

**INCORPORATING INTERSECTIONALITY AND GENDER-  
BASED ANALYSIS IN THE VANCOUVER COASTAL  
HEALTH AUTHORITY: RECOMMENDATIONS TO  
IMPROVE IMMIGRANT HEALTH RESEARCH, POLICY,  
AND PROGRAM DEVELOPMENT**

by

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Bachelor of Arts (Honours), McGill University 2005

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THE REQUIREMENTS FOR THE DEGREE OF

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RECOMMENDATIONS TO IMPROVE  
IMMIGRANT HEALTH RESEARCH, POLICY  
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## **ABSTRACT**

This paper examines gender differences in an immigrant health report produced by the Vancouver Coastal Health (VCH) authority in 2008. Gender is a determinant of health particularly relevant to immigrant health. The immigrant health report illustrates multiple gender differences in access to health services, in migration experiences, and in health status among immigrants in the VCH region. The information in the report suggests that the health needs of female immigrants are not being adequately recognized within existing VCH programs and policies. A review of Canadian literature reveals that current health care policies and services across Canada often fail to recognize existing research on gender differences within the health needs of immigrants. This paper recommends the incorporation of gender-based analysis and intersectionality within immigrant health research, policy, and program development in VCH. If incorporated, these frameworks could enhance the ability of VCH to address the diverse health needs of immigrants.

**Keywords:** immigrant health; gender-based analysis; intersectionality; gender; health inequities; determinants of health

**Subject Terms:** Gender-based analysis – Canada; Women immigrants – Health and hygiene – British Columbia; Immigrants – Services for – British Columbia – Vancouver; Medical care – Utilization – British Columbia; Immigrants – Health and hygiene – Canada; Health services accessibility – British Columbia

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## INTRODUCTION

Immigrants represent an increasing proportion of British Columbia's population. Immigrants comprise almost 28% of the province's total population, over half of which immigrated before 1991 (Statistics Canada, 2007). The source countries of immigrants to Canada have dramatically shifted over the 20<sup>th</sup> and 21<sup>st</sup> centuries: prior to 1970, most immigrants came from European countries, whereas Asia and the Pacific have become the main sources of immigrants in the last four decades (Beiser, 2005). Statistics Canada defines immigrants as people who are, or have been, landed immigrants in Canada. A landed immigrant is a person who has been permitted by immigration authorities the right to live in Canada permanently. Very recent immigrants are defined as immigrants who came to Canada up to five years prior to a given census year (WelcomeBC, 2008a). In 2007, 38,893 new immigrants moved to British Columbia, slightly more than half of which were female (WelcomeBC, 2008).

The City of Vancouver is the most popular intended destination for new immigrants to British Columbia (Statistics Canada, 2007; WelcomeBC, 2008). As immigrants from around the world continue to settle in Vancouver and its surrounding communities, a greater understanding and awareness of the health issues and health needs of immigrants is essential. While new immigrants to Canada are generally considered to be in better overall health than the Canadian-born population ('the healthy immigrant effect'), the longer the period

of time an immigrant has lived in Canada, the more likely their health status will diminish to the same level or below that of the Canadian-born population (Bowen, 2006; Ng, Wilkins, Gendron & Berthelot, 2005). While research has examined the 'healthy immigrant effect', immigrant health in British Columbia and Canada is largely under-studied. There is limited data and research on determinants affecting the health of immigrants, on the health issues that disproportionately affect immigrants, or on the health services used by immigrants.

Recently, the Health Officers Council of BC released a discussion paper on health inequities in BC. Although British Columbians are among the healthiest people in the world, there are numerous disadvantaged groups within the province, new immigrants being one of them (Health Officers Council of BC, 2008). Within the Vancouver Coastal Health authority, immigrants have been identified as a population with the potential to have significantly worse health outcomes than the general population (VCH, 2008). The components that shape the health of immigrants may differ from those that shape the health of the Canadian-born population. The health of immigrants is influenced by a variety of factors including pre- and post-migration experiences, language barriers, racism, socio-economic factors, cultural factors, and barriers to health care services (Beiser, 2005).

When discussing immigrant health within British Columbia, it is important to note the heterogeneity and diversity of the immigrant population. Immigrants differ by country of origin, entry class, levels of cultural retention and

acculturation, length of time in Canada, exposure to disease, knowledge of the Canadian health care system, and many other factors related to health habits. While some generalizations can be made, it is important to keep in mind that differences exist not only between the health needs of immigrants and refugees (who may face additional health challenges resulting from experiencing violence, malnutrition, exposure to communicable diseases, and the traumas of war), but also among immigrants from similar cultural backgrounds or countries of origin (Bowen, 2006). Furthermore, there are significant variances in health and levels of vulnerability within the immigrant population. Female immigrants have higher levels of vulnerability related to settlement and isolation than their male counterparts do, and are at greater risk for mental illnesses and of underutilizing health services (Vissandjee, Desmeules, Cao, Abdool & Kazanjian, 2004). However, while the determinants and experiences that shape female immigrants' health may differ from those of male immigrants, immigrants are often treated as a homogenous group within health research as well as within program and policy development.

If British Columbia is to reduce health inequities, an increased focus on the health of immigrant populations within Vancouver Coastal Health is necessary. As such, recognizing the heterogeneity of the immigrant population and exploring the variance in health patterns, access to health services, settlement experiences, and determinants affecting the health of male and female immigrants is essential.

## PURPOSE

This project has evolved out of a practicum conducted in 2008 with the Population Health department of the Vancouver Coastal Health (VCH) authority as part of the requirements of Simon Fraser University's Masters in Public Health program. Vancouver Coastal Health is one of six health authorities in British Columbia and serves a population of 1.1 million over a large geographic area including the urban, semi-urban, and rural settings of Vancouver, Richmond, the North Shore, and Coast Garibaldi (See Appendix A). A report entitled *Immigrant Health in Vancouver Coastal Health: An Overview of Key Priority Areas* was submitted to VCH at the end of the practicum (Woermke, 2008). The report presents a summary of the social determinants and behaviours influencing the health of immigrants in the VCH region. In addition, the report presents what is currently known about the immigrant population of VCH and discusses key issues presented in the literature on certain chronic and infectious diseases that are of significant risk to certain immigrant groups. The purpose of the report is to contribute to the health region's understanding of the range of social determinants affecting the health of immigrants as well as to add to the current knowledge base on immigrant health for future policy, service, and program development within VCH communities.

Based on the literature, this project will first provide an overview of the health of immigrants in Canada and will discuss the determinants that shape the

health of immigrants. Second, this project will highlight trends identified in the report produced for VCH on immigrant health in the region (Woermke, 2008). More specifically, gender differences in migration and re-settlement experiences, in income and unemployment, in access to health services, and in risk levels for certain priority areas in immigrant health will be examined. The purpose of this examination is to assess differences in health needs between male and female immigrants and whether such differences are considered within current policies and programs related to immigrant health. Third, this project will discuss the prevailing treatment of immigrants as a homogenous group within current health care policies and services across Canada, with a focus on the lack of recognition of existing research on gender differences in experiences and health needs of immigrants within policies. The manner in which existing federal and provincial policies contribute to unequal access to health services for female immigrants will also be examined. Finally, this project will recommend the incorporation of gender-based analysis as well as an intersectionality approach within immigrant health research, policy, and program development in VCH and will explain how this will be beneficial to improving the health of both male and female immigrants.

## **METHODS**

Although there is little information or data available on the health of immigrants and their use of health care services within VCH, the VCH's report on immigrant health presents what is currently known about the immigrant population and discusses key issues from the literature on certain health conditions that are of significant risk to certain immigrant groups within VCH (Woermke, 2008). The creation of the report involved: a review of relevant grey, primary, and secondary literature, including government documents and peer-reviewed journals from across Canada and within British Columbia; research into ongoing services available for immigrants in VCH through online research and through consultation with VCH's Regional Coordinator of Language Services and Cross-cultural Care and Diversity; an assessment of databases for information on immigrants in VCH; analysis of data from the 2005 Canadian Community Health Survey; and collaboration with the VCH Planning Department to obtain data from the Statistics Canada 2006 Census<sup>1</sup>. In addition, informal discussions with VCH employees on immigrant health and participation in the 2008

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<sup>1</sup> See Appendix D for an assessment of the databases completed during the practicum.

Settlement Needs of Immigrant / Refugee Children & Families Conference<sup>2</sup> have helped to inform and shape my understanding of immigrant health in VCH.

For this project, the data in the VCH report on immigrant health is reviewed to look specifically for gender differences in pre and post-migration experiences, differences in access to health services, and differences in health conditions among immigrants in VCH. This information is then contextualized with available grey literature, government reports, peer-reviewed articles, and edited books on immigrants, immigrant health, gender differences in health, gender-based analysis, and intersectionality. Lastly, this project puts forth recommendations to address the ongoing inequities in immigrant health within VCH<sup>3</sup>.

## **Limitations of this Project**

There are a few limitations of this project that should be acknowledged. First, the category of ‘gender’ as described in this paper does not address the many different conflicting understandings of the meaning and relevance of the term (Varcoe, Hankivsky & Morrow, 2007), nor does it include transgendered or intersexed persons. Further research into the health needs of transgendered or

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<sup>2</sup> The conference featured a Ministry Panel consisting of representatives from the Ministry of Attorney General and Minister Responsible for Multiculturalism, the Ministry of Children and Family Development, the Ministry of Health, and the Ministry of Education. This panel provided information regarding current services provided by the Ministries and policy perspectives. The conference also featured research presentations on current research regarding newcomer children and implications for programming. Community organizations that provide early child development / early learning services also provided information regarding the challenges and successes in serving newcomer children and their families. The conference also included small-group discussions to discuss modifications to improve existing services for newcomers to BC and to address service gaps.

<sup>3</sup> It should be noted that gender-based analysis was not specifically incorporated into the research and creation of the VCH report on immigrant health; however, this is unlikely to have affected the main findings of the VCH report nor the conclusions of this paper.

intersexed immigrants would be useful to determine their health status and the challenges they might face obtaining appropriate health care services in BC and throughout Canada.

Another limitation of this paper is that no formal discussions, interviews, or focus groups were conducted with individuals working within VCH, affiliated programs, or with immigrants that have used the programs or services of VCH. However, the many informal discussions with VCH employees during my practicum provided significant insight into immigrant health in VCH, and it is unlikely that any formal discussions would have changed the results or recommendations of this paper.

A final limitation is that the specific health concerns and health needs of refugees in VCH are not formally addressed in this project. While refugees are a more vulnerable group and are at greater risk for developing mental illnesses, their experiences and needs will not be specifically addressed due to the confines of this project. Further research into refugee health and gender differences in terms of the health needs of refugees in VCH is recommended as it would be useful in assessing whether the current health services and health care system are adequately addressing their health needs.

## **THE HEALTH OF IMMIGRANTS IN CANADA**

Although immigrants make up a significant portion of Canada's population, the health of immigrants in Canada has been under-studied. While there is extensive research highlighting the 'healthy immigrant effect', until recently there has been limited research on the determinants of health which affect the health of immigrants or health issues that disproportionately affect immigrants within Canada or British Columbia (Beiser, 2005; Desmeules et al., 2004; Hyman, 2001; Kinnon, 1999; Woermke, 2008). Furthermore, there continues to be limited data on the quality of health care, health care utilization, and health care outcomes of immigrants in British Columbia (Woermke, 2008). Research has demonstrated that recent immigrants to Canada are generally in better overall health than the Canadian-born population, however, the longer the period of time an immigrant has lived in Canada, the more likely their health status will diminish (Bowen, 2006; Ng, Wilkins, Gendron & Berthelot, 2005a). In other words, the healthy immigrant effect diminishes over time. Immigrants are generally in better health when they arrive in Canada for two main reasons. First, individuals in good overall health with the motivation and stamina to undergo immigration are more likely to emigrate from their home countries. Second, the Canadian immigration screening process ensures that immigrants are screened on health-related criteria before being admitted into Canada and immigrants with serious

medical conditions are denied entry (Kinnon, 1999; Ng, Wilkings, Gendron & Berthelot, 2005).

According to data from Canada's National Population Health Survey and the Canadian Community Health Survey, recent immigrants are more likely to rank their overall health higher than the Canadian-born population and suffer from fewer chronic illnesses and long-term disabilities than native-born Canadians (Beiser, 2005; Newbold, 2005; Ng et al., 2005). Unfortunately, many immigrants eventually face a subsequent decline in health after their arrival in Canada and many see a convergence with the health status of the general Canadian population once they have been in Canada for over ten years (Beiser, 2005; Ng et al., 2005).

Researchers have linked the decrease in health of immigrants to a range of factors. These factors include linguistic and cultural barriers to health promotion and preventive services, a range of environmental factors, the migration experience, and the stress of resettling in a new country (Bowen, 2006; Vissandjee, 2004). In addition, refugees and refugee claimants may face additional health problems resulting from malnutrition, trauma, and previous exposure to communicable diseases (Bowen, 2006). While immigrants do receive health care coverage, they may face additional barriers to care. Such barriers include the availability of specialized services, such as mental health services, financial barriers, orientation to the health care system, barriers to contact with the health care system, access to health promotion and prevention information, policy and program responsiveness, and health care provider

knowledge and attitude towards treating patients from diverse backgrounds (Bowen, 2006).

Research has also demonstrated that gender is an important dimension within the context of migration (Vissandjee, Thurston, Apale & Nahar, 2007). In addition to the aforementioned factors contributing to the decline in health status of immigrants, Vissandjee et al. (2007) argue that female immigrants face distinct challenges. For instance, some female immigrants are more likely than their male counterparts to suffer from language barriers, unemployment, social isolation, and low income, which place them at higher risk for ill health (*Ibid*).

## **Determinants of Immigrant Health**

The determinants of health framework asserts that health is influenced by a broad range of interrelated factors, with associations between overall health status and demographic, social, economic, and environmental variables (Newbold, 2005). According to the Public Health Agency of Canada, gender is one of the twelve key determinants of health, and is particularly relevant to immigrant health (PHAC, 2003). According to the Canadian Women's Health Network, put simply, sex refers to the biological differences between men and women, while gender refers to the social and cultural differences experienced by men and women<sup>4</sup> (Greaves et al., 1999). Gender is quite complex and tied to the fluid and ever-changing nature of social and cultural systems (O'Mahony &

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<sup>4</sup> Although biological and genetic endowment are determinants of health, the social determinants of health are of much greater influence to the health of immigrants, especially to the frequent decline in health among immigrants post-migration (Frank et al., 2006). As such, this paper will focus almost exclusively on the social determinants of health.

Donnelly, 2007). Consequently, male and female immigrants' experiences of some of the determinants of health may differ (Horne, Donner & Thurston, 1999). For example, immigrants may have emigrated from countries with expectations of women's roles or gender prescriptions that differ from Canada's. Upon their arrival in Canada, some women may carry dual roles as paid workers and homemakers and may lack the social support from an extended family system that they may have depended on in their country of origin; such is often the case for immigrants from South Asia (Grewal, Botorff & Hilton, 2005). Many immigrant women are vulnerable to excessive workloads, isolation, and low wages (Oxman-Martinez, Abdool & Loiselle-Leonard, 2000). Furthermore, cultural and linguistic barriers in access to health services are identified as a potential concern for female immigrants (*Ibid*).

In addition to the twelve determinants of health, pre-migration, settlement, and post-migration experiences are also influential to the health of immigrants. The immigration experience can be both stressful and disruptive and may have detrimental health consequences. While some immigrants may have a very positive immigration experience with few or no health consequences, immigrants who lack social support networks and who encounter unemployment and financial constraints upon their arrival are more vulnerable to these effects (Ng et al., 2005). Women with precarious immigration status (meaning their status does not allow them to remain in the country permanently or their status is dependent on a third party, such as a spouse), have also been found to be especially vulnerable to a variety of socio-cultural and policy barriers that inhibit their access

to health care and health services (Oxman-Martinez et al., 2005). Many women immigrate to Canada in the family class (sponsored by family members who have previously immigrated to Canada), which can affect both their economic and social position in Canada. Research has also found that female immigrants, who have moved to Canada on temporary work visas as live-in caregivers and who live in the homes of their employers, are more likely to be subjected to financial, physical, and sexual abuse (CRIA, n.d.; Pratt, 2005; UNHCR, 1999).

Certain factors have been identified which may ease the adjustment period for new immigrants. These factors include knowledge of the English or French languages, education level, economic situation, family and community support, familiarity with Canadian culture, and personal characteristics such as marital status, age, and gender (Kinnon, 1999). One of the most important factors identified in the literature as an important contributor to the future health of immigrants, is the role of strong social support networks (Kinnon, 1999; Simich et al., 2005). As one of the twelve determinants of health, social support provides a coping mechanism to reduce potential stressors, which helps to maintain health and wellbeing (Beiser, 2005; Simich et al., 2005). A lack of adequate social support among new immigrants can result in loneliness, social isolation, and discouragement about adjusting to life in Canada (Simich et al., 2005).

It is clear that the overall health status of immigrants is not only influenced by socio-economic, cultural, environmental, behavioural, and biological factors, but also from factors and experiences emerging from pre-migration, resettlement,

and adjustment in a new country. While stress from poverty, lack of social support, and unemployment may lead to adverse health effects in all individuals, immigration and resettlement increase the likelihood of exposure to poverty, unemployment, and a decline in overall health status (Beiser, 2005).

# **IMMIGRANT HEALTH IN THE VANCOUVER COASTAL HEALTH AUTHORITY**

## **Vancouver Coastal Health**

Vancouver Coastal Health is comprised of three Health Service Delivery Areas—Vancouver, North Shore/Coast Garibaldi, and Richmond—and fourteen smaller Local Health Areas. VCH serves a population of 1.1 million, many of whom were born outside of Canada (VCH, 2008). According to the 2006 census, the metropolitan area of Vancouver is home to almost 40% of all foreign-born individuals in BC (BC Statistics, 2008). Vancouver also remains the most popular destination for new immigrants to British Columbia (WelcomeBC, 2008). The top five source countries for immigrants to BC in 2007 were: Mainland China, India, the Philippines, the United States of America, and South Korea (see Figure 1). In addition, slightly more than half of the immigrants arriving to BC in 2007 were female (WelcomeBC, 2008).

While Asia and the Pacific have replaced Europe as the main sources of immigrants since the 1970s, Vancouver Coastal Health's immigrant population is quite heterogeneous. Not only do immigrants to VCH differ by country of origin, but they can also differ by entry class, length of time in Canada, levels of cultural retention and acculturation, previous exposure to illness, and knowledge and experience with Canada's health care system. While some generalizations can be made, pre- and post-migration stressors, coping methods, socio-economic

status, personal characteristics, and the resettlement experience are different for each immigrant. That is, differences may exist between the health needs of immigrants from similar cultural backgrounds or countries of origin.

## **Gender Differences in Determinants of Health among Immigrants in VCH**

Drawing on the available literature, the 2008 VCH report on immigrant health demonstrated differences between male and female immigrants in terms of their settlement experiences, access to health care services, and other determinants, such as employment and social support, which can affect overall health status (Grewal, Bottorff & Hilton, 2005; Oxman-Martinez, Abdool & Loiselle-Leonard, 2000; Woermke, 2008). The VCH report reviewed 2006 census data highlighting various social determinants in the *British Columbia Immigration and Diversity Profiles* produced by BC Statistics (WelcomeBC, 2008a; Woermke, 2008). Based on the available data, charts were produced which highlighted education, employment, income, and language rates compared between immigrants and the total population in communities within VCH (Woermke, 2008). In almost all VCH communities except Vancouver, a greater proportion of immigrants have post-secondary education than the total population. However, despite this greater level of education, for the most part a greater proportion of immigrants experience unemployment, lower median incomes and low income than does the total population (WelcomeBC, 2008a). The data only had available information on employment and income for both

male and female immigrants. Examination of these two determinants demonstrated considerable differences between male and female immigrants.

## **Employment**

According to BC Statistics (2007), recent immigrants that have lived in British Columbia for less than five years have an unemployment rate of 9.7%, which is more than twice the rate of Canadian-born residents of BC. Comparatively, recent female immigrants have a slightly higher unemployment rates than recent male immigrants at a rate of 10.7%, with males at 8.9% (BC Statistics, 2007). While established immigrants that have lived in BC for over ten years have an unemployment rate slightly below the Canadian-born average, the unemployment rate of established female immigrants remains higher than the rate of established male immigrants (BC Statistics, 2007). The Longitudinal Survey of Immigrants to Canada (Statistics Canada, 2007a) offers some insight into the difficulties experienced by new immigrants to Canada when seeking employment. New immigrants that participated in the Longitudinal Survey cited a lack of Canadian work experience, a lack of contacts in the job market, a lack of recognition of foreign experience and qualifications, and language barriers as the main difficulties faced when seeking employment (Statistics Canada, 2007a). Given such difficulties, it is not surprising that according to BC Statistics (2007) very recent immigrants to BC experience higher unemployment rates regardless of their education levels than do Canadian-born residents of BC.

In terms of the employment positions taken up by new immigrants to VCH, according to the BC Statistics data, more female immigrants than male

immigrants are likely to be employed in sales and service occupations or business, finance and administration positions (WelcomeBC, 2008a). While male immigrants also work in those sectors, a large number of them work in management positions, natural and applied science occupations, and in trades, transport, and equipment operator positions (WelcomeBC, 2008a). Female immigrants are also more likely to work as domestic workers such as live-in caregivers, which can place them at higher risk of living in abusive situations, and may limit their social and economic independence (CRIA, n.d.; Pratt, 2005). Furthermore, because Canada does not recognize all foreign credentials or experience, female immigrants must often turn to working as manual labourers even if they have the education or training for other jobs (CRIA, n.d.).

## **Income**

In terms of income, the data from BC Statistics reveals that in nine out of eleven communities in VCH, the prevalence of low income is much greater among immigrants than the total population (WelcomeBC, 2008a). With the exception of immigrants in Whistler and on the Sunshine Coast, immigrants consistently earn a median employment income below that of the total population (WelcomeBC, 2008a). In addition, female immigrants in BC earned a median employment income of \$34,469 in 2005, approximately \$8,000 less than the median income of male immigrants (WelcomeBC, 2008a).

Given that unemployment and low income increases an individual's risk of experiencing poor health (VCH, 2008), the data on employment and income reveal inequities not only among the immigrant population of VCH that may affect

their overall health status, but also within the immigrant population between male and female immigrants. Overall, female immigrants appear to have greater difficulty finding employment in BC and earn a lower median employment income than male immigrants, which may put them at greater risk for experiencing poor health.

### **Priority Areas in Immigrant Health with Greater Risk among Female Immigrants**

Based on the available literature, five priority areas in immigrant health were identified in the VCH report on immigrant health as most likely to be significant for immigrant populations in VCH: tuberculosis, cancer, diabetes, mental health, and low health service utilization (Woermke, 2008). Two of the five priority areas, mental health and low health service utilization, highlighted a greater risk among female immigrants. The following sections will explore these two priority areas and the reasons for the increased risk among female immigrants.

#### **Mental Health**

Research has shown that factors surrounding displacement and resettlement are significant in determining the mental health of immigrants (Fung & Wong, 2007; Hyman, 2001). Such factors include pre- and post-migration stresses, family, employment, and social support. Other determinants that may reduce the mental well-being of immigrants include cultural, linguistic, economic, and informational barriers to care (Fung & Wong, 2007). While pre-migration factors, such as stress, may influence mental health immediately after arrival,

post-migration factors, such as unemployment, can be a serious threat to mental health even 10-12 years after arrival in Canada (Hyman, 2001).

Female immigrants and refugees may experience an increased risk of developing mental health problems post-migration than their male counterparts (O'Mahony & Donnelly, 2007). Female immigrants may experience increased stress or depression post-migration resulting from an increased risk of unemployment and low income due to a lack of education, a lack of recognition of foreign credentials, and/or language barriers (Oxman-Martinez, Abdool & Loiselle-Leonard, 2000). For example, a recent study that explored the effects of income, immigration, and gender on depression, found that depression is more prevalent among female immigrants with low incomes than among female immigrants with middle-high incomes (Smith, Matheson, Moineddin & Glazier, 2007). In addition, many female immigrants are more prone to isolation post-migration because of insufficient language skills, unfamiliarity with services, and low socioeconomic status as well as being more prone to the stresses of childcare responsibilities, which may restrict their ability to engage in their new environment or to acquire new language skills (O'Mahony & Donnelly, 2007). O'Mahony and Donnelly (2007) argue that the double burden faced by many immigrant women, which includes engaging in paid work outside of the home while maintaining family responsibilities in a new country can result in both "role overload and cultural conflicts" (p. 1178). Such high expectations of female immigrants can increase stress levels and stress related disorders (*Ibid*). Furthermore, immigrants who have previously experienced traumatic events

such as forced migration, abduction, famine, torture, and war may suffer from increased risk of mental health problems (Hyman, 2001). Post-traumatic stress disorder, chronic depression, and suicide have been highlighted in the literature to be significant mental health problems among female immigrants and refugees who have experienced such highly traumatic events (Hyman, 2001; Oxman-Martinez, Abdool & Loiselle-Leonard, 2000).

### **Low Health Service Utilization**

The second priority area with greater risk among female immigrants is low health service utilization (HSU). HSU includes the use of medical services, preventive health services, mental health services, and complementary and alternative medicine. A study from 2000 revealed that immigrants in BC had 40% less contact with physicians than the general population (Kliewer & Kazanjian, 2000). Other Canadian studies have also shown that immigrants are less likely to use health care services and to have fewer mean visits to health services than Canadian-born individuals (Chen & Kazanjian, 2005; Curtis & MacMinn, 2008). In particular, the underutilization by immigrants of mental health services and preventive health services has been well documented in the literature (Hyman, 2001; Kirmayer, du Fort, Young, Weinfeld & Lasry, 1996). Many studies have also found that female immigrants are at greater risk of underutilizing mental health services and in terms of preventive health services, are less likely to be screened for breast and cervical cancer than Canadian-born females (Donnelly, 2006; Hislop et al, 2004; Oelke & Vollman, 2007; O'Mahony & Donnelly, 2007). Although the underutilization of health services may indicate

that new immigrants are healthy and therefore using less health services, the lower rates may also be a reflection of barriers in access to health services (Desmeules et al., 2004; Quan et al., 2006).

### **The Underutilization of Mental Health Services**

Language barriers, poverty, unemployment, cultural and social stigma, discrimination, and marginalization all influence immigrant women's ability to utilize available services (O'Mahony & Donnelly, 2007). Furthermore, structural barriers and gender roles, such as the double burden of maintaining family responsibilities while engaging in paid work outside the home, can also act as barriers to accessing mental health services (O'Mahony & Donnelly, 2007). O'Mahony and Donnelly (2007) argue that such prescribed gender roles can often influence whether or not mental health services are accepted and accessed. In addition, since female immigrants often come to Canada in the family class and are quite reliant on their spouses, their loss of autonomy and lack of independence may affect their ability to access support for their mental health needs (*Ibid*). Further, a perceived lack of access to culturally, linguistically, and gender appropriate care may also explain the low utilization rates of mental health services by immigrant women (Fung & Wong, 2007).

### **The Underutilization of Preventive Health Services**

In terms of the underutilization of preventive health services by immigrant women, many research studies have found that immigrant women are less likely to be screened for cancer compared to the Canadian-born population, especially

for breast and cervical cancer (Donnelly, 2006; Hislop et al., 2004; Oelke & Vollman, 2007). While the prevalence of cancer among immigrants and the Canadian-born population tends to be comparable, immigrants may detect cancer later due to lack of awareness of early signs and symptoms and lower participation rates in screening programs (Hyman, 2001). Research has demonstrated that being in Canada less than 10 years and speaking a language other than English or French at home are both significant predictors of immigrant women never having had a Pap test or a mammogram (Goel & Mercer, 1999). Although cervical cancer screening rates improve with years in Canada for many immigrants, screening rates among immigrants from certain regions such as Southeast Asia, China, and other Asian backgrounds, often remain low (McDonald & Kennedy, 2007; Oelke & Vollman, 2007; Woltman & Newbold, 2007). Within BC, a 2004 community based survey of Chinese immigrant women found that cervical cancer was a significant cause of mortality and morbidity for these women, due in large part to low rates of Pap testing. A lack of knowledge about cervical cancer and Pap tests was found to be prevalent among this population, especially among those with low levels of education (Hislop et al., 2004).

Numerous barriers to participating in preventive screening and treatment programs for cancer have been identified. These barriers include low levels of education, lack of knowledge about available screening methods and prevention, low income, language barriers, and recent immigration to Canada (Gupta, Kuman & Stewart, 2002; Hislop et al., 2004; Lofters, Glazier, Agha, Creatore &

Moineddin, 2007; Oelke & Vollman, 2007). These barriers may be associated not only with late detection of cancer, but also with a greater risk of mortality (Hyman, 2001). Challenges to participating in screening activities for many immigrant women may also include issues with health care professionals and the influence of family and community (Oelke & Vollman, 2007). For instance, a study exploring the participation of Vietnamese-Canadian women in screening programs found that the perceived hierarchical relationship between an immigrant woman and her physician served as a barrier to her seeking care (Donnelly, 2006). Cultural factors may also influence immigrant women's level of participation in screening programs and include cultural knowledge and values with regards to women's bodies, conceptualization of health and illness, and beliefs and values concerning the patient-provider relationship (Donnelly, 2006).

## **CRITICAL REVIEW: WHAT DO THESE TRENDS DEMONSTRATE WITH RESPECT TO GENDER?**

As was previously discussed, VCH's immigrant population is quite diverse, with significant socio-cultural and economic differences even among those immigrants from similar cultural backgrounds or countries of origins. As was made clear in the previous sections, in terms of gender, the health needs and determinants shaping the health of male and female immigrants can be quite different. However, despite such diversity among VCH's immigrant population, immigrants have largely been treated as a homogenous group in research, programs and policies. For instance, the VCH report on immigrant health lists twelve ongoing services within VCH that are currently available for immigrants and refugees (Woermke, 2008). Besides services that are available for expectant mothers or new parents, none of the programs address the unique health needs and interests of female immigrants. Furthermore, no overarching body or association within VCH ties the programs together or works to identify gaps or unmet needs within the ongoing programs.

The situation at VCH reflects the prevailing practice of treating immigrants as a homogenous group within health care policies and services across Canada. According to Vissandjee et al. (2007), recognition of the diversity within the immigrant population has yet to be fully realized within Canadian health care policies and services. Health Canada (2005) has also stated that little attention

has been paid to the organization of health services for immigrants in Canada and that until recently there has been little research on culturally appropriate systems of care, including current health delivery models or health promotion strategies. As Vissandjee et al. (2007) point out, although Canada prides itself on its multicultural identity and universal health care system, in reality the existing health policies and services neither reflect Canada's diverse population nor offer an integrated approach to the needs of female immigrants.

Although studies within Canada and British Columbia are beginning to highlight differences between male and female immigrants in terms of both their health needs and the factors that influence their health status, the uptake of this evidence into policies is lacking. The additional determinants influencing the health of immigrants, such as migration and re-settlement, and the different experiences of such determinants among male and female immigrants have yet to be fully acknowledged at the policy or program level (Vissandjee et al, 2007). The situation reflects the general trend in mental health, where evidence exists which demonstrates that the mental health needs of women are significantly different from the needs of men, yet this evidence has yet to be translated into policy (Morrow, 2003).

Recent Canadian research has also highlighted the manner in which existing federal and provincial policies contribute to the unequal access to health services for female immigrants. For instance, Oxman-Martinez et al. (2005) argue that current federal and provincial health policies intersect with immigration policies and thereby create barriers to health and access to health services for

immigrants. The authors argue that female immigrants with precarious immigration status are especially vulnerable to barriers to accessing health care. For instance, women with precarious immigration status have to pay for health services when waiting the three-month delay period before being entitled to provincial health care (*Ibid*). Anderson and Kirkham (1998) have similarly concluded that although legislation exists to ensure equality in access to health care services, institutional structures do not reflect these principles. A study on the impact of health and social policy changes on the health of recent immigrants in Toronto's inner city demonstrated that female immigrants are particularly affected by such policy changes (Steele, Lemieux-Charles, Clark & Glazier, 2002). For example, reductions in funding of community-based health and social services left immigrant women, who are most likely to be the primary caregivers in their families, to "bear the burden of cuts" (Steele et al., 2002, p. 122). Vissandjee et al. (2007) argue that "if policies remain insensitive to the gendered conditions that limit women's access to resources and opportunities, female immigrants will continue to experience ... inequities" (p. 229). In order to more effectively maintain the health of female immigrants and to reduce the current inequities in immigrant health, further examination of the needs and interests of female immigrants and the gender-specific effects of migration on the health of the immigrant population will be essential.

## **GENDER-BASED ANALYSIS AND INTERSECTIONALITY FRAMEWORKS**

It is clear that the experiences of immigrant women are not currently informing policy and practice. Their health needs are not being addressed by the current system and changes need to be made to ensure that their needs and interests are met, and that their health does not decline after their arrival in Canada. In order to address the needs of both male and female immigrants, the incorporation of a gender-based analysis, supported by a framework of intersectionality, is recommended to improve immigrant health research and to inform future policy and program development.

Gender-based analysis (GBA) is an analytical tool that integrates a gender perspective into the development of programs, policies, and legislation as well as into planning and decision-making processes (Health Canada, 2003a). GBA can be used to identify potential inequalities among men and women as well as to understand how and why inequalities occur in health (BCCEWH, 2004; Hankivsky, 2007). Such an analysis seeks to address differences between men and women including disparities in the roles they play, power imbalances, differences in their needs, opportunities and social/cultural realities, as well as how such differences impact their lives, health status, and access to or interaction with the health care system (Health Canada, 2000; Reid, 2002). As stated by the British Columbia Centre of Excellence for Women's Health,

“gender-based analysis illuminates both women’s and men’s roles” and allows for the identification of potential influences on health (BBCEWH, 2004, p. 19). GBA can also compare why and how programs, policies or legislation affect women and men differently. For example, a GBA can examine how differences between genders can result in different risk exposures, awareness and access to resources, services, and information (Reid, 2002). Through the use of GBA, researchers and program and policy developers can improve their understanding of gender as a determinant of health as well as how gender interacts with other determinants to affect health (Health Canada, 2003a).

According to Health Canada (2000), GBA provides a framework for conducting research as well as analysing and developing programs, policies, and legislation, which recognizes differences between and within men and women. GBA can be incorporated throughout all aspects of a project or research, from beginning to end. Health Canada (2000) describes GBA as an effective method to challenge “the assumption that everyone is affected in the same way by policies, programs, and legislation, or that health issues such as causes, effects and service delivery are unaffected by gender” (p. 2). GBA is a tool that enables an understanding of social processes, which helps create solutions to existing inequities. Furthermore, GBA takes into account the diversity of the Canadian population.

According to the Status of Women Canada (2004), GBA is based on a few key values and assumptions which include: there is a need for constructive partnerships between men and women; gender equality does not mean that

women must become the same as men; and every action, policy, program or socio-economic trend affects men and women differently. If GBA is conducted at the beginning of any research project, program, or policy, gender issues that need to be considered will be identified and plans to overcome inequities can be developed (Status of Women Canada, 2004).

Although GBA is a beneficial framework and tool, critiques of GBA have emerged. Such critiques have drawn attention to the possibility that exclusive attention to gender in GBA "...carries the risk of treating all women the same; essentializing sex and gender; overlooking the fluid and changing nature of gender; overlooking the ways in which economics, race, ability, geography, sexuality, and other influences shape and intersect with gender..." (Varcoe, Hankivsky & Morrow, 2007, p.18). Within GBA, less recognition is given to other social variables because gender is the primary variable of interest. In response to these critiques, intersectionality has emerged as a new model with which to understand women's health. According to Hankivsky and Cormier (2009), intersectionality considers the dynamics and interactions of different social identities (such as race, gender, class, age, ability, immigration status et cetera), as well as the impact of systems and processes of oppression and domination in order to understand differences in health needs and outcomes. As such, intersectionality can be used within research as well as within program and policy planning to understand the numerous ways in which gender intersects with other variables and how the interactions of such variables result in different and unique experiences of health and illness (*Ibid*). Gender is not viewed as the most

important variable but is experienced alongside an individual's experiences of race, sexuality, age, class, and other aspects of social identity (Hankivsky & Cormier, 2009; Varcoe, Hankivsky & Morrow, 2007). In terms of this paper's earlier critique that immigrants are often treated as a homogenous group within immigrant health research, policies and programs, the use of intersectionality would be effective in helping to avoid this problem. Within this project's recommendations, intersectionality will be used as a supplemental tool to GBA, given the Canadian government's promotion and support of GBA in health research.

### **Current Government Position on GBA**

The Canadian government has both domestic and international commitments to equality between men and women<sup>5</sup> (Health Canada, 2003). The Government of Canada committed to gender equality and to the adoption of a policy on GBA in the 1995 *Federal Plan for Gender Equality* (Health Canada, 2000). Health Canada formalized its commitment to gender equality in *Health Canada's Women's Health Strategy* in 1999 and to implementing GBA throughout all areas of the department in *Health Canada's Gender-based Analysis Policy* in 2000 (Health Canada, 2003). This commitment to gender equality measures success in producing equal results, not just in providing equal opportunities to both men and women (*Ibid*). The Canadian Institute of Health Research has also committed to being part of the initiative to apply GBA in health

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<sup>5</sup> Examples of Canada's formal commitments to equality include the Ottawa Charter for Health Promotion and The Canadian Charter of Rights and Freedoms (Health Canada, 2003).

research in Canada and has implemented a set of policies and practices on gender and sex-based analysis (CIHR, 2007). GBA is also consistent with a population health approach that aims to reduce health inequities by recognizing that the health of a population is influenced by social, economic, and physical environments, personal health practices, early childhood development, nutrition, physical activity, and access to quality health care services (VCH, 2008).

### **The Application of GBA and Intersectionality**

There are numerous ways a GBA can be applied within the health sector. Some examples include: the recognition of social context influences on health; focusing on equality of outcomes (not just equal treatment or opportunities); broadening the focus of women's health from reproductive health to include other conditions that are prevalent among women; and the inclusion of gender-sensitivity in all programs for both men and women (Horne et al., 1999). Questions that can be used to examine aspects of health care through GBA include: what policies help women and men stay or become healthy?; what policies pose a threat to women's or men's health?; what policies provide women or men with appropriate services and high quality care?; and does the program or policy in question discriminate against men or women in its outcome? (Government of New Brunswick, n.d.; Women & Health Care Reform 2008).

There are also many resources available to help guide the integration of gender-based analysis into research, policy and program development. Methods to apply GBA in research design, in the formulation of research questions, in literature reviews, in research methods and data collection, in data analysis and

interpretation, and in the language of research reports are included in such resources. Organizations that have produced such resources include the Canadian Institute of Health Research (2007), Health Canada's Women's Health Bureau (2003) and the Status of Women Canada (2004)<sup>6</sup>.

Intersectionality can also be incorporated into different phases of research, program, and policy design. In their intersectionality primer, Hankivsky and Cormier (2009) provide ways in which health researchers can incorporate the intersectionality perspective into their research design. For instance, they suggest that research should use a "bottom-up" approach that assumes that individuals are knowledgeable about their own lives and the context in which they live, instead of research that is "top-down" or "for or about women" (Hankivsky & Cormier, 2009, p. 21). The authors also present questions to consider when conducting literature reviews, when choosing a research design, when choosing tools of inquiry, and when developing a knowledge translation plan<sup>7</sup>. While intersectionality on its own may be difficult to operationalize due to its complexity, incorporating the suggested methods and questions into research, program, or policy design which are already utilizing the GBA approach will allow such designs to be more effective, responsive, and efficient.

## **Benefits of GBA and Intersectionality**

As demonstrated in Health Canada's (2003) *Exploring Concepts of Gender and Health*, GBA is essential to the complete understanding of health in

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<sup>6</sup> See Appendix B for suggested questions to use when applying GBA.

<sup>7</sup> See Appendix C for suggested questions to use when applying Intersectionality.

diverse populations, such as in VCH. Conducting GBA, supported by an intersectionality framework, can allow for more informed decision-making and an increased likelihood of programs and policies on immigrant health being effective and achieving their objectives for both men and women. These frameworks can also help identify successful policies and programs that have contributed to improving immigrants' health and those policies or programs that may have a negative impact on the health of male or female immigrants. GBA and intersectionality can also be used to monitor and evaluate the impact of programs and policies. In addition, both GBA and intersectionality are highly adaptable and can be used in many different settings to promote gender equity. Reducing health inequities has many potential benefits for the health of British Columbians, as demonstrated in the discussion paper *Health Inequities in British Columbia* released by the Health Officers Council of BC in 2008. Such benefits include improving the health of all individuals, economic benefits such as easing demand on health services, and improving people's quality of life and ability to be a productive member of society (Health Officers Council of BC, 2008).

### **Challenges of Using GBA and Intersectionality**

A challenge to the incorporation of GBA into immigrant health research, policy, and program development in VCH may be that some health planners may not fully perceive gender analysis as necessary in program and policy development. Another potential challenge may be the lack of GBA training amongst researchers and individuals involved with program planning and policy development. However, the ongoing implementation of gender inclusive training

within VCH and other health authorities (discussed further in the next section), could present the opportunity to train researchers and health developers about GBA. Further, more concrete challenges such as a lack of funding or lack of time could arise. To address such concerns, Prairie Women's Health Centre of Excellence (2005) recommends: that GBA be promoted at both the high decision-making levels and more micro-levels of an organization; that GBA be a required component of all planning documents; that funding and direction be provided for training in GBA; and that departments be monitored and rewarded for conducting GBA. In addition, the increased attention to gender differences in health in Canada within the last few years should help provide some momentum to apply such knowledge and evidence to immigrant health as well.

The term 'gender' has also been identified as a conceptual issue in the use of GBA (Hankivsky, 2007). Debates continue as to the meaning of the term gender, and how to measure gender differences in health status (*Ibid*). Furthermore, Hankivsky (2007) identifies the possibility of "[essentializing] women on the basis of gender" as problematic within GBA (p. 156). Using intersectionality as a supplemental tool to GBA will help reduce the likelihood of privileging gender over the other determinants of health in research, policy, and program development surrounding immigrant health. However, because intersectionality has been criticized as being quite complex and difficult to operationalize on its own, the framework is only recommended to be used as a supplemental tool to GBA, not as its replacement.

## RECOMMENDATIONS

In accordance with current research and government policies / recommendations on GBA, this paper recommends the incorporation of a GBA supported by a framework of intersectionality, within immigrant health research, policy, and program development in the VCH region. This recommendation coincides with statements made by O'Mahony & Donnelly (2007) which conclude that the inclusion of more gender analysis is necessary to understand immigrant women's values and experiences. Gaining a better understanding will allow those individuals responsible for providing care or developing policies to do so in a manner that is more appropriate for the needs of immigrant women. As previously mentioned, current access to health care (especially preventive and mental health care services), is not equal for immigrant men and women. The application of a gender-based analysis and an intersectionality framework to research the social, economic, and political dimensions of immigrant women's health will help facilitate support for the creation of policies and practices that will better meet the needs and interests of female immigrants and improve equity within the health care system (*Ibid*).

Health Canada (2005) has put forward two critical questions to policy makers in regards to immigrant health: 1) What conditions (i.e. determinants of health) contribute to changes in the health status of immigrants over time?; and 2) How can government programs and services help to maintain and promote the

health status of immigrants over time? To answer these questions, Health Canada has stated that recognizing the determinants of health as key contributors to the decline in immigrant health and the use of a multisectoral approach is necessary to maintain and promote the health of immigrants. They also call for increased attention to the needs of immigrant sub-groups, including female immigrants (*Ibid*). The incorporation of GBA and an intersectional approach would allow for a better understanding of the experiences and health needs of female immigrants. Furthermore, longitudinal studies, research within immigrant communities, and multi-method studies have all been recommended to enhance the existing information on immigrants in Canada (Health Canada, 2005; Woermke, 2008). Utilizing a GBA along with an intersectional framework within all these approaches would increase the evidence and findings that emerge from these studies, and allow the results to better inform future programs and policies for both male and female immigrants.

Currently, the BC Ministry of Health Services and VCH are co-funding gender inclusive health training to promote awareness of sex differences and gender influences on health care practice and policy (BCCWEH, 2004). Both front-line health workers and health care planners will receive this training. The British Columbia Centre of Excellence for Women's Health has stated that new training programs will continue to be developed over the next few years to advance the health of women in British Columbia (*Ibid*). The inclusion of information on the unique needs of female immigrants is recommended to be included in such programs and initiatives.

As was previously mentioned as one of the highlights in the VCH report on immigrant health, the process of resettlement and the changes in social and economic environments post-migration tend to affect female immigrant's mental health more so than for their male counterparts (Woermke, 2008). The incorporation of GBA along with intersectionality to program and policy analysis would allow us to better understand not only the mental health issues that female immigrants are experiencing, but also the reasons why they underutilize available mental health services. The incorporation of these frameworks could help identify strengths and weaknesses of the current available mental health services for immigrants. This insight could allow for programs and services to be more tailored, culturally appropriate, and acceptable to meet the mental health needs of immigrant women and acknowledge the broader social context of their health.

Furthermore, while cultural factors such as the conceptualization of health and illness have been shown to influence immigrant women's participation in screening programs for breast and cervical cancer, research has demonstrated that barriers to preventive care are also due to factors besides traditional beliefs, values, and practices (Donnelly, 2006). In order to fully understand immigrant health and the reasons for differences between male and female immigrants, immigrants' experiences of health and participation in health services should be analysed with an intersectional approach (Varcoe, Hankivsky & Morrow, 2007; Vissandjee et al., 2007). As such, gender should be examined within the intersection of the social, political, and economic circumstances of their lives, as well as within their personal and familial identities.

## **Recommendations for Future Directions in VCH**

Although VCH has ongoing micro-level programs and clinics for new immigrants, there needs to be macro-level changes in order to be responsive to the needs of the VCH immigrant community. The introduction of an overarching body to evaluate the ongoing initiatives to address immigrant health and to identify gaps in programs and services would be useful. Although the quality of the quantitative data available on immigrant health within VCH is poor, interim methods, such as utilizing the substantial qualitative research and data available to inform decisions is necessary. Considering the lack of immigrant and gender-specific data, qualitative information can be valuable by providing personalized information gathered from observations, interviews and focus groups. Additionally, the current internal databases within VCH are insufficient in providing information on immigrant's use of health services or reasons for health service utilization. Improving the existing databases or creating new databases that include data on immigrant status and gender is essential to better understanding the health of a significant and growing population within VCH.

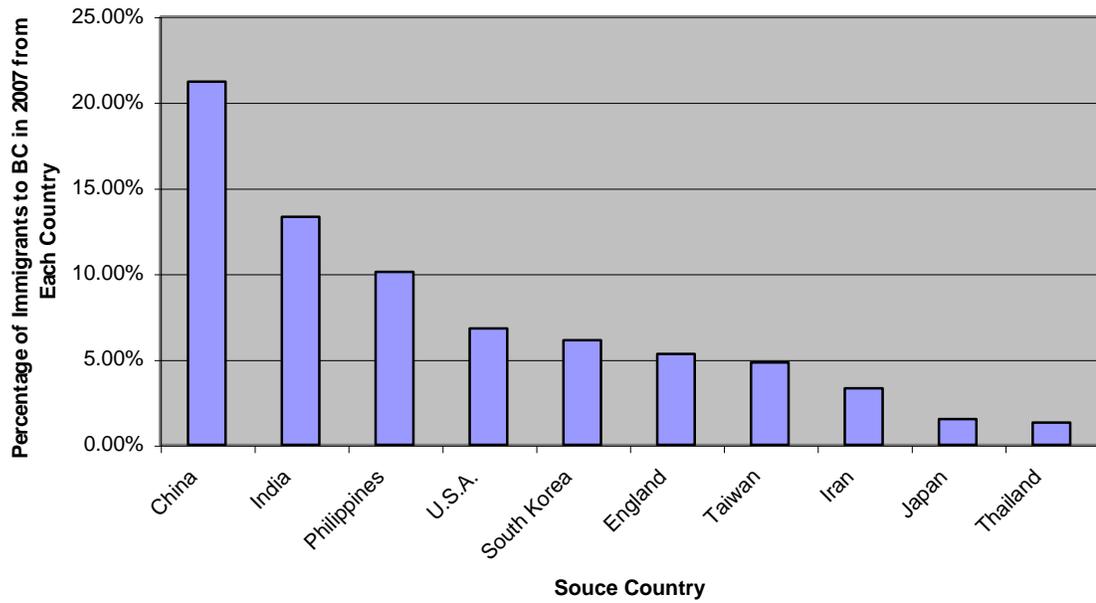
## **CONCLUSION**

Pursuing gender-based analysis as well as an intersectional approach in future research, policy, and program development in immigrant health has the potential to lead to enhanced ability of the current health care system to address the needs of both male and female immigrants. Not only could recognizing the unique circumstances of female immigrants improve the likelihood of developing appropriate services and making them more accessible, but it could also lead to improved health and quality of life for a growing population within British Columbia. The integration of gender dimensions into immigrant health is critical if British Columbia is going to maintain the health and quality of life of new immigrants, and especially of female immigrants in the province. Without making the necessary changes within our existing system to address the unique needs and interests of female immigrants, we risk the continuing decline in health among a growing number of individuals within the province.

# FIGURES

Figure 1

Top Ten Source Countries of Immigrants to BC in 2007



(Source: WelcomeBC, 2008)

# APPENDICES

## Appendix A



Map of the Vancouver Coastal Health Authority (in yellow).

(Source: VCH, 2009).

## Appendix B

Suggested questions to use when applying GBA (adapted from the Government of New Brunswick's *Gender-Based Analysis Guides* (n.d.) and the Status of Women Canada's *An Integrated Approach to Gender-Based Analysis* (2004)):

- 1) Is it possible to analyse the impact of the program or policy on men and women separately?
- 2) Does the policy or program improve the well-being of women/men?
- 3) Does the data or information indicate that women might encounter barriers to participating in the program?
- 4) Do the differences in life, social, economic, and familial experiences of men and women affect their outcome of the policy or program?
- 5) What resources does a person need to benefit from this program or policy? Do men and women have equal access to these necessary resources?
- 6) Does the policy or program benefit men more than women (or vice versa)? If so, why?

## **Appendix C**

Suggested questions to use when applying intersectionality (adapted from *Intersectionality: Moving Women's Health Research and Policy Forward* (Hankivsky and Cormier, 2009)):

- 1) Is the research question framed within the current cultural, social, societal, or situational context?
- 2) Does the literature address issues of diversity between groups of men and women?
- 3) What issues of exploitation or domination does the research address?
- 4) Is the issue of power at the centre of all analyses?
- 5) Are the research findings communicated in a way that is consistent with an intersectionality approach?

## Appendix D

The following assessment of the databases was taken from the VCH report *Immigrant Health in Vancouver Coastal Health: An Overview of Key Priority Areas* (Woermke, 2008, p. 56-58):

### Assessment of the Databases

Overall there was a significant lack of data available with specific information on immigrants in VCH. While some provincial information was available, specific information on the health status and health service utilization of immigrants in VCH was severely lacking. The four available data resources regarding immigrant-related issues were the Canadian Community Health Survey (CCHS) from Statistics Canada, Canadian Census data from Statistics Canada, the Longitudinal Survey of Immigrants to Canada, and the National Population Health Survey (NPHS).

The CCHS is a cross-sectional survey that collects a wide range of information about the health status of Canadians, factors determining their health status and their use of health care services. Information is self-reported by the respondents. Starting in 2007, the CCHS began collecting information yearly from more than 65,000 individuals over the age of twelve across the country. Before 2007, information was collected for over 130,000 individuals every second year (Statistics Canada, 2008). Data for this report was taken from the Public Use Microdata File, which contains data collected for the CCHS Cycle 3.1 between January 2005 and December 2005. It was possible to examine the variables by Health Service Delivery Area and by either immigrant status or length of time in Canada since immigration (please consult the CCHS Cycle 3.1 Data Dictionary Public Use Microdata File for further details on the variable names and other details) (Statistics Canada, 2006). The self-reported health information that was collected for this report from the CCHS data was on mental health status, smoking behaviour, physical activity, total fruit and vegetable consumption, and food security.

The 2006 Canadian Census Data from Statistics Canada was used in this report to gather demographic information about immigrants within Vancouver Coastal Health communities and LHAs (dissemination areas – small geographic units composed of one or more adjacent dissemination blocks – were built up to cover LHAs (with some areas of overlap)). This information was particularly useful to be able to examine such variables as unemployment, income, knowledge of official languages, and language most spoken at home. The 2006 Census information was obtained from both BC Statistics reports and from the help of a Health Information Systems employee in the VCH Planning Department who had access to the actual 2006 Census data.

The Longitudinal Survey of Immigrants to Canada was a survey designed to provide information on how new immigrants adjust to life in Canada and to understand the factors that help or hinder this adjustment. Immigrants who participated in the three wave survey arrived in Canada between October 1, 2000 and September 30, 2001 and were aged fifteen or older at the time of their arrival (Statistics Canada, 2005). The first wave of the survey was released in September 2003, the second wave in Fall 2005 and the third and final wave in April 2007. While the survey provides good generalized information on immigrants in Canada and broad overall health information, the results are not broken down more than by province. British Columbia and Vancouver in particular were highlighted as popular settlement areas for immigrants participating in the LSIC and general trends in employment and gender differences were highlighted in the survey's results (Statistics Canada, 2003; Statistics Canada, 2005).

Statistics Canada's National Population Health Survey (NPHS) collected information from the same individuals over an eight-year period from 1994/95 to 2002/03. The study compared patterns of change in health care use, health-related behaviours, and overall health status among immigrants with those of the Canadian-born population (Ng et al., 2005a). While general findings from the NPHS are relevant to help understand the "Healthy Immigrant Effect" and to discuss potential lifestyle changes and social determinants of health, the findings did not provide any specific immigrant data at the HSDA level and therefore could only be used to discuss generalized patterns of immigrant health in Canada.

Other resources that were consulted to see whether relevant and appropriate information on immigrant health was available included the following:

#### *BC Vital Statistics*

- Unfortunately, BC Vital Statistics does not track immigrant mortality rates. While a birthplace is included on the Registration of Death, this information would not provide any indication as to when the individual immigrated to Canada. In addition, it would not be possible to produce mortality rates specific to certain immigrant communities as there would not be a population for the denominator. It was decided that collecting mortality data by the country of birth was insufficient for this report.

#### *The McCreary Adolescent Health Survey*

- This survey did not contain specific immigrant data and the McCreary Centre Society advised that while the survey includes a question about ethnic background, the data does not provide a clear or accurate picture of the relationship between ethnic background and health (Tonkin, 2005).

#### *The British Columbia Atlas of Wellness*

- The Atlas contains some information on recent immigrants and languages spoken in BC but the information is from the 2001 Census (Foster & Keller, 2007). Because we now have access to the data from the 2006 Census, the information from the Atlas of Wellness was no longer up-to-date.

#### *Canadian Cancer Surveillance Online*

- This resource provides the most current cancer statistics in Canada but does not have an immigrant status component. Correspondence with the BC Cancer Society confirmed that to date there is no information on the BC Cancer Registry website in regards to ethnicity and cancer.

Within Vancouver Coastal Health's own information systems, relevant fields of interest (country of birth, ethnicity, and immigrant flag) exist, but their reliability is poor. The most that would be possible at the moment would be an ecological analysis at the LHA level. In terms of healthcare utilization, a recent Provincial Health Services Authority and Vancouver Coastal Health pilot study examined the patterns of health care use by Richmond residents as recorded in Hospital Discharge Abstract Databases and the Medical Services Plan. The results found significant differences in the risk of hospitalization by neighbourhood. Risk of hospitalization was much lower in the ethno-cultural neighbourhoods and higher in economically well-off neighbourhoods, indicating an unbalanced use of hospitals (PHSA & VCH, 2008). This report does however provide some preliminary information regarding health services utilization within VCH.

As a result of the significant gaps existing in the current available databases, the ability to present a full immigrant health profile was not possible. Nonetheless, the information that could be pulled from the existing databases as well as the current literature on immigrant health allowed for an extensive overview of the health issues and social determinants influencing immigrant health within Vancouver Coastal Health.

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