



Situational Analysis

***SITUATIONAL ANALYSIS OF THE SOCIAL AND POLITICAL FACTORS
THAT INFLUENCE DISEASE PREVENTION AND HEALTH PROMOTION
AMONG NEW IMMIGRANTS TO CANADA AND TO MANITOBA
SPECIFICALLY***

MARCH 2009

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Executive Summary

Immigration is ingrained in the fabric of Canada; it is part of Canada's political, social and economic profile, and immigrants and their diverse contributions have shaped the land. In the past century, technology, pharmaceuticals and improved health practices have enhanced how health care is delivered to Canadians. Notwithstanding these achievements, the quality and accessibility to health and social services are a poignant issue for many new immigrants. Literature shows that one of the most significant factors affecting the well being of immigrants is communicable diseases. This document examines the role that social and political factors have in influencing health promotion and prevention, specifically around Human Immunodeficiency Virus and Tuberculosis. Addressing these issues not only benefits immigrant populations, but it also strengthens entire communities and the country as a whole.

Acknowledgements

This document was produced with the contribution from literature and research studies completed by various organizations in Canada and Manitoba. Acknowledgement is also given to Dr. Carole Beaudoin for her guidance in the compilation of data and her role as a supervisor for this project.

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Situational Analysis of the Social and Political Factors that Influence Disease
Prevention and Health Promotion among New Immigrants to Canada and to Manitoba
specifically

Introduction

This project will describe the social and political factors that influence disease prevention and health promotion among new immigrants to Canada and to Manitoba, specifically. Literature review of the immigrant experience, the current status of this population and the general influence of the health and social influences will be explored. Despite healthy appearances and prolonged residence in Canada, communicable diseases are a factor for many immigrants new to Canada. Communicable diseases encompass a broad range of different manifestations; however this paper will focus specifically on Human Immunodeficiency Virus (HIV) and Tuberculosis (TB).

Background

Worldwide estimates show that about 2% of the world's population live in a nation other than the one in which they were born (Gushulak & McPherson, 2004). These migrants are composed of several different groups, including immigrants, seasonal migrant workers, refugees, asylum seekers, and international students. The 2001 Canadian census indicates that between 1990 and 2000, Canada admitted 2.2 million immigrants and this saw a 1.1 million people increase in the country's working labour size (Statistics Canada, 2001). In many cases the prevalence and types of

communicable diseases at the point of origin differ from those in the final destination (Gushulak & McPherson, 2004); the process of migration and travel can bridge this difference and transfer disease between multiple locations. Over the past century the process and scope of migration has changed significantly and thus has altered the nature of migration related diseases (Gushulak & McPherson, 2004).

Regions supplying migrants to Canada have changed since the early part of the 21st century when immigrants were more likely to come from Western and European nations. This shift is now seeing migrants from predominantly Asian, African, Eastern European and Latin American countries. Due to historical and recent conditions determining health factors, public health and institutional health services have greatly suffered in these regions (Gushulak & McPherson, 2004). Structural inequalities in the host country can greatly influence the effects of communicable diseases and in turn lead to barriers to access to health care (Gushulak & McPherson, 2004). There are numerous factors that can contribute to these inequalities, including level of education, health seeking behaviours, economic resources, legal status in host country, and re-exposure to illnesses when traveling from the host country back to country of origin (Gushulak & McPherson, 2004).

Conceptual Framework

Host countries such as Canada have made great strides over the past 50 years to control communicable diseases using education, immunization and screening practices (Gushulak & McPherson, 2004). Whether the disease is acquired from the source region or contracted in the transition region en route to the host country, as a result of

globalization, and/or barriers to health care and social services, Canadian authorities face the challenge of recognition, control and management of communicable diseases that are consequences of the migration process. The challenge now is to identify key issues that require further research, and to acknowledge existing conditions on the health of migrant populations with respect to the social and political factors that influence management of communicable diseases such as HIV and TB.

Literature Review

A communicable disease is an illness caused by transmission of an infectious agent to a susceptible host (Shah, 2003). Infectious agents include viruses, bacteria, cetoparasites, protozoa, and fungi. Two communicable diseases that are of particular importance to new immigrants are Tuberculosis and HIV.

Tuberculosis. Tuberculosis is a respiratory illness that, in addition to infecting the respiratory tract (lungs, pharynx) can also affect the lymph nodes, bones, kidneys and urinary tract. It is caused by bacteria called *Mycobacterium tuberculosis* and it is treatable with antibiotics although it can be reactivated later on in life if an individual's immune system is compromised (Shah, 2003). TB kills 2 million people worldwide and in Canada, while the numbers have improved vastly since the mid 1990s, it is still a concern for public health authorities due in part to the high proportion of infected immigrants (Health Canada, 2007). TB may be spread by droplets in the air when an affected person sneezes, coughs or when one spits in the air by singing or talking. To be infected a person has to be repeatedly exposed to a person with TB. Many people who are exposed to this illness do not develop TB disease because of their healthy

immune system but if that immune system is compromised, for example due to HIV infection, diabetes, cancer, chronic alcoholism, poor nutrition, etc., the likelihood that exposure will lead to TB disease increases considerably (Health Canada, 2007). In addition, those exposed and infected that do not develop active TB (latent TB infection) are at risk for later activation should their immune system become compromised. To treat TB, it is recommended that the afflicted individual take a 6-9 month course of antibiotics. If not taken as prescribed there is a greater chance of spreading the illness to others and also developing a TB strain that is resistant to antibiotics (Health Canada, 2007).

Human Immunodeficiency Virus. HIV has been well documented over the past 25 years in Canada. It is an illness that has no cure but is now considered a chronic illness due to the advancement in treatment options that prolong life expectancy (Public Health Agency of Canada, 2008). It can be transmitted from person to person through blood, semen, vaginal secretions, and breast milk (PHAC, 2008). It is a deadly virus that does not discriminate, but disproportionately affects much of the globe's poor and vulnerable populations. Here in Canada, about 2.1% of immigrants come from a country that is considered an HIV endemic country (Public Health Agency of Canada, 2007). Immigrant communities in Canada are often unevenly affected by unfavorable social and economic issues and are therefore vulnerable to increased risk for HIV and other communicable illnesses (Public Health Agency of Canada, 2007). A study that was conducted in an African and Caribbean community in Canada revealed that barriers to screening and treatment were further exacerbated by racism, settlement and status concerns, underemployment, and poverty concerns. The same study also found

that there was a significant level of fear of stigma, social isolation, job loss, and fear of deportation in light of revelation of HIV status (Public Health Agency of Canada, 2007). HIV rates in Manitoba have increased by 53% in the last 5 years and statistics show that the proportion of persons with HIV who report as having migrated from an HIV-endemic country as a risk factor has tripled since 1999 (Project Positive, 2005). The risk for TB infection is greatly increased for people who have HIV, and conversely those with TB are more susceptible to HIV infection and/or HIV disease progression (Public Health Agency of Canada, 2007).

Who Is An Immigrant And Who Is A Refugee?

The term 'immigrant' refers to a person who has moved to another country for the purpose of residence. Within the term immigrant there are those who are classified as refugees and the flight of refugees often occurs in the setting of war, famine, or human rights violations, resulting from a "well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion" (Bowen, 2006). Thus, there are those that wish to come to Canada on their own terms (immigrants), and those who do not want to leave their home countries but do so only out of the necessity to survive; these individuals are commonly referred to as refugees. While there is a political distinction between immigrants and refugees, there is little research that compares the health status of immigrants to refugees (Bowen, 2006). Therefore, throughout this project there will be points of reference to immigrants and refugees under a general umbrella of classification within the term immigrant unless the context is specific only to the refugee population.

For both immigrants and refugees, the health characteristics of the foreign born individual are influenced by the health environment and their situation at their original residence, their transitional residence, and finally their new destination (Gushulak & McPherson, 2004). For many the transitional experience is irrelevant to their health experience due to the short duration of the period. However, for those who are transitioning through refugee camps and those who experience trafficking or smuggling as a means of arrival, the transitional experience can greatly affect health and the possibility of contracting diseases such as HIV and TB (Gushulak & McPherson, 2004).

Project Goals/Objectives

The purpose of this situational analysis is to obtain a better understanding of the elements that put new immigrants to Canada at risk for acquiring or transmitting communicable diseases, specifically HIV and TB. Its purpose is also to identify the factors that affect health promotion and illness prevention among new immigrants. This was done using available secondary data. The analysis is a systemic scan of the existing situation of the new immigrant experience and its aim is to provide a means for further research and development of health planning processes as it relates to this specific population.

Methodology

The process of conducting this analysis was controlled by time constraints and therefore it takes information from previously reported literature and key informant interviews. It includes reviewing quantitative and qualitative data from a number of

organizations and sources that serve the immigrant and refugee populations in Canada and Manitoba. It involves the collection of information referenced by Nine Circles Community Health Centre (Winnipeg, MB), Manitoba Labour & Immigration, Winnipeg Regional Health Authority, (Winnipeg, MB), AIDS Community Action Program of the Public Health Agency of Canada (Brandon & Winnipeg, MB), Statistics Canada and Citizenship and Immigration Canada. Information about the immigrant/refugee experience with the health care and social systems is also reported in this discussion paper. The final document will be disseminated to those that request it and it will be available to any other persons who wish to view it.

This analysis considers:

- Manitoba's immigrant community demographics & perceptions of determinants of health
- The political, economic, & social themes that affects immigrants
- Characteristics of new immigrants, including:
 - Social support networks
 - Cultural characteristics
 - Income and Employment
 - General health practices, with a focus on HIV and TB awareness and management
- Services available and any other aspect of society that may be useful in assessing factors such as attitudes, motivation, and other characteristics of the specified group

Results

New immigrants to Canada often come from countries where communicable diseases are common, therefore Canadian law gives the authority for immigration officials to screen immigrants and those seeking refugee status (Haag & Gilbert, 2007). All immigrant applicants to Canada are required to undergo a thorough medical examination to identify those who may be at risk to public health safety and those who may place excessive demands on the Canadian health and social systems. For the most part immigration medical examination occurs in the country of origin before arrival in Canada and in Canada for those already in the country (usually refugees). The exam consists of a physical examination, a medical history-taking, and four routine tests:

- urinalysis (for those >5 years old)
- syphilis serology (for those >15 years old)
- chest radiography for TB (for those >11 years old)
- HIVserology (for those > 15 years old) (Haag & Gilbert, 2007)

Examining immigration physicians can request further tests and information if needed. Those that test positive for an active communicable disease that can be treated are usually required to complete a satisfactory course of treatment before they are allowed entry into Canada (Haag & Gilbert, 2007). Those that have a latent illness such as Latent TB Infection or a chronic condition such as HIV may be allowed entry but are required to undergo medical surveillance as a condition of entry. They are also expected to report to a public health authority within 30 days of entry into the country (Pottie, Janakiram, Topp, & McCarthy, 2007).

Immigrants who have been flagged to report to the public health authority within 30 days of arrival for a follow up of any reportable diseases most often do not abide (Morrison, 2002). Morrison (2002) notes that 80% of immigrants with active cases of TB were supposed to report regularly to local health units, but failed to comply. In Ontario, one of the issues new immigrants point out is that there is a three-month Ontario Health Insurance Plan (OHIP) benefits wait, therefore they are forced to pay for any medical care and cannot afford to do so. Recent high profile deportations have instilled fear in many legal and illegal immigrants into canceling appointments at clinics serving the uninsured (Haag & Gilbert, 2007). In Magoon's (2005) research study, she constructed a profile of refugees living in Winnipeg and then interviewed key informants who provided personal accounts of their experience with the service and referral networks that exist in the Winnipeg Health Region. She was also able to highlight some of the gaps in these services, service delivery and organizational culture, partnerships with different organizations that service this population, system navigation, and the capacity of the organizations in delivering their services. She concluded that health determinants of culture, employment, income, health services, physical environments and social support networks were key concepts in the health of immigrants, and in this case refugees.

Between 1980 and 1995, Health Canada reported an increase from 35% to 64% in TB cases among new immigrants to Canada but this has slowly leveled off since 1987 (Health Canada, 2005). Compared to the general Canadian population, immigrants are at greater risk for HIV and TB; it is suggested that this is primarily because of the

greater likelihood of exposure while in their country of origin. Individuals are able to carry the communicable diseases without the presence of symptoms and are therefore at risk of transmission and re-activation of disease. As is the case with TB, previous infection can become re-activated many years after migration (Health Canada, 2007). Health Canada (2005) reports that, although studies are limited, TB, hepatitis, HIV, and parasites have been cited in the literature as communicable diseases that immigrants are at high risk of carrying. Immigrants account for a greater percentage of TB cases due to several factors such as reactivation of the infection post-migration and primary infection just prior to immigration. They also cite strong evidence that certain social conditions post migration contribute to the reactivation of TB, such as poor living conditions, poor sanitation, substance abuse, malnutrition and homelessness (Health Canada, 2005).

Montreal researchers Decostas and Adrien (Health Canada, 2005) however, suggest that the relationship between mobility and HIV infection are better explained by life during the journey and point of destination rather than origin of the immigrant. There are also distinctions that should be made between migrants, such as labor migration, refugee migration, internal migration and resettlement migration. Vulnerability to HIV was determined by poor working conditions, reduced access to health care, and cultural and linguistic barriers to treatment. They also report that male immigrants under isolated conditions in the host country contracted more sexually transmitted illnesses in the host country due to lower chances of building stable relationships. Another Montreal study reported that lower socioeconomic status and poor housing contributed to increased TB rates among immigrants (Health Canada,

2005). Poor access to health care, poor adherence to treatment therapy, resettlement stress, political barriers to health services and lack of coordination between levels of government, continue to represent major barriers to TB management (Health Canada, 2005).

Across the range of indicators studied, compared to the Canadian-born, immigrants are generally in as good or better health, have similar or better health behaviours, and similar or less frequent health service use (the “healthy immigrant effect”) (Statistics Canada, 2001). These indications appear to be strongest among recent and non-European immigrants. Evidence indicates that post-arrival, migrants access health services significantly less than endemic residents, and over time, a migrant’s health starts to reflect that of the endemic population. Immigrants do experience less chronic illnesses compared to their Canadian born counterparts, however there are significant health issues that are emerging that indicate social, ethnic, cultural, demographic, and economic characteristics play a larger role in the disparities between mortality and morbidity patterns (Pottie et al, 2007). Elevated rates of infectious diseases, which include preventable and treatable illnesses, are apparent in many new immigrant populations in Canada (Pottie et al, 2007).

The legislation and policy that guides immigration issues in Canada is the Immigration and Refugee Act. This legislation provides the main framework for which immigrants are able to enter Canada and it also provides a background for admissibility or inadmissibility for persons deemed as a safety risk, or as a burden to Canada’s health care and social system (Manitoba Labour and Immigration, 2007). For persons who have HIV and TB, this is a source of stress as they often have fears of

failed refugee claims, medical inadmissibility, and exclusion and discrimination due to their status (Committee for Accessible AIDS Treatment, 2006). HIV and TB are not considered risks to public health or to public safety in and by themselves, but they are considered to be conditions that may place excessive demands on Canada's health and social services system (Committee for Accessible AIDS Treatment, 2006).

Discussion

The Interim Federal Health Program

New immigrants to Canada do not receive health care funding until they are eligible for their provincial/territorial health care insurance. Depending on where you reside in Canada, for some immigrants this could represent a three-month waiting period after their arrival to Canada (Citizenship and Immigration Canada, 2008). The Interim Federal Health Program (IFH) is a temporary health insurance program for refugees, refugee claimants and protected persons, and all their dependants who are not yet covered by any health insurance plan (Citizenship and Immigration Canada, 2008). The IFH program was developed on humanitarian grounds, and it is managed by Citizenship and Immigration Canada. The program is almost exclusively limited to those individuals who fall under the refugee class (Citizenship and Immigration Canada, 2008). This leaves many immigrants who are excluded from this class stranded and in need of financial assistance to pay for health care out of their own pocket until they are eligible for coverage. They do not qualify for the temporary emergency and necessary health services provided by the IFH program and it can contribute to barriers that lead to increased susceptibility to health risks like TB and

HIV (Citizenship and Immigration Canada, 2008). In Manitoba, immigrants who do not fall under the refugee class can qualify for Manitoba Health Benefits Insurance, all landed immigrants are eligible, however some restrictions also placed on Ministerial permits (Magoon, 2005). A subsequent table outlining services available to all permanent residents of all classes to Manitoba is illustrated in tables in Appendix B. These tables describe social services and the criteria that are used to describe eligibility to these services. While some may be eligible others may not be and this complicated system can be confusing, especially for those not familiar with the system navigation and also face language barriers.

Immigration in Manitoba

Winnipeg, Manitoba is a city with a history of immigration and a rich cultural heritage; it is home to many immigrants from around the globe (Manitoba Labour & Immigration, 2007). Immigration to Manitoba has seen a significant rise over the past decade from 3,000 in 1998 to over 8,000 in 2005 (Bowen, 2006). In 2007, about 70% of the province's immigrants arrived through the Provincial Nominee Program, and in that same year Manitoba's population increased by 13,000 people, much of which was credited to increased immigration (Figure 1; Manitoba Labour & Immigration, 2007). Manitoba attracted 4.6% of all immigrants to Canada and many have settled in Winnipeg and Winkler. Over the past few years many have settled outside of Winnipeg and these communities have had to accommodate for an influx of immigrant groups who require diverse and specific services (Figure 2; Manitoba Labour & Immigration, 2007).

Figure 1. Canada's Immigration Levels by Province/Territory

MANITOBA SUMMARY

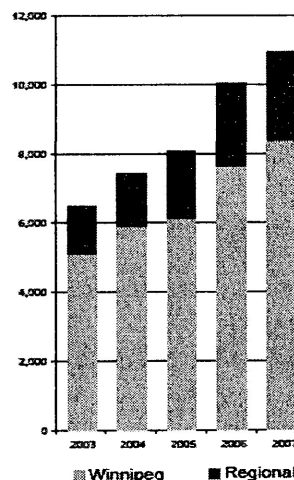
Principal Applicants and Dependants	2005		2006		2007	
	Number	Percentage Canadian levels	Number	Percentage Canadian levels	Number	Percentage Canadian levels
Family Class	1,192	1.9	1,332	13.3	1,343	12.3
Economic Class	1,106	0.7	714	7.1	641	5.9
Provincial/Territorial Nominees*	4,619	57.4	6,661	66.3	7,689	70.2
Refugees	1,094	3.1	1,241	12.3	1,170	10.7
IRPA Other/Missing/Backlog/Unknown	86	0.1	103	1.0	112	1.0
TOTAL	8,097	3.1%	10,051	4.0%	10,955	4.6%
Difference from previous year	670	9.0%	1,954	24.1%	904	9.0%

Figure 2. Manitoba Immigration by Community Destination

MANITOBA IMMIGRATION BY COMMUNITY DESTINATION (TOP 10)

Principal Applicants and Dependants	2005			2006			2007		
	Number	Percentage	Rank	Number	Percentage	Rank	Number	Percentage	Rank
Winnipeg	6,134	75.8	1	7,641	76.0	1	8,386	76.5	1
Winkler	693	8.6	2	830	8.3	2	710	6.5	2
Brandon	181	2.2	4	172	1.7	4	642	5.9	3
Steinbach	369	4.6	3	399	4.0	3	369	3.4	4
Morden	68	0.8	5	158	1.6	5	125	1.1	5
Reinfeld							42	0.4	6
Thompson	48	0.6	6	53	0.5	6	39	0.4	7
Portage La Prairie							28	0.3	8
Ste Anne				32	0.3	9	23	0.2	9
Altona				45	0.4	7	22	0.2	10
Virden				38	0.4	8			
Teulon				31	0.3	10			
Stonewall	21	0.3	7						
Selkirk	18	0.2	8						
Plum Coulee	17	0.2	9						
Grunthal	16	0.2	10						
TOTAL TOP TEN ONLY	7,565	93.4%		9,399	93.5%		10,386	94.8%	
TOTAL OTHER DESTINATIONS	532	6.6%		652	6.5%		569	5.2%	
TOTAL	8,097	100%		10,051	100%		10,955	100%	

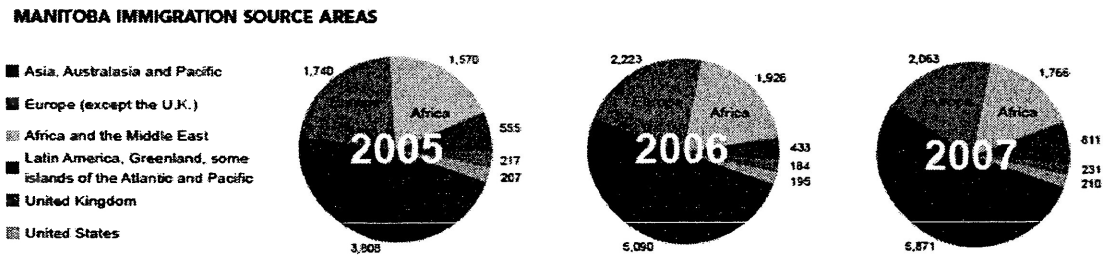
MANITOBA IMMIGRATION BY WINNIPEG AND REGIONAL DISTRIBUTION



In 2007, 2,273 immigrants to Manitoba were from Europe and the United Kingdom, 5,871 were from Asia, Australia, Asia and the Pacific, 1,766 were from Africa and the Middle East, and 811 were from Latin America and other nations (Figure 3; Manitoba Immigration Facts, 2007). This increase in immigration is related

to an agreement between the provincial and federal government to increase immigration numbers (Bowen, 2005).

Figure 3. Source Geographical Areas *From “Manitoba Immigration Facts”, by Manitoba



Labour and Immigration

Social Factors of Health and Barriers

About thirty years ago, The Lalonde Report was published in Canada; it brought forth evidence that there are key factors that determine health status in Canada (Lalonde, 1981). It states that to improve health status, Canadians need access to income, education, and social/community supports. These factors have since been referred to as some of the determinants of health. Furthermore in 2005 the World Health Organization (WHO) established a commission on the social determinants of health to address the growing health disparities between and within nations around the globe (Public Health Agency of Canada, 2007). In 2007, the Public Health Agency of Canada reflected on the state of the social determinants of health and published a document that highlighted the on-going themes that need to be addressed by Canadian authorities to accomplish optimum health for its citizens, including new immigrants. Some of these include more efficient collaboration between different levels of governments and sectors, and increased efforts in research and evaluation of current

influences on health outcomes (Public Health Agency of Canada, 2007). The themes they identified fall in line with evidence that points out that disparities in health and social and political barriers affect the immigrant population and play a part in the management of communicable diseases.

Magoon's (2005) research highlighted that health determinants of culture, employment, income, health services, physical environment and social support networks were key areas of importance for immigrants and refugees. Magoon's study also noted that areas of mental health and communicable disease are the most forefront concerns of most new immigrant populations in Canada. She identified major themes that had gaps in services and barriers to healthy living in Canada. The report emphasized six determinants of health in regards to barriers to presentation of need, specific health concerns regarding communicable diseases of which HIV was a key concern, barriers with health service delivery, and the efficiency of existing immigrant/refugee serving systems (Magoon, 2005). The research also emphasized that caution should be taken in using the North American determinants of health model and applying it to the immigrant and refugee experience because it does not put as much emphasis on the social roots of health and illness (Magoon, 2005).

Culture. In needs assessment completed in Winnipeg, Manitoba by Foster and McPherson (2007), cultural factors were described by the focus groups they interviewed as issues that incite social exclusion. They described daily events in their lives that made them feel marginalized and discriminated against. They stated it was very evident in their interactions with some health care providers and it made them feel distrust in giving information about their health practices. Recommendations made included

opportunities for members of the health care teams to access educational workshops or seminars to expose them to alternate cultural beliefs and improve sensitivity to cultural differences in new immigrant communities. Also, one of the factors participants in that focus group pointed out is their own lack of awareness in regards to the cultural norms in their new community.

In the needs assessment, immigrants identified their struggles with health care expectations, separation from previous social supports, the assimilation of their children into the dominant society, and the expectations around partner relationships and behaviour. The underlying theme was their fear of losing their own culture and beliefs and still not being able to assimilate into the Canadian society (Foster & McPherson, 2007). The cultural divide and feeling of social isolation can lead to the emergence of risky behaviours that increase HIV and also compromise health status due to their inability to utilize the health care system because of negative perceived notions. The immigration process causes much stress for many migrants and the results can often exacerbate the disparity in health (Foster & McPherson, 2007).

One issue to note is that many participants were aware of the risk factors associated with HIV and TB, however many stated that when it came to HIV it was less related to their own knowledge about the risk factors (Foster & McPherson, 2007). They acknowledge that the immigration process leaves many of them lonely and isolated and as a result they turn to behaviours that increase their risk factor which can include excessive alcohol and drug use and sex with multiple partners. A sense of anonymity and freedom to engage in behaviours that would normally be considered taboo in their home culture also increases their risk (Foster & McPherson, 2007).

Many of the immigrants who participated in studies regarding their health and settlement in Manitoba, state it would be ideal if cultural adaptation was facilitated through efficient settlement and orientation programs (Magoon, 2005). Many felt that although there were programs like this in operation in their communities, they felt that the programs could not meet the demand. They also pointed out that they would like to obtain information from their own community leaders and those who had lived through the experience of immigrating to Canada. This would give credibility to the information they receive and builds rapport and understanding of the new climate and culture they now call home (Magoon, 2005).

Discrimination is a factor that hinders opportunities for advancement in health status and social standing for many immigrants. Systemic racism trumped overt racism as a major concern for immigrants new to Manitoba (Magoon, 2005). It was identified to exist not only in the broader community but also in the health and social services sectors. The undermining of human value and experience for many immigrants diminished their sense of self worth and potential for advancement in society. Interaction with health care providers who become frustrated with a particular immigrant's lack of command of the English language and perceived stereotypes about their country of origin and its cultural beliefs increased the mistrust and hesitation of utilizing available services (Foster & McPherson, 2007).

A factor that is noted throughout the research and cited in these studies is that for many immigrants, their experiences are not always negative and many positive and life changing events have characterized their experience in Canada. The difficulty lays in the expected struggles that they inevitably face in the search for integration into their

new society and the acculturation into the new belief system and the alteration of their own cultural integrity (Foster & McPherson, 2007).

Income & Employment. Income and employment are significant factors in the overall health status of new immigrants and are indicated as a major barrier to the way immigrants utilize health care services. For example, for those that are able to secure employment once they arrive, the issue of sick time and the loss of wages is a major factor in when and how they access health care (Foster & McPherson, 2007). There is confusion among many immigrants with the policy around sick time and their perceived risk of losing their jobs if their attendance record is not good. There was also the fear of stigma associated with their employers or colleagues' perception of the type of illness reported as being either acceptable or taboo, such as HIV (Foster & McPherson, 2007).

Immigrant women are more likely to experience unemployment during their initial years in Canada than those who have been in the country for a longer period of time (Citizenship and Immigration Canada, 2005). The hierarchical structure that prevents new immigrants from the distribution of opportunity is a disservice for the economy of Manitoba and Canada, as a whole. Skilled immigrants who come to Canada, especially the provincial nominees who at times are qualified professionals are sold on the fact that immigrating to Canada will improve their lives and their potential to succeed using their skills (Teeluchsing & Galabuzi, 2005). However many are relegated to settling for precarious jobs and low paying wages that do not improve their socio-economic status and contribute to ongoing struggles with the Canadian economic system. Immigrants who come here through the recruitment of immigration policy

find that they are constantly struggling to prove their skills and experience to employers who are also faced with bureaucratic red tape due to socio-economic and political barriers (Teeluchsing & Galabuzi, 2005).

In Manitoba it is challenging for immigrants to both find and keep employment where wages would keep them above the poverty line. They speak about the sadness they feel when they can no longer provide for their families and have to rely on social assistance to survive (Magoon, 2005). In Manitoba, immigrants with professional skills state that they experience a cycle of frustration because they have to go through much bureaucracy to get their credentials recognized, and are then required to pass a series of Canadian professional exams which are costly in both time and money (Magoon, 2005). Furthermore, many require documentation to illustrate that they possess the stated skills in their professed occupation; this can prove challenging for some who have fled their resident country without essential documentation.

Immigrants have also expressed their anger at having to start a degree in its entirety, which may not necessarily be feasible because they had to also work to support their families (Magoon, 2005). Many are lobbying the government for increased recognition of foreign trained professionals and they add that it is an added incentive for the overall Canadian society to see an increase in many of the professional disciplines that are facing shortages, such as physicians and nurses (Teeluchsing & Galabuzi, 2005).

There are many complications expressed by different immigrant groups all with different backgrounds and situations. It is not fair to say that the system should cater to each individual situation, but immigration officials and immigrant advocates are

trying to address these concerns (Teeluchsing & Galabuzi, 2005). Guidance regarding financial management in the Canadian economy and navigation of the social and health services system are supports offered through various community centres and government agencies. Many immigrants hold the hope that educational attainment will translate into comparable occupational status and compensation so that they can bridge their economic gap (Teeluchsing & Galabuzi, 2005).

Health Services. Health services are services that are primarily funded by federal and provincial governments. These services include coverage of accessing physicians, nurses, medical professionals, laboratory services and hospital care including pharmaceuticals (Committee for Accessible Aids Treatment, 2006). Social services include vocational rehabilitation services, homecare, special education services and personal support services (Committee for Accessible Aids Treatment, 2006). Lack of access to health services is detrimental to persons living with HIV/AIDS, TB, and other communicable diseases. Some of the consequences of lack of access to health services include;

- no treatment or limited choice
- disrupted treatments
- increased viral resistance
- sub-optimal care
- delayed diagnosis
- untimely death
- loss of dignity
- loss of confidentiality

- fear, stigma, and stress
- lack of support
- depression and despair (Committee for Accessible Aids Treatment, 2006).

The Winnipeg Regional Health Authority's (WRHA) population and public health program has a mission to assess the health of the population, protect the public from health threats, prevent disease and injury, promote and advocate for good health status of citizens and for reduction in health disparities (WRHA, 2005). Through the WRHA and various other organizations in Manitoba, immigrants can access health services as soon as they arrive (Magoon, 2005). Many immigrants are pleased and expressed relief for the existence of universal health care in Canada (Magoon, 2005). The barriers to accessing health services are not primarily focused on the financial standing of the immigrants. Much can be said about the difficulty in acquiring a family physician, long wait times for health services, language barriers and gender incompatibility (Magoon, 2005). Accessing non-insured health services, counseling physical therapy and medication can also be difficult (Magoon, 2005). For many new immigrants the greatest barrier to health service access lies in the difficulty in navigating the Canadian health care system (Committee for Accessible Aids Treatment, 2006). As previously discussed, the Interim Federal Health Program (IFH) covers necessary health services for immigrants who are not covered by Manitoba Health (Magoon, 2005). However access to fully affordable insured health care can be limited even with the existing programs in place and IFH is time limited and can expire (Committee for Accessible Aids Treatment, 2006).

Immigrants who do not have permanent status in Canada, face difficulties in achieving permanent resident status at times due to Citizenship and Immigration Canada's (CIC) criteria of who places "excessive demand" on the country's health and social services (Committee for Accessible Aids Treatment, 2006). While HIV-positive refugees and their families are exempt from the criteria, this does not serve other HIV-positive immigrants who do not fall under the refugee category. This can discourage those who may be HIV-positive, or those at risk from accessing appropriate health care services (Committee for Accessible Aids Treatment, 2006). They voice their fears that if they are indeed HIV-positive their eligibility of permanent Canadian residency is threatened (Committee for Accessible Aids Treatment, 2006). IFH is narrow in its eligibility and according to some refugees in Manitoba, many physicians will not treat clients with IFH coverage or they will bill them directly (Magoon, 2005). Physicians state that the amount of time it takes to bill and the restricted coverage available with IFH is the main barrier (Magoon, 2005). This leads to a heavy reliance on community-based supports which are already taxed due to limited resources in the area of ongoing health care and treatment available for HIV, TB and other communicable diseases (Committee for Accessible Aids Treatment, 2006). The immigration medical exam is also a stressful issue due to what many immigrants say is the lack of training and adherence to guidelines around diagnosing and treating HIV (Committee for Accessible Aids Treatment, 2006). Refugee claimants who have to prove factors such as torture, require psychological assessments and medical reports, but are also challenged to find professionals who are willing to do them (Magoon, 2005).

Foster and McPherson (2007) interviewed immigrants in Winnipeg and Brandon, MB who identified that they were surprised at the lack of public education around communicable diseases like HIV. It was striking that many of them questioned if HIV/AIDS was even a threat in Canada. Those interviewed also discussed their lack of understanding around the responsibilities of governments in the plan and execution of policies regarding immigration and communicable diseases (Foster & McPherson, 2007).

For immigrants who live in the country without any status, accessing health services is a constant struggle and greatly affects their health (Committee for Accessible Aids Treatment, 2006). Some describe surrendering their children to Child and Family Services (CFS) so they could have health coverage because they would be ineligible if they stayed with their non-status parents (Committee for Accessible Aids Treatment, 2006). Organizations like the WRHA who face challenges in delivering health services to new immigrant groups acknowledge these facts. They and many other organizations see a need for a more efficient collaboration between various levels of health service providers (WRHA, 2005).

Social Support Networks. Perceived lack of social networks and supports are identified as major sources of stress for new immigrants (Ng, Wilkins, Gendron, & Berthelot, 2005). Research clearly indicates that new immigrants (especially visible minorities) living in Canada are more vulnerable to HIV/AIDS, for example, because of structural and systemic inequalities that result in economic and social isolation (Interagency Coalition on AIDS & Development, 2006). In general, Canadians with low social supports are 1.3 times more likely to have a lowered health status than those

with high levels (Ng et al., 2005). Evidence points out that the loss of social support networks from the country of origin can be a risk factor for a decline in health (Ng et al., 2005). In Magoon's (2005) research immigrants interviewed described their social isolation in relation to language barriers, climate, cultural misunderstanding, transportation barriers, lack of knowledge of resources and gender inequalities. Those interviewed also point out that individuals living with HIV were more isolated and outcast from their communities (Magoon, 2005).

There are several organizations in Winnipeg that cater to the new immigrant population by providing a venue for social and cultural connections (Magoon, 2005). However immigrants point out that at times even within their communities there are sub-cultural divides that can make it hard to identify with each other in a new country (Magoon, 2005). Social networks and social supports in immigrant groups are strongly linked in relation to human rights, race relations, and discrimination (Association of Local Public Health Agencies, 2003). There is profound diversity among immigrant groups, and while members may be from similar geographic areas they may not belong to the same linguistic or ethnic group (Bowen, 2006). In the case of refugees there may even be the same type of divisions that they left in their countries of origin. Factors such as politics, ethnicity, socio-economic status and religious affiliations may create an atmosphere of fear and mistrust (Bowen, 2005). This atmosphere can create challenges for health care providers and community based support agencies in the delivery of care to these groups (Bowen, 2005). Another contributor to social isolation among immigrant groups is acculturation (Bowen, 2006). Immigrants vary in their length of time they have lived in Canada, their age or arrival, education levels,

language proficiency and their lived experiences (trauma, torture, etc). These factors can greatly affect their ability to merge into Canadian society and may, at times, reinforce their perceived lack of social supports and feelings of isolation (Bowen, 2006).

Physical Environment. Physical environment can be categorized as housing, the living conditions, and the environment that immigrants face in their host country (Magoon, 2005). The lack of affordable housing is not isolated to the immigrant population; it affects all Canadians (Magoon, 2005). However for immigrants who arrive in Canada without any social supports or financial standing, housing is emphasized as an important component of health status (Magoon, 2005). Negotiating housing and at the same time establishing themselves in Canada can be daunting and stressful for new immigrants (Committee for Accessible Aids Treatment, 2006). Most will apply for subsidized housing that are provided by the government who offsets the cost associated with the homes to make it affordable for lower income families to inhabit (Committee for Accessible Aids Treatment, 2006). The need for safe housing is recognized as vital and the responsibility for housing falls in the hands of the federal and provincial governments as per the Affordable Housing Initiative in 2002 (Committee for Accessible Aids Treatment, 2006). This initiative was put in place to help families and immigrants who fit the criteria by providing funding for a new rental housing supply program, a new home buyer down-payment program, and a home ownership supply program (Committee for Accessible Aids Treatment, 2006).

New immigrants continue to find it challenging to find safe housing and more often they settle in urban, low income and unsafe residences (Committee for Accessible Aids

Treatment, 2006). For refugees who came from traumatic or war torn areas, the need for safe housing was seen as vital for appropriate adjustment and healing (Magoon, 2005). Overcrowding and unsanitary housing can aid in the transmission of TB and among immigrants who have active or latent TB, this can be a high risk factor (Shah, 2003). For immigrants with HIV, it can cause added stress because HIV is a risk factor for TB and it can have a large impact on their health status (Shah, 2003).

According to the Manitoba Housing Authority (2009), Canadian citizens, landed immigrants and refugees, and person's 18 years of age or older can apply for subsidized housing. For immigrants living with HIV/AIDS, affordable housing is a struggle even though HIV status can place one on a priority standing for housing. To secure this standing, immigrants living with AIDS who do not yet have permanent residency have to prove that they have a life expectancy of at least 2 years (Committee for Accessible Aids Treatment, 2006). This places them in a compromising position because if they have to still prove their case for approval for landing in Canada, it impedes their case to demonstrate their ability to contribute to Canada through working (Committee for Accessible Aids Treatment, 2006). The end result is a lowered opportunity to qualify for housing because they also have to prove their health is compromised and many would rather choose to increase their case of contribution to Canadian society (Committee for Accessible Aids Treatment, 2006).

Limitations

Like most literature searches, this project was limited by the accessibility of research data, the capabilities of library database and limited research in the area of

immigrant health in the context of communicable diseases, specifically in Manitoba. There are evidence based literature about various regions in Canada that sees an influx of immigrants, specifically Toronto, Vancouver and Montreal. However in Manitoba, research in this area is growing and attempt has been made to access the relevant data. There are several inquiries that can be made in the health of immigrants and to attempt to summarize or address them all is a task that is not supported by the time limits of this project.

Conclusion

Due to the changing economic and political climate of the globe, immigration to Canada will bring more individuals into the country. There will be a diversity of lifestyles, norms and expectations of the health and social services sectors. It is a challenge to meet the health expectations of every individual immigrant that arrives in Canada; however it is essential to incorporate equity, flexibility and accessibility when providing services. The concerns around TB and HIV are longstanding and prove to be a challenge for the health and social services sectors. Meeting the needs of new immigrants in the determinants of culture, income, employment, health services, physical environment and social support networks is vital when aiming to maintain the “healthy immigrant effect”.

It is evident immigrants are not homogeneous groups and that there are multiple factors that embody who they represent. Access to health and social services should be available to all Canadians and these barriers should be addressed. The limitations can be addressed to provide accurate information to be considered in planning effective actions that bridge the gap in health disparities. The threat of HIV and TB is not solely

an immigrant issue but due to the vulnerabilities this population faces it is imperative to consider further research. The WRHA Research and Evaluation Unit have made several recommendations that can be considered to address these limitations, including:

- Identifying populations within the immigrant groups that are at greatest need
- Identifying priority service needs and addressing them
- Models of service response
- Organizational responsiveness and adaptability
- Education around immigrant health issues (Bowen, 2006)

The government of Canada recognizes the contributions of immigrants and there are several divisions and organizations dedicated to the advancement of health in this population (Public Health Agency of Canada, 2003). The Public Health Agency of Canada (2003) lists several including the Surveillance Risk Assessment Division, in the Centre for Chronic Disease Prevention and Control. This division is working on addressing the need for a comprehensive surveillance of immigrant health in Canada. There are also the national projects on Immigrant Health Status and Health Service Utilization, which are funded by Health Canada and the Canadian Institute of Health Information (Public Health Agency of Canada, 2003).

It is evident that health of new immigrants is influenced by their region of origin, transitional journey and finally their final destination (Gushulak & McPherson, 2004). There is a clear connection between the determinants of health discussed in this document and diseases such as TB and HIV (Health Canada, 2005). Social support is

vital to the health of immigrants and it is imperative for officials to consider the flexibility of policy that can reunite families in Canada (Health Canada, 2005).

Physical environment is largely influenced by income and employment factors and this has an impact on the substandard housing that is a risk factor for the spread of TB.

Accessibility to health services and cultural sensitivity in the delivery of these services is another factor that can promote and sustain the health of immigrants (Health Canada, 2005). Although the rates of TB and HIV in foreign born Canadians have increased over the years, there is relative low risk in the transmission of the diseases to the general Canadian population (Public Health Agency of Canada, 2003). However it is an area that requires further surveillance, control and research because the health of new immigrants is compounded by the status of the determinants of health and the ability of current system to support them in integrating into the general Canadian population.

Appendix A

IMMIGRATION CATEGORIES

There are three categories under which person`s can apply to immigrate to Canada.

- 1. Family Class: Persons who join family already established in Canada**
- 2. Economic Class: Persons who seek to settle in Canada, skilled workers, business immigrants and live-in-caregivers**
- 3. Refugee Class: Persons requiring protection and relief under international law**

Manitoba has historically accepted more refugees compared to other provinces. In 2002, 11% of immigrants who came to Canada were refugees compared to 21.1% in Manitoba.

Manitoba Labour and Immigration, (2007)

HEALTH BENEFITS ELIGIBILITY

Appendix B

Examples of Social Services Eligibility by Immigration Status

NOTE: 1. “Eligible” indicates that a person in the specific immigration category is eligible for the social service if they meet the other criteria not related to immigration 2. Eligibility does not guarantee service.

Table 1: Examples of Health Benefit Eligibility by Immigration Status

	Permanent Resident			Refugee Claimant/Asylum Seeker	Convention refugee or protected person determined in Canada	Visitor/Temporary Resident
	Family Class	Economic Class	Refugee Class			
Characteristics*	Foreign nationals sponsored by close relatives or family members in Canada.	People selected for their skills and ability to contribute to Canada's economy, including skilled workers, business persons and provincial nominees.	Convention refugees or persons in similar circumstances selected at a visa office abroad	People who have arrived in Canada seeking protection and whose claim will be assessed in Canada	People in Canada whom the Immigration and Refugee Board (IRB) has accepted as Convention refugees or persons in need of protection	People visiting, studying or working temporarily in Canada
Planned departure from home country	Yes, planned and prepared to leave		May not have planned or prepared to leave			Varies
Immigration Status in Canada	Permanent Resident status upon arrival			No status in Canada, allowed to remain temporarily pending decision of Immigration and Refugee Board	Eligible to apply for Permanent Resident status	Temporary Resident
Manitoba Health Insurance Eligibility	Eligible immediately upon arrival			Eligible if have work permit that is valid for 1 full year. Dependents of this person eligible if they have any immigration document that confirms their right to be in Canada for at least six months.	Eligible once declared a Convention refugee or person in need of protection.	Eligible if have work permit that is valid for 1 full year. Dependents of this person eligible if they have any immigration document that confirms their right to be in Canada for at least six months.
Interim Federal Health Program Eligibility	Not Eligible		Eligible for one year for limited IFH coverage, services not covered by Manitoba Health Insurance.	Eligible while refugee claimant in renewable 1- year terms. If covered by Manitoba Health Insurance then only eligible for limited IFH coverage.	Not Eligible	Not Eligible

*From "You asked about ... immigration and citizenship" by Citizenship and Immigration Canada, Minister of Public Works and Government Services Canada, 2002

Examples of Social Services Eligibility by Immigration Status...Continued...



Winnipeg Regional Health Authority
Office régional de la santé de Winnipeg

	Program Description	Permanent Resident			Refugee Claimant/ Asylum Seeker	Convention refugee or protected person determined in Canada	Visitor/ Temporary Resident
		Family Class	Economic Class	Refugee Class			
Characteristics*		Foreign nationals sponsored by close relatives or family members in Canada.	People selected for their skills and ability to contribute to Canada's economy, including skilled workers, business persons and provincial nominees.	Convention refugees or persons in similar circumstances selected at a visa office abroad.	People who have arrived in Canada seeking protection and whose claim will be assessed in Canada.	People in Canada whom the Immigration and Refugee Board (IRB) has accepted as Convention refugees or persons in need of protection.	People visiting Canada or working temporarily in Canada.
Immigration Status in Canada		Permanent Resident status upon arrival			No status in Canada, allowed to remain temporarily pending decision of Immigration and Refugee Board	Eligible to apply for Permanent Resident status	Temporary Resident
55 PLUS	Income supplement for lower-income Manitobans who are 55 years of age and over.		Eligible		Eligible if have valid Manitoba Health Registration Number, requiring work permit that is valid for 1 full year.	Eligible	Eligible if have valid Manitoba Health Registration Number, requiring work permit that is valid for 1 full year.
Canada Child Tax Benefit (CCTB)	Non-taxable amount paid monthly to help eligible families with the cost of raising children under the age of 18.		Eligible		Not Eligible	Eligible	Eligible if have lived in Canada throughout previous 18 months, have a valid permit in the 19th month.

Examples of Social Services Eligibility by Immigration Status...Continued...

Program Description	Permanent Resident			Refugee Claimant/ Asylum Seeker	Convention refugee or protected person determined in Canada	Visitor/ Temporary Resident	
	Family Class	Economic Class	Refugee Class				
Child Related Income Support Program (CRISP)	Assists lower-income families with the cost of raising their children.	Eligible			Not Eligible because not eligible for Canada Child Tax Benefit	Eligible	Eligible if have valid Manitoba Health Registration Number, requiring work permit that is valid for 1 full year, and receiving the Canada Child Tax Benefit, requiring that have lived in Canada throughout previous 18 months and have a valid permit in the 19th month.
Children's Special Services	Provides supports and services to families parenting children with disabilities.	Eligible					
Complementary Assistance Program (CAP)	Provides grant assistance to housing co-operatives, to lower housing charges for income-tested occupants.	Eligible after period of sponsorship ends or citizenship is obtained, whichever comes first.	Eligible	Eligible after period of sponsorship ends or citizenship is obtained, whichever comes first.	Not Eligible	Not Eligible	Not Eligible

Program Description	Permanent Resident			Refugee Claimant/ Asylum Seeker	Convention refugee or protected person determined in Canada	Visitor/ Temporary Resident	
	Family Class	Economic Class	Refugee Class				
Employment and Income Assistance Program	Provincial program of last resort for people who need help to meet basic personal and family needs. Wherever possible, the program is aimed at helping people find a job or get back to work.	Eligible after period of sponsorship ends. Eligible during sponsorship period if sponsor unable or unwilling to honour sponsorship undertaking; legal action can be taken against defaulting sponsor.	Eligible	Eligible after period of sponsorship ends. Eligible during sponsorship period if sponsor unable or unwilling to honour sponsorship undertaking; legal action can be taken against defaulting sponsor.	Eligible, except for health benefits that are covered by the Interim Federal Health Program.	Eligible	Not Eligible
Healthy Baby Prenatal Benefit	A monthly cheque during pregnancy is available to income-eligible women to help with eating well.	Eligible			Eligible if have valid Manitoba Health Registration Number, requiring work permit that is valid for 1 full year, and Social Insurance Number.	Eligible if have Social Insurance Number.	Eligible if have valid Manitoba Health Registration Number, requiring work permit that is valid for 1 full year, and Social Insurance Number.
Manitoba Child Care Subsidies	Provides subsidies for child care fees.	Eligible			Eligible if have Social Insurance Number.	Eligible if have Social Insurance Number.	Eligible if have Social Insurance Number.
Manitoba Housing Authority - Public Housing	Affordable and subsidized accommodation for people who are living on low or moderate incomes.	Eligible			Not Eligible	Not Eligible	Not Eligible

Table 2: Examples of Social Services Eligibility by Immigration Status...Continued...

	Program Description	Permanent Resident			Refugee Claimant/ Asylum Seeker	Convention refugee or protected person determined in Canada	Visitor/ Temporary Resident
		Family Class	Economic Class	Refugee Class			
Old Age Security	Pension is given to people 65 and over.	Eligible			Not Eligible	Not Eligible	Not Eligible
Rent Supplement Program	Assists low and moderate-income households to obtain affordable, adequate and suitable housing in the private rental sector and in private non-profit or not-for-profit co-operative housing projects.	Eligible after period of sponsorship ends or citizenship is obtained, whichever comes first.	Eligible	Eligible after period of sponsorship ends or citizenship is obtained, whichever comes first.	Not Eligible	Not Eligible	Not Eligible
Shelter Allowance For Elderly Renters (SAFER)	Financial assistance for persons aged 55 and over who rent their living accommodation in the private marketplace and who are required to spend a large portion of their income on rent.	Eligible after period of sponsorship ends or citizenship is obtained, whichever comes first.	Eligible	Eligible after period of sponsorship ends or citizenship is obtained, whichever comes first.	Not Eligible	Not Eligible	Not Eligible
Shelter Allowance For Family Renters (SAFFR)	Financial assistance for families who rent their living accommodations in the private marketplace and spend a large portion of their income on rent.	Eligible after period of sponsorship ends or citizenship is obtained, whichever comes first.	Eligible	Eligible after period of sponsorship ends or citizenship is obtained, whichever comes first.	Not Eligible	Not Eligible	Not Eligible

	Program Description	Permanent Resident			Refugee Claimant/ Asylum Seeker	Convention refugee or protected person determined in Canada	Visitor/ Temporary Resident
		Family Class	Economic Class	Refugee Class			
Social Insurance Number (SIN)	Nine-digit number used in the administration of various Canadian government programs. Required to work in Canada or to receive government benefits.	Eligible			Eligible for temporary SIN if have work permit/employment authorization or study permit/student authorization and contract of employment. Eligible for these permits if 1) found eligible to have claim referred to Immigration and Refugee Board (IRB), 2) had and passed refugee medical examination, 3) submitted personal information form to IRB.	Eligible for temporary SIN if have work permit/employment authorization or study permit/student authorization and contract of employment.	Eligible for temporary SIN if have work permit/employment authorization OR study permit/student authorization and contract of employment OR a visitor record indicating eligibility to work in Canada OR a diplomatic identity card and a letter of permission of employment.
Supported Living	Person-centered services are provided to eligible adults with a mental disability to meet the unique need of each individual.	Eligible after period of sponsorship ends. If during sponsorship period and sponsor is unable or unwilling to honour sponsorship undertaking then case considered.	Eligible	Eligible after period of sponsorship ends. If during sponsorship period and sponsor is unable or unwilling to honour sponsorship undertaking then case considered.	Eligible	Eligible	Not Eligible

Table 2: Examples of Social Services Eligibility by Immigration Status...continued...

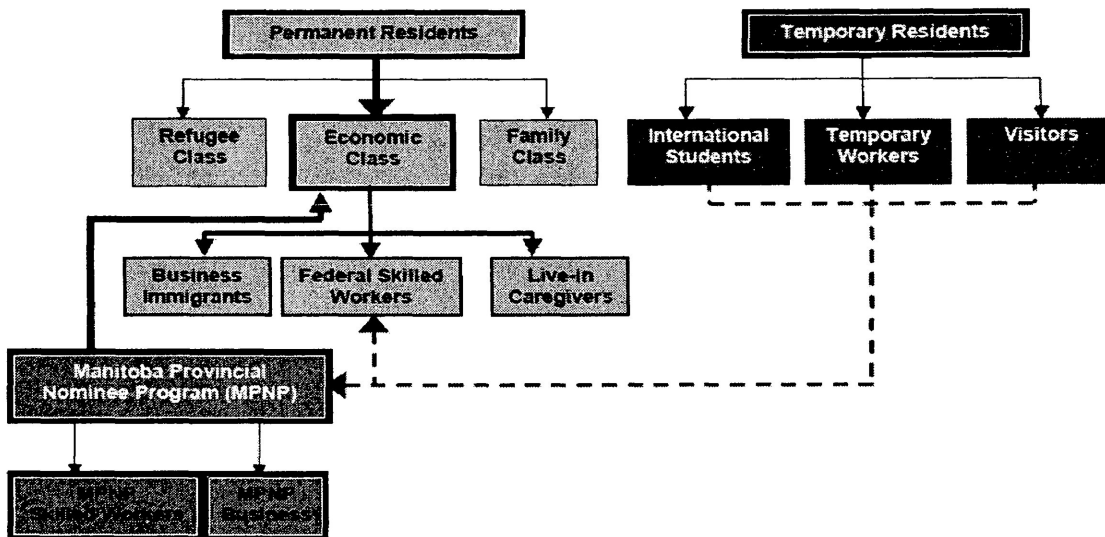
	Program Description	Permanent Resident			Refugee Claimant/ Asylum Seeker	Convention refugee or protected person determined in Canada	Visitor/ Temporary Resident
		Family Class	Economic Class	Refugee Class			
Vocational Rehabilitation Program	Assists eligible adults with a disability to pursue and secure gainful employment, by providing a range of vocational training, education and support services.	Eligible			Not Eligible	Not Eligible	Not Eligible

*From "You asked about ... immigration and citizenship" by Citizenship and Immigration Canada, Minister of Public Works and Government Services Canada, 2002

Appendix C

Pathways to Manitoba Federal and Provincial Entry Streams

PATHWAYS TO MANITOBA FEDERAL AND PROVINCIAL ENTRY STREAMS



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