Canada 10 or more years.³⁸

➤ *Newcomer sub-populations at greater risk for TB in Toronto and Ontario*

Toronto Public Health data and local, provincial and national research have identified some sub-populations of immigrants, based on the following factors, who are at high risk for active TB:

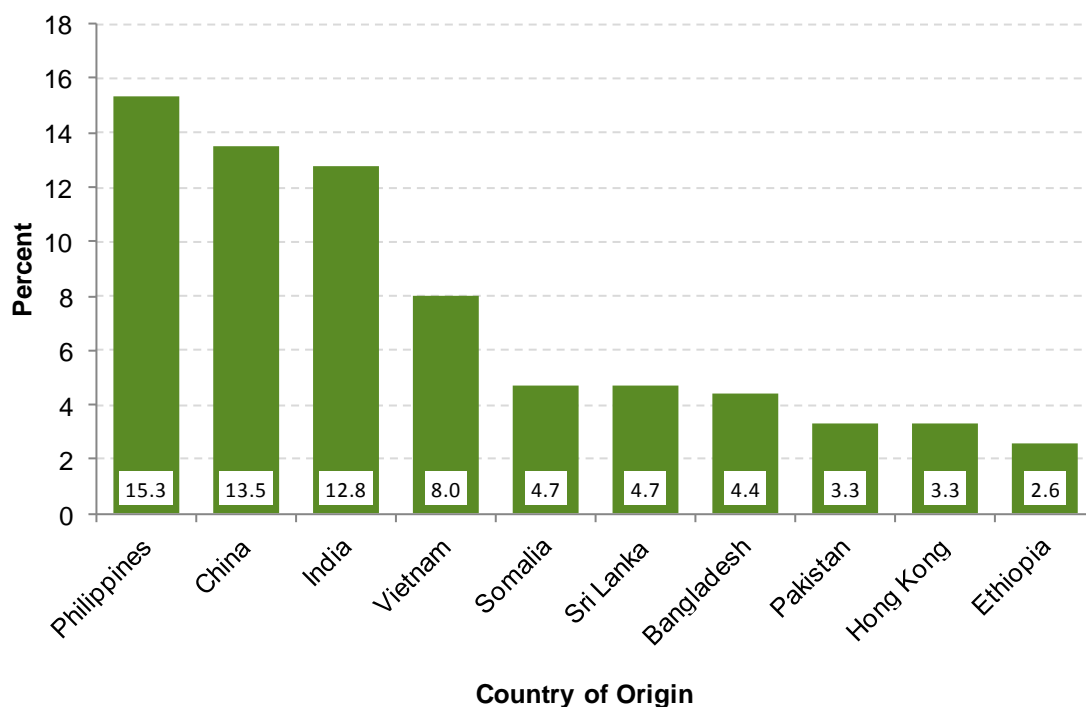
Age

Research on TB among immigrants in Ontario found **adolescents and young adults** (aged 16–30), as well as **older immigrants** (over 65 years), to be at higher risk for TB,¹⁰⁵ though the number of adolescents with active TB in Ontario is small. Research on TB cases among adolescents (aged 13–18) in a Toronto hospital found that approximately 65% of cases were among immigrants,¹⁰⁶ while research looking at 121 cases of TB among patients under 17 years of age in Ontario found that 69% were immigrants.¹⁰⁷ Most other pediatric cases were Canadian-born children or grandchildren of immigrants with infectious TB.

Region of origin

As shown in Figure 3.10, the top countries of origin among immigrants for Toronto's TB cases in 2010 were the Philippines, China, India, Vietnam, and Somalia, reflecting recent immigrant patterns.¹⁴ This is consistent with findings that show TB rates in Ontario and across Canada and other high-income countries are highest among immigrants from regions with high rates of TB, including Sub-Saharan Africa, South Asia, East Asia, Southeast Asia and the Pacific, Latin America, the Caribbean and the Eastern Mediterranean.^{105,104,108} Other Toronto research has identified immigrants in the Somali community¹⁰⁹ and the Tibetan community¹¹⁰ to be at particularly high risk for active TB, with extremely high rates of latent TB and high rates of drug-resistant TB in active cases identified among Tibetan immigrants. Service providers in the focus groups conducted for this report identified newcomers from China, India, Pakistan, Vietnam, some African countries and some Eastern European countries as groups with high levels of TB.

Figure 3.10 Percent of Foreign-Born Tuberculosis Cases by Top Countries of Birth, Toronto, 2010



Data Source: Ontario Ministry of Health and Long-Term Care, Integrated Public Health Information System (iPHIS), Date Extracted: July, 2010

Housing status

As the Toronto's homeless population increasingly reflects the immigrant make-up of the city, local research indicates some increases in the number of cases of TB among **homeless residents** who were born outside of Canada.¹¹¹ While many are originally infected with TB in their country of origin, infectious TB in a congregate setting, such as a shelter, poses a significant risk of spreading to others. Research on TB among Somali immigrants in Toronto found that overcrowded housing conditions might be contributing to the high rates of TB seen among Somali immigrants.¹⁰⁹ Both of these studies point to the additional risk faced by newcomers who experience homelessness and sub-standard housing.

Immigration status

Canadian research looking at TB among immigrants in Canada and other high-income countries has found that, compared with the general population of immigrants, **refugees** face twice the risk for active TB, likely due to higher rates of latent TB in this population and to overcrowded conditions refugees often live in before and after moving to Canada.¹⁰⁴ A Toronto Public Health report identified refugee claimants, particularly those staying in homeless shelters, as being at high risk for TB.¹¹²

Pre-existing health issues

National research has shown that immigrants and refugees with other medical conditions are at higher risk for TB. In particular, residents with latent TB who are also **HIV-positive** are at very high risk for active TB.¹⁰⁴

➤ *The national context*

The Toronto experience of TB among immigrants is broadly similar to the Canadian experience, though Toronto has more foreign-born cases and less Aboriginal cases than the rest of Canada. Overall, TB rates in Canada are low, at 5 cases per 100,000 residents. However, 65% of TB cases in Canada are among immigrants, who experience a TB rate that is 20 times that of Canadian-born residents who are not Aboriginal.¹⁰⁴ TB rates are two times higher among newcomers within the first 5 years of arrival in Canada, and are 5–10 times higher among newcomers within the first year of arrival.¹⁰⁴

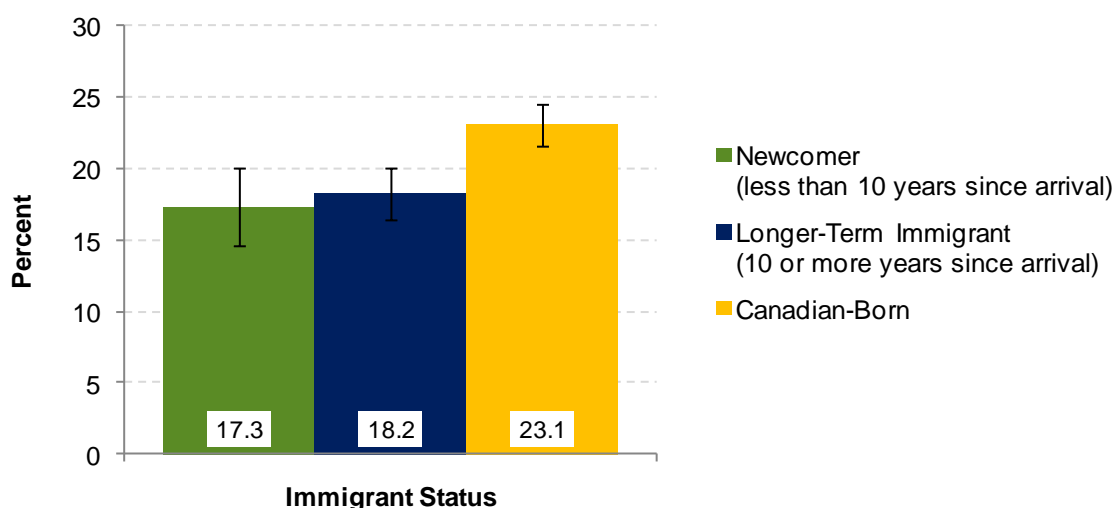
3.6 - DISABILITY

Disability can include a broad range of health issues and conditions, including physical, mental and learning disabilities, hearing or vision disabilities, mental and physical health issues, and many others. A disability can affect a person's participation in activities at home, school and work. Having a disability may result from other health conditions, and, at the same time, may be a risk factor for other health conditions, including mental health problems and health problems related to lack of physical activity.

➤ *Participation and activity limitations among immigrants in Toronto*

An analysis of Toronto CCHS data on "participation and activity limitations" was conducted as part of this report. These limitations are defined as being limited in selected activities (home, school, work or other activities) because of a physical condition, mental condition or health problem that has lasted or is expected to last 6 months or longer. The analysis shows that, overall, newcomers in Toronto are less likely than Canadian-born residents to report having a participation and activity limitation. Longer-term immigrants in Toronto are also less likely than Canadian-born residents to have a participation and activity limitation (see Figure 3.11).

Figure 3.11 Participation and Activity Limitation among Newcomers, Longer-Term Immigrants, and Canadian-born residents, Toronto, 2001 to 2008 Combined[†]



Error bars denote 95% confidence intervals

[†] - Data age standardized to the 1991 Canadian Population

Data Source: Canadian Community Health Survey, 2001, 2003, 2005, 2007 and 2008. Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario Ministry of Health and Long-Term Care.

Despite newcomers' health advantage in terms of participation and activity limitations found in this analysis, Toronto stakeholders have identified disability as an important issue for newcomers.⁶⁴

➤ *Disability and participation and activity limitations among newcomer sub-populations in Toronto*

The analysis of CCHS data as well as focus groups and the literature review conducted for this report have identified some differences in participation and activity limitations and disability among different newcomer sub-populations in Toronto, as determined by the following factors:

Gender

The analysis of CCHS data show **newcomer men** and longer-term immigrant men are significantly less likely than Canadian-born men to report having a participation and activity limitation. The analysis shows that there are no differences among women based on immigration status.

Age

The CCHS analysis has found that newcomer and longer-term immigrant **older adults** (aged 40–64) are significantly more likely than their younger counterparts (aged 15–39) to have a participation and activity limitation. This finding is not surprising and is consistent with findings from the focus groups, where Toronto newcomers identified disability as an area of need for newcomer seniors.

Income

There are no significant differences in the likelihood of having a participation and activity limitation among newcomers across income levels, according to the analysis of CCHS data. However, longer-term immigrants living with low incomes are significantly more likely to have a participation and activity limitation than their counterparts with medium high or high incomes.

Ethno-racial identity

Based on CCHS data, **White newcomers** in the Greater Toronto Area (GTA)^{xvii} are significantly less likely than White Canadian-born residents to report having a participation and activity limitation.

Immigration category

Refugees have been identified in focus groups conducted by the Toronto Region Canadian Red Cross as a particularly vulnerable population with high levels of need.¹¹³

➤ *The provincial and national context*

Although there has been little recent research on the prevalence or experiences of immigrants with disabilities in Canada, some older studies have found that immigrants have more disability-free years and are less likely to suffer from a longer-term activity limitation than Canadian born residents.¹¹⁴ More recent Canadian research on disabilities has looked at differences between ethno-racial groups and has examined specific conditions that may be disabling, such as arthritis and osteoporosis. Canadian research has found that immigrants are 20% less likely to have arthritis or rheumatism than Canadian-born residents, and that longer-term immigrants (more than 5 years since arrival) are twice as likely to report having arthritis than newcomers (5 years or less since arrival).⁷

➤ *Notes about the data*

A limitation of the analysis of CCHS data is that self-reported “participation and activity limitations” status may be open to interpretation, since “limited participation” may have a different meaning for different people. Diverse cultural perceptions and varying levels of language proficiency among immigrant survey respondents may also impact interpretations.

3.7 - MORTALITY

Mortality data are not currently available for newcomers and newcomer sub-populations in the City of Toronto. However, several researchers have used national-level data to explore mortality rates among immigrants. Overall, this research has found that, across Canada, mortality rates are substantially lower among newcomers than Canadian-born residents, but that this advantage decreases with length of time in Canada, so that mortality rates for immigrants gradually become more similar to the rates for those born in Canada.^{77,36} Specifically, research on immigrants and refugees arriving in Canada from 1980–1990 has found that age-standardized^{xviii} all-cause mortality is lower among newcomers than in the general Canadian population, but that this rate increases among immigrants who have been in Canada longer.³⁷

➤ *Mortality among newcomer sub-populations in Canada*

Immigration category

Lower mortality has not been found to be consistent across all immigrant classes. **Refugees** have been found to have an increased risk of all-cause mortality compared with other newcomers. However, unlike other newcomers, this risk does not increase with length of stay.

^{xvii} Data from the GTA were used in this case because the sample size for the City of Toronto was too small to allow for an analysis of differences between White and racialized respondents.

^{xviii} Age-standardized mortality rates allow comparison of the rate of deaths in different populations due to one or multiple causes while adjusting for differences in the age breakdown of those populations.

Region of origin

All-cause mortality rates also differ by region of origin. Mortality rates for some conditions, such as stroke, diabetes, infectious diseases and some cancers (liver and nasopharynx) have been found to be higher among immigrants and specific immigrant sub-populations than in the Canadian-born population.³⁷

3.8 - GENETIC CONDITIONS

Immigrants from certain regions and from particular ethno-racial backgrounds may be at higher risk for some genetic conditions, particularly some blood conditions and disorders. The literature review conducted for this report identified limited Canadian research on these conditions. Here, local and national evidence on some of this research is outlined.

Hemoglobinopathies and thalassemias are genetically inherited conditions causing abnormalities related to the blood that can lead to anemia and other health issues. Some of these conditions are more common among individuals from regions of the world where malaria is common, and they may provide some protection against malaria. These conditions include:

- **Sickle-cell anemia**, which can lead to various complications and reduced life expectancy. Sickle-cell anemia is most commonly found in Sub-Saharan Africa, India and the Middle East, and immigrants from these regions are at higher risk for it.
- **Glucose-6-phosphate dehydrogenase deficiency (G6PD)**, which is an enzyme deficiency that can exist without symptoms but can lead to mild or severe complications and symptoms. G6PD is most common among people from Africa, the Middle East and South Asia, and therefore immigrants from these regions are at higher risk for it. Individuals with G6PD may be advised to avoid a range of foods and medications in order to minimize health risks.¹¹⁵
- **Thalassemias** are a group of diseases that can cause anemia and other health issues, and can reduce life expectancy. Thalassemias are common among individuals from the Mediterranean, South Asia, East Asia, Southeast Asia, Africa and the Americas. Research on immigration and thalassemia in North America has shown that thalassemias are common in Ontario, and that Asian patients account for more than half of thalassemia patients in North America.¹¹⁶

Local stakeholders consulted for this report identified the need to increase awareness among health care providers about genetic conditions that typically affect certain newcomer and ethno-racial groups. Lack of awareness and knowledge about genetic conditions such as the ones described above can lead to misdiagnosis and inappropriate treatment.

3.9 - REPRODUCTIVE, MATERNAL AND INFANT HEALTH

A high proportion of births in Toronto are among newcomers and longer-term immigrants, making pregnancy, birth outcomes and maternal health important health issues for this group. Immigrants are, on average, younger and have more children than the Canadian-born population. While immigrants make up 50% of Toronto's population, 66% of all births in Toronto in 2006 were to immigrant women.² Although newcomers account for approximately 11% of Toronto's total population, in a recent study looking at birth outcomes for all singleton births in Toronto between 1996–2001, approximately 31.5% of all births were to newcomer women who had arrived in Ontario within 5 years of the birth.¹¹⁷

Community members and service providers in focus groups conducted for this report identified pregnancy and childbirth as important health issues impacting newcomer women and their families. Participants also identified pregnant newcomers as a particularly vulnerable group due to social isolation, lack of social and familial support, financial and income issues, and unmet nutritional needs. Service providers identified non-status immigrant women and those who have been in Canada less than 3 months and who are not yet eligible for OHIP coverage as particularly vulnerable due to the barriers they face in accessing needed health care.

Pregnancy and Birth Outcomes

Low birth weight and preterm birth are important and commonly used measures of infant health in Canada because they are associated with short- and longer-term health risks for infants.

➤ *Pregnancy and birth outcomes among newcomers and newcomer sub-populations in Toronto, Ontario and Canada*

Much Canadian and international research has found that birth outcomes are better among newcomers than among longer-term immigrants and Canadian-born residents. However, this health advantage has not been seen in all research, for all indicators, or in all sub-populations of newcomers. Some Canadian research has found no difference in the rates of low birth weight babies and preterm births among foreign-born and Canadian-born mothers.¹¹⁸ A systematic review of studies on migration to western industrialized countries and perinatal health found that in half or more of the studies, low birth weight and preterm birth outcomes were the same or better for immigrant women compared with their native-born counterparts. However, this study found that certain sub-populations, including Asian, North African and Sub-Saharan African immigrants, were at higher risk for some negative birth outcomes.¹¹⁹

Low birth weight, preterm birth and neighbourhood income: Several recent studies have examined birth outcomes among immigrant women in Toronto and Ontario. Research comparing low birth weight and preterm birth outcomes for newcomer women (who had registered for provincial health services within 5 years of the birth) and longer-term residents (including Canadian-born and longer-term immigrant women) in Toronto found that newcomer women are significantly more likely to have a low birth weight baby, but significantly less likely to have a preterm birth than longer-term residents.¹¹⁷ Although longer-term residents in low-income neighbourhoods are at higher risk for poor birth outcomes, newcomers' rates for these birth outcomes do not vary by neighbourhood income level. Reasons for lower rates of preterm birth among newcomers may include the lower prevalence of maternal illnesses and risk behaviours such as smoking and alcohol use in this population. The higher rates of low birth weight found among newcomers may be explained by differences in body size, body shape and diet, where newcomers may gain less weight during pregnancy, have lower body mass index, and have a shorter stature.¹¹⁷

Research on immigrants in cities across Ontario has also found that newcomers have lower rates of preterm birth and that these rates do not vary by neighbourhood income level. However, among longer-term immigrants who have lived in Canada for 15 years or more, rates of preterm birth are higher for immigrants living in low-income neighbourhoods.¹¹⁷ This suggests that newcomers living with low income and who live in low-income neighbourhoods may be at higher risk for preterm birth in the future.

Maternal placental syndrome: This syndrome refers to problems with the placenta during pregnancy, including pre-eclampsia, eclampsia, placental abruption or placental infarction. Research has found that rates of these conditions are lower among newcomers (who registered for provincial health services within 5 years of the birth) than among longer-term residents (including Canadian-born and longer-term immigrant women), with the lowest

rates found among women who had immigrated most recently, and the highest seen among longer-term residents living in Ontario 5 years or more.¹²⁰

Female Genital Mutilation (FGM): FGM is the collective name given to a number of cultural practices that involve the partial or total cutting of female genitals. Most commonly, girls experience FGM between the ages of 4–12, but it can be performed as early as infancy and as late as age 30.¹²¹ The practice is illegal in Canada. However, FGM is performed in some countries in Africa, Southeast Asia, the Middle East, and Central and South America, and among 80–90% of women from Djibouti, Somalia and Sudan.¹²¹ International research shows that pregnant immigrant and refugee women who come from countries where FGM is performed experience barriers to delivery and greater risk of cesarean section, postpartum hemorrhage, extended hospital stay, infant resuscitation, and stillbirth or early neonatal death.^{122,123} One study of Somali women in Ontario with previous female genital mutilation who had given birth to a baby in Canada in the previous 5 years showed that clinical practitioners attending to their births often lacked knowledge of female genital mutilation and treated the women in ways that were perceived to be harsh and insensitive to their cultural values.¹²⁴

Breastfeeding

Breastfeeding is recognized and promoted in Canada and internationally as the best method of feeding babies. Breastfeeding has important nutritional benefits, and research has shown that it has many short- and longer-term health benefits for mothers and their babies. Current provincial, national and international guidelines recommend feeding *only* breast milk to babies up to 6 months old, and continuing to breastfeed infants from 6 months to two years old in addition to supplying other foods.¹⁷ Although exclusive breastfeeding is recommended, many mothers feed their infants a combination of breast milk and formula.

➤ ***Breastfeeding among newcomers and newcomer sub-populations in Toronto and Canada***

Toronto Public Health conducted a survey on breastfeeding 2 weeks and 6 months after birth with over 1,500 new mothers in Toronto, 62.3% of whom were immigrants and 33.6% of whom were newcomers who had lived in Canada for 5 years or less.¹⁷

The study found that newcomers (5 years or less since arrival) are:

- *significantly more likely* than longer-term immigrant (more than 5 years since arrival) and Canadian-born women to continue to breastfeed for up to 6 months after their baby is born (either breast milk only or in combination with formula);
- *significantly less likely* than longer-term immigrant (more than 5 years since arrival) and Canadian-born women to *only* feed their babies breast milk at the time they are discharged from the hospital; and
- *significantly less likely* than Canadian-born women to *only* feed their babies breast milk for up to two weeks after their baby is born.¹⁷

Despite the fact that newcomer women in Toronto are less likely to *exclusively* breastfeed their babies in the short-term, international and Canadian research has found that, generally, immigrant mothers are more likely to breastfeed their babies than native-born mothers. Specifically, research among mothers across Canada has shown that immigrant women are more likely to start breastfeeding and more likely to breastfeed exclusively at 4 and 6 months after birth than their Canadian-born counterparts, and that immigrant mothers feed their babies only breast milk for a longer period of time than non-immigrant mothers.^{125,126} However, some national research has found that the likelihood of breastfeeding initiation and exclusive breastfeeding decreases among immigrant women who have lived in Canada for longer periods of time.¹²⁶

Postpartum Depression

After giving birth, women may experience postpartum depression, which can be a moderate or severe form of depression.

➤ *Postpartum depression among newcomers and newcomer sub-populations in Canada*

Canadian research has found that after giving birth, newcomer mothers experience depression symptoms at 3 to 5 times the rate Canadian-born mothers do, and that newcomers are at high risk for postpartum depression.^{127,128} Canadian studies have found that immigrant women face unique and multiple stressors that can make them vulnerable to postpartum depression.¹²⁹

In a study exploring the experiences of 10 newcomer new mothers in Toronto with depression symptoms, participants identified social isolation, physical changes, feeling overwhelmed and financial worries as contributing to their depression.¹³⁰ Because of traumatic experiences they may have experienced before and during the migration process, **refugee women** have been identified as being at particularly high risk for postpartum depression.¹³¹

3.10 - SEXUAL HEALTH

Local literature and service providers and newcomers in focus groups conducted for this report frequently identified sexual health as an important health issue and area of need for newcomers in Toronto. Although aspects of sexual and reproductive health are discussed in sections 3.5 and 3.9, there are many other important sexual health issues, including safe sex practices, birth control and sexually transmitted infections.

➤ *Sexual health issues and needs among newcomer sub-populations in Toronto*

Pointing to the reality that their immigrant clients have real sexual health concerns, one service provider focus group participant noted that "*We see a significant number of immigrants of all classes, including [those without] status, at the sexual health clinics*".

The focus groups and local research also identified several sub-populations of newcomers, as defined by the following factors, as having particular sexual health needs and risks:

Gender

Newcomer women and service providers in the focus groups identified abortion services as an unmet health need for some immigrant women.

Age

At least one service provider focus group participant noted that they see a lot of **newcomer youth** clients looking for information on abortion.

Region of origin

The East African Health Study in Toronto (EAST), which surveyed 456 **East African** community members, 98% of whom were immigrants who had been in Canada an average of 10 years, found that 72% of sexually active respondents reported not using condoms at least once in the past year. Condom use with regular partners was low, with 44% reporting never using condoms and 29% reporting not consistently using condoms. Condom use with casual partners was higher, with 18% reporting not using condoms at least once in the past year.⁵⁷

Immigration status and sexual orientation

Sexual health was identified in the focus groups as an important health issue for **non-status immigrants** and also for **LGBTQ newcomers** to Toronto.

➤ *The provincial and national context*

Analysis of CCHS data for Ontario has found that sexually active newcomers (less than 5 years since arrival) aged 15–49 are more likely to report using a condom at their last sexual encounter than their Canadian-born counterparts. Longer-term immigrant women (10 or more years since arrival), meanwhile, have significantly lower rates of condom use than their male counterparts. However, these results do not account for marital status, awareness of sexually transmitted infections or other factors that might differently impact condom use among newcomers and longer-term immigrants.¹⁰²

As described in section 3.9 (Reproductive, Maternal and Infant Health), female genital mutilation is performed in some countries in Africa, Southeast Asia, the Middle East, and Central and South America, with the most severe form being performed on a high proportion of women from Djibouti, Somalia and Sudan.^{122,123} In addition to difficulties that may arise in labour and childbirth, female genital mutilation is associated with a range of chronic health issues, including urinary tract infections and painful menstruation.¹³¹

3.11 - MENTAL HEALTH AND WELL-BEING

“We come here...our language is different, accent is different, experience of job[s] is different, so when we try to accommodate in this society...as a result, there is a huge mental pressure on the newly migrated people.” (participant – service user focus group)

Mental and emotional health and well-being are central to overall health and are significant health issues for newcomers. As described in section 5 (Social Determinants of Health for Immigrants in Toronto), newcomers face multiple and intersecting stressors and challenges that may affect their mental and emotional health, some which are unique to newcomers and others which are more universal.

Mental Health (overall)

Several recent Canadian studies using data from population-based surveys have found that immigrants, particularly newcomers, have better self-reported mental health status and lower rates of some self-reported mental health problems, including stress, depression and its symptoms, mood disorders, anxiety disorders, suicidal ideation and alcohol dependence.^{18,7,19,39,40} Several of these studies also show that self-reported mental health is worse among immigrants who have lived in Canada for longer periods of time,^{18,7,19,39,40} and that newcomers, who have been followed over time, experience rapid deterioration of their self-reported mental health.^{41,42} An analysis of 2005–2008 CCHS data for Ontario shows that immigrants report worse mental health status than their Canadian-born counterparts, as they were significantly less likely to rate their health “very good” or “excellent”.⁹

Although much of the recent Canadian research comparing the mental health of immigrants with their Canadian-born counterparts has shown a health advantage for immigrants, this advantage varies for different mental health issues and immigrant sub-populations. This variation is described in more detail below.

Participants in the focus groups conducted as for this report and the community-based literature reviewed identified mental and emotional health as priority health issues for newcomers. These sources identified many

sub-populations of newcomers affected by mental health issues, including men, women, children, youth, seniors, refugees, non-status immigrants and LGBTQ newcomers. The specific mental health issues identified included depression, anxiety, trauma, and suicidal thoughts. Stress, which is a risk factor for mental health problems, was frequently discussed by focus group participants and in the literature. Canadian research has documented the mental health impacts of stressors related to settlement and integration, including economic and financial pressures, unemployment, housing, intergenerational conflict and family problems, changing gender roles and experiences of social exclusion and racism.^{132,133,134,128} Findings related to these determinants of health are discussed in more detail in section 5.

➤ ***Mental health issues among newcomer sub-populations in Toronto and Canada***

National and local research as well as participants in the focus groups identified mental health issues that are specific to newcomer sub-populations, as determined by the following factors, who may be at higher risk of mental health problems:

Gender

Several Canadian studies have found that **newcomer women** report higher rates of mental health problems than their male counterparts, including higher levels of psychological distress¹³⁵ and emotional problems.²⁰ This is also true for longer-term immigrants. Focus group participants identified women who had been trafficked and women who had been victims of torture and war as being at high risk for mental health issues.

Meanwhile, a study looking at age at arrival to Canada has found that **immigrant men who immigrated as children (under 12)** are at higher risk for mental health issues, while men who arrived after age 50 enjoy better mental health. This trend was not found for immigrant women.⁴⁰ Focus group participants suggested that some newcomer men are more likely to delay seeking help for a mental health problem until it becomes very serious.

Sexual orientation

Newcomers and service providers in the focus groups identified **LGBTQ newcomers**, and particularly **LGBTQ youth**, as facing substantial mental health issues. As one service provider described, “*depression, anxiety, issues around trans, like being victims of violence and trauma, are common. Most of them come for counselling but [there are] not enough resources to support them.*”

Age

- One Canadian research study has found that mental health problems are most common among **middle-aged immigrants** and less so among immigrant youth and seniors.⁴⁰
- Newcomers and service providers in the focus groups as well as the local and community-based research reviewed for this report frequently identified **newcomer children and youth** as having unique mental health, social and emotional challenges. These relate to pre-migration experiences and to the experience of settling in Canada, including adjusting to school, intergenerational pressures and increased family responsibilities.
- Research on the mental health of **Southeast Asian refugee youth** has found that refugee children who experienced trauma and stress prior to migration, including natural and human-made disasters, are at higher risk for mental health issues, including depression, anxiety, anger and psychosomatic symptoms.²¹
- Key findings from research on the mental health of **immigrant children from Hong Kong, Mainland China** and the **Philippines** living in 6 Canadian cities include that Mainland Chinese immigrant children experience a lower risk of mental health problems than Hong Kong Chinese and Filipino children; that family separation during the migration process is more common in this group compared to the latter two groups; that children living in Toronto have worse mental health than children living in the other 5

Canadian cities; and that Toronto may be less welcoming than other urban centres in terms of services, supports and policies offered to immigrants.²²

- **Roma children and youth** in Toronto were identified as a group with significant mental and emotional health challenges and needs by a service provider in one of the focus groups.
- Several national studies on mental health have identified a high level of resilience among **immigrant and refugee children and youth**, showing that despite living in poverty they experience better mental health and fewer behavioural issues than children and youth born in Canada.^{136,137,138}
- Focus groups conducted for this report and community-based literature reviewed identified **newcomer seniors** as having significant mental health needs, particularly related to isolation and financial insecurity.^{139,78} A national study on the mental health of **Chinese** seniors found that Chinese seniors experience poorer mental health than Canadian-born seniors, with senior Chinese immigrant women reporting poorer mental health than their male counterparts.¹⁴⁰

Income

- Canadian research has found that **newcomers living with low incomes** are more likely to report emotional problems and declines in health status than higher income newcomers.^{41,20}
- Research on Sudanese immigrants and refugees in Canada has found that **Sudanese newcomers experiencing economic hardship** were much more likely to experience symptoms of mental distress than those who were not experiencing financial hardship.¹⁴¹

Ethno-racial identity and region of origin

- Some Canadian research has shown that some **racialized immigrant groups** are at higher risk for psychological distress and deteriorating mental health status than non-racialized immigrants.^{41,135} Conversely, another study has found that immigrants from Asian and Black ethno-racial groups experience fewer mental health problems than White immigrants.⁴⁰
- A study looking at region of origin found that **immigrants from Central and South America, Africa and the Middle East** experience higher levels of stress, which is a risk factor for mental and physical health problems, than immigrants from other regions.²⁰ The same study found that women from Central and South America were more likely to have emotional problems.

Immigration category

- The focus groups and literature review identified **refugees** as being at particularly high risk for mental health issues due to traumatic experiences from before migration, such as war, torture and other trauma; the stress of being a **refugee claimant** in Canada, including the application process, living with precarious status and limited access to services, and family separation; as well as settlement-related stresses faced by all newcomers.
- Canadian research has demonstrated that refugees experience greater mental health risks and have higher rates of mental health issues, including high levels of stress and deteriorating mental health status.^{42,20} However, findings from a study among **Southeast Asian refugees** were less clear cut, finding that this group experienced a risk period for mental health issues such as depression and anxiety for a few years after arrival, but that mental health status improved over time.⁴⁴
- Newcomers and service providers in the focus groups identified **immigrants without recognized status** as being at higher risk for mental health issues and for high levels of stress due to their precarious status and limited access to health and other services.

In addition, sub-populations of immigrants have been identified as being at higher risk for specific mental health issues. These are outlined below.

Canadian research is lacking with respect to some mental health and developmental issues affecting immigrants and immigrant sub-populations. Local stakeholders raised the following topics:

- International research has found **psychosis** to be a common psychiatric disorder among immigrant populations. European studies have found that immigrants, particularly of African-Caribbean origin, are at an increased risk for **schizophrenia and other psychoses**, but no large-scale study has been conducted in Canada.
- Some international research has found higher rates of **autism** among children born to immigrant mothers, and there is some evidence that autism may be more common among immigrants from certain ethno-racial groups and countries of origin, including children of Somali origin. However, limited evidence exists on ethno-racial differences and autism, and Canadian research is lacking in this area.

Depression and Mood Disorders

Canadian research on depression among immigrants indicates that rates of depression are significantly lower among newcomers than in the Canadian-born population.^{18,45} One cross-sectional study found that depression rates are lower among newcomers, even after adjusting for demographic, socio-economic and other factors, including income, education, proficiency in English or French, and employment status. However, this research found that rates of depression among longer-term immigrants who have been in Canada for 10 years or more are similar to rates among Canadian-born residents.¹⁸ Another Canadian study found that rates of bipolar disorder (over a person's lifetime) are significantly lower among immigrants compared with Canadian-born residents.¹⁴² Despite research findings, newcomers in the focus groups conducted for this report identified depression as a problem in the community.

“There is a high rate of depression among newcomers. It is hard to function with depression but they have to take care of others.” (participant – service provider focus group)

➤ *Newcomer Sub-populations in Toronto and Canada with a greater risk of depression and mood disorders*

Gender

- **Immigrant women** are at higher risk for postpartum depression than their Canadian-born counterparts, according to some research findings, as discussed in section 3.9.
- A study examining immigration, gender, income and depression in Canadian cities found that **low-income newcomer women** were four times as likely to experience depression compared with their male counterparts in the study.⁴⁵ The same study showed that low-income immigrant women who had been in Canada longer (10 or more years since arrival) had even higher rates of depression than low-income newcomer women.⁴⁵
- A study following 43 Chinese immigrant women in Toronto over 6 months found that **Chinese immigrant women with low incomes** were more likely to experience symptoms of psychological distress than those with higher incomes.¹³³

Age

- A study looking at age upon arrival to Canada found that **immigrants who arrive as children and youth** under age 18 face a higher risk of depression than newcomers who arrive at an older age.³⁹
- A local qualitative research study found surprisingly high levels of depression among **newcomer seniors**.¹³⁹

- A national study on the mental health of **Chinese seniors** found that they experience much higher rates of depression symptoms than seniors in the general Canadian population; low-income Chinese immigrant seniors are at highest risk for depression.¹⁴³

Region of origin

- The finding of higher depression rates among longer-term immigrants was not seen in several other studies of immigrant sub-populations. In one study involving **Ethiopian immigrants and refugees** in Toronto, participants experienced a low risk of depression upon arrival, which increased a few years after arrival and then reached its maximum and levelled off at approximately 15 years after immigration to Canada¹³².
- Similarly, a study of **Southeast Asian refugees** in Canada found that this group experiences a period of high risk for depression shortly after arrival that then decreases over time and remains fairly stable.⁴⁴

Post-Traumatic Stress Disorder (PTSD)

National and international research suggests that newcomers, and particularly refugees, are at higher risk for post-traumatic stress disorder (PTSD) than longer-term immigrants and the Canadian-born population.

Several Canadian and local studies have looked at PTSD among specific immigrant sub-populations, mostly refugees:

- A study of **Tamil refugees** in Toronto found an overall PTSD prevalence of 12% among study participants, a substantially higher rate than the estimated 1% seen in the general Canadian population, but one that is comparable to rates seen in other refugee populations.¹⁴⁴
- Research on **Southeast Asian refugees** in Canada have found that although these refugees experience improvements in mental health over time, PTSD rates tend to remain stable and do not decline.⁴⁴
- A study involving **Kosovar and Czech Roma refugees** in Hamilton, Ontario found that 22% of Kosovar participants had experienced PTSD, but none of the Roma participants had.¹⁴⁵ A study of the impact of the 1999 Kosovo conflict on the mental health of newcomer Serbian children and youth in the Toronto area found that a high proportion of children and youth in the study (26%) met the criteria for a PTSD diagnosis.¹⁴⁶
- While studies of **Tamil refugees** in Toronto⁴⁴ and **Kosovar refugees** in Hamilton¹⁴⁵ found that PTSD rates were higher among women than men, this gender difference was not seen among **Ethiopian immigrants** in Toronto.¹³²
- A Toronto study of **immigrants coming from war zones** found that participants reported high levels of post-traumatic stress symptoms shortly after their exposure to past traumatic events, but all participants reported improved health and psychological well-being at the time of the study.¹⁴⁷ Results were discussed in terms of the processes of positive adaptation and growth that may occur among immigrants who have been exposed to war-related trauma.

Suicide

Some Canadian research has looked at suicide among immigrants and immigrant sub-populations. One study found that suicide rates among immigrants are approximately half as high as in the Canadian-born population. This study found that although suicide rates are higher among immigrant men than their female counterparts, the difference between male and female suicide rates is smaller for immigrants than for the Canadian-born population. In addition, suicide rates among immigrants increase with age, with the highest rates seen among older immigrants aged 75 or older for men, and 55 or older for women.¹⁴⁸ This suggests that immigrant seniors may be at higher risk for suicide. An older study that examined suicide rates among immigrants from 25 different

countries found evidence that suicide rates among immigrants became more similar to suicide rates of the Canadian-born population over time; among immigrants from countries with lower suicide rates than Canada, rates increased to rates closer to those of Canada, while among immigrants from countries with high rates, suicide rates decreased.¹⁴⁹

3.12 - ADDICTIONS

Addictions are dependencies on substances and activities, including alcohol, other substances and gambling. In addition to the physical health impacts of alcohol and other substance use, which are described in section 3.3 (Risk Factors for Chronic Disease and Poor Health), addictions can have negative impacts on a person's mental health and social well-being.

➤ *Addictions among newcomers and newcomer sub-populations in Canada, Ontario and Toronto*

National research on alcohol dependence among immigrants has found that rates of alcohol dependence are significantly lower among newcomers than among Canadian-born residents, even after adjusting for demographic and socio-economic factors, including income, education, proficiency in English or French and employment status. This research has also found that rates of alcohol dependence are lower among longer-term immigrants (10 to 30 years since arrival) compared with Canadian-born residents, but that alcohol dependence rates among immigrants who have been in Canada for 30 years or more are similar to rates among Canadian-born residents.¹⁸ Research on Ontario youth in grades 7–12 has also found that immigrant youth are significantly less likely to report having a hazardous drinking problem or a drug use problem than Canadian-born youth.⁶⁹

➤ *Newcomer sub-populations in Toronto and Canada at risk of addictions*

Age

- In several local research reports, **newcomer youth** in Toronto are identified as having substance abuse challenges.^{150,64,151}
- Service providers and newcomers in focus groups conducted for this report identified addiction as an important issue among newcomer youth, including addictions to illicit drugs and prescription drugs for youth who have been prescribed mental health medications for issues such as PTSD. An important issue related to newcomer youth addictions is the lack of awareness or acknowledgement of these addictions among parents.
- In focus groups with **Afghan, Pakistani and Russian immigrants** in the GTA, participants identified substance use and abuse, particularly marijuana use, as an issue of concern for immigrant and refugee youth in all of these communities.⁷²
- In focus groups with Russian immigrants in Toronto, youth identified alcohol and marijuana use and addictions as serious issues among **Russian immigrant youth**.⁷²

Ethno-racial identity and place of origin

- **Somali men and women** were identified in focus groups conducted for this report as being at risk for addictions. Specifically, addiction to khat^{xix} among Somali men, and addiction to shisha (flavoured tobacco) among Somali women were identified as issues.
- In focus groups with **Pakistani immigrants** in Toronto, community members identified addictions to alcohol, cigarettes and prescription drugs as serious issues.⁷²

^{xix} Khat are leaves from the shrub *catha edulis* which contains Cathinone and is highly addictive.

- In focus groups with **Russian immigrants** in Toronto, community members identified computer/internet use and gaming as serious addiction issues in the Russian community, particularly among Russian immigrant youth and men.⁷²
- In focus groups with **Afghan immigrants** in Toronto, community members identified substance use and addictions, including addictions to cigarettes, hashish and gambling, particularly among older community members, as serious issues in the Afghan community.⁷²

3.13 - ORAL HEALTH

Oral health is an important part of overall health and well-being. Poor oral health can include cavities, gum disease, and oral pain and discomfort. Research has also shown that poor oral health may be linked to diabetes, respiratory disease among seniors, heart disease and premature and low birth weight babies.¹⁵² Immigrants who lacked access to dental health services prior to arriving to Canada may have considerable oral health needs.¹⁵³ Newcomers may also have greater oral health needs due to barriers to dental hygiene care in Canada because of lack of insurance, low income and having limited awareness of available oral health services and the need for oral health care.¹⁵⁴

➤ *Oral health among newcomers and newcomer sub-populations in Toronto*

Although limited research exists on the oral health status of immigrants in Toronto and Canada, oral health was frequently identified as an important area of need for Toronto immigrants and sub-populations in focus groups conducted for this report and in the literature reviewed. Community members and service providers in the focus groups identified poor and deteriorating dental health as a significant concern for Toronto newcomers.

“[Dental] outreach and screening programs have identified many dental issues [among newcomers] – some clients have cavities, pain, swelling or some have not had any dental care at all. Others have had previous treatment that required follow-up care.” (participant – service provider focus group)

Two older studies examined oral health among youth in Toronto. A study of disadvantaged youth in the North York area of Toronto, including immigrant youth, found that disadvantaged youth had high rates of oral disease, pain, gum disease and tooth decay, and had urgent needs for oral health care.²³ A study comparing immigrant and Canadian-born youth aged 13–14, also in North York, found that immigrant youth had worse oral health and worse access to dental care than their Canadian-born counterparts. This study also found that newcomer youth, particularly those who had arrived within the previous 2 years, had significantly worse oral health than longer-term immigrant youth who had been in Canada 6 years or more.¹⁵⁵ A study on early childhood cavities among children of Portuguese-speaking immigrants in Toronto found that a lack of dental care and lack of dental insurance were the strongest predictors of caries.¹⁵⁶ This relationship between lack of dental care, lack of dental insurance and poor oral health is likely relevant to other newcomer groups as well. Focus groups in Toronto with government-assisted refugees from Afghanistan identified dental problems as an important health issue in this community.¹⁵⁷

3.14 - FAMILY AND INTIMATE PARTNER VIOLENCE

Family and intimate partner violence are serious social and health issues faced by some newcomers. Family and intimate partner violence have a range of health impacts, including physical injuries, chronic health conditions, mental health issues and symptoms, and increased use of health services.¹⁵⁸ Family and intimate partner violence

can include physical, sexual, emotional and financial abuse and can impact immigrant women, children and seniors. While immigrant and Canadian-born women experiencing violence face many of the same issues, including the process of recognizing and acknowledging abuse, and feelings of fear and shame, immigrant women also face some unique vulnerabilities, including linguistic, informational and social barriers.¹⁵⁸

Service providers and newcomers in the focus groups conducted for this report as well as several local research reports identified family violence as an important health issue in Toronto newcomer communities. Focus group participants and local research pinpointed settlement-related stress, including the challenges of integration, changing gender roles, financial pressures, and mental and emotional challenges, as contributing to increased violence against intimate partners and elder family members. Factors impacting immigrants' vulnerability to family and intimate partner violence as well as the likelihood of reporting violence and seeking help are discussed further in section 5.11.

Family and intimate partner violence are difficult to quantify in the general population. Similarly, only estimates are possible for rates among newcomers. Due to the sensitivity of the topic, reported rates of family violence may underestimate its prevalence. Research in Canada has found that reported rates of family and intimate partner violence are lower among immigrant women, particularly newcomer women, compared with their Canadian-born counterparts,^{159,160} but also that reports of violence increase among immigrant women who have lived in Canada for a longer time.¹⁶¹ Service providers and newcomers in the focus groups supported this finding, commenting that although intimate partner violence is often an issue upon arrival or shortly after arrival in Canada, immigrant women will often begin to report it only after living in Canada for 5 to 10 years.

3.15 - WORK-RELATED INJURIES

Unsafe working conditions, including the physical conditions of the workplace, tasks being done at work, work pace and working hours, can lead to work-related injuries. Newcomers' likelihood of working in precarious jobs may put them at higher risk for work-related injuries. Working conditions as a determinant of health are discussed further in section 5.2.

➤ *Work-related injuries among newcomers and newcomer sub-populations in Toronto and Canada*

Newcomer men in the focus groups conducted for this report identified work-related injuries as an important issue for them. Local research in Toronto's Black Creek neighbourhood has also identified workplace injuries as one of the health issues facing low-income racialized residents, many of whom are newcomers.¹⁶²

A study on self-reported work-related injuries among immigrant workers in Canada found that newcomer men (less than 5 years since arrival) are twice as likely to report having a workplace injury that required medical care compared with Canadian-born men in the workforce. Female immigrant workers, however, have not been found to be at higher risk for workplace injuries than Canadian-born women workers.¹⁶³ Temporary foreign workers, including those working in construction and on farms, may be at higher risk for workplace injuries due to their working conditions, which may not adequately conform to health and safety precautions, and because their precarious status may make it difficult for them to raise concerns or refuse unsafe work.¹⁶⁴ Immigrant women, refugees, refugee claimants and non-status immigrants are also more likely to work in precarious jobs with poor working conditions than other immigrants¹⁶⁵ and may therefore be at higher risk for workplace injuries. Service providers and newcomers in the focus groups also identified non-status men as being at high risk for work-related injuries.

3.16 - ENVIRONMENTAL HEALTH

Environmental health hazards such as pollution, contaminants and other dangerous substances in the air, water, food, soil and buildings people live and work in can lead to many health problems, including cancer, birth defects, respiratory disease and gastrointestinal issues. Newcomers may be more likely to be exposed to environmental health risks in their neighbourhoods, homes and workplaces¹⁶⁶ because of their increased likelihood of having low incomes, living in poor quality housing and working in precarious jobs. However, little Canadian research has looked at environmental exposure and health impacts among immigrants.

➤ *Air pollution and asthma among immigrants in Canada*

A Vancouver-based study that examined relationships between neighbourhood air pollution, socio-economic factors and asthma rates among immigrants found that immigrants have lower asthma rates than Canadian-born residents, and that asthma rates are not associated with higher levels of neighbourhood air pollution.⁹³ However, Canadian research on asthma among immigrants has found that more longer-term immigrant adults and children have higher rates of asthma than their newcomer counterparts, suggesting that environmental factors and length of time exposed to these factors both play a role in determining asthma prevalence.^{92,94}

➤ *Lead exposure and levels of lead in blood among newcomers and newcomer sub-populations*

Exposure to lead is another important environmental health concern. Lead exposure has been associated with several health effects, including a negative impact on intellectual functioning and behaviour, cardiovascular disease and all-cause mortality.¹⁶⁷ People can be exposed to lead through many sources, including old lead paint, imported consumer products and some traditional medicines.^{168,169} Those at risk of nutritional deficiencies are more susceptible to uptake and toxicity of lead.^{170,171} The populations that are most vulnerable to the effects of lead include fetuses, children and residents with a low income.¹⁷⁰

Although blood lead levels have decreased in the Canadian population over the past 30 years,¹⁷² some vulnerable populations continue to be at risk for elevated blood lead levels. It has recently been recognized that newcomers may be one of the populations at risk.¹⁶⁸ Toronto Public Health conducted a review of the literature in order to explore this issue and the potential relevance to newcomers in the City of Toronto. The next paragraph summarizes the conclusions from that review.

Although no research has been conducted on lead levels among newcomers in Canada, the Canadian Health Measures Survey found that immigrants have higher blood lead levels on average than Canadian-born residents.¹⁷² Research from the U.S. has found elevated blood lead levels among newcomers in that country, including immigrant children, refugee children, internationally adopted children and pregnant immigrant women.^{173,174,175} Studies on refugee children suggest that immigrant populations from Central and South America, the Middle East, Africa and South Asia may be at higher risk for elevated blood lead levels compared to U.S. children or those from other regions.¹⁷⁶ Some studies have also found that blood lead levels increase among some newcomers after arrival in the U.S., suggesting new exposure to lead or changes in physiological factors that increase uptake of lead (e.g., nutritional deficiencies).^{173,177} These findings suggest that some newcomers, including refugee children and women of childbearing age in Toronto may also be at higher risk for elevated blood lead levels compared to other newcomers.

Summary: Key Health Status Findings for Newcomers

Self-Reported Health Status:

- Similar or better self-reported health compared to Canadian-born residents
- Decline over time in both the short-term and long-term, with longer-term immigrants having worse self-reported health than Canadian-born residents
- Vulnerable sub-populations include women, older adults, residents with low income, and refugees

Risk Factors for Chronic Disease:

- Less likely than Canadian-born residents to be overweight or obese or to drink heavily
- Among females, less likely to smoke than Canadian-born residents
- Possible increase in risk factors over time, with longer-term immigrants more likely than newcomers to be overweight, drink, or smoke
- Less likely than Canadian-born residents to be physically active in leisure-time
- Similar rates of high blood pressure and similar likelihood of eating sufficient amounts of vegetables and fruit

Chronic Diseases:

- Similar or lower likelihood of having one or more chronic diseases compared to Canadian-born residents
- Lower incidence and mortality rates of most cancers compared to Canadian-born residents; higher risk for cervical, liver, and nasopharyngeal cancers
- Lower rates of heart disease, stroke, and some respiratory diseases compared to Canadian-born residents
- Increasing cancer and heart disease rates with length of stay in Canada
- Particular risk for diabetes and heart disease among newcomers from some regions, particularly South Asia and the Caribbean

Communicable Diseases:

- Higher rates of communicable diseases than Canadian-born residents, including TB and HIV
- Increased risk for newcomers from endemic countries
- Other vulnerable sub-populations include women for HIV, and refugees for TB

Reproductive, Maternal, and Infant Health:

- Less likely to have a preterm birth than Canadian-born residents, but more likely to have a low-birth weight baby
- Women likely to breastfeed for longer periods of time compared to Canadian-born women, but less likely to exclusively breastfeed
- More likely to experience post-partum depression than Canadian-born women

Mental Health and Addictions:

- Better self-reported mental health status than Canadian-born residents and lower rates of stress, depression, and anxiety
- Declining self-reported mental health with duration of stay in Canada
- Sub-populations vulnerable for mental health issues include women, LGBTQ newcomers, some racialized groups, refugees, immigrants without recognized status, children and youth, and seniors

Oral Health:

- Oral health a significant concern for Toronto newcomers
- Newcomer youth have higher rates of oral pain, tooth decay, and gum disease compared to Canadian-born youth

Other areas of concern for newcomers:

- Family and intimate partner violence
- Work-related injuries
- Environmental health



Health care, settlement and other social services play a vital role in sustaining and promoting the health and well-being of newcomers to Toronto, especially during the early settlement period.

Above: A Toronto teen receives free dental care at a Toronto Public Health dental clinic.

4. ACCESS TO HEALTH CARE AND SERVICES

Health care, settlement and other social services play a vital role in sustaining and promoting the health and well-being of newcomers to Toronto, especially during the early settlement period. This section describes access to health services for newcomers in Toronto and touches on some other important services newcomers need. Key barriers to accessing services are also highlighted.

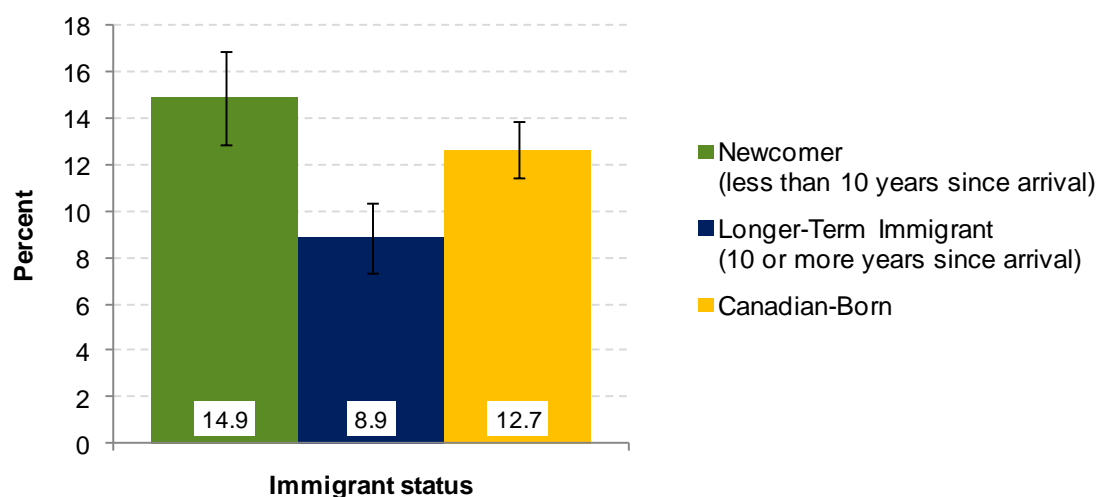
4.1 - PRIMARY CARE

Primary health care is an essential part of health care for everyone. Primary care provides a first point of entry into the health care system, as well as ensuring continuity of care. Good primary care is generally delivered by a stable health care provider, such as a family doctor or nurse practitioner, who knows their patients' medical history and with whom patients feel comfortable. Primary care usually includes recommended preventive health care, including regular physical check-ups, vaccinations and screening for diseases. Primary health care providers also help people access the specialist care they need. For newcomers, culturally and linguistically appropriate primary care is important.

➤ *Having a regular doctor among newcomers in Toronto*

An analysis of CCHS data from Toronto on having a regular medical doctor was conducted for this report. The analysis found that, overall, newcomers in Toronto are less likely than longer-term immigrants to report having a regular doctor. Longer-term immigrants are more likely than Canadian-born residents to have a regular doctor, whereas there is no significant difference between newcomers and Canadian-born residents (see Figure 4.1).

Figure 4.1 Not Having a Regular Doctor among Newcomers, Longer-Term Immigrants, and Canadian-born residents, Toronto, 2001 to 2008 Combined[†]



Error bars denote 95% confidence intervals

[†] - Data age standardized to the 1991 Canadian Population

Data Source: Canadian Community Health Survey, 2001, 2003, 2005, 2007 and 2008. Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario Ministry of Health and Long-Term Care.

➤ *Access to primary care among immigrants in Toronto*

Although the analysis suggests that the majority of newcomers have access to a regular doctor, Toronto stakeholders in the focus groups and the local literature identified accessibility of primary health care as an important issue.^{178,64,78} Service providers and newcomers in the focus groups reported that many newcomers in Toronto, even those who have been here for several years, do not have a family doctor. Without a regular doctor, they will often rely on walk-in clinics, which may negatively affect the continuity of their care.

“One of my friends had gone through a lot of problems because the walk-in clinic didn’t have the information about the child for an emergency purpose. The child was bleeding and because the walk-in clinic hadn’t got any records of it and the child suffered a lot.” (participant – service user focus group)

Participants in the focus groups also reported that many Toronto newcomers are concerned about the quality of primary care they receive. Newcomer focus group participants described long wait times for services (particularly at walk-in clinics); being rushed in medical appointments; not getting adequate explanations about medical procedures; doctors being quick to prescribe medication; and experiencing a lack of empathy from services providers about their particular circumstances as newcomers.

Local literature as well as service providers and service users in the focus groups identified a need for better access to health services that are culturally and linguistically appropriate.^{178,64,78} This includes offering culturally competent services; being client-centred and holistic; acknowledging and incorporating traditional and alternative medicine; delivering services in various languages; and using tools and approaches that are culturally specific.

As one service provider participating in the focus groups stated, *“Because of fear and lack of comfort as well as language reasons, newcomers often only want to see health care providers from their own ethnic group. Also many newcomer women are concerned about seeing [male] health care providers.”* Other focus group participants echoed this preference by many newcomer women to see female health care providers, and they noted that this option is not always available. Participants also noted that many providers use inaccessible language and that there is a need for more and better interpretation services.

➤ *Access to primary care among newcomer sub-populations in Toronto*

Local CCHS data as well as the literature reviewed for this report have identified some differences in access to primary care among newcomers. These differences point to sub-populations, as determined by the following factors, who may be at higher risk for poor primary care access now or in the future:

Gender

The analysis of CCHS data finds **newcomers men** are less likely to have a regular doctor than their female counterparts. This is also true for longer-term immigrants.

A provincial study that analyzed data from the Ontario Primary Care Access Survey found that **newcomer women** report more difficulties accessing care from a family doctor to monitor health problems than longer-term immigrant and Canadian-born women.¹⁷⁹

Age

The analysis of CCHS data shows that among newcomers, **younger residents** aged 15–39 are less likely to have a regular doctor than their older (aged 40–64) counterparts. This is also true for longer-term immigrants.

Meanwhile, local research has identified urgent gaps in primary health care and culturally competent services for **older immigrant women**.⁷⁸

Ethno-racial identity and region of origin

- The analysis of CCHS data for the Greater Toronto Area (GTA)^{xx} by ethno-racial identity finds that among newcomers in the GTA, **South Asian, West Asian and Arab residents** are more likely to have a regular doctor than other ethno-racial groups. In addition, among **White and Black ethno-racial groups**, newcomers are less likely to have a regular doctor than their longer-term immigrant and Canadian-born counterparts.
- Research on newcomers in Ontario (less than 15 years since arrival) has found that **Southeast Asian and African newcomers** as well as newcomer women from the **Eastern Mediterranean** visit doctors more often than Canadian-born residents and longer-term immigrants (15 or more years since arrival).¹⁸⁰
- The East African Health Study in Toronto (EAST), which surveyed 456 residents from five different **East African communities**, 98% of whom were immigrants who had been in Canada an average of 10 years, found that the majority of survey participants reported having a family doctor (87%) and having had a physical check-up within the past 3 years (96%). However, fewer Ugandans (70%) had a family doctor compared with other East African immigrants in the study.⁵⁷

➤ *The provincial and national context*

National and provincial findings on access to primary care are mixed, with some research showing poorer access to care among newcomers and some showing no difference:

- *Less access:* Two provincial studies that analyzed data from the Ontario Primary Care Access Survey found that newcomers are less likely to have a primary care doctor than longer-term immigrants and Canadian-born residents.^{179,4} One of these studies showed that newcomers are less likely than longer-term immigrants and Canadian-born residents to be satisfied with their experience of getting an appointment for a regular check-up; more likely to have difficulties getting an appointment with a family doctor for an urgent, non-emergency health problem; and more likely to report having unmet health care needs.¹⁷⁹
- *Similar access:* Another study analyzed Ontario health system data and showed that newcomers had similar numbers of primary care visits to family doctors and similar levels of continuity of primary care, compared with Canadian-born residents and longer-term immigrants.³
- *Similar or greater access:* An analysis of 2005–2008 CCHS data for Ontario found that immigrants are significantly more likely than Canadian-born residents to have had contact with medical professionals in the past year, but that immigrants and Canadian-born residents report similar rates of having a regular doctor.⁹

Canadian research suggests that, overall, immigrants, particularly newcomers, use health services less than their Canadian-born counterparts:

- One national study examining health care use among immigrants in Ontario, Quebec and British Columbia who had arrived between 1985 and 2000 showed that, overall, **newcomers** (less than 15 years since arrival) had 5–24% fewer doctor visits than their Canadian-born and longer-term immigrant (15 or more years since arrival) counterparts.¹⁸⁰ The same study found that newcomers have high rates of doctor visits when they first arrive in Canada, but that this rate decreases over the next few years before increasing again several years after arrival.¹⁸⁰ The initial higher rates of doctor visits soon after arrival to

^{xx} Data from the GTA were used in this case because the sample size for the City of Toronto was too small to allow for an analysis of differences among different ethno-racial groups.

Canada may be due in part to a build-up of health care need prior to migration or while waiting for health care eligibility (e.g., due to the 3-month waiting period for health care coverage in Ontario and Quebec).

- The study mentioned above also found that in Ontario and B.C. **refugees granted status** in Canada visit doctors more often than the rest of the population. In Ontario only, female refugees granted status abroad and female family class immigrants visit doctors more often than other Canadians.¹⁸⁰
- A second Canadian study has shown that **immigrants** are slightly more likely than Canadian-born residents to report visiting a family doctor recently, but that after adjusting for socio-demographic factors, there are no significant differences in recent primary care doctor visits between these two groups.¹⁸¹
- A third Canadian study found that **newcomers (five years or less since arrival)** have lower rates of family doctor use than Canadian-born residents, but that rates increase among longer-term immigrants (6–9 years since arrival) to match those of Canadian-born residents.⁶

The findings on access to primary care for newcomers in Toronto are consistent with the mixed findings at the provincial and national levels. However, national and provincial research does not support the finding that longer-term immigrants are more likely to have a family doctor than Canadian-born residents.

4.2 - PREVENTIVE CARE

“The key to unlocking the potential of primary prevention is to better link communities to primary health care and public health services.”¹⁸²

Preventive health care helps to ensure that some diseases are avoided and others are detected and treated early. Preventive health care includes screening for chronic diseases, such as cervical and breast cancer screening, as well as immunizations against communicable diseases, such as influenza.

➤ ***Preventive care among newcomers and newcomer sub-populations in Toronto and Ontario***

Some provincial and local research has examined immigrants’ access to preventive health care overall. One provincial study used Ontario health system data to analyze the use of a range of preventive health services, including influenza vaccinations, blood pressure checks, breast examinations, mammograms, cervical smear tests and dental care. This study found that newcomers, particularly older adults (women aged 50 and older and men aged 70 and older), have low rates of preventive health care.³ In contrast, another study found that more recent immigrants (less than 15 years since arrival) in Ontario have similar rates of annual check-ups and immunizations compared with their Canadian-born and longer-term immigrant (15 or more years since arrival) counterparts.¹⁸⁰

Service providers and newcomers in the focus groups identified a need to improve newcomer access to preventive health care and screening, and to promote and offer free mobile screening clinics for adults in community settings, such as during lunch and dinner breaks at workplaces where there are many newcomer employees.

Some research has explored relationships between doctor characteristics and cervical and breast cancer screening rates among Tamil, Caribbean, Chinese and Vietnamese immigrant women in Toronto and Canada. Findings from this research suggest that male and ethnically-identified doctors with relatively high numbers of newcomer women patients may be less likely to perform Pap testing on newcomer women and to refer them for mammograms. However, the studies could not determine whether this trend was due to services not being offered by doctors, or services being refused by newcomer women.^{183,184}

➤ ***Access to preventive care for newcomer sub-populations in Toronto***

Local and provincial research has identified some sub-populations of newcomers, as determined by the following factors, who may have worse access to preventive care:

Gender and Age

Local research that included focus groups with **older immigrant women** in Toronto has identified important gaps in access to preventive and diagnostic health services for these women, including screening and testing for breast and gynecological cancers.⁷⁸

And, as outlined above, provincial research has shown that **older immigrants** (women aged 50 and older and men aged 70 and older) have low rates of preventive health care.³

Immigration Status

In the focus groups with service providers and newcomers, **non-status newcomers** were identified as being at particularly high risk for poor access to preventive care.

Similarly, a survey of **female refugees** from Kosovo in Hamilton showed that female refugees have low rates of preventive care, including mammograms and Pap tests, and that this may be related to the fact that they have little or no history of the kind of preventive care that is routine in countries like Canada.¹⁴⁵

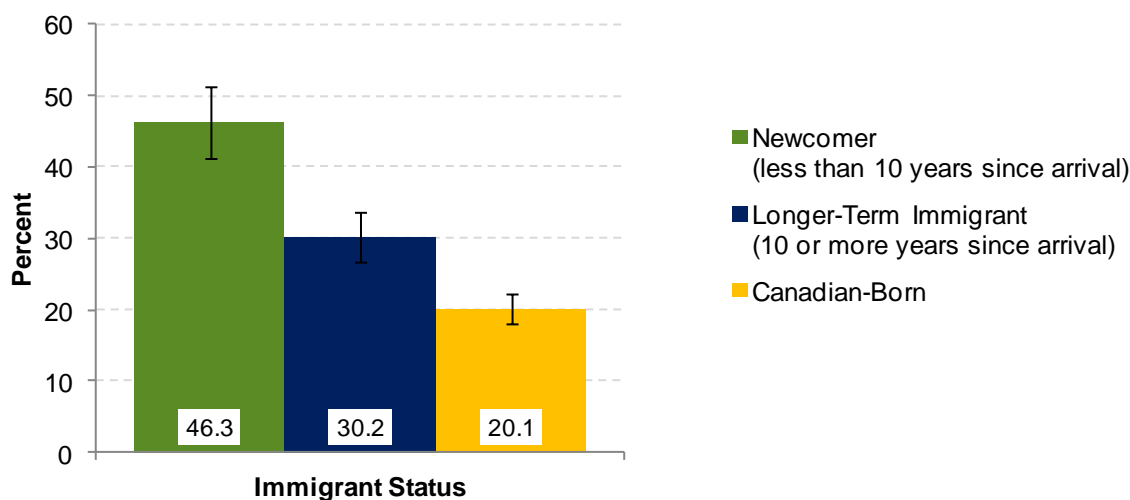
➤ ***Cervical cancer screening among newcomer women in Toronto***

The Papanicolaou (Pap) test, also known as a cervical smear, is a screening test used to detect possible signs of cancer in the cervix. Cervical cancer is 90% preventable by having regular Pap tests. Pap tests are recommended for women who are 18 or older and those who are sexually active. Women should continue having Pap tests every year until they have three negative tests in a row, at which point the test can be done every two or three years until the age of at least 70.

An analysis of CCHS data from Toronto for women aged 18–64 on recent Pap tests (defined as having had a Pap test within the past 3 years) was conducted for this report. The analysis found that, overall, newcomer women are significantly less likely than longer-term immigrants and Canadian-born women in Toronto to have had a Pap test within the past 3 years. Longer-term immigrants are also less likely to have had a recent Pap test than Canadian-born women (see Figure 4.2).

These findings are consistent with those from a Toronto study that analyzed Ontario health system data among women in Toronto aged 18–66. This study found that women, over 80% of whom were newcomers to Canada, who had registered for Ontario health insurance (OHIP) in the previous 10 years were much less likely than Canadian-born and longer-term immigrant women to have had a Pap test in the previous 3 years. Specifically, 36.9% of recent registrants had had a Pap test in the previous 3 years, compared with 60.9% of non-recent registrants.¹⁸⁵

Figure 4.2 No Recent Pap Test among Newcomer, Longer-Term Immigrant and Canadian-Born Women Aged 18 to 64, Toronto, 2001 to 2008 Combined[†]



Error bars denote 95% confidence intervals

[†] - Data age standardized to the 1991 Canadian Population

Data Source: Canadian Community Health Survey, 2001, 2003, 2005, 2007 and 2008. Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario Ministry of Health and Long-Term Care.

➤ *Access to cervical cancer screening among newcomer sub-populations in Toronto*

The analysis of CCHS data as well as the literature review conducted for this report have identified some differences in access to cervical cancer screening among newcomers. These differences point to newcomer sub-populations, based on the following factors, who may be at higher risk for poor access to cervical cancer screening now or in the future:

Age

An analysis of provincial health system data showed that the lowest rates of cervical cancer screening are among **older recent registrant women** (aged 50–69) living in low-income areas.¹⁸⁵

Ethno-racial identity and region of origin

- The analysis of CCHS data for the GTA^{xxi} by region of origin finds that **newcomers from Asia and Europe** (excluding the U.K.) are less likely to have had a recent Pap test than their counterparts from the U.S.A., U.K., and Oceania.
- The analysis of CCHS data for the GTA by ethno-racial identity finds that longer-term immigrant women in the GTA who are of South Asian, West Asian and Arab as well as East and Southeast Asian ethno-racial background are less likely than women of other ethno-racial backgrounds to have had a recent Pap test.
- The East African Health Study in Toronto (EAST), which surveyed 230 **East African immigrant adult women**, most of whom were immigrants, found that 30% had not had a Pap test in the previous 3 years, with 24% of women reporting never having had a Pap test.⁵⁷
- A survey of **female refugees from Kosovo** in Hamilton indicated that only 34% of female Kosovo refugees had ever received a Pap test.¹⁴⁵

^{xxi} Data from the GTA were used in this case because the sample size for the City of Toronto was too small to allow for an analysis of differences among different ethno-racial groups.

➤ ***The provincial and national context***

Provincial research on access to cervical cancer screening has found that newcomer women have worse access to cervical cancer screening than longer-term immigrant and Canadian-born women.^{186,187} An analysis of National Population Health Survey data in Ontario found that 22% of newcomer women reported never having had a Pap test, compared with 12% of longer-term immigrant and 5% of Canadian-born women.¹⁸⁶ An analysis of provincial health system data found that cervical cancer screening rates are lower among Ontario women who registered for provincial health insurance in the past 10 years, the majority of whom are newcomers to Canada, compared with Canadian-born and non-recent immigrants.¹⁸⁷ An analysis of 2005–2008 CCHS data for Ontario found that immigrant women aged 18–69 are significantly less likely than Canadian-born women to have had a Pap test in the past 3 years.⁹ Canadian research on access to cervical cancer screening has also shown that newcomer women are substantially less likely than Canadian-born women to have had a Pap test, but that rates tend to increase slowly with length of time since immigration.^{188,189}

National research has also found important differences in cervical screening access for immigrant women by ethno-racial background and region of origin. One national study has shown that although cervical cancer screening rates increase with time since immigration among immigrant women from some regions, rates among immigrant women from Asia remain low over the long-term.¹⁸⁸

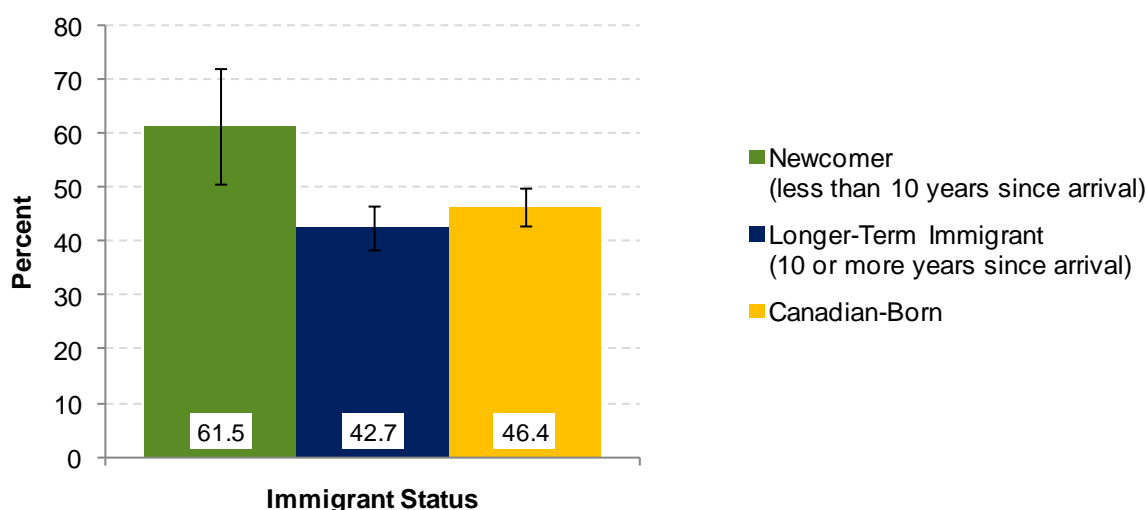
Provincial and national findings on access to cervical cancer screening are consistent with the Toronto findings from the analysis conducted for this report on recent Pap tests among newcomers and longer-term immigrants overall, as well as with some of the findings on differences in access by ethno-racial background and region of origin.

➤ ***Breast cancer screening among newcomer women in Toronto***

Breast cancer is the most common cancer in women and has the third highest mortality rate of all cancers in Canada. A mammogram is a screening test conducted to detect possible signs of cancer in breast tissue. Mammograms can identify breast cancer at an early stage in the disease, when treatment is most likely to be effective. It is recommended that women aged 50 years and over get a mammogram every two years. Women aged 40 to 49 are also encouraged to talk to their doctor about mammography, especially if they have a family history of breast cancer.

An analysis of CCHS data from Toronto for women aged 40–64 on recent mammograms (defined as having had a mammogram within the past 2 years) was conducted for this report. The analysis finds that, overall, newcomer women are significantly less likely than longer-term immigrant and Canadian-born women in Toronto to have had a mammogram within the past 2 years (see Figure 4.3).

Figure 4.3 No Recent Mammogram among Newcomer, Longer-Term Immigrant, and Canadian-Born Women Aged 40 to 64, Toronto, 2001 to 2008 Combined[†]



Error bars denote 95% confidence intervals

[†] - Data age standardized to the 1991 Canadian Population

Data Source: Canadian Community Health Survey, 2001, 2003, 2005, 2007 and 2008. Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario Ministry of Health and Long-Term Care.

➤ *Access to breast cancer screening for newcomer sub-populations in Toronto*

The analysis of CCHS data as well as the literature review conducted for this report have identified some differences in access to breast cancer screening among newcomers. These differences point to newcomer sub-populations, as defined by the following factors, who may be at higher risk for poor access to breast cancer screening now or in the future:

Neighbourhood income

A Toronto study that compared mammography rates in different areas of the city found that the lowest rates of mammograms were among **women living in low-income areas with high proportions of newcomers** (less than 5 years since arrival). Access to mammograms was lower among women in these areas than it was in low-income areas with low proportions of immigrants, demonstrating an association between recent immigration, low income and access to mammograms.¹⁸⁹

Ethno-racial identity and region of origin

- **Newcomer women from Asia and Africa** are less likely to have had a recent mammogram than their longer-term immigrant counterparts and Canadian-born women, according to the analysis of CCHS data for the GTA^{xxii} by region of origin.
- The analysis of CCHS data for the GTA^{xxiii} by ethno-racial identity shows that longer-term immigrant women in the GTA of Black ethno-racial identity are significantly less likely to have had a recent mammogram than longer-term immigrant women of other ethno-racial groups.
- A survey of **female refugees from Kosovo** in Hamilton indicated that just 5% of female Kosovo refugees aged 50 or more had ever received a mammogram.¹⁴⁵

^{xxii} Data from the GTA were used in this case because the sample size for the City of Toronto was too small to allow for an analysis of differences among newcomers from different regions.

^{xxiii} Data from the Greater Toronto Area were used in this case because the sample size for the City of Toronto was too small to allow for an analysis of differences among different ethno-racial groups.

➤ *The provincial and national context*

Provincial and national research on access to breast cancer screening has found that newcomer women have worse access to breast cancer screening than longer-term immigrant and Canadian-born women.^{186,190} An analysis of National Population Health Survey data in Ontario found that 26% of newcomer women reported never having had a mammogram, compared with 18% of longer-term immigrant and 19% of Canadian-born women.¹⁸⁶ The findings on recent mammograms presented above, emerging from the analysis conducted for this report, are consistent with national and provincial findings showing that newcomer women have worse access to breast cancer screening.

Vaccinations among newcomers and newcomer sub-populations in Toronto and Ontario

Although limited research and data exist on vaccination rates in Toronto and Ontario, some research has been conducted on rates of vaccinations among immigrants, mainly immigrant children.

One provincial study used Ontario health system data linked with immigration landings data to determine the proportion of 2-year-old children with immigrant mothers who had complete, up-to-date immunization coverage. The study found that children with immigrant mothers are more likely to have up-to-date immunizations than children with Canadian-born mothers. Compared with immigrants from other regions, children whose mothers are from Southeast and Northeast Asia are more likely to have up-to-date immunizations; and compared with other immigrant classes, the children of refugees are least likely to be up to date¹⁹¹.

This is consistent with a focus group conducted in Toronto with government-assisted refugees from Afghanistan, in which participants identified immunizations for children as an important area of need¹⁵⁷. A study of 200 immigrant patients at the Volunteer Clinic for the Medically Uninsured in Scarborough (in Toronto), who had been in Canada an average of 2 years and the majority of whom were female newcomers from the Caribbean, South Asia and East Asia, found that many children who were clinic patients were in need of immunizations, such as for the measles, mumps and rubella (MMR).⁸⁹ Service providers in focus groups for this report also identified newcomer children in schools as being at risk for lack of awareness about and access to complete, up-to-date immunization coverage.

Another study examining access to influenza (flu) vaccinations among Toronto children aged 5–9 found that immigrant children are more likely to have had a flu vaccination than Canadian-born children.¹⁹² An analysis of 2005–2008 CCHS data for Ontario on residents aged 12 and older found that immigrants are significantly more likely than Canadian-born residents to report having had a flu shot in the past year.⁹

4.3 - CHRONIC DISEASE CARE AND MANAGEMENT

“Many people come with existing health issues like diabetes, hypertension – but these issues get ignored because health services are not available.” (participant – service provider focus group)

Good quality health services that treat, monitor and help to manage existing health conditions can help decrease morbidity and mortality and improve overall quality of life. Service providers and newcomers in the focus groups as well as local reports all identified chronic and communicable disease management as areas of need for Toronto newcomers. Focus group participants discussed how many newcomers with chronic diseases such as diabetes are not able to access quality health care, or any health care at all to manage their illnesses. Participants also said newcomers experience difficulty with the cost of supplies and medications for chronic disease management.

Local research that included focus groups with older immigrant women also highlighted urgent gaps in chronic disease health services for older immigrant women.⁷⁸ A telephone survey of Chinese adults in Toronto and Vancouver, 97% of whom were immigrants, and 53% of whom were newcomers, found low levels of awareness of heart disease and stroke symptoms among respondents.¹⁹³ In focus groups conducted with Chinese community members and service providers working them in the GTA and other parts of Ontario, The Ontario Heart and Stroke Foundation also identified low awareness of risk factors for heart disease and stroke among Chinese focus group participants, as well as a need for post-stroke information and for culturally appropriate information on healthy eating and cooking.⁸⁶ A study of 200 immigrant patients at the Volunteer Clinic for the Medically Uninsured in Scarborough (Toronto) found that diabetes and hypertension are an issue for many uninsured patients, and that these issues are often poorly managed.⁸⁹

➤ *Diabetes care and management among newcomers in Toronto and Ontario*

A Toronto study surveyed 227 newcomers with diabetes from Mainland Chinese, Sri Lankan Tamil, Pakistani and Bengali backgrounds, as well as a Canadian-born comparison group, about diabetes risk factors, management and care.³⁴ The study found that, compared with their Canadian-born counterparts, newcomers with diabetes are significantly more likely to access diabetes-related care from a family doctor and significantly less likely to access specialist care, care from a dietician or care from an alternative care provider. Newcomers and Canadian-born participants with diabetes have similar rates of eye examinations, according to the survey, but newcomers are significantly less likely to have ever had a foot exam. In the area of self-management, newcomers are less likely to smoke, more likely to do regular physical activity, and more likely to reduce dietary fat, but are significantly less likely than Canadian-born residents to perform regular glucose checks and regular foot checks for themselves. Newcomers are also significantly more likely to rely on family or friends for diabetes-related information, and less likely to access information provided by formal resources, such as diabetes associations.³⁴

Ethno-racial background is an important factor in determining rates of diabetes among immigrants and Canadian-born residents. One Ontario study that used provincial health care system data to examine access to diabetes care among different ethno-racial groups showed that use of primary care and diabetes specialist care are similar among all ethno-racial groups; however, racialized residents with diabetes are less likely to have an eye examination compared with their White counterparts.¹⁹⁴

4.4 - PERINATAL HEALTH CARE

Perinatal health care includes health care, information and supports through pregnancy, childbirth and post-birth. To help ensure a healthy pregnancy, pregnant women should receive prenatal care and support as early as possible in the pregnancy. As outlined in section 3.9 (Reproductive, Maternal and Infant Health), a high proportion of births in Toronto are among newcomers and longer-term immigrants, making access to perinatal care an important health care need for both groups.

➤ *Access to perinatal health care among newcomer women and sub-populations in Toronto*

Service providers and newcomers in focus groups conducted for this report identified access to perinatal health care, information and support as important health service needs impacting many newcomer women and their families. Pregnant newcomers may have unique health service needs as a result of social isolation, lack of social and familial support, financial and income issues, nutritional needs and barriers to health care. A study on the post-birth experiences of immigrant women in Toronto, Montreal and Vancouver found that immigrant, refugee and refugee claimant women in Toronto are more likely to have post-natal health concerns that are not addressed

by the health care system compared with Canadian-born women.¹³¹ Two Canadian studies focusing on care for immigrant women with postpartum depression identified a need for more culturally competent and linguistically appropriate information and health care for immigrant women that address issues such as stigma and validates postpartum depression.^{195,196}

Service providers in the focus groups and local research reports reviewed for this report identified the existence of critical and urgent perinatal health care needs for newcomers in Toronto, particularly among pregnant women who do not have provincial health care coverage because they are non-status or because they have been in Canada less than 3 months and are not yet eligible for OHIP coverage.^{89,197} Local service providers and local reports described as a common experience the inability of uninsured pregnant women to access any care until 6 or 7 months into their pregnancy. A study of 200 immigrant patients at the Volunteer Clinic for the Medically Uninsured in Scarborough (in Toronto), found that among those receiving perinatal care, the average gestational age when women first access care is 26 weeks, with some not accessing care until just before their due date.⁸⁹ As a participant in the service provider focus group put it, *“Sometimes, pregnant women come here six months [pregnant] and then wait three months to get their OHIP. And then they need the doctors right away. It’s difficult to find doctors at that very moment.”* Service providers in the focus groups also cited instances where non-insured pregnant women in need of prenatal care were refused services even when they were able to pay for these services.

Research on Somali immigrant women in Ontario found that changes in health care practices, including less interventionist care and increased cross-cultural sensitivity, were needed to improve Somali women’s birth experiences, particularly for those women who had undergone Female Genital Mutilation.^{198,199}

4.5 - SEXUAL HEALTH SERVICES

Sexual health services can include health promotion and education, counselling, testing and treatment that address a range of health needs, including birth control, sexually transmitted infections, HIV/AIDS, healthy sexuality and relationships.

➤ *Access to sexual health services among newcomer sub-populations in Toronto*

The literature review conducted for this report, as well as service providers in the focus groups, identified sexual health promotion and services as important areas of need for Toronto newcomers. Several newcomer sub-populations, as determined by the following factors, were specifically identified as having sexual health service needs:

Gender

Newcomer women in the focus groups identified information about and access to **abortion-related care** as an important sexual health need for newcomer women.

Sexual orientation

Sexual health services, particularly counselling and other supports, were identified in the focus groups as key areas of need for **LGBTQ newcomers**.

Age

A need for more accessible and appropriate sexual health services for **newcomer youth** was identified by several local research reports^{200,201,202} and by service providers and newcomers in the focus groups. The Toronto Teen

Survey, which canvassed 1,200 Toronto youth, 12% of whom were newcomers who had immigrated in the previous 3 years, on the issue of sexual health services found that newcomer youth (3 or less years since arrival) are less likely than Canadian-born youth to access sexual health services (23% of newcomer youth versus 43% of Canadian-born youth accessed services), and that newcomer youth are less likely than longer-term immigrants and Canadian-born youth to have received any formal sex education. The survey also identified several sexual health needs among newcomer youth, including:

- the need for sexual health services promotion targeted at them and related to services that are free of charge;
- opportunities for sexual health education for them and their parents through community agencies and ESL classes;
- youth-friendly interpretation services where youth have the choice of whether or not to use the interpreter; and
- reliable and culturally appropriate sexual health information provided through media such as websites and promoted among newcomer youth.²⁰²

Service providers and newcomers in the focus groups also named several areas where newcomer youth had significant sexual health service needs. These were: sex education, access to birth control, information about and access to abortion clinics, sexually transmitted infection testing and treatment, and sexual clinics geared towards newcomer youth. As one participant in one of the service provider focus groups stated, *“Due to the generational gap between immigrant parents and their children, being able to talk about sexual health becomes really important.”*

Region of origin

In the focus groups, **Latin American newcomer women** were identified as having unmet needs in sexual health education and access to birth control.

Immigration status

Service providers and newcomers in the focus groups identified **non-status newcomers** as a group with significant sexual health needs. In particular, access to abortion, which is free under OHIP but not accessible to non-status and non-insured women and youth, is an issue, as these groups have to find alternative means of covering the procedure.

➤ ***Access to HIV and AIDS programs and services among newcomer sub-populations in Toronto***

Service providers in the focus groups and several local research reports identified the need to improve newcomer access to HIV-related services in Toronto, including prevention, screening, treatment and support. In particular, the need for outreach and prevention programs that are culturally and linguistically appropriate, that target Toronto newcomers at risk of infection, and that aim to raise awareness and prevent transmission were identified as key areas of need, since most existing services are targeted primarily to residents living with HIV/AIDS.^{203,204}

A study examining the location and distribution of HIV-related services across Toronto neighbourhoods found that HIV-related services were unevenly distributed and were less accessible for several Toronto neighbourhoods. Areas of Toronto with better access to HIV-related services were located in the downtown core of Toronto, were densely populated and had greater proportions of young residents aged 15–34. Areas of the city with fewer accessible HIV-related services tended to have higher proportions of immigrants, residents of Black ethno-racial identity and residents with low socio-economic status.²⁰⁵

Some Toronto studies have focused on the HIV and AIDS service needs of the African and Caribbean

communities. This research has identified HIV and AIDS outreach and prevention programs that effectively target Toronto's African and Caribbean communities as an area of significant need. Researchers have also flagged the importance of engaging African and Caribbean women, including those affected by HIV/AIDS and their communities, in the design and delivery of prevention, support and care related to HIV/AIDS, in order to make these services culturally appropriate and relevant.²⁰⁴

The East African Health Study in Toronto (EAST), which surveyed 456 residents from five different East African communities, 98% of whom were immigrants who had been in Canada an average of 10 years, found that the majority (75%) of participants had been tested for HIV an average of 2.8 times. More men than women reported ever having been tested, and there were differences in testing rates by region of origin, with Somalis and Ethiopians being least likely to ever have been tested, and Somali respondents being tested less often than those from other countries. The survey also identified awareness and education about HIV testing as an area of need for the East African community, as almost one third of survey participants were not aware that the results of an HIV test would be kept confidential; almost three quarters did not know about anonymous testing; and 16% did not know where to get an HIV test.⁵⁷

4.6 - FAMILY AND INTIMATE PARTNER VIOLENCE SERVICES

As described in section 3.14 (Family and Intimate Partner Violence), family and intimate partner violence are important health issues facing Toronto newcomer communities. Services that can help address these issues include crisis counselling, shelter services, health care and social services.

➤ *Access to family and intimate partner violence services among newcomer women and newcomer sub-populations in Toronto and Canada*

Research on use of family and intimate partner violence services in Canada suggests that immigrant women are less likely to use health services, legal services, shelters and hotlines compared with Canadian-born women.^{206,207} Research focused on newcomers has also found that newcomer women experiencing violence are less likely to use social services but more likely to report violence to police than their longer-term and Canadian-born counterparts.¹⁶⁰ These contrasting findings suggest that some newcomer women experiencing violence do not seek help as early or through traditional social service channels, compared to women born in Canada.

One literature review has identified several key service needs for newcomer women experiencing intimate partner violence, including:

- prevention strategies to address the determinants of intimate partner violence;
- information and awareness-raising among newcomer community members about available resources;
- access to physical and mental health service information and awareness-raising among health service providers about how to address this issue and make appropriate referrals;
- crisis intervention services, including counselling and shelters;
- supports and services to assist with longer-term independent living for women who choose to permanently leave their partner, including help with housing, income supports, language and job training; and
- legal support and information about legal rights, Canadian laws, and the law enforcement and justice systems.²⁰⁶

Local research reports have also highlighted the need for linguistically and culturally appropriate services, information and support,²⁰⁶ and for supportive services, regardless of whether women choose to leave a relationship.¹⁵⁸

4.7 - DENTAL CARE

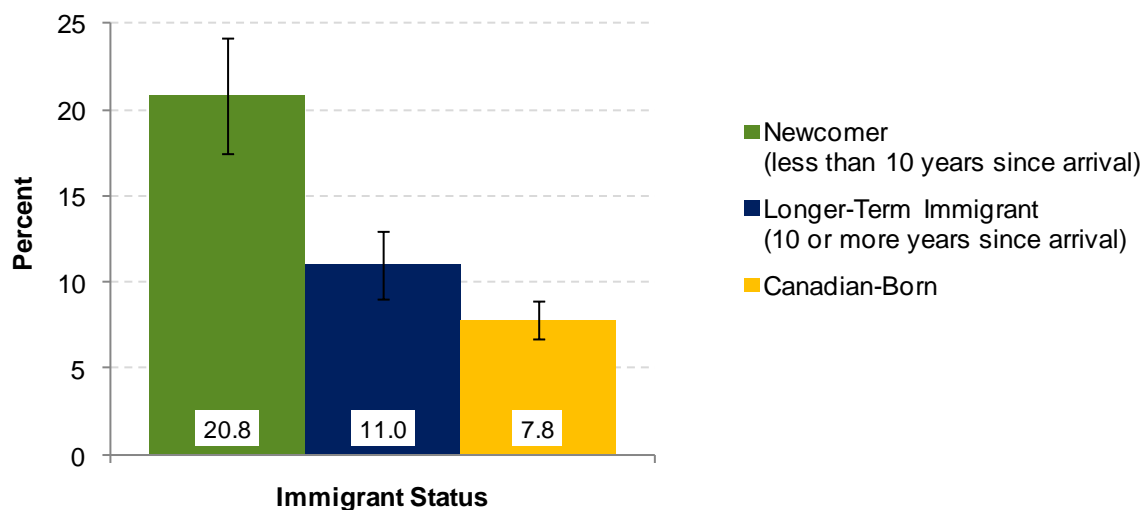
“Canadian health doesn’t consider teeth as a part of the body.” (participant – service user focus group)

Dental care is a critical part of oral health prevention and usually includes regular check-ups and tooth cleaning. Regular dental visits can reduce the likelihood of cavities, gum disease and oral pain and discomfort. As outlined in section 3.13 (Oral health), research on children of Portuguese-speaking immigrants in Toronto has found that lack of dental care and lack of dental insurance are the strongest predictors of tooth decay,¹⁵⁶ and this is likely true for other immigrant groups as well. However, preventive dental care is not covered by the provincial health care system for most Ontario residents, including most newcomers. Refugees and refugee claimants are an exception; they are eligible for some dental services for a limited period of time under the Interim Federal Health Program (IFHP).

➤ *Recent dental visits among newcomers in Toronto*

An analysis of CCHS data from Toronto on recent dental visits (defined as having visited a dentist within the past 3 years) was conducted for this report. The analysis shows that, overall, newcomers are significantly less likely than longer-term immigrants and Canadian-born residents in Toronto to have visited a dentist within the past 3 years. Longer-term immigrants are also less likely to have visited a dentist recently than Canadian-born residents (see Figure 4.4).

Figure 4.4 No Recent Dentist Visit among Newcomers, Longer-Term Immigrants, and Canadian-born residents, Toronto, 2001 to 2008 Combined†



Error bars denote 95% confidence intervals

† - Data age standardized to the 1991 Canadian Population

Data Source: Canadian Community Health Survey, 2001, 2003, 2005, 2007 and 2008. Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario Ministry of Health and Long-Term Care.

Access to dental care was also frequently identified as a priority area of need for Toronto newcomers in the focus groups and in community-based literature that was reviewed for this report that documents local consultations and focus groups across the city.^{178,64,208}

➤ *Access to dental care for newcomer sub-populations in Toronto*

The analysis of CCHS data as well as the literature review and focus groups conducted for this report have identified some differences in access to dental care among newcomers. These differences point to newcomer sub-populations, as determined by the following factors, who may be at higher risk for poor dental care access now or in the future:

Gender and age

Community members and service providers in the focus groups identified **senior newcomers** as a group with significant dental care needs, and the community-based literature specifically identified **older immigrant women** as having these needs.⁷⁸

Education and income

- Although no difference by education level was found among newcomers in the analysis done for this report, among longer-term immigrants, residents with no post-secondary degree or diploma are significantly less likely to have visited a dentist recently than residents with a post-secondary degree or diploma.
- The analysis shows that **low-income newcomers** are less likely to have visited a dentist recently than their high-income counterparts. This is also true for longer-term immigrants.
- Community members and service providers in the focus groups, as well as the community-based literature reviewed identified **newcomers with lower incomes, unstable and precarious jobs, and lack of dental insurance** as being unable to access needed dental services.

Ethno-racial identity and region of origin

- The analysis of CCHS data for the GTA^{xxiv} by ethno-racial identity finds that **newcomers belonging to a racialized group** are significantly less likely to have recently visited a dentist than White newcomers.
- The analysis of CCHS data for the GTA by region of origin demonstrates that **newcomers from Asia** are less likely than those from Europe (excluding U.K.) or Canadian-born residents to have recently visited a dentist.
- The East African Health Study in Toronto (EAST), which surveyed 456 residents from the Ethiopian, Kenyan, Somali, Ugandan and Tanzanian **East African communities**, 98% of whom were immigrants who had been in Canada an average of 10 years, found that more than half (55%) of the sample reported that they had not seen a dentist in the previous year.⁵⁷

Immigration status

Focus groups and community-based literature identified **refugees, refugee claimants and non-status immigrants** as newcomer sub-populations with significant dental care needs. This is in spite of the fact that refugees and refugee claimants are entitled to coverage under IFHP for a limited period of time.¹¹³

^{xxiv} Data from the Greater Toronto Area were used in this case because the sample size for the City of Toronto was too small to allow for an analysis of differences between White and racialized respondents.

➤ ***The provincial and national context***

Relatively little Canadian research has examined access to dental care among newcomers, but some studies do exist. Research at the provincial and national levels has found that newcomers have poorer access to dental care, which is consistent with the findings for Toronto emerging from the analysis done for this report. An analysis of Ontario-level data shows that newcomers are less likely than longer-term immigrants and those born in Canada to have seen a dentist in the past year.¹⁷⁹ One national study showed that, overall, immigrants are somewhat more likely than Canadian-born residents to have visited a dentist within the past year.¹⁵⁴ However, the same study showed that newcomers (less than 5 years since arrival) are significantly less likely than longer-term immigrants (10 or more years since arrival) to have seen a dentist in the past year. Canadian research, meanwhile, has found that immigrants from Asia are less likely to have had a recent dental visit than those from other regions.¹⁵⁴

4.8 - PRESCRIPTION MEDICATION, VISION CARE, SUPPLIES AND DEVICES

Prescription drugs; medical supplies, such as blood sugar testing equipment; and assistive devices, such as glasses, hearing aids and wheelchairs, are all essential to health and well-being. If one cannot obtain the medication a doctor prescribes, or use the assistive device that is recommended, one cannot follow the doctor's advice on how to maintain or improve health. Eye examinations to test vision and to determine if vision aids are needed are also a central part of health care. However, prescription drugs, vision care, medical supplies and assistive devices are not covered by the provincial health care system for most Ontario residents, including most newcomers. Refugees and refugee claimants are an exception; they are eligible for some services, including essential medications and eye exams, under the IFHP.

Service providers and newcomers in the focus groups and in local research reviewed for this report identified access to prescription medication and to vision care as unmet needs for newcomers. As discussed further in section 4.12, many newcomers face barriers to these essential services, which are not covered by the provincial health care system. Many newcomers lack private insurance benefits that would cover such services, and they cannot afford the cost of paying out of pocket.

4.9 - MENTAL HEALTH SERVICES

Mental health services include treatment, counselling and support for people experiencing mental health issues, as well as prevention strategies that promote mental and emotional health and well-being.

➤ ***Access to mental health services among newcomers in Toronto and Canada***

"And it [is] so difficult to get access to psychiatric help or psychologist or things like this. If they do get a referral it usually takes about six months. By that time, you know the problem has got a lot worse." (participant – service provider focus group)

Local and national literature, and service providers and newcomers in the focus groups conducted for this report all identified mental health care and services as an important area of unmet need for newcomers and newcomer sub-populations. Several national studies have found that immigrants, particularly newcomers, are less likely to use mental health services.^{180,142} A national study examining health care system data for immigrants in Ontario, Quebec and British Columbia who arrived between 1985–2000 found that, overall, use of mental health services is much lower among more recent immigrants (less than 15 years since arrival), and particularly among newcomer

women, than among their Canadian-born and longer-term immigrant (15 or more years since arrival) counterparts.¹⁸⁰ A study using CCHS data on bipolar disorder found that immigrants with bipolar disorder are significantly less likely to have seen a mental health professional than Canadian-born residents with bipolar disorder.¹⁴²

The review of local research reports and the focus groups with service providers and newcomers conducted for this report point to a need for culturally appropriate and accessible mental health care and support services. Specific areas of need for Toronto newcomers that were highlighted include improved access to and shorter wait times for specialists; counselling and therapy; group programs; early intervention programs and services (in addition to crisis care); and education and prevention programs on topics including stress management, anger management, reducing stigma related to mental illness, and framing mental and emotional health as legitimate health issues.

➤ ***Access to mental health services among newcomer sub-populations in Toronto and Canada***

Several newcomer sub-populations with particular mental health service needs, as determined by the following factors, were identified in local reports and the focus groups:

Gender

Newcomer men were identified as needing programs and services addressing anger management and identity issues.²⁰⁸

Sexual orientation

Counselling and support services for **LGBTQ newcomers**, and particularly **LGBTQ youth** are an important area of need, as identified in the focus groups. These services are required to address a range of concerns, including intergenerational issues, stigma related to sexuality, depression, anxiety, issues about being transgender or transsexual, and the experience of violence and trauma.

Age

- **Newcomer children and youth** have particular mental health service needs, according to service providers and newcomers in the focus groups, who also specified the need for more mental health specialists focusing on children and youth. Local research, meanwhile, has identified the need for youth-focused counselling and support services, particularly for **male youth**,¹⁵⁰ including addictions programs to prevent and address smoking, substance and gambling addictions among youth.⁶⁴
- **Newcomer seniors** were identified as needing supports for mental health issues such as depression.²⁰⁰
- **Family-oriented** counselling and support services, including parenting programs, education and prevention programs to increase family resiliency to violence; counselling to help families deal with intergenerational issues; and support and education for those dealing with family members who have mental health issues have all been identified as important areas of need.^{150,200}

Immigration status

- Refugees and refugee claimants have significant and specific mental health care needs. Specific sub-populations and needs identified by local reports include supports for trauma and post-traumatic stress disorder for **government assisted refugee families**³⁰⁶ and specialized counselling and emotional support for **refugee claimants** to help them address issues related to trauma, the impact of resettlement on their families, and any resulting family conflict or spousal abuse.¹¹³

4.10 - NUTRITION AND RECREATION PROGRAMS

Healthy food, exercise and recreation are very important to overall health and well-being. Eating well and participating in recreational activities can help to prevent physical and mental health issues; manage chronic disease and other health problems; and improve overall well-being. Programs and services that provide opportunities to learn about health and participate in healthy activities can often lead to better health outcomes for participants, especially when they are accessible in terms of cost, location and other factors.

➤ ***Access to nutrition and recreation programs among newcomers and newcomer sub-populations in Toronto***
Nutrition programs and accessible recreation programs are areas of unmet need for all ages of Toronto newcomers, according to service providers and newcomers in the focus groups conducted for this report and based on other local research findings.^{62,200,64}

Service providers and newcomers in the focus groups named community kitchens, community cooking programs and peer nutrition programs, where members of ethno-cultural communities are trained to provide nutritional advice, as needed nutrition-related programs that should exist in various parts of the city. Focus group participants and local research¹⁵⁷ have identified key educational topics that should be addressed in nutrition programs for newcomers, including:

- the benefits of healthy eating;
- the links between healthy eating and health outcomes;
- the healthfulness of culturally appropriate and familiar foods;
- recipes for healthy food in multiple languages;
- information on feeding babies, young children and older children; and
- how to shop for affordable and culturally appropriate food.

Service providers and newcomers in the focus groups also pointed to a need for nutrition-related programs and services for some specific sub-populations. Children need nutritional education and access to fresh and culturally appropriate food in schools through community kitchen programs in public schools. Similarly, in focus groups conducted with Chinese community members and service providers working with them in the GTA and other parts of Ontario,⁸⁶ The Ontario Heart and Stroke Foundation identified a need for culturally appropriate information on healthy eating, cooking and recipes directed to the Chinese community.

More affordable and accessible fitness and recreational programs for adults, youth and children, including access to gymnasiums and swimming, as well as group classes such as aerobics and yoga are also needed, according to participants in the focus groups conducted for this report. Several local research projects and consultations have confirmed this, pointing out that newcomer youth in particular need more accessible recreational programs and facilities.^{150,64,208} Seniors have also been identified as a newcomer sub-population that is particularly in need of access to exercise and recreation facilities.²⁰⁰

4.11 - OTHER SERVICES

Below, findings related to the role of settlement services and childcare are discussed briefly. While these are not health services per se, they were frequently highlighted by local stakeholders, given their importance to the successful adaptation and integration of newcomers to Toronto.

➤ *Settlement services*

Settlement services provide critical support to newcomers through language training and by helping them to navigate a complex array of services and processes related to immigration, employment, education, housing and health.

The importance of settlement services in promoting successful integration and positive health outcomes for newcomers is underscored in the local literature and was discussed by participants in the focus groups. In many cases, settlement workers are an initial point of contact for newcomers experiencing stress and mental health challenges related to the processes of settlement and acculturation.

A recent study of settlement services in Toronto notes that there is an increasing need for mental health support for newcomers whose backgrounds have included traumatic situations and experiences.²⁰⁹ The study also points out that settlement service providers require additional skills and expertise to work effectively with clients who have mental health needs.^{64,209}

However, service providers in Toronto^{210,209} have noted that underfunding of the settlement sector is a serious concern. The number of permanent residents initially settling in Toronto has recently declined, but this does not necessarily translate into a decrease in settlement needs overall. Settlement workers are required to deal with new and emerging immigrant and refugee communities and newcomers who face difficult and often protracted challenges in the labour market. Recent cuts by the federal government to settlement services in Toronto may particularly affect certain new sub-populations, such as Francophones, some racialized women, and LGBTQ newcomers, many of whom rely on immigrant and refugee-serving agencies for refuge and support.²¹⁰

Not all immigrants are able to benefit from government-funded settlement services. The criteria for accessing Citizenship and Immigration Canada–funded settlement services and ESL classes exclude longer-term immigrants and some specific sub-populations of newcomers, such as refugee claimants and undocumented migrants.

➤ *Childcare*

The availability of high quality, affordable childcare is a particularly important issue for newcomer families with young children, given that immigrants have a higher rate of births than the Canadian-born population and that many newcomers bring young children with them when they migrate to Canada.²¹¹ A report prepared by the Central East Local Immigration Partnership (LIP) states that childcare is a key need, given the high percentage of lone parents in some East Toronto neighbourhoods.²⁰⁰ In addition, the lack of accessible and affordable childcare is frequently identified in the literature as a barrier to accessing other services, such as ESL classes.

4.12 - BARRIERS TO ACCESSING HEALTH SERVICES

The importance of affordable and accessible health services was strongly emphasized by newcomers who participated in the focus groups conducted for this report and in other local consultations. At the same time, findings also show that newcomers to Toronto experience multiple barriers to accessing health services. In this section, key barriers identified through the research activities undertaken for this report are summarized.

➤ *Cost and eligibility*

Cost can be a strong deterrent to accessing health care for newcomers, especially for those with limited financial resources. This is a serious issue for residents who do not have health insurance because they have not yet met the

three-month residency requirement for OHIP coverage, or because they are living without recognized immigration status.

The three-month waiting period for OHIP is a major access barrier for new permanent residents arriving in Ontario. Some of these newcomers cannot afford private health insurance coverage during this period, and those with a pre-existing illness or condition may not qualify for private insurance, leaving them without any options for coverage.²¹² Individuals without coverage are usually required to pay considerable amounts of money for services that they receive during this period.^{xxv} Others may delay non-urgent and preventive care. Participants in the focus groups frequently spoke about the negative impacts of this waiting period for themselves and, in the case of service providers, of their clients:

“You have to wait for 3 months to get your health card, so during this time period I really hope that I don’t get sick, although I am worried that this [weather] is too cold for me and my body won’t be able to cope with it.” (participant – service user focus group)

“I admitted my kid into the hospital [for pneumonia] and they charged me \$500. I was without job and I had no health card, so I was in a dilemma. So, it was really, how stressful, I cannot explain... I’m still paying the bill... it’s really difficult because without a job and my kid got pneumonia, and at that time my wife was pregnant. So, it is really difficult. So, I’m giving advice to the government that they should do something, so that we can cope with that situation.” (participant – service user focus group)

Even for those with OHIP coverage, there are many services that are not covered, including dental services, vision care, prescription drugs, medical supplies and equipment. Because they are less likely to be employed, newcomers are less likely than other Toronto residents to have extended health and dental coverage through an employer. The cost of these uninsured health services can be prohibitive for some. As one service user in the focus groups told us: *“I have been living here 4 years.... I’ve worked for the same company for 3–4 years and they are not giving us permanent [jobs]... Regular medicine we have to buy, but how can we buy it?”*

In some cases, newcomers do not know the cost of certain health services, i.e., which services are free and which ones are not.²¹³ For example, one newcomer focus group participant noted that they had heard about the flu shot through advertising, but it was not clear whether this was a free service.

Accessibility of health services is partly determined by a person’s immigration status. Table 4.1 summarizes eligibility for health care coverage according to status.

^{xxv} To date, some Community Health Centres have received funds from the Ministry of Health and Long-Term Care to pay for services for uninsured clients, but the funds are not sufficient and can be exhausted with several high-needs patients.²⁰⁰ For more serious issues, uninsured clients must rely on the goodwill of hospitals to provide necessary care.

Table 4.1: Immigrant and Refugee Categories and Health Care Benefits

Category	Definition	Health Care Benefits
Permanent Residents (PRs)	<ul style="list-style-type: none"> • can live permanently in Canada • must live in Canada for 2 years within a 5-year period • possess all rights guaranteed under the Canadian Charter of Rights and Freedoms • cannot vote in elections 	<ul style="list-style-type: none"> • eligible for the Ontario Health Insurance Plan (OHIP) after a 3-month waiting period.^{xxvi}
Government-Assisted Refugees	<ul style="list-style-type: none"> • permanent residents in the refugee category selected abroad for resettlement to Canada • arrive as Convention refugees under the Immigration and Refugee Protection Act or as members of the Convention Refugees Abroad Class • receive resettlement assistance from the federal government 	<ul style="list-style-type: none"> • entitled to OHIP health care services upon arrival • may be eligible for limited coverage under the Interim Federal Health Program (IFHP) for up to 12 months from time of arrival • IFHP covers essential medications, dental services and annual eye exams (not covered by OHIP)
Privately Sponsored Refugees	<ul style="list-style-type: none"> • PRs in the refugee category selected for resettlement • privately sponsored by organizations, individuals or groups of individuals 	<ul style="list-style-type: none"> • same as for Government Assisted Refugee
Refugee Claimants	<ul style="list-style-type: none"> • request refugee protection upon or after arrival in Canada • if claim is accepted, may apply in Canada for permanent residence • application may include family members in Canada and abroad 	<ul style="list-style-type: none"> • refugee claimants may apply for IFHP coverage for themselves and their in-Canada dependent children. Coverage is usually for one year; eligible claimants can apply for an extension • in addition to those benefits mentioned above, IFHP covers essential and emergency health services, standard immunizations, contraception (birth control), prenatal and obstetrical care
Temporary Foreign Workers	<ul style="list-style-type: none"> • issued a work permit by Citizenship and Immigration Canada • can stay as long as the permit is valid (not as long as the job is available) • programs include the Seasonal Agricultural Worker Program, the Live-In Caregiver Program and the Temporary Foreign Worker Program 	<ul style="list-style-type: none"> • eligible for OHIP if work permit is valid for at least 6 months and have a formal agreement to work full-time for an employer in Ontario • spouses, same sex partners or dependent children of an OHIP-eligible foreign worker are also eligible for OHIP • seasonal agricultural workers with a valid work permit are immediately eligible for OHIP

^{xxvi} Ontario, B.C. and Quebec are the only provinces that impose a waiting period for health coverage for PRs. In Quebec, certain health services are exempt from the 3-month waiting period, including treatment of infectious diseases, pregnancy and services related to domestic violence.

➤ **Health system capacity**

Some local reports suggest that health service organizations in Toronto often lack the capacity to provide quality services to newcomers. Those that participated in the focus groups conducted for this report and in other consultations frequently mentioned long wait times for health services as a barrier to access. Some local reports indicate that there are not enough health service providers (including family doctors and mental health workers) to meet demand. For example, in east Toronto, 40% of organizations surveyed in 2010 had waiting lists, mostly for mental health counseling and other health services.²¹⁴ Furthermore, not all service providers will accept patients that are covered only by the Interim Federal Health Program (IFHP), thereby limiting health care access and choice for refugees and refugee claimants.

➤ **Culture and Language**

“Language and culture play an important role in mental health service delivery. For example, if I go to a service provider who doesn’t know my language and is not familiar with my culture, first of all I will not be able to explain my problem to him/her as I want to say it, secondly, even if he/she gets me, will still not be able to provide me with culturally appropriate treatment which is very important.”

(focus group participant – the “Improving mental health services for immigrant, refugee, ethno-cultural and racialized groups” project²¹⁵)

Cultural and linguistic accessibility are also critical considerations. Findings from a multi-method project on health equity conducted by the Central East Local Health Integration Network (LHIN) indicate that newcomers often prefer to see health service providers who speak the same language and/or are from the same culture as theirs.²¹⁶ However, many participants said that it is almost impossible to find such a service provider. On the other hand, participants in a roundtable to identify gaps in health promotion for South Asian communities in Ontario pointed out that seeing a health provider from the same ethno-racial background does not necessarily lead to appropriate and respectful care.²¹⁴ Rather, social class and power must be taken into consideration, particularly in South Asian communities that are divided along class, caste and religious lines.²¹⁴

*“Accessibility is about more than getting community members to services; it includes all dimensions of planning and providing effective, inclusive, contextualized care that reaches the most disengaged individuals”.*²¹⁷

Cultural Competency among service providers

Several local reports have identified barriers related to cultural sensitivity and competency among health service providers.^{204,218,219} In section 5.9 (Racialization and Race-based Discrimination) several studies that document experiences of discrimination and racism by newcomers when accessing services are highlighted. Such experiences can lead to distrust of service providers, which may ultimately discourage some newcomers from seeking necessary health care. These studies also speak to systemic factors within the health care sector that perpetuate discrimination and inequitable care for some groups of residents. For example, a report on health equity released by the Central East LHIN notes a lack of clinical training and education among providers in “culture, diversity, and equity”,²¹⁶ and a lack of commitment to diversity and equity among health care organizations, even where policies exist. Similarly, a local report examining health equity in the South Asian community has concluded that institutions need to carefully assess whether their internal governing structures, organizational culture and staffing hinder accessibility.²¹⁷

“In the changing socio-cultural landscape in Canada, cultural competence is a requirement for all organizations to stay relevant and be responsive to the complex needs of diverse populations. ...

Mainstream service providers need to embark upon thoughtful, coherent and system-wide efforts to integrate cultural diversity into all organizational aspects, including governance, policies, resource allocation, communication plans, effective intercultural community relations, personnel practices, service delivery, and evaluation.”²²⁰

Some local reports recommend that organizations implement anti-oppression and anti-racism frameworks, instead of focusing only on the cultural competence of providers.²¹² An anti-oppression approach incorporates an analysis of the power relationships that lead to health inequities; it highlights the need to centre the individual’s needs within a larger socio-political context grounded in the social determinants of health, such as racialization and poverty.²¹⁷ Organizations with anti-oppression policies and practices must be committed to monitoring and assessing them in order to ensure that they are implemented consistently.²²¹

Language and literacy

Language barriers reduce access to information about and access to effective health services. As noted by Goggins, “Language barriers... combined with ineffective interpretation can greatly affect the health and well-being of clients, due to misdiagnosis, incorrect treatment and wrong referrals”.²²² Interpreter services and/or health providers that speak newcomers’ first language have been repeatedly identified as essential needs in various local reports. Researchers examined Chinese immigrants’ health-seeking behaviour and how Chinese immigrants in the Toronto region (Census Metropolitan Area) choose between ethnic Chinese family physicians and other family physicians.²²³ Approximately 80% of Chinese newcomers surveyed stated a preference for physicians of Chinese ethnicity. Many said it was easier to communicate with Chinese physicians, and therefore they could better understand the physician’s instructions.

A report produced by the Toronto Central LHIN (TC LHIN) and the Hospital for Sick Children found that even though the reported need for language services is high, only 55% of organizations in the TC LHIN actually use professional interpreters to deliver care, and in only 25% of the situations that may warrant an interpreter.²²⁴ Most organizations in the TC LHIN do not collect any form of client language information, and most do not collect data related to the need for and use of language services.²²⁴ Several local reports have specifically highlighted the lack of health and other services available in French in Toronto.^{225,216,209} Quality of interpretation services is also an important consideration; unlike in the United States, no nationally established policies or standards exist to oversee the translation profession.²²²

Service providers that participated in the focus groups conducted for this report also noted that basic literacy is a barrier for some newcomers:

“Newcomer challenges are exacerbated when newcomers can’t read, can’t write.” (participant – service provider focus group)

“In many of our programs we rely too much on printed materials, forgetting that many people can’t read, there is a need for a range of learning strategies including audio-visual materials.” (participant – service provider focus group)

➤ ***Socio-cultural barriers and stigma***

Beliefs about health and illness, and perceptions about cultural (in)compatibilities may affect whether newcomers choose to access certain kinds of health services. Socio-cultural factors have been identified in both academic and community-based literature as barriers to accessing services. Some reports highlight attitudes and beliefs of specific newcomer groups that might affect access. For example, some newcomers may not place much

importance on preventive health care, while others may favour traditional or alternative approaches to health care over western ones.^{86,214}

Participants in the focus groups suggested that some newcomers are reluctant to accept help from health service providers based on their experiences with persons of authority in their home country. Others may prefer to access services or medications that they are familiar with.

“Many newcomers I talk to will go and see a doctor but then they won’t fill their prescription: some will try to get the prescription for, e.g., antibiotics, from their home country instead of a local pharmacy; others use their own traditional health knowledge and practices.” (participant – service provider focus group)

Stigma related to certain health issues has also been identified as an issue affecting service access in newcomer communities. Stigma is a term applied widely to any condition, attribute, trait or behaviour that marks an individual or community as culturally unacceptable or inferior.

Focus group participants and local reports have identified stigma around mental illness and mental health services as a significant barrier to care.^{225,226,215,214} One service provider focus group participant noted that *“due to the stigma associated with mental health services, newcomer men with mental health problems will seek help only when faced with legal risks or when the matter is at its worst.”*

Several local and provincial reports have highlighted stigma as a barrier to accessing mental health services among specific newcomer communities:

- Participants in a roundtable undertaken to identify gaps in health promotion for **South Asian communities** in Ontario identified stigma as a barrier to accessing mental health services among many South Asians.²¹⁴

*“A South Asian family may not seek support from their own relatives or close friends to deal with their child’s mental health issues because it may bring a “bad name” or shame for the family. If there’s a female sibling in the family, it could ruin her chances of getting married. Therefore, these perceptions make it one step more difficult for South Asians to access mental health care services.”*²¹⁴

- A survey of the local **Afghan community** indicated that there is significant stigma attached to mental illness as well as to substance abuse and gambling in the community.²¹⁹
- Mental health service providers serving the **Somali community** in the GTA have noted that there is a high degree of stigma about mental health issues in the Somali community, and that there are cultural and religious barriers to women and men receiving mental health services from providers of the opposite sex, even when both the provider and client are Somali.²¹⁸

Stigma related to HIV and AIDS was identified by service providers in the focus groups conducted for this report and in several research reports as an important barrier to accessing HIV-related services, as are cultural and linguistic barriers.^{225,227,204} Based on interviews with local service providers working in agencies that directly serve immigrants who are living with HIV/AIDS, one researcher reported that stigma was the most important barrier that affected their client’s access to their services or interactions with service providers.²²⁸

Fear of HIV-related stigma and discrimination has been identified as a barrier to accessing services for African and Caribbean women in Toronto.²⁰⁴ In another study, focus group participants from Toronto's African and Caribbean communities discussed religious beliefs and norms; homophobia or the denial of homosexuality within communities; and silence about health and sexuality as issues affecting responses to HIV within their communities.²²⁷ Participants noted that gossip and fear within communities contribute to the isolation of residents living with HIV and discourage many from seeking testing, treatment or support services. The racialization of HIV as a Black or African disease by mainstream cultural media and institutions also has a negative impact on the willingness of these populations to approach health or support services, and on HIV knowledge and awareness.²²⁷

Other studies have noted that some newcomer communities may be also uncomfortable discussing and seeking services related to substance abuse, gambling problems, sexual health and breast health.^{217,229,202,72}

➤ ***Awareness of services (informational barriers)***

Access to relevant, timely and appropriate information is useful for newcomers who are learning to navigate a new health care system and who may need to absorb a very large amount of information during the early settlement period. For some newcomers, it is difficult to find information about health services, even on relatively basic topics, such as how to get a health card, how to find a family doctor, and the cost of and eligibility for different kinds of health services. One focus group participant suggested that there should be a centralized information portal for health information that is relevant to newcomers to Toronto.

"I am here four months [and] I don't know how I can select a family doctor. What is the criteria... can I go to any doctor, any time, what is a walk-in doctor? This is absolutely new. I am knowing it from my parents, from my neighbour, but I think as an immigrant, I should know from the government, from the city authority or something like that." (participant – service user focus group)

➤ ***Transportation***

Transportation is another barrier to health care for newcomers, according to focus group participants and the local literature. People who have to go far for medical appointments or who do not have a private vehicle may find it harder to access health services. Travelling with small children or elderly relatives can be especially challenging without a car. Related barriers include living too far from public transportation and unfamiliarity with these systems, especially for very recent newcomers. Finally, work duties can make it hard to book health-related appointment during regular business hours.^{86,214}

Access to health care and other services is influenced by the location of service providers and where people live.²²³ One study used data from the Canadian National Population Health Survey to show that the use of health services by immigrants in Canada increases with the number of doctors that speak their language in their neighborhood.²³⁰ Given the increasing number of newcomers opting to live in the inner suburbs of the city instead of downtown, adequate services must be available outside of the downtown core (where many health and settlement service providers have traditionally been situated) in order to facilitate access.

➤ ***Barriers to accessing health services among newcomer sub-populations in Toronto and Ontario***

Based on the local and provincial literature reviewed and the contributions made by participants in the stakeholder focus groups, various kinds of barriers to accessing services have been identified for specific sub-populations, based on the following factors:

Gender

- Some **newcomer women** may prefer to see a female provider, especially for gynecological matters.²³¹ Similarly, a study of women's health needs by Women's College Hospital reports that **Muslim women** want the option of exclusively receiving care from female staff.²³²
- Among the barriers to promoting breast health among **first-generation racialized women** in Windsor, Ontario are: stigma about breast health in their communities, the complexity of the health care system, the scarcity of female health practitioners, and values of modesty and privacy that make it difficult for women to expose themselves during breast screening (especially to male providers).²²⁹
- Researchers identified organizational, cultural, linguistic and systemic barriers that negatively affect access to health care for **older immigrant women**.²³³

Age

Based on a literature review and focus groups with older newcomer women in Toronto conducted for one local study, several key barriers to accessing health services for **older immigrant women** were identified. These include the three-month waiting period for OHIP, linguistic barriers (lack of interpretation in hospitals, misinterpretation by family members), lack of cultural competency in the health system, and lack of mental health services.⁷⁸ Finding transportation to appointments can also be especially challenging for **newcomer seniors**.^{234,64}

Meanwhile, **newcomer youth** report multiple barriers to accessing services, including discrimination and racism, lack of adequate interpretation, lack of information, and shame or embarrassment related to sexual health services.^{202,151,201} Fitness and recreation programs for newcomer children and youth may be inaccessible as a result of location or cost, particularly for lower-income families.¹⁷⁸

Sexual orientation

- Participants in the focus groups identified access to services for **LGBTQ newcomers**, particularly mental health counseling, as an area of concern.
- As noted above, one local study with Toronto's **African and Caribbean communities** reported that homophobia or the denial of homosexuality within communities and silence about health and sexuality were barriers to effectively responding to HIV within their communities.²²⁷
- Another local study that included interviews with **Black men who have sex with men (BMSM)** in Toronto found that some newcomers may not feel comfortable disclosing their orientation as MSM for fear of discrimination. The study findings also showed that: "for newcomers accessing LGBT-sensitive services outside of their community of origin, language barriers, cultural differences and discrimination are issues. These BMSM are then forced to choose between services that meet their cultural or linguistic needs and those that address their sexual health and lifestyle concerns".²³⁵

Immigration status

- Fear and distrust are significant barriers to accessing care for **uninsured and undocumented newcomers**, which can lead to serious delays in accessing care.²³⁶ Uninsured and undocumented women may wait to access care until late in their pregnancy due to fear of being deported and the expense of care.²²⁷ Delaying care means that women miss important screening tests that could help prevent complications. Barriers to access may also lead women to seek alternative care or to have a home birth, which could be very risky for mother and child.
- **Uninsured and undocumented newcomers** face bureaucratic hurdles in dealing with hospital, lab and specialist staff.²³⁶ There is also a lack of knowledge and information regarding services available to uninsured and undocumented migrants by both uninsured/undocumented individuals and health care providers in Toronto.²³⁷

- Research has identified lack of coverage, cost and negative health care experiences as major barriers for **refugee mothers** in Hamilton when responding to an acute, minor illness experienced by their preschool children.²³⁸
- Research with seasonal agricultural workers in Ontario found several barriers to accessing healthcare among this population. In Ontario, 93% of workers did not know about the Workplace Safety and Insurance Board, 19% were without OHIP and 46% reported language as a barrier.²³⁹

Summary: Key Barriers to Accessing Health-Related Services for Newcomers

Cost and Eligibility:

- OHIP waiting period for new permanent residents
- Lack of OHIP coverage for non-status migrants and refugee claimants
- Lack of extended health coverage for some services (e.g., dental and vision care, prescription drugs, psychotherapy)

Health System Factors:

- Service gaps/availability (e.g., hours of operation, services available only in certain locations, waiting lists for some health services)
- Language interpretation not widely available
- Services not sensitive to cultural or faith-based needs of diverse communities
- Distrust of service providers due to prior experiences of discrimination and **racism** when accessing services
- Long wait times for appointments (e.g., at walk-in clinics, ER and specialist visits)
- Complexity of the health system and social services that makes them difficult to navigate, especially for newcomers with limited English proficiency and/or low literacy

Socio-cultural:

- Attitudes and beliefs about health and illness
- Stigma, shame or embarrassment around certain health issues, including HIV/AIDS, sexual health and mental illness
- Perceptions about health service providers and/or institutions

Awareness of Services (Informational Barriers):

- Lack of awareness of existing programs and services
- Possible information overload for newcomers, especially during the early settlement period
- Inaccessibility of communications and outreach activities (e.g., use of complex language, English-only) and lack of targeting/tailoring for specific groups

Other:

- Transportation barriers



Each person has a unique mix of personal characteristics, such as their socio-economic status, age, gender, sexual orientation, race, ethnicity, cultural values and immigration status. These characteristics interact and overlap, affecting health in different ways.

Above: Community members discuss the health of newcomers at the *Income Security, Race and Health* project, led by Access Alliance.

5. SOCIAL DETERMINANTS OF HEALTH

“The Social Determinants of Health establish the extent to which people can possess the physical, social, and personal resources to identify and achieve personal aspirations, satisfy needs and cope with the environment. [They] are about the quantity and quality of... resources that a society makes available to its members.”²⁴⁰

Health is more than the condition of being free of illness. It relates to a person’s overall well-being and capacity to realize their potential and to live with dignity.^{240,241} Many different factors determine whether or not residents of Toronto are healthy. For example, health is affected by having a good job and an adequate income, having safe and affordable housing, and having access to both social support from friends and family and quality health and social services. Therefore, promoting health and well-being goes beyond just treating medical issues or changing individual behaviours. A determinants of health framework recognizes the need to proactively address the full range of social, economic and political factors that contribute to positive or negative health outcomes.

“Social determinants of health need to be widely communicated within the bigger community. If they are not committed to this model, they treat only the disease and they don’t address the entire issue. So, maybe we can do more education about the underlying issues that people may overlook.”
(participant – service provider focus group)

In many respects, the determinants of health for newcomers are similar to those of other Toronto residents. Some issues and services, however, are particularly important for newcomers especially in their early years of settlement. This section describes some of the key factors that affect the health of newcomers. The understanding of health determinants and how they shape people’s experiences and health presented here includes the following principles:

Determinants operate at multiple levels: the system or societal level (e.g., government economic and social policies), the community level (e.g., neighbourhood factors, access to services) and the individual level (e.g., income and social status, education, employment, personal health behaviours). Some health determinants operate at multiple levels to influence health outcomes. For example, minimum wage and other labour laws are enacted by the provincial government, but they impact individual workers on a daily basis.

Health determinants intersect and overlap: each person has a unique mix of personal characteristics, such as their socio-economic status, age, gender, sexual orientation, race, ethnicity, cultural values and immigration status. These characteristics interact and overlap, affecting health in different ways. Individuals may also face systemic barriers to social inclusion on the basis of these characteristics. For example, there is evidence that older immigrant women are at a high risk of poor health outcomes on the basis of their gender, ethno-racial background and age.⁷⁸

5.1 - MIGRATION EXPERIENCE AND IMMIGRATION CATEGORY

Newcomer health needs and access to services can differ substantially based on an individual’s migration experiences and immigration status and category.

The health of newcomers to Canada is influenced by their background and experiences *before* coming to Canada (e.g., socio-economic status, socio-cultural norms), by their experiences *during* migration (e.g., experiences of displacement or family separation) and by their experiences of the processes of settlement and adaptation *after* arriving in Canada (e.g., labour market opportunities, access to services). An individual's experiences before coming to Canada will influence their health outcomes after they arrive. For example, country of origin and socio-economic status are factors that determine exposure to certain infectious diseases. Also, experiences of trauma, displacement or family separation may contribute to future mental health issues. The processes of migration and settlement also influence health in various ways. Adapting to a new (social and physical) environment and culture can be very challenging and stressful. After arriving in Canada, many newcomers go through significant changes in terms of their income and employment, housing, social support networks, health behaviours and access to services. In addition, many newcomers also encounter systemic barriers to successful integration on the basis of their skin colour, language proficiency and immigration status, among other factors.

"Immigration status" refers to a person's standing according to Canadian immigration law. It determines one's rights, entitlements and obligations in Canada. "Immigration category" generally refers to specific groups of permanent residents and temporary residents as defined by Citizenship and Immigration Canada. Most research on immigration health in Canada focuses on permanent residents (see section 2.1), more than 60% of whom are economic-class immigrants and their dependents. Relatively little is known about the health of temporary foreign workers or migrants without status. This section considers evidence on the health of refugees, refugee claimants, migrants without status and temporary foreign workers. Note that research findings about the health status, needs and determinants for these groups are also discussed in sections 3 and 4 of this report.

➤ **Refugees**

Between 2000 and 2009, nearly 60,000 refugees arrived as permanent residents in Toronto. The majority of these were refugees landed in Canada (successful refugee claimants) and their dependents, but many government-assisted and privately-sponsored refugees have also settled in Toronto during this period (these categories are defined in section 2.1).¹ Refugees represent approximately 12% of permanent residents arriving in Toronto during this period. The top countries of origin for recent refugee arrivals are China, Colombia, Afghanistan, Iraq and Sri Lanka (see section 2.2 for more details).

Because the pre-migration experiences of many refugees are different from those of economic and family class immigrants, they often face greater health risks and access challenges. Refugees come to Canada with lower levels of education and English proficiency. For example, only 13.6% of refugees (arriving between 2005 and 2009) came with a university education compared to more than 80% of economic immigrants (principal applicants). These factors contribute to poverty and employment challenges, which are discussed in sections 5.2 and 5.3.

Many refugees that migrate to Canada have undergone difficult and traumatic pre-migration experiences, including exposure to war, torture, violence, targeted persecution, forced labour, forced migration and family separation.²⁴² These experiences are significant sources of stress and are therefore risks to refugees' mental health. Some examples of findings that relate to traumatic pre-migration experiences to health include the following:

- *Settlement challenges:* Research reports that Afghan, Karen and Sudanese refugees experience unique settlement challenges as a result of the traumatic pre-migration experiences that many have had and lower levels of education and literacy upon arrival (compared to other categories of migrants).²⁴²
- *Depression:* Pre-migration trauma (e.g., refugee camp internment) and post-migration events have both been associated with depression among Ethiopian newcomers in Toronto.¹³²

- *Children's mental health issues:* Pre-migration trauma and stress greatly influence mental health problems and illness among Southeast Asian refugee children in Toronto.²¹ In particular, refugee children exposed to natural and human-perpetrated disasters have been found to be at higher risk for depression, anxiety, anger and psychosomatic symptoms.
- *Post-traumatic stress:* Authors investigated psychological health and post-immigration adaptation among newcomers in Toronto from areas affected by war. Although high levels of post-traumatic stress symptoms were reported immediately after exposure to traumatic events, lower rates were reported at the time of the study, and all participants reported greatly improved health and psychological well-being.¹⁴⁷
- *Added stress for women:* Refugee women, in particular, may have experienced rape, sexual abuse, harassment and/or the obligation to grant sexual favours in return for food or necessary papers before or during their migration process, which exacerbates their risk for post-traumatic disorders.^{243, 244} Research notes a high incidence of depression, post-traumatic stress, psychosis and suicidal thoughts among refugee counselling clients from Central and South America, based in past experiences of violence and trauma.²⁴⁴

➤ **Refugee Claimants**

An average of 32,800 refugee claimants entered Canada annually between 2000 and 2009, including approximately 6,400 per year in the City of Toronto.¹ Of these, roughly 59% are men. There were 34,000 new claims made in 2009 before dropping to just over 22,000 new claims in 2010.^{xxvii, 245} As of December 31, 2009, there were 103,894 refugee claimants in Canada waiting for a decision on their claims (number not available for the City of Toronto).¹ Of refugee claims processed between 2000 and 2009, approximately 44% were accepted and 39% were rejected (the remainder were abandoned or withdrawn).²⁴⁵ Unsuccessful claimants are left without permission to remain in Canada.

For refugee claimants, delays in decisions about their claims can affect access to health services, education, employment and Language Instruction for Newcomers in Canada (LINC) classes due to their uncertain status, leading to depression and mental health issues.²⁰⁰ Research found that separation from loved ones can be painful for refugee claimants, and that the duration and complexity of the refugee determination process can have serious mental, emotional and financial impacts.¹¹³ One report has highlighted concerns about the potential negative implications of HIV testing and disclosure during the immigration process (e.g., for refugee claimants).²⁰⁴ For rejected refugee claimants not immediately deported (because no country can take them), access to employment, health care, housing and social services is simply cut off. Because immigration officials retain their documents, they may be forced to rely on charity or to go underground.²⁴⁶

➤ **Temporary foreign workers**

Since the mid-80s there has been a significant increase in temporary work permits issued in Canada; more temporary migrant workers have been admitted than permanent skilled workers.²⁴⁷ An average of 15,000 foreign workers came to Toronto each year between 2000 and 2009. Of these, two thirds were men. As noted earlier, the United States is the top source country for foreign workers. Other major source countries include the U.K., India, Philippines, Mexico, Australia, Japan and Jamaica.¹

^{xxvii} The sharp drop in claims in 2010 is a result of Canadian visa policies, notably new visa restrictions imposed on Mexico and the Czech Republic. Prior to these changes, Mexico was the top source country for refugee claimants. Other top source countries in recent years include China, Colombia, Sri Lanka, Pakistan and Haiti. Hungary was the top source country in 2010.

Although there is limited research evidence on the health of temporary workers in Canada, existing findings suggest that they face a high risk of health problems due to factors such as:

- social isolation, language barriers and lack of transportation;
- fear of loss of employment, work permits or wages; and
- lack of information on health care coverage or services.²³⁹

Many temporary workers find themselves subject to poor working conditions, including long hours, lack of benefits and various health and safety risks.²³⁹ Migrant farm workers, for example, face significant health risks as a result of their work, their limited access to services and their precarious status. While not directly applicable to Toronto, a large number of migrant farm workers are employed in Southwestern Ontario.^{247,248,164}

➤ *Migrants without status*

Migrants without status are those who are living in Canada without a recognized immigration status. They are sometimes referred to as “undocumented” migrants. Often, these are individuals who have stayed in Canada after their visa has expired or after their refugee claim has been rejected. The term can also cover an individual who falls between the cracks of the system, for example, a refugee claimant whose application is rejected but who is not removed from Canada because of a situation of “generalized risk” in their country of origin.²⁹

The number of migrants living in Toronto without recognized immigration status is unknown. However, anecdotal evidence from advocates and service providers working with non-status individuals suggests that their numbers are considerable. Living without recognized status presents many challenges and barriers. Non-status individuals often face poor working conditions, social isolation and limited access to health and other social services.³¹

Women without status are especially vulnerable, often living in conditions of deep poverty, housing instability, abuse and exploitation.²⁴⁹ Women without status may have family members who depend on their income, and they are therefore unwilling and unable to report exploitative work practices.²⁵⁰

Migrants without status also face unique and serious health needs and access challenges. Some of the mental, sexual and reproductive health consequences of being non-status are examined under the relevant subheadings of section 3 (Health Status of Immigrants to Toronto). Research found that non-status migrants in Toronto present signs of trauma, chronic stress and depression from family separation, and physical illnesses associated with stress.²⁵¹ One local study has noted that those living with precarious status experience a constant fear of deportation, along with anxiety about becoming ill and not having the economic means to seek care.³¹ Social isolation, stress and fear of being unable to access required health care can have a significant impact on the mental health of individuals facing these circumstances, potentially contributing to depression, suicidal thoughts, PTSD and addiction.²⁵² It is important to recognize that the challenges facing residents without status are often persistent; they are not unique to those who have recently arrived in Canada.

Health service providers have identified significant barriers and challenges to providing uninsured clients with necessary services. The most obvious of these is that services for this group are not covered by OHIP. Providers are not typically funded to address the health needs of this group. Some Community Health Centres (CHCs) in the Toronto area receive provincial funding (from the Ministry of Health and Long-term Care) to provide a narrow range of health care services to clients without status. However, these CHCs only have the capacity to see a limited number of these clients. Therefore, there are likely significant unmet needs for affordable health services among those without status in Toronto.

➤ *Access to Services*

Health care, settlement and other social services play a vital role in sustaining and promoting the health and well-being of newcomers to Toronto. Some services that are particularly important for newcomers during the early settlement period include employment services and child care. Over time, health services often become increasingly important. The various categories of health services are discussed in more detail in section 4.

5.2 - INCOME AND EMPLOYMENT

Newcomers make a crucial contribution to Toronto's economic prosperity. As the workforce ages, Toronto and other Canadian cities will continue to rely on immigration as a key source of talent to maintain its workforce and to sustain economic growth.^{253,254} However, employers are not yet taking full advantage of newcomers' talents. Instead many struggle to realize their full economic potential even over the longer term, often as a result of systemic barriers that they encounter. Concerns related to income and employment and their links to health were repeatedly identified as crucial issues by local stakeholders and in the literature reviewed for this report.

➤ *Income and poverty*

"Many newcomers are disappointed and suffer a loss of income and status in coming to Canada. This can cause a lot of stress – the stress of the loss of status, less income, change in gender roles; this stress can lead to mental health issues, family violence, and abuse." (participant – service provider focus group)

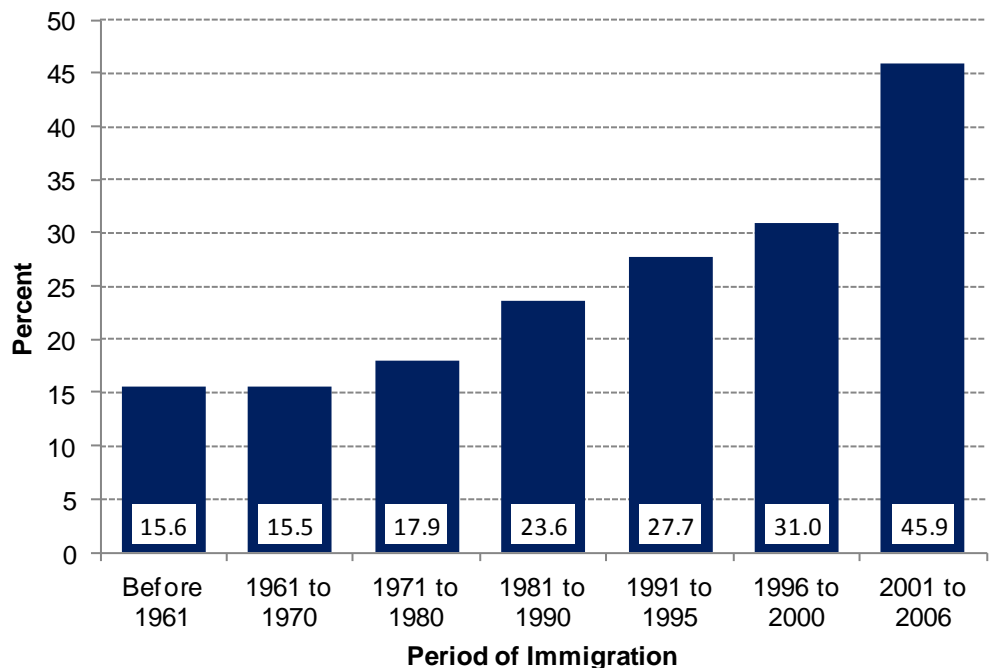
Newcomers and their families need access to adequate financial resources in order to successfully establish themselves within a new society. Statistics show that immigrants, particularly newcomers, are disproportionately poorer than the population as a whole.

- As of 2005, 46% of newcomers (all ages) in Toronto were living with a low income, compared to 23.2% of longer-term immigrants and 19.5% of the Canadian-born population. While newcomers (arriving 2001–2006) make up 10.8% of the population in Toronto, they represent 36% of low-income households.
- Newcomers are overrepresented in lower-income neighbourhoods.²⁴¹ In some neighbourhoods, as many as two thirds of newcomers (arriving 2001–2006) had low income (before tax) in 2005. Appendix B shows the rate of low income among newcomers for neighbourhoods with a high concentration of residents who fall into this category.

As shown in Figure 5.1, low income rates for immigrants are highest for those who have recently arrived in Canada. The rates for immigrants who arrived before 1991 are similar to those for non-immigrants.

The earnings gap between newcomers and Canadian-born residents has been widening in spite of the fact that newcomers are highly educated overall.²⁵⁵ In 2005, recently-arrived men earned 63 cents for every dollar earned by their Canadian-born counterparts, down from 85 cents in 1980.²⁵⁶ This gap widened for both individuals with a university degree and those without one. A recent longitudinal study using census data from 1981 to 2006 shows that, overall, there have been significant declines in earnings for immigrants upon arrival in Canada.²⁵⁷

Figure 5.1 Low Income Rate by Period of Immigration, Toronto, 2006



Data Source: Statistics Canada, 2006 Census of Canada, Custom Cross-Tabulations

Trends toward increasing polarization of income distribution in Toronto are a concern for all residents, including newcomers. In part, this is because income distribution affects health. Relatively equal income distribution across the population has been shown to be one of the best predictors of better overall health of a society.²⁵⁸ A recent study documents the growing income inequality among Toronto neighbourhoods between 1980 and 2005.²⁵⁹ Census data show that 20% of Toronto neighbourhoods have become much wealthier over the last 30 years, while 40% have become considerably poorer. This trend of growing socio-economic inequality has the potential to negatively impact the overall health of the city’s population.²⁴¹

As of 2006, newcomers (arriving 2001-2006) were almost four times as likely to live in one of the neighbourhoods where incomes had decreased significantly than they were to live in one where incomes had grown. This income inequality has been attributed to two factors:

- the growing income gap between an increasingly well-paid managerial occupational group and workers employed in lower-wage occupations; and
- the growing income gap between newcomers and the Canadian-born population, and between racialized and non-racialized residents.

Newcomers are generally healthy when they arrive in Canada, but loss of social status along with persistent poverty and financial insecurity may contribute to deterioration of health over time. Financial insecurity affects health in multiple ways. Income levels shape overall living conditions, affect psychological functioning and influence health-related behaviours, such as quality of diet, level of physical activity and tobacco use. Income also determines the quality of other basic prerequisites of health, such as food security and housing.^{258,241} Data from a national longitudinal survey show that immigrants with lower levels of income are more likely than those with higher incomes to report that their mental health status has deteriorated over time.⁴¹ Participants in focus groups conducted for this report noted that for many newcomer seniors, health issues are exacerbated by their lack of financial independence and by their poor financial situation.

Specific findings related to the negative impact of low income on levels of self-reported health, disability, chronic disease, physical activity and reproductive health are summarized under relevant headings in section 3 of this report (Health Status of Immigrants in Toronto).

➤ *Employment and working conditions*

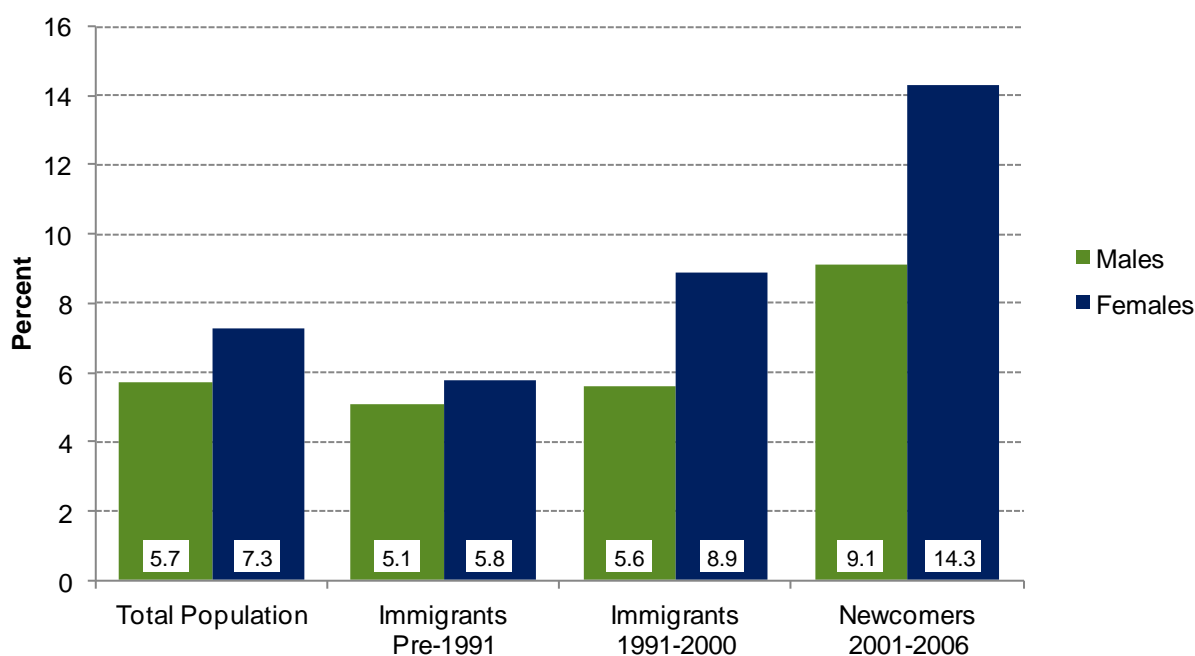
The link between employment, working conditions and health is well established. A number of work dimensions affect health outcomes, including:

- employment security;
- physical conditions in the workplace;
- work pace and stress;
- working hours; and
- opportunities for self-expression and individual development at work.²⁵⁸

Many newcomers experience acute and often prolonged labour market challenges. In fact, in recent years, immigrants have faced weaker long-term employment prospects than those who arrived in previous generations: In 2005, 13% of newcomers aged 15 and over in the labour market in Toronto (less than 5 years since arrival) were unemployed, compared with 7% of longer-term immigrants and 7% of Canadian-born residents. As shown in Figure 5.2, the unemployment rate for newcomer women in 2005 (14.3%) was more than 50% higher than that for their male counterparts (9.1%).

By 2009, the unemployment rate for newcomers (less than 5 years since arrival) was 17%, compared with 10% unemployment for the total city population.²⁶⁰ Even among newcomers with college or university degrees, unemployment more than doubled among 25–44-year olds from 7.8% in 2008 to 16.2% in 2009 (compared to an increase from 6.5% to 10% for those with the same education in the total population).²⁶⁰

Figure 5.2 Unemployment Rate, by Period of Immigration and Sex, Toronto, 2006



Data Source: Statistics Canada, 2006 Census of Canada, Custom Cross-Tabulations

Newcomers must confront a particular set of barriers when looking for good jobs, including lack of “Canadian experience”, non-recognition of foreign credentials and labour market discrimination. Many newcomers find themselves underemployed or working in jobs unrelated to their experience and qualifications.²⁶¹ National data show that the proportion of newcomers with a university degree working at jobs with low educational requirements grew between 1991 and 2006 from 22% to 28% for men, and from 36% to 44% for women.²⁶² The experiences and stories of downward occupational mobility and unemployment among newcomers in Toronto have been captured in various reports.^{162,263} In terms of what this means for the city, the annual cost of failing to recognize the qualifications and experience of immigrants in the greater Toronto region is estimated to be at least \$1.5 billion.²⁶⁴

Some newcomers need to take multiple jobs and/or do temporary, precarious work in order to make ends meet. Canadian labour force data show that, as of 2008, 16% of newcomers worked in temporary positions compared to 8.3% of their Canadian-born counterparts.²⁶⁵ Newcomers were also less likely to have supervisory responsibilities, to be unionized or to have non-wage employment benefits.²⁶⁶ Economic class immigrants and newcomer males appear to fare best in the labour market, while women, government assisted refugees, refugee claimants and those without status are more likely to encounter employment barriers and to be working in jobs with low pay and poor working conditions. While some newcomers are able to find better employment over time, there is evidence that those whose early work experience in Canada is characterized by precarious jobs are more likely to remain in precarious work, regardless of education and time in Canada.¹⁶⁵ The rise of temporary and precarious employment and unsafe work conditions can have many negative impacts on health.^{267,162,268}

A number of local and national studies and reports have documented the health impacts of unemployment, precarious employment and poverty on newcomers and their families. The following are some examples:

- *Physical and mental impacts:* One study used a community-based research approach to look at the health impacts of employment and income insecurities for low-income, racialized residents of Toronto’s Black Creek neighbourhood, many of whom were newcomers.¹⁶² Participants indicated that these insecurities contribute to mental health and addiction issues, digestive disorders (e.g., ulcers, constipation and diarrhea), physiological impacts (e.g., fatigue, exhaustion, weight gain/loss and chronic pain), cardiovascular impacts (e.g., hypertension and high blood pressure) and workplace injuries. The study also found that precarious income and employment have a negative impact on the health of participants’ family members.
- *Work as a health risk:* Another study looked at the impacts of working conditions on the health of hotel housekeepers in the GTA, most of whom are racialized immigrant women.²⁶⁹ The findings suggest that, even for unionized employees, working conditions have a negative impact on physical and mental health, with participants reporting injuries and severe fatigue due to their work. Some participants have experienced racial and ethnic discrimination in the workplace. Also, in spite of having extended health insurance coverage, the women do not make use of benefits such as massage and chiropractic care, due to their work hours and the loss of wages associated with taking time off work.
- *Employment and mental health:* Research indicates that feelings of disappointment and frustration, particularly with respect to gaining quality employment, are factors that contribute to mental health issues among newcomers in east Toronto.²⁰⁰
- *Mental health strain on sub-populations:* Unemployment and unmet employment expectations have been shown to be strongly associated with stress and psychological distress among specific newcomer communities in Toronto, including Afghanis Somali and Sudanese communities.^{178,219,218,141}
- *Unemployment and addiction:* Underemployment and unemployment, as well as poverty and economic pressures have been identified by members of Afghan, Pakistani and Russian communities in Toronto as factors that contribute to addictions and substance abuse.⁷²

"High-stress jobs predispose individuals to high blood pressure, cardiovascular diseases, and development of physical and psychological difficulties such as depression and anxiety".²⁵⁸

Newcomer focus group participants spoke about various ways that financial and employment challenges have affected their health:

"When I came [to Toronto] I had normal blood pressure and no other problem. After a month I got a job but it wasn't my related job- more like an odd job. Job is [a] job, I know, but I cannot set up my mind that I was doing that. After 6 months I feel that my [blood] pressure is going high day by day and I got to the doctor and doctor is giving me the medicine, and I am having the medicine but it is not controlled". (participant – service user focus group)

"Right now I am having the blood clot related medicine and the high blood pressure medicine every day and my husband is taking medicine for diabetes and cholesterol. So ...if you think always about your money and your job satisfaction, you'll be depressed, you'll be tense, you'll be thinking always, and it is related like that." (participant – service user focus group)

Finally, employment and income insecurities also affect health indirectly, for example, by making it more difficult to access health and other social services, particularly when people's hours are unpredictable and they juggle work and family responsibilities.

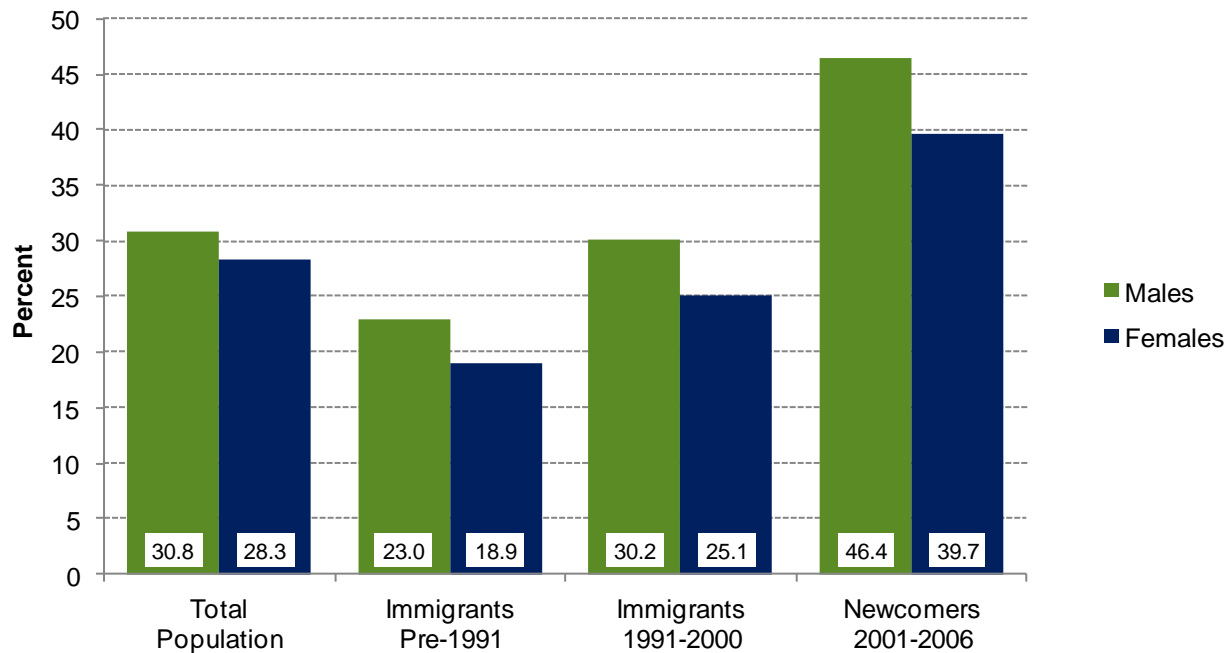
5.3 - EDUCATION

Education helps people to move up the socioeconomic ladder and provides better access to other societal and economic resources.¹

Most newcomers in Toronto are highly skilled and educated when they arrive. Of those arriving between 2001 and 2006, 42.8% had a university certificate or degree (46.4% of men and 39.7% of women^{xxviii}). Figure 5.3 shows that newcomers are considerably more likely to have a university degree than longer-term immigrants and those who were born in Canada. Levels of education also vary by immigration category. Citizenship and Immigration Canada data show that only 13.6% of refugees arriving in Toronto between 2005 and 2009 came with a university education compared to more than 80% of economic immigrants (principal applicants).

^{xxviii} Citizenship and Immigration Canada landing data from 2005–2009 show that 45.8% of men arriving in Toronto during this period had a university degree, compared to 42.4% of women (Citizenship and Immigration Canada, 2010). This suggests that the education gap between male and female newcomers may be narrowing.

Figure 5.3 Percent Aged 15 and Older with a University Degree/Certification, by Period of Immigration and Sex, Toronto, 2006



Data Source: Statistics Canada, 2006 Census of Canada, Custom Cross-Tabulations

There is a strong positive relationship between education and health. As seen in section 3, lower education can be a negative predictor of some aspects of health, including self-reported health status, chronic disease, and overweight and obesity. However, one study has found that difference in health between less educated and more educated immigrants is relatively small, and that the impact of a university education on health may actually be weaker for immigrants than for non-immigrants.⁵¹

For newcomer children and youth, education and schools are very important. Schools are essential not only for providing education to newcomer children and youth, but also because many critical programs and services that support their integration are housed within them.¹⁵⁰ One study found that newcomer parents in Ontario put major emphasis on education and school, and that they often find a second job or borrow money to help children concentrate on education.²⁷⁰

The following local studies have looked at educational experiences and attainment among immigrant children and youth:

- A study commissioned by the Ontario Ministry of Education and Training revealed that first- and second-generation youth in Toronto and Kitchener-Waterloo experience unique challenges in secondary school.²⁷¹ These youth became “disengaged” from school for a number of reasons, including language barriers and lack of language instruction, unfamiliarity with the Canadian school system, as well as stress associated with resettlement, loneliness, isolation and lack of friends. The study also found that assessments of linguistic ability were often inappropriate, and students were placed in the wrong grades as a result. Age at the time of migration was critical, with youth arriving in the later high school years most at risk for leaving school early.

- A recent study has used data from the Toronto District School Board to explore early school leaving among immigrants in Toronto secondary schools.²⁷² Region of origin is a significant predictor of dropping out for first-generation youth. Students from the Caribbean are significantly more likely than native-born students to drop out of school, while students from Europe, Eastern Asia and South Asia are less likely to leave school early. Also, dropout rates are significantly higher among youth living in lower-income neighbourhoods.

Finally, education increases overall literacy and understanding of the actions individuals can take to promote their own health.²⁵⁸ There are also strong associations between health literacy and self-reported health status. Beyond literacy and education, health literacy involves understanding health issues, knowing how to use the health care system, having the ability to advocate for health care and having access to information and resources that help to promote physical and mental health in everyday life.²⁷³ Health literacy (defined as an understanding of issues, the health system, and health promotion) was identified in one local report as an important need for newcomers seeking to improve their access to health services.²²⁶ Health literacy applies not only to interaction with medical providers, but also to a variety of other settings and life situations, which makes it an important enabler of newcomer settlement and integration.

5.4 - LANGUAGE PROFICIENCY

The ability to speak and read English is a key prerequisite to social inclusion and securing adequate employment. In 2006, 90% of newcomers in Toronto (arriving 2001-2006) spoke either English or French. However, English is not the first language of most newcomers: four in five newcomers reported having a mother tongue besides English or French. The level of English proficiency varies considerably among newcomers. Newcomer men are more likely to speak English or French upon arrival than are women. Language ability also varies significantly by immigration category. Among new arrivals accepted as economic immigrants in Toronto, most speak English. However, their dependents as well as family class immigrants and refugees are less likely to speak English when they first arrive.¹

Newcomers with limited English- or French-language proficiency are more likely to report poor health than those who are more proficient.⁵² Language proficiency influences and/or intersects with other key health determinants in the following ways:

- *Employment:* Some research has drawn direct connections between language proficiency and the ability to obtain good quality jobs.^{178,274}
- *Discrimination and employment:* A recent community-based research study found that racialized residents of Toronto's Black Creek area, many of whom are newcomers, report experiences of discrimination based on low English proficiency and speaking with an accent. This, along with other forms of discrimination, affects their ability to find stable employment.¹⁶²
- *Education:* Linguistic and cultural barriers can make it challenging for newcomer children and youth to enter the school system at an age-appropriate level.
- *Housing status:* Some research has linked lower levels of language proficiency to homelessness among immigrants.²⁷⁵
- *Social support:* A report based on interviews with older immigrants in Ontario indicates that lack of English ability contributes to social isolation and depression.²³⁴
- *Access to health services:* A literature review found strong international evidence of the negative impacts of language barriers not just on clients but also on providers and healthcare institutions in terms of health care accessibility, quality, efficiency and cost.²⁷³

A number of reports have identified a need to make ESL and LINC programs more inclusive and accessible by tailoring them to the needs of specific newcomer sub-populations, such as women and refugees, and providing supports, such as childcare.^{242,276,139} A recent report by the TD Bank Financial Group suggests that businesses can also play an important role in promoting newcomer literacy by providing or subsidizing language skill courses and encouraging employees to improve their English and French proficiency.²⁷⁴

5.5 - HOUSING

Housing is another critical determinant of health. Living in adequate, safe and affordable housing can contribute to good health. At the same time, poor housing conditions can put health at risk (see Communicable Diseases, Mental Health and Well-Being and Environmental Health in section 3).

Table 5.3 shows that newcomers to Toronto (arrived between 2001–2006) spend a greater proportion of their income on housing and are considerably less likely to own their homes compared to other Torontonians. However, longer-term immigrants are slightly more likely to be homeowners than those born in Canada.

Table 5.3: Housing Indicators, City of Toronto

Housing Indicator	% City of Toronto (all)	% Newcomers (arrived between 2001 and 06)	% Longer-term Immigrants	% Canadian-Born
% Home Owners	54.4%	24.7%	59.6%	54.5%
% Renters	45.6%	75.3%	39.4%	45.5%
% Spending >30% of their income on <i>housing</i>	33.0%	57.5%	29.9%	21.6%
% Spending >30% of their income on <i>rent</i>	47.0%	52.0%	46.0%	44.0%

Source: Statistics Canada, 2006 Census, Target Group Profiles

Finding adequate and affordable housing can be a major challenge for newcomers to Toronto, given the high cost of renting or purchasing a home or apartment and the low rental vacancy rates in the city. Access to social housing is also very limited. As of May 2011, there were 67,714 households active on the waiting list for social housing in the City of Toronto.²⁷⁷ Experiences of discrimination and linguistic barriers can make the search for appropriate housing even more difficult for newcomers.^{278, 279} It is particularly difficult for large families to find appropriate housing, and in some cases newcomer families will share housing with another family to make housing more affordable.²⁷⁵

Financial problems based on housing costs and, sometimes, housing itself are significant sources of stress for newcomers and their families.²⁰⁹ The reality is that affordable housing is too often of poor quality, i.e., crowded, inadequate, infested or unsafe. A recent report by the United Way of Greater Toronto speaks to high levels of poverty and poor living conditions in Toronto high-rise buildings, many of which house large numbers of newcomer families.²⁸⁰

Type of housing may also influence settlement and social inclusion, although the evidence here is mixed. In spite of poor living conditions in many of Toronto's high rise buildings, there are often extensive bonds of friendship, mutual support and reciprocity, and considerable social cohesion among the tenants living in them. This appears

to be especially so where there are large numbers of newcomer families who share common origins, religions and languages.²⁸⁰ By contrast, research found that newcomers who rent or live in apartments in Toronto, Montreal and Vancouver know and trust fewer neighbours and have a lower sense of belonging than those who own homes.²⁸¹

Immigrants in Toronto may be somewhat more vulnerable to homelessness than those born in Canada.²⁷⁹ One study describes homelessness among immigrants as “hidden”, as it includes those who “couch surf” from place to place or stay in non-residential or wholly inappropriate accommodations.²⁸² Another study cites local literature suggesting that “[living in] poor housing and poor neighbourhoods act as barriers to economic success, increase the likelihood of poor health, contribute to social exclusion and ultimately raise the risk of homelessness”.²⁸³ Of course, housing difficulties are often closely related to underlying financial difficulties. One recent study has shown that compared to other homeless residents in Toronto, homeless newcomers are more likely to report financial reasons for being homeless (i.e., insufficient income and lack of employment) and less likely to report reasons related to mental health conditions or addiction.²⁸⁴ The study authors concluded that homeless newcomers represent a distinct group that has very different service needs compared to other homeless residents.

Women without status are particularly vulnerable to homelessness and its health consequences. When precariously employed, and therefore in situations that are more prone to exploitation, it is difficult to break the cycle of homelessness.²⁴⁹ Live-in caregivers and refugee claimants may also be vulnerable because they are not eligible for social housing or for most housing support services.^{285,113}

5.6 - NEIGHBOURHOOD FACTORS

The physical and social environment at the neighbourhood level can have an important impact on health. Newcomers in Toronto are overrepresented in lower-income neighbourhoods.²⁴¹ They have settled in large numbers in many of the city’s identified “Priority Areas”. These areas have higher rates of low-income and unemployed residents. Many of these areas also have less access to social services relative to other Toronto neighbourhoods.²⁸⁶

The resettlement experience of Canadian immigrants differs vastly from that of newcomers to the U.S. in terms of exposure to neighbourhood crime and racial segregation.²⁸⁷ Newcomers in Toronto are more likely to reside in racially diverse neighbourhoods or ethnic enclaves organized on the basis of cultural and national origins and that are seldom exclusive. By contrast, urban ghettos are residentially segregated on the basis of race, ethnicity and/or religion and exhibit very high levels of physical and social deprivation.²⁸⁸

There is evidence that ethnic neighbourhoods and spatial concentrations of ethnic groups can both positively and negatively affect the process of newcomer integration. Canadian research suggests that ethnic enclaves can be sources of social capital, mutual support and ethnic economies.^{289,290} Ethnic enclaves may be especially beneficial for immigrant women, children and seniors, immigrants who are not fluent in English, and immigrants who are accustomed to the supportive presence of family and friends.²⁹¹

However, suburban ethnic enclaves pose a challenge for service providers and municipal authorities in Toronto. Many services in the Greater Toronto Area are centralized, while immigrants are increasingly concentrated around the perimeter of the City of Toronto and surrounding GTA communities.²⁹² Similarly, research has noted that access to health care and other services is influenced by the location of service providers and where people live.²²³ Given the increasing number of newcomers opting to live in the inner suburbs of the city instead of the downtown

core, it is critical that adequate services are available outside of the downtown core, where many health and settlement service providers have traditionally been situated.

Access to transportation is an important aspect of a neighbourhood; it affects access to services, education, employment and other necessities. Lower rates of car ownership among newcomers, combined with inadequate transit service, can contribute to the social and economic challenges that newcomers face. Participants in focus groups for this report identified lack of transportation as a barrier to accessing services. Specifically, the need to travel long distances to medical appointments and lack of access to a private vehicle were cited, especially when travelling with children. Many newcomers live in neighbourhoods that lack access to rapid transit (subways or light rapid transit (LRT)). In addition, some recent newcomers have limited knowledge of the city and how to navigate the transit system, particularly when they first arrive. For some, it can be difficult to take time off work to travel to appointments. Reliance on transportation in order to obtain services can be especially challenging for newcomer seniors.^{234,64}

In order to explore the link between neighbourhood and immigrant health, researchers conducted a qualitative study with residents of St. James Town (SJT), a neighbourhood in downtown Toronto.²⁹³ The study involved three ethno-racial newcomer immigrant populations: Tamil, Filipino, and Chinese (Mandarin speaking), and compared their experiences with those of Canadian-born residents in the neighbourhood. The study explored both characteristics of the neighbourhood and individual-level factors, including newcomers' perceptions of the neighbourhood, their social relations and their access to health and social services. Findings suggest that all participants, regardless of immigration status, felt that access to public transportation, proximity to grocery stores that sell their culture's food, and the presence of other residents of similar ethnic origin are important and positive aspects of SJT. Participants also described the negative aspects of SJT that they believe impact their health and well-being. Overcrowding, poorly maintained residential buildings, a lack of sufficient recreational space and the presence of crime are all factors that contribute to residents' dislike of the neighbourhood. Economic circumstances that constrain their ability to move to other neighbourhoods were also identified as a negative factor.

A study on neighbourhood environments and diabetes in Toronto has found strong associations between lower rates of diabetes and both activity-friendly neighbourhoods (e.g., that are conducive to walking and cycling) and neighbourhoods offering greater access to health-enhancing resources (e.g. stores selling fresh fruit and vegetables, recreational space, parks or schoolyards, and family physicians). These relationships hold true for low-income areas and areas with a combination of low-income and racialized residents.²⁹⁴

Faced with economic disadvantage and social instability, newcomers to Canada may be disproportionately exposed to environmental health hazards in their neighbourhoods, homes and workplaces.¹⁶⁶ A recent report on urban physical environments and health inequalities in Canada noted that individuals and families living in lower socio-economic status areas are more likely to be exposed to outdoor air pollution and extreme heat.²⁹⁵ These exposures may contribute to higher rates of morbidity and mortality from circulatory and respiratory illnesses. Overall, however, very little Canadian research has directly examined the effects of the physical environment on the health of newcomers.

5.7 - FOOD SECURITY

Food security can be defined as having access to adequate amounts of safe, nutritious, culturally appropriate food for everyone, produced in an environmentally sustainable way, and provided in a manner that promotes human

dignity.²⁹⁶ This includes both physical and economic access to food that meets people's dietary needs as well as their food preferences. Living with a low income or in poverty increases the risk of experiencing food insecurity. The 2004 CCHS also showed a high rate of food insecurity among low-income and newcomer households.⁶⁵ The 2009 Ontario Material Deprivation Survey reported that 12% of newcomers (less than 5 years in Canada) cannot afford to eat fresh fruit and vegetables, compared to 4% of longer-term immigrants and 5% of Canadian-born respondents.²⁹⁷

Relatively few local and Canadian research studies have examined food insecurity among newcomers. Local findings that were compiled for this report include the following:

- *Many newcomers rely on food banks:* A survey conducted by the Daily Bread Food Bank found that 37% of Toronto residents who relied on food banks in 2009/2010 had been in the city less than five years.⁶⁰ Just over a quarter (26%) of newcomers using Toronto food banks had gone hungry at least once a day in the previous year and 30% had not eaten for a whole day. The situation was similar among non-recent immigrants.
- *Income directly impacts food security:* Research examined the extent of food insecurity and related factors among Latin American newcomers in Toronto.⁶⁵ Of 70 adults recruited from several Community Health Centres across the city, 56% experienced food insecurity. Household food security status was closely related to income, which suggests the need for strategies to improve the ability of new immigrants to purchase sufficient, nutritious and culturally acceptable food.
- *Newcomers experience food insecurity despite high education levels:* In order to examine food security and dietary intake, researchers conducted in-depth interviews with adult newcomers from Colombia in London, Ontario who used a food bank.²⁹⁸ Despite being highly educated, all respondents had experienced some form of food insecurity within the previous 30 days. Total daily energy intake was low, and a majority of participants consumed a diet low in vegetables and fruit (73%) and milk and dairy products (58%). The degree of food insecurity was higher for those with lower incomes and those who were newer to Canada.

5.8 - FAMILY AND SOCIAL SUPPORT NETWORKS

Social and family support networks play a vital role in promoting good health among all Canadians by helping them solve problems and deal with challenges they encounter.²⁹⁹ For newcomers, social support networks involving family, friends, groups and organizations promote health by enhancing coping, helping them deal with the stress of migrating and resettlement, and facilitating access to health care, employment and other services.^{300,301,302} Several local and Canadian studies have looked at the relationship between social support networks and health:

- One study used data from the Canadian National Population Health Survey to show that social networks were positively associated with the decision to use health services among immigrants.²³⁰
- For newcomer youth in Toronto, the quality of social relationships is related to acquiring a sense of belonging. Similarly, relationships with parents and friends play an important supportive role for female newcomer youth.^{303,304}
- Local research has shown that social support and connectedness are positively related to health for older immigrant women.¹⁶⁷
- For recently arrived refugees, social supports, services and opportunities have been shown to contribute to positive health outcomes.⁴⁴

Access to social support networks, however, does not necessarily protect newcomers from the health effects of other factors, such as poverty. One study examined the life events and difficulties experienced during the immigration process by Chinese women who had migrated to Canada with their spouses in the previous decade.¹³³ The financial strain of living in poverty was a significant predictor of symptoms of psychological distress for participants. The level of social support available to these women did not seem to affect the relationship between life events, difficulties and mental health.

In considering how social support networks help to promote good health, it is important to note that many newcomers actually lose access to their social and family supports as a result of migrating to Canada. Moreover, once in Canada, they may face barriers to accessing social networks for cultural, religious, linguistic, or gender-based reasons.²⁰⁰ The resulting social isolation can have a negative impact on health, as demonstrated in the following findings from the recent literature:

- Among some newcomer youth, social isolation and racism negatively affect mental health, and negative peer pressure may contribute to addiction and substance abuse.^{200,72}
- Among newcomer seniors, isolation in the family home (due to limited English proficiency and access to transportation) has been identified as a factor that contributes to depression.²³⁴
- Lack of social support and unsatisfactory marital relations were two of the three factors found to be significantly and independently associated with depression among pregnant immigrant women in Montreal.¹²⁸

Many immigrants from non-European countries have a broad concept of family that includes extended family members and often friends and community members.³⁰⁴ As a result, family takes on a more important role in the provision of support and in individuals' sense of responsibility for providing support, which extends to family members remaining in their country of origin or who are in the process of resettling in other countries. In addition, better access to transportation and cheaper communication technologies has enabled some groups of immigrants to retain close ties with family and friends back home.

Family dynamics and the availability of family support change during the process of migration, and these changes impact on health. Family loss or separation, gender role changes, intergenerational tensions and post-migration lifestyle changes often lead to increased stress combined with a loss of support from extended family and community members.³⁰⁰ Those who are unable to retain close ties with family and friends due to financial, geographic and/or political barriers are affected by the stress of separation and by anxiety about the welfare of their loved ones.^{305,306,301,144} The experience of being separated from family for an extended period is often an unexpected and difficult barrier to settlement.¹⁵³ Therefore, policies that limit family reunification or prolong its process can impact health by extending the negative effects of family separation over time and delaying the beneficial social support that family members can provide.

Some newcomer youth feel burdened by familial/social expectations and responsibilities and may prioritize the needs of their family over their own.³⁰⁷ Intergenerational conflicts (about sexual health, dating, sexuality, education, career choices, etc.) also present considerable challenges for youth. Youth who identify as gay, lesbian, bisexual or transgendered may be especially vulnerable to family conflict, since the values held by their parents may be incongruent with their identity.²⁰⁶

Many newcomer seniors are under the care of their family members who sponsored them to come to Canada. Depending on the quality of this relationship, newcomer seniors may face health risks due to isolation, depression, abuse and lack of financial independence, as well as barriers related to language, poverty, transportation and mobility (see the relevant sections of section 3 for more about specific health issues facing older newcomers). As

has been noted in other sections of the report, older newcomers are at high risk of transitioning to poor health compared to younger newcomer adults.^{41,42,43}

Family stressors may also contribute to the physical and domestic abuse of newcomer women and girls. This topic is discussed below in section 5.11.

Social support networks outside of the family often involve newcomers' ethnic community and religious organizations that cater specifically to that community. For example, some newcomers receive informal settlement support from religious institutions, such as mosques or churches.³⁰⁷

5.9 - RACIALIZATION AND RACE-BASED DISCRIMINATION

*"People in Canada should not be prevented from reaching their full health potential because of their race, ethnicity, religion, income or other socially determined circumstance."*³⁰⁸

In the 2006 census, 81% of newcomers in Toronto (arriving 2001-2006) identified themselves as a member of a racialized group^{xxix} (visible minority), versus 47% of all Torontonians.³³ Therefore, considerations of race and ethnicity figure prominently in efforts to understand the health status and needs of recent arrivals. The combination of racialized identity and newcomer status results in different experiences for those individuals with regards to health compared to non-racialized immigrants. Some of these differences, and the added risks faced by members of some ethno-racial groups for everything from cancer, diabetes, obesity, certain genetic conditions and work-related injury are discussed in section 3 of this report.

Discrimination is a key form of social exclusion affecting newcomers to Toronto. It can be defined as unfair behaviour or differential treatment on the basis of a group characteristic that results in negative consequences for that group.³⁰⁹ Although there are many forms of discrimination (e.g., due to race/ethnicity, gender, religious beliefs or sexual orientation), racial discrimination is frequently identified as a concern for newcomers.

Racialized newcomers face discrimination based on their skin colour, language proficiency, culture and immigration status. Data from the Longitudinal Survey of Immigrants to Canada (LSIC) show that racialized newcomers are more than twice as likely as White immigrants to perceive discrimination (after controlling for gender, education and fluency in English or French).³¹⁵ Several research studies and community consultations have documented racism and other forms of discrimination experienced by newcomers to Toronto. Newcomers encounter discrimination when accessing health and social services, in the labour market, in the educational system and when seeking housing.^{225,310,278,78,275} Several reports have also highlighted that newcomer and racialized youth in Toronto commonly report experiences of race-based discrimination.^{242,307,202, 151,311,312,218,304}

Levels of poverty and unemployment tend to be greater for some racialized newcomers, especially racialized women. Newcomers that are not of European descent are more likely to experience lower earnings and non-recognition of their skills.³¹³ One study reports that racialized immigrant men in Canada earn only 68.7% of what non-racialized immigrant men earn.³¹⁴ Racialized immigrant women earn only 48.7 cents for every dollar that a non-racialized male immigrant earns.

^{xxix} The term "racialized groups" is defined in section 1.3 (Key Definitions).

Several studies and reports have documented newcomers' experiences of discrimination in the workplace on the basis of their skin colour, language and/or accent, birthplace, and cultural and religious practices.^{315,162,269,316} National data reveal a large earning gap between racialized and non-racialized Canadians and show that the former are overrepresented in insecure, temporary and low-paying jobs.³¹⁴

Inequities in health status associated with race and ethnicity have been well documented internationally. These inequities are the result of multiple factors, including socio-economic status, discrimination and bias, and differential access to care.³¹⁷ Several studies (mostly from the U.S.) have shown strong associations between racial discrimination, health and the development of chronic disease.^{318,319,320,321} There is also evidence from the U.S. literature that racialized Americans have poorer access to health care, have more unmet health needs and experience worse health status than White residents.³²²

Relatively few studies have looked at the impact of discrimination on the health of newcomers in Canada. Some findings from studies that have done so include the following:

- An analysis of data from LSIC showed that newcomers to Canada (permanent residents) who reported experiencing discrimination or unfair treatment were more likely to show deterioration in self-reported physical and mental health status over a four-year period.⁴¹
- Racial discrimination was a predictor of depression among Southeast Asian refugees.³²³ However, the same study found that early integration into Canadian society reduced the impacts of discrimination and the likelihood of depression.
- Another study found a strong relationship between mental health and experiences of harassment and victimization among immigrant children in Canada.³²⁴

Other local studies have connected discrimination with negative health impacts for racialized groups (not necessarily newcomers). For example:

- 85% of respondents to the Korean Health Study in Toronto reported experiences of racial discrimination, and, after controlling for other variables, perceived discrimination was associated with depressive symptoms.^{325,326}
- A local participatory research study conducted found that racism was a risk factor for physical health problems and stress among female youth of colour in Toronto.³²⁷

Many local reports also highlight the experiences of discrimination among racialized individuals accessing (or attempting to access) health care and other services. Some specific findings include the following:

- *Poorer health care:* Racism may compromise the quality and effectiveness of health care in the South Asian community. Participants in one local study observed that some health providers do not screen South Asian women for sexually transmitted infections because it is assumed that they are not at risk.²¹⁷
- *Systemic racism:* Somalis in the GTA have reported experiences of racism within the immigration, education, social services and employment sectors.²¹⁸
- *Barrier to HIV care:* The racialization of HIV as a Black or African disease by mainstream cultural media and institutions has a negative impact on the willingness of these populations to approach health or support services, and on HIV knowledge and awareness.³²⁸
- *Barrier to better sexual health:* Newcomer young women identify fear of racism as a reason for not accessing sexual health services.²⁰²
- *Neighbourhood profiling:* Youth in the Regent Park neighbourhood, many of whom are newcomers, report experiencing racism when accessing services, and describe compounded stigma and discrimination based on their ancestry.¹⁵¹

- *Barrier to mental health care:* Racialized community members in Toronto report that their encounters with the mental health system are mostly negative, both in terms of access to, and the quality of services received.²²¹ The same study found that consumers of mental health care from racialized communities feel misunderstood, alienated and stigmatized when accessing mental health services, and feel that their experiences of race-based discrimination are often dismissed and discounted.

Overall, there is considerable evidence that newcomers to Toronto experience race-based discrimination in a variety of ways, and that these experiences are a serious risk to their health and well-being.

5.10 - CULTURE AND HEALTH BELIEFS

Culture is a product of both personal history and wider situational, social, political, geographic and economic factors.²⁹⁹ Various aspects of culture relate to health, including shared beliefs, values, traditions and behaviours. When newcomers come to Canada from non-western countries, they encounter different cultural constructs, such as those that underlie Western approaches to health and medicine, like the emphasis on biomedicine, individualism, and notions of efficiency.

Although it is not always clear which aspects of culture determine health, it is well established that there are considerable ethno-cultural variations in perceptions of health, illness and of help-seeking behaviour. Kathryn King, of the University of Calgary, has done extensive work on the ways in which culture and gender influence people's beliefs and understanding about health and disease risks, access to health-management resources, and ultimately their behavioural choices.^{329,330} It has been noted that culture shapes perceptions of illness, including how people experience and report symptoms and their severity, and beliefs about illness, including its causes and which treatments to seek and how.³³¹ Cultural psychiatrists in Canada have documented cultural differences in the presentation, interpretation and response to mental health symptoms.^{332,333,334} This is also the case for other health and social issues that may be considered to be stigmatizing within a cultural community, such as HIV, tuberculosis, diabetes and intimate partner violence. Misdiagnosis can occur when clinicians do not recognize diverse ways of expressing distress; this may be a particularly risk with respect to mental health.³³⁵

In 2000, a five-year participatory action research study was initiated with five ethno-cultural communities (Latin American, Mandarin-speaking Chinese, Polish, Punjabi Sikh and Somali) in Ontario to examine community perspectives on mental health, mental illness and mental health experiences.³³⁶ Focus group participants affirmed the need to incorporate considerations of culture and power disparities into health policy and practice. The researchers propose a theoretical framework that lays out how mental health policy and practice can change to become more responsive to residents from diverse cultural-linguistic backgrounds.

Some reports highlight attitudes and beliefs of specific newcomer groups that might affect health and access to health services. For example, some ethno-cultural groups may have strong attitudes and beliefs about sexual and reproductive health issues.^{61,204,227} Cultural attitudes about sexuality contribute to stigma, which may be a deterrent to accessing sexual health testing and services. Stigma and access to health services are discussed further in section 4.12.

The religious and spiritual beliefs of certain groups may also affect beliefs about health, illness and accessing health care. Little Canadian research has addressed this issue. A participatory research study of the health care needs of Muslims in the U.S. found that many participants assigned responsibility for one's health, disease and healing to God.³³⁷ These views are accompanied by a holistic view of healing involving a combination of spiritual

and medical agents. Study participants frequently discussed the health care role of imams, the spiritual leaders of the Muslim community.

5.11 - GENDER

“Gender” refers to the social norms, perceptions and meanings associated with being a woman or a man. Gender shapes distribution of resources and opportunities, power relationships, perceptions of capacities, interests and ways of knowing and being.³³⁸

Newcomer women and men experience immigration and settlement in different ways and often have unequal access to social resources that affect health. As highlighted in section 2 (Socio-Demographic Profile of Immigrants in Toronto), there are gender differences in terms of immigration categories at time of arrival:

- men are more likely to arrive as skilled workers and as refugees; and
- women are more likely to arrive as dependents of skilled workers, family class immigrants and through the live-in caregiver program.

➤ *Women*

Given that women are more likely to come to Canada as dependents (family members) of their male relatives, their unique health needs and barriers to access may be overlooked. As has been noted in this report, newcomer women are less likely than newcomer men to speak English or French, and to have a university degree upon arrival. These factors contribute to the risk of negative health outcomes and to the likelihood of experiencing barriers to accessing services. Other interrelated stressors for newcomer women have also been identified in the literature and elsewhere in this report, including poverty, underemployment, discrimination, low social status, social isolation, losses of social support, family issues (e.g., the burden of multiple roles within the family, changes in marital relationships), lack of affordable childcare and exposure to violence. As a result of these stressors, newcomer women experience a higher risk of developing mental health problems and of transitioning to poor health relative to their male counterparts and to Canadian-born women.^{45,46} Some newcomer women experience health risks related to the kinds of work they do, especially when that work is precarious or when working conditions are poor (e.g., for live-in caregivers and hotel cleaners).

Newcomer women and girls are also vulnerable to physical and domestic abuse. Post-migration changes, including changes in social status, poverty, social isolation and gender relations, have been cited as contributing to relationship difficulties as well as increasing levels of divorce and intimate partner violence in some newcomer communities.^{339,5} Similarly, settlement workers in Toronto have linked family stressors to what they perceive as an increase in spousal and elder abuse among newcomers.²⁰⁹ Participants in another local study suggest that senior abuse is widespread and that the phenomenon is linked to financial stress felt by families and exacerbated by the density and demands of living arrangements, differences in childrearing practices, and, to a much lesser extent, the claims on family time made by trying to meet seniors’ needs.¹³⁹

"Because culturally, in South Asian families, men are the bread earners for the entire family. And when he is unemployed and the woman has to go out, it suddenly changes the dynamics of the family. That turns into [a] lot of abuse and violence within the family". (participant – service provider focus group)

Other factors that contribute to vulnerability and violence among newcomer women include loss of support networks, difficulty navigating social services and the legal system, discrimination, and linguistic and cultural

factors (e.g., patriarchal norms that perpetuate gender inequality).³⁴⁰ Women with precarious status, such as those without any status, refugee claimants and women sponsored by spouses, may be particularly vulnerable to abuse.²⁵⁹ A Canadian study elaborated on the reasons why some immigrant women do not report or disclose intimate partner violence and stay in abusive relationships in spite of the serious mental health consequences of doing so.³⁴¹ These include fear of jeopardizing their immigration claim by separating from their sponsor, fear of deportation if their partner/sponsor is criminally charged, financial concerns, and the burden of leaving their community or losing their children. Health effects are further discussed in section 3.14 (Health Status of Immigrants to Toronto: Family and Intimate Partner Violence).

Refugee women may be more likely than other categories of newcomers to have experienced rape, sexual abuse, harassment and/or the obligation to grant sexual favours (in return for food or necessary papers) before or during their migration process, which increase their risk for post-traumatic disorders.²⁴³ Service providers that participated in focus groups conducted for this report identified uninsured pregnant women as a particularly vulnerable group that faces significant barriers in accessing medical services in Toronto despite urgent need. The providers also noted that (migrant) women working in the sex trade require abortion services and related health care. However, no published literature on the health needs of international sex workers in Canada was found as part of this study.

➤ *Men*

Newcomer men also face various settlement challenges that affect their health. Some of the key sources of stress for newcomer men mirror those of women, including poverty, underemployment, discrimination and changes in family relationships. As noted previously, some newcomer men are forced to take physically demanding or even dangerous jobs that increase their risk of work-related injuries. Some service providers that participated in the focus groups noted that some newcomer men with mental health or addiction problems will delay seeking help until the problem becomes very serious. Men may delay mental health care for a variety of reasons, including stigma, lack of knowledge about services and difficulties getting time off work.

5.12 - SEXUAL ORIENTATION AND GENDER IDENTITY

Many LGBTQ newcomers come from countries where they have faced overt discrimination, violence and persecution as a result of their sexual orientation or gender identity. Discrimination or violence may occur within families, community settings, and institutions, such as law enforcement or health care, or may be perpetrated by a country's government.^{342,244}

Few local or Canadian research studies have investigated the health issues faced by LGBTQ newcomers. Participants in the stakeholder focus groups conducted for this report identified mental health, HIV and sexual health as important areas of need among LGBTQ newcomers to Toronto. Access to services is also an issue of concern.

In 2010, Access Alliance conducted a focus group with newcomer clients identifying as LGBTQ as part of the organization's strategic planning process.¹⁷⁸ Participants discussed at length the mental health concerns that they faced related to stress, self-esteem, abuse, depression, fear and trauma. They made clear that they want support in this area. They identified employment as a top determinant of health and emphasized the importance of job search and support services. Language and education support were also strongly emphasized, including a desire for conversation groups to practice English. Social support was another key determinant of health for participants,

who were eager to take part in regular social events and community groups. Participants also requested LGBTQ-specific resources regarding “coming out” that were appropriate for newcomer family and friends.

Another project undertaken by Access Alliance, called “Stepping Up”, addressed issues of violence and community safety with trans and LGBTQ newcomer women in Toronto.³⁴³ Women that participated in focus groups and interviews for this report indicated that they have experienced and continue to experience different forms of violence, including harassment, abuse, racism and homophobia. The women reported that they feel a need to be extremely vigilant about protecting themselves from harm and that this leads to health effects such as exhaustion, social isolation, hopelessness and depression. Similarly, drawing on experiences of working with refugee women from Central and South America, another study noted that lesbian and bisexual immigrant women feel a sense of social alienation and shame as a result of past violence and discrimination, and that these contribute to depression and unresolved anger.²⁴⁴

Data collection activities for this report did not yield any local or Canadian data specifically on the health status or needs of transgendered newcomers. This is clearly an area where local data and research are needed.

5.13 - CHILDHOOD DEVELOPMENT

Early childhood experiences (0-6 years) have an important impact on health throughout a person’s life. There is an extensive body of research showing that successful early childhood development depends on factors such as adequate income, nutrition, environment/housing, maternal and child health, parenting, social support and early childhood services. Poor early childhood development can result in diminished brain development, reduced language development and capacity to communicate, and poor physical and mental health throughout life.⁸¹⁴

One literature review identified several key issues that affect the early childhood development of immigrant children, including:

- access to quality childcare and education programs that are culturally respectful;
- early academic disengagement that may lead to dropping out of school;
- language proficiency and the retention of the home language while learning English;
- inter-generational problems that arise between parents and their children as they juggle values and practices at home versus school; and
- socio-emotional consequences of certain migration experiences, such as trauma or family separation.²⁰⁶

A notable issue related to families and early childhood is the practice of sending infants back to the country of origin to be raised by members of extended families. This practice has been noted among immigrants from China, but it occurs in other communities as well. After several years of separation, the children return to the biological parents to attend school in the adopted country, a custom that, according to Western mental health models, could significantly affect attachment relationships and other facets of development. Researchers conducted a longitudinal study that explored the advantages and potential repercussions, for both infants and parents, of a transnational lifestyle.³⁴⁴ Findings show that concerns about disrupting attachment relationships are considered by participants within the context of more pressing economic needs and cultural perspectives.

Migration Experiences and Immigration Category:

- Newcomer health needs and access to services can differ substantially based on an individual's migration experiences and immigration status and category
- Refugees, refugee claimants, temporary workers and migrants without status all face unique health challenges

Income and Employment:

- Newcomers to Toronto face high levels of poverty and systemic barriers to finding secure, stable employment
- The financial challenges and employment barriers encountered by many newcomers affect their health directly and also hinder access to other key determinants of health, such as housing, education and healthy food

Education:

- Most newcomers to Toronto are highly skilled and educated when they arrive, but refugees have significantly lower levels of education than other newcomers
- Newcomer women are also somewhat less likely to have a university degree than newcomer men.

Language Proficiency:

- The ability to speak and read English is an important prerequisite to social inclusion and securing adequate employment in Toronto
- While most newcomers arrive with some knowledge of English, levels of English proficiency vary considerably
- Newcomer men are more likely to speak English or French upon arrival than are women, and language ability also varies significantly by immigration category.

Housing:

- Finding adequate and affordable housing can be a major challenge for newcomers to Toronto, given the high cost of renting or purchasing a home or apartment and the low rental vacancy rates in the city
- Newcomers in Toronto may be somewhat more vulnerable to homelessness than those born in Canada
- Women without status are particularly vulnerable to homelessness and its health consequences.

Neighbourhood Factors:

- Newcomers in Toronto are overrepresented in lower-income neighbourhoods, which often have relatively poor access to services and to rapid transit
- Ethnic enclaves, which exist in some parts of the city, may have both positive and negative impacts on integration and health

Food Security:

- There is some evidence that newcomers experience high rates of food insecurity, and that this is often related to living with a income which affects the ability to purchase sufficient, nutritious and culturally-appropriate food

Family and Social Support Networks:

- For newcomers, social support networks involving family, friends and groups and organizations promote health by enhancing coping, helping them deal with the stress of migrating and resettlement, and facilitating access to services
- However, many newcomers lose access to their social and family supports as a result of migrating to Canada and the resulting social isolation can have a negative impact on health

Racialization and Race-Based Discrimination:

- There is considerable evidence that newcomers to Toronto experience race-based discrimination in a variety of ways, and that these experiences are a serious risk to their health
- Local research studies and community consultations have documented experiences of racism and other forms of discrimination in the labour market, in the educational system and when seeking housing, health care and other services

Culture and Health Beliefs:

- There are many ethno-cultural variations in perceptions of health, illness and of health-related behaviours
- Socio-cultural barriers and stigma have been identified in both academic and community-based literature as barriers to accessing health services

Gender:

- Newcomer women and men experience migration and settlement in different ways and often have unequal access to social resources that affect health
- Newcomer women are less likely than men to speak English and have a university education upon arrival and newcomer women are more likely than men to be unemployed
- In addition, newcomer women experience a higher risk of developing mental health problems and of transitioning to poor health relative to their male counterparts and to Canadian-born women
- Newcomer women and girls are also vulnerable to physical and domestic abuse, with some sub-populations of newcomer women being particularly vulnerable, such as refugees, refugee claimants, women with precarious status, seniors and women sponsored by spouses

Sexual Orientation and Gender Identity:

- Few local or Canadian research studies have investigated the health issues faced by LGBTQ newcomers
- Participants in stakeholder focus groups conducted for this report identified mental health, HIV and sexual health as important areas of need among LGBTQ newcomers to Toronto

Early Childhood Development

- The early childhood experiences of newcomer children are affected by a variety of factors, including access to quality childcare and education programs that are culturally respectful, inter-generational problems that arise between parents and their children, and the socio-emotional consequences of certain migration experiences, such as trauma or family separation



Local and Canadian data on certain topics related to newcomer health are limited. A variety of research approaches and the collection of different kinds of data are needed to provide a comprehensive understanding of newcomer health needs and to identify sub-populations most at risk for negative outcomes.

Above: Refugees from Myanmar at the *First Contact Clinic*, a partnership between Access Alliance and COSTI Immigration Services.

6. KNOWLEDGE AND INFORMATION GAPS

As this report shows, a substantial and growing body of evidence now exists about the determinants, needs and health status of newcomers in Canada. In this review of the literature, strong interest in newcomer health research has been noted at the local level and in other parts of Canada,^{xxx} and there are a number of current and recent research initiatives looking at issues relevant to immigrant health and to improving health equity more generally. Findings from those initiatives, along with the existing evidence should be used to inform policies, strategies, programs and services that promote the health of newcomers to Toronto.

Local and Canadian data on certain topics related to newcomer health are still limited, however. This report has identified specific information gaps throughout. In this section, some broad areas of research that could be further explored are highlighted in order to improve the understanding of factors that affect newcomer health and to inform policy and practice.

It is crucial to recognize that a variety of research approaches and the collection of different kinds of data are needed to provide a comprehensive understanding of newcomer health needs and the identification of sub-populations most at risk for negative outcomes. Data from large-scale longitudinal studies can influence and inform macro-level policies, while findings from smaller, targeted studies that use qualitative and participatory methods generate deeper insights into the needs of specific sub-populations that may lead to more responsive programs and services. Applied evaluation research is also a valuable source of information for identifying effective or promising programs and practices that improve health outcomes. In sum, plans for future research must take into account the value of these different, but complementary approaches.

6.1 - SOCIO-DEMOGRAPHIC DATA

Current and reliable data on the changing cultural, linguistic and socio-economic characteristics of newcomer populations are very important for the health sector. Several gaps exist with respect to existing data sources:

- *Census data:* Census data are particularly valuable for capturing data on individuals' time of immigration, country of birth and knowledge of official languages, each of which can then be linked to socio-economic variables (such as income, employment and education), family characteristics and disability, among others. Census data are also available at the local area level (i.e., neighbourhood and census tract). Most of the questions on these topics were included in the mandatory, long-form census questionnaire, which was recently replaced by the voluntary National Household Survey.^{xxxi} As a result of this change, the ability to obtain accurate data that can be compared to historical census data will be seriously compromised. This will lead to a serious gap in information for those involved in planning and responding to health and social services for newcomers to Canada.
- *Landing statistics:* CIC publishes current information on arrivals by immigration status (including a detailed breakdown by immigration status, location, age, gender and other variables). It would be useful

^{xxx} See, for example: <http://www.hc-sc.gc.ca/sr-sr/pubs/hpr-rpms/bull/2010-health-sante-migr/index-eng.php> and http://canada.metropolis.net/publications/toc_cdnissues_summer10.html.

^{xxxi} For information on the National Household Survey, visit: <http://www.statcan.gc.ca/survey-enquete/household-menages/5178-eng.htm>

for CIC to collect and publish data on other characteristics of immigrants and temporary residents, such as race, ethnicity and sexual orientation. Given that CIC data only capture place of initial arrival, there is also a need for longitudinal data that would chart geographic trajectories of newcomer communities over time (i.e., secondary migration).

- *Information on sub-populations:* There is also a need to measure health disparities among different newcomer sub-populations and to establish meaningful indicators of health equity to measure progress. This means that relevant socio-demographic data^{xxxii} should be collected from clients at the health system level, and by service providers, such as doctors, hospitals and Community Health Centres. This data are needed in order to understand health disparities and health needs among specific groups of newcomers and to monitor service access and quality among different providers.
- *Information on ethno-racial identity and immigration status:* There is also an opportunity to increase the amount of information on ethno-racial identity and immigration status (current and historical) that is collected through national and provincial surveys on topics related to health and settlement. This could be achieved, for example, by oversampling for specific communities, such as newcomers and smaller ethno-racial groups.
- *Information on migrants without status:* Little data are available on the number and characteristics of migrants living without status in Toronto. This data would be very useful for health and other social service providers and could also help to motivate policy change by demonstrating need. Unfortunately, given the undocumented nature of this population, it is not possible to collect this data through traditional means, such as large-scale surveys or government databases. However, it may be possible for hospitals and Community Health Centres to collect and share data on clients without status in order to better inform programs and services for this vulnerable population.

6.2 - HEALTH STATUS AND NEEDS

The availability of data on the health status and needs of newcomers to Canada is steadily increasing. However, there are many important topics where local and Canadian data are limited, including the prevalence of and risk factors for mental health, addictions, certain chronic diseases, such as diabetes, and infectious diseases. Evidence is also lacking on the health status and needs of specific newcomer sub-populations, especially those that may be at risk of certain health issues or that have unmet health needs, like seniors and children, new and emerging ethno-cultural communities, LGBTQ newcomers, temporary residents and newcomers without status. In addition, more longitudinal research and data are needed to improve understanding of changes in newcomer health status and risk factors over time.

6.3 - ACCESS TO HEALTH SERVICES

Barriers to accessing health services for newcomers in Toronto have been widely discussed in various studies and reports. As a result, these are relatively well understood. The following broad research questions, however, could further inform the design and delivery of health services to newcomers in Toronto:

- What factors affect access and utilization by newcomers of particular forms of health care, including specialist care, emergency services and alternative medicine?

^{xxxii} Relevant socio-demographic data might include age, gender, race and ethnicity, language ability, preferred language, immigration status and length of time in Canada.

- What effective and promising practices and models exist for health service delivery, primary prevention and health promotion for newcomers and specific ethno-cultural groups?

Finally, in order to supplement the existing qualitative data that speak to the negative impacts of restricted access to needed health services, and to make a stronger case for expanding access to populations without OHIP coverage, research could help to answer the following questions:

- What are the costs and anticipated benefits (outcomes) of policy changes that would expand access, such as removing the 3-month waiting period, greater provision of interpretation services and enhanced training for service providers?
- What are the public health risks and costs to the health care system of denying coverage to undocumented and uninsured individuals?

6.4 - SOCIAL DETERMINANTS OF HEALTH

As noted in this report, many newcomers face challenges in obtaining adequate income, employment and housing, as well as barriers to accessing health and other services. Additional multi-method, participatory and/or longitudinal research can help to inform the pathways and mechanisms through which specific determinants affect newcomer health. Some questions for future research might include the following:

- How do **pre-migration experiences** (e.g., family separation, trauma) affect newcomer health needs after coming to Canada?
- What **health beliefs and behaviours** affect health among newcomers of diverse ethno-cultural backgrounds, religious and spiritual beliefs, particularly among newer and emerging immigrant communities?
- What are the specific **health impacts of discrimination** experienced by newcomers (especially in the labour and housing markets)?
- What are the **health effects of community and neighbourhood** factors for newcomers, including impact of segregation, ethnic enclaves, and living in low-income neighbourhoods?
- What factors relate to successful **settlement and integration outcomes** for newcomers such as personal and social resources that help them to deal with the stress of settlement, and the role of settlement and other community services?



Newcomers arrive with a wealth of education, skills, experience, and good health; however, their health advantage is often lost over time. Preventing this decline and improving the health of all residents are key to a prosperous and healthy city.

Above: Peer Outreach Workers from Access Alliance.

7. KEY THEMES AND IMPLICATIONS

Immigration is an essential source of talent and new growth in Toronto. Newcomers arrive with a wealth of education, skills, experience, and good health; however, their health advantage is often lost over time. Preventing this decline and improving the health of all residents are key to a prosperous and healthy city.

In this section, several overarching themes that have emerged from the evidence reviewed and from discussions with local stakeholders are highlighted. These themes and their implications for the health and settlement services sectors are discussed below.

➤ *Most newcomers arrive in good health*

Research has shown that, on average, newcomers are in better health than Canadian-born residents, particularly with respect to many chronic diseases and their risk factors. Medical screening prior to arrival as a part of the immigration process and the relatively young age of newcomers contribute to this health advantage. However, this advantage was not found for all health outcomes or for all groups of immigrants.

Implications

- The overall good health of newcomers means that health service providers may choose to focus on strategies that promote and maintain healthy behaviours.
- It is important to **connect newcomers to health services** (including primary and preventative care) within the first months of their arrival, and to **ensure that access is sustained** over time.

➤ *Overall, newcomers lose their health advantage and their health gets worse over time*

There is strong evidence showing that the longer immigrants live in Canada, the more their health deteriorates in terms of overall health status, rates of chronic disease, mental health and other areas. This is true for newcomers who arrive with good health and for those who arrive with pre-existing health issues. The health of some groups of newcomers declines more quickly than others and is directly affected by social and economic factors that increase health risks and create barriers to preventative care and treatment.

Implications

- **Improve access** to health care services for newcomers, especially for marginalized and high risk sub-populations. Newcomers and service providers emphasize the need to increase the affordability and accessibility of services not covered by OHIP (e.g., dental care, eye care, prescription drugs and physiotherapy).
- **Increase points of access to healthcare and services** in schools, settlement agencies and community centres that serve large numbers of newcomers, thereby proactively connecting newcomers groups to services where there are the highest levels of unmet need.
- **Strengthen the capacity of healthcare providers** to provide equitable, culturally sensitive care to diverse groups of newcomers with varied health status, health risks and health needs.

➤ *Newcomers have diverse health needs*

The findings in this report highlight the great diversity and differences among newcomers to Toronto. Health needs often vary based on factors such as age, gender, sexual orientation, ethno-racial identity, migration experiences, income level and education. Therefore, it is important for planners and service providers to apply a health equity lens to health assessment, analysis and planning in order to improve understanding of the unique

barriers and burdens that some groups face, as well as the underlying causes and potential ways to address them.²⁸⁵ Evidence can be drawn from a wide variety of sources to inform the development of appropriate policies, programs and services to meet diverse needs.

Implications

- “One-size fits all” approaches to addressing the health needs of newcomers are unlikely to be effective. Various reports by local stakeholders emphasize the importance of **tailoring programs, services and outreach strategies to the needs of specific sub-populations** whenever possible, and of using a client-centred approach that recognizes and responds to the unique needs of diverse service users. Client-centred models of care that address the multiple health needs of individuals and that are sensitive to gender and cultural differences can improve clients’ experiences with care and increase satisfaction with access to care and the care received.³⁴⁵
- There are many service providers in Toronto who would benefit from **information, training and networking opportunities** on topics related to the health needs of established and emerging newcomer communities.
- The development of **partnerships and collaborative endeavours between health service providers and community agencies/groups that represent or work closely with specific newcomer and ethno-cultural communities** can lead to more comprehensive and responsive programs and services.
- Meaningful **indicators of health equity are needed in order to measure and respond to health disparities** among newcomers and other underserved populations. This means that relevant socio-demographic data, including data related to immigration, should be collected from clients at the health system level, and by service providers, such as doctors, hospitals and Community Health Centres.

➤ *Settlement is a health issue*

Newcomer health needs are different, in many ways, from those of the Canadian-born population. The health of newcomers is clearly affected by the processes of migration, settlement and adaptation. The impact of settlement on health points to the need for concrete program and policy responses that will enable newcomers to stay healthy and fulfil their potential.

Implications

- **Comprehensive settlement services** that facilitate access to employment, housing, education, language training and health services are critical to promoting and maintaining good health among newcomers.
- Both the **immediate and longer-term needs of newcomers must be taken into account** when planning and implementing health and settlement services. Pre-migration and early settlement experiences may affect health needs many years later.
- A **coordinated and integrated approach to providing health and settlement services** in Toronto can support health and improve accessibility. This could be achieved through enhanced knowledge exchange, partnerships, collaborations and referrals between these sectors.^{xxxiii} The establishment of community hubs,^{xxxiv} in which multiple services are co-located in the same building, is one local example of an approach to improving access through service coordination and integration.

^{xxxiii} The Toronto Local Integration Partnerships (LIPS) have laid some of the groundwork in terms of identifying key settlement needs for newcomers to the city and strategies for addressing them. LIP partners can continue to build upon this work. For more information, refer to: <http://www.toronto.ca/newcomer/neighbourhoods.htm>.

^{xxxiv} As part of the United Way of Greater Toronto’s “Building Strong Neighbourhoods Strategy”, community hubs will open in eight Toronto neighbourhoods (four of these are already open). These hubs will serve areas of the City that are home to large numbers of newcomers. For more information, refer to: <http://www.unitedwaytoronto.com/whatWeDo/neighbourhoods.php>.

- It is necessary to carefully **assess the potential health impacts of future changes to policies and programs** affecting settlement services, health care and other social services and programs that newcomers rely on to settle in Toronto and maintain their health.

➤ ***Social and economic exclusion has a major impact on the health of newcomers***

Newcomers begin to experience marginalization almost immediately after arrival. High rates of unemployment, precarious types of employment and work environments, income insecurity, discrimination, social isolation, housing insecurity, and barriers to health and other services often result in declining health among newcomers. The findings underscore the need to expand and coordinate efforts across the health, settlement and other sectors to advocate for policy changes that promote the social and economic inclusion of newcomers.

Implications

- Efforts to address social determinants of health can be strengthened through **inter-sectoral partnerships and collaborations** among health service providers, community organizations and advocacy groups.
- The direct **engagement of newcomers** can improve the effectiveness of outreach and advocacy efforts, while also helping participants to expand their knowledge, skills and social networks.

Examples of Policy and Policy Options to Address Financial and Employment Challenges

Many of the reports and articles that we reviewed and stakeholders in our focus groups have made policy recommendations with respect to addressing income insecurity and employment challenges (and related health determinants) experienced by newcomers to Toronto. Some examples include the following:

- Accelerate efforts to improve recognition of foreign credentials and experience
- Expand employment mentoring, paid internships, apprenticeships and bridging Programs for newcomers
- Expand and enforce employment standards to protect new immigrants and temporary foreign workers from unsafe and discriminatory working environments and other violations
- Implement a comprehensive provincial employment equity program in Ontario to address racialized employment inequities
- Increase benefits offered by Ontario Works and the Ontario Disability Support Program and reduce barriers to accessing these benefits
- Increase funding for affordable housing in Toronto
- Improve access to education and training for newcomer adults, including access to LINC and ESL programs
- Increase the availability of affordable childcare throughout the city

➤ ***Newcomers experience multiple barriers to accessing necessary services***

Health care and other social services play a vital role in sustaining and promoting the health and well-being of newcomers to Toronto. The findings in this report suggest that newcomers encounter multiple barriers to accessing services, and health services in particular. Many of these relate to cost and eligibility (e.g., the 3-month waiting period for OHIP coverage for new permanent residents). Accessible and culturally appropriate information and resources are also essential for enabling access to various health services. Cultural and linguistic barriers to services, including experiences of racism, were repeatedly emphasized by local stakeholders and in the

published literature. Failure to address these barriers may lead newcomers to forgo or delay care, which can lead to more serious health problems and greater health care costs.

Implications

- **Changes at the program, organizational and system levels, with the explicit goal of addressing barriers**, are required to improve access to health care and related services for newcomers. Efforts to improve access will benefit from meaningful community engagement and partnerships.
- Efforts to **enhance cultural competency** among service providers and to **provide professional language interpretation** are essential components of effective health service delivery, outreach and public health programming.
- **Developing and implementing measures of health disparities** among different sub-populations, including newcomers, and measuring progress to demonstrate improvement are essential for improving access.

Examples of Strategies to Improve Access to Health Services for Newcomers

Many different strategies for improving access to health services have been identified in the literature reviewed for this report and by local stakeholders. The following list includes a few examples of these strategies:

- Eliminate the 3-month waiting period for OHIP coverage that applies to new permanent residents
- Improve access to extended health insurance coverage (prescription drugs, dental care, eye care and other services) for low-income, newcomer families that are not covered by employer-funded extended health insurance programs
- Maintain and expand health care services for those who are uninsured and/or without status, and ensure appropriate distribution of funds on the basis of need
- Increase funding for professional interpretation and translation services within the health sector^{xxxv}
- Improve service coordination and integration (e.g., “one-stop shop” service delivery integrating health, settlement and other services)
- Expand efforts to educate and train service providers on effective practices for culturally competent care and anti-oppressive practices
- Engage newcomers in planning and decision-making at the organizational and health system levels
- Expand tailored outreach and health education strategies to target newer and at-risk newcomer communities (e.g., through the use of peer outreach workers and cultural brokers)

➤ ***Newcomers' health knowledge and positive behaviours should be acknowledged and promoted***

Newcomers bring considerable health knowledge as well as healthy behaviours to Toronto. These include significantly lower rates of heavy alcohol drinking, substance misuse, overweight and obesity, smoking among women, and longer-term breastfeeding. These behaviours increase the health of our population and can result in major savings to the healthcare system.

^{xxxv} A shared system of interpretation and translation services was recently identified as a top equity priority by the Toronto Central LHIN (Toronto Central LHIN, 2011).

Implications

- Ways in which newcomers can maintain a healthy lifestyle while adhering to religious beliefs and cultural practices should be acknowledged and promoted.
- Health promotion initiatives could feature stories of newcomers who have successfully adapted and integrated their positive health behaviours into their new lives in Toronto.

➤ ***Research on newcomer health in Canada yields vital data***

There is a substantial and growing body of local and Canadian evidence available to health organizations, coordinating bodies and policy makers that can be used to inform their strategic priorities as well as the development of programs and services for newcomers. Continuing research on the health and well-being of newcomers and longer-term immigrants and refugees in Canada is vital to understanding these populations and to an effective response to their diverse health needs. Different kinds of data and research approaches, including longitudinal studies, clinical research and community-based participatory research are needed to provide a comprehensive understanding of newcomer health needs and to identify sub-groups that are most at risk. Ongoing surveillance and population health assessment, including longitudinal studies, are also needed to measure health disparities over time. Although a lot of evidence related to newcomer health is already available, local and Canadian data on certain topics and sub-groups are limited.

Implications

- **Investment in ongoing research** related to the health of newcomers in Canada is essential in order to build upon existing evidence. In particular, research should focus on identifying high risk sub-groups and improving understanding of key determinants of health and the pathways through which they affect health outcomes.
- Opportunities exist for **greater collaboration among researchers** in order to identify research gaps and priorities, as well as to improve the sharing of and use of data and research findings to inform policies, programs and services.

APPENDIX A: METHODS

LITERATURE REVIEW

The literature search for this project consisted of a search of multiple databases including Medline, Scopus and CINAHL. The literature search focussed on three major areas of inquiry: (i) health status, (ii) determinants of health, and (iii) access to health services:

- For literature on health status, the following were used as keywords and descriptors/ subject headings: immigrants, refugees, foreign-born, newcomer AND health status (including subheadings: self-rated health, mortality), mental health (including subheadings: schizophrenia, affective disorders, suicide, psychosis), chronic diseases (including subheadings: heart disease, diabetes, stroke, disability, genetic disorders), infectious diseases (including subheadings: TB, HIV/AIDS), oral health, reproductive and perinatal health (including, birth outcomes, breastfeeding, low birthweight, prematurity), disability AND Toronto or Ontario (in title or keyword or abstract).
- For literature on determinants of health, the following were used as keywords and descriptors/subject headings: immigrants, refugees, foreign-born, newcomer AND determinants, social conditions, poverty, health practices (all subheadings) AND Toronto or Ontario (in title or keyword or abstract).
- For literature on access to health services, the following keywords and subject headings were used: immigrants, refugees, foreign-born, newcomer AND health services utilisation, preventive screening (including subheadings: health behaviour, health promotion, mass screening, complementary and alternative therapies).

The database searches were supplemented by a search of relevant websites for Ontario and materials including CERIS working papers, and queries to Toronto based academics working in immigrant health for non-peer-reviewed or unpublished reports or reports in press (in coordination with the External Review/Scan process). The literature search was further broadened by searching articles/reports reference lists and article citations for relevant articles post publication (as appropriate).

The formal literature review was conducted by Ilene Hyman. The findings of this review were supplemented with findings from additional reviews for which Ilene Hyman was the principal author. These include general findings on recent immigration and health in Canada,^{23,5,346,347} immigrant women's health and mental health,^{186,348} determinants of immigrant health³⁴⁹ and racism as a determinant of immigrant health¹³⁴.

The specified search terms assured that the vast majority of published research related to immigrant health in Toronto or Ontario was captured. However the search may not have captured all studies that examined determinants of immigrant health in Toronto or Ontario such as poverty, employment and income. Another major limitation was that keywords related to ethnicity and ethno-racial identity, which may have yielded additional studies with immigrant study populations, were not included in the search terms.

ENVIRONMENTAL SCAN

The purpose of the community/grey literature review was to collect and summarize:

- reports and publications that have not been published in peer-reviewed periodicals, including, community-based research reports, planning documents, government reports, fact sheets, briefing notes and web-based information; and
- research findings from community and government initiatives that may not be published, such as evaluations and needs assessment, as well as research projects in progress.

This review was intended to complement to the literature review that incorporated recent literature that was published in peer-reviewed journals and other related sources such as CERIS publications. Documents were collected by project team members from various sources including:

- Documents on file at Access Alliance
- Documents identified by project team and advisory group members
- On-line searches and scans of relevant websites

The criteria for inclusion in this report were as follows:

- Published between 2000 and 2010
- Scope includes recent immigrants
- Scope includes health status, health needs or social determinants of health.
- Based on data from Toronto or the GTA (selected documents that are based data from other Canadian cities, but that met the other criteria for inclusion, were also included in the report).

In total, approximately 90 documents were reviewed and summarized. A summary report was prepared based on the research framework and guiding questions. Forty-eight of the 90 documents reviewed (53%) were directly referenced in the summary report.

In addition to collecting the documents described above, the environmental scan also identified and summarized other selected reports (e.g., policy reports and synthesis documents) as well as health-related resources that might be useful to newcomers in Toronto and/or service providers who work with them.

DATA REVIEW AND ANALYSIS

➤ *Canadian Community Health Survey (CCHS)*

The CCHS is a joint initiative between Statistics Canada and Health Canada aimed at providing health information at the regional and provincial levels. Data used in this report were collected between January 2001 and December 2008, from individuals aged 15 to 64 living in private occupied dwellings in Toronto and the Greater Toronto Area (GTA).

The survey sampled one randomly selected respondent per household, either through face-to-face or telephone interview. The CCHS is weighed to account for proportional representation of groups with different characteristics. The health behaviour data, used in this report, are self-reported. Therefore, these data may be subject to inaccurate recall and social acceptability bias.

The CCHS excludes people living on Indian reserves and Crown Lands, residents of institutions, full-time members of the Canadian Forces, and some residents in remote areas. The telephone sampling frame

methodology used by the CCHS only covers people with listed phone numbers and who are at home when the surveyor calls. Under-coverage of potential respondents is a growing problem with the increasing popularity of cellular phones. This under-coverage can bias the results. Complex, multi-stage weighting strategies are used to moderate these and other biases (i.e., non-response). Despite the weights, the CCHS still under-represents low-income and lower-education populations.

Four cycles of CCHS data were combined to stabilize the estimates in this report. This means that changes over time will not be seen, however the larger sample allows for potential patterns in the data across immigrant status groups to be shown.

The estimates reported are for the Toronto Health Unit, except in cases where sample size at the Toronto level did not allow for analysis, in which case estimates are for the GTA (Toronto, Peel, Halton, York, and Durham regions). Estimates are age- and sex-standardized to the 1991 Canadian population to account for the younger age distribution of recent immigrants and the older age distribution of established immigrants. Estimates given for age groups are only sex-standardized and those given for each sex are only age-standardized. Coefficients of Variance were calculated to determine the releasability of each estimate, as per Statistics Canada's guidelines. Significant differences were determined based on overlapping confidence intervals.

Definitions

The basic definitions of health indicators used in the CCHS are provided in the relevant parts of section 3. More detailed definitions can be found on the Association of Public Health Epidemiologist of Ontario (APHEO) Core Indicators Page: <http://www.apheo.ca/index.php?pid=55>.

Income Level

The three income levels used in reference to the CCHS data in this report are based on an income adequacy variable that combines self-reported family income and size, similar to the Statistics Canada low income cut-off (LICO) measure. The income data were captured using ranges of income and thus do not exactly match the LICO. The variable, created by Statistics Canada as a part of the CCHS data set, has four categories, but for the analysis in this report the first 2 categories of the income adequacy variable were combined to ensure sufficient sample size and to ensure that all respondents living below the LICO were included in this category.

Limitation of Toronto CCHS Data Analysis

An important limitation to our analysis of Toronto CCHS data is that there are some substantial differences in the composition of the recent immigrant (less than 10 years since arrival), established immigrant (10 or more years since arrival) and Canadian-born groups we compared. Although our analysis accounted for differences in the age and sex breakdown of these groups, it did not account for differences in education level, income, and ethno-racial identity. Compared with the established immigrant and Canadian-born groups, more people in the recent immigrant group have a post-secondary degree or diploma, live in low income and belong to a racialized group. Compared with the established immigrant group, the recent immigrant group has fewer people born in Europe, U.S.A., U.K. and Oceania, and more people born in African and Asia. Compared with the Canadian-born group, more established immigrants have no post-secondary degree or diploma, live in low income and belong to a racialized group. For these reasons, our comparison of immigrant and non-immigrant groups using CCHS data should be interpreted with caution, as should inferences of risk identified among established immigrants may also suggest risk now or in the future for recent immigrants.

An additional limitation to our analysis of Toronto CCHS data is that the size of the recent immigrant sub-sample is substantially smaller than the established immigrant (about half the size) and the Canadian-born (about a third

of the size) sub-samples. As a result, there is a greater level of variability for our findings on recent immigrants, making it less likely for significant differences to be apparent.

➤ ***Longitudinal Survey of Immigrants to Canada (LSIC)***

The LSIC survey was designed to collect longitudinal data on immigrant arrivals to Canada in order to better understand the adaptation process and to provide information on the factors that hinder or assist adjustment to Canada. The LSIC target population consists of Canada's foreign born that (i) arrived in Canada between October 1, 2000 and September 30, 2001; (ii) are aged 15 or older at the time of landing; and (iii) 'landed' from abroad, and applied through a Canadian Mission abroad. In total, the LSIC includes three 'waves,' collected at six months ('Wave 1'), two years ('Wave 2'), and four years ('Wave 3'). For the current analysis, only participants with valid Toronto postal codes are included in the sample. The sample consisted of 12,040, 9,322, and 7,716 participants in Waves 1, 2, and 3, respectively.

An individual was randomly selected from each immigrating household unit to answer the LSIC questions. The survey contains information including self-assessed health, settlement location, sociodemographic characteristics, language, housing, values and attitudes, and social networks of the respondent, amongst other variables. Immigrant class is defined as economic arrivals (including skilled workers and business class arrivals), family reunification immigrants, and refugees. Economic immigrant arrivals represent the largest proportional share of recent arrivals to Canada (66%), while family class arrivals represent approximately 27% of new arrivals. By definition of the LSIC sampling frame, only convention refugees (i.e., claiming refugee status outside Canada) are included in the sample.

Descriptive analyses were conducted on self reported health status at each Wave. Immigrants were also asked if they had sustained any new emotional or mental health problems since the period leading up to the interview. A logistic regression and a survival analysis were done to determine characteristics associated with reporting "fair" or "poor" health and those associated with transitioning from "excellent", "very good" or "good" to "fair" or "poor" health, respectively. The variables included in the logistic regression and survival analysis were

- Age (15-39, 40-64)
- Sex (Male, Female)
- Marital Status (Married, not Married)
- Visible Minority (Yes, No)
- Region of Origin (Asia, Europe, Africa, Americas)
- Immigrant Class (Economic, Family, Refugee)
- Income (< \$20,000, ≥ \$20,000)
- Home owner (Yes, No)
- Education (Post-secondary graduate, Not post-secondary graduate)
- Currently working (Yes, No)
- Knowledge of English (Yes, No)
- Family in City (Yes, No)
- Friend in City (Yes, No)
- Daily Interaction with Friends (Yes, No)
- Member of an Organization or Group in Canada (Yes, No)
- Experienced Discrimination (Yes, No)
- Has a Health Card (Yes, No)
- Satisfied with Immigration Experience

More details on the methodology used can be seen in previously published work.³⁵⁰

➤ ***Canadian Landed Immigrants Database and Ontario Diabetes Database***

The Registered Persons Database, an electronic registry of all people who are eligible for health coverage in Ontario in a given year, was probabilistically linked to the Canadian Landed Immigrant Database (LIDS) maintained by Citizenship and Immigration Canada (linkage rate of 84%). From this data set, all adults aged 20 years or older who were eligible for coverage under the province's universal health insurance program and who had a Toronto postal code as of Mar. 31, 2008 were included in the study if they had a valid health card number and their date of birth was available. People who had been granted permanent residency status in Canada between 1985 and 2000 and claimed Ontario as their destination province were classified as recent immigrants and people who were born in Canada or who immigrated before 1985 were classified as long-term residents. The sample does not include anyone who immigrated to Canada after 2000.

The Canadian Landed Immigrant Database includes information collected at the time of application for immigrant status on education level, intended occupation, language ability, immigration category, country of origin, sex and date of birth. The feasibility of linkage between this database and health-specific administrative data sets was tested in pilot projects, which showed that differences in linkage by immigration class, date of immigration, education and country of birth were not likely sufficient to produce significant bias in any study results. We identified people who had been diagnosed with diabetes on or before March 31, 2008, using the Ontario Diabetes Database, which is a validated administrative data registry created from hospital records and physician services claims. The database uses an algorithm of two primary care visits or one admission to hospital for diabetes within a two-year period to identify diagnosed cases of diabetes (excluding gestational diabetes). This algorithm has a sensitivity of 86% and a specificity of over 97% in identifying patients with confirmed diabetes.

We calculated age-standardized point prevalence rates of diabetes for recent immigrants and long-term residents on March 31, 2008. For each population, sex-specific rates were also generated by age group (20–34 years, 35–49 years, 50–64 years, 65–74 years, and 75 years or older) and, for the immigrant population, by country of birth and world region. The 10 countries that experienced the highest prevalence of diabetes were also identified. We used direct age-standardization to the 1991 Canada Census population to adjust for differences in population distribution across different world regions.

More details on the methodology used can be seen in previously published work.⁹¹

➤ ***Census Data***

Conducted by Statistics Canada, the census provides information about Canada's demographic, social and economic characteristics. The Census is conducted every five years. Most of the data used in this report were drawn from the 2006 census (conducted in May of 2006). We compiled data on top countries of origin, new and emerging immigrant communities, ethno-racial identity, languages, family composition and age as well as socio-economic indicators. We also looked at selected census data at the City and neighbourhood level.

Census data are particularly valuable for capturing data on individual's time of immigration, country of birth, knowledge of official languages, which can then be linked to various socio-economic variables (such as income, employment and education), family characteristics, and disability among others. Census data are also available at the local area level (i.e., neighbourhood and census tract).

Although Statistics Canada attempts to count every individual, some individuals or groups are missed or underrepresented in each census. For example, people may be travelling, some dwellings are hard to find, some

are homeless and some individuals or groups refuse to participate. Statistics Canada takes this into account and estimates an "under coverage" rate.

➤ *Immigration Statistics*

Citizenship and Immigration Canada (CIC) publishes annual data about new permanent residents to Canada as well as temporary residents entering Canada to work, study or for humanitarian and compassionate reasons. These statistics are essential for understanding immigrant trends over time. And unlike data from the census, CIC statistics are published more frequently and data on permanent residents are broken down into subcategories (including economic and family class immigrants as well as refugees). They also include detailed information on temporary residents and various sub-categories of temporary residents. Where possible, data for the City of Toronto were used.

These (CIC) statistics look only at the immigrants' first place of settlement in Canada. They do not capture the movement of new arrivals to subsequent destinations within Canada or abroad (i.e., secondary migration) which in some cases may occur relatively soon after arrival. CIC does not collect data on additional characteristics of immigrants to Canada such as race, ethnicity and sexual orientation.

STAKEHOLDER FOCUS GROUPS

Data were collected using semi-structured focus groups in January 2011. In order to reflect a diversity of stakeholder perspectives, the focus groups focused on these distinct groups:

- users of newcomer health services;
- settlement workers;
- health care providers;
- outreach workers (employed by Access Alliance); and
- Toronto Public Health service providers and other staff.

The recruitment criteria and methods are summarized in Table A1. Recruitment of focus group participants followed ethics approval by Professional Development & Education Unit at Toronto Public Health.

Each focus group was moderated by 2 staff members from Access Alliance and/or Toronto Public Health. Each focus group was scheduled for 120 minutes and included an introduction to the broader project. A focus group moderator's guide was developed for each stakeholder group (service providers, clients/service users). The focus group questions and format were adapted to each group of participants:

- The *service provider* focus groups examined key health service needs, gaps and barriers from the perspective of service providers; as well as challenges experienced by service providers working with recent immigrants. Background information on participants' organization, position and area of work were collected verbally in the introduction to the focus group discussion.
- The *community member* focus group focused on identifying priority health needs as well as barriers to accessing health-related programs and services for recent immigrants. Select demographics were collected verbally in the introduction to the focus group discussion, specifically country or region of origin and length of time in Canada.

Table A1: Focus Group Recruitment Criteria and Methods

Focus Group	Criteria	Method
Service Users (clients)	<ul style="list-style-type: none"> • 18 years of age or older • Have immigrated to Canada within the last 10 years • Currently residing in the City of Toronto • English language fluency (self-identified) • Unrelated to another participant • Capable of understanding the study purpose and providing informed consent to participate 	Recruited from individual accessing services at AccessPoint on Danforth (located at Danforth and Victoria Park). Participants that met the criteria were offered a \$30 honorarium to attend.
Settlement Workers	<ul style="list-style-type: none"> • currently working within the City of Toronto • job responsibilities include provision of health or settlement services to recent immigrants (<10 years in Canada), either directly or as a coordinator/manager of these programs/services 	Combination of a purposive sample of individuals/organizations known to the Access Alliance project coordinator and responses to an invitation that was distributed through the Toronto City-Wide Local Integration Partnerships.
Health Service Providers	Same as above	Purposive sample of individuals/organizations known to the Access Alliance project coordinator. Invitations were sent directly to participants or management staff at selected organizations that provide health services to recent immigrants and refugees in Toronto.
Toronto Public Health	Same as above	Purposive sample (names suggested by TPH project steering committee). Individuals were invited by the TPH project coordinator to attend a meeting (on paid time).
Outreach Workers	Outreach workers employed at Access Alliance and their supervisors those that currently work with recent immigrants in Toronto and have lived experience of immigrating to Canada	All members of the peer outreach team were invited by the Access Alliance project coordinator to attend a meeting during paid time.

In total, 75 key informants with expertise, knowledge and/or experience in the immigrant health sector participated in the focus groups. The breakdown of participants by focus group is summarized in the Table A2.

The focus groups were recorded and note-takers also recorded key topics of discussion within each group. Using the notes and the recordings, the data were organized into key topics and themes based on the pre-determined research framework and guided questions.

Table A2: Focus Group Recruitment Criteria and Methods

Focus Group	Date	Location	Number of Participants	Participant Description
Service Users (Women)	Jan 20, 2011	AccessPoint on Danforth, 3079 Danforth Ave.	11	newcomer women from Bangladesh, Tajikistan, Afghanistan, India, Pakistan and the Philippines.
Service Users (Men)	Jan 27, 2011	AccessPoint on Danforth, 3079 Danforth Ave.	9	newcomer men from Bangladesh, USSR, Dubai and India
Settlement Workers	Jan 24, 2011	Access Alliance 340 College St.	14	Staff from CHCs, Settlement Organizations and Community Centers providing frontline services to newcomers to Toronto
Health Service Providers	Jan 24, 2011	Access Alliance, 340 College St.	10	Staff from CHCs, Hospitals, and a midwives agency in Toronto
Outreach Workers	Jan 26, 2011	AccessPoint on Jane, 761 Jane St.	7	Outreach workers, 1 health promoter (who coordinates outreach activities) and 1 manager
Toronto Public Health Staff I	Jan 28, 2011	Toronto Public Health, 277 Victoria Street,	13	Staff from Access & Equity, Communicable Disease Control, Dental Services, Healthy Environments, Healthy Families, Healthy Living-Chronic Disease Prevention, and Healthy Living-Healthy Communities
Toronto Public Health Staff II	Jan 28, 2011	Toronto Public Health, 277 Victoria Street,	11	Staff from Access & Equity, Communicable Disease Control, Dental Services, Healthy Families, Healthy Living-Chronic Disease Prevention, and Healthy Living-Healthy Communities

APPENDIX B: NEIGHBOURHOOD STATISTICS

As indicated in section 2 of this report, newcomers to Toronto are more likely to live in certain neighbourhoods, particularly in the north and eastern parts of the city. Table A3 presents selected statistics for the 25 (of 140) neighbourhoods with the highest number of newcomers (that arrived in the previous 5 years) as of 2006. These 25 neighbourhoods were home to 45.2% of all newcomers in Toronto.

Those neighbourhoods labelled with an asterisk (*) are located within one of the Toronto's identified priority areas. Ten of the neighbourhoods listed below are located within priority areas. The City of Toronto has designated 13 "Priority Areas" through its Neighbourhood Action Plan. These areas were selected because they were found to have significant needs for investment in community services and facilities.

Table A3: Newcomer (Arrived between 2001 and 2006) Statistics by Neighbourhood, City of Toronto, 2006

Neighbourhood	# of Newcomers (2001-2006)	Newcomers as % of population	Top 5 Places of Birth	% Visible Minority	Top 5 Home Languages	% No English or French
City of Toronto (TOTAL)	267,855	10.8%	China India Philippines Pakistan Sri Lanka	81.0%	Chinese Urdu Russian Farsi Tamil	10.1%
1. Woburn*	9,135	17.5%	India Sri Lanka China Philippines Pakistan	97.2%	Gujarati Tamil Urdu Tagalog Mandarin	8.3%
2. L'Amoureux*	7,890	17.2%	China Sri Lanka India Philippines Afghanistan	97.1%	Chinese Mandarin Tamil Cantonese Farsi	17.4%
3. Mt. Olive-Silverstone-Jamestown*	7,125	22.2%	India Iraq Pakistan Sri Lanka Guyana Nigeria	95.8%	Gujarati Punjabi Arabic Urdu Tamil	11.9%
4. Don Valley Village	6,960	26.1%	China Iran India Philippines Romania	82.3%	Chinese Mandarin Farsi Russian Romanian	6.9%

Neighbourhood	# of Newcomers (2001-2006)	Newcomers as % of population	Top 5 Places of Birth	% Visible Minority	Top 5 Home Languages	% No English or French
5. Willowdale East	6,425	15.7%	China Iran South Korea Russian Fed. Taiwan	85.5%	Farsi Mandarin Chinese Korean Russian	11.1%
6. Westminster-Branson*	5,850	24.0%	Russian Fed. Ukraine Philippines Israel Moldova	33.2%	Russian Tagalog Korean Hebrew Farsi	8.6%
7. Parkwoods-Donalda	5,685	16.8%	China Romania Pakistan India Philippines	78.9%	Chinese Romanian Urdu Farsi Spanish	6.9%
8. Thorncliffe Park	5,580	31.1%	Pakistan India Afghanistan Philippines Sri Lanka	92.7%	Urdu Farsi Gujarati Tagalog Pashto	9.3%
9. Tam O'Shanter-Sullivan	5,280	19.4%	China Philippines Pakistan India Sri Lanka	96.3%	Chinese Mandarin Urdu Cantonese Tagalog	12.9%
10. Malvern*	4,995	11.3%	Sri Lanka India Pakistan Philippines China	98.2%	Tamil Urdu Gujarati Tagalog Bengali	10.9%
11. Flemingdon Park*	4,890	23.0%	Pakistan China India Afghanistan Philippines	86.1%	Urdu Farsi Russian Mandarin Chinese	5.6%
12. Agincourt North	4,270	14.2%	China Sri Lanka India Philippines Pakistan	98.8%	Chinese Mandarin Cantonese Tamil Tagalog	25.6%

Neighbourhood	# of Newcomers (2001-2006)	Newcomers as % of population	Top 5 Places of Birth	% Visible Minority	Top 5 Home Languages	% No English or French
13. York University Heights	4,135	15.8%	China India Pakistan Sri Lanka Philippines	93.6%	Mandarin Chinese Tamil Urdu Spanish/ Gujarati	10.4%
14. West Humber-Clairville	3,825	11.9%	Guyana Pakistan Jamaica Ghana Sri Lanka	95.8%	Punjabi Gujarati Hindi Urdu Tamil	7.3%
15. Steeles*	3,790	15.3%	China Philippines India South Korea Pakistan	98.8%	Chinese Mandarin Cantonese Tagalog Hindi/Urdu	29.4%
16. Newtonbrook West	3,780	18.4%	Iran Philippines Russian Fed. South Korea India	55.7%	Russian Farsi Korean Tagalog Spanish	10.4%
17. South Parkdale	3,735	17.8%	India China Nepal Philippines Sri Lanka	88.6%	Tamil Spanish Chinese Bengali Mandarin	4.0%
18. Henry Farm	3,705	32.8%	China India Iran Philippines Pakistan	88.5%	Mandarin Chinese Farsi Arabic Urdu	8.2%
19. North St. Jamestown	3,685	21.5%	Philippines China India Pakistan Sri Lanka	83.2%	Tagalog Mandarin Russian Tamil Chinese	6.7%
20. Dorset Park*	3,660	15.0%	India China Sri Lanka Philippines Middle East	94.4%	Tamil Gujarati Chinese Mandarin Tagalog	10.0%

Neighbourhood	# of Newcomers (2001-2006)	Newcomers as % of population	Top 5 Places of Birth	% Visible Minority	Top 5 Home Languages	% No English or French
21. Crescent Town*	3,650	24.0%	Bangladesh Pakistan India China Romania	84.9%	Bengali Urdu Romania Mandarin Chinese	6.3%
22. Islington-City Centre West	3,555	10.8%	India Philippines Yugoslavia China South Korea	63.6%	Russian Korean Serbian Arabic Mandarin	5.5%
23. Milliken	3,405	13.0%	China India Sri Lanka Pakistan Middle East	99.6%	Chinese n.o.s. Cantoneae Mandarin Tamil Spanish	30.7%
24. Agincourt South-Malvern West	3,060	14.2%	China India Sri Lanka Philippines Pakistan	98.2%	Chinese Mandarin Cantonese Gujarati Tamil	22.1%
25. Glenfield-Jane Heights*	3,005	9.7%	India Vietnam Guyana Colombia Iraq	92.3%	Spanish Gujarati Vietnamese Arabic Farsi	15.0%

Source: Statistics Canada, 2006 Census of Canada – Target Group Profiles

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