

Final Report

# Engaging Marginalized Communities for Better Health Outcomes

Themes from conversations with immigrant women and youth  
in Kitchener, Waterloo, and Cambridge

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**Social Planning Council**  
of Cambridge and North Dumfries

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## Background and Methods

### Project goals and objectives

The Engaging Marginalized Communities Project (EMC Project) sponsored by the Social Planning Network of Ontario (SPNO)<sup>1</sup> and funded by the Ministry of Health Promotion and Sport (MHPS) worked through local social planning councils in four regions across the province: Halton, Waterloo, Sudbury and Peterborough.

The EMC Project aimed to develop and test a model for engaging the participation of members from high health risk populations at the Healthy Communities Partnerships planning tables in their respective communities for input into planning on service development, prevention strategies and policy development related to the health risk factors of the Healthy Communities Fund (HCF)<sup>2</sup>. This initiative was the first stage in the development of a community engagement strategy model that could be replicated in other communities throughout the province following the one and a half year project funded period.



Figure 1: Outreach and Engagement Strategy in Waterloo Region

The stated objectives of the EMC Project were:

- To work collaboratively with local Public Health Units (PHUs) and other local partners to plan and implement the Healthy Communities Ontario Policy Framework for Community Action in four communities across Ontario;
- To reach out, engage and support marginalized persons with high health risks to participate in the planning processes for development and implementation of the Framework for Community Action;
- To build the on-the-ground capacity for community members, local health practitioners and a broader set of partners (e.g. municipal parks & recreation, public education, non-profit community services, etc.) to engage and work effectively with members of marginalized communities in the planning and implementation of health promotion strategies to achieve better health outcomes; and
- To document the process of outreach and engagement of marginalized communities in the planning process as an action planning model for potential use in other communities across the province.

<sup>1</sup> For more information about the SPNO visit [www.spno.ca](http://www.spno.ca)

<sup>2</sup> The Ministry of Health Promotion and Sport developed this approach to advance the province's vision of Healthy Communities working together and Ontarians leading healthy and active lives. <http://www.mhp.gov.on.ca/en/healthy-communities/hcf/Framework-2011-2012.pdf>

The populations engaged in the EMC Project varied by region. As well, there was diversity in the methods and approaches used. Figure 1 on the preceding page diagrams the outreach and engagement strategy used in Waterloo Region. Table 1 on page 6 lists some important dates related to the project.

### **Target group**

In Waterloo Region, project staff researched and engaged local stakeholders in discussions for the identification of priority populations. A review of local health data and demographics along with stakeholder consultations identified newcomers, and specifically newcomer women, as a population that experiences significant health barriers.

### **Outreach strategy**

Focus groups were chosen as the primary methodology for this study since they have been used effectively in working with other marginalized and underserved populations, and they give attention to participatory processes and incorporate the oral traditions of many immigrant Canadians.<sup>3</sup> Interview questions were developed and pre-tested with members of an immigrant women's group in Cambridge. The goals of the pre-test were to determine the reactions of immigrant women to the questions, estimate the time needed to complete the interviews, and ascertain whether the sequence of questions solicited the desired information. Questions were revised and finalized on the basis of the pre-test results and focus group interviews began in September 2010.

### **Community consultations**

#### ***Recruitment***

Recruitment is one of the most significant challenges in conducting research with ethnic minority populations.<sup>4</sup> We found that linking with organizations that serve ethnic minority communities helped facilitate recruitment for this project. Community leaders were instrumental in making introductions and building trust. They also assisted with translation and interpretation in instances where English was not the language of choice of participants. A total of thirteen focus groups were conducted with between 4 and 12 participants per group. One focus group was arranged specifically for youth. Sessions were held in various locations in the cities of Kitchener, Waterloo, and Cambridge. The following questions were asked:

- What makes you feel healthy? What are the things that make you feel healthy and good about your life?
- What do you like best about the community where you live? What makes it a healthy community?
- What are the good things that are happening in your life, your family's life?
- What are the biggest challenges you are facing?
- What would you like to change about the community where you live? What is missing so that your community can be a healthy community?

For the benefit of the participants we elaborated on the concept of a 'healthy community' (equitable access to such basics as food, shelter, clean air & water, adequate resources, education, income, a safe physical environment, social supports, and so on).

In addition to focus group interviews, a couple of casual discussions were held with community leaders. We also had an opportunity to sit in on two workshop sessions dedicated specifically to immigrant women's health as 'outside observers' and listen to the ideas and experiences of participants. Our research concluded in January 2011 and in total we spoke with 135 different women and youth.

#### ***Participant demographics***

The women and youth who participated in our research ranged in age from high school students to senior citizens and hailed from a variety of countries located in Central America, South America, the Caribbean, Asia, Africa and the Middle East. They were both single and married; many were parents; and there was considerable diversity in

<sup>3</sup> Social Planning Council of Cambridge and North Dumfries. (April, 2010). *Engaging Marginalized Populations: A literature scan of national and international print publications and web articles*. Cambridge: Social Planning Council of Cambridge and North Dumfries, p.26.

<sup>4</sup>Ibid., p.20.

terms of educational background and income level. Different immigration categories including economic class and refugee class were represented. Time in Canada varied from 3 weeks to 20 years. Approximately 40% of the participants were recent immigrants (i.e. had arrived in Canada between 2005 and 2010).

### Recording and data analysis

Detailed interview notes and field notes were taken. Handwritten notes were typed into the computer. Microsoft Word was used to sort, arrange and rearrange the data. Quotes and ideas were grouped by theme and placed in the most appropriate of the six MHPS health promotion priority areas – healthy eating; tobacco use/exposure; mental health promotion; substance and alcohol misuse; injury prevention; and physical activity, sport and recreation.

**Table 1: Some Important Dates Related to the EMC Project in Waterloo Region**

May 2009	MHPS launches Healthy Communities.
November 2009	Together 4 Health community consultation held and presentation of the EMC Project in Waterloo Region.
June 2010	Pre-test of EMC focus group moderator guide.
July 2010	PHU hosts a series of Healthy Communities Partnership information meetings.
July 2010	EMC project update prepared and submitted to PHU.
September 2010	EMC focus groups begin.
November 2010	EMC project update presented to the Healthy Communities Interim Advisory Committee.
January 2011	EMC focus groups complete.
February 2011	PHU hosts workshops to inform the development of the Waterloo Region Community Picture.
March 2011	Draft report of EMC project results submitted to PHU.
March 2011	EMC project report-back in Cambridge. Project participants, neighbourhood organizations, agency reps and PHU staff in attendance.
March 2011	PHU hosts an event to give organizations a voice in identifying priorities that will inform the MHPS Healthy Communities Fund – Local Grant and Partnership Stream.
March 2011	EMC project report-backs in Kitchener and Waterloo. Project participants, neighbourhood organizations, and agency reps in attendance.

## Findings

### Health Promotion Priority: Healthy Eating

*“Food is one of the basic human needs and it is an important determinant of health and human dignity. People who experience food insecurity are unable to have an adequate diet in terms of its quality and quantity. Food insecure citizens are uncertain if they are able to acquire food in socially acceptable ways. Food insecurity is a barrier to adequate nutritional intake.”<sup>5</sup>*

#### a) Preserving a traditional diet

The immigrant women participating in our focus groups expressed great interest in preserving the food preparation customs and traditions from “back home”. There was consensus that eating homemade, traditional food was best for their health and the health of their families. A number of immigrant youth echoed the same sentiment, and stressed the importance of family influence in establishing healthy eating patterns:

- *“Your family and their habits help you out a lot. We have foods that my mum loves so we have it a lot. You’ll eat what you have, what you’re used to.”*
- *“Healthy eating relies on your parents, if you have healthy parents you’ll eat healthy. Your parents buy the food; you have to eat what is in your house.”*

There was general acknowledgement that the ingredients of ethnic dishes are getting easier to find. Certain food products that used to be in very limited supply are now available through an increasing number of ethnic specialty stores. Mainstream grocery stores too have undergone some changes and today offer a greater selection of spices and a wider selection of vegetables than they have in the past.

#### b) Health consequences related to diet and lifestyle

Recent immigrants, especially women and those of South Asian or African descent have been found to have a higher risk of diabetes compared with long-term residents of Ontario.<sup>6</sup> In one focus group session some predisposing factors were discussed. It was pointed out that traditional Somali diets are laden with fat, protein, and carbohydrates. The traditional Somali lifestyle, with its higher level of physical activity, allows for this type of diet with fewer consequences. However, after arriving in Canada people’s activity levels tend to decrease and health issues develop. Health concerns specific to this population include high cholesterol, high blood pressure, and diabetes.

Among the challenges for health care providers is the fact that people from immigrant communities don’t typically attend preventative programs. It was suggested that immigrants need to be made aware of these programs. They need to be given appropriate knowledge about different types of food and about healthy eating. Programs need to be targeted to specific communities.

#### c) Factors that can lead to (negative) dietary changes

Focus group participants identified a number of factors that can make achieving and maintaining a healthy diet difficult; foremost among them was living in a low income situation. In their efforts to provide for their families immigrant women access whatever resources they can, including food banks.

- *“Eating healthy is hard when you have a low income, you have to try to eat, eat the food you can, adapt food in whatever way you can.”*

<sup>5</sup> Mikkonen, J., & Raphael, D. (2010). *Social Determinants of Health: The Canadian Facts*. Toronto: York University School of Health Policy and Management. p.26.

<sup>6</sup> Creatore, M., Moineddin, R., Booth, G., Manuel, D., DesMeules, M., McDermott, S., and Glazier, R. (2010). Age- and sex-related immigrants to Ontario, Canada. *Can. Med. Assoc. J.* online <http://www.cmaj.ca/cgi/content/abstract/cmaj.091551v1>

- ***“With Ontario Works you don’t get much. With 3 or 4 kids, sometimes you run out so you have to go to the food bank. You go there, you don’t like the food. It’s stress.”***

The children of immigrant families are drawn to the fast foods, pop, and high-fat snacks that are so popular and readily available in Canada. Despite their parents’ best efforts, the temptation is hard to resist. One high school aged girl admitted, *“It’s difficult to eat healthy because healthy food doesn’t taste as good as junk food. I just try to eat a little bit, to get the taste on my tongue.”*

Immigrant children experience a great deal of pressure from their peers to change their eating habits. One mother whose son brought Indian food to school for lunch noted, *“Kids were making fun of him so he wasn’t eating.”* Others were in agreement. *“I’m sending a lunch bag and everybody said ‘eeewww’”* reported another mother, *“but I sent a salad! They are saying it’s yucky because they eat junk food.”*

The inability to find traditional cooking ingredients is yet another factor that can lead to dietary change. While it is becoming increasingly easier to obtain various ingredients, there are still some items that remain in short supply. One example given was the making of injera (an East African bread staple), where sometimes less nutritious all-purpose flour is substituted for the harder to find traditional millet flour.

Some food-related benefits to living in a multicultural society were also noted. One mother pointed out, *“They’re learning about other cultures now, kids are more open; they know what’s each other. My son said ‘we don’t eat the pepperoni, you know who else doesn’t? Josh, he’s Jewish,’ so now he knows he’s not alone, the other people have their belief. Now he’s starting to understand the other stuff, it’s making stuff more easy.”* As well, diverse culinary influences are sometimes incorporated into traditional recipes. As one immigrant from China shared, *“We like to try to cook the Canadian vegetables in the Chinese way, it’s really delicious.”*

#### **d) Food and language literacy and implications for healthy eating**

Language literacy was brought up as an issue when shopping for food. Without the basics of reading, food shopping can become very confusing. As one focus group participant observed, *“[Some immigrants] can’t read the label, so they don’t know what’s inside the can. They have to shake it to tell if it’s a fruit or a vegetable.”*

The names for food items are often unknown or misunderstood. This too can make choosing appropriate foods a challenge. One Muslim woman recounted the following incident: *“We didn’t know - the word ‘pepperoni’ sounds like the word in our language for green pepper, and we accidentally ordered pizza with pepperoni and couldn’t eat it.”*

What’s missing, especially for the most recent arrivals, is the skill set needed for shopping at a mainstream grocery store. It was suggested that providing information on topics such as food identification, nutrition, food storage, and food preparation would help people make more informed food choices. To some extent this is happening already in the community. As one woman recounted, *“At the rehabilitation training centre, they used to take us shopping and they told us everything in English, which helped me a lot.”* It was agreed that these types of programs should be made more widely available.

## Health Promotion Priority: Physical Activity, Sport, and Recreation

### a) Interest and attitudes towards physical activity

Focus group participants held many positive beliefs about the benefits of exercise and physical activity. They listed a number of non-competitive or recreational activities such as walking, bicycling, swimming, yoga and pilates in which they regularly took part. Although competitive sports were mentioned far less frequently, volleyball and badminton seemed to be the sports of choice among the women. The most commonly reported positive effects of exercise and physical activity were: increased feelings of health, more energy with which to carry out daily tasks, and relief from stress. Several women saw informal play activities as a valuable form of exercise as well as a way of connecting with their children.

- *“Going to the ‘Y’ makes me feel healthy.”*
- *“I exercise to deal with arthritis, to feel better [and have]no pain.”*
- *“I go for a walk when I’m stressed, go to the mall and look around, eye shopping.”*
- *“Seeing my kids going outside and playing with them makes me feel healthy.”*
- *“Healthy is having the energy to run after 5 kids.”*
- *“To make myself busy makes me happy and healthy. If I sit without doing anything I feel homesick or nervous, so I have to do something: cleaning the house, cooking different recipes, trying them on my husband.”*

Many of the women we spoke with held deep family values and mentioned doing activities with their families whenever possible. Often these get-togethers marked religious occasions. As one participant explained, *“Socialization, lots of family gatherings, is probably the most common. We do our own, like Eid: we do one dish parties, no alcohol. Food plays a big role, and kids running around.”*

Several high school aged girls indicated that while they enjoy going for walks and riding their bikes, they were not sports-minded. They noted that although opportunities to take part in sports existed through school, their own interests and those of their friends lay more towards academics:

- *“Fewer girls want to play sports. They aren’t interested, it’s not a conspiracy.”*
- *“My friends are more on the academic side, in DECA [an association of marketing students]. They have initiative in other things instead of sports. We aren’t on a specific team.”*

Walking was mentioned not only as a recreational pursuit, but was also regarded as a form of travel - to the workplace, to school and for shopping. Reasons for walking included cost-savings, convenience, and enjoyment.

### b) Barriers to participation

It was suggested that participation in recreational activities and sport may be influenced by length of time in Canada. The need to attend to immediate needs makes it harder for newly arrived immigrants to pursue leisure activities:

- *“You need to get your basic needs met first – housing, food, familiarize with transportation system and attending to emotional need and tending to problems still present in your life.”*
- *“I’ve recently joined a badminton team - it took 10 years in Canada.”*

Often people reported facing multiple barriers. Distance to recreational facilities, the cost and inconvenience of public transportation, as well as childcare costs make it hard for some immigrant women and youth to integrate physical activity into their daily routines.

- *“Going to the ‘Y’ is great however getting there is difficult because of the cost of transportation and child care.”*

- *“Sometimes I need someone to drive me somewhere, but I can’t get a drive, so I can’t play soccer.”*

One woman reported that transportation barriers had impacted her ability to follow a regimen of medically prescribed exercise: *“I’ve been sent to exercise at special places because of health problems, but I stopped going because of the difficult transportation to get there.”*

The cost of formal programs is also a barrier. Participants noted the availability of recreational subsidies is limited. The typically larger size of immigrant families makes any kind of outing or activity expensive. As one participant lamented: *“We [immigrants] have larger families; anything we go to is \$100 to \$150 minimum for everyone.”*

With limited disposable income, families must make decisions among competing priorities. One mother gave the following example: *“I go to [a woman’s fitness club] and pay 50 dollars a month. The school system is ok, but only for good students; if your son is in the middle, you need to support him...he needs tutoring. I’m thinking of quitting the membership and pay \$400 a month for the learning centre.”* In situations where only one family member is working, participating in formal and organized activities just gets harder.

Some participants felt that North American society is “too organized”, that everything is controlled and there is a lack of opportunity for people to pursue informal recreational and leisuretime activities. As one mother lamented, *“There are groups doing everything, you have to pay entry to be part of that group. You have laws against street hockey now; you need to pay money to get into physical activities.”*

### **c) Cultural and religious considerations**

Despite their interest, immigrant women cannot always participate in physical activities to the extent they might like. This is because many recreational facilities do not accommodate cultural differences. As one woman commented, *“Physical activity...we don’t have much in our community for Muslim women. You need to have women-only activities; we have some restrictions for physical activity.”* One way that religious and cultural groups have dealt with this up to now has been to rent public facilities. It was pointed out, however, that *“renting a pool is expensive.”*

Participants emphasized that as the community becomes increasingly diverse, cultural sensitivity in the delivery of programs and services will become increasingly important. At the core of the issue is inclusion and full participation in society. One woman summed it up this way, *“We want to be just normal human beings with others.”*

## Health Promotion Priority: Tobacco and Substance Use

### a) Tobacco use and exposure

We heard anecdotal evidence to suggest that the rate and type of tobacco use varies by immigrant community. We were told that in the Somali community, for example, significantly more men than women are smokers. Smoking habits can negatively impact families as, in some cases, scarce resources are spent on tobacco rather than on food or other essentials.

We heard that smoking is a very common practice in the Middle Eastern Arab community and that waterpipes are popular with people of all ages. Waterpipe smoking takes place in restaurants and gathering places throughout the Middle East and is practiced here in Canada as well. Although there is evidence that waterpipe smoking can pose the same health risks as cigarette use<sup>7</sup>, waterpipes are not banned from public places in Waterloo Region.

Smoking in the Sudanese community has traditionally been more prevalent among males than females. However, there was some suggestion that young people - girls in particular- are being influenced by the North American culture. One woman shared her reaction upon seeing a young Sudanese girl smoking: *"I was so shocked, and she just threw it away. I've never seen a girl in our community smoking [before]."*

Just as smoking rates and the cultural norms of ethnic communities vary, tobacco cessation programs need to be tailored to the needs of different communities. It was felt that programs would be more effective if they were culturally appropriate for the populations they served. As one participant noted, *"Almost 80% of ladies in my [Middle Eastern Arabic] community are smokers. It's hard to have long sessions with a male educator."*

It was noted that although the need exists, currently there are no special programs available to refugees to help them stop smoking when they arrive in Waterloo Region.

Adolescence is a very difficult time for people in any culture. A motivator for smoking among immigrant youth is the desire to 'fit in' with friends. One girl gave the following illustration: *"I had a friend who thought it would make her accepted or cool or whatever. She knew this guy who would go out to take a smoke every day... she thought she had to do that to experience a part of life, or be cool, or whatever."* Another student agreed, *"Yeah that happens a lot at school, at dancing or school events. That's what people do to get accepted. It happens at parties and stuff, it's all people think about most of the time."* Parents and children alike felt that strong family support during adolescence was a protective factor: *"You have to have good support from your family, constantly giving good advice."*

### b) Substance and alcohol misuse

We were told that alcohol abuse exists in immigrant communities and that the use of alcohol, at least in some instances, is a way of coping with the stresses of adapting to the Canadian culture. Overall, however, very little was shared with us about substance and alcohol misuse. Given that addiction information is considered private by many cultures, we feel that this lack of response is not so much a reflection of the true situation in Waterloo region as it is a reflection of our methodology.

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<sup>7</sup> WHO Study Group on Tobacco Product Regulation. (2005). *Waterpipe Tobacco Smoking: Health Effects, Research Needs and Recommended Actions by Regulators*. Geneva: World Health Organization.

## Health Promotion Priority: Mental Health Promotion

Participants reported a number of stresses associated with immigration and resettlement which can be framed around the social determinants of health. The social determinants of health have long been studied in relation to health inequalities.

### a) Income

*"Income is perhaps the most important social determinant of health. Level of income shapes overall living conditions, affects psychological functioning, and influences health-related behaviours such as quality of diet, extent of physical activity, tobacco use, and excessive alcohol use."*<sup>8</sup>

In Waterloo Region, recent immigrants tend to be over-represented in lower income categories. On average, the incomes reported by recent immigrants are much lower than the population as a whole. In 2005, 25% of recent immigrants were living in low-income situations. This was over 3 times as large a share as for the rest of the population. Approximately 1 in 4 recent immigrant children under 6 years of age live in low-income families.

Focus group participants represented a range of income levels - there were families struggling in low income situations and there were also highly skilled professionals who came to this country with significant savings. Canada didn't turn out to be "the land of milk and honey" for either group. Many focus group participants reported feeling disillusioned and disappointed.

- *"I work very hard to not be on welfare but God doesn't help me."*
- *"You think Canada's the best place but when you get in it's different."*
- *"They make sure you bring money for 6 months of life here; no one tells you your experience means nothing here."*
- *"Canada gets lots of money from immigrants, they give a false image of the country. When you get here you see there's no money to buy the house, no rent even, it's a big issue. They don't see it now but after 40 years they'll have to support us"*

### b) Social networks

*"In Canada, Aboriginal Canadians, Canadians of colour, recent immigrants, women, and people with disabilities are especially likely to experience social exclusion. Many aspects of Canadian society marginalize people and limit their access to social, cultural, and economic resources."*<sup>9</sup>

#### Separation from extended family

Families can and do provide support that makes their members stronger and more resilient against the stresses of life. Focus group participants reported that separation from family members presented one of their greatest hardships. For many this separation was a voluntary decision; however, for others (as in the case of refugees) the separation was both traumatic and unplanned.

- *"I don't have family here. I don't know anyone, don't have babysitters. When you have worries you aren't healthy."*
- *"A lot of things I want in the different society we're in, it's our family that we left; we're alone here, that makes us sick."*
- *"I'm alone with my children all day. I have no opportunity to work because of language barriers...I cannot integrate into society...I'm alone."*
- *"There are struggles with every new situation, changes come with challenges. The houses here are haunted through the day; they're empty through the day. I'm not used to it. I'm used to a house with lots of extended family at home; you gain this but you're still missing that. You're always going to be missing something. I miss that sense of family, closeness."*

<sup>8</sup> Mikkonen & Raphael, op. cit., p.12.

<sup>9</sup> Ibid., p.32.

Canada's immigration policies only exacerbate the situation. It is not unusual for refugee women not to be able to find work because they are unable to speak the language of their new country. And because they can't work they can't meet the financial requirements to unite their families; they can't sponsor them to come to Canada.

### **Familial/generational tensions**

Immigration may be accompanied by familial or generational tensions brought on by the many changes which can include role reversals, financial pressures, and trying to socialize children to their ethnic culture while at the same time trying to learn to live and work in a new culture.

- *"Canada is a very busy place to live where there is not enough time for family, and the parents and the children are too busy for the parents to have a chance to model for the children."*
- *"Six hours of the day she's at school and I'm not there, she has another expectation for her. It's like they have double personalities, at home versus at school."*
- *"Raising a child is difficult here. It's hard on parents and on children too."*
- *"Money is very important, but not only money; families are separating."*

It was noted that immigrants' needs go beyond the purely physical and that psychosocial needs are just as important. As one participant observed, *"food is not enough if there is no social world."* This is in agreement with the larger body of research that has demonstrated the importance of friends and social supports in women's mental health.<sup>10</sup>

An inclusive relationship with other immigrants, especially immigrants from the same country of origin, was important to focus group participants. Some women mentioned suffering from depression upon first arriving in Canada. They described feelings of hopelessness and suicidal thoughts. Joining a social group and meeting other women played a big role in alleviating their depression. As one woman noted *"It is important as sisters to share each other's stories"*. Formal programs, like those offered through the YMCA or the neighbourhood organizations are highly valued since they have both a social as well as an educational component and participants have input into what is discussed.

Many women confirmed that religion is important in their lives and helps them cope with life situations. As one woman explained, *"It helps me a lot having full contact with my church; religious things help me a lot for my life these days. The connection with my God - praying a lot, reading the Bible, singing songs, listening to spiritual songs makes me comfortable. I feel like I have a response from my God, I get comfort from my God, maybe my belief helps me."*

### **c) Education and literacy**

*"Education is an important determinant of health. People with higher education tend to be healthier than those with lower educational attainment."*<sup>11</sup>

While the above quote may hold true for the population as a whole, education does not seem to have the same protective role for new Canadians. More so than in the past, today's immigrants are arriving with strong academic and professional credentials. In 2006, 48% of the Region of Waterloo's recent immigrant population reported having undergraduate or graduate level university degrees. This compares with only 21% of the population as a whole. Despite this, many immigrants struggle to get established and often work at menial, low-paying jobs.

Foreign trained professionals in our focus groups felt that the process for getting their credentials validated was their greatest barrier to employment. The lengthy time commitment and financial investment required were among their frustrations.

<sup>10</sup> Kendler, K., Myers, J., Prescott, C. (February 2005). Sex Differences in the Relationship between Social Support and Risk for Major Depression: A Longitudinal Study of Opposite-Sex Twin Pairs. (Am J Psychiatry 2005; 162:250-256). <http://ajp.psychiatryonline.org/cgi/reprint/162/2/250>

<sup>11</sup> Mikkonen & Raphael, op cit., p.15.

- *“I want to share my experience. They’re making money from us; look at TOEFL [Test of English as a Foreign Language]. You study, to get a high mark, and then the program takes three years. 6000 dentists try to get in program every year; it costs more than \$10,000 through three years. If you did well in, you pay \$2500 application fee, \$2500 to enrol in one week course. You go to the interview, they accept 50 people from interview, accept 15 people [to the program]. They do all this, you can’t support your family; you aren’t here just to have food and shelter”*
- *“Before we came here, they advertised we need professionals, dentists, doctors. I’m a doctor, my husband is a pharmacist. To do the exams, they cost a lot, we can’t find jobs. It’s a bad system, one exam per year; nowadays he’s back in the home country and sending money for us to live in Canada”*

Volunteering was another topic that was raised. Immigrants are often encouraged to volunteer, and while a number of benefits can be derived - it can be a way to spend time, contribute to the community, and also get one’s foot ‘in the door’ - in some cases volunteering was understood to be a requirement for future employment. Several focus group participants felt that current policies around unpaid work need to be changed.

- *“Six months in London I worked at a research lab. He promised to pay after 3 months; after 4 months I asked him to pay just the gas, he said no. I said if you don’t want me to be here, he said I do...taking advantage of people. Making them work one year volunteer to get into school”*
- *“There is an expectation to volunteer so you can get Canadian work, volunteer so you can get a job, so it’s like, forced upon you”*
- *“We’re working for free and making a difference. Volunteering must be looked at again.”*

There was considerable frustration among the women and a feeling that despite their best efforts obtaining employment was by no means assured.

- *“Even job interviews, if your résumé is perfect - when they see your accent, it’s really, yeah”*
- *“Muslim women don’t work as engineers. Lots of them can’t work here. People think a woman, covered, combine all these things together. It doesn’t fit in their view. Plus she’s married and has kids. I have yet to see one woman engineer who’s covered and works here”*
- *“It’s interesting that the women coming from countries thought to be not good with women’s education, not being able to work here because of gender”*

The inability to speak English was identified as the single greatest barrier to successful integration. It was noted that while the principal applicant for Canadian immigration must demonstrate proficiency in an official language, he or she usually brings 4 to 6 other people who probably have less language proficiency. Refugees are less likely to know English or French than other immigrant classes.<sup>12</sup> Some focus group participants felt that the adult ESL curriculum should be modified and adapted to better meet the needs and limitations of a very diverse group of students.

- *“English instruction is very fragmented. Refugees and Canadian citizens can’t attend each other’s programs.”*
- *“I’ve been going to school three times a week since 2002 and I’m still level 2”.*
- *“For me, I need to get someone to teach me English one on one, I go to school, but...”*

Men are typically the priority for ESL because they can’t get work, and children learn the language in school. Typically, mothers end up isolated at home. It was felt that programs delivered through community centres and neighbourhood organizations were an effective way of reaching immigrant women who might otherwise have challenges around transportation and childcare.

<sup>12</sup> DeVoretz, D., Pivenko, S., & Beiser, M. (March 2004). The Economic Experiences of Refugees in Canada. Bonn: Institute for the Study of Labor. p. 11.

#### d) Employment and working conditions

*“Working conditions are an important social determinant of health because of the great amount of time we spend in our workplace. People who are already most vulnerable to poor health outcomes due to their lower income and education are also the ones most likely to experience adverse working conditions.”<sup>13</sup>*

There was a great deal of frustration among focus group participants regarding employment and the lack of job opportunities. They felt the Canadian immigration points system gives people the false impression that it will be easy to find work. Instead, many arrive to find that their skills and qualifications aren't recognized.

- ***“Not being able to find work you want, your degrees not being recognised, is the biggest lesson in a new immigrant's life. I always heard about how hard this one single factor is, how important it is in feeling like you belong, feeling happy and healthy”***

When jobs are obtained they are typically not in people's field of choice and are often low-paying with difficult working conditions. Jobs, as one participant described, that *“break your body.”* Hardships include working long hours, driving great distances to get to work, and not being paid when absent from work even if the absence is due to a short term illness.

- ***“My husband is a civil engineer and is driving a taxi”***
- ***“We can't get a job right away; we are educated in India, and here you can't get a job, and there is a depression. My husband is waiting 6 months; he's working in labour now, he was an engineer in India”***

Several women expressed an interest in starting home-based businesses. They wanted to explore their talent in arts and crafts, for example painting, quilting or beading. They wanted to use their skills to open a booth in the mall or at a fair and sell their crafts to make some money for their families. The challenge for these women was in knowing where to get supplies, as well as the high cost of these supplies.

Many felt that Canada's immigration policies ought to be changed, or at least that there should be greater clarity:

- ***“They should tell us the truth. If they don't have the jobs for engineers and doctors, why should we come [to Canada] to work at Tim Horton's or factory or taxi?”***

Others felt that steps should be taken to make it more efficient and faster for immigrant professionals to establish their careers in Canada:

- ***“With money but no stable income, your money will go. You come here with 20 years savings, but Canada will eat your money...maybe they have to change the immigration system; they know all about us, our degrees, etc, they should open opportunities for people to stay, not come and run away.”***

#### e) Social and physical environments

##### **Stereotypes, prejudice, bullying and differential treatment**

There are stereotypes about immigrants in general, and about certain groups in particular that need to be dispelled. One common stereotype is that immigrants are a burden to society and are receiving unwarranted advantages. Focus group participants were quick to point out that rather than being a burden on society, today's immigrants are arriving with valuable skill sets and assets in hand.

- ***“I was thinking, people talk about immigrants: they came here, they were lucky, they should be happy for what they get here. No one knows what kinds of immigrants come here today; they pay to come***

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<sup>13</sup>Mikkonen & Raphael, op. cit., p.20.

*here, they pay taxes, and a lot of times I hear these comments about 'oh, we're paying from our taxes to have these immigrants here,' they don't know what they're talking about. If they only knew what one family brought here and then spent that money here."*

- *"I didn't come for charity."*

Society tends to associate certain characteristics with certain ethnic groups. Girls and women with head scarves are seen as Muslims regardless of their actual faith or nationality, and Muslims are the object of stereotypes and fears that have no basis in reality.

- *"How the media portrays Muslim people and Islamic society - you think after a while that it's going over, but then something else comes up. The culture as a whole is portrayed as corrupt or something, but really it's only one or two people. Just because you tell people you're Muslim or from Pakistan, they think you're a terrorist"*
- *"I get along with most people. But other people get bullied; get called names because of how they dress or where they're from. They can't speak the language. It affects everyone, I see it a lot; even walking down the street, you'll just feel it, the way people look at you and how they judge you"*

People don't realize how hurtful prejudice can be; everyone needs to be treated with respect. Focus group participants felt that intercultural dialogues would be helpful in sharing cultural heritage, traditions and viewpoints and increasing understanding. There should be more opportunities to learn from each other.

- *"I would change people stereotyping each other. They have a general idea of a group of people and judge them. They should know about a group instead of judging. My school had a huge ESL group but they didn't mingle with the rest of the school, so we started a group to join with the rest of the population, have a cultural mix."*
- *"I like what she said about how at our school, people sit together with their own group; I want more like, get to know each other and get more integrated."*

Today's immigrants are coming largely from non-Christian countries. It was noted that some employers have been reluctant to honour differing religious beliefs and practices. It was suggested that this could easily be accommodated by allowing flexible work schedules or voluntary shift changes arranged among employees.

#### **f) Housing and transportation**

Many focus group participants were renters, and a number were renters with low incomes. The generally accepted definition of 'affordable' is for households to pay no more than 30 percent of their income on housing. Families that pay more can be considered cost burdened and may have difficulty affording other things like food, clothing, and transportation. Even with subsidies, today's housing costs present a challenge for some local immigrant families. As one Cambridge resident lamented, *"They say this is a low income complex but my husband is earning \$10 per hour and the cost of our unit is \$650 per month."*

Rent is affected by location. While everyone wants to live in a safe neighbourhood, not all focus group participants felt they were safe. One woman described the stress of living and raising a family in what she perceived to be an unsafe neighbourhood:

- *"We have a complex in the neighbourhood. Everyone is very good people, we all communicate together, but others come from outside to our place, they make the place worse. My kids, sometimes I don't let them go outside to play. Some boys that come from outside, drinking in the parking lot, don't live there. My boy is ten and I'm so scared."*

Focus group participants spoke about the time lags and inconvenience associated with public transit. Public transit was relied on for many things - to attend school, receive medical care, access affordable goods and services, and participate in community events. Some women reported a need to take up to 3 buses in order to reach a desired

destination. Transportation-related challenges limited the ability of some to participate fully in the community. As one woman lamented, *“Buses aren’t frequent enough, you need to switch buses at least once to get anywhere, it takes forever, isn’t very efficient to get around. If the system was better we would want to use it.”*

### **g) Health services**

*“High quality health care services are a social determinant of health as well as a basic human right. The main purpose of a universal health care system is to protect the health of citizens and spread health costs across the whole society. A universal health care system is especially effective in protecting citizens with lower incomes who cannot afford private health care insurance.”<sup>14</sup>*

Focus group participants reported they found the health care system difficult to navigate, frustrating and confusing, and in some cases staffed by providers with insufficient knowledge or a lack of willingness to help. Low income families have limited access to health services that are not covered by provincial insurance, such as dentistry.

There is a lack of ethnic-specific health data and preventative programming. Focus group participants noted the need for more clinics and education geared towards certain at-risk groups, such as people of South Asian origin who carry a high risk of diabetes and cardiovascular disease.

English proficiency is a barrier for some people. There is a need for interpretation and bilingual services in health care as well as in other areas. Certain languages are in high demand in Waterloo Region but are not reflected in services. One woman noted:

- ***“There should be somebody who speaks your language. At the beginning it was ok, this was what’s available, 8-10 workers speaking other languages, and none of them were mine. But later on I found the statistics, there are certain languages in demand and that’s not apparent in service.”***

The use of plain language is important. Medical language is extremely hard to understand and many immigrants cannot understand the outcome when they have to visit a walk-in clinic or hospital. Making the language used to explain injuries and illnesses clearer and plainer, and making the directions for taking prescription easier to comprehend would be very helpful.

In addition to the use of plain language, participants noted that written material is not available in enough languages. For example, Canada’s Food Guide is printed in a number of different languages but Turkish isn’t one of them even though Turkish is among the recommended top languages for interpretation and translation in Waterloo Region<sup>15</sup>. In order to reach the greatest number of people, *“Canada should translate into many [more] languages.”*

There is a need for greater representation of culturally diverse communities among health care professionals. This will lead to greater cultural understanding and more effective programming. The following example was given:

- ***“If you’re doing a mental health program [for instance] the people doing the survey should be from this community they’re targeting. Keywords are very essential in mental health. ‘I want to kill myself’ here means call 911. In our community the response is ‘ok, go do that and then go home.’ It’s all cultural differences. People from that community should put their input into the survey and reading it. These are the major issues... I can see different situations: wrong assessments, premade evaluations, token involvement, and if you took a little consideration into it a lot of problems would be improved”***

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<sup>14</sup> Ibid., p.38.

<sup>15</sup> Martell, E. (2008). *Recommended Top Languages for Interpretation and Translation in Waterloo Region*. Waterloo: Region of Waterloo Public Health.

There is a need for health care providers to understand cultural norms about modesty. Although some women request same gender health care providers, their requests are not always accommodated. In order to provide optimal care for them, health care providers need to have a better understanding of the beliefs and preferences of their patients.

Health care providers need to avoid stereotypes and generalizations. As one participant put it:

- ***“The way you understand or analyse the situation is different than my way. I think that’s one of the most important parts we’re missing here. I think we need more research targeting immigrants, not just as immigrants - ethnic groups or different backgrounds too because not everyone speaking Spanish has the same background and difficulties. Not everybody Muslim is the same. When they take this thing seriously, we will see different results.”***

The way that people describe illnesses and interact with medical helpers varies by ethnicity and culture. As one woman explained:

- ***“In our country the Doctor asks, ‘are you okay?’ The patient will respond, ‘yes I am blessed in health.’ The doctor will repeat this often several times before the issue is discussed. This [North American] culture does not allow for that kind of interaction or understanding.”***

Refugees have health needs that are different from other classes of immigrants. Not only do they encounter many of the same stresses once in Canada, but often they have experienced war and persecution in their home countries. Refugees can arrive with serious mental health disorders like post-traumatic stress disorder and don’t have access to the same supports that landed immigrants have access to. Psychological assessment, trauma support, and social support are needed for this population.

Their past has a huge impact on refugee children. Born and raised in refugee camps, they are expected to go to Canadian schools and ‘fit in’. The lived experience and challenges that these children experience must be acknowledged. More needs to be done to assist the process of adjustment for these children.

## **h) Gender**

*“Women in Canada experience more adverse social determinants of health than men. The main reason for this is that women carry more responsibilities for raising children and taking care of housework. Women are also less likely to be working full-time and are less likely to be eligible for unemployment benefits. In addition, women are employed in lower paying occupations and experience more discrimination in the workplace than men.”<sup>16</sup>*

The cost and availability of child care was a concern for many immigrant mothers. Some neighbourhoods, like the Hespeler area of Cambridge, don’t have any schools offering full-day kindergarten so these women have few opportunities to ‘get a break’ and interact with other adults. The half-day every day kindergarten schedule that is offered also makes it hard for women with young children to have employment.

Immigrant women who are in the workforce face many stresses. In addition to their professional commitments, often they continue to have primary responsibility for home and family. As one woman noted, *“Our men, they’re totally dependent on woman for house. They depend on wife for cleaning, cooking. If a Muslim woman goes out of the house, she has much more work to do than a white woman.”*

In instances where immigrant women find themselves alone due to divorce or the death of a spouse they have many challenges. The multiple demands on their time and resources (shift work, caring for children, etc.) don’t leave much time to learn English, and consequently these women face difficulties improving their opportunities.

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<sup>16</sup>Mikkonen & Raphael, op. cit., p.44.

## Recommendations

Project findings were presented at four report-back events held in February and March of 2011. The purpose of these sessions was to verify the findings of the focus group research and begin discussions on priority outcomes and key areas for possible future action. The recommendations that follow were generated from a combination of the focus group research as well as these facilitated discussions.

### Healthy Eating

- Make information on healthy eating available in multiple languages.
- Provide newcomers with information on where to obtain certain foods.
- Make specialty foods (such as halal foods) more widely available and at better prices.
- Provide information that focuses specifically on nutrition label reading.
- Increase access to fresh produce at reasonable cost.

### Physical Activity, Sports and Recreation

- Improve opportunities for exercise-oriented activities such as bicycling and walking.
- Design public spaces for increasing physical activity.
- Provide women-only hours at gyms and swimming pools.
- Increase the affordability of sport and recreational activities.
- Encourage demographic diversity on sports teams.
- Provide newcomers with detailed information on recreational activities.

### Tobacco Reduction

- Tailor tobacco-related health messages and modify program delivery for different ethnic communities.
- Make tobacco cessation services more easily available to all classes of immigrants and refugees.
- Ban waterpipe smoking in public places.

### Health Services

- Provide interpretation and bilingual services in hospitals and pharmacies.
- Make written material available in multiple languages.
- Increase the cultural competence of health providers and practitioners.
- Target outreach and modify programs such as diabetes prevention programs to specific cultural or ethnic groups.

### Social Networks and Social Inclusion

- Provide social and emotional support to immigrant and refugee women transitioning to a new culture.
- Create opportunities for open and respectful exchange or interaction between individuals and groups with different cultural backgrounds or world views.

### Education and Literacy

- Modify and adapt the adult ESL curriculum to better meet the needs and limitations of a very diverse group of students.

### Income and Employment

- Provide faster recognition of the credentials of internationally trained professionals.
- Follow the lead of the Toronto Foundation for Student Success (TFSS) and offer jobs to international medical graduates that will provide sought-after Canadian medical experience and a decent wage.

### Housing

- Increase access to adequate, suitable, and affordable housing for immigrant households.

**APPENDIX 1: Recent Immigrants in Kitchener CMA – A Demographic Overview**

	Recent Immigrants	Total Population
<b>Population</b>		
<b>Total population</b>	16,890	452,235
<b>0-4</b>	4.9%	6.1%
<b>5-14</b>	17.4%	13.0%
<b>15-24</b>	15.5%	14.6%
<b>25-44</b>	46.2%	30.1%
<b>45-64</b>	12.6%	24.6%
<b>65+</b>	3.4%	11.6%
<b>Family</b>		
<b>Population 15+</b>	13,105	364,995
<b>Legally married</b>	67.3%	52.0%
<b>Separated</b>	3.0%	3.5%
<b>Single</b>	24.7%	32.2%
<b>Divorced</b>	2.4%	6.8%
<b>Widowed</b>	2.6%	5.4%
<b>Language</b>		
<b>Knowledge of English only</b>	86.5%	91.7%
<b>Knowledge of French only</b>	<1%	<1%
<b>Knowledge of English &amp; French</b>	4.5%	6.8%
<b>Knowledge neither English nor French</b>	8.8%	1.5%
<b>Education</b>		
<b>Population 25-64</b>	9,930	246,985
<b>Population 25-64 with post secondary qualifications</b>	74.0%	61.0%
<b>Labour Force</b>		
<b>Population 15+ in labour force</b>	8,810	360,335
<b>Employment rate</b>	60.0%	67.5%
<b>Unemployment rate</b>	11.0%	5.6%
<b>Income</b>		
<b>Media income – persons 15 years+ (before tax)</b>	\$15,804	\$29,366
<b>Median income – persons 15 years+ (after tax)</b>	\$15,342	\$26,126
<b>Persons in private households</b>	16,785	444,050
<b>% in low income before tax</b>	30.0%	10.5%
<b>% in low income after tax</b>	25.0%	7.8%

Source: Statistics Canada, 2006 Census

Note: The Kitchener Census Metropolitan Area (CMA) includes the cities of Waterloo, Kitchener, Cambridge, and the townships of Woolwich and North Dumfries.

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