February 15, 2013

Special Report: Immigration Experience and Health

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The Black, African and Caribbean Canadian Health (BLACCH) Study is a community-based research project designed with the goal of improving access to health care and the health status of Black people from Canada, Africa, the Caribbean, and other parts of the world who reside in London and Middlesex County, Ontario, Canada.

The Black, African and Caribbean Canadian Health (BLACCH) Study Special Report #2, February 15, 2013

Background

From 1986 to 2006, Canada's immigrant population increased from 3.9 to 6.2 million, accounting for respectively 15.6% and 19.8% of the Canadian population (Statistics Canada 2008). If current immigration trends continue in the coming years, the proportion of immigrants in Canada could reach slightly over 22% by 2017 (Statistics Canada 2008). The maintenance of the health and well-being of this growing group is necessary to the social and economic prosperity of the nation and is an important issue of justice and equity.

Immigrants to Canada are diverse with respect to source country, length of stay, immigration class upon arrival and socio-economic status (Hyman 2004). Health status varies by immigration status with skilled workers being more "likely to be in excellent, very good, or good health, while refugees are more likely to rate their health status as fair or poor" (Citizenship and Immigration Canada 2010). According to the literature, recent immigrants are more likely to be in good health compared to long-term immigrants and Canadian-born individuals in terms of chronic conditions (Hyman 2004, Vissandjee 2004). This is particularly true of non-European immigrants (Hyman 2004). This "healthy immigrant effect" is likely partly a consequence of the "self-selection process that basically includes people who are able and motivated to move and excludes those who are sick, disabled, and in institutions" (Hyman 2004 pi4). Additionally, this effect partly results from immigration procedures that accept only the most educated, skilled, and job-ready immigrants (Hyman 2004). According to Hyman (2004), these characteristics make social and economic integration easier and coincide with healthy lifestyles—the medically ill are often excluded from the immigrant pool.

Usually within two to ten years, the health status and chronic disease profile of the immigrant becomes more similar to that of born Canadians and immigrants who have resided in Canada for a longer period of time (De Maio 2010). Refugees especially, are most likely to experience this transition to poor health (Newbold 2009). It has been hypothesized that the loss of the health advantage may be due in part to adoption of the Canadian lifestyle, including eating habits. However, not all researchers agree that westernization or acculturation (i.e. the assimilation of the Canadian lifestyle) is responsible for causing the decline in health over time (Lear 2009). The social determinants of health and the social context of their lives are likely more viable explanations for the health of immigrants in Canada.

According to De Maio and Kemp's (2010) findings, ethnicity and Canada's (non)acceptance of diversity may also play a role, as immigrants who experienced discrimination were most likely to experience worsening of self-reported mental health. These researchers reported that 30% of respondents in the Longitudinal Survey of Immigrants to Canada (LSIC) had experienced discrimination or unfair treatment due to their ethnicity, culture, race or skin colour, language or accent, or religion, and this was associated with an increased odds of experiencing a worsening of self-reported mental health even after controlling for socioeconomic status and demographics (De Maio & Kemp 2010).

This report examines the relationship between immigration experience and health for African, Caribbean and other Black (ACB) populations in London, Ontario, Canada.

Our Approach

In Phase I of the Black, African and Caribbean Canadian Health (BLACCH) Study, a purposive sample of 22 local ACB community members were interviewed about their immigration experience, health care access, health services they

used, cultural competence and health behaviours. In Phase II of the research project, 188 self-identified ACB people residing in London and area completed a paper-based survey. All survey participants were ages 18 and over. Respondents were asked questions about their: immigration experience, socioeconomic conditions, general health, HIV screening, health service use and health behaviours, among other things. Immigrant classes were divided into: Canadian-born, family class, skilled worker class, refugee class and other. Below, we present a summary of responses from community members in Phases I and II as they pertain to immigration experience and health status. Interview results were analyzed using qualitative content analysis, and survey results were analyzed using chi-square tests. Fisher's exact test, with and without the Monte Carlo approximation, was used when appropriate.

Key Findings

Phase I: A little more than half of the interview participants had access to a family doctor. All participants who indicated having a refugee immigration class reported having family physicians, but only half of the Canadian-born individuals indicated having a family physician in London. Some participants expressed that illness was a pre-requisite for having the desire to get a family doctor.

> *Well, when I... catch a cold, when I feel... abnormal I go right away to see the doctor. (Male, undeclared immigration status, in Canada 6-10 years)*

When asked what types of health care services they used, interview participants reported accessing a family doctor, pharmacies, walk-in clinics, specialists, and dentists more frequently than other types of health services. The family doctor and pharmacy were used most frequently, and immigrants residing in Canada for more than six years were more likely to report utilizing these two services. Walk-in clinics were frequently used by individuals who had been living in Canada for more than 11 years. The majority of participants reported being generally satisfied with health care services in Canada. Though, individuals who had resided in Canada for more than 11 years reported being unsatisfied with Canada's health care provision; this dissatisfaction extended to social services for these individuals as well. Individuals expressing dissatisfaction with the system cited a shortage of doctors and long wait times as an issue. Some community members also discussed the tendency for doctors to address only one health issue per visit as a shortcoming of Canadian health care provision. According to community members, this sent the message that doctors had no time for them.

> *[N]ot 100% like... of course we get to see the doctor and I mean a family doctor and they send you to a specialist what have you, but I don't think there is enough… [I]f you have to go see a specialist, you have to wait three, four months, maybe longer… like there isn't enough doctor especially in London so you have to go and wait. Then even then I don't know if you can count on them in some cases like because they have to see so many patients so I don't know.(Male, refugee, in Canada more than 10 years)*

> *[T]he way I see it, it's getting deteriorated. Like the doctor doesn't give enough time to their patient. Even in now, there for the newcomer finding a doctor is very difficult especially for immigrants. It's a lost cause. (Female, refugee, in Canada for more than 10 years)*

Community members had many suggestions for how health and social services could be made more culturally-appropriate to better address their issues. According to one community member, service providers need to first determine if different cultural groups have unique needs. Several mentioned increasing accessibility to information, education and health resources in general, as well as making ACB people more aware of these services. The major theme that emerged, however, was the need to have people who understand ACB communities, preferably ACB people themselves, providing the health care and social services to ACB individuals. Participants thought that at the very least, providing culturally-appropriate health care to ACB people required the input of ACB communities.

> *Well, the easiest answer is to have people of varied cultures working for their organization. Like that's my solution. Is it simple? Are they able to attract them? I don't know, but it sure makes a difference because you know what everything in this life is about relationships and… if people don't know your organization and/or trust them, they're not going to avail themselves of your services, no matter how good those services might be... The bottom line is within our own communities we have to train people to have the education to provide the services and people hate hearing that. It's like you become sort of segregationalist in how you're speaking. And that's not what I'm advocating but the bottom line is there's certain things that I understand and know because of who I am as a Black woman that I bring to the table that isn't explained to me…it's not something I studied in school; it's just part of who I am and it's what I bring to the table, in the same way that what my*

Latino or White colleague brings to the table…[N]o matter how much I may like their food or the way they look or dress and think it's neat.. I'm still not going to be them and I'm not going to bring that to the table. (Female, Canadian-born)

One participant, who had lived in Canada for more than 11 years, emphasized the difficulty people sometimes have finding culturally-competent physicians, and suggested that doctors often misdiagnosed their patients due to a lack of awareness of the patients' cultural backgrounds. On the other hand, two other participants – one who had been in Canada less than five years and one more than 11 years, reported being asked about their cultural backgrounds during visits with their physicians, suggesting that doctors in Canada were aware that an individual's background provides information important to making a correct diagnosis. According to a Canadian-born participant, service organizations need cultural training. Still, a few participants felt that there was no need to provide "special" services to ACB people; reporting that North American health care was designed for North Americans and that was the way it should be. One participant pointed out that in a multi-cultural society it would be difficult to have culture-specific services.

...[B]ecause we are in a... multicultural society and sometimes it's difficult having different kinds of thing for every culture... it's difficult to say oh, this is for this community, this is for other communities, very complicated. (Male, refugee, in Canada for 0-3 years)

When asked about how people in the community stayed healthy, community members overwhelmingly pointed to physical activity and diet as the most important elements for maintaining health. In addition, three individuals reported that going to the doctor and getting regular health checks was important –two of these individuals had lived in Canada for at least six years, and one was Canadian-born. These findings indicate that all participants recognize the importance of preventing illness, but it appears that those residing in Canada longer also recognize medical care as a means of achieving health.

Well, I'm sure they stay healthy by going to their doctors, get help from the doctor,… keep clean and try to eat good food and support their, with necessary supplements, things like that. Mostly getting advice from the doctors, that's what I think. (Male, refugee, in Canada for more than 10 years)

Newcomers reported that Canadian society sometimes made it difficult to achieve and maintain health, reporting that while it is important to avoid certain things (e.g. unprotected sex, drugs), it can be difficult to avoid all health risk behaviours. For instance, they reported that many individuals strive for health on one hand but indulge in behaviours that are dangerous to health on the other, such as eating at MacDonald's or smoking. The aforementioned newcomers were usually in Canada on student visas; thus their responses regarding physical activity, diet and lifestyle may be related to their educational statuses or school environments. Participants in general attributed health to their personal life, and two mentioned the importance of community social support in maintaining health.

Phase I participants reported having diverse experiences related to migrating to Canada. Some people with family and "other" immigrant classes and immigrants who had been in Canada for six or more years talked about having to leave family behind. Family class immigrants, refugees and those with "other" immigrant classes talked about migrating to Canada after migrating to at least one other country; this pattern of migration was mentioned by newer and longer-term immigrants, too. Participants from the family, refugee and "other" immigrant classes also relayed that they had no problems migrating, regardless of length of time spent in Canada.

I came to France as student … and I lived there for five years and then…I come here in Canada to, to continue my studies so all my migration experience was about studies so. [I]t wasn't very complicated for me to, from [COUNTRY OF ORIGIN] to France was easy because our government are one like I think they have one relation… For Canada the thing…the big problem was the English that I have trying to speak it. (Male, student visa, in Canada 0-3 years)

Community members gave a variety of responses to the question about whether or not they were healthier or less healthy since immigrating to Canada. Refugee class immigrants were the only group to state they were less healthy since immigrating, and this was true regardless of how long they had been in Canada. Family class immigrants and those with an "other" immigration class were the only ones to say that their health had not changed since immigrating, and the amount of time spent in Canada did not impact their responses. No participant said they have been healthier since immigrating to Canada. Skilled workers and those who did not indicate their immigration class cited bad habits and unhealthy foods as factors impacting their health in Canada. Immigrants who had been in Canada for six or more years talked about their activity level being higher prior to coming to Canada. One participant said that the change in diet since immigrating to Canada has made him physically less healthy, but he is psychologically

healthier because of what was left behind upon immigration.

> *[B]ecause of the context and the opportunities habits have changed. My eating habits in [COUNTRY OF ORIGIN] would have been more ground provisions and fish from the sea and so the diet was, was great... [T]hat is what the foundation is, what prepared me for any of the bad habits that I picked up in Canada. However, I slowly enough came to realize that discipline with regards to diet is really a big plus towards getting, having and maintaining decent health. So I lean towards eating proper as much as possible…Without my [COUNTRY OF ORIGIN] training and exposure and type of diet, it would have been [a] tragedy coming to Canada because of the abundance of fatty, unhealthy exposure. (Male, skilled worker, in Canada 10+ years)*

Phase II: In this section of the report, we only discuss statistically significant relationships, but results for all analyses are presented in the tables. Except for Table 1, all tables have two sides. The results for years in Canada are on the left side of the table, and the results for immigration class upon arrival in Canada are on the right side. The two sides of the tables are separated by a line. Furthermore, Canadian-born is part of both sets of results, hence its position in the middle of each table, the lines on both sides of its column, and the separating line above it.

There was relationship between immigration class and the number of years in Canada. Most new immigrants arrived through the family immigration class, and the proportion of immigrants in the family immigration class was lower among longer term immigrants. Notably, the proportion of skilled worker class immigrants was highest among immigrants who had been in Canada for over five years, compared to newer immigrants (Table 1).

Table 1: Immigration Class by Years in Canada

Immigration Class	Years in Canada			
	≤3	>3 to ≤5	>5 to ≤10	>10
Family	20 (63%)	3 (27%)	6 (29%)	14 (21%)
Skilled worker	7 (22%)	3 (27%)	9 (43%)	27 (40%)
Refugee/ Refugee claimant/ pre-removal risk assessment (PRRA)/ Judicial Review	4 (13%)	1 (9%)	1 (5%)	5 (7%)
Other	1 (3%)	4 (36%)	5 (24%)	21 (31%)
Missing	1	1	4	16
Total	33	12	25	83

**= statistically significant at p=0.05
Fisher's exact test (MC): p< 0.0001**

Skilled workers reported that they had no difficulty speaking English. This was likely due to English-language skills being part of the strict selection criteria for this immigrant group. Family class immigrants, refugees and "other" classes of immigrants reported having difficulties speaking English at least some of the time (Table 2).

Table 2: Spoken English Proficiency by Immigration Experience

Difficulty Speaking English	Years in Canada				Immigration Class				
	≤3	>3 to ≤5	>5 to ≤10	>10	CA-born	Fam	SW	R	Other
None of the time	27 (82%)	9 (75%)	18 (72%)	64 (77%)	28 (100%)	23 (72%)	11 (100%)	32 (70%)	36 (84%)
Some of the time	5 (15%)	2 (17%)	5 (20%)	17 (20%)	0	7 (22%)	0	11 (24%)	7 (16%)
Most of the time	0	0	0	1 (1%)	0	1 (3%)	0	0	0
All of the time	1 (3%)	1 (8%)	2 (8%)	1 (1%)	0	1 (3%)	0	3 (7%)	0
Missing	----	----	----	----	1	----	----	----	----
Total	33	12	25	83	29	32	11	46	43

CA-born= Canadian-born
Fam= Family Class
SW= Skilled Worker Class
R= Refugee Class, Refugee Claimant/ PRRA

*= approaches statistical significance (p=0.10)
**= statistically significant (p=0.05)
Time in Canada: Fisher's exact test (MC): p=0.0598*
Immigration class: Fisher's exact test (MC): p=0.0121**

Table 3: Sexual Orientation Identity by Immigration Experience

Sexual Orientation	Years in Canada				Immigration Class				
	≤3	>3 to ≤5	>5 to ≤10	>10	CA-born	Fam	SW	R	Other
Bisexual	1 (3%)	0	0	4 (5%)	3 (10%)	1 (3%)	0	3 (7%)	0
Gay or Lesbian	0	0	0	1 (1%)	1 (3%)	1 (3%)	0	0	0
Straight	27 (82%)	11 (92%)	25 (100%)	76 (92%)	24 (83%)	27 (84%)	11 (100%)	40 (87%)	41 (95%)
Other	5 (15%)	1 (8%)	0	2 (2%)	1 (3%)	3 (9%)	0	3 (7%)	2 (5%)
Missing	----	----	----	----	----	----	----	----	----
Total	33	12	25	83	29	32	11	46	43

CA-born= Canadian-born
Fam= Family Class
SW= Skilled Worker Class
R= Refugee Class, Refugee Claimant/ PRRA

*= approaches statistical significance (p=0.10)
**= statistically significant (p=0.05)
Time in Canada: Fisher's exact test (MC): p=0.1547
Immigration class: Fisher's exact test (MC): p=0.5108

Post-baccalaureate education was more common among newer immigrants and skilled worker class immigrants than among other groups. It is important to note that many of the immigrants who had been in Canada for over five years and had at least some university education may have arrived as children and were raised in Canada (Table 4).

Table 4: Highest Level of Education by Immigration Experience

Level of Education	Years in Canada				Immigration Class				
	≤3	>3 to ≤5	>5 to ≤10	>10	CA-born	Fam	SW	R	Other
Less than high school	0	1 (8%)	1 (4%)	6 (7%)	2 (7%)	2 (6%)	1 (9%)	1 (2%)	0
Completed high school	6 (18%)	5 (42%)	3 (12%)	7 (8%)	3 (10%)	3 (9%)	0	5 (11%)	8 (19%)
Some community college to completed community college	6 (18%)	0	7 (28%)	19 (23%)	4 (14%)	8 (25%)	0	15 (33%)	6 (14%)
Some university to Bachelor's	9 (27%)	6 (50%)	7 (28%)	31 (37%)	16 (55%)	14 (44%)	2 (18%)	15 (33%)	17 (40%)
Above Bachelor's	12 (36%)	0	7 (28%)	20 (24%)	4 (14%)	5 (16%)	8 (73%)	10 (22%)	12 (28%)
Missing	----	----	----	----	----	----	----	----	----
Total	33	12	25	83	29	32	11	46	43

CA-born= Canadian-born
Fam= Family Class
SW= Skilled Worker Class
R= Refugee Class, Refugee Claimant/ PRRA

*= approaches statistical significance (p=0.10)
**= statistically significant (p=0.05)
Time in Canada: Fisher's exact test (MC): p=0.0352**
Immigration class: Fisher's exact test (MC): p=0.0170**

When compared to Canadian-born individuals, student status was high among immigrants living in Canada for five years or less, and unemployment and underemployment were high among immigrants living in Canada for greater than five years. Self-employment was only present among immigrants living in Canada more than 10 years and Canadian-born persons (Table 5).

Table 5: Employment by Immigration Experience

Employment Status	Years in Canada				Immigration Class				
	≤3	>3 to ≤5	>5 to ≤10	>10	CA-born	Fam	SW	R	Other
Unemployed	2 (6%)	1 (8%)	5 (20%)	7 (9%)	1 (3%)	2 (6%)	1 (10%)	5 (11%)	4 (9%)
Underemployed+	2 (6%)	2 (17%)	3 (12%)	17 (21%)	1 (3%)	7 (22%)	3 (30%)	5 (11%)	6 (14%)
Student	22 (67%)	8 (67%)	9 (36%)	22 (27%)	14 (48%)	11 (34%)	2 (20%)	18 (39%)	22 (51%)
Employed full-time	7 (21%)	1 (8%)	8 (32%)	28 (34%)	11 (38%)	11 (34%)	4 (40%)	13 (28%)	10 (23%)
Self-employed	0	0	0	8 (10%)	2 (7%)	1 (3%)	0	5 (11%)	1 (2%)
Missing	----	----	----	1	----	----	1	----	----
Total	33	12	25	83	29	32	11	46	43

CA-born= Canadian-born
Fam= Family Class
SW= Skilled Worker Class
R= Refugee Class, Refugee Claimant/ PRRA

+= People who are not permanently employed full-time
**= statistically significant (p=0.05)
Time in Canada: Fisher's exact test (MC): p=0.0059**
Immigration class: Fisher's exact test (MC): p=0.4434

Across all groups, most people reported living in their own homes. The proportion of people living in their own homes

was lowest among the newest immigrants and highest among Canadian-born persons. Furthermore, the proportion of people living with relatives and friends or living in residences, group homes or boarding homes was lowest among immigrants who have been in Canada for the more than 10 years (Table 6).

Table 6: Housing Status by Immigration Experience

Housing Situation	Years in Canada				Immigration Class				
	≤3	>3 to ≤5	>5 to ≤10	>10	CA-born	Fam	SW	R	Other
Living in own home	19 (61%)	7 (64%)	20 (80%)	67 (83%)	25 (86%)	22 (73%)	8 (80%)	35 (78%)	30 (73%)
Living with friends, relatives	6 (19%)	3 (27%)	4 (16%)	13 (16%)	3 (10%)	6 (20%)	2 (20%)	10 (22%)	4 (10%)
Living in residence, group home, boarding home	6 (19%)	1 (9%)	0	1 (1%)	1 (3%)	2 (7%)	0	0	6 (15%)
Living on streets or in a homeless shelter	0	0	0	0	0	0	0	0	0
Other	0	0	1 (4%)	0	0	0	0	0	1 (2%)
Missing	2	1	----	2	----	2	1	1	2
Total	33	12	25	83	29	32	11	46	43

CA-born= Canadian-born
Fam= Family Class
SW= Skilled Worker Class
R= Refugee Class, Refugee Claimant/ PRRA
*= approaches statistical significance (p=0.10)
**= statistically significant (p=0.05)
Time in Canada: Fisher's exact test (MC): p=0.0164**
Immigration class: Fisher's exact test (MC): p=0.1717

Table 7: Self-Reported Health Status by Immigration Experience

Health Rating	Years in Canada				Immigration Class				
	≤3	>3 to ≤5	>5 to ≤10	>10	CA-born	Fam	SW	R	Other
Excellent	15 (45%)	5 (42%)	11 (44%)	28 (34%)	10 (36%)	13 (41%)	7 (64%)	14 (30%)	15 (35%)
Very good	12 (36%)	3 (25%)	7 (28%)	28 (34%)	9 (32%)	9 (28%)	1 (9%)	17 (37%)	16 (37%)
Good	5 (15%)	3 (25%)	6 (24%)	20 (24%)	9 (32%)	8 (25%)	3 (27%)	11 (24%)	9 (21%)
Fair	1 (3%)	1 (14%)	1 (4%)	4 (5%)	0	0	0	4 (9%)	2 (5%)
Poor	0	0	0	3 (4%)	0	2 (6%)	0	0	1 (2%)
Missing	----	----	----	----	1	----	----	----	----
Total	33	12	25	83	29	32	11	46	43

CA-born= Canadian-born
Fam= Family Class
SW= Skilled Worker Class
R= Refugee Class, Refugee Claimant/ PRRA
*= approaches statistical significance (p=0.10)
**= statistically significant (p=0.05)
Time in Canada: Fisher's exact test (MC): p=0.9567
Immigration class: Fisher's exact test (MC): p=0.5233

Table 8: Stress by Immigration Experience

Level of Stress	Years in Canada				Immigration Class				
	≤3	>3 to ≤5	>5 to ≤10	>10	CA-born	Fam	SW	R	Other
Not at all stressful	6 (18%)	0	3 (12%)	6 (7%)	0	4 (13%)	1 (9%)	6 (13%)	2 (5%)
Not very stressful	9 (27%)	1 (8%)	9 (36%)	25 (30%)	6 (21%)	6 (19%)	4 (36%)	13 (28%)	14 (33%)
A bit stressful	14 (42%)	8 (67%)	8 (32%)	35 (42%)	13 (46%)	17 (55%)	5 (45%)	15 (33%)	18 (42%)
Quite a bit stressful	3 (9%)	3 (25%)	4 (16%)	12 (14%)	8 (29%)	3 (10%)	1 (9%)	10 (22%)	6 (14%)
Extremely stressful	1 (3%)	0	1 (4%)	5 (6%)	1 (4%)	1 (3%)	0	2 (4%)	3 (7%)
Missing	----	----	----	----	1	1	----	----	----
Total	33	12	25	83	29	32	11	46	43

CA-born= Canadian-born
Fam= Family Class
SW= Skilled Worker Class
R= Refugee Class, Refugee Claimant/ PRRA
*= approaches statistical significance (p=0.10)
**= statistically significant (p=0.05)
Time in Canada: Fisher's exact test (MC): p=0.3350
Immigration class: Fisher's exact test (MC): p=0.5196

Table 9 shows that HIV testing was most common among newer immigrants, and was lowest among Canadian-born persons and immigrants who had been in Canada for over 10 years. Although not significant, the results suggest that

skilled worker class immigrants were far more likely to have been tested than other immigrant classes, and testing frequencies among family and refugee class immigrants were similar. These results are not surprising, because it is mandatory for skilled worker class immigrants to receive an HIV test as part of the medical exam for immigration purposes. The results may not have been statistically significant due to the relatively small sample size.

Table 9: HIV Testing by Immigration Experience

Ever Tested for HIV	Years in Canada				Immigration Class				
	≤3	>3 to ≤5	>5 to ≤10	>10	CA-born	Fam	SW	R	Other
Yes	28	5	17	40	16	17	9	28	21
	(85%)	(45%)	(68%)	(51%)	(55%)	(59%)	(90%)	(62%)	(49%)
No	3	5	7	37	12	12	1	17	17
	(9%)	(45%)	(28%)	(47%)	(41%)	(41%)	(10%)	(38%)	(40%)
Don't know	2	1	1	2	1	0	0	0	5
	(6%)	(9%)	(4%)	(3%)	(3%)				(12%)
Rather not say	0	0	0	0	0	0	0	0	0
Missing	----	1	----	4	----	3	1	1	----
Total	33	12	25	83	29	32	11	46	43

CA-born= Canadian-born
Fam= Family Class
SW= Skilled Worker Class
R= Refugee Class, Refugee Claimant/ PRRA

*= approaches statistical significance (p=0.10)
**= statistically significant (p=0.05)
Time in Canada: Fisher's exact test (MC): p=00045**
Immigration class: Fisher's exact test (MC): p=0.1076

The results show that the number of years spent living in Canada was related to having a sex partner who had been tested for HIV. The proportion of people whose partners had been tested for HIV was higher among immigrants who had been in Canada for five years or less, and lower among longer term immigrants and Canadian-born persons (Table 10).

Table 10: Sex Partner's HIV Testing by Immigration Experience

Sex Partner Ever Tested for HIV	Years in Canada				Immigration Class				
	≤3	>3 to ≤5	>5 to ≤10	>10	CA-born	Fam	SW	R	Other
Yes	14	6	8	22	9	13	5	13	14
	(58%)	(60%)	(33%)	(29%)	(36%)	(42%)	(56%)	(31%)	(40%)
No	2	2	5	31	5	9	1	14	8
	(8%)	(20%)	(21%)	(40%)	(20%)	(29%)	(11%)	(33%)	(23%)
Don't know	7	1	9	21	10	8	2	12	13
	(29%)	(10%)	(38%)	(27%)	(40%)	(26%)	(22%)	(29%)	(37%)
Rather not say	1	1	2	3	1	1	1	3	0
	(4%)	(10%)	(8%)	(4%)	(4%)	(3%)	(11%)	(7%)	
Missing	9	2	1	6	4	1	2	4	8
Total	33	12	25	83	29	32	11	46	43

CA-born= Canadian-born
Fam= Family Class
SW= Skilled Worker Class
R= Refugee Class, Refugee Claimant/ PRRA

*= approaches statistical significance (p=0.10)
**= statistically significant (p=0.05)
Time in Canada: Fisher's exact test (MC): p=0.0571*
Immigration class: Fisher's exact test (MC): p=0.7122

There was a strong relationship between immigration experience and having health insurance. The number of years spent in Canada was related to the types of health insurance people had. Immigrants who had been in Canada for five or fewer years were more likely to have private insurance alone, which is not surprising, since many were international students who had health insurance through their educational institution. A combination of public and private insurance was more common among longer-term immigrants, skilled worker immigrants and Canadian-born persons. Family class immigrants had the lowest proportion of combined public and private health insurance (Table 11).

Table 11: Health Insurance by Immigration Experience

Type of Health Insurance	Years in Canada				Immigration Class				
	≤3	>3 to ≤5	>5 to ≤10	>10	CA-born	Fam	SW	R	Other
None	0	0	2 (8%)	0	0	0	0	0	2 (5%)
Public only	11 (33%)	3 (25%)	12 (48%)	39 (47%)	10 (34%)	16 (50%)	3 (27%)	25 (54%)	9 (21%)
Private only	13 (39%)	4 (33%)	0	12 (14%)	2 (7%)	5 (16%)	2 (19%)	6 (13%)	16 (37%)
Public and private	9 (27%)	5 (42%)	11 (44%)	32 (39%)	17 (59%)	11 (17%)	6 (55%)	15 (33%)	16 (37%)
Missing	----	----	----	----	----	----	----	----	----
Total	33	12	25	83	29	32	11	46	43

CA-born= Canadian-born
Fam= Family Class
SW= Skilled Worker Class
R= Refugee Class, Refugee Claimant/ PRRA

*= approaches statistical significance (p=0.10)
**= statistically significant (p=0.05)
Time in Canada: Fisher's exact test (MC): p<0.0001**
Immigration class: Fisher's exact test (MC): p=0.0051**

Participants' comfort level with family doctors and nurse practitioners in London was related to how many years they had lived in Canada. Most Canadian-born participants felt comfortable or very comfortable with their family doctor. Nearly half of respondents who had lived in Canada for less than five years did not have a family doctor or nurse practitioner (Table 12).

Table 12: Comfort with Primary Care Providers by Immigration Experience

Comfort Level with Family Doctors and Nurse Practitioners in London	Years in Canada				Immigration Class				
	≤3	>3 to ≤5	>5 to ≤10	>10	CA-born	Fam	SW	R	Other
Very comfortable	6 (18%)	2 (20%)	4 (17%)	23 (29%)	9 (32%)	7 (25%)	3 (27%)	11 (26%)	9 (21%)
Comfortable	7 (21%)	4 (40%)	11 (16%)	36 (46%)	11 (39%)	12 (43%)	6 (55%)	14 (33%)	17 (40%)
Uncomfortable	3 (9%)	1 (10%)	0	2 (3%)	0	1 (4%)	0	2 (5%)	0
Very uncomfortable	7 (21%)	1 (10%)	7 (29%)	13 (16%)	2 (7%)	6 (21%)	1 (10%)	10 (24%)	7 (16%)
Do not have a family doctor or nurse practitioner	10 (30%)	2 (20%)	2 (8%)	5 (6%)	6 (21%)	2 (7%)	1 (9%)	5 (12%)	10 (23%)
Missing	----	2	1	4	1	4	----	4	----
Total	33	12	25	83	29	32	11	46	43

CA-born= Canadian-born
Fam= Family Class
SW= Skilled Worker Class
R= Refugee Class, Refugee Claimant/ PRRA

*= approaches statistical significance (p=0.10)
**= statistically significant (p=0.05)
Time in Canada: Fisher's exact test (MC): p=0.0234**
Immigration class: Fisher's exact test (MC): p=0.6954

As shown in Table 13, the number of years spent in Canada was associated with accessing some service providers. For instance, people who had lived in Canada longer were more likely to have accessed family doctors, dentists and eye specialists in the past year. There was no evidence to suggest that the amount of time immigrants spent in Canada had an impact on accessing some service providers, like physiotherapists, nurse practitioners, or chiropractors. The evidence suggests that immigration class was associated with accessing counsellors and social or case workers. Compared to immigrants, Canadian-born people were more likely to have accessed counsellors, and they were followed by family-class immigrants. Accessing social or case workers was more common among family-class immigrants and skilled worker class immigrants.

Table 13: Service Providers Accessed by Immigration Experience

Service Providers Accessed in Past Year	P-value	Years in Canada ≤3	>3 to ≤5	>5 to ≤10	>10	CA-born	Immigration Class Fam	SW	R	Other	P-value
Family doctor	<0.0008[a]**	18 (55%)	7 (58%)	9 (38%)	65 (79%)	22 (76%)	23 (77%)	8 (73%)	29 (63%)	25 (58%)	0.3635[a]
Dentist	0.0378[a]**	5 (15%)	2 (17%)	10 (42%)	28 (34%)	14 (48%)	11 (37%)	4 (36%)	12 (26%)	11 (26%)	0.2503[a]
Eye specialist	0.0078[a]**	2 (6%)	0	7 (29%)	27 (33%)	9 (31%)	11 (37%)	2 (18%)	9 (20%)	7 (16%)	0.2357[a]
Other specialist	0.5956[b]	3 (9%)	1 (8%)	5 (21%)	11 (13%)	6 (21%)	3 (10%)	0	8 (17%)	5 (12%)	0.4740[b]
Chiropractor	0.4200[b]	4 (12%)	1 (8%)	0	10 (12%)	2 (7%)	3 (10%)	0	3 (7%)	6 (14%)	0.6767[b]
Counsellor	0.0089[b]**	0	0	0	4 (5%)	6 (21%)	2 (7%)	0	0	1 (2%)	0.0032[b]**
Physiotherapist	0.6907[b]	2 (6%)	1 (8%)	2 (8%)	3 (4%)	1 (3%)	2 (7%)	0	0	5 (12%)	0.1058[b]
Social or case worker	0.6070[b]	1 (3%)	1 (8%)	2 (8%)	3 (4%)	2 (7%)	4 (13%)	1 (9%)	1 (2%)	0	0.0463[b]**
Nurse	0.2930[b]	1 (3%)	2 (17%)	0	5 (6%)	1 (3%)	4 (13%)	1 (9%)	1 (2%)	2 (5%)	0.2636[b]
Psychologist	0.3872[b]	0	0	0	6 (7%)	1 (3%)	1 (3%)	0	2 (4%)	2 (5%)	1.0000[b]
Nurse practitioner	0.5246[b]	2 (6%)	1 (8%)	1 (4%)	3 (4%)	0	2 (7%)	0	1 (2%)	3 (7%)	0.5426[b]
Foot care specialist	0.5571[b]	0	0	0	5 (6%)	1 (3%)	0	0	1 (2%)	3 (7%)	0.5952[b]
Dietitian/ nutritionist	0.5326[b]	0	0	0	4 (5%)	0	2 (7%)	0	1 (25%)	1 (2%)	0.6557[b]
Speech specialist	1.0000[b]	0	0	0	1 (1%)	0	0	0	0	1 (2%)	0.7125[b]
Missing		----	----	1	1	----	2				
Total		33	12	25	83	29	32	11	46	43	

CA-born= Canadian-born
Fam= Family Class
SW= Skilled Worker Class
R= Refugee Class, Refugee Claimant/ PRRA

*= approaches statistical significance (p=0.10)
**= statistically significant (p=0.05)
[a] Chi-square test
[b] Fisher's exact test

Table 14: Having to Educate Doctors by Immigration Experience

Had to Educate Doctor or Nurse Practitioner about Health Care Needs	Years in Canada ≤3	>3 to ≤5	>5 to ≤10	>10	CA-born	Immigration Class Fam	SW	R	Other
Yes	6 (18%)	1 (9%)	5 (22%)	17 (22%)	5 (18%)	7 (25%)	1 (9%)	9 (21%)	8 (19%)
No	27 (82%)	10 (91%)	18 (78%)	62 (78%)	23 (82%)	21 (75%)	10 (91%)	34 (79%)	34 (81%)
Missing	----	1	2	4	1	4	----	3	1
Total	33	12	25	83	29	32	11	46	43

CA-born= Canadian born
Fam= Family Class
SW= Skilled Worker Class
R= Refugee Class, Refugee Claimant/ PRRA

*= approaches statistical significance (p=0.10)
**= statistically significant (p=0.05)
Time in Canada: $\chi^2(4)=1.12$ p=0.8910
Immigration class: $\chi^2(4)=1.39$ p=0.8459

Table 15: Drinking Problem by Immigration Experience									
Drinking Problem	**Years in Canada**				**Immigration Class**				
	≤3	**>3 to ≤5**	**>5 to ≤10**	**>10**	**CA-born**	**Fam**	**SW**	**R**	**Other**
Drinking is a problem	0	0	0	0	0	0	0	0	0
Drinking is sometimes a problem	0	0	2 (9%)	2 (3%)	0	0	0	0	3 (7%)
Drinking is not a problem	32 (100%)	11 (100%)	21 (91%)	77 (97%)	27 (100%)	30 (100%)	11 (100%)	41 (100%)	39 (93%)
Missing	1	1	2	4	2	2	----	5	2
Total	33	12	25	83	29	32	11	46	43

CA-born= Canadian-born
Fam= Family Class
SW= Skilled Worker Class
R= Refugee Class, Refugee Claimant/ PRRA
*= approaches statistical significance (p=0.10)
**= statistically significant (p=0.05)
Time in Canada: Fisher's exact test (MC): p=0.2927
Immigration class: Fisher's exact test (MC): p=0.1446

Consumption of fruits, fruit juices, carrots, potatoes, and other vegetables was not impacted by the number of years spent in Canada. Only the consumption of green salads appeared to be related to how long participants had lived in Canada, with more green salads being eaten by respondents who lived in Canada for more than five years (Table 16).

Table 16: Fruit and Vegetable Consumption by Immigration Experience											
Fruits and Vegetables		**Years in Canada**				**Immigration Class**					
Usually Eaten Each Week	**p-value**	**≤3**	**>3 to ≤5**	**>5 to ≤10**	**>10**	**CA-born**	**Fam**	**SW**	**R**	**Other**	**p-value**
Fruit	0.4622[a]	26 (79%)	8 (73%)	14 (64%)	62 (78%)	24 (86%)	23 (79%)	8 (73%)	28 (65%)	35 (83%)	0.2144[a]
Fruit juice	0.5560[a]	24 (73%)	9 (82%)	18 (82%)	53 (66%)	21 (75%)	20 (69%)	6 (55%)	32 (74%)	32 (76%)	0.6596[a]
Green salad	0.0557[a]*	14 (42%)	6 (55%)	16 (73%)	56 (70%)	19 (68%)	20 (69%)	8 (73%)	29 (67%)	24 (57%)	0.7648[a]
Carrots	0.1817[a]	17 (52%)	2 (18%)	13 (59%)	33 (41%)	14 (50%)	13 (45%)	5 (45%)	19 (44%)	21 (50%)	0.9777[a]
Potatoes	0.4694[a]	8 (24%)	4 (36%)	10 (45%)	27 (34%)	12 (43%)	8 (28%)	4 (36%)	21 (49%)	11 (26%)	0.1830[a]
Other vegetable	0.4443[a]	20 (61%)	9 (82%)	18 (78%)	58 (73%)	22 (79%)	23 (79%)	8 (73%)	32 (73%)	29 (69%)	0.8594[a]
Missing		----	1	3	3	1	3	----	3	1	
Total		33	12	25	83	29	32	11	46	43	

CA-born= Canadian-born
Fam= Family Class
SW= Skilled Worker Class
R= Refugee Class, Refugee Claimant/ PRRA
*= approaches statistical significance (p=0.10)
**= statistically significant (p=0.05)
[a] Chi-square test

Table 17: Exercise by Immigration Experience									
Physical Activity in Last	**Years in Canada**				**Immigration Class**				
3 Months	**≤3**	**>3 to ≤5**	**>5 to ≤10**	**>10**	**CA-born**	**Fam**	**SW**	**R**	**Other**
Yes	27 (82%)	11 (92%)	19 (76%)	72 (87%)	26 (90%)	27 (84%)	11 (100%)	37 (80%)	37 (86%)
No	6 (18%)	1 (8%)	6 (24%)	11 (13%)	3 (10%)	5 (16%)	0	9 (20%)	6 (14%)
Missing	----	----	----	----	----	----	----	----	----
Total	33	12	25	83	29	32	11	46	43

CA-born= Canadian-born
Fam= Family Class
SW= Skilled Worker Class
R= Refugee Class, Refugee Claimant/ PRRA
*= approaches statistical significance (p=0.10)
**= statistically significant (p=0.05)
Time in Canada: Fisher's exact test (MC): p=0.6075
Immigration class: Fisher's exact test (MC): p=0.5857

Table 18: Sharing Injecting Equipment by Immigration Experience									
Sharing Needles or Injecting Equipment	**Years in Canada**				**Immigration Class**				
	≤3	**>3 to ≤5**	**>5 to ≤10**	**>10**	**CA-born**	**Fam**	**SW**	**R**	**Other**
Yes	0	0	0	0	1 (3%)	0	0	0	0
No	12 (36%)	6 (50%)	10 (42%)	31 (37%)	6 (21%)	10 (32%)	4 (36%)	17 (37%)	15 (36%)
Have never injected drugs	21 (64%)	6 (50%)	14 (58%)	52 (63%)	22 (76%)	21 (68%)	7 (64%)	29 (63%)	27 (64%)
Missing	----	----	1	----	----	1	----	----	1
Total	33	12	25	83	29	32	11	46	43

CA-born= Canadian-born
Fam= Family Class
SW= Skilled Worker Class
R= Refugee Class, Refugee Claimant/ PRRA

*= approaches statistical significance (p=0.10)
**= statistically significant (p=0.05)
Time in Canada: Fisher's exact test (MC): p=0.3118
Immigration class: Fisher's exact test (MC): p=0.6200

Recommendations to Impact Policy and Practice

Based on the information gleaned from the results included in these analyses, we are comfortable making the following recommendations:

1) Organizations providing health services should hire ACB people as service providers, because they tend to be more knowledgeable about ACB communities and issues than service providers with other ethno-racial backgrounds. Hiring ACB staff can help to build trust between ACB communities and these organizations, and help reduce the isolation some ACB immigrants face when they arrive in Canada. Additionally, by hiring ACB staff, agencies will be able to craft culturally-sensitive health messages that go beyond simply translating messages from English into another language. Although not shown in these results, it is important to note that some ACB community members prefer to receive health services from people of a specific gender or ethnic group (Baidoobonso 2012). Hence, it may be important to have multiple ACB staff within an organization.

2) When designing health services for ACB communities, it is important to employ a participatory framework that involves ACB people in the process. Participation can be broken down into five levels—informing ACB communities about services that will be provided, consulting with ACB communities about services that should be provided, encouraging ACB communities to provide additional ideas and including them in decisions about how to move forward, collaborating with ACB communities to make decisions and execute plans, and supporting initiatives led by ACB communities. The lower levels of participation require less commitment from the community; and the appropriate level of participation will depend on the availability of resources, community interests, and the stakeholders involved in the process. Effective participation is achieved when key stakeholders (i.e. ACB communities, service organizations, community advocates, etc.) are satisfied with their level of participation.

3) It is important for health service providers to inform ACB people about the range of health services that are available to them and the benefits of each of these services. From the results presented in this report, it is evident that many ACB immigrants are either unaware of, or are unwilling to use, the services provided by health service providers other than doctors, nurses or dentists. Despite defining health holistically (Baidoobonso 2012), many people seemed to limit their health service use to services associated with physiological health, thus ignoring psychological, social and spiritual health, for example. These findings are not very surprising, however, because many ACB immigrants are from countries where the predominant forms of health services focus on physiological health, and the health care providers with which they are most familiar are doctors, dentists and nurses.

4) Health service providers should be mindful that longer-term immigrants have different health care access needs than newer immigrants, and English speakers' needs might be different from those of non-English speakers. Although longer-term immigrants appear to have greater health care access than newer immigrants, they tended to be more dissatisfied with the quality of health care they receive than other groups. Programs and services aimed at improving immigrants' health tend to focus on newcomers, and longer-term immigrants are often forgotten. It is important to view immigrant health more broadly, and recognize that while longer-term immigrants might be more able to access health services than newer immigrants, the services they access might not be appropriate for their needs, and the quality of those

services might not be of good calibre. Similarly, oftentimes the discussion about health care access for immigrants focuses on translating health information into immigrants' languages. This narrow focus ignores the unique needs of immigrants who already speak English fluently. Upon arrival in Canada, English speakers are not connected with English as a Second Language (ESL) programs, which typically provide immigrants with an orientation to Canada and information about services that are available to them (Baidoobonso 2012). Hence, in this respect, English speakers might be at a disadvantage.

5) Lastly, unemployment and underemployment were high among ACB immigrants who have lived in Canada longer, and health service providers must recognize that the burden these place on ACB immigrants. Many ACB immigrants are financially supporting relatives in their countries of origin (Baidoobonso 2012), which strains the limited resources they have and are a source of stress. This context must be taken into consideration when health services are being provided to ACB people, and when ACB people are being asked to participate in designing health services for ACB populations.

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