Immigrants

The immigrant population is considered a special population within the Winnipeg Health Region, which may require increased monitoring over the next few years. There are several reasons for this including, expected rapid growth in population size, socio-economic disadvantage (short-term or long-term), cultural and language barriers that may affect access to the health care system, and unique health issues (in particular in mental health and communicable disease). For this report, refugees are included as a subgroup within the immigrant population.

Population Characteristics

Expected Growth of the Population

There is rapid growth expected of the immigrant population in Manitoba, over the next few years (and thereby Winnipeg) which may warrant attention for planning and program development by the WRHA. In 2002, the Government of Manitoba entered a tri-level agreement with the City of Winnipeg and Citizenship and Immigration Canada to increase its share of immigrants to the province through the Manitoba Government's Provincial Nominee Program. The goal is to increase the number of immigrants to Manitoba to 10 000 per year by the year 2006. This will assist the province in maintaining its population base, and in providing the province with a young and healthy workforce.

Over the past five years (1998-2002), an average of 4 092 immigrants per year came to Manitoba, and the majority (75-80%) settled in the Winnipeg Health Region.[1] In 2003, 6 474 immigrants settled in Manitoba, and of these, 5 097 in Winnipeg.[2] This is an increase of approximately 58% over the 1998-2002 average. The increasing trend is expected for the next three years, until the target of 10 000 immigrants is reached, which will be maintained as the new *status quo* for immigration.

Refugee Subgroup

The refugee sub-group may have acute health issues that merit attention, particularly in communicable disease, lack of immunization against childhood diseases and mental health. It is important to clarify the definition of refugee status as a subgroup of the immigrant population. The *Immigration and Refugee Protection Act* of June 2002 (a federal act) defines three categories under which persons may apply to immigrate to Canada. They are briefly described below:

- Family Class: Individuals who join family members already established in Canada;
- Economic Class: Individuals who actively seek to settle in Canada. This includes skilled workers, business immigrants and live-in caregivers.
- Refugee Class: Individuals who are deemed to require protection or relief under international law. This may include 'Convention refugees' or 'refugee-like persons'.

Manitoba has traditionally accepted more than its proportional share of refugees compared to other provinces. It is interesting to note that the proportion of refugees, out of all immigrants that came to Canada 2002, was 11%.[1] In 2002, while the majority of immigrants to Manitoba were of the Economic Class (57.6% or 2647), there were 21.1% or 971 immigrants who were of the Refugee Class.

In 2003, almost 19% of the immigrants to Manitoba were classified as having refugee status. However, Winnipeg appears to receive a higher proportion of refugees. In 2003 approximately 23% of Winnipeg immigrants had refugee status.

[1] Manitoba. Manitoba Labour and Immigration. (2003) Manitoba Immigration Facts, 2002 Statistics Report. Government of Manitoba, Summer, 2003.
[2] Data source: Preliminary immigration data received from Manitoba Labour and Immigration for 2003.

Table 1: Immigration by Category Manitoba versus Winnipeg, 2003

	Manitoba		Winnipeg	
Class	Number	Percentage	Number	Percentage
Family	1152	17.8%	926	18.2%
Economic	972	15.0%	829	16.3%
Refugee	1222	18.9%	1185	23.2%
Provincial/Territorial Nominee	3085	47.7%	2121	41.6%
Other/Unknown	43	0.7%	36	0.7%
Total	6474	100.0%	5097	100.0%

Source: Manitoba Labour and Immigration, 2004

Since the Canadian government (Citizenship and Immigration Canada, CIC) is responsible for determining the proportions of the three classes of immigrants that will be annually accepted, it is difficult to project the proportions of each class that will make up the Manitoba, and thereby the Winnipeg, immigrant group in future years.

Source Areas (Countries)

Over the past 30 years, the source areas for immigration have changed dramatically, from that of Europe to Asia. This changing pattern may affect disease patterns in Manitoba and Canada. The country of last permanent residence is used to determine the Source Area and Source Country. In 2002, the majority of immigrants to Manitoba came from Asia and the Pacific Source Area (44.7%).[2] For the past three years (including 2003), the Philippines, Germany and India (in that order) have been the leading source countries of immigrants for Manitoba.[2] In contrast, the top three source countries for Winnipeg, were the Philippines, Ethiopia and India (tied for second place), followed by Korea in 2003.[2]

Demography

In 2002, the majority of Manitoba immigrants were in the 25-44 years age group, which may be indicative of young families immigrating to Manitoba. The ratio of males to females is approximately equal in all age groups except for the 65+ years group.

Table 2: Age and Sex Distribution of Immigrants to Manitoba in 2002

Age (years)	Male	Female	Total
0-14	14.3%	13.4%	27.7%
15-24	8.4%	8.3%	16.7%
25-44	22.3%	22.3%	44.6%
45-64	5.0%	4.4%	9.4%
65+	0.5%	1.1%	1.6%

Source: Manitoba Labour and Immigration, 2003

Health Issues and Determinants of Health

The literature shows that the most significant issues affecting the health and well-being of the immigrant and refugee population in Canada are in the areas of mental health and communicable disease.[3] The determinants of health that may be of particular influence in this population include language, culture, age, gender, socio-economics and social support. It is also important to consider that access to health care and social services by

[3] Fowler, N. (1998) Providing primary health care to immigrants and refugees: the North Hamilton experience. Canadian Medical Association Journal. 159(4).

immigrants may not be equal to that of other Canadians due to language barriers and lack of knowledge about navigating the system.

In regards to chronic disease, immigrants have been found to have better health status than those born in Canada. Also known as a 'healthy immigrant' effect, where it is believed that the newest of immigrants have better health behaviours (e.g. lower rates of smoking, lower consumption of meats and fats, more physically active, etc.) than those born in Canada.[4] However, it is interesting to note that over time (about 2-3 decades of residence in Canada), the eventual adoption of the "less healthy" lifestyles of those who were Canadian-born, diminishes the healthy immigrant effect. A paper by Newbold and Danforth supports this. They found that those who have resided in Canada for more than ten years report less favourably on health status outcome measures than their Canadian-born counterparts and recent immigrants (those residing less than ten years in Canada).[5] The determinants of health appear to play a role in this effect.

Communicable disease, particularly tuberculosis and emerging infectious disease (for example: Severe Acute Respiratory Syndrome (SARS) and the avian influenza virus) are significant health issues that are mediated by the immigrant population. Citizenship and Immigration Canada does screen immigration applicants for significant health issues which may over-burden the healthcare system or present a threat to public health in Canada. Among the screening tests are those for HIV (human immunodeficiency virus), tuberculosis, and syphilis. Those who have active tuberculosis are denied entry until they have completed a satisfactory course of treatment. Those who have or possibly have latent tuberculosis (or syphilis) are accepted for immigration, but are required to undergo medical surveillance upon entry into Canada. This requires that they report to a public health authority in the province or territory of destination.

There is a national monitoring program in place for tuberculosis, with guidelines to follow for identification and treatment of individuals with TB, in order to limit spread of the disease.[6] In 2001, Manitoba had 115 tuberculosis cases, of which 33 were to foreign-born Canadians, as well, the prevalence rate among the foreign-born in Manitoba was 23.9 per 100 000, the third highest rate among the provinces.[7] An increase in the immigrant population in Manitoba may also result in an increase in the tuberculosis prevalence rate. This is especially true if the source areas for immigrants continue to be Asia and Africa, where tuberculosis is a high burden.

Other communicable disease issues may include helminthes, as well as hepatitis B and C.[8] These communicable diseases are not screened for by CIC. The WRHA may need to look to centres with larger immigrant populations, such as Toronto and its Public Health Unit, in order to examine means of addressing communicable disease threats specific to the immigrant population in the region.

Mental health issues in the immigrant population in Canada are a significant yet under-researched area.[9] It should be noted that immigrant and refugee women may be particularly vulnerable to such issues. Factors that may affect mental health in the immigrant population include difficulties in adjusting to Canadian lifestyle, cultural and language barriers and racism. However, one Canadian study using CCHS data, found that immigrants had much lower rates of depression and alcohol dependence than the Canadian–born interviewed in the survey.[5] One limitation of this type of survey is that it is possible that cultural differences may limit the willingness of immigrants to report on these and other mental health issues in a government-sponsored survey, leading to under-reporting of such issues as alcohol abuse and depression.

Much of the study of mental health issues in the immigrant population comes from qualitative rather than quantitative evidence, which may be a more reliable method for gathering this type of data. A qualitative study

---

[4] Perez, C. (2002) Health status and health behaviour among immigrants. Supplement to Statistics Canada Health Reports. 13: 89-100.

[5] Newbold KB and Danforth, J. (2003) Health status and Canada's immigrant population. Social Science and Medicine. 57:1981-1995.

[6] Heywood, N. et al. (2003) Guidelines for the investigation and follow-up of individuals under medical surveillance for tuberculosis after arriving in Canada: a summary. Canadian Medical Association Journal. 168(12):1563-1565.

[7] Health Canada. Tuberculosis in Canada 2001. Tuberculosis Prevention and Control, Centre for Infectious Disease Prevention and Control. Ottawa: Minister of Public Works, 2003. (p.51).

[8] Adams, KM et al. (2004) Health care challenges from the developing world: post-immigration refugee medicine. British Journal of Medicine. 328:1548-52.

[9] Ali, J. (2002) Mental health of Canada's immigrants. Supplement to Statistics Canada Health Reports, Vol 13.

involving immigrant women in Alberta found that immigrant women were unlikely to talk about health when asked directly.[10] However, when the discussion focussed on aspects of everyday life, the issues around mental and physical health as well as social determinants emerged.

A significant mental health issue within the refugee subpopulation is post-traumatic stress disorder (PTSD).[11] This is an issue where access to adequate care may be an issue as healthcare providers may not be familiar with PTSD and not able to easily diagnose or refer patients for help.[12] Qualitative studies suggest that this may be an under-diagnosed issue. Other examples of possible mental health issues include somatisation and the after-effects of ritual female genital surgery.[8] It may be necessary to examine the potential for increased demand for mental health services as a result of the increasing immigrant and refugee population.

Summary of the Key Issues

The new immigrant population in Manitoba (and therefore Winnipeg) is expected to double in size between 2001 and 2006. This population also has unique health issues related to mental health and communicable disease that, when combined with the expected population growth, may produce an increase in their incidence. Population health determinants that affect immigrant health, should also be given consideration. It is recommended that the WRHA monitor this situation, and look to other health regions with large immigrant populations for guidance about future program planning and development.

[10] Meadows, LM, et al. (2001) Immigrant women's health. Social Science and Medicine. 52: 1451-1458.
[11] Prairie Women's Health Centre of Excellence. (2001) Post-traumatic stress disorder: The lived experience. Prairie Women's Health Centre of Excellence. Web publication. 2001.
[12] Prairie Women's Health Centre of Excellence. (2003) Women and Post Traumatic Stress Disorder: Moving Research to Policy. Prairie Women's Health Centre of Excellence. Project #61, 2003.