

Guest Editorial and Discourse

Health and Immigration

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In 2010 there were an estimated 214 million migrants worldwide (United Nations Department of Economic and Social Affairs, 2009). Migrants are persons moving to a geographical unit with the intention of settling indefinitely or temporarily in a place other than their place of origin (International Organization for Migration, 2011). Through World Health Assembly Resolution 61.17, *Health of Migrants*, the international community identifies migrant health as a priority and a human right and calls for member states of the World Health Organization (including Canada) to promote migrant-sensitive health policies and programs (World Health Organization [WHO], 2008). Nurse researchers have a key role to play in meeting this challenge, through their clinical knowledge of the needs of this population, their understanding of the social determinants of migrant health, and their expertise in a range of research methods that can be brought to bear to inform responsive policies and programs.

A migrant is referred to as “immigrant” when the speaker positions himself or herself in the place where the migrant is settling; the term “immigrant” thus describes the move relative to the destination (Urquia & Gagnon, 2011), and it is from this perspective that the majority of health-care providers in the Western world view the migrants with whom they are in contact — as the “other,” moving in the direction of the Western world. However, the notion of unidirectional immigration is becoming obsolete. Movement trends now include secondary migration (i.e., to another place after the initial migration), serial migration (to more than two destination countries), and return migration (to the country of last residence) (Urquia & Gagnon, 2011).

On the other hand, the notion of “immigration” is still relevant. Nation-states have the legal right to decide who may cross their borders, the conditions under which they may cross, and the benefits and responsibilities entailed in so doing. Immigrants are categorized by official immigration-regulating agencies of receiving countries based on criteria defined by these countries. Although there is no universally accepted classification system, the immigration classes applied in a number of

countries include the following: economic class (working-age migrants to be integrated into the labour force — these may include business persons, entrepreneurs, and skilled workers); family class (dependants of the main applicant, such as spouse and children, who are allowed to migrate for the sake of family reunification); and refugees (any persons who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion, are outside the country of their nationality and are unable or, owing to such fear, unwilling to avail themselves of the protection of that country; UN High Commissioner for Refugees, 2005) (Urquia & Gagnon, 2011). Other labels might include “receiving-country citizen,” “foreign-born citizen,” “documented resident,” “undocumented resident,” “asylum-seeker” (i.e., a person who has applied to the immigration authorities of the receiving country for protection and is awaiting determination of status), “student,” and “visitor.” An understanding of where a migrant sits with regard to these immigration classes is relevant to research on immigration and health, since these classes provide information about both health and exposure risk profiles as well as eligibility for services (with asylum-seekers and undocumented residents at greatest risk for inadequate access).

Within receiving countries, assignment of migrants to immigration classes serves to operationalize population interventions (i.e., policies and programs) that apply to them. For example, in Canada asylum-seekers (also known as “refugee claimants”) who have inadequate financial resources have access to federal health insurance through the Interim Federal Health Program, although insurance is restricted to emergency care. Economic class immigrants do not have access to this federal scheme but do have access to provincial schemes offering coverage beyond emergency care, regardless of financial means, after a certain amount of time in the province. Access to employment, social benefits, and other resources also differs by immigration class. Hence, the legally defined immigration class of an individual directly determines several key social determinants of health as outlined in the *Ottawa Charter* (Health Canada, 2010). Other determinants of health that are not legally proscribed but that may be more common among or more applicable to international migrants than non-migrants include language or cultural mismatch with health professionals, lack of familiarity with the health and social service systems, and limited social support networks.

The range of population interventions that affect migrants, including the right to provincially supported health services, the right to work, and the right to seek formal education, suggests the need for researchers to work closely with policy-makers responsible for these areas, to ensure that timely research questions are being asked and that results emanating

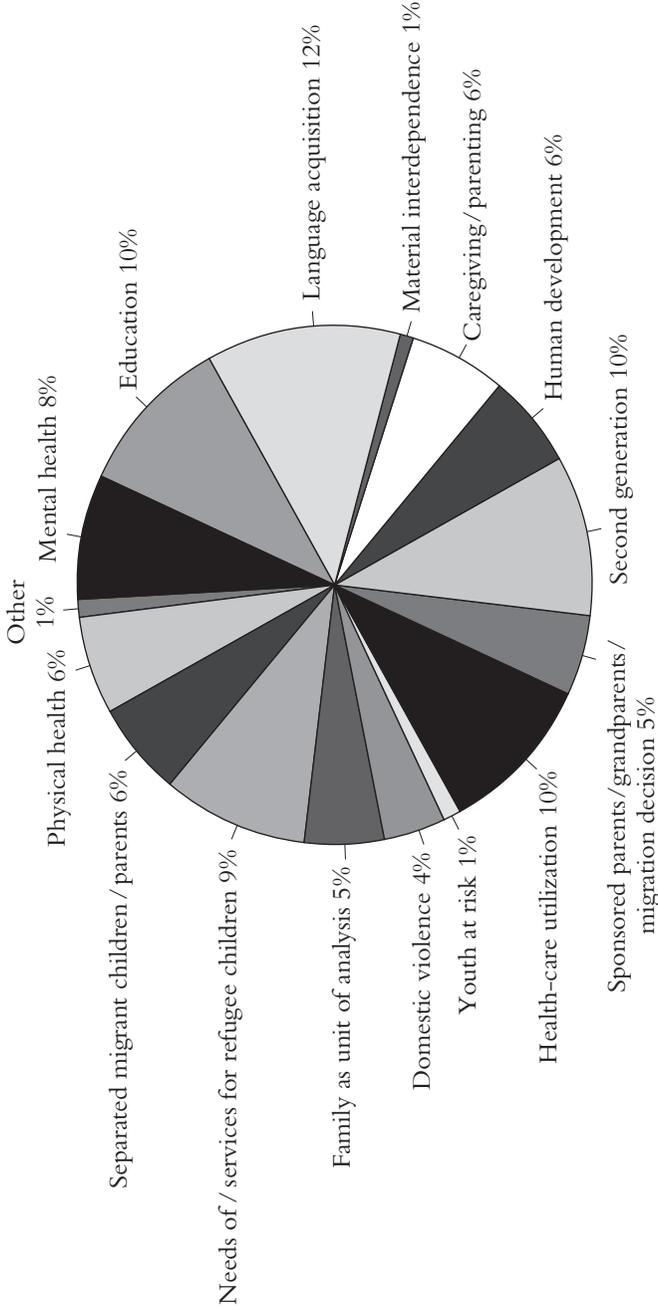
from research will be ultimately useful in developing or revising responsive policies and programs that affect the social determinants of migrant health.

Canadian policy-makers have identified “family, children, and youth” migrants to Canada as a priority *group* for policy-relevant research (through a memorandum of understanding with the Social Sciences and Humanities Research Council within the Metropolis Project). As an initial step, and to help further refine their research goals with regard to this group, the policy-makers sought to learn about current Canadian research with migrant families. Hence, a review of studies published in 2009 on families, children, and youth migrants to Canada was conducted. This review offers nurse researchers a single-year snapshot of the state of knowledge of immigration and health in Canada, specifically through the lens of the social determinants of health that can be affected by population interventions.

More than 1.2 million migrants were included in the reports reviewed. At least one report was located for each of the following *themes* identified a priori as priority by federal policy-makers with regard to migrant families, children, and youth: mental health; language acquisition; material interdependence; caregiving; human development; second generation; sponsored parents/grandparents; health-care utilization; cultural competence; youth at risk; education; family as the unit of analysis; separated migrant children/youth; family violence; needs of/services for immigrant and refugee children and youth; and physical health. The distribution of research within these themes and others not identified by federal policy-makers is shown in Figure 1.

Nurse researchers may also be interested to know the specific policies or programs addressed in this literature. These include the Immigration Medical Examination (McElroy, Laskin, Jiang, Shah, & Ray, 2009); the Interim Federal Health Plan (Wahoush, 2009); Canada’s Multiculturalism Policy (Chuang & Su, 2009b; Costigan, Su, & Hua, 2009; Stroink & Lalonde, 2009); the Live-In Caregiver Program (Pratt, 2009; Rousseau et al., 2009); the Canadian *Immigration Act* (Alaggia, Regehr, & Rishchynski, 2009; Aydemir, Chen, & Corak, 2009; Collicelli, 2009; Lu, Zong, & Schissel, 2009; Roessingh & Elgie, 2009; Vatz Laaroussi, 2009); the Family Class Migration Program (VanderPlaat, Ramos, & Yoshida, 2009); the *Immigration and Refugee Protection Act* (Grenon, Kerisit, & Magunira, 2009); the Ontario Health Insurance Plan (Wahoush, 2009); the Reasonable Accommodation crisis in Quebec (Vatz Laaroussi, 2009); Prior Learning and Experience Assessment for Midwives in Manitoba (Kreiner, 2009); the Multicultural Health Brokers Co-operative in Edmonton (Chiu, Ortiz, & Wolfe, 2009); and francophone minority schools in New Brunswick (Bouchamma, 2009).

Figure 1 Themes Reported in the 2009 Literature on Family, Children, and Youth Migrants to Canada



Methodological elements of interest to policy-makers included the extent to which comparative studies, longitudinal designs, and population data sets were employed. Comparisons of Canada to the United States (Collicelli, 2009; Rothon, Heath, & Lessard-Phillips, 2009), to China (Chuang & Su, 2009a; Chuang & Tamis-LeMonda, 2009), and to Great Britain (Rothon et al., 2009) were identified in this body of literature. Longitudinal designs included studies addressing physical health (Newbold, 2009); language acquisition (Roessingh & Elgie, 2009); and sponsored parents/grandparents/migration decisions (Vatz Laroussi, 2009). Population-based data sets included, at the federal level, the Longitudinal Survey of Immigrants to Canada (Newbold & Willinsky, 2009; VanderPlaat et al., 2009); the Landed Immigrant Data System (Urquia et al., 2009); the Census (Han, Rotermann, Fuller-Thomson, & Ray, 2009; Rothon et al., 2009; Smythe, 2009; Urquia et al., 2009); the Youth in Transition Survey (Thiessen, 2009); the Ethnic Diversity Survey (Abada, Hou, & Ram, 2009; Abada & Kenkorang, 2009a, 2009b); the Labour Force Survey (Thiessen, 2009); the Understanding the Early Years Community Survey (Kohen, Oliver, & Pierre, 2009); the National Longitudinal Survey of Children and Youth (Kohen et al., 2009); and the Maternity Experiences Survey (Han et al., 2009). At the provincial level, population-based data sets included the Quebec Birth Registry (Moore, Daniel, & Auger, 2009); Ontario Birth Records (Urquia et al., 2009); the RAMQ Database (Bérard & Lacasse, 2009); and the Ontario Student Drug Use Survey (Hamilton, Noh, & Adlaf, 2009).

In addition to methodological elements that nurse researchers may wish to consider in conducting research on immigration and health, policy-makers find research results to be most useful to them if reported by immigration class and by identity markers. Reports were found specific to economic class immigrants (Bernhard, Landolt, & Goldring, 2009; Frideres, 2009; Gagnon, Joly, & Bocking, 2009; Newbold, 2009; Thiessen, 2009; Urquia et al., 2009; Yohani & Larsen, 2009); family class immigrants (Bernhard et al., 2009; Frideres, 2009; Gagnon et al., 2009; Newbold, 2009; Thiessen, 2009; Urquia et al., 2009; VanderPlaat et al., 2009); refugees (Abada et al., 2009; Abada & Tenkorang, 2009a, 2009b; Alaggia et al., 2009; Bernhard et al., 2009; Chiu et al., 2009; Dumbrill, 2009; Este & Tachble, 2009a, 2009b; Frideres, 2009; Gagnon et al., 2009; Grenon et al., 2009; Kanu, 2009; Kreiner, 2009; Magro, 2009; Newbold, 2009; Stewart, 2009; Urquia et al., 2009; Vatz Laaroussi, 2009; Wahoush, 2009; Yohani & Larsen, 2009); and asylum-seekers (Bernhard et al., 2009; Gagnon et al., 2009; Wahoush, 2009). It should be noted that studies with migrants often report their results applying unspecific labels such as “immigrant,” “foreigner,” or “migrant,” without specifying status, thus rendering the research less useful than it might otherwise be. In terms of

identity markers, reports included results by *gender*, with the majority including both genders (61.0%) and a minority looking exclusively at men (Este & Tachble, 2009a, 2009b); *age*, with the vast majority between 15 and 64 years of age; recommended *migration indicators* (Gagnon, Zimbeck, & Zeitlin, 2010) — these commonly included “country of birth,” “fluency in host country language,” and “length of time in Canada,” with “ethnicity,” as defined by maternal parents’ place of birth, only infrequently reported (Auger, Giraud, & Daniel, 2009; Gagnon et al., 2009; Moore et al., 2009); *religion*, which was reported infrequently (Abada & Tenkorang, 2009a, 2009b; Alaggia et al., 2009; Brar et al., 2009; Guo, Lund, & Arthur, 2009; Merali, 2009); *visible minority status*, with a variety of definitions applied by several authors; *citizenship*, which was recorded in several studies; and *others*, including “ethnicity,” with either a definition that was different from that given above or with no definition used, “country/region of origin” with an unclear meaning, since birth countries of participants were not specified, and with two articles reporting “age at arrival” (Aydemir et al., 2009; Roessingh & Elgie, 2009).

The volume and quality of literature on health-care utilization and language acquisition made it possible to summarize what was learned about these issues. The health-care utilization literature covers a range of topics across the lifespan, from pre-conception to elder care. The majority of this literature is based on reports from southern Ontario ($n = 5$), although it includes studies from the Prairies ($n = 3$), Vancouver ($n = 2$), and Quebec ($n = 2$), and also national studies ($n = 1$); this distribution reflects the distribution of immigrant communities across Canada. Studies are, for the most part, qualitative in nature, and this seems appropriate in attempting to understand the reasons for accessing or not accessing available services. Language continues to be a key stumbling block to full access to the range of services available in Canada. The groups at greatest risk are those who are or who perceive themselves to be dependent on their sponsors (e.g., spousal sponsorships and family sponsorships of elders), as they are at the greatest risk for abuse/neglect by their sponsors. Holders of insurance through the Interim Federal Health Program are also at risk, because this program is not well known by health-care providers and is administratively burdensome for them. Missing from this body of literature are studies focused directly on interventions, especially concerning language difficulties related to health-care utilization.

Literature on language acquisition by migrants to Canada covers topics from preschool age to adulthood, with more emphasis on university educational achievement than the literature of the preceding 2 years. This literature includes national studies ($n = 3$), with Vancouver and suburban British Columbia equally represented ($n = 3$) and with one report each from Calgary, Toronto, Montreal, and New Brunswick. Although

this geographic distribution does not reflect the distribution of immigrant communities across Canada, the national studies serve to strengthen this body of literature. The reports describe the use of both quantitative and qualitative methods. The population groups that appear to need greater attention now are not those children who are learning English in early primary school (as they seem to be doing well) but, rather, students who are at a later stage in their schooling, when gaps in their educational successes begin to appear. The fact that these inequalities exist as late in the educational trajectory as university — as the literature suggests — indicates a need for closer scrutiny of second-language learners over the years.

This snapshot of Canadian research on immigration and health, even with the methodological limitations inherent in a review of a single year of literature, does offer nurse researchers a glimpse of the state of knowledge in this very broad field of inquiry. A range of themes related to health and determinants of health are being examined, with only two themes appearing to have enough studies to permit syntheses of what is known. Reviewing a greater number of years of literature would no doubt result in an ability to synthesize additional aspects. The review shows that research themes and methodologies identified as key by those responsible for taking action on behalf of migrant health are being taken up, and reports of these studies are including results presented by immigration classes and by relevant identity markers. Qualitative and quantitative studies are included in this body of literature, and a range of determinants of health are being examined. This review serves to challenge nurse researchers to examine their approaches to studying and reporting on migrant health, to ensure that their research activities can ultimately be optimally used by key stakeholders to optimize migrant health.

This focus issue of *CJNR* on Health and Immigration extends our knowledge in this area by offering readers a set of articles covering both a range of relevant issues and a range of research methodologies. We begin at the end of the research process by presenting a Commentary suggesting how results of studies by nurse researchers might be used for the benefit of a specific group of migrants to Canada. “Nursing Research With Refugee Claimants: Promoting the Protection of Human Rights” refers to the current public debate on Bill C-4, *Preventing Human Smugglers From Abusing Canada’s Immigration System Act*. The next article examines social support on a broad scale. “Immigrant and Refugee Social Networks: Determinants and Consequences of Social Support Among Canadian Women Newcomers” describes the effects of situational and personal variables on the benefits and limitations associated with the social networks of migrant women. The study involved 87 women from seven ethnocultural communities currently living in the Toronto area.

From this broad perspective, we move to the care of individual women with a specific health concern. “Social Support for Breast Cancer Management Among Portuguese-Speaking Immigrant Women” presents the results of an applied ethnographic study conducted in Toronto with 12 women from Brazil, Portugal, and Angola, who describe their need for, access to, and use of social support in the management of breast cancer.

The next two contributions in this issue describe investigative functions that are usually carried out at the beginning of the research process. “The Health of Women Temporary Agricultural Workers in Canada: A Critical Review of the Literature” synthesizes the theoretical and empirical literature on gendered and temporary migration in the context of globalization and the health of temporary agricultural workers, particularly women in Canadian programs. And finally, “Population Health Intervention Research in Canada: Catalyzing Research Through Funding” provides an overview of the activities of the Institute of Population and Public Health of the Canadian Institutes of Health Research as they apply to research on health and immigration and related funding opportunities.

The editorial team is happy to share this focus issue with you and, in addition to contributing to the body of knowledge on immigration and health, to further stimulate inquiry in this area by nurse researchers in Canada and elsewhere.

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