Migration Health National Conference:
Towards a Migration Health Framework for the 21st Century

Ottawa, March 2003

Final Report

Hosted by

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This Report was made possible with financial contribution from Health Canada Policy Research Program, Health Canada (file number 6795-15-2002/4420003). The views expressed herein do not necessarily represent the official policy of Health Canada.

The Migration Health Conference was held at the Westin Hotel, Ottawa, Ontario on March 25th and 26th, 2003.

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1. One-Page Summary

On March 25 and 26, 2003, Toronto Public Health (TPH) and the Association of Local Public
Health Agencies (alPHa) held a conference on Migration Health in Ottawa, under the auspices
of, and with funding from, Health Canada. This national conference, which focused on four
themes (communicable diseases, non-communicable diseases, access to health services and other
issues), provided a forum to discuss the current state of research on migration health in Canada
and develop some consensus around research priorities.

Due to growing globalization and technological developments, migrant health has become a
quickly changing, complex issue, which encompasses everything between short-term trips to
permanent resettlement. Some studies have found that this increase in population mobility
significantly affects the health of communities. Other studies suggest that immigrants are
healthier than the endemic population due to rigorous entry health requirements for them.

At the beginning of relocation, a migrant’s health reflects the health environment at the point of
origin. But the nature of the migratory journey may also affect the migrant’s health. Evidence
indicates that post-arrival, migrants access health services significantly less than the endemic
residents, and over time, a migrant’s health starts to reflect that of the endemic population.

All four sessions concluded that more research needs to be done and that existing models need to
be overhauled. Focus should be broadened to include refugees, illegal immigrants, travellers and
short-term migrants. Information on both communicable and non-communicable diseases, social
determinants and emerging infectious diseases needs to be included.

The current epidemiological model dealing with communicable diseases needs to be re-evaluated
and revised accordingly. To improve research in this field better quantitative information is
essential. Recommendations included studying different types of migrants, the sustainability of
the health service infrastructure and access to services.

Regarding non-communicable diseases, relevant areas for future were identified as establishing
research priorities, building momentum towards a programme of research and developing a
forward-thinking, proactive agenda. To improve the theoretical understanding of the relationship
between migration and health, it is vital to expand data collection, establish long-term programs
and co-operation between key players.

Access to health services was identified as a key area for concern. Immigrants face a variety of
barriers to health care services: the three-month waiting period; the limitations of the Interim
Federal Health Plan; lack of awareness of available health services; regionalization; culture; and,
language. Other areas/issues that were identified for future research were the effects of
regionalization, human rights, discrimination, and barriers to the workforce on migrant health.

In sum, it was highly recommended that more research be conducted in all of these areas, expand
existing data collection, facilitate access to information and build a strong network among key
players and stakeholders.
2. Executive Summary

On March 25 and 26, 2003, Toronto Public Health (TPH) and the Association of Local Public Health Agencies (alPHa) held a day and a half conference on Migration Health in Ottawa, under the auspices of, and with funding from, Health Canada. This national conference provided a forum to meet and discuss the current state of research on migration health in Canada. The conference was segmented into four main themes: communicable diseases; non-communicable diseases; access to health services; and, other issues.

Migrant health is a quickly emerging, complex new issue. Due to growing globalization and technological development, migration now addresses everything between short-term trips to permanent resettlement. The impacts of these different forms of migration can be quite diverse. Some studies have found that this increase in population mobility has become a significant factor, which affects the health of communities. Other studies suggest that immigrants are healthier, at least in the short run than the endemic population - the so-called healthy immigrant effect, due to Canada’s rigorous entry health requirements.

In order to study the effects of migration on health, a variety of factors have to be considered, including geographical, behavioural, environmental, educational and social determinants. At the beginning of relocation, a migrant’s health reflects the health environment at the point of origin. Then, the type and nature of the migratory journey itself may also affect the health of migrants. Factors such as the duration of the journey, the nature of transportation and the type of entry at destination (legal or illegal) can all have significant impacts.

Once migrants have arrived and are settled, evidence indicates that they access and use health services significantly less than the endemic population. Lack of awareness and access to health programs play a role in the under-utilization of health services by migrants. Over time, a migrant’s health starts to reflect that of the endemic population. With increasing population mobility, it is vital to fully understand the impact on public health. Traditionally, research on migrant health has exclusively focused on communicable diseases. It is now expanding to include non-communicable diseases, social determinants and emerging infectious diseases.

On the first main theme of the conference, communicable diseases, the desired goals were identified as the protection of public health, optimization of health in migrant populations and elimination of health disparities in source countries. It was agreed that the current epidemiological model needs to be re-evaluated. As well, better research is dependent upon improved quantitative information on epidemiology and cost of specific diseases. Other issues that were identified for improvement include studying different segments of migrant populations, the sustainability of the health service infrastructure in relation to immigration quotas, and access to services.

Many of the issues identified for communicable diseases also apply to the second theme, non-communicable diseases. Other relevant areas for future research into non-communicable diseases were identified as establishing research priorities, building momentum towards a program of research and developing a forward-thinking, proactive agenda. To achieve these goals it is vital to expand data collection, supported by a long-term program structure. There
also needs to be a better theoretical understanding of the relationship between migration and health and co-operation between key players.

Access to health services, the third main theme, was identified as a key area for concern, both in relation to communicable and non-communicable diseases. Immigrants face a variety of barriers to health care services: the three-month waiting period; the limitations of the Interim Federal Health Plan; lack of awareness of available health services; regionalization; culture; and, language. In order to overcome these barriers, it is important to study the cause and effects of barriers to access.

Another aspect that was identified at the conference was regionalization, and its effects on migrant health. Identifying the specific needs of immigrant groups in different regions should be addressed in future research. Creating an initiative that allows researchers across Canada to exchange findings will also help to provide a better understanding of the effects of regionalization.

The fourth theme of the conference, “other issues”, encompasses a variety of areas related to migration and health. It was pointed out that health considerations need to be recognised and included in all official immigration matters. Migrant health in relation to human rights, race relations and discrimination also needs to be explored. Other aspects that were highlighted were improving access to professional training for migrants by assisting with language and regulatory matters and also facilitating easier transfer of credentials acquired outside Canada. As with the other themes, more research is needed and, most importantly, there is a strong need to establish a strong network among stakeholders and professionals.

Strong partnerships among stakeholders, communities, research institutions, and all levels of government pave the way for community development, health promotion and disease prevention. Each stakeholder brings different experiences and responsibilities to the table. Government’s focus is on access and equity, non-discrimination, and human rights, while community service agencies and NGOs have direct contact with migrant communities and have an in-depth understanding of their complex health needs. Public health units operate at the local level, providing a link between government and local organisations. A strong network will allow for these different players to align their interests and objectives for future research.

In sum, participants at the conference strongly recommended that existing research needs to be expanded, since the current migration health model is no longer adequate. A new approach should focus on the dynamics of population mobility, its impact on immigrants’ health, public health, communities and on government policies. It is important that research includes and examines refugees and illegal immigrants, as well as travellers and short-term migrants. As well, non-communicable disorders, emerging infectious diseases, access and regionalization need to be incorporated into this new model. A new national strategy needs to be proactive and flexible, based upon an encompassing vision.
3. Context

One of Health Canada’s research priorities in 2002 was to improve its understanding of migration health policy issues. To address this goal, interested parties were asked to submit a proposal, under the Health Policy Research Program, for the development, organisation and delivery of a workshop, seminar or conference that meets the following three objectives:

1. To develop, in collaboration with Health Canada, a Migration Health Framework that identifies and clarifies the key issues which require further research for eventual policy decision-making.
2. To share existing research on the health of migrant populations with respect to the four topic areas described below.
3. To achieve consensus on a Migration Health research strategy, in support of possible future health policy options.

The proposal also needed to focus on certain key topic areas that required the development of research strategies and methodologies to address:

- The incidence/prevalence attribution
- Tuberculosis reactivation
- Health services access during the first 90 days following arrival in Canada
- The extent to which “place matters”

4. Conference Background

The proposal made by Toronto Public Health (TPH) and the Association of Local Public Health Agencies (alPHA) to conduct a full-day conference on Migration Health in Ottawa in March 2003 was accepted by Health Canada (HC). Subsequently, approximately 80 participants attended the conference, which took place in Ottawa on March 25 and 26, 2003. It was held after the “National Symposium on Immigrant Health”, a related but independent conference. Keynote Speakers included J. Scott Broughton (Assistant Deputy Minister, PPHB, Health Canada), Dr. Basanti Majumdar (Researcher, McMaster University), Dr. Pierre Dongier (Physician, Clinique Santé-Accueil), Dr. Brian Gushulak (Director-General, MSB, Citizenship and Immigration Canada), Dr. Ron St. John (Executive Director, CEPR, HC). Dr. Sheela Brasur (TPH) was unable to chair the conference and deliver her paper due to the SARS outbreak in Toronto, an issue related to migration health. She was replaced by Joe Mihevc, Chair of Toronto Board of Health, TPH.

The conference was structured around four major themes, developed by the Conference Program Committee: communicable diseases; non-communicable diseases; access to health services; and, other issues. For each theme, the conference sought to identify research priorities and future steps required to ensure the provision of effective, accessible and timely health care to migrants.

This national conference provided a forum for researchers, policy advisors, administrators and client representatives from all levels of government and non-government organisations to meet...
and highlight the current state of research on migration health policy in Canada. Discussion focused on determining a consensus for directing research strategies and methodologies needed to move closer to a new migration health paradigm. The results of this consultative process are reported on in this document.

5. Introduction

Migration has historically been thought of as the process of moving from one country and settling into another. However, technology has shrunk distances and travel has become more prevalent. Migration therefore, now encompasses everything between short-term trips to permanent resettlement. Immigration, settlement and tourism have different impacts on migration health and these impacts should be considered individually, as well as collectively.

Globalization has increased over the past five decades by advances in telecommunication, technology, trade and transportation. This has resulted in the rapid movement of business travellers, tourists and immigrants, also refugees, temporary workers, students, international travellers, smuggled and trafficked persons and returning citizens and in doing so, influenced the spread of new emerging diseases. A number of studies have indicated that an increase in population mobility has become a significant factor, affecting the health of communities. Other studies indicate that a phenomenon called the healthy immigrant effect suggests that immigrants are healthier than the endemic Canadian population due to rigorous entry health requirements and their own personal characteristics before migration.

These and other issues were explored at the conference. The unfortunate concurrence of the SARS outbreak with the conference highlighted the importance of migration health. It underscored the essential need to fully understand all the challenges, and their consequences, and have the ability to react quickly.

6. Health, Migration and Policies

Health issues in migrant populations have long been acknowledged as a public policy concern. The development and implementation of public health measures to protect the health of the local populations from adverse migrant health impacts has therefore become paramount.

Historically, national and international health policies prescribed practices that predominantly focused on the one-way and permanent movement of individuals from a point of origin to a host community. These practices, in wide use as early as the 1800s, mainly involved containment and exclusion to protect the host population against the introduction and spread of new infections such as leprosy and plague. The planning and application of these policies relied on controlled and organised movement of people and goods.

This approach has become outdated, as migration is no longer largely based on the traditional pattern of permanent resettlement. Increased ease of movement between countries and
communities provides new challenges to protect the health and well being of migrants and their host communities.

In order to meet these challenges, careful consideration must be given to the migration process. At the beginning of relocation, migrants’ health reflects community and health environments at the point of origin. In addition to prevalent diseases, factors such as poverty, housing, nutrition, education, and availability of, and access to, health care services are important clues to identifying related health issues. The type and nature of the migratory journey itself may also affect the health and well being of some the migrant populations. The health status can be affected and influenced by the duration of the journey, the nature of transportation and the type of entry at destination (i.e. licit or illicit).

Post arrival, health service utilization patterns show that immigrants use fewer health care services over the first few years. Lack of awareness and access to health programs are both factors in the under-utilization of health services by migrants. In some cases, migrant communities have health determinants that initially are more favourable than those observed at the destination. Unfortunately, analysis shows that these apparent health advantages often erode over time.

The focus of migration health is expanding from the customary acute communicable diseases to include non-communicable diseases, social determinants and emerging infectious diseases. The health of migrants is now recognized to be directly related to geographical, behavioural, environmental, educational and social factors. In sum, globalization in relation to health legislation and regulation now represents the collision of two fundamentally conflicting processes. The first favours monitoring and controlling the international movement of diseases. The other promotes and supports an ever increasing and less controlled flow of individuals and goods in response to economic factors. As a result of the emergence of these trends, Canada’s current migration health model under-represents daunting health challenges. Developing a new, more inclusive and flexible model is therefore paramount.

7. New Realities of Migrant Health

With over 100 million border crossings into Canada and 17.5 million international trips taken by Canadians in 2000, migrant health is rapidly becoming an increasingly important health determinant. The depth and breadth of the new realities of migrant health in Canada are well illustrated by the example of Toronto.

Consider that:

- 85% of population growth in Toronto is due to immigration
- 50% of Toronto’s population is foreign born
- 60% of GTA residents identify as visible minorities
- 43% of newcomers to Canada settled in Toronto
- 169 different countries of origin (UN has 190 member countries)
- Over 100 languages regularly spoken
Top four visible minority groups: Chinese, South Asian, Blacks and Filipino
And, over 50% of recent immigrants live in poverty

8. Theme I: Approach to Communicable Disease

Objective: To identify research priorities and future steps required ensuring the provision of effective, accessible and timely health care to migrants with communicable diseases.

The desired outcomes were identified as the protection of public health, optimization of health in migrant populations and elimination of health disparities in source countries.

Key Issues and Needs

Participants in this group discussion agreed that the current epidemiological model needs to be re-evaluated. Identification of diseases, health care cost, public and individual health are important factors that should be integrated into the model. Specifically, the current model needs to differentiate between diseases with immediate versus long-term impacts. The public health care system must have the ability to handle emerging infectious diseases and create a disease-specific screening approach, taking into account country of origin, type of migrants, cost-effectiveness, and timing (e.g. 12 month window for arrival).

Better quantitative information on epidemiology and cost of specific diseases is essential to improve both the approach to communicable diseases and policy development. Aggregating data allows for assessing the disease and cost burden in migrant populations compared to the endemic Canadian population. While, the healthy immigrant effect is not highly relevant to communicable disease it may impact on non-evident or not immediately contagious diseases and should be studied further.

Not only is it important to examine the migrant population as a whole in comparison to the endemic community, but it is also crucial to segment migrants for research purposes. Segments could include travellers, short-term migrants, permanent settlers, in-country refugees and illegal immigrants.

There are several questions that need to be asked including:

- Do any of these groups represent a higher risk to public health than others?
- Is there a relationship between time prior to assessment and risk to public health?
- How does each group compare to other migrant groups and to the endemic population?

The communicable disease risk needs to be described and documented for each of the different migrant populations. This should include public perception of risk versus reality; expectation of absolute safety versus Canada’s immigration quotas; acceptable travel risk perceptions within the migrant community; and public education regarding risks. Better data are needed that include
electronic information exchange, two-way communication, data linkages, and key variables (i.e. country of birth, status at arrival).

Access to health services for communicable diseases can be difficult for migrants. Participants felt that eligibility for insured services across jurisdictions and impact of delayed access can have both negative and positive impacts. Other barriers to access are awareness of available services, language and having to take time off work. Understanding barriers and providing incentives to adhere to medical surveillance requirements may increase the follow-up success rate after arrival.

Some communities have greater difficulty in sustaining the health service infrastructure in relation to quotas given by the federal government for immigration. Challenges are particularly evident in Toronto, especially when considering the ratio between the percentage of immigrants settling in Toronto and allocated resources. Resource allocation on a per capita basis for settlement vary greatly across the country. They include: Ontario $700; New Brunswick $1,200; and, Quebec $3,000. Disparities also exist in how these funds are allocated within jurisdictions, especially to health and communicable diseases.

Social capital needs to be augmented to include an active network between the community, non-governmental organisations and the health system. Demonstration and reproducibility of effective models need to be explored and developed. An evaluation of the impact of de-listing travel health services for visiting family and relatives in relation to diseases of public health importance, based upon an examination of trends over time is needed.

RESEARCH STRATEGIES AND PRIORITIES

A database is required that includes identification and collection of important variables, such as country of birth, ethnicity, country of residence prior to arrival, data standards and definitions, electronic data transfer, record linkages, notifiable diseases and immunisation registries. Such a database allows for mathematical modelling that permits migration denominators to be sufficiently granular and therefore make valid comparisons. Other factors that can be addressed include: data linkages; cohort: prospective and retrospective for specific diseases, such as TB, HIV; use of existing survey instruments; Canada health survey; and, biological measurements.

RECOMMENDATIONS FOR FUTURE RESEARCH

It is important to improve the approach to communicable diseases through the use of creative, effective partnerships. Collecting more and better data and providing access is one key step to improve and facilitate research. There needs to be an inventory of existing research, databases, resources, research capacity, pre/during/post migration, participatory research where appropriate, CIHR, Global Health Research Initiative, CIDA, Health Canada, IDRC involvement.
9. Theme II: Approach to Non-Communicable Disease

Objective: To identify research priorities and future steps required ensuring the provision of effective, accessible and timely health care to migrants with non-communicable diseases.

Key Issues

Group discussion revealed that many of the issues outlined in the communicable disease section also apply to non-communicable diseases (NCD). Three key issues were identified: establishment of research priorities; building momentum towards a program of research; and development of a forward-thinking, proactive agenda. It is vital to move away from a reactive approach that merely fills gaps based on past actions.

Research Priorities

Existing data collection should be expanded to include data on migration. This needs to be accomplished by a long-term program structure to ensure that migration health data is available to support policy development. Aspects to be explored are: information on health impact of internal migration; pre-immigration health; determinants of successful settlement/integration; health and health systems.

There needs to be more qualitative research in health migration and a better theoretical understanding of the relationship between migration and health. Understanding of the following areas, which are currently lacking information and/or research, needs to be improved:

- Gender analysis in migration health research
- Risks and behaviours of migrants at difference stages
- Migrant patterns of use, access, gaps, barriers for preventive services
- NCD effectiveness
- Utilization of alternative and complementary health services
- Impact of migration, including 1st and 2nd generations, on NCD behaviours
- Etiologic research into health immigrant effect, lessons for Canadians including resilience, spirituality and health behaviours
- Excessive demand that may result from economic impact of current policy
- Health service demand for all immigrants
- Impact of foreseeable health risks for NCD
- Information on health service utilization for NCD
- How organisations and structures and health care system affects access and utilization
- Understanding the process of acculturation in use of health services
- Role of acculturation in health service utilization on the health immigrant effect
Development of an analytical framework for migration and health research

RECOMMENDATIONS FOR FUTURE STEPS

To initiate a shift in migration health policy regarding non-communicable diseases, a strategic initiative in Canadian Institute for Health Research for migration and health research needs to be established. As well, development of a national data strategy for migration and health involving Statistics Canada, Citizenship and Immigration Canada, Health Canada, FTP, and the Provinces is highly recommended. Advocacy efforts should be made to NCD research funders to include migration and health. Citizenship and Immigration Canada might have the capabilities and existing framework to conduct pre-migration research.

10. Theme III: Access to Health Services after Entry into Canada

Objective: To identify research priorities and future steps required ensuring the provision of effective, accessible and timely health care to migrants.

KEY ISSUES

The conference identified several key barriers to access for migrants to the current health care system. The first barrier is the inequity of health care services available to migrants, especially considering the three-month waiting period that migrants have to undergo until receiving health coverage. Other barriers include the limitations of the Interim Federal Health Plan and limitations to access because of immigration status. Access to basic services needs to be available to all migrants from the moment of entry. A cost-benefit analysis can identify the social cost versus the financial cost of providing migrants with health coverage immediately upon entry. A key question that needs to be answered is what are the benefits of early detection? And what is the impact of the existing three-month waiting period on the endemic society? The research needs to explore the best model for funding, whether based on a global funding formula or a fee for service.

Both immigrants and providers lack the awareness of available health care services. New approaches need to be identified and addressed to close these information gaps. Additionally, there is a need for raised understanding and awareness about the importance of migration for Canada. Comprehensive training of health care providers on issues related to migration health is required and should be coupled with solid partnerships between institutions and communities.

Different types of care need to be made available to migrants, which should include mental health counselling, dental health services, home care and prenatal care. To overcome language barriers, reliable interpretation services need to be made available to all migrants. Improved use of participatory research will lead to the development of new models of care and better information on health determinants related to migratory patterns.
Culture is another barrier to health care services that immigrants face. There is a clear need for specialised services, consultation teams, better training of providers and interpreters, increased awareness at the level of primary care and funding to implement effect models. To fill this knowledge gap there is a need to evaluate new models of care, which address cultural competency in all areas of health in a way that will allow for evidence-based decision-making. A demonstration of all of the costs associated with of specialised services is also required.

The effects of regionalization need to be explored. As well, identifying the needs of immigrant groups in different regions should be addressed and incorporated. Creating an initiative that allows researcher across Canada to exchange findings will help to provide a better understanding of the effects of regionalization.

It is also desirable to re-evaluate the methods used for delivering resources, such as comparing targeted versus integrated programs. The question of what are the impacts of targeted programs on integration and do targeted programs prevent inappropriate use of services, must be answered.

**Recommendations For Future Steps**

For the migration health framework to change there needs to be several linkages developed focused on access issues and barriers. The first is to develop a better link between researchers and decision-makers at all levels; followed by the development of a national network to share research; and mechanisms are needed to involve communities in research and decision-making.

**11. Theme IV: Other Issues**

*Objective:* To identify research priorities and future steps required ensuring successful settlement and integration of migrant populations.

**Key Issues**

Participants agreed that that in the future, health considerations need to be included explicitly in all federal and provincial immigration agreements and communications, as well as in all provincial working groups on migration health. Issues such as human rights, race relations and discrimination should be explored consistent with Canadian values. A national vision for immigration, based upon multiculturalism, can be achieved by providing guidance and connection of policies at all levels.

Settlement and integration are a long process. Migrants need to have access to training for trades and professions, as well as being able to transfer previously acquired credentials. To facilitate this step, it is important to recognise skills, supplement training, assist with language and regulatory agencies. As well, pre-migratory expectations should be considered and incorporated.
Issues related to social determinants were also discussed and determined to be a major focus on migration health into the future.

**Research Needs and Priorities**

Key aspects to be considered are: effectiveness of interventions including health, labour market, settlement, integration and pilot projects; and, existing frameworks including policy, legal, international and health. Best practices are required in each of these areas.

Research priorities should include evaluating the primary and secondary education system for capacity and training of teachers on diversity issues. The impact of poverty and underemployment on health and mental health should also be studied. Most importantly, there is a strong need to collaborate, partner and dialogue among various stakeholders and players.

**12. Stakeholders and Key Players**

The conference identified that in order to further develop strategies and research into migrant health, it is crucial to form partnerships among stakeholders, communities, research institutions, and all levels of government.

The local key players are the public health units, the municipal government, non-governmental organisations (NGOs) and community service agencies. Their combined role is to lead community development, health promotion and disease prevention. In particular, the responsibility of the municipal government is to guide programs on access and equity, non-discrimination, human rights, harassment, and the elimination of racist policies.

Community Service Agencies and NGOs, as key players in the settlement and integration of immigrants, complement the role of local governments by identifying and addressing complex health needs of migrant communities. With different priorities and agendas, it is essential to encourage these key players to establish a network, which will facilitate the alignment of interests and objectives.

The conference also concluded that it is important to continue to build on the existing research, focusing on the dynamics of population mobility, its impact on immigrants’ health, communities and on government policies. Past research on migration and health, to build on, has provided insight into:

- The differences in TB and HIV prevalence between migrant and host populations
- Higher prevalence of mental health problems among some migrant groups, especially refugees
- Differences in Cancer and Cardiovascular Risk, Child Health and Healthy Lifestyles

Migration also has other impacts and requirements on the health care system, such as the delivery of culturally competent health care, which is pivotal in multicultural areas. For
example, the number of foreign-trained nurses is increasing in Toronto, which allows health care providers to better serve various cultural and ethnic communities.

Examples of public health responses to diversity include:

- Healthy Babies Healthy Children – Lay Home Visitor Program:
  - Support and parenting skills for new moms
  - Program staff come from many cultural groups and speak up to 30 languages
- Peer Nutrition Programs:
  - Workshops led by Community Nutrition Assistants
  - In 2001, the program was offered in 71 locations in 23 languages
  - First point of contact with Health and Community Service system for many participants

13. Conclusion

For all nations, migration health is a very important issue in a world that is increasingly interconnected. In particular, for a country like Canada, that has a high rate of population mobility, understanding migration health is paramount. The movement of people around the globe is an increasingly important health determinant.

Governments have long recognized the health implications of population mobility. Beginning in the Middle Ages, quarantine regulations were put in place to prevent the importation of communicable disease by permitting the inspection of people, goods and conveyances. People with certain communicable diseases could be detained, or denied entry. These measures continue today. However, recent global changes in the nature, speed and scale of human migration described above mean that current policy responses to migration are inadequate. A new policy framework/ national strategy is needed.

Research has shown that most new immigrants are actually healthier than the endemic population. As time of settlement lapses, immigrants’ health actually adapts to that of the endemic population. However, the current migration health model is no longer adequate. It has some significant shortfalls. Research is mostly focused on permanent immigrants (i.e. landed immigrants/ permanent residents) and is deficient on tracking refugees and illegal immigrants, as well as travellers and short-term migrants.

The model also needs to be expanded to incorporate non-communicable disorders and emerging infectious diseases. Furthermore, aspects such as access and regionalization need to be taken into account, considering that most immigrants settle in the main urban centres. A national strategy needs to be developed that is proactive, not reactive, and based upon a broad, encompassing vision.
Migration Health National Conference:
Towards a Migration Health Framework for the 21st Century

Ottawa, March 2003

Appendix A

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Appendix A
Towards an Inclusive Migration Health Framework: A Large Urban Perspective

by
Dr. Sheela Basrur
Medical Officer of Health
Toronto Public Health

Introduction
• Local impact of Migration Health Framework
• The role of key local/municipal players
• The challenges and opportunities of population diversity

Current Migration and Health Framework
• Immigration status affects access to health services
• Focus on immigrants through pre-selection medical examinations
• Focus on disease prevention and minimizing cost to health care system

Emerging Migration and Health Framework
• Broader focus on population mobility:
  • Pre-migration experiences in host country
  • The migratory journey itself, and
  • Post-migration experiences in receiving country

Shift in Migration and Health Framework is Influenced by ....

Key Players in Migration and Health Framework
• Community, Community Service Organizations and NGOs
• Research institutions
• Government (Federal, Provincial and Municipal)
Community Diversity, Our Strength

- Diversity provides opportunities and challenges for host communities
- Recognition of roles of Community Service Organizations and NGOs

Toronto’s Poverty Rates

- All persons: 23% (national rate: 19%)
- All seniors: 12% (unattached female: 52%)
- Children & youth: 32% (national rate: 25%)
- Lone-parent families: 42%
- Recent immigrants: over 50%
- Urban Aboriginal peoples and racial groups: 41%

Dimensions of Diversity

- 50% of Toronto’s population foreign born
- 60% of GTA residents identify as visible minorities
- 43% of newcomers to Canada settled in Toronto
- 169 different countries of origin (U.N. has 190 member countries)
- Over 100 languages regularly spoken
- Top four visible minority groups: Chinese, South Asian, Blacks and Filipino

Immigration Drives Population and Economic Growth

- 85% of population growth in Toronto is due to immigration
- New immigrants represented 70% of the total growth in Canadian labour force between 1990 – 2000


Immigration and the Health Care System

- Immigrants enrich the Canadian Health Care System:
  - Foreign trained /immigrant nurses increasing in numbers in Toronto
  - Delivery of culturally competent health care is paramount in diverse populations

Local Players in Migration and Health

- Local Public Health Units
- Municipal Governments
- NGOs and Community Service Agencies

Migration Health National Conference March 2003
Role of Local Public Health Units in Migration and Health Framework

- Community Development
- Health Promotion and Disease Prevention
- Social Marketing

Role of Municipal Government

- Partnership with Community Service Organizations
- Programs guided by Access and Equity, and Non-Discrimination, Human Rights, Harassment, Elimination of Racism policies
- Toronto City Council’s Strategic Plan addresses equity and inclusion

Public Health Responses to Diversity

Examples:
- **Peer Nutrition Programs**
  - Nutrition workshops led by Community Nutrition Assistants
  - In 2001, the program was offered in 71 locations in 23 languages
  - First point of contact with Health and Community Service system for many participants

Role of Community Service Agencies and NGOs

- Identify and address complex health needs of communities
- Key player in settlement and integration of newcomers
- Crucial Partners in Community Needs Assessment/Evaluation

Public Health Responses to Diversity (cont’d)

- **Healthy Babies Healthy Children-Lay Home Visitor Program**
  - Support and parenting skills for new moms
  - Program staff come from many cultural groups and speak up to 30 languages

Research can illuminate:

- Dynamics of population mobility, and its impact on health of immigrants,
- Impact of government policies on health of local communities
Some Highlights of Policy and Applied Research on Migration and Health

• Differences in TB, HIV prevalence between migrant and host populations
• Mental Health: higher prevalence among some migrant groups, especially refugees
• Differentials in Cancer and Cardiovascular Risk, Child Health and Healthy Lifestyles

Questions to Assess Relevance of Research

• What is the basis of selecting research themes?
• Are research findings relevant to local communities?
• Research Transfer: Does research help local or community groups understand Migration Health Issues?
• Is community actively involved in setting research agenda, analysis and dissemination?

Role of Local Government

• Immigration is an urban phenomenon
• Municipalities face the day-to-day impact of federal and provincial immigration-related policies
• Direct experience with diversity
• Large urban centres should be at decision making table

Partnerships: Alignment of Strategic Intent is Key to Success

• Partnership among Stakeholders
  • Community
  • Research Institutions,
  • Government (federal, provincial and municipal)
• Stakeholders may be unique/have different strategies
  • But share same goal - have aligned intent

In Summary: the Need for Inclusive Migration Health Strategies Involves Recognition that...

Health is a basic right
Population mobility drives diversity
Diversity is beneficial

Inclusive Migration and Health Framework

Community
Research Institutions
Government
What Is Migration?

J. Scott Broughton, ADM, Population and Public Heath Branch, Health Canada

Acknowledgement

Contribution by:

Douglas W. MacPherson MD, FRCPC
McMaster University

Migration – the process

Three Considerations*:

• The People
• The Phases of Migration
  ➢ Pre-departure
  ➢ Transit
  ➢ Post-arrival
• 3. The Outcome Determinant Differentials
   (Prevalence Gaps)


The People

What is Migration?

Implications for Population and Public Health

➢ understanding the process
➢ measuring past and current impacts
➢ evaluation of policy consequences
➢ looking to the future & preparing today.

Migration Health - Context

Appendix A
Appendix A

Migration – Canada and the World

Between 1901 and 1914, over 750,000 immigrants entered Canada from the United States. While many were returning Canadians, about one-third were newcomers of European extraction—Germans, Hungarians, Norwegians, Swedes, and Icelanders—who had originally settled in the American West.

Citizenship and Immigration Canada - archives

In 2000:

- ~ 100 million border crossings into Canada (tourists, business travel, migrant workers, students, immigrants, refugees, asylum claimants, . . . smuggled and trafficked persons)
- ~ 17.5 million international trips by Canadians (~ 3.5 million trips to non-USA destinations)
- ~ 225,000 immigrants, including 15,000 refugees (permanent settlements)

WTO data. 2002* projected

Globalization and Migration

Push pull factors of:

- population: size, demographics and biometrics
- processes of movement
- prevalence gaps: source and host countries
  - Education & training
  - Cultural influences and beliefs
  - Behaviour
  - Language
  - Health

WTO data. 2001 ~ US $463 Billion

Migration Health National Conference March 2003
Appendix A

Immigration to Canada – 1860-2001

The Phases

“Pre-departure” Phase
Effect may be:

- negative: e.g., poverty, lower education, poorer health systems
- neutral: e.g., similarity in environment, education, genetics/biology
- positive: e.g., healthier behaviours

“Transit” Phase
Advances in Transportation technology, accessibility and affordability has virtually eliminated the health risks associated with the movement phase

EXCEPT:
- trafficking in humans
- smuggling in humans
“Post-arrival” Phase
Effects of “pre” and “transit” phases plus:

Balance of “imported” cultural, genetic, behavioural influences with host destination determinants: e.g., health care, environment

BUT attainable socio-economic goals now permit reverse migration not possible in previous generations of migrants

“VFR” effect: Visiting Friends and Relatives on recent migrant and 1st generation.

Prevalence Gap

Refugees & Asylum Seekers, by Host Region, 1999

Educational Attainment

Globalization and Migration

• 140 million people live outside of their country of birth (1/40 persons)
• migrants represent > 15% of the population in over 50 countries worldwide
• OECD, Canada, USA –migrants represent ~ 2/3 of population growth
• 45 million migrants from developing nations will enter the workforce globally to 2015

Worldwide Persons in need of Protection, UNHCR. * est.
International Movements

Complex Representation of Inter-related Factors:

- The People
- The Migration Process
- Differentials in Outcome Determinants.

Migration

Looking to the future & preparing today

- Challenge to academics & researchers, social scientists, program administrators, and governmental policy makers
- Evidence-based decision-making.

Migration

Measuring Past and Current Impacts

- Canada is a nation built on migration
- Canada will grow and compete based on migration
- Canada is changing demographically and biometrically, including health determinants, directly related to migration

Migration

Evaluation of Policy Consequences

- foreign policy - trade
- immigration policy
- international security policy
- health policy

Conclusion

Migration is:

- A complex phenomenon
- A characteristic of humans
- Interactive/interdependent with trade, security
- Part of globalization

and a major determinant of what Canada is today and will be like in the future.
MIGRATION AND HEALTH

The experience of a refugee clinic in Montreal
Dr Pierre Dongier
Clinique Sante-Accueil
CLSC Cote des Neiges

CLINIQUE SANTE ACCUEIL

• Medical clinic for refugee claimants in Montreal
• Created in 1984, based in CLSC Cote des Neiges since 1996
• Main objectives:
  1. Provide access to primary health care for refugees
  2. Assess the health status of newly arrived refugee claimants

Federal Interim Health Program

• Urgent and essential care
• Medical consultation, selected medications, laboratory and radiology investigations
• Authorisation required for physiotherapy and psychotherapy and other unusual treatments
• Urgent dental care and contribution for glasses

REFUGEE CLAIM PROCESS

• Legal procedures (access to legal aid)
• Immigration medical exam
• Medical care through FIHP
• Access to work permit and social welfare
• IRB hearing for status determination

Results of studies conducted at Clinique Sante Accueil

<table>
<thead>
<tr>
<th>Year</th>
<th>Study</th>
<th>Origin</th>
<th>Results</th>
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<tr>
<td>2000</td>
<td>PPD screening study 409 patients</td>
<td>India</td>
<td>39% PPD positive</td>
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<td>Africa</td>
<td>29%</td>
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<td>Europe</td>
<td>11%</td>
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<td>S. America</td>
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<td>25% PPD positive</td>
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<td>1987-88</td>
<td>Health status among refugee claimants</td>
<td>Lebanon</td>
<td>14.3%</td>
</tr>
<tr>
<td></td>
<td>(6400 patients)</td>
<td>Bangladesh</td>
<td>8.5%</td>
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<td>Sri Lanka</td>
<td>6.1%</td>
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<td></td>
<td></td>
<td>Nicaragua</td>
<td>5.9%</td>
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<td></td>
<td></td>
<td></td>
<td>20% test positive</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>&lt;4% malnutrition</td>
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<td></td>
<td></td>
<td></td>
<td>10% women pregnant</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>59% complete vaccine</td>
</tr>
<tr>
<td>1985-86</td>
<td>Health status among refugee claimants</td>
<td>Iran</td>
<td>87% good health</td>
</tr>
<tr>
<td></td>
<td>(2099 patients)</td>
<td>Sri Lanka</td>
<td>15% dental problems</td>
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<tr>
<td></td>
<td></td>
<td>Dominican Republic</td>
<td>7.9% malnutrition</td>
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<td></td>
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<td>Haiti</td>
<td>22% parasitosis</td>
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<td></td>
<td></td>
<td></td>
<td>23.4% PPD positive</td>
</tr>
<tr>
<td>1985-86</td>
<td>Health status among refugee claimants</td>
<td>87 countries</td>
<td>Low rate of anemia</td>
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<tr>
<td></td>
<td>(3000 patients)</td>
<td></td>
<td>5.8% and other hematologic abnormalities</td>
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<td>Up to 10% in some groups</td>
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<td></td>
<td>87% patients good health</td>
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<td></td>
<td></td>
<td>10% dental problems</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>25% proteinuria</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>2.5% PPD positive</td>
</tr>
</tbody>
</table>
Health status screening study

- Done between October 2000 and May 2002
- 161 files reviewed
- Anamnesis and physical examination
- Laboratory tests:
  - CBC
  - Serology for strongyloides
  - Hep B+C
  - HIV
  - Stool analysis for O+P

Results of screening study

- Anemia: 19.3%
- Eosinophilia: 6.8%
- Active Hep B: 3.9%
- Active Hep C: 4.3%
- PPD+: 45%
- HIV+: 2.4%
- VDRL+: 9.7%

Conclusions of screening study

- Health status of refugee claimants generally good
- Pertinence of screening beyond the immigration medical examination
- Infectious diseases screening according to region of origin

Parasites

- Intestinal parasites: 7% (mainly giardia, amoebas, ringworm and trichuris)
- Serology:
  - Strongyloides: 16%
  - Filaria: 7.6%
  - Schistosomas: 3.1%

Main reasons for consultation

- Common health problems: acute (URIs, gastroenteritis) or chronic (hypertension, diabetes)
- Pregnancy
- Infectious diseases
- Mental health

Psychiatric questionnaire

- When discussed:
  - 55% normal
  - 45% psychiatric diagnosis:
    - PTSD: 46%
    - Adaptation disorder: 30%
    - Mood disorder: 20%
    - Anxiety: 15%
Access to health care system

- Difficulties related to the FIHP: some institutions refuse to give services
- Language barrier: unequal access to interpreters
- Cultural barrier: understanding health messages, compliance with treatment, punctuality

Conclusions

- Need to facilitate access to health services and sensitize health care providers
- Approach based on health promotion rather than health protection
- Special attention to certain problems: infectious diseases, mental health problems
History of the Current Migration Health Paradigm

Migration Health Conference

Management of Leprosy

- Medieval Society unable to provide preventive or curative treatment
  - similarities to Ebola, SARS and VHFs
- First Health Regulations and Legislation
  - Medical Inspection (Leprachau)
  - Civil Isolation (Case Holding)
  - Public Health Warning (Lazarus Bell)

Medical Screening for Travel

- Amongst the oldest public health measures.
- Response to fear in the absence of effective measures
- Associated with the international movement of people

The Development of Quarantine

- Resulted from the Second Pandemic of Plague
  - late 14th Century
  - period of great growth (emerging disease paradigm)
  - population
  - trade/commerce
  - travel

History of Medical Screening

- Antiquarian Principles that Continue Today
  - Feared illnesses
  - Desire to limit introduction

Application of Quarantine

- Diseases and illnesses of epidemic potential
  - Plague
  - Smallpox
  - Cholera
  - Yellow Fever
Standardization

- Begun in the 19th Century
  - International Sanitary Conferences
  - 60 year process
  - diseases, vector control & standards
- International Sanitary Regulations 1951

Challenges

- Post arrival follow up
  - not a part of classic quarantine
  - more relevant in today’s world
  - costly
  - major gap

International Health Regulations

- Replaced International Sanitary Regulations
- purpose
- ensure maximum security against international spread of disease with a minimum interference on world traffic

Traditional Approaches to Migration Health

- Immigration Medical Assessment
  - Infectious Diseases
    - Quarantine Health
  - Fitness for Establishment
    - Immigration Health

Traditional Focus

- Border or Frontier
  - Primarily of interest to large receiving countries
  - Limited to arrival phase
  - Little concern for integration into health systems
    - Homogenous populations

Article 84

“Migrants, nomads seasonal workers or persons taking part in periodic mass congregations, and any ship, in particular small boats for international coastal traffic, train, road vehicle or other means of transport carrying them, may be subjected to additional health measures conforming with the laws and regulations of each State concerned and with any agreement conclude between such States.”
**Application**

- Often applied under immigration legislation
  - reference to national quarantine system
- national differences as opposed to international situation
  - movement from high to low prevalence areas

**Immigration Health Screening**

- reflects national concerns
  - great variability
- related to social policy
  - employability
  - independence
  - eugenics
  - contagious diseases

**Why this is not already apparent to many**

- Historic Canadian focus is inadmissibility
  - screening focus limited to exclusion (few)
  - limited attention on long term impacts of arrivals (TB good example)
  - limited attention to forward looking issues of those who arrive

**Policy is designed for Homogeneous Populations - Migrants Vary**

- While the unifying factor may be being foreign born, other characteristics can be markedly different:
  - History
  - Economic status
  - Education
  - Legal status
  - Local environment
- All of these characteristics can affect health outcomes

**Pressures on the Paradigm**

- Population flows
- Globalization
- New prevalence gaps
- Evolution of travel
Reduction of Interest in International Disease Control and Regulation

- Limited revision and modernization of legislation
  - national: quarantine
  - international: IHRs
- Retention of antiquated regulatory instruments
  - wrong tools for the wrong place at the wrong time

The Lessons of History may not be Relevant

Evolution: Demography

- More people on the move for more reasons
  - displacement
  - post
  - (natural / man made)
- More destinations
- More origins
- Different ages

Demographics

- @ 175 million persons live and often work outside of their country of citizenship
- @ 1-2 more million migrate permanently every year
- @ 1 million others seek political asylum
- Added to this are some 24 million refugees and millions of internally displaced individuals

Reduction of the Impact of Infectious Disease

- Pharmacology (a drug for every bug)
- Improved control and reduction of disease prevalence
  - in the developed world
- Lowered appreciation of threat
- Decreased appreciation of importance of Public Health

Demographics

- Older and younger
- Bringing with them the health parameters of where they left
- Health care professionals may not be ready for previously geographically isolated diseases (SSD, Trypanosomiasis)
**New Factors Continued**

- **Social**
  - Increasing conflict/social/political unrest
  - Internally and externally displaced
  - Globalized economy
    - Exchange of commerce and labour and merchandise
    - Dietary patterns, pharmaceutical use global
  - Continued population pressures
  - Sustained economic disparity

**Geo-Biologic Boundaries**

- Consequences of travel speed and availability
- Incubation period less than journey
- Vectors in conveyances
- Humanity as a vector
  - Parasitic
  - Vaccine preventable

**Prevalence Gaps**

- Movement from local level to prevalence at destination
  - Implication for diseases that have mandated public health response
  - Costs and resource utilization
  - BioSafety IV diseases
  - Managing small risks

**New Factors Continued**

- **Speed of Travel**
  - Incubation period greater than travel time
  - Frontier focus requires reassessment

Appendix A
Forgotten Risk Groups

- descendants of migrants
  - who return to region of origin
  - concept that citizenship provides public health protection
  - travel medicine is generically applied to passport not risk
    - children return to high risk environment
    - prophylaxis may not be taken

Risks of Rare or Uncommon "Low Incidence" Diseases

- In developed countries, certain groups of migrants can be expected to become high risk groups for diseases and illnesses controlled or eliminated in native-borne populations.

The Relationship Between Migration and Health

Professor Basanti Majumdar RN, MSc, MEd, MSc(T), PhD
School of Nursing, McMaster University
Faculty of Health Sciences

How does the health of migrants differ systematically from non-migrants?

Introduction

1. Immigrants (focus: legal landed immigrants) in Canada constitute a diverse and generally healthy population

2. The health problems of arriving and returning populations will become an increasingly important concern for all Canadians

3. Recent changes in Canada's immigration patterns have made this country more ethnically diverse than ever before

4. People migrate from different cultural backgrounds where their experiences are different from the health and disease patterns that are common in Canada (Majumdar et al., 1995; Health Canada, 1998; Ray, 2002)

Health of Migrants

Assumptions:
When immigrants arrive in Canada, they are a healthy group. (Chen et al., 1994-95). This is assumed to be associated with:

a. Good health - More inclined than those in poor health to emigrate
b. Employability - Granting permission to immigrate requires a certain level of health.
c. Screening - Screening that ensures that they do not suffer from serious medical conditions (Immigration Act of Canada)

Illegal and trafficked migrants do not go through this process

Myths

- Immigrants are unhealthy
- Immigrants bring diseases
- Immigrants have low health habits
- Immigrants believe in mysterious health practices

Appendix A 21
Health of Recent Migrants

Studies Indicate
• Recent immigrants are healthier than the Canadian-born population—
  “healthy immigrant effect” (Fowler N., 1998; Ali J., 2002)
• Recent immigrants, less likely than the Canadian-born population to have chronic conditions or disabilities
  (Chen et al, 1994-95)

Physical Health
• Study on physical health of recent immigrants (women) show that they have healthier lifestyles. They
  • Smoked less
  • Drank less
  • Ate more fruits and vegetables

2. On the other hand, native-born Canadians, in general exercise more than immigrants (Chen et al 1994-95, Perez CE 2002)

Chronic Conditions
Incidence of chronic conditions in general rose with time since immigration to Canada (Ali J., 2002)

In general, but focuses mainly on heart disease, diabetes, high blood pressure, and cancer

Mental Health

Depression in the previous 12 months (Age 16-75 yrs)

Recent and Long Term Immigrants
1. Language barriers, immigrants’ higher unemployment rates, their lower sense of belonging to the local community did not diminish the gap with respect to depression or alcohol dependence.

2. Immigrants who had been in Canada the longest had health outcomes similar to those of their Canadian counterparts

Immigrant Canadians have a higher percentage of people from cultures and religions that forbid alcohol, specially in the past couple of decades where a high number of new Canadians have arrived from Africa and Asia (Ali J., 2002)
Mental Health

Other Studies

- Immigrants represent a vulnerable population at risk with higher rates of depression and alcohol dependence.
- Discrepancies may relate to the fact that literatures has typically focused on specific subsets of individuals (such as refugees) (Owen et al. 2000, Noh et al. 1999).

Mental Health

- It is clear that there are vulnerable subgroups among immigrants. Though, recent immigrants exhibit fewer mental health problems than the Canadian-born population. It cannot be assumed that immigrants have better mental health than the Canadian-born population.

Chronic Conditions

In terms of chronic conditions in general, immigrants and non-immigrants appear to converge in health status over time.


Origin and Destination

The impact of mobility on health risk may be beneficial, neutral, or unfavorable with respect to the adult population. Example:

Movement from a tropical area endemic for malaria to a temperate region, where the disease is not transmitted (MacPherson DH et al., 2001).

Infectious Diseases

1. Health is directly related to the origin, behavior, environment, and social make up of the population in question (Gushulak, 2000).
2. The volume of international travel precludes individual screening of travelers for infections (Gushulak, 2000).
3. Recent major changes in migration health: concern for re-emergence and growing threats of infectious diseases.
Infectious Diseases

4. High speed air travel = the international movement of individuals within the incubation time of all infectious diseases such as tuberculosis, HIV/AIDS, hepatitis, malaria and parasitic diseases

(Cookson et al 1998)

5. Migrants come from developing areas with prevalence of infectious diseases such as tuberculosis, HIV/AIDS, hepatitis, malaria and parasitic diseases

Infectious Diseases

Migrant children and the newly-born may have risks to certain diseases that are different from Canadian children. Examples are:

• tuberculosis
• malaria
• intestinal parasites and
• hepatitis

(Mortenson J et al, 1989, Gushulak, 1999)

Other Diseases

Children who come from environmental polluted regions may carry the effects with them (e.g. lead poisoning, arsenic poisoning in Bangladesh)

Increased risk of ill health due to a combination of dietary and cultural factors (e.g. low levels of Vitamin D & Iron deficiency anemia in children of Asian families)

Infectious Diseases

Specific Diseases

Tuberculosis

Dramatic increase in the proportion of foreign-born cases of TB has been observed over the past 20 years in Canada.

TB in immigrants and refugees results from reactivation and a smaller proportion from primary infection just prior to post-migration

Specific Diseases

Tuberculosis

Risk of TB transmission within immigrant communities are considerable (Carballo et al 1998)

A 5 year Alberta study (1990-1994) – 351 cases of TB diagnosed, immigrants accounted for 70.6% of these cases. 73.4% were from Asian countries (Cook & Sharpe 1998)

Toronto Study- Immigrants account for 92% of TB cases

Risk of TB transmission within immigrant communities are considerable

(Tuberculosis)

Risk of TB transmission within immigrant communities are considerable

(Tuberculosis)

Determinants of Tuberculosis

Individuals born in countries with a high TB prevalence represent a high risk group (Brancker 1991, Wobeser et al 2000)

Predisposing causes:

- poverty
- substandard housing
- substance abuse
- poor sanitation and malnutrition

Contribute to the reactivation of TB in immigrants

(Tuberculosis)

(Tuberculosis)
Barriers to Surveillance and Treatment

Major barriers to TB surveillance and treatment in Canada:
- lack of awareness / accessibility of available services
- lack of coordination between health care services


HIV/AIDS

Human Mobility is associated with the risk of HIV infection.

Major barriers to HIV/AIDS surveillance and treatment in Canada:
- Stigma and isolation of HIV-positive individuals
- Sociocultural behavior and language differences within the immigrant community
- Awareness of the condition, availability and accessibility of the health care services


Controversies Related to Mental Health

Studies have demonstrated negative psychological effects of migration on mental health. Others have suggested that immigrants have a mental health advantage over their native-born counterparts.

Suicide rates among 25 immigrant groups in Canada converged with those of the Canadians

(Kliers and Ward 1988, Klierer, 1991)

For immigrant women, loneliness and depression were a daily feature and high suicide rate among Asian women. Studies have shown that Asian women who face stress from workplace and family suffer from feelings of isolation and depression. At the same time, they indicated majority of them use complementary therapy e.g. meditation and prayer

(Majumdar et al 1998, Majumdar et al 1999)

Other Diseases

Certain conditions, including:
- anemia
- dental caries
- intestinal parasites
- nutritional deficiencies

appear more commonly in newly arrived refugees from developing countries

(Foster 1998)

What are the impacts of migration on health?

Impacts of Immigration

Immigrants go through three distinct resettlement stages:

a. initially a period of euphoria

b. followed by a period of disillusionment, during which depression is common

Impacts of Immigration

- Language difficulties
- Multiple responsibilities
- Financial and employment stressors
- Lack of acceptance by their host communities
- Culture conflict
- Perceived lack of social support

(Research and Analysis Directorate - http://www.hc-sc.gc.ca)

Stresses faced by migrants:
- sense of loss
- helplessness
- alienation
- Language difficulties
- Multiple responsibilities
- Financial and employment stressors
- Lack of acceptance by their host communities
- Culture conflict
- Perceived lack of social support

Impacts of Immigration (cont):
- poverty resulting from academic deskilling
- under-employment and unemployment
- the disruption of social ties
- lack of immediate supportive networks

Impacts of Immigration: Women

Multiple roles they are required to play within the home and the external society (Miles, 1991)

“Role overload” as one of the defining stressors in the lives of immigrant women (Waterstone M et al 2001)

Poor pregnancy outcomes of women due to:
- social exclusion
- being non-white

Impacts of Immigration (Children)

- Poor mental health outcomes: associated with political violence in the country of origin and stress.
- Unaccompanied migrant children have higher risk for inter-familial conflict and disagreement: Children, may acquire behavior and psychosocial problems (Hjern A 1998) aspects of the new cultural environment more rapidly than adults who maintain traditional values (Rakoff 1981, Freire 1985,1991, Gushulak 1999)

Conclusion

Canada has a long tradition of opening its doors to people from all over the world. As regional, international and global factors including wars and conflicts affect different parts of the world, patterns and profiles of migrants and mobile populations has and will continue to change.

In summary, raising awareness of health issues related to migrants among:
- Health care providers
- Educational institutions
- Social agencies
- NGOs and communities

Within the context of historical sociocultural & economical factors geographical backgrounds of the migrants is essential
Conclusion
Appropriate prevention and control of health conditions related to migrant population can be achieved by:

• positive awareness
• planning strategies and implementation of educational interventions and
• ongoing outcome evaluations of health and social services

Remarks
This presentation is based on questions raised by the organizers.

A framework could be used based by the conceptualized theme “place effects” as suggested by Macintyre, Ellaway and Cummins (2002)
It is also important to integrate the issues, concepts, and research identified by Blouin, Foster, and Labonte (2002)
Migration Health National Conference March 2003

Migration Health Conference
Ottawa March 25-26, 2003

What are the “Players” in Migration?

Ronald K. St. John, Director General, Center for Emergency Preparedness and Response, Health Canada

Acknowledgement

Contribution by:

Douglas W. MacPherson MD, FRCPC
McMaster University

Migration Health Paradigm

Working at the National Level:

- history
- understanding the federal processes
- impacts: local to international
- does the paradigm work?

Migration – history

Biblical: Oldest regulatory intervention was to prevent disease importation impact on local population.

“Inspection, detain, exclude”.

Migration – history

500 years ago: “Quarantine” – 40 days

“Inspection, detain, exclude”.

Travellers shy away from international travel

War, pneumonia outbreak, North Korea blamed for decline in Air NZ bookings on key international routes Air New Zealand

21 March 2003

http://home.nzcity.co.nz/news/default.asp?id=29857&cat=976
Appendix A

Migration – history

1851: 12 European states met in Paris for 6 months, produced 131 sanitation regulations in response to the *Asiatic Cholera* outbreaks - to regulate the “lazarettos & quarantine”.

“*Inspection, detain, exclude*”.

2001: *International Health Regulations*

“To regulate the movement of goods, conveyances and people without unduly or adversely impacting on freedom of movement or trade.

International Health Regulations (WHO)

Provides the international regulatory framework for Quarantine Act and the medical screening provisions in the *Immigrant and Refugee Protection Act* (2001).

Understanding the federal processes

Migration Health – federal roles and responsibilities

- **International levels**
- Federal level
- Provincial/territorial
- National levels
- *CIC and HC*

Migration Health National Conference March 2003
### Immigration – Federal Departments

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<td>CIC</td>
<td>DFAIT</td>
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<tr>
<td>Health Canada</td>
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<td>RCMP</td>
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<td></td>
<td>others</td>
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### Federal Departments

**Interests:**
- Public health
- Public safety
- Exclusive on excessive demand (social and health)
- Labour markets
- Trade

**Interests:**
- Economic
- Trade
- Population growth
- Human capital
- Humanitarian

### CIC-HC Technical Working Group on Immigration Health

- Technical issues
- CIC – Medical Services Branch
- HC – Population and Public Health Branch
- Reports to the ADM level in CIC & HC
- Access via ADM to DM and Minister.

### Citizenship Immigration Canada & Health Canada

- CIC ➔ Health Canada
- Programs and Operations ➔ Health advice and Health Policy

### Migration Health Task Force

- **non**-Technical issues
- CIC – Medical Services Branch
- HC – Population and Public Health Branch
- Reports to the ADM level in CIC & HC
- Access via ADM to DM and Minister.
Appendix A

Migration Health Task Force

- Non-Technical issues
- 2 year mandate (June 2001-June 2002)
- Working papers
- “Environmental” scan on FPT, processes, consultations, communications...

Federal Inter-departmental Mechanism

- Minister's Office
- Deputy Minister
- Assistant Deputy Minister
- Director General
- Director

Migration Health Paradigm & Impacts

Migration Health National Conference March 2003
Travellers shy away from international travel

War, pneumonia outbreak, North Korea blamed for decline in Air NZ bookings on key international routes

Air New Zealand

21 March 2003

http://home.nzcity.co.nz/news/default.asp?id=29857&cat=976
National Migration Health Conference

Towards a Migration Health Framework for the 21st Century
March 26, 2003

Approach to Communicable Disease

Key issues
- Goal - protection of public health/ optimizing health in migrant populations/ eliminate health disparities in source countries
- Evaluation of current epidemiological model: identification of diseases of public health, individual, and health care cost importance
  - diseases with immediate versus long-term impact and ability to handle emerging infectious diseases
  - screening approach disease specific to take into account country of origin, type of migrant, cost-effectiveness, timing (e.g., 12 month window for arrival)

Key issues cont’d
- describe/ document risks in the different migrant populations
  - public perception of risk versus reality; expectation of absolute safety versus Canada’s immigration quotas and acceptable travel risk; perceptions within the migrant community; public education re risks
  - better data needed: electronic information exchange, two way communication, data linkages; key variables: country of birth, status at arrival

Approach to Communicable Disease

Key issues cont’d
- Needs: better quantitative information on epidemiology and cost of specific diseases to inform policy development
  - absolute numbers rolled up to assess the disease and cost burden in these populations compared to “endemic” Canadian population
- Healthy immigrant effect:
  - not highly relevant to CDs
  - issues relevant to non-evident or not immediately contagious diseases
- In country refugee claimants:
  - do these represent a higher risk to PH than others?
  - Time prior to assessment and risk to PH
  - vis a vis other types of migrants: visitors (long term, visa, visa exempt), other shorter term migrants, students, VFR; describe/ document risks in the different migrant populations

Key issues cont’d
- Objective
  - To identify research priorities and future steps required to ensure the provision of effective, accessible and timely health care to migrants with communicable diseases.

Key issues cont’d
- Vis a vis other types of migrants: visitors (long term, visa, visa exempt), other shorter term migrants, students, VFR; describe/ document risks in the different migrant populations

Appendix A 33
**Key issues cont’d**

- Access to health services on communicable diseases
  - eligibility for insured services across jurisdictions and impact of delayed access
  - negative/positive impact
  - other access issues: language, lost time from work
  - effect of incentives for adherence to medical surveillance requirements; evaluation of barriers/strategies to improve success of FU post arrival

**Approach to Communicable Disease**

- Research Strategies:
  - Databases:
    - ID and collection of important variables: COB, ethnicity, countries of residence prior to arrival
    - data standards and definitions
    - electronic data transfer
    - record linkages, e.g. notifiable diseases, immunization registries
  - Mathematical modelling
    - migration denominators sufficiently “granular”

**Key issues cont’d**

- Sustainability of services infrastructure vis a vis quotas for immigration esp. Toronto
  - disparities in per capita new resource allocation for settlement, ON $700, NB $1200, Que $3000 and how these funds are allocated within the jurisdiction esp. to health / CD

**Approach to Communicable Disease**

- Data linkages
- Cohort: prospective and retrospective for specific diseases, TB, HIV
- Use of existing survey instruments
  - Canada Health Survey, biological measurements

**Key issues cont’d**

- Social capital
  - social networking
  - interface between the community/ NGOs and the health system
  - demonstration and reproducibility of effective models
  - Impact of delisting travel health services on VFP group on diseases of public health importance
  - examination of trends over time in % of cases attributed to VFR

**Approach to Communicable Disease**

- Recommendations for Future Steps
  - partnerships for creation/improvement and sharing of data to facilitate research and provide access by researchers
  - new WG with academic/community participation
  - inventory of existing research and DBs, resources, research capacity; pre/during/post migration
  - participatory research where appropriate
  - CIHR, Global Health Research Initiative: CIDA, HC, IDRC involvement

Appendix A
### Approach to Communicable Disease

- **Research Priorities**

### Approach to Non-communicable Disease

- **Objective**
  - To identify research priorities and future steps required to ensure the provisions of effective, accessible and timely health care to migrants with non-communicable diseases
  - there was a strong desire to ensure any research agenda was forward thinking and not filling current gaps based on past actions
  - move toward a program of research

- **Research Priorities**
  - inclusion of migration data in existing data collection
  - long-term program/structure to ensure there is migration health data to support policy
  - information on health impact of internal migration
  - information on pre-immigration health
  - information on determinants of “successful” settlement/integration
  - health and health system impact on immigrant

- **Approach to Non-communicable Disease**

  - more use of qualitative research to understand health –migration relationship
  - better theoretical understanding of migration and health
  - more gender analysis in migration health research
  - information on the risks and behaviours of migrants at different stages
  - information on migrant patterns of use/access/gaps/barriers for preventive services
  - information on NCD service effectiveness for migrants

- **Approach to Non-communicable Disease**

  - information on the utilization of alternative/complementary health services
  - impact of migration (1st and 2nd generation) on NCD behaviours
  - etiologic research into healthy immigrant effect; lessons for Canadians; this includes resilience, spirituality, health behaviours
  - excessive demand – economic impact of current policy
  - health service demand for all immigrants

- **Approach to Non-communicable Disease**

  - impact of foreseeable health risks for NCD
  - information on health service utilization (for NCD) of migrants
  - how organizations and structures and health care system affects access/utilization for migrants
  - understanding the process of acclimation in use of health services
  - role of acclimation in health service utilization on the “healthy immigrant effect”; unbundling the healthy immigrant effect
  - need to develop analytical framework for migration and health research
Access to Health Services
After Entry into Canada

- Problems with different type of care
  - Mental health
  - Dental health
  - Home care
  - Perinatal care
- Interpretation
- Regionalization
- Resources

Access to Health Services
After Entry into Canada

- Research and Policy Priorities
  - Equity
    - Access to basic service be available to all from moment of entry
  - Knowledge needs
    - Cost benefit analysis of the impact including social cost and benefits
      - Include the benefit of early detection
      - Include the impact of a waiting period on the individual and on society
    - The best model for funding: global funding vs. fee for service

Access to Health Services
After Entry into Canada

- Objective
  - To identify research priorities and future steps required to ensure the provisions of effective, accessible and timely health care to migrants

Access to Health Services
After Entry into Canada

- Key issues
  - Equity
    - 3 months delay
    - IFHP limitations
    - Limitation to access by status
  - Knowledge
    - Immigrants and providers
    - Cultural competence

Access to Health Services
After Entry into Canada

- Recommendations for Future Steps
  - Establish a strategic initiative in CIHR for migration and health research (CPHI)
  - Develop a national data strategy for migration and health (Stats Can, CIC, HC, FTP, Provinces)
  - Conduct pre-migration research (CIC)
  - Advocate to NCD research funders to include migration and health

Appendix A
Access to Health Services After Entry into Canada

- Cultural Competence
  - Recommendations
    - Need for specialized services and consultation teams
    - Better training of providers and interpreters
    - Increased awareness at the level of primary care
    - Funding to implement effective models
  - Knowledge gaps
    - Need to evaluate new models of care addressing cultural competency in all areas of health in a way that will allow evidence based decision making
    - Demonstrate the cost of specialized services

- Regionalization
  - Respond to the needs of diverse immigrant groups in different regions
  - Create initiative to allow researchers across Canada to exchange findings
- Resources
  - Knowledge: Comparison of targeted vs integrated programs
    - What is the impact of targeted programs on integration
    - Do targeted programs prevent inappropriate use of services

Access to Health Services After Entry into Canada

- Recommendations for Future Steps
  - Develop a better link between researchers and decision makers at each level
  - Develop a national network to share research on access to health care services
  - Develop mechanisms to involve the communities in research and decision making

Other Issues

- Covers items other than access to healthcare such as settlement and integration issues
- Objective
  - To identify research priorities and future steps required to ensure successful settlement and integration of migrant populations

Other Issues

- Key Issues
  - Include "health" in future fed-prov immigration agreements and communication
  - Establish fed-prov working group on migration health
  - Human rights, race relations and discrimination issues vis-à-vis Canadian values
  - Need for national vision for immigration/multi-culturalism (interconnections between policies)

Other Issues

- Accreditation and access to trade and professions
  - Recognition of skills
  - Language and other training
  - Regulatory agencies
  - Pre-migratory expectations
Other Issues

- Research Needs and Priorities
  - effective of interventions
    - health
    - labour market
    - settlement/integration
    - pilot projects
  - frameworks (principles)
    - policy; legal; international; health

Other Issues

- Best practices
  - Primary and secondary education system
    - capacity
    - training of teachers on diversity issues
  - impact of poverty/underemployment on health and mental health

Other Issues

- Recommendation for Future Steps
  - need to collaborate, partner and dialogue among various stakeholders and players
Migration Health National Conference:
Towards a Migration Health Framework for the 21st Century
Ottawa, March 2003

Appendix B

Hosted by

[Logos]

With Recognition from

[Logos]
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1. Agenda

PROGRAM AT A GLANCE

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<tr>
<th>Tuesday, March 25, 2003</th>
<th>Wednesday, March 26, 2003</th>
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<tbody>
<tr>
<td>12:00 pm</td>
<td>8:00 am</td>
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<tr>
<td>Registration</td>
<td>Breakfast</td>
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<td>1:00 pm</td>
<td>9:00 am</td>
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<tr>
<td><strong>Opening General Session</strong></td>
<td><strong>Concurrent breakout sessions</strong></td>
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<tr>
<td>Welcome by Andrew Papadopoulos, Association of Local Public Health Agencies; and Dr. Sheela Basrur, Toronto Public Health</td>
<td>Session 1: Management of Communicable Disease (including TB)</td>
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<tr>
<td>1:15 pm</td>
<td>Session 2: Management of Non-communicable Disease</td>
</tr>
<tr>
<td><strong>Keynote Speaker</strong>: J. Scott Broughton, Assistant Deputy Minister, Population and Public Health Branch, Health Canada</td>
<td>Session 3: Access to health services after entry into Canada</td>
</tr>
<tr>
<td><strong>Theme</strong>: What is migration?</td>
<td>Session 4: Other Issues (Other than access to healthcare, i.e. settlement and integration)</td>
</tr>
<tr>
<td>2:00 pm</td>
<td>10:30am</td>
</tr>
<tr>
<td><strong>Keynote Speakers</strong>: Dr. Basanti Majumdar, Researcher, McMaster University; and Dr. Pierre Dongier, Physician, Clinique Santé-Accueil</td>
<td><strong>Health &amp; Fitness Break</strong></td>
</tr>
<tr>
<td><strong>Theme</strong>: What is the relationship between migration and health?</td>
<td>11:00 am</td>
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<tr>
<td>3:00pm</td>
<td><strong>Concurrent Sessions resume</strong></td>
</tr>
<tr>
<td><strong>Health &amp; Fitness Break</strong></td>
<td>12:00 pm</td>
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<tr>
<td>3:30 pm</td>
<td>Lunch</td>
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<tr>
<td><strong>Keynote Speaker</strong>: Dr. Brian Gushulak, Director General, Medical Services Branch, Citizenship and Immigration Canada</td>
<td>1:00 pm</td>
</tr>
<tr>
<td><strong>Theme</strong>: History of the current migration health Paradigm</td>
<td><strong>Key Wrap Up Plenary</strong>: Summary of breakout sessions</td>
</tr>
<tr>
<td>4:15 pm</td>
<td>2:30 pm</td>
</tr>
<tr>
<td><strong>Keynote Speakers</strong>: Dr. Ron St. John, Executive Director, Centre for Emergency Preparedness and Response, Health Canada and Dr. Sheela Basrur, Medical Officer of Health, Toronto Public Health</td>
<td><strong>Health &amp; Fitness Break</strong></td>
</tr>
<tr>
<td><strong>Theme</strong>: Who are the players?</td>
<td>4:00 pm</td>
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<tr>
<td>6:00 pm – 9:00pm</td>
<td><strong>End of Conference</strong></td>
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<tr>
<td><strong>Reception and Hor D’Oeuvres</strong></td>
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## 2. Participant List

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3. Background Document

Thank you for registering for the National Migration Health Conference organised by the Association of Local Public Health Agencies (alPHa) and Toronto Public Health. Contained within this package is an updated agenda, list of registered participants, references for background information relating to migration health, speakers’ biographies, acknowledgements and directions to the conference.

Health issues in migrant populations have long been acknowledged as a public health concern and the importance of implementation of public health measures to protect the health of the local populations has therefore become paramount. For the purpose of the conference migrant population will be defined as including: refugee claimants, convention refugees, independent immigrants, family-class immigrants, Canadian tourists, and business travellers, international students, temporary workers, smuggled and trafficked persons, international travellers and returning citizens.

Historically, national and international health legislation and regulations prescribed practices that predominantly focused on the one-way and permanent movement of individuals from a point of origin to a host community. These practices, in wide use as early as the 1800’s, mainly involved containment and exclusion to protect the host populations against the introduction and spread of new infections such as leprosy and plague. The planning and application of these policies relied on controlled and organised movement of people and merchandise. This approach has become outdated, as migration is no longer based on the traditional pattern of permanent resettlement. Increased ease of movement within and between countries and communities and the resulting emergence of a more integrated world are accompanied by new challenges to the services that are provided to protect the health and well being of migrants and their host communities.

In order to meet these challenges, careful consideration must be given to many factors in the migration process. At the beginning of the process of relocation, the migrants’ health reflects community and health environments present at their point of origin. In addition to prevalent diseases, factors such as poverty, housing, nutrition, education, and availability and access to health care services are important clues to identifying related health issues. The type and nature of the migratory journey itself may also affect the health and well being of some the migrant populations. The health status of the migrant during the journey can be affected and influenced by the duration of the journey, the nature of transportation and the type of entry into the destination (i.e. licit or illicit). Post arrival, health can be influenced by the lack of awareness or accessibility to health programs and services.
The focus of migration health is expanding from the customary acute communicable disease to include non-communicable diseases, social determinants and emerging infectious diseases. The health of migrants is now recognised to be directly related to geographical, behavioural, environmental, educational and social factors. In some cases, migrant communities have health determinants that are more favourable than those observed at the destination. Canada's current migration health model under-represents the health challenges presently in the Canadian population.

To address this challenge, the conference has been structured in such a way that the key speakers on the first day will set the tone for lively debates and discussions within each of the four concurrent breakout sessions on the second day. Participants will be assigned a particular breakout session. These sessions will focus on the approach to communicable and non-communicable diseases, access to health care services after entry into Canada and other migration-related non-health issues in hopes of identifying key issues, research priorities and recommendations for future steps. Outcomes of these sessions will be presented in a plenary forum on the afternoon of the second day and later compiled into a final report that will be widely disseminated to aid in the further development of migration health policy.

The explicit objective of this conference is to provide a forum for the expression of views that will contribute to a consensus for directing research strategies and methodologies needed to move closer to a new Migration Health Paradigm. This is the challenge that has been extended to you. This conference affords you the opportunity to express your views and the hope is that important elements will be determined to facilitate moving migration health policy forward.

*Acknowledgement to Dr. Brian Gushulak and Dr. Douglas MacPherson for their assistance with contextual information utilised in this background paper.*
4. References


Macintyre, Sally, Anne Ellaway, and Steven Cummins, “Place Effects on Health: How Can We Conceptualise, Operationalise and Measure them?” in Social Science & Medicine, Volume 55, 2002.


5. Breakout Session 1: Approach to Communicable Disease

The objective of this breakout session is to identify research priorities and future steps required to ensure the provisions of effective, accessible and timely health care to migrants with communicable diseases. To address this goal the participants need to consider the following:

- Current methodologies for estimating the risk of migrant population acquiring communicable disease outside of Canada.
- Strategies for linking agencies for the purpose of improving insights into communicable diseases acquired outside of Canada.
- Interventions to identify, prevent and treat communicable disease.

Questions to be addressed:

1. **Key Issues:** Brainstorm a list of key issues in the workgroup area.

2. **Research Needs:** Suggest information, which would be needed to develop appropriate public policy to address each of the key issues.

3. **Research Priorities:** Select most important five research topics and research strategies from the list in step 2.

4. **Recommendations for Future Steps:** Identify any specific actions, which would assist in developing appropriate research.
6. Breakout Session 2: Approach to Non-communicable Disease

The objective of this breakout session is to identify research priorities and future steps required to ensure the provisions of effective, accessible and timely health care to migrants with non-communicable diseases. To address this goal the participants need to consider the following:

- Current methodologies for estimating the risk of migrant population acquiring non-communicable disease outside of Canada.
- Strategies for linking agencies for the purpose of improving insights into non-communicable diseases acquired outside of Canada.
- Interventions to identify, prevent and treat non-communicable disease.
- Consequence of chronic non-communicable disease (i.e. Hepatitis C).
- Diseases which are related to but not directly communicable (i.e. irritable bowel disease).
- Non-infectious diseases health determinants (e.g., smoking, drug use, diet).

Questions to be addressed:

1. **Key Issues:** Brainstorm a list of key issues in the workgroup area.

2. **Research Needs:** Suggest information, which would be needed to develop appropriate public policy to address each of the key issues.

3. **Research Priorities:** Select most important five research topics and research strategies from the list in step 2.

4. **Recommendations for Future Steps:** Identify any specific actions, which would assist in developing appropriate research.
7. Breakout Session 3: Access to Health Services after Entry into Canada

The objective of this breakout session is to identify research priorities and future steps required to ensure the provisions of effective, accessible and timely health care to migrants. To address this goal the participants need to consider the following:

- What are the factors affecting services that are not utilised or under-utilised during the first 90 days (lack of awareness of Interim Federal Health program, cultural factors, illegal refugee status, disconnect between public health and general health care system)?
- Estimates of the health consequences of service non-utilisation or under-utilisation.
- Address the issue of lack of access/availability to physicians and specialty health care providers and the need for health services to adapt to migrant’s needs.

Questions to be addressed:

1. **Key Issues:** Brainstorm a list of key issues in the workgroup area.

2. **Research Needs:** Suggest information, which would be needed to develop appropriate public policy to address each of the key issues.

3. **Research Priorities:** Select most important five research topics and research strategies from the list in step 2.

4. **Recommendations for Future Steps:** Identify any specific actions, which would assist in developing appropriate research.
8. Breakout Session 4: Other Issues (Other than access to healthcare, i.e. settlement and integration)

The objective of this breakout session is to identify research priorities and future steps required to ensure successful settlement and integration of migrant populations. To address this goal the participants need to consider the following:

- Comparisons between locations which are popular immigrant destinations and those which are not.
- Comparisons between locations with established but different approaches to settlement and integration programs.
- Ability of health and social authorities in specific locations and jurisdictions to anticipate and meet the health needs of immigrants.
- Influence of social determinants such as poverty, housing, nutrition and education.

Questions to be addressed:

1. **Key Issues:** Brainstorm a list of key issues in the workgroup area.

2. **Research Needs:** Suggest information, which would be needed to develop appropriate public policy to address each of the key issues.

3. **Research Priorities:** Select most important five research topics and research strategies from the list in step 2.

4. **Recommendations for Future Steps:** Identify any specific actions, which would assist in developing appropriate research.
Propositions about Migrant Adjustment Then and Now
Migration Health Conference, March 26, 2003

The goal of the presentation is to give a macro level overview of how the environment faced by migrants to Canada will be different in the decade ahead from that of the 1980s and 1990s. Such an overview is valuable as good public policy is about making sure that the solutions that are proposed now are for the problems of now, not those of the past. This is especially important for those working at the ‘coal face’ of migrant adjustment issues, as they often aren’t that aware of the evolution of the macro-level environment which determines the micro-level adjustment problems that migrants face.

This presentation is organized as a simple series of propositions, some of which are true and some of which are debatable!

**Proposition 1**: The integration of migrants into the community and economy is important - from an economic and health perspective. The health perspective reflects the fact that failure to adjust economically will, in the long run, lead to an adverse impact on health via the usual channels of the impact of socio-economic status on health.

**Proposition 2**: The 1980s and 1990s were, for the most, very part difficult decades for integration into the Canadian labour market. All the evidence shows a slower rate of convergence of immigrant standards of living to the Canadian-born average than for previous cohorts of immigrants. This slower adjustment needs some perspective, though. The 1980s and early 1990s were difficult from the perspectives of anyone with some form of labour market limitation, not just many migrants but also many Canadian-born people with limited skills and educational attainment. This reflected poor macro economic performance in general that resulted in an economy with prolonged periods of excess unemployment (that is employment above an underlying structural unemployment rate).

**Proposition 3**: By the end of the 1990s, the circumstances had changed and Canadian labour markets were strong, with high employment growth, and a high employment ratio (the percentage of the working age population that was employed, a combination of low unemployment and high labour force participation). Employers were starting to face issues of finding qualified employees, not just for highly skilled workers but across the skill spectrum.

**Proposition 4**: Despite the economic “slowdown” of the last two years, low unemployment and a high employment ratio still characterizes the Canadian economy. In 2002 the Canadian
economy created an all-time record number of jobs in 2002 with an unemployment rate hovering around 7 ½ per cent. This does not mean there are not economic risks facing Canada, ....but Canada was still doing well as it entered into 2003.

**Proposition 5:** Labour markets are likely to stay relatively”tight” (that is with low unemployment and a high employment ratio) for the foreseeable future because of (1) the overall state of the economy and (2) demographics.

**Proposition 6:** The demographics of the baby boom ensure slower and slower growth in potential employment in the decades ahead. This will result from the ageing of the baby-boom generation to the point of full retirement. It could well be compounded by a reduction in average hours worked as older workers start to partially withdraw from work earlier than the standard retirement age. This phenomenon may be slower due to the effects on household net wealth and pension prospects from the equity market collapse of the last several years and the revaluation of actuarial positions of pension plans. But this changes timing only, not the inevitable outcome.

**Proposition 7:** Worries about slowing labour force growth have been a key factor driving public policy with respect to immigration. This is driven in part from a perspective, not necessarily true, that growth is always good and in part because of concerns about the fiscal consequences of impending demographics.

**Proposition 8:** Worries about fiscal consequences of slowing population growth are legitimate, not so much from the perspective of pension sustainability but from the perspective of health care sustainability. The former is less of an issue as, in the mid 1990s, Canada put its pension system (specifically the Canada and Quebec Pension Plans) on a much more sustainable basis while private pension plans must always stay actuarially sound. In contrast, the latter – the sustainability of health care provision – is an issue because health care provision is run on a ‘pay-as-you-go’ basis. That is the costs of each year are paid out of each year, unlike a well-funded pension system in which each generation initially pays more, builds up a surplus and then draws it down. Currently, from a health care perspective we are still in “the good old days “, with a baby-boom generation in good health and in their peak earning years, meaning that the health expenditure share of national income is currently unusually low because of the existence of the baby boom generation. But, that will not continue forever as health care expenditures are much higher for older people, not so much simply because they are older, that is further from birth, but because they are closer to death and the share of the elderly will grow enormously as the baby boom generation ages.

**Proposition 9:** Immigration will not, however, change the demographics much. This is especially so in the rural, smaller provinces that are simply not the destination of choice for international migrants.

**Proposition 10:** The pressure of these demographic developments will come in the more labour intensive sectors of the economy. These are (1) health services and (2) education. These are
sectors not very prone to gains in output-per-worker productivity, because of their intrinsic labour intensity.

**Proposition 11:** Canadian employees likely got used to having “a surplus army of the unemployed” in the 1980s and 1990s. That is, when jobs were available there were always qualified people available to fill them. This led to specific hiring/managing/HR practices that likely focussed on candidates with ready-to-use skills more than on training candidates with potential. Such practices will likely have to change in this decade and next and employers will have to focus more on developing the staff skills they want. Something like this happened in US in the 2nd half of 1990s, as they got to full employers earlier than did Canada.

**Proposition 12:** Such changes in hiring and development practices will likely make a huge difference, over the medium term, to the ability of new migrants to adapt and be economically integrated

**Proposition 13:** Most industries, including the public sector, will face broadly similar pressures. There will increasingly be what is now called in the federal public service a “war for talent”. This will certainly benefit skilled immigrants. But, the general labour market pressures will “trickle down” to those with lesser skills.

**Proposition 14:** But the public sector will have a very important role in helping to facilitate adjustment. While this will be true for all ages, it is especially true for the young children of immigrants. The front line in this effort will be the school system. But, a worry here is that the health care file seems to be eclipsing education, especially primary and secondary education, in the contest for (1) policy attention and (2) fiscal resources.

**Proposition 15:** Urban design policies may also have a key role. Immigrants to Canada largely settle in urban areas. Canadian urban areas are becoming very heterogeneous, including multicultural, (unlike rural areas). But, the evidence suggests that the mixing that is taking place at the level of a Census Metropolitan Area (CMA) (that is a large city) is less evident when one looks at specific neighbourhoods. Here there seems to be less mixing, perhaps even increasing homogeneity as small neighbourhoods become more different from other neighbourhoods in terms of socio-economic status, race and ethnicity. This suggests that the cities, and how we design them, are as important as many traditional socio-economic policies in encouraging, or not, immigrant adjustment.