April
2016

Newcomer Health Project
Final Report

Prepared by
Cara Robinson, BSc, BASc
MPH candidate

Introduction

Canada's health care system must strive to meet the needs of a multicultural population consisting of individuals with varying length of residence in Canada, official language proficiency, and knowledge of the system. The capacity of the health care system to provide appropriate primary and preventative care to culturally unique population cohorts is wholly dependent on establishing a comprehensive understanding of the existing challenges experienced by individuals when they attempt to access care. The research conducted by the Newcomer Health Project will contribute to improved stakeholder understanding in this regard and will thus have both economic and quality of life impacts.

A recent document released by the Ontario Ministry of Health and Long-Term Care outlines a number of new initiatives proposed with the objective of enhancing Ontario's health care system by focusing on patient needs [1]. The Ontario Ministry of Health and Long-Term Care has identified the need to improve health system equity as a priority [1]. It is recognized that the system's current structure may disadvantage certain cohorts of the population, including newcomers, in terms of their ability to access the care they need in a culturally and linguistically comfortable manner [1]. The proposals brought forth aim to restructure the health care system such that all components of primary and preventative care will be better integrated and more accessible [1]. The Newcomer Health Project aligns well with this strategic direction by investigating newcomer care access challenges within Chatham-Kent.

Newcomer Health Project Overview

The Newcomer Health Project is a joint initiative involving stakeholders from the Erie St. Clair Local Health Integration Network, the Chatham-Kent Local Immigration Partnership, and the Municipality of Chatham-Kent, with the objective of investigating barriers to access of primary and preventative health care services by newcomer populations within Chatham-Kent. The project has consisted of several sequential components, including primary qualitative data collection through local survey administration and focus group engagement, analysis and coding of collected data, a scan of existing relevant Canadian literature to establish an evidence base, integration and synthesis of all information, and development of recommendations to support newcomer care access within Chatham-Kent. These recommendations are the culminating pinnacle of the Newcomer Health Project. It is intended that project stakeholders will fully implement these recommendations by strategically investigating and pursuing feasible action items which will most significantly facilitate improved newcomer access to health services.

The purpose of this report is to outline the literature scan process and results, to highlight Chatham-Kent survey findings, to comprehensively synthesize all acquired evidence, and to establish evidence-informed recommendations.

Project Limitations

The Newcomer Health Project was conducted with as much diligence and rigor as available resources permitted. In spite of this, there were methodological limitations that may have impacted project findings. Potential biases as well as mitigation efforts to limit the bias are described in this section.

Primary Data Collection Limitations

Non-random methods were used for participant solicitation, resulting in selection bias. It is possible that the newcomers, migrant workers, and service providers who opted to participate in survey completion may not have been an accurate cross-representation of the respective target groups.

Analysis and coding challenges arose from the qualitative, free-text format of the surveys. The structure of the surveys resulted in the researcher having to independently and manually extrapolate themes for each question and aggregate responses accordingly. Although this process was conducted with due diligence and was repeated for added rigor, it was subject to the inevitable personal biases and perspectives of the researcher. Furthermore, different survey versions were used for different target groups, resulting in comparison challenges.

Newcomer and migrant worker respondents were offered assistance with interpretation and response transcription. This process may have introduced inaccuracies in question translation, response interpretation, and response transcription. The impact of this limitation is presumably minimal among newcomer survey responses, as very few newcomers required interpretation assistance for survey completion. The impact on migrant worker survey responses is likely much more significant, as assistance with interpretation and transcription was frequently required among this group.

Lastly, a high rate of no response to survey questions was noted, particularly among migrant worker surveys, potentially skewing data. This outcome may have been the result of poor respondent confidence in anonymity and confidentiality of results. Fear of sensitive responses being revealed to employers or immigration officials may have compelled respondents to either avoid responding to particular questions altogether or to mask their true perspectives and opinions. This limitation could be construed as a type of social desirability bias.

Literature Scan Limitations

Literature reviews are typically conducted prior to primary data collection, as existing evidence is used to inform and direct study design. In this case, circumstances were such that data collection activities were already underway when the scope of the project was expanded to

include a literature scan, resulting in deviation from the typical sequence of research events. In spite of the fact that the results of the literature scan were not used to direct primary data collection, the information provided by the literature serves to add rigor to the Newcomer Health Project.

A comprehensive systematic review of the literature was not conducted due to time and resource constraints. Instead, the researcher conducted a smaller-scale environmental scan of the literature.

The researcher restricted literature inclusion to Canadian articles, resulting in exclusion of any research conducted internationally.

Originally, it was the intent of the researcher to include journal articles pertaining to newcomer mental health; however, following the article searching portion of the process, it was established that newcomer mental health was too comprehensive a topic to include. As such, articles exclusively addressing newcomer mental health were excluded. The topic of newcomer mental health will be addressed further in the future research section.

Immigration Statistics

According to existing federal statistics, the proportion of foreign-born individuals residing in Canada is increasing significantly. Recent estimates suggest that 20.6% of the Canadian population is foreign-born [2]. In 2014, 260 404 individuals were granted permanent resident status, with the majority settling in Ontario [2]. Most of these individuals were accepted as economic immigrants, and most fell within the 25-44 year age group [2]. Notably, 9133 were 65 years of age or older [2]. Fifty-one percent originated in the Asia and Pacific source area, followed by 23.9% from Africa and the Middle East [2]. In terms of official language proficiency, 30.9% of this cohort lacked proficiency in English or French [2]. It was noted that poor official language proficiency was most prevalent in the family and refugee immigrant classes [2].

According to the 2011 National Household Survey, there were 8695 immigrant households within Chatham-Kent [3]. The largest proportion of immigrants residing in Chatham-Kent arrived prior to 1971, and only 530 arrived within the five years prior to National Household Survey data collection, suggesting that Chatham-Kent is home to more long-term than recent immigrants [3]. The largest proportion reported having immigrated from European countries; however, among more recent immigrants, the largest proportion reported having come from countries comprising the Americas [3].

Literature Scan

The research questions for the literature scan were established by the researcher in consultation with stakeholder representatives. The literature review sought to answer one primary research question and three sub-questions, which were as follows:

- What are the existing barriers and challenges inhibiting individuals who are new to Canada from accessing health services?
    - What are the unique challenges experienced by migrant workers when accessing health services in Canada?
    - How do the needs of newcomers shift as they age?
    - How can Public Health better serve newcomers?

The article search process took place between October 9 and December 13, 2015. Databases searched through the University of Waterloo's electronic library access included the Cochrane Library, Pubmed, and Scopus. In order to establish a baseline of literature reviews completed on this topic, the Cochrane Library and Pubmed were initially searched for existing relevant systematic reviews. Following that, Pubmed and Scopus were extensively searched for articles pertaining to the main research question as well as each of the research sub-questions. Search terms utilized in various search strategies included 'immigrants', 'newcomers', 'refugees', 'migrant workers', 'temporary workers', 'health care', 'health services', 'aging', 'older', 'public health services', and 'Canada'. Search filters were applied in order to restrict articles to those most relevant as well as those published between January 1, 2010 and the date of search in 2015.

Ultimately, ten relevant systematic reviews were identified and were utilized to provide foundational direction for the literature review conducted. A total of 52 relevant articles were initially identified and included.

When article searching was completed for all four research questions, each included article was comprehensively reviewed, critiqued, and annotated independently by the researcher. This process resulted in exclusion of additional articles due to insufficient relevance. Upon completion of the annotation process, a total of 42 articles were deemed highly relevant to the research questions and were included.

Literature Evidence Synthesis: Primary Research Question

"What are the existing barriers and challenges inhibiting individuals who are new to Canada from accessing health services?"

The Healthy Immigrant Effect is a concept that is foundational to understanding newcomer health service access patterns and experiences. It is a phenomenon suggesting the health of recent immigrants is quite good due to the fact that, most often, only individuals in good health opt to embark on the immigration process. Moreover, all immigrants must undergo health screening prior to being granted landed immigrant status. Evidence exists to suggest that as acculturation progresses and newcomers integrate into Canadian cultural norms, their health status declines. Fuller-Thomson et al. investigated the Healthy Immigrant Effect by analyzing secondary data that had been collected jointly by Statistics Canada and Citizenship and Immigration Canada through a longitudinal survey of 7716 recent immigrants [4]. Participants had originally been interviewed at six months, two years, and four years post-arrival in Canada, and data analysis revealed marked declines in self-reported health status after four years of residence [4]. Research conducted by Meshefedijan et al. compared lifestyle habits and health indicators of immigrants with Canadian-born individuals by analyzing 2009 and 2010 data extracted from the Canadian Community Health Survey, a national cross-sectional survey [5]. Results are based on a study sample of 2705 respondents [5]. Data analysis suggests that lifestyle habits and health indicators were better among recent immigrants compared with their Canadian-born counterparts, and declines occurred among immigrants with increased length of residency in Canada [5].

Although the Health Immigrant Effect is a widely accepted concept, conflicting research does exist. Muggah et al. investigated immigrant access to primary health care services by analyzing secondary data obtained from the Comparison of Models of Primary Care study [6]. The original data was collected from 137 randomly sampled primary care practices in Ontario between 2005 and 2006 [6]. The research conducted by Muggah et al. was based on 5269 patients who reported country of birth, which includes 1099 who reported having been born outside of Canada [6]. Poorer health was reported among recent arrivals as well as those who had been in Canada for longer than 20 years [6]. It is worth noting that in this particular study, immigrant status was not captured, so comparisons between status groupings could not be made and may be the reason for the observed outcomes [6].

The reasons behind the frequently observed decline in newcomer health status are likely multifaceted; however, one proposed contributing factor is inhibited newcomer access to health care. In answer to the primary research question, the literature scan revealed six prevalent themes based on 21 research articles.

Theme 1: The general immigrant population has access to primary health care providers in Canada

It is often thought that newcomers to Canada may lack a family physician or a primary health care provider; however, evidence suggests that this is not a significant barrier to care access for the general immigrant population. In order to investigate immigrant health care access in Canada, Quesnel-Vallee at al. analyzed a large secondary dataset that was collected longitudinally by Statistics Canada as part of the National Population Health Survey [7]. This dataset was based on 7268 participating individuals who were surveyed multiple times between 1994 and 2007 [7]. Health care access measurement was based on two variables: whether the respondent reported having a regular doctor and whether the respondent reported an unmet health care need in the past 12 months [7]. Quesnel-Vallee et al. found that immigrant participants had similar likelihood of having a family physician as non-immigrant participants [7]. More recent immigrants were less likely to have a regular health care provider, which could be attributed to poor knowledge of the health care system or a desire to find an ethnically matched provider [7]. Increased time since arrival was associated with increased access to a regular physician [7]. This was corroborated by Muggah et al., who found similar access to primary care among immigrant and Canadian-born respondents [6]. Notably, lack of a primary health care provider may be more of a significant barrier for certain immigrant cohorts, such as refugees or undocumented immigrants. In studies [6], [7], immigrant status of participants was not captured, so comparisons between statuses could not be made. Campbell et al. conducted a small-scale, qualitative investigation of the experiences of undocumented immigrants accessing health care compared to those of refugee claimants and permanent residents [8]. Results were based on primary data collection via 21 one-on-one interviews, and they suggest that although most permanent residents had a regular family physician, refugee claimants did not [8]. Refugee claimants were more likely to rely on emergency departments or walk-in clinics [8].

Theme 2: Communication challenges are the most prevalent barrier to immigrant health care access in Canada

A review of the literature provides extensive evidence to suggest that communication challenges most prominently impede newcomer access to needed health care services. Studies obtained have found that language barriers contributed to reduced access to and utilization of health care in Canada, were associated with health declines among immigrants, and persisted across immigrant classes as obstacles to health care access [9] [4] [8].

Ng et al. investigated immigrant official language proficiency and health status by analyzing secondary data collected as part of Statistics Canada's Longitudinal Survey of Immigrants to Canada, a population-based cohort survey [10]. Data on 7716 respondents was available for

each of the three survey waves conducted [10]. Ng et al. found that within the first four years post-immigration, limited proficiency correlated with health declines among males and females [10]. The reasons for this were varied and likely related to inability to express needs when attempting to access care, thereby fostering economic challenges and increasing social isolation [10]. Improvements in language proficiency were found to be associated with better health outcomes [10].

Qualitative, participatory research was conducted to investigate how newcomers diagnosed with asthma were conveyed information about asthma and its management [11]. Data collection involved four focus groups with 29 total participants held in Latino, Chinese, Iranian, and Punjabi communities [11]. Poor ability to communicate with health care providers was the most commonly reported barrier to information conveyance, and it was found to adversely affect treatment compliance [11]. Poureslami et al. indicate that access to interpreters is key, but it is not the absolute solution [11]. They suggest that health care providers must engage newcomer patients in condition management rather than view them as passive recipients of information [11]. Providers should also consider more effective methods of communication, such as visual forms [11].

Dastjerdi et al. conducted qualitative, unstructured interviews with 17 Iranian recent immigrants to investigate the processes they use to learn to access Canadian health care services [12]. Participants indicated that language discrepancies were a major barrier to health care access during the settlement process, due to an inability to express needs [12]. This fostered a lack of trust in the system as well as difficulty learning how the system works [12]. Study participants reported frustration even when interpreters were used as they felt ignored by the health care provider [12]. Recipients of care also expressed discomfort with the use of family members or friends for translation [12]. Further work was conducted investigating challenges faced by Iranian immigrants when accessing health care services from the perspective of Iranian service providers [13]. Qualitative methods (interviews and focus groups) were used to obtain the perspectives of a cohort of 50 Iranian health care professionals and service providers [13]. Participating service providers reported that language barriers were a challenge among Iranian immigrants, and ethnically-matched care providers helped to overcome communication barriers [13]. Similar outcomes were found by Lee et al. when maternity experiences of Chinese immigrant women were investigated [14].

Gulati et al. investigated the communication challenges faced by Chinese and South Asian immigrant parents of children with cancer when interacting with the health care system [15]. Participants included 50 Chinese and South Asian immigrant parents of children with cancer who were recruited via six Canadian paediatric oncology centres [15]. Primary data collection occurred through qualitative, semi-structured interviews [15]. Although 62% of participants

reported no difficulty communicating with health care providers, 38% reported struggling to communicate or a complete inability to communicate with health care providers in English [15]. This was found to be particularly problematic in emergency situations [15]. Poor ability to communicate in English resulted in difficulty understanding diagnoses, hesitancy to ask further questions, and difficulty completing medical forms [15]. This gave rise to feelings of uncertainty, frustration, and helplessness, and it was found to negatively impact the ability of parents to tend to the needs of their child [15]. Study participants also reported limitations with the availability of formal interpreters, resulting in frequent use of informal interpreters [15]. Results support the need to fund, implement, and evaluate interpretation services [15].

Qualitative questionnaires completed by a random sample of 598 family physicians in Montreal found communication to be the most significant barrier in providing care to immigrants [16]. Respondents reported that professional interpreters were only used 39% of the time, and that ad hoc interpreters were much more common (such as family members and friends) [16]. Concerns expressed over the use of informal translators in health care settings included confidentiality, lack of correct translation of medical terms, and lack of patient engagement [16]. The most common suggestion for care improvement was improved access to formal interpreters [16].

Theme 3: Persistent cultural incompatibility impedes immigrant health care access in Canada

A third emerging theme is the impact cultural incompatibility has on newcomer access to health care in Canada. This is a broad concept that can refer to any situation or interaction which may result in newcomer alienation due to disparate treatment on the basis of culture or ethnicity. As is evidenced by the literature, it can present in many different ways. For example, Canadian-born service providers may overlook the fact that in many cultures, the tendency is not to ask for help and to put others' needs before one's own, resulting in personal care avoidance. Understanding different cultural tendencies is critical in order to appropriately and effectively adjust the approach to service provision.

In their investigation of post-immigration health decline based on prospective secondary data, Fuller-Thomson et al. found that 15% of 7716 immigrant respondents reported consistent discriminatory experiences when attempting to access health care [4]. This was found to have a significant impact on health due to less frequent usage of health services resulting in care delay [4]. Examples of cultural incompatibility can be found in a number of additional small-scale studies involving collection of qualitative, primary data through participant interviews. Research involving Iranian immigrants found that immigrant ethnicity was often misidentified by Canadian service providers [12]. Immigrant participants indicated that they were often given information pamphlets in languages they did not understand, contributing to feelings of

frustration and confusion [12]. Immigrant Chinese women participating in research on maternity health care expressed concerns regarding health care practitioner cultural insensitivity during labour as well as post-partum [14]. Lack of knowledge of Chinese culture by health care staff resulted in provision of taboo items or lack of adherence to traditional Chinese practices, resulting in added patient stress [14]. Lastly, Gulati et al. (2012) found that Chinese and South Asian immigrant parents of children with cancer had difficulty finding culturally appropriate information, which is suggestive of poor clinical cultural competence [15].

Theme 4: Negative service provider attitudes constrain immigrant health care access in Canada

A number of studies that investigated newcomer health care access from the perspectives of service providers were reviewed, and the findings of these studies formulate the basis of a fourth noted trend. Outcomes provide evidence to suggest that health care provider attitudes significantly impact newcomer access to health care. Provider perspectives permeate their approach to service provision, and they are foundational to the newcomer health care experience.

Health care provider attitudes regarding undocumented immigrant access to health care were investigated by collecting and analyzing data through a largescale cross-sectional online survey [17]. All clinicians, administrators, and support staff in three hospitals and two primary care facilities operating in Montreal were invited to complete the online survey, resulting in 1036 analyzed responses [17]. Data indicated that although 61% of respondents supported comprehensive health care access by undocumented immigrants, there were key differences in Canadian-born and foreign-born provider perspectives [17]. Foreign-born providers were more likely to report poor health status, lack of health insurance, service refusal, institutional racism, and social prejudice as barriers to care access than were Canadian-born providers [17]. Canadian-born providers were less likely to believe that access to specialized services, such as dental or prenatal care, is important, and they were more likely to support service restriction for undocumented immigrants [17]. Notably, more restrictive views were reported among support staff respondents as well as respondents working in hospital settings compared with other primary care settings [17]. This finding is concerning because undocumented immigrants more frequently access care through hospital settings, and support staff often serve as a gateway to care access [17]. Vanthuyne et al. utilized the same dataset to build on this body of evidence. Only participants who provided responses to the open-ended survey questions were included in the analysis, resulting in the inclusion of 237 surveys. Health care providers had widespread and variable perspectives on provision of services to immigrants with precarious status [18]. Most respondents were not in favour of universal health care access to immigrants in this situation; however, opinions were impacted by country of origin, institutional affiliation,

and professional role [18]. Foreign-born respondents were found to be most supportive of unrestricted health care access [18]. Notably, Vanthuyne et al. were in favour of universal health care as a right rather than an earned privilege [18]. They noted the fact that all immigrants, regardless of status, contribute to federal and provincial sales tax and therefore do support funding of social services even if they do not pay income tax [18].

In their investigation of physicians' attitudes on caring for immigrant patients, Papic et al. also noted fairly closed-minded and restricted perspectives on management of immigrant patients [16]. Sixty-nine percent of 598 randomly selected physician respondents had no cultural competency training [16]. Most physcians felt that arrangements for interpretation are the responsibility of the patient rather than the care provider [16]. Moreover, only 7% reported that increased practitioner open-mindedness to different cultures would improve care delivery [16]. Respondents who had received any cultural competency training were more likely to believe that it is the practitioner's responsibility to mitigate barriers to care [16].

Theme 5: The level of trust newcomers have in the health care system significantly influences health care access

A fifth permeating theme in the literature is the impact that trust or lack thereof has on facilitating or inhibiting newcomer access to health care. Considerable evidence exists suggesting that initial interactions with the health care system either foster trust and confidence or mistrust and apprehension, significantly influencing subsequent help-seeking behaviour.

Dahal et al. investigated the impact of trust on diabetes education and care among Somali, Latin American, Punjabi, and Nepali immigrant populations by collecting qualitative data through unstructured workshops and focus groups [19]. One hundred thirty-one community members participated in workshops and 34 community leaders participated in focus groups [19]. The primary theme noted from participant responses was that establishment of trust at multiple levels is critical to care effectiveness [19]. This includes feeling accepted when initially accessing a service, feeling confident in the capability of the service provider, and trusting that privacy and confidentiality will be maintained [19].

Additional qualitative research based on 21 participant interviews investigated the experiences of undocumented immigrants accessing health services and found that undocumented immigrants only sought care in dire situations, as they feared being reported to immigration authorities [8]. This finding was corroborated by research investigating access challenges faced by Iranian immigrants [13]. Coupled with lack of coverage for care, undocumented immigrants reported difficulty accessing emergency care, primary care, and needed medications [8].

Respondents also reported feeling discriminated against when trying to access care, which contributed to mistrust of providers and apprehension in seeking care [8].

Research by Isaacs et al. took a different approach and studied inter-organizational trust and collaboration, and its impact on culturally competent care delivery for immigrant families [20]. Twenty-seven organizations and four proxy organizations were identified as part of a care network serving a particular neighbourhood in Atlantic Canada [20]. All organizations were invited to participate in a network survey. Staff representatives from 21 of the 27 organizations completed an online survey [20]. Additionally, 14 key informants representing different organizations from the service community were interviewed [20]. A positive correlation between trust and collaboration (referrals, shared resources, and shared information) was found [20]. Results suggest that trust between agencies is critical to establishing a culturally competent framework, as it promotes service uptake by immigrant clients [20].

Theme 6: Certain newcomer populations are disproportionately impacted by barriers to health care access

It is also notable that certain newcomer classes and cohorts appear to be particularly affected by health care access barriers. These include refugees (especially refugee claimants as opposed to convention refugees), undocumented immigrants, and those subject to the three month waiting period.

Qualitative research on access barriers faced by refugees involved semi-structured interviews conducted with 14 health care providers and social services providers who work with refugees in the Hamilton area [21]. Service provider responses revealed that refugees experience a number of challenges leaving them disproportionately impacted compared with the general immigrant population [21]. Language and interpretation barriers, lack of culturally competent care, and hesitancy of health care providers to accept patients with complex medical histories and complex health insurance coverage emerged as prevalent trends [21]. Authors argue that although many of these challenges may be faced by the entire immigrant population, refugees are especially disadvantaged [21]. Poor client medical histories and lack of continuity of care also contribute to health declines [21].

Merry et al. utilized data collected as part of a larger prospective cohort study to investigate barriers faced by female refugee claimants in accessing health and social services during the postpartum period [22]. For the purpose of this subproject, 112 postpartum refugee claimants were included who had unaddressed health concerns as determined by research nurse assessment [22]. Results were based on reviewing and coding the qualitative notes of the research nurse [22]. Language barriers and communication challenges were prevalent and resulted in poor knowledge about self-care and baby care [22]. Lack of transportation, lack of

child care, and expense further exacerbated this issue by preventing access to language classes [22].

Newbold et al. conducted a study investigating the challenges and barriers faced by female refugees when accessing the Canadian health care system by analyzing data collected from semi-structured interviews and focus groups conducted with nine service providers and 37 refugee participants. Notably, refugee participants included 23 convention refugees and 14 refugee claimants. Responses revealed that refugee claimants are particularly susceptible to language and communication barriers, as interpretation assistance through settlement services is not immediately available to them [23]. They must first apply for and receive permanent status before they can receive settlement assistance [23]. Some respondents reported instances of health care providers refusing to provide care because of immigration status and confusion around interim federal health coverage [23]. Lack of immediate access to settlement services also resulted in no assistance in health care system navigation [23].

Extensive research reviewing 2035 emergency department files of immigrant, refugee, and undocumented children not covered by provincial health insurance provided evidence of different patterns of health care access by this cohort [24]. A large proportion of uninsured children were found to have been triaged as urgent more frequently, possibly suggesting delayed care access [24]. It was also found that refugee children were seen more often for less urgent issues [24]. This may indicate that emergency departments are the easiest way for refugees to access care, as interim federal health coverage is limited to urgent and essential needs [24].

Kiss et al. conducted research on refugee health service utilization by collecting data on 2280 refugees who were matched with 9120 non-refugees for comparison purposes [25]. Existing secondary data was analyzed to determine participant health service utilization over a two year period [25]. Results were found to conflict with prior research, in that more refugees used general practitioners, emergency departments, and hospital services compared to non-refugees [25]. In spite of their somewhat contradictory findings, study authors reiterate the fact that refugees may still encounter barriers to health care access, and equal access to care is not the same as equal quality of care [25]. It is noteworthy that study participants were convention refugees (government assisted or privately sponsored refugees), as refugee claimants were excluded [25]. It is possible and likely that refugee claimants may have different and more complex health needs compared with convention refugees, resulting in skewed, conflicting results.

Literature Evidence Synthesis: Research Sub-Question 1

"What are the unique challenges experienced by migrant workers when accessing health services in Canada?"

Research sub-question 1 pertains to health care access among temporary migrant farm workers, and the unique challenges they experience when attempting to access care. The scan of the literature revealed that research on Canadian health care access barriers faced by migrant workers is sparse. This can likely be attributed to the fact that the migrant worker population is difficult to study due to their temporary presence in Canada as well as their reluctance to participate in research. Considerably more anecdotal rather than evidence-based information exists on migrant workers. The literature scan revealed four relevant research articles in answer to this question.

Migrant farm workers are a prominent part of Canada's workforce and economy. In 2015, 64 145 temporary foreign workers were permitted entry into Canada for work purposes, 20 150 of whom worked in Ontario [26]. Within Chatham-Kent, the population of temporary foreign workers is particularly prevalent due to a large agricultural sector. In 2015, it is reported that 1145 migrant farm worker positions were filled in Chatham-Kent [27].

Migrant farm workers are employed under Canada's federal Temporary Foreign Worker program, which has two streams: the Seasonal Agricultural Workers (SAW) stream and the Low Skilled stream [28]. The SAW stream, which began in 1966, employs workers from the Caribbean and Mexico and allows workers to stay for up to eight months per year [28]. The Low Skilled stream was implemented much more recently, and it employs workers primarily from Guatemala, Thailand, and the Philippines [28]. Under this stream, workers are permitted to stay for up to two years [28].

In Ontario, migrant farm workers have full access to provincial health care coverage; however, they face numerous challenges when attempting to access care. Often, they are faced with barriers similar to those experienced by all other newcomers. Additionally, they experience challenges that arise as a result of their temporary status.

The literature revealed three prevailing themes pertaining to the unique health care access challenges of temporary migrant farm workers and will be discussed subsequently.

Theme 1: Employers function as gatekeepers to worker health care service access

For many reasons, the current structure of the Temporary Foreign Worker program gives rise to significant worker dependence on the employer for all of their needs, including access to health care. In order to be eligible to hire workers within the program, employers must provide

housing for workers. In most cases, this housing is on the employer's property, which proves convenient in terms of proximity to the workplace; however, it also provides the employer with extensive control over workers. Housing is often located in rural areas, impeding workers from being able to access needed services and medications independently, as they must request employer assistance with transportation. They are also inhibited by time constraints, as they work long hours most days of the week. Requesting time off work means that they will lose pay and be forced to divulge their health matter to their employer. Often times, poor English proficiency and lack of access to formal interpretation services results in worker reliance on the employer for assistance with translation. This creates issues with confidentiality, and it may result in workers avoiding health care altogether unless it is absolutely necessary. These structural flaws resulting in employer mediation barriers are evidenced by a study investigating access to sexual health care services among temporary foreign migrant farm workers in Canada [29]. This study was conducted in Niagara Region and involved qualitative data collection through the administration of semi-structured surveys to migrant farm workers [29]. Recruitment occurred through convenience sampling at a migrant worker health fair [29]. One hundred three migrant farm workers completed the survey, and 21 agreed to participate in a follow up focus group [29]. Employer mediation barriers such as transportation, translation, and time off work were pervasive themes noted in the survey responses and focus group comments [29].

Theme 2: Widely varying employer views exist on responsibility for migrant worker health protection

This theme is supported by research conducted by Narushima and Sanchez, who investigated employers' attitudes toward occupational health and safety as well as personal and professional health promotion among migrant farm workers [30]. As migrant farm worker employers are difficult to access, multiple methods of recruitment were conducted, including phone calls, door to door visits, and newspaper advertisements [30]. Although over 80 farms were contacted, considerable reluctance was encountered, and employers from only nine farms agreed to participate in interviews [30]. Interview responses revealed that employers' views were quite paradoxical and contradictory in terms of responsibility for worker health [30]. Respondents recognized and readily acknowledged how economically crucial migrant farm workers were to their business operations [30]. Although respondents reportedly felt that worker occupational health and safety fell within their realm of responsibility, most felt that worker personal health was an entirely separate issue [30]. Opinions varied as to the required level of employer involvement in workers' personal health matters [30]. Some expressed greater levels of compassion, whereas many others conveyed indifference and apathy [30]. Although most respondents expressed concern over unhealthy personal lifestyles and

behaviours among migrant farm worker staff, only two of nine expressed the need for more health promotion programs [30].

Narushima and Sanchez indicated dismay over the structural vulnerability of migrant farm workers as well as the lack of consistency with respect to employer approaches to worker health [30]. These widely varying employer views are concerning due to the significant role employers play in terms of either facilitating or impeding worker access to health care. This means that the ability of a migrant worker to obtain the care that he/she needs in order to preserve his/her health is far too dependent upon employer perception of responsibility. Researchers argue that a more supportive environment facilitating employer participation in health promotion programs must be developed [30].

Theme 3: Workers fear repatriation

As previously discussed, migrant farm workers are heavily dependent on their employers in a variety of ways that relate to health care access, resulting in a unique set of barriers. Notably, when an individual is accepted into Canada as a temporary foreign migrant worker, he/she is committed to a particular employer, and switching is not readily possible. Workers know that their ability to return to Canada to work in subsequent years is uncertain and is largely dependent upon evaluations by previous employers. This leaves workers even less inclined to inconvenience their employers in any way. Furthermore, employers have extensive authority to repatriate workers if they feel it is necessary, and workers have little recourse. Notably, workers may be repatriated for medical reasons that prevent them from fulfilling their work duties.

Until recently, the extent of medical repatriations among migrant workers was unknown due to lack of availability of relevant data. Information pertaining to migrant worker repatriation is not collected by any government agency; however, it is collected by Foreign Agricultural Resource Management Services (FARMS), which is a private agency that assists employers with their application for temporary foreign agricultural workers [31]. The repatriation dataset possessed by FARMS was not publicly available until a Freedom of Information request was made for it as part of a human rights tribunal hearing [31]. The availability of this data permitted groundbreaking research by Orkin et al., which retrospectively investigated the reasons for medical repatriation of Ontario migrant farm workers [31]. It was found that between 2001 and 2011, there were 787 medical repatriations among 170 315 migrant farm workers, most commonly for reasons of surgery or external injury [31]. Although this information indicates that medical repatriation among migrant workers is not very common, it gives some credence to the structurally-imposed fear of repatriation that burdens migrant workers. It is also possible that migrant worker perception of the frequency of medical repatriation is inflated. In any case, fear of repatriation is a critical barrier to personal health maintenance as well as health care access. This is further evidenced by recent work conducted by Hennebry et al., who

investigated barriers to health care access in Canada among migrant workers [32]. Five hundred seventy-six migrant workers were interviewed and administered a standardized questionnaire [32]. Forty-five percent of migrant farm worker respondents indicated that their co-workers work while ill because they are afraid to tell their employer [32].

Literature Evidence Synthesis: Research Sub-question 2

"How do the needs of newcomers shift as they age?"

Research sub-question 2 pertains to the needs of aging newcomers, barriers to health care faced by this cohort, and important considerations by health care practitioners when providing care. It was found that the literature on this sub-topic is fairly limited. Six relevant research articles revealed three prevalent themes pertaining to aging newcomers.

Theme 1: Conflicting evidence exists pertaining to the impact of length of residency in Canada on health care access

An investigation of the predictors of breast and colon cancer screening among 103 Chinese immigrant women 50 years of age or older was conducted using interviews and questionnaires as data collection tools [33]. It was found that increased length of residency in Canada was positively associated with higher screening rates, particularly for colon cancer [33]. Longer length of residency in Canada may be an indicator of improved official language proficiency, further progression of acculturation and integration, improved knowledge of the health care system, and positive attitudes toward screening due to exposure awareness campaigns [33].

In their work investigating hospitalization rates and length of residency among immigrant seniors, Ng et al. linked data from two secondary databases in order to review hospitalization usage history among 279 175 Ontario immigrants (both immigrant and Canadian-born) [34]. Higher rates of hospitalization were found among long term immigrant seniors compared with those who had arrived more recently [34]. This finding could be a function of the healthy immigrant effect [34]. An additional research finding was that immigrant seniors had lower odds of hospitalization compared with Canadian seniors [34]. This discrepancy could be due to service underutilization by immigrant seniors as a result of unmet needs, or differences in health status compared with Canadian seniors [34].

Dean and Wilson conducted research investigating immigrants' perceptions of changes in health status following immigration by conducting 23 interviews with recent, mid-term, and long-term immigrants [35]. Reported changes in health varied minimally based on length of residency in Canada [35]. Participants did not report acculturation or access to health care as factors contributing to health status change [35]. Participants attributed health improvements to improved physical environment and access to amenities, such as grocery stores [35]. Conversely, health declines were attributed to settlement stress for recent and midterm immigrants and the natural aging process for long term immigrants [35].

In their research investigating usage of General Practitioner (GP) services among older immigrants in Canada, Latif and Miles conducted a retrospective analysis using secondary cross-

sectional and longitudinal data collected as part of cycle three of the Canadian National Population Health Survey [36]. Only data from respondents ages 55 and older was used for analysis, resulting in a sample size of 4560 [36]. No significant difference was found between older Canadian immigrants and their Canadian-born counterparts in terms of number of GP visits [36]. Furthermore, results showed no significant difference in number of GP visits made among immigrants based on length of residency in Canada [36]. In spite of these findings, immigrant participants reported poorer health than non-immigrant participants, suggesting that health care access barrier may still exist [36].

Theme 2: Cultural factors are important predictors of health service use

Surood and Lai conducted research investigating the effects of cultural factors on the use of Canadian health services by South Asian immigrants over the age of 55. Primary data collection methodology involved administering structured questionnaires by telephone [37]. Using surnames in the phone directory, 4719 individuals were randomly selected for eligibility screening, and 220 ultimately completed the survey [37]. Data analysis revealed that cultural factors are important in predicting Canadian health service use by older South Asian immigrants [37]. Specifically, fewer cultural incompatibility issues, being less committed to traditional South Asian health beliefs, and having strong ethnic social supports were found to be associated with increased use of Canadian health services [37]. Traditional values must be understood and considered when designing health intervention initiatives and when providing care [37].

In their work investigating predictors of cancer screening rates among older Chinese immigrant women, Todd et al. found that factors related to cultural perspectives were significantly influential [33]. Data based on 103 participant responses by interview and questionnaire indicated that culturally, considerable importance is placed on figures perceived as being in positions of authority, and as such, physician referral was a significant predictor of screening [33]. Furthermore, having a female health care provider was associated with higher rates of breast screening due to a cultural tendency toward modesty [33]. These findings provide critical information in terms of designing promotional interventions that will increase uptake of health services by aging immigrants.

Theme 3: Personal attitude toward health care is a predictor of health outcomes

Lai and Surood conducted further research investigating the relationship between health care access barriers and the health status of South Asian immigrants utilizing existing data they had collected for previous work in 2010 [38]. The data collected from structured telephone questionnaires administered to 220 participants was reanalyzed [38]. Although participants reported a number of barriers to health services, negative personal attitudes were found to be

the most significant predictor of negative health outcomes, even though they were the least reported barrier [38]. In this context, personal attitude can be interpreted to refer to any inhibitive feeling experienced by immigrants that may depress proactive help-seeking behavior, such as shame, discomfort, or lack of confidence in the abilities of health care providers [38]. These attitudes may be culturally-related, or they may be related to lack of familiarity with services available [38]. They may also exist as a result of previous negative interactions with the health care system [38]. Negative personal attitudes among aging immigrants can be combatted by health care provider awareness and interventions, community education, culturally appropriate health promotion information, and engagement of immigrant seniors by cultural brokers to improve knowledge of available services [38].

Literature Evidence Synthesis: Research Sub-question 3

"How can public health better service newcomers?"

Research sub-question three relates to newcomer interaction with local public health agencies as well as methods these agencies can employ to increase newcomer uptake of programs and services offered. The initial literature search strategy to investigate this issue involved the specific phrase 'newcomer access to public health services'. This search strategy yielded no new, relevant article results, indicating that lack of research on newcomer access to public health services is a definite gap in the existing literature. Nine previously acquired articles regarding newcomer access to different types of preventative health services were used as proxy evidence for information on public health services. This research pertains to various methods of disease screening, pregnancy assistance, dental care, vision care, and sexual health.

Theme 1: Newcomer uptake of preventative health services is low

Research comparing access of foreign and non-foreign born individuals to primary and preventative health care in Canada and the United States involved analysis of secondary data collected as part of the Joint Canada United States Survey of Health [39]. The study sample was restricted to individuals 18 – 64 years of age for whom foreign birth status was available, resulting in a sample of 6620 [39]. It was found that fewer foreign-born adults compared with native-born adults in Canada reported having a Pap test within the past three years [39]. Lebrun conducted further work to investigate the impacts that length of stay and language proficiency have on utilization of primary and preventative health care among immigrants involved analysis of secondary data that was obtained as part of the Canadian Community Health Survey as well as the National Health Interview Survey [9]. The results of this study are based on a sample of 12 870 individuals [9]. Recent, short-stay immigrants had reduced odds of having had a dental visit in the past year and a Pap test in the past three years compared with longer-stay immigrants [9]. Additionally, those with limited official language proficiency had lower odds of having had an optometrist consultation and a flu shot in the past year compared with those who were language proficient [9].

An investigation of cervical screening rates among a study cohort of 455 864 immigrant women in Ontario revealed that nearly half of the study participants had not been screened during the three year study period [40]. Factors associated with lack of screening included low income, not being rostered in a patient enrollment model, not having a female health care provider, and having a provider from the same world region [40]. Ontario has since transitioned from opportunistic cervical screening to centrally organized screening with mail out invitations. Further research is needed to assess the impact this change has had on screening rates among immigrant women.

Vahabi et al. analyzed secondary data to research prevalence of mammography uptake among 1 457 136 Ontario women based on immigration status and found lower screening rates among immigrants [41]. Lowest screening rates were observed among new immigrants compared with intermediate and established immigrants [41].

Mumtaz et al. investigated newcomer experiences with maternity services compared with those of Canadian-born individuals [42]. Secondary data from the Canadian Maternity Experiences Survey was used to establish a random sample of participants to be interviewed, and ultimately, 140 newcomer and 1137 Canadian-born women met inclusion criteria [42]. Contrary to the general trend, findings indicate that newcomers were able to navigate the health care system similarly to their Canadian-born counterparts in terms of accessing prenatal care [42]. In spite of this, newcomers reported barriers to receiving pregnancy information, which could be related to language barriers or reluctance to accept practices they are not used to [42].

Research conducted by Salehi et al. also revealed findings that conflict with this theme [43]. They investigated the impact that immigration has on access to sexual health services among 1216 surveyed teenagers [43]. Results indicate that immigration status was not a predictor of youth access to sexual health services [43].

Theme 2: Newcomer understanding of the importance of preventative health services is poor

Vahabi and Cockwell interviewed a convenience sample of 50 Iranian immigrant women to investigate what methods of breast screening education they would find most useful [44]. One of the most outstanding findings was the fact that 20% of study participants reported not wanting any information on breast screening, as they felt that thinking about breast cancer would bring bad luck [44]. This gives an indication of the prominence of culturally-rooted beliefs impeding newcomer access to prevention screening.

Ahmad et al. investigated perspectives of South Asian immigrant women on barriers to mammography by conducting qualitative, semi-structured focus groups with 35 health and social service professionals [45]. Fear of cancer resulting in screening avoidance was one of the most commonly reported barriers [45]. Ahmad et al. then presented identified barriers to a cohort of community-based public health and social services professionals to discuss mitigation strategies [46]. Public Health and social services professionals stressed the importance of recognizing the heterogeneity that exists within immigrant groups and developing interventions based on the specific needs of subgroups [46]. They identified the importance of culturally-tailored interventions as well as inclusion of families in education to address such issues as patriarchal norms and lack of priority on self-care [46]. Participants also indicated that

programs addressing financial or logistical barriers are more effective than educational interventions [46].

Following their largescale investigation of mammography uptake among 1 457 136 immigrants, Vahabi et al. report that disease prevention is frequently poorly understood by immigrants, as the focus of health care in countries of origin is often disease management [41]. They go on to suggest that many immigrants believe that thinking or talking about disease can cause disease to manifest; therefore, disease prevention is considered a taboo subject in many cultures [41]. Lastly, authors indicate that internationally-trained health care practitioners must be made aware of Canadian disease screening standards and the importance of disease prevention [41].

Summary of Themes

It appears that most newcomers are gaining access to a consistent primary health care provider fairly promptly, suggesting that Health Care Connect is functioning effectively as a linkage point for newcomers. The most prevalent barriers to newcomer health care access appear to be patient-provider communication challenges, cultural incompatibility and misunderstanding leading to newcomer alienation, and negative or restrictive health care provider attitudes regarding newcomer service provision giving rise to unfavourable newcomer interactions with the health care system. Evidence also supports the fact that certain newcomer cohorts are particularly disadvantaged by these barriers due to temporary status, precarious status, or limited coverage. These cohorts include refugees (particularly refugee claimants), undocumented immigrants, and migrant workers.

Migrant workers appear to experience unique challenges in addition to the barriers faced by the overall newcomer population. These additional challenges include significant dependence on employers to facilitate access to health services, inconsistent employer perspectives on required level of involvement in migrant worker health care, and fear of being repatriated or not asked to return in subsequent years due to medical issues brought forward. These issues exist largely as a result of the legislated structure of Canada's Temporary Foreign Worker program.

In terms of aging newcomers, the literature is variable regarding the impact that length of residency in Canada has on health care access. Some studies reviewed found a positive correlation between longer Canadian residency and care access, whereas others found lower access with longer length of residency. Still others found that length of residency had no impact on health care usage. Cultural factors such as cultural incompatibility, commitment to traditional health beliefs, cultural perceptions of gender, and cultural perceptions of authority figures also appear to impact health care access among older immigrants. This factor appears to exist across newcomer age groups. Lastly, personal attitude toward health care seems to direct help-seeking behavior among the older immigrant age group.

The literature provides evidence to suggest that newcomers often do not understand the importance of public health services and preventative health care, leading to poor service uptake in this regard.

Barriers to newcomer health care access are concerning for a number of reasons. Newcomer settlement is an extremely stressful period of transition and unfamiliarity. Difficulty accessing health care places unnecessary added stress on an already anxious population, thereby straining the integration process and negatively impacting quality of life. Furthermore, negative interactions with the health care system can lead to total care avoidance, resulting in

exacerbation of conditions until they can no longer be ignored. This pattern strains the health care system, as extreme conditions often require more comprehensive treatment, management, and resource commitment than conditions addressed early on.

Chatham-Kent Survey Highlights

Data highlights from the Chatham-Kent newcomer, service provider, and migrant worker surveys and focus groups were reported upon in the Newcomer Health Project Preliminary Report [47]. Data highlights as they relate to literature themes will be discussed subsequently.

> ***Primary Research Question: "What are the existing barriers and challenges inhibiting individuals who are new to Canada from accessing health services?"***

Chatham-Kent newcomer survey data largely aligns with the literature trend pertaining to the fact that most newcomers have access to a primary health care provider. Newcomer survey responses revealed that most (80%) of respondents had a family physician or a nurse practitioner, and the vast majority (89%) go to a doctor's office when they or family members need care. Moreover, 46% reported not having visited a hospital emergency department in the past 12 months, which was the largest proportion of responses for this question. Responses obtained during the Low German Mennonite focus group corroborate newcomer survey responses in this regard, as all participants indicated that they visit their family doctor for care, unless the situation is particularly urgent. Only 11% of newcomer respondents reported difficulty getting a family doctor as a challenge in obtaining care. Notably, all newcomer respondents were either Canadian citizens or permanent residents. More vulnerable immigrant classes who may have greater difficulty obtaining a primary health care provider were not represented.

By contrast, 74% of service providers reported that they believe newcomers go primarily to emergency departments to access health care. Only 21% reported that newcomers go to family doctors for care. Finding a family doctor was the second most common barrier reported by service providers in accessing care. This suggests disconnect between newcomer and service provider perceptions of care access.

Newcomer survey data pertaining to language and communication conflicts with literature review findings. This is reflected in the fact that only 6% reported language/communication as a challenge in accessing care, and only 14% suggested that more translation services would improve care delivery. This discrepancy could be attributed to the fact that most respondents were proficient in English, as only 20% indicated that they required an interpreter to complete the survey. Clearly, newcomers with greater communication challenges were not represented in the newcomer survey participant cohort. Moreover, 69% indicated that they do not need someone to interpret English for them when accessing care. The survey data obtained in this regard likely does not accurately represent the communication challenges experienced by the general immigrant population at large.

Newcomer perspectives on language/communication are in contrast to service provider perspectives. Service provider responses suggest that although the majority of represented organizations support access to interpretation services, language and cultural barriers were the most commonly reported barrier, both for newcomers and service providers. Interestingly though, when asked what they would do differently the next time they provided care to a newcomer, only one respondent indicated they would use translation services.

Service provider identification of language and communication issues as important barriers to newcomer health care access and service provision may be indicative of the difficulty that comes with having to explain complex medical terms and concepts. It also suggests that service providers may not be aware of the existing translation services that are available to them. This is further evidenced by the fact that among the organizations that reported being supportive of newcomer access to interpretation services, most reported the use of cultural community members, family members, or friends for assistance with translation. Formal interpretation services were reportedly rarely used.

Although found to be a prevalent theme in the literature, issues relating to cultural incompatibility were not directly addressed in the newcomer survey. Questions pertaining to newcomer perceptions of health care access and recommendations for improved care delivery did not yield any responses relating specifically to cultural incompatibility. However, cultural incompatibility is a concept that newcomers may not associate with reduced access to health services. Newcomers may believe that cultural discrepancies must be personally absorbed and ignored rather than addressed through cultural competence by health care providers, resulting in underreporting.

Conversely, service providers identified language and cultural barriers as the most significant barrier to newcomer health care access and service provision, suggesting that this is something that they struggle with. Notably, at the time survey responses were coded, language and cultural barriers were grouped together at the discretion of the researcher, preventing further analysis of individual cultural barriers.

Restrictive health care provider attitudes and perspectives did not emerge as a prominent theme based on newcomer responses and focus groups, although, again, it was not directly addressed in the survey. Reported newcomer respondent interactions with health care providers were largely positive, in contrast to literature trends. That said, when asked how care delivery could be improved, one newcomer respondent indicated that ‘health care providers should care more about the patient as a person’. Moreover, one service provider respondent noted generalized lack of interest in newcomer health care, insensitivity, and personal biases as challenges for providers in serving newcomers.

Although the literature suggests that certain newcomer populations are disproportionately impacted by barriers to health care access, the Chatham-Kent newcomer survey responses did not permit investigation in this regard. All respondents reported their current immigration status as Canadian citizen or landed immigrant/permanent resident, with the exception of five who did not provide a response. As such, response comparisons based on immigration status could not be made.

Research Sub-Question 1: "What are the unique challenges experienced by migrant workers when accessing health services in Canada?"

Among the Chatham-Kent surveys collected, the largest proportion of migrant worker respondents (46%) indicated that they utilize emergency departments as their primary source of health care when they or their family have a health problem. Only one migrant worker respondent indicated the use of a doctor's office for health care. Two respondents indicated that they do not go anywhere to seek care for problems they may have. Moreover, 85% of respondents indicated that they only attempt to access care when they or family members are sick. These results suggest that, in contrast to the general newcomer population, migrant workers do not have access to a consistent primary health care provider in most cases. As a result of their precarious, temporary status, they are relegated to relying on hospital emergency departments for care. Emergency department reliance results in workers receiving inconsistent care from providers who have no knowledge of their medical history. These providers may not fully understand their culture or the challenges they face. Furthermore, emergency department reliance places unnecessary economic strain on the health care system.

In terms of health care access barriers, the largest proportion of migrant worker respondents (69%) reported language and communication barriers as significantly inhibiting. Additionally, 38% suggested that more interpretation services would improve care delivery. This finding aligns with the predominate challenge faced by newcomer populations in general, as evidenced by literature review outcomes. Also of note is the fact that one migrant worker respondent indicated fear of employer involvement as challenging, which coincides with the fear of repatriation theme that emerged from the literature.

The final question on the migrant worker survey investigated the origin of healthy living information provided to migrant workers. The largest number of responses, in equal proportions, suggested that this information is either not received at all or is received from the employer. These survey findings support the second theme that emerged from the literature, which pertained to inconsistent employer views on responsibility for migrant worker health protection.

Research Sub-Question 2: "How do the needs of newcomers shift as they age?"

No insights could be gleaned from the Chatham-Kent newcomer survey results pertaining to health care access barriers faced by aging newcomers. Only one newcomer survey respondent fell within the 65 years of age and greater age range, impeding any analysis based on age.

Research Sub-Question 3: "How can public health better serve newcomers?"

The Chatham-Kent newcomer, migrant worker, and service provider surveys did not specifically investigate access to public health or preventative health services; however, the surveys did make general inquiries about access to healthy living and health promotion information. Although responses to these questions can be used as a proxy for how preventative health information is being accessed by newcomers, they provide no information pertaining to preventative service uptake and utilization.

Based on survey responses, it appears that newcomers are obtaining healthy living information from a variety of sources. Forty percent of newcomer respondents indicated they obtain healthy living information from the internet, followed by 23% from community services and 20% from public health. Although the internet is a popular source of information, the reliability and accuracy of the information being accessed is unknown. Notably, 14% of newcomer respondents indicated that they get information on healthy living from no one. When asked how health promotion/prevention information is provided to newcomers, the largest proportion of service providers (32%) said printed materials, followed by verbal education (21%). Only 16% indicated that they elicit services from outside agencies, suggesting that there may be opportunities for greater inter-agency integration and collaboration.

Recommendations

1. ***Lobby for the elimination of the three month waiting period for health care coverage in Ontario.***

   The three month waiting period for health care coverage in Ontario was implemented in 1994 as a cost saving measure, and it applies to new legal immigrants, Canadians returning to Ontario after having been away for a minimum specified period of time, and Canadians moving to Ontario from another province [48]. Uninsured individuals can access some primary care services free of charge through Community Health Centres (CHCs), but wait lists are often long, and CHCs are concentrated in large urban centres [48]. If newcomers want coverage within the first three months, they must apply for and purchase private insurance, which is often not cost feasible [48]. Health care providers who provide care to uninsured individuals are often put in the awkward, ethically difficult position of having to request payment for their services [48]. Due to their inability to pay, uninsured individuals often delay seeking care, risking exacerbation of their conditions as well as transmission of communicable diseases to others [48]. Others rely on emergency departments for care, unnecessarily increasing the provincial economic burden of health care costs [48]. Anecdotal evidence suggests that the three month waiting period has not delivered the cost savings that were anticipated [48]. In fact, care delays may result in greater system costs in addition to reduced quality of life for those impacted. Further research is needed in this regard [48].

   The Ontario Medical Association has adopted the position that the three month waiting period for full health coverage access for new immigrants and returning Canadians should be rescinded [48]. It is recommended that stakeholders of the Newcomer Health Project actively support this stance in order to eliminate this policy barrier to newcomer health care access.

2. ***Improve cultural knowledge and sensitivity of health care providers.***

   Barriers relating to persistent cultural incompatibility issues and negative service provider attitudes were noted as common themes in the literature. These barriers are rooted in poor health care provider knowledge of and sensitivity toward different cultures they encounter. Lack of understanding of a patient's history and culture is severely detrimental to his/her care experience. Repeated poor health care experiences will dictate how and when newcomers seek care in the future, possibly resulting in delays and avoidance. Care delay and avoidance negatively impact the entire health care system and can ultimately result in greater resource expenditures, as existing conditions will worsen, resulting in increased treatment difficulty and cost. Lack of

consistent interaction with health care providers will also result in reduced uptake of preventative screening.

It is recommended that Newcomer Health Project stakeholders work with local health care providers to investigate and implement feasible methods of enhancing cultural awareness within primary and preventative care practices of Chatham-Kent. In order to be of greatest benefit, it is suggested that strategies implemented be based on the current Chatham-Kent immigrant profile, so that improved knowledge and understanding of the cultures that are prevalent within Chatham-Kent be prioritized.

3. ***Promote health care provider use of formal medical interpretation services.***
   The literature revealed that communication challenges were found to be the most prevalent barrier to immigrant health care access in Canada. Although Chatham-Kent newcomer survey results were found to be conflicting in this regard, this discrepancy can be attributed to the fact that the vast majority of respondents were proficient in English. As a result, it can be assumed that communication challenges do exist within the Chatham-Kent newcomer population. Chatham-Kent service provider responses suggest that although most organizations support access to interpretation services, most often translation occur informally by cultural community members, family members, or friends. The literature supports the overwhelming prevalence of informal methods of interpretation during immigrant interaction with the health care system. Although well-intended, reliance on informal interpreters to facilitate patient-provider communication often creates privacy and confidentiality issues, and it can result in inaccurate translation of medical terms and concepts, leading to confusion and misunderstanding.

   Based on collected evidence, it appears that formal medical interpretation services are being underutilized. It is recommended that Newcomer Health Project stakeholders explore strategies to increase local health care provider knowledge and usage of formal interpretation services. Furthermore, health care providers must be encouraged to ascertain client needs regarding communication assistance in advance of appointments, so that necessary arrangements can be pre-arranged.

4. ***Improve newcomer knowledge of preventative health services.***
   The literature overwhelmingly indicates that newcomer uptake of preventative health care and screening is poor. This is further evidenced by the fact that 63% of Chatham-Kent newcomer survey respondents indicated that they only see a doctor when they or their family members are ill, suggesting inconsistent, infrequent interaction with health

care providers. It could be argued that many Canadian-born individuals do not routinely access preventative care either, suggesting that poor newcomer access to preventative care is not disproportionate. It is true that an entire system shift in focus from primary to preventative care as foundational to the health and well-being of the population is needed. However, research supports the fact that newcomers are accessing preventative health services at disproportionately low levels. The literature scan revealed multiple studies comparing uptake of services among foreign-born and Canadian-born participants, with findings showing lower uptake among foreign-born participants. The reasons for this are likely multi-faceted and may be related to poor understanding of the importance of preventative health care, lack of importance placed on preventative care in their country of origin, or poor understanding of the Canadian health care system.

It is recommended that Newcomer Health Project stakeholders collaborate with local health care providers, including the Chatham-Kent Public Health Unit, to develop strategies to improve newcomer knowledge and uptake of preventative health care. This may involve supporting the development of culturally and linguistically appropriate promotional resources for preventative services to be disseminated through health care provider offices and settlement services.

5. **Strengthen outreach strategies to migrant farm workers.**

Migrant farm workers are an extremely difficult population to engage due to difficulty accessing them as well as hesitancy on their part to offer information for fear of retribution. This group is particularly marginalized due to the existence of many high level structural barriers. Advocacy efforts to address these structural barriers are occurring; however, affecting change pertaining to Temporary Foreign Worker program structure and legislated employer responsibility is a long term and complicated process. It is recommended that Newcomer Health Project stakeholders support these continued efforts, as high level legislative change is critical to maintaining the health and well-being of migrant workers.

Additionally, strategies for mitigating health care access barriers imposed on migrant workers locally must be investigated. In order to accomplish this, it is recommended that Newcomer Health Project stakeholders establish a task group to address migrant worker health care accessibility within Chatham-Kent. Alternative care delivery options and unique methods of service delivery should be investigated. It would be prudent to review strategies utilized in other jurisdictions and evaluate their feasibility within Chatham-Kent. Strategies may include the establishment of evening migrant worker

health clinics with transportation and translation provided, or mobile health services that set up at a location convenient for clients. It is imperative that health care professionals providing care are appropriately educated regarding history, culture, and experiences of migrant workers. The establishment of successful strategies is dependent upon task group collaboration with community partners that have the capacity to provide services. Engagement of local migrant farm worker employers is also an important consideration.

Opportunities for Future Research

Newcomers, whether landed immigrants, undocumented immigrants, convention refugees, refugee claimants, or temporary foreign workers, endure arduous journeys during the relocation process. The process brings on considerable stress and uncertainty, resulting in significant impacts on mental health and well-being. It was originally intended that the Newcomer Health Project would include an investigation of newcomer mental health needs and barriers to mental health care access. Ultimately, however, this domain was excluded from the literature scan, as it was determined to be a topic that warrants individual focus. Chatham-Kent newcomer, service provider, and migrant worker surveys included brief mental health components, so some information has been gathered on respondent perceptions of the local situation in this regard. A scan of the existing literature pertaining to newcomer mental health and mental health care access should be conducted to determine whether mental health care needs are being appropriately met in a culturally sensitive manner. An appraisal of the mental health services available to newcomers within Chatham-Kent should also be conducted in order to identify and remedy any existing gaps.

Conclusion

In closing, the Newcomer Health Project has effectively accomplished its original objective of investigating barriers to access of primary and preventative health care services by newcomer populations within Chatham-Kent. Administered surveys provided insight into the perspectives and experiences of newcomers locally. The literature scan augmented survey data by successfully addressing research questions pertaining to health care access barriers experienced by the newcomer population in general, the migrant worker sub-population, and aging newcomers. Additionally, barriers to access of public health and preventative health services were investigated. Research questions were answered through identification of prevalent trends and themes in the literature. Evidence obtained from the literature and from Chatham-Kent surveys was synthesized, integrated, compared, and contrasted to give rise to culminating recommendations for project stakeholders. It is the sincere hope of the researcher that these recommendations will be utilized to facilitate the mitigation of identified access barriers and the improvement of health service delivery to Chatham-Kent newcomer populations.

References

[1] Ontario Ministry of Health and Long Term Care, "Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario," Queen's Printer for Ontario, Ottawa, 2015.

[2] Government of Canada, "Citizenship and Immigration Canada," 7 August 2015. [Online]. Available: http://www.cic.gc.ca/english/resources/statistics/menu-fact.asp. [Accessed 29 February 2016].

[3] Statistics Canada, "National Household Survey (NHS) Profile," Statistics Canada, 11 September 2013. [Online]. Available: http://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/index.cfm?Lang=E. [Accessed 2016 March 8 2016].

[4] E. Fuller-Thomson, A. Noack and U. George, "Health Decline Among Recent Immigrants to Canada: Findings from a Nationally Representative Longitudinal Study," *Can J Public Health,* vol. 102, no. 4, pp. 273-280, 2011.

[5] G. Meshefedijan, V. Leaune, M. Simoneau and M. Drouin, "Disparities in Lifestyle Habits & Health Related Factors of Montreal Immigrants: Is Immigration an Important Exposure Variable in Public Health?," *J Immigrant Minority Health,* vol. 16, pp. 790-797, 2014.

[6] E. Muggah, S. Dahrouge and W. Hogg, "Access to primary health care for immigrants: results of a patient survey conducted in 137 primary care practices in Ontario, Canada," *BMC Family Practice,* vol. 13, pp. 1-7, 2012.

[7] A. Quesnel-Vallee, A. Setia, M. Abrahamowicz, P. Tousignant and J. Lynch, "Access to Health Care in Canadian Immigrants: A Longitudinal Study of the National Population Health Survey," *Soc Care Community,* vol. 19, no. 1, pp. 70-79, 2011.

[8] R. Campbell, A. Klei, B. Hodges, D. Fisman and S. Kitto, "A Comparison of Health Access Between Permanent Residents, Undocumented Immigrants & Refugee Claimants in Toronto, Canada," *J Immigrant Minority Health,* vol. 16, pp. 165-176, 2014.

[9] L. Lebrun, "Effects of length of stay & language proficiency on health care experiences among immigrants in Canada & the United States," *Social Science & Medicine,* vol. 74, pp. 1062-1072, 2012.

[10] E. Ng, K. Pottie and D. Spitzer, "Official language proficiency & self-reported health among immigrants to Canada," *Health Reports,* vol. 22, no. 4, pp. 1-10, 2011.

[11] I. Poureslami, I. Rootman, M. Doyle-Waters, L. Nimmon and J. FitzGerald, "Health Literacy, Language, & Ethnicity-Related Factors in Newcomer Asthma Patients to Canada: A Qualitative Study," *J Immigrant Minority Health,* vol. 13, pp. 315-322, 2011.

[12] M. Dastjerdi, K. Olson and L. Ogilvie, "A study of Iraniam immigrants' experiences of accessing Canadian health care services: a grounded theory," *International Journal for Equity in Health,* vol. 11, pp. 1-15, 2012.

[13] M. Dastjerdi, "The case of Iranian immigrants in the greater Toronto area: a qualitative study," *Journal for Equity in Health,* vol. 8, pp. 1-8, 2012.

[14] T. Lee, C. Kurtz Landy, O. Wahoush, N. L. Y. Khanlou and C. Li, "A descriptive phenomenology study of newcomer's experience of maternity care services: Chinese women's perspectives," *BMC Health Services Research,* vol. 14, pp. 1-9, 2014.

[15] S. Gulati, L. Watt, N. Shaw, L. Sung, I. Poureslami, R. Klaassen, D. Dix and A. Klassen, "Communication & Language Challenges Experienced by Chinese & South Asian Immigrant Parents of Children with Cancer in Canada: Implications for Health Services Delivery," *Pediatr Blood Cancer,* vol. 58, pp. 572-578, 2012.

[16] O. Papic, Z. Malak and E. Rosenberg, "Survey of family physicians' perspectives on management of immigrant patients: Attitudes, barriers, strategies, & training needs," *Patient Education & Counseling,* vol. 86, pp. 205-209, 2012.

[17] M. Ruiz-Casares, C. Rousseau, A. Laurin-Lamothe, J. Rummens, P. Zelkowitz, F. Crepeau and N. Steinmetz, "Access to Health Care for Undocumented Migrant Children & Pregnant Women: The Paradox Between Values & Attitudes of Health Care Providers," *Matern Child Health J,* vol. 17, pp. 292-298, 2013.

[18] K. Vanthuyne, F. Meloni, M. Ruiz-Casares and A. Ricard-Guay, "Health workers' perceptions of access to care for children & pregnant women with precarious immigration status: Health as a right or a privilege?," *Social Science & Medicine,* vol. 93, pp. 78-85, 2013.

[19] G. Dahal, A. Qayyum, M. Ferreya, H. Kassim and K. Pottie, "Immigrant Community Leaders Identify Four Dimensions of Trust for Culturally Appropriate Diabetes Education & Care," *J Immigrant Minority Health,* vol. 16, pp. 978-984, 2014.

[20] S. Isaacs, R. Valaitis, K. Newbold, M. Black and J. Sargeant, "Competence trust among providers as fundamental to a culturally competent primary healthcare system for immigrant families," *Primary Health Care Research & Development,* vol. 14, pp. 80-89, 2013.

[21] M. McKeary and B. Newbold, "Barriers to Care: The Challenges for Canadian Refugees & their Health Care Providers," *Journal for Refugee Studies,* vol. 23, no. 4, pp. 523-545, 2010.

[22] L. Merry, A. Gagnon, N. Kalim and S. Bouris, "Refugee Claimant Women & Barriers to Health & Social Services Post-birth," *Can J Public Health,* vol. 102, no. 4, pp. 286-290, 2011.

[23] K. Newbold, J. Cho and M. McKeary, "Access to Health Care: The Experience of Refugee & Refugee Claimant Women in Hamilton, Ontario," *Journal of Immigrant & Refugee Studies,* vol. 11, pp. 431-449, 2013.

[24] C. Rousseau, A. Laurin-Lamothe, J. Rummens, F. Meloni, N. Steinmetz and F. Alvarez, "Uninsured immigrant & refugee children presenting to Canadian emergency departments: Disparities in help-seeking & service delivery," *Paediatr Child Health,* vol. 18, no. 9, pp. 465-469, 2013.

[25] V. Kiss, C. Pim, B. Hemmelgarn and H. Quan, "Building Knowledge About Health Services Utilization by Refugees," *J Immigrant Minority Health,* vol. 15, pp. 57-67, 2013.

[26] Government of Canada, "Quarterly Labour Market Impact Assessment Statistics," 11 March 2016. [Online]. Available: http://www.esdc.gc.ca/en/reports/foreign_workers/2015/lmia_quarterly_statistics/province.page. [Accessed 22 March 2016].

[27] F.A.R.M.S., "Foreign Agricultural Resource Management Services," [Online]. Available: http://www.farmsontario.ca/. [Accessed 22 March 2016].

[28] M. Pysklywec, J. McLaughlin, M. Tew and T. Haines, "Doctors within borders: meeting the health care needs of migrant farm workers in Canada," *Canadian Medical Association Journal,* vol. 183, no. 9, pp. 1039-1043, 2011.

[29] M. Narushima, J. McLaughlin and J. Barrett-Greene, "Needs, Risks, & Context in Sexual Health Among Temporary Foreign Migrant Farmworkers in Canada: A Pilot Study," *J Immigrant Minority Health,* pp. 1-8, 2015.

[30] M. Narushima and A. Sanchez, "Employers' paradoxical views about temporary foreign migrant workers' health: a qualitative study in rural farms in Southern Ontario," *International Journal for Equity in Health,* vol. 13, pp. 1-12, 2014.

[31] A. Orkin, M. Lay, J. McLaughlin, M. Schwandt and D. Cole, "Medical repatriation of migrant farm workers in Ontario: a descriptive analysis," *Canadian Medical Association Journal,* vol. 2, no. 3, pp. 1-7, 2014.

[32] J. Hennebry, J. McLaughlin and K. Preibisch, "Out of the Loop: (In)access to Health Care for Migrant Workers in Canada," *Int Migration & Integration,* pp. 1-18, 2015.

[33] L. Todd, E. Harvey and L. Hoffman-Goetz, "Predicting Breast & Colon Cancer Screening Among English-as-a-Second Language Older Chinese Immigrant Women to Canada," *J Canc Edu,* vol. 26, pp. 161-169, 2011.

[34] E. Ng, C. Sanmartin, J. Tu and D. Manuel, "Use of acute care hospital services by immigrant seniors in Ontario: A linkage study," *Health Reports,* vol. 25, no. 10, pp. 15-22, 2014.

[35] J. Dean and K. Wilson, ""My health has improved because I always have everything I need here....": A qualitative exploration of health improvement & decline among immigrants.," *Social Science & Medicine,* vol. 70, pp. 1219-1228, 2010.

[36] E. Latif and S. Miles, "Utlization of General Practitioners: A Comparison of Immigrant & Non-Immigrant Older Canadians," *Canadian Public Policy,* vol. 38, no. 4, pp. 573-589, 2012.

[37] S. Surood and D. Lai, "Impact of Culture on Use of Western Health Services by Older South Asian Canadians," *Can J Public Health,* vol. 101, no. 2, pp. 176-180, 2010.

[38] D. Lai and S. Surood, "Effect of Service Barriers on Health Status of Aging South Asian Immigrants in Calgary, Canada," *Health & Social Work,* vol. 38, no. 1, pp. 41-50, 2013.

[39] L. Lebrun and L. Dubay, "Access to Primary & Preventive Care Among Foreign-Born Adults in Canada & the United States," *Health Services Research,* pp. 1693-1719, 2010.

[40] A. Lofters, R. Moineddin, S. Hwang and R. Glazier, "Predictors of low cervical cancer screening among immigrant women in Ontario, Canada," *BMC Women's Health,* vol. 11, no. 20, pp. 1-11, 2011.

[41] M. Vahabi, A. Lofters, M. Kumar and R. Glazier, "Breast cancer screening disparities among urban immigrants: a population-based study in Ontario, Canada," *BMC Public Health,* vol. 15, pp. 1-12, 2015.

[42] Z. Mumtaz, B. O'Brien and G. Higginbottom, "Navigating maternal health care: a survey of the Canadian prairie province newcomer experience," *BMC Pregnancy & Childbirth,* vol. 14, no. 4, pp. 1-9, 2014.

[43] R. Salehi, M. Hynie and S. Flicker, "Factors Associated with Access to Sexual Health Services Among Teens in Toronto: Does Immigration Matter?," *J Immigrant Minority Health,* vol. 16, pp. 638-645, 2014.

[44] M. Vahabi and D. Cockwell, "Breast cancer & screening information needs & preferred communication medium among Iranian immigrant women in Toronto," *Health & Social Care in the Community,* vol. 19, no. 6, pp. 626-635, 2011.

[45] F. Ahmad, S. Mahmood, I. Pietkiewicz, L. McDonald and O. Ginsburg, "Concept Mapping with South Asian Immigrant Women: Barriers to Mammography & Solutions," *J Immigrant Minority Health,* vol. 14, pp. 242-250, 2012.

[46] F. Ahmad, B. Jandu, A. Albagli, J. Angus and O. Ginsburg, "Exploring ways to overcome barriers to mammography uptake & retention among South Asian immigrant women," *Health & Social Care in the Community,* vol. 21, no. 1, pp. 88-97, 2013.

[47] C. Robinson, "Newcomer Health Project Preliminary Report," Municipality of Chatham-Kent, Chatham, 2015.

[48] Ontario Medical Association, "Reviewing the OHIP Three-Month Wait: an unreasonable barrier to accessing health care," Ontario Medical Review, 2011.

[49] S. Isaacs, R. Valaitis, K. Newbold, M. Black and J. Sargeant, "Brokering for the primary healthcare needs of recent immigrant families in Atlantic Canada," *Primary Health Care Research & Development,* vol. 14, pp. 63-79, 2013.

Appendix 1: Definitions

Researcher: In the context of this report, the term 'researcher' refers to the individual who compiled, coded, and analyzed Chatham-Kent survey results, conducted the literature scan, and synthesized all evidence gathered as part of the Newcomer Health Project.

Newcomer: The term 'newcomer' refers generally to any individual who was not born in Canada and is now a Canadian resident, irrespective of immigration status.

Acculturation: The terms 'acculturation' refers to the process by which newcomers to Canada integrate into Canadian society, and the extent to which they choose to adopt Canadian cultural norms.

Undocumented Immigrants: The term 'undocumented immigrants' refers to those newcomers who do not have any specific status. Their lack of immigration status may exist for a variety of reasons, including undocumented entry into the country or lapse of previously acquired temporary status.

Refugees: The term 'refugees' refers to individuals who leave their country of origin to escape unrest or any other situation that compromises their safety.

> **Convention Refugees**: These individuals are sponsored either privately or by the government to relocate. They possess refugee status immediately upon arrival in Canada and therefore receive immediate settlement support and Interim Federal Health Coverage.
>
> **Refugee Claimants/Asylum Seekers**: These individuals receive no sponsorship assistance for relocation. They must apply for refugee status when they arrive. Until they receive official refugee status, they are not able to access settlement support or Interim Federal Health Coverage.

Cultural Broker: The term 'cultural broker' refers to an individual who, in any capacity, facilitates the settlement and integration process of newcomers.