Exploring the Link Between Neighbourhood and Newcomer Immigrant Health

St. James Town Initiative

By Nasim Haque, Nazilla Khanlou, Stephanie R. Montesanti, and Brenda Roche

WELLESLEY INSTITUTE
advancing urban health

WELLESLEY INSTITUTE
advancing urban health

Exploring the Link between Neighbourhood and Newcomer Immigrant Health

A Qualitative Study

Authors:

Nasim Haque[1]

Nazilla Khanlou[2]

Stephanie R. Montesanti[1]

Brenda Roche[1]

July 2010

[1] Wellesley Institute

[2] OWHC Chair, Women's Mental Health Research, Faculty of Health
Academic Lead, Lillian Wright Maternal Child Health Scholars Program
Associate Professor, School of Nursing, York University

Acknowledgements

We would like to acknowledge the support of our community partner and collaborators, the St. James Town Safety Committee and members of the community advisory group, for their valuable input in structuring the study. We would like to thank Community Project Coordinator Shinta Martina, and the residents of St. James Town that we worked with. We are also grateful to our moderators and note takers who helped us accomplish this challenging and rewarding study.

We would also like to thank all the participants for their time and commitment to the study, and for sharing their perspectives on the St. James Town neighbourhood. We sincerely thank Wellesley Community Center manager, Bhim Rana, and the community's library manager for providing us with meeting space.

Executive Summary

This qualitative research study was conducted in St. James Town (SJT), an urban multicultural neighbourhood located in the northeast corner of Toronto's downtown core. This study examined both the "place-based" characteristics of SJT and individual-level factors, including newcomer immigrants' perceptions of the neighbourhood, their social relations, and their access to health and social services in the neighbourhood. This study was based on focus groups and individual interviews with three ethno-racial immigrant populations: Tamil, Filipino, and Chinese (Mandarin speaking). It compared their experiences with those of Canadian-born residents in the neighbourhood. The objectives of the study were as follows:

1. To explore how newcomer immigrants in SJT define health;
2. To increase our understanding of how place influences newcomer-immigrant health;
3. To explore what neighbourhood factors (e.g., housing quality, social networks and supports, safety, and access to services and recreational space) newcomer immigrants in SJT identify as influencing their own health and health risks; and
4. To examine how neighbourhood factors are conceptualized and experienced across and within different groups.

This descriptive study employed a qualitative research design to allow for an in-depth understanding of newcomer immigrants' perceptions on the ways in which the neighbourhood context influences their health. Data collection involved focus groups and individual interviews with residents of SJT, as well as interviews with health and social service providers in SJT and the surrounding area. The discussion guidelines were translated into Tamil and Chinese (Mandarin) by fluently bilingual speakers and checked for semantic equivalence by back translation. The translated guidelines were also reviewed by the community advisory group for cultural appropriateness.

The main findings from the study are summarized according to the following categories:

1. Perceptions of Health and Wellbeing

Participants demonstrated an understanding of the impacts of factors such as their work environment, the quality of their housing, and available social networks on their health and wellbeing. Health and wellbeing were understood to be the absence of disease in the body, the ability to participate in society and the workforce, individual satisfaction, psychological balance, family harmony, and the availability of 'good' medical services.

2. The Impact of Migration and Settlement on Newcomers

The themes that emerged from participant responses on the impacts of migration on their health and wellbeing include employment barriers, language barriers when seeking employment and accessing health and social services, the challenge of adapting to a new physical environment, and the loss of social support upon immigration. In addition, the limited availability of health and social services upon immigration was a concern expressed by participants.

3. Place-Based Characteristics of St. James Town

Participants raised concerns about aspects of the SJT neighbourhood that they felt impacted their health and wellbeing. A major concern is the quality of housing. Residential high-rise buildings are poorly maintained, and landlords fail to address the concerns of residents. Newcomer immigrants stated that the cheap rent in the neighbourhood makes it difficult for them to move elsewhere. Participants mentioned that the crowdedness of the neighbourhood could result in health problems with sanitation and the spread of illness. Safety in SJT is another concern for residents who have experienced crime and been exposed to drug use in the neighbourhood. However, participants spoke positively about the convenient location of SJT to their place of work, its local grocery and ethnic food stores, as well as the presence in SJT of people of similar ethnic origin to their own.

4. Availability and Quality of Health and Social Services

Participants expressed concerns about the availability and quality of health and social services in SJT. Several participants felt that there were not enough quality services available in the neighbourhood and surrounding area that met their needs. Some participants described their difficulties with finding a family physician upon arrival in the area. Also, there was limited information available to newcomer immigrants on how to navigate the healthcare system and community health and social services.

5. Service Provider Interviews

Service providers described the challenges of providing services to different ethnic groups with different needs. Service providers were also very aware of the barriers and inequalities that newcomer immigrants experience, such as, employment barriers, language barriers, and issues with discrimination of ethnic groups.

Conclusions

The results indicate that SJT newcomer immigrant residents experience a range of manifestations relating to physical, mental, and social health and wellbeing. Therefore, health outcomes and wellbeing are the result of a complex web of causation where risks are related to individual behaviour, neighbourhood, access to social and health services, and social support. Responses and experiences were similar across the ethnic groups and non-immigrant residents in SJT. Participants described both positive and negative aspects of living in SJT. Residents felt that access to public transportation, the vicinity to grocery stores that sell their culture's food, and the presence of other residents of similar ethnic origin were important and positive aspects of SJT. Participants also described the negative aspects of SJT that they believed impacted their health and wellbeing. Crowdedness, poorly maintained residential buildings, a lack of sufficient recreational space, and the presence of crime were all factors that contributed to residents' dislike of the neighbourhood. However, economic circumstances constrained their ability to move to other residential neighbourhoods that did not possess these negative factors.

The service providers interviewed described the challenges and barriers to providing services and care to newcomer immigrants who have diverse needs. They also indicated that funding constraints limit their ability to design and administer services and programs that accommodate the particular needs of the different ethnic groups.

Table of Contents

1. Introduction

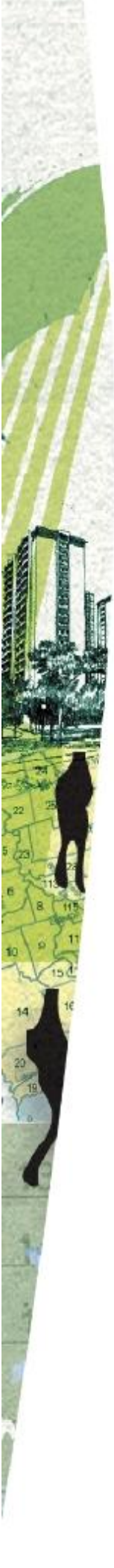
This case study examines the St. James Town (SJT) neighbourhood in Toronto's downtown core. An established immigrant-receiving area of great ethno-racial diversity, SJT shares similarities with several immigrant-receiving areas in other Canadian cities in the prevalence of aging high rises, limited open space, dense social networks, and convenient location. The study focuses on the experiences of three ethno-racial immigrant populations: Tamil, Filipino, and Chinese (Mandarin speaking) and compares their experiences with those of Canadian-born residents in the neighbourhood. It also explores how newcomer immigrants in SJT define health and wellbeing as well as the links they make between health and neighbourhood.

Extensive research through both theoretical and empirical studies indicates that area of residence is associated with health, above and beyond individual-level factors. The fields of epidemiology, sociology, and geography have been prominent in understanding the role of "place" in shaping health and health inequalities. The idea that place matters for individual health are not new (Cummins et al., 2007). Sociologists and geographers have long recognized the importance of neighbourhood environments as structural conditions that shape individual health and wellbeing (Diez-Roux, 2001).

Research on neighbourhoods and health has addressed two main concerns (Wilson et al., 2004). First, quantitative ecological studies measure neighbourhood effects of deprivation or socio-economic status (SES). Second, a qualitative approach investigates the association between "physical environments" in which people live and their perceptions of those environments on their health.

Much of the research on neighbourhood and health has relied on predetermined/predefined neighbourhood factors and has used methodological approaches that do not enable an understanding of the experiences of immigrants themselves (Asanin & Wilson, 2008). The demand is growing for research that looks at the ways in which local populations conceptualize health and wellbeing, by grounding these experiences within a specific neighbourhood context (Lindenbaum, 2005). Ethnographic work yields important insights into the lived experiences of populations, and how they define health as well as the connections they make between health and neighbourhood (Warr, 2007). Wilson et al. (2004) considers the link between neighbourhood residents' perceptions of neighbourhood (e.g., social and physical aspects) and health outcomes. Their findings point to the importance of neighbourhood perceptions as a determinant of health.

While Warr (2007) and Wilson et al.'s (2004) work illuminates some of the effects of place on health, further investigation is needed, particularly in the area of immigrant health. In order to address the gaps in the literature, this qualitative research project examined both the "place-based" characteristics of SJT and individual-level factors, including newcomer immigrant perceptions of the neighbourhood, their social relations, and their access to health and social services in the neighbourhood. By capturing the concerns and experiences of different newcomer immigrant populations, we can develop an in-depth understanding of the relationship between place and health that will help to formulate policy and program recommendations that are population-specific. This study speaks to the interrelationship



between place and other social determinants of health, and contributes to a growing body of research related to neighbourhood and health.

This report begins by providing a demographic context, with some statistics on immigration into Canada, followed by a brief overview of national and international responses, as well as legal frameworks, to address health inequalities of disadvantaged populations. The results of the study are presented according to the following categories: 1) newcomer immigrant perceptions of health and wellbeing; 2) impact of migration and settlement on newcomers; 3) place-based characteristics of SJT; and 4) availability and quality of health and social services.

2. Context

Canada welcomes 200,000 immigrants annually. Immigrants accounted for 20% of Canada's population in 2006, and this proportion is projected to reach between 25% and 28% by 2031 (Statistics Canada, 2010). Three-quarters of Canadian newcomer immigrants (i.e., landed immigrants and refugees) settle in Toronto and other metropolitan gateways such as Vancouver and Montreal. Research shows that newcomer immigrants' health declines to Canadian-born levels relatively soon after arriving in Canada (Chen, Ng, Wilkins, 1996; Chen, Wilkins, Ng, 1996; Ng, Wilkins, Gendron, & Berthelot, 2005a). The reasons for this are as of yet unclear, but research on the social determinants of health demonstrates that a number of social, environmental, and economic factors contribute to individual health and wellbeing. Researchers and policy-makers who are intent on curbing rising healthcare costs and improving Canadians' health need a better grasp of the forces influencing newcomer immigrant health to define policies, programs, and actions to sustain newcomer immigrant health after arrival, particularly during the resettlement period.

Canadians want to live in healthy and secure communities and environments that promote their health. Access to quality healthcare services is a human right that all Canadians expect to have. Primary care with universal access and social protection represents a key response to these expectations. Since the release of the seminal report *New Perspectives on the Health of Canadians* (Lalonde, 1974), the provincial and federal governments of Canada recognize that good physical and mental health is necessary for maintaining the quality of life to which all populations aspire. It also recognizes that the health system alone is not enough to produce good health (Jackson & Riley, 2007). Addressing the social determinants of health and the improvement of the environment in which people live is necessary if more Canadians are to live a full, happy, long, and illness-free life (Health Canada, 2001; Raphael, 2009).

Immigrant health and wellbeing can be understood through a human rights framework. The *Constitution of the World Health Organization* (1946) states: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (p. 1). Similarly, Article 2 of the Universal Declaration of Human Rights (UDHR) states: "Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status" (United Nations, 1948). Newcomers admitted to a country, until they have received permanent residency or citizenship status, "may be subject to disadvantages or limitations in access to health care and health rights in relation to nationals of

those countries" (WHO, 2003, Annex I). These legal frameworks are well known, and governments and policy-makers are constantly reminded of them. However, there has been slow progress in the actualization of basic rights among ethnic and racial groups and newcomer immigrants in industrialized countries such as Canada.

In order to understand and improve the health and wellbeing of Canadian urban areas, there is a call for greater emphasis and policy development on the social determinants of health; as well, community-based participatory research that incorporates people's lived experiences at the neighbourhood level is needed (Bryant, Raphael, & Travers, 2007; Caughy, Campo, and Muntaner, 2003; Sooman & Macintyre, 1995). Factors commonly understood as "determinants of health" are discussed in World Health Organization (WHO) documents on a variety of topics, including sex, gender, age, ethnicity, race, education, income, social support, geographical location, and healthcare access (Benoit et al., 2009). Health Canada's 12 social determinants of health have been adopted by Canada's federal health policy-makers and have offered a comprehensive perspective on the scope of policy that can be developed to reduce population health inequalities (Health Canada, 2001). Health Canada's 12 social determinants of health are as follows:

1. Income and social status
2. Social support networks
3. Education and literacy
4. Employment and working conditions
5. Social environments
6. Physical environments
7. Personal health practices and coping skills
8. Healthy child development
9. Biology and genetic endowment
10. Health services
11. Gender
12. Culture

3. Literature Review of Health and Wellbeing

This study was interested in understanding the factors that influence the health and wellbeing of newcomer immigrants in St. James Town. There is no general agreement regarding a "gold standard" definition of *wellbeing* or how it can be measured (Hird, 2003). However, Hird's definition includes the conditions in which people live and people's thoughts, interpretations, and experiences of the place in which they live. Hird argues that although there is no consensus on the definition, there is considerable overlap in the components deemed to contribute to wellbeing. These components are physical wellbeing, material wellbeing, and social wellbeing. Hird considers that *objective wellbeing* comprises these three components. By contrast, *subjective wellbeing* focuses on the process by which people perceive and understand social conditions. Subjective wellbeing is sometimes referred to as *psychological wellbeing*. Health is considered an important component of wellbeing that benefits people by influencing their subjective feelings of wellness and enabling them to participate in society in a way that is meaningful and productive.

The following review of recent literature on health and wellbeing is organized according to the main research areas of interest in our qualitative study: (1) the physical environment (i.e., place and health, and newcomer immigrant health and place); (2) the social environment (i.e., social capital and social networks); and (3) health services (i.e., the availability, accessibility, and acceptability of health and social services to newcomer immigrant groups).

3.1 The Physical Environment

3.1.a Place and Health

Increasing attention is being paid to the influence of "place" on people's health (Macintrye, Ellaway, & Cummins, 2002; Rosenberg & Wilson, 2000; Surtees, Wainwright, Khaw, & Day, 2003) and neighbourhoods (Kawachi & Berkman, 2001; Sampson, 2003). Studies focusing on the *quality of the local environment* examine neighbourhood features such as perceived neighbourhood problems and crime, the "built environment," and access to amenities.

Several studies document links between neighbourhood residents' perceptions of neighbourhood problems (e.g., social and physical), including perceived neighbourhood stressors (e.g., crime and high-density housing) and both physical and mental health outcomes (Agyemang et al., 2007b; Aneshensel & Sucoff, 1996; Bowling, Barber, Morris, & Ebrahim, 2006; Chapman, 2005; Ellaway & Macintyre, 1996; Ellaway, Macintyre, & Kearns, 2001; Feldman & Steptoe, 2004; Gary, Stark, & LaVeist, 2007; Hill, Ross, & Angel, 2005; Latkin & Curry, 2003; Pampalon, Hamel, De Koninck, & Disant, 2007; Parkes & Kearns, 2006; Phongsavan, Chey, Bauman, Brooks, & Silove, 2006; Ross & Mirowsky, 2001; Steptoe & Feldman, 2001; Wilson, Elliott, Law, Eyles, Jerrett, & Keller-Olaman, 2004; Yen, Yelin, Katz, Eisner, & Blanc, 2006; Young, Russell, & Powers, 2004; Ziersch, Baum, Macdougall, & Putland, 2005). On the other hand, neighbourhood satisfaction is independently associated with mental health and may mediate the effects of perceived neighbourhood problems (Cerin, Leslie, Toit, Owen, & Frank, 2007). Khanlou (2009b) describes that factors associated with the *macro*, *meso*, and *micro* levels impact mental health among new immigrants. The macro level includes aspects related to the physical environment such as the availability of appropriate services, access to healthcare, and experiences of discrimination and racism. Safety is an important concern of the living environment. Research associates safety and stability in one's living situation with an increased ability to work, be productive, and become part of the community (Geller & Kowalchuk, 2002; Herb, Miller, & O'Hara, 2003), as well as with an increased sense of security (Borg et al., 2005; Browne & Courtney, 2005).

The "built environment" refers to the physical structures and infrastructures of neighbourhoods. Research has found significant links among neighbourhood material and physical structures (e.g., internal and external housing conditions, access to parks, transportation systems, presence of graffiti, and proximity to amenities), health risk behaviours (e.g., low physical activity, smoking), and physical health (Cohen, Farley, & Mason, 2003; Ellaway & Macintyre, 1996; Gordon-Larsen, Nelson, Page, & Popkin, 2006; Keller-Olaman et al., 2005; Maas et al., 2007; Poortinga, Dunstan, & Fone, 2007). Features of the built environment (e.g., poor-quality housing) have also been shown to adversely affect mental

health (Carter et al., 2008; Evans et al.,, 2003; Galea et al., 2005; Gee et al., 2004; Putnam, 2001; Truong & Ma, 2006; Weich et al., 2002).

The notion that the environment, whether neighbourhoods or larger urban centres, affects individuals and communities emerge from the seminal work of Jane Jacobs. In *The Life and Death of the Great American Cities* (1961), Jacobs described cities as living beings and ecosystems. She suggested that over time, buildings, streets, and neighbourhoods function as dynamic organisms, changing in response to how people interact with them. She explained how each element of a city—sidewalks, parks, neighbourhoods, government, and economy—functions together synergistically, in the same manner as the natural ecosystem. This understanding helps us discern how cities work, how they break down, and how they could be better structured. Jacobs also advocated for "mixed-use" urban development that involves the integration of different building types, whether residential or commercial, and old or new. According to this idea, cities depend on a diversity of buildings, residences, businesses, and other non-residential uses, as well as people of different ages and different socio-economic classes using areas at different times of day to create community vitality.

Bernard et al. (2007) conceptualize neighbourhoods as environments for accessing resources. Health inequalities are determined to a significant extent by the resources to which individuals have access (Benoit et al., 2009; Bernard et al., 2007; Carpiano, 2006). Neighbourhoods offer resources such as recreational space, food stores, schools, neighbourhood organizations, and community centres (Benoit et al., 2007). Aside from resources in the physical environment, neighbourhoods also offer resources for social capital or forming social networks (Carpiano, 2006). Bernard et al. (2007) make an important argument for understanding how particular groups, such as ethnic minorities and newcomer immigrants, come to occupy particular places. They describe how social and political forces shape the physical structure of neighbourhoods, as governments decide which services to locate in urban neighbourhoods, and as community organizations struggle to influence such decision making. The authors also note that socially defined characteristics explain the distribution of people in a region. Low-income groups may move to neighbourhoods with low rent housing. However, these areas are typically characterized by physical disorder, high pollution, and crowdedness (Bernard et al., 2007).

3.1.b Immigrant Health and Place

Most research on immigrant health to date has focused on determinants operating at the individual level. The social determinants of health approach recognizes that both individual and structural factors affect individual health and wellbeing. The National Collaborating Centre for Determinants of Health and the World Health Organization (WHO) Commission on Social Determinants of Health both highlight gender and culture as individual-level factors that affect health inequalities. Also, at the individual level the perceptions and experience of one's status can lead to stress and poor health. What constitutes determinants of health has been debated across the research literature. Many Canadian health studies have identified social structural factors (e.g., employment, income, and education) as stronger predictors of immigrant health than behavioural factors (e.g., drinking, smoking, diet, physical activity) (Beiser, 2006; Chen, Ng, Wilkins, 1996; Dunn & Dyck, 2000; Newbold & Danforth, 2003; Newbold & Filice, 2006; Prus & Lin, 2005). Substantial evidence indicates that migration-specific factors including

resettlement stress (Tang, Oatley, & Toner, 2007), racial discrimination (Dunn, Veenstra, & Ross, 2006, and government policies (Wayland, 2006) also influence immigrant health and wellbeing.

Recent research shows that while immigrants arrive in Canada healthier than native-born Canadians, they lose this health advantage relatively quickly, particularly with respect to chronic physical health conditions (Hyman, 2001, 2006; Newbold, 2005, 2006). Findings are similar for immigrants' mental health, though its trajectory is less clear (Ali, 2002; Beiser, 2006; Fenta, Hyman, & Noh, 2004). To understand this phenomenon, more research is needed on the effects on health of immigrant characteristics (e.g., poverty, unemployment, social exclusion) and the supportive and stress-buffering effects of personal and social resources at both the community and neighbourhood levels (Beiser, 2005; Guruge & Khanlou, 2004; Thurston & Vissandjee, 2005).

Socio-economic factors are important social determinants of health and the cause of health inequalities. Odoi et al. (2005) argue that understanding the socio-economic characteristics of neighbourhoods is critical to understanding health needs and health inequalities at a neighbourhood level. Research on newly arrived immigrants in Montreal found a high rate of community unemployment related to a high level of psychological distress (Zunzunegui, Forester, Gauvin, Raynault, & Willms, 2006). Other research has found that neighbourhoods with a high proportion of new immigrants are typically poorer than others (CIHI, 2006a). Living in a poor neighbourhood with people of similar ethnic origin may in fact offer benefits to immigrants, facilitating integration and reducing stresses associated with racism and cultural incongruity (Kazemipur & Halli, 2000). The development of a strong social support network is suggested to be a key factor for the successful settlement and integration of immigrants (Carter, et al., 2008). Beiser et al. (2002) have speculated that the social disadvantages that mediate the relationship between poverty and mental health in non-recent immigrant and Canadian-born families may not be the same for newcomer immigrants. Moreover, social networks have been associated with positive mental health. The characteristics of a social network, including its size and composition, have been positively associated with mental health and wellbeing for immigrants as compared with other groups.

Although there is a growing body of research on the relationship between housing and health in Canada (Dunn, Hayes, Hulchanski, Hwang & Potvin, 2006) and on the housing experiences of new immigrants (Carter et al., 2008), limited research exists on the effects of the built environment on newcomer immigrant health.

Newly arrived immigrants may experience a number of barriers or difficulties in adapting to their new environment and in accessing community support. However, many newcomer immigrants demonstrate coping mechanisms to deal with the changes resulting from immigration. Dyck and Dossa (2007) examined how immigrant women in British Columbia construct "healthy spaces" in an ethnically diverse city.

> *Despite the differences in their dislocation and settlement experiences, the narrative accounts of the women express a collective experience of positioning in Canadian society as "Other." In the course of their day-to-day practices—obtaining*

and preparing nutritious foods, dealing with illness, and prayer—the women actively seek to create their homes as healthy space. (Dyck & Dossa, 2007:699)

3.2 The Social Environment

3.2.a Social Capital and Social Networks

Edmondson (2003) discusses the idea of social capital as a source of support for health. Formal and informal social resources have been shown to shape health and wellbeing. Some research hypothesizes that *social capital*—defined as the degree of interpersonal trust, norms of reciprocity, and membership in civic organizations (Putnam, 2001)—can have compositional effects (e.g., social networks) and contextual effects (e.g., community access to resources) on people's health. In a study of newcomer immigrant housing experiences in Winnipeg, Carter et al., (2008) found that newcomers' perceptions of their neighbourhood and their neighbours influenced their sense of belonging and the extent to which they felt settled or integrated. The problem with linking social networks and social capital with health is the lack of clarity on which kinds of networks are most effective in creating social capital and protecting health (Cattell, 2001: 1502).

The compositional effects attribute the geographical clustering of health outcomes to the shared characteristics of residents (Bernard et al., 2007). Newcomer immigrants are predominant in SJT, where there are individuals with similar cultural backgrounds and socio-economic status. Bernard et al. (2007) state that similar people (e.g., similar in terms of socio-economic status or educational level) tend to aggregate within geographical proximity, whether purposefully to share a common culture or because they are driven to certain areas because of lack of personal resources, money, etcetera.

Social exclusion or the inability of certain groups to participate fully in society may substantially impair the ability of community members to proactively engage in health-promotion practices. Social exclusion may operate in subtle and complicated ways; for example, socially and culturally through isolation, stigma, and discrimination; and spatially through substandard housing or the presence of structural barriers. Previous research sponsored by the Wellesley Institute within the SJT area confirms that members of the community experience high degrees of isolation, fear, and racism (LIFT, 2006). Yet, the relationship of this to immigrants' perceptions of the factors that contribute to the different forms of inequality remains under-examined.

Very little discussion has taken place on the declining social capital among newcomer immigrants. Declining social capital can be the result of a loss of family ties (Edmondson, 2003). The loss of family ties is part of the experience of immigration. Pierre Bourdieu has used the concept of social capital to show inequalities of resources and power among groups (Carpiano, 2006; Edmondson, 2003). Within social groups, there may be inequalities in resources and power imbalances.

3.3 Health Services

3.3.a Availability of Health Services

When immigrants first arrive in a new country, they require assistance to adjust to their new environment (Truelove, 2000). Settlement services offer a range of services to help newcomers adjust to their new environment and Canadian society (Truelove, 2000). Services may include providing information on Canadian laws; translation services; short-term counseling; language training; and assistance in finding employment, housing, or other services. Newcomers who already have family and friends in the country often receive assistance from pre-existing social networks.

The location of agencies or organizations that provide services to newcomers has been identified as a barrier to access. Truelove (2000) describes that the very limited financial resources of many organizations that provide services to immigrant populations means that their programs are often dependent on grants for the survival of their programs. The financial constraints of organizations can also influence the availability of services to newcomers. Some researchers argue that the use of or access to health and social services among immigrant populations should be interpreted as a supply concept, relating to the availability of services, measured by physical-patient ratios (Mcintyre et al., 2002;). Steele et al. (2002) states that policy changes that result in reductions in services to newcomers may impact the health outcomes of individuals living in low-income newcomer communities.

3.3.b Accessibility of Health Services

One of the biggest challenges in Ontario is the three-month waiting period for eligibility for OHIP, which creates significant access problems to healthcare services (Steele et al., 2002). Many immigrants cannot afford private healthcare coverage in the three-month waiting period, which leaves them without access to healthcare during that time. *Accessibility* generally means the relative ease with which individuals from one location can reach other locations (Wang, 2007). Accessibility can also be conceptualized as the trade-off between the time and monetary cost associated with reaching a health facility and the location of the facility (Wang, 2007). Access to physicians is generally regarded as influenced by physician distribution and where people reside (Wang, 2007). This access relates to spatial considerations of healthcare provision and healthcare demand. Wang (2007) examined Chinese immigrants' health-seeking behaviour and how Chinese immigrants in the Toronto Census Metropolitan Area choose between ethnic Chinese family physicians and other family physicians. Approximately 80% of Chinese newcomers surveyed stated a preference for physicians of Chinese ethnicity. In this study, Chinese immigrants expressed that it was easier to communicate with Chinese physicians, so that they can gain a good understanding of the physician's instructions.

Newcomer immigrants' perceptions of the accessibility of health services also relates to familial or caregiver burdens. Steele et al. (2002) found that newcomer immigrants described a cultural-specific notion of familial duty that leads to greater caregiver burden, since new immigrant families tend to assume more of the responsibility for the care of family members than is typical of a Canadian-born family.

Furthermore, Steele et al. indicate that reductions in welfare benefits and prescription-user fees had a significant impact on health outcomes, in particular on quality of life and mental health issues. In addition to financial constraints, the stress associated with negotiating the restricted social service system can impact the health and wellbeing of newcomer immigrants.

3.3.c Acceptability of Health Services

Acceptability here means cultural acceptability or cultural appropriateness of services for immigrants. Services must be linguistically and culturally appropriate to be considered truly accessible. Newcomer immigrants may face language barriers and a lack of familiarity with the system (Steele et al., 2002). Mederios (1991) found four systemic barriers to access to acceptable family services for ethno-cultural and racial communities in Toronto: (1) lack of recognition of ethnicity and racial factors; (2) lack of capacity to address language needs; (3) inappropriateness of methods of delivery; and (4) location.

4. Study Context

St. James Town is a central Toronto neighbourhood that is home to 18,000 people (community estimates are higher at 25,000). A full 64% of SJT residents are newcomer immigrants, 26% of whom arrived in Canada within the last five years, and the majority are visible minorities (Statistics Canada, 2006). SJT is home to many ethno-racial communities, including Filipino, Tamil, Chinese, Pakistani, Korean, Bangladeshi, Indian, Nepali, Ethiopian, Somali, and Eastern European communities (Statistics Canada, 2006). Interestingly, about 25% of SJT residents have a university degree, and the average household income in SJT is only $32,539, almost half of that reported for Toronto ($69,194) (Toronto Community Health Profiles Partnership, 2005).

SJT is located in the northeast corner of Toronto's downtown core, and is within walking distance of schools, community services, stores, public transit, other newcomer and visible minority communities, some of the city's wealthiest and poorest neighbourhoods, and the financial district. Shopping, transit, and health and social services are available, but recreational and green spaces are limited. However, the availability of health and social services alone does not determine the use of these services or reflect access barriers related to cultural practices, time constraints, hours of operation, household responsibilities, and education about health and illness.

St. James Town: Neglected Urban Immigrant Neighbourhood

- Lack of sufficient basic services
- Substandard high-rise housing
- Overcrowding and high density
- Unhealthy living conditions
- Lack of green space
- Poverty and social exclusion

The neighbourhood's design (i.e., the presence of recreational space, community services, and stores, as well as the quality of residential buildings) poses safety risks. However, residents' low household incomes (41% below city average), high unemployment (12%), and social assistance rates (Statistics Canada, 2003) partially explain the lure of SJT's relatively low rents and subsidized housing. The design of a neighbourhood also influences the establishment of neighbourhood alliances and social networks. SJT has a rich tapestry of social networks, neighbourhood alliances, ethnic-specific

stores, and cultural facilities for many resident groups, which suggests a high neighbourhood (or inter-neighbourhood) level of social capital and the strong potential for social cohesion (solidarity) and collective efficacy.

5. Objectives

The objectives of this study were as follows:

1. To explore how newcomer immigrants in St. James Town define health;
2. To increase our understanding of how place influences newcomer-immigrant health;
3. To explore what neighbourhood factors (e.g., housing quality, social networks and supports, safety, and access to services and recreational space) newcomer immigrants in SJT identify as influencing their own health and health risks; and
4. To examine how neighbourhood factors are conceptualized and experienced across and within different groups .

6. Sampling and Participant Recruitment

Three groups of participants were recruited for this study: (1) newcomer immigrants, (2) non-immigrants, and (3) service providers. A total of 89[1] participants took part in this study (see Table 1).

Newcomer Immigrants: Purposeful sampling was used to obtain a sample of participants. Purposeful sampling is often used in qualitative research. In this sampling strategy, "the inquirer selects individuals and sites for the study because they can purposefully inform an understanding of the research problem and central phenomenon in the study" (Creswell, 2007:125). The sample consisted of newcomer immigrants, male and female adults between the ages of 25 and 64 years who have been in Canada for less than 10 years and have resided in the St. James Town neighbourhood of Toronto for a minimum of four months. The study focused on adults because a majority of the immigrants who have arrived in Canada since 2001 were between 25 and 64 years of age (Statistics Canada, 2006). Participants were recruited from three ethno-racial groups: Chinese, Filipino, and Tamil. These groups were selected due to their predominance within the SJT neighbourhood. A total of 52 newcomer immigrants participated in the study.

Non-immigrants: A comparative group of non-immigrant residents (i.e., Canadian-born individuals) who reside in SJT was recruited. A total of 11 non-immigrants (5 male and 6 female) between the ages of 25 to 64 years participated in the study.

Service Providers: Representatives from various immigrant community service organizations and other relevant health and social service agencies in SJT and the surrounding area were recruited to explore how neighbourhood-level factors influence health and health-related practices among newcomer immigrants. Interviews with service providers differed depending on the type of agency represented (e.g., settlement, health, education, or other social services); the position of the service provider within the agency (e.g., front-line worker,

[1] Includes 16 individual interviews and 10service provider interviews.

manager, director); the ethnic background of the service provider; and the gender of the service provider. A total of 10 service providers were interviewed.

Table 1: Sampling and Number of Participants

Participants	Focus Groups		Individual Interviews	
	Male	**Female**	**Male**	**Female**
Newcomer immigrants:				
• Chinese	9	11	2	2
• Filipino	6	10	2	2
• Tamil	9	7	2	2
Comparative group:				
Canadian-born individuals	5	6	2	2
Service providers	-	-	2	8
TOTAL	29	34	10	16

7. Methodological Approach

7.1 Study Design

A qualitative descriptive design was used for the study (Sandelowski, 2000). The research employed multiple methods of data collection to allow for data triangulation of sources and an in-depth understanding of newcomer immigrants' perspectives on the ways in which neighbourhood context influences their health.

7.2 Data Collection

Data was collected between April and August 2009. The discussion guidelines were translated into Tamil and Chinese (Mandarin) by fluently bilingual speakers and checked for semantic equivalence by back translation (Chen & Boore, 2009). The translated guidelines were later reviewed by the community advisory group for cultural appropriateness. Triangulation of data was employed by collecting data through focus groups and interviews to ensure the validity of results. The project incorporated a participatory research approach to involve a community advisory committee (CAC) who assisted the research team by providing input and guidance on

the implementation of the project. The CAC was not involved in the data-gathering process to maintain the confidentiality and privacy of participants.

Data collection involved focus groups and individual interviews with residents of St. James Town and individual interviews with service providers. Language was not an inclusion criterion for participation in the study. The focus groups and individual interviews were conducted in the language of the ethnic group. Three trained moderators from outside the neighbourood were recruited, one fluent in Chinese (Mandarin), one fluent in Tamil, and one fluent in English. Filipino and Canadian-born focus groups and interviews were conducted in English. The service provider interviews were conducted in English.

7.3 Focus Groups

Focus groups are a research method whereby data is produced via group interaction around a subject chosen by researchers. In contrast with individual interviews that capture the sole story of one participant, a focus group captures multiple stories, diverse experiences, and a group's collective understanding of a phenomenon (Brown, 1999). The focus groups explored newcomer immigrants' conceptualization and understanding of health and wellbeing, and the factors that influence health in St. James Town.

The focus groups were conducted in three languages: English for Filipino and Canadian-born groups, Tamil, and Chinese (Mandarin). Discussion guidelines were used by all three moderators to conduct the focus groups. After greeting participants, the moderator explained the purpose of the project and distributed consent forms (and explained the purpose of the consent form). Participants were given 10 minutes to read the form and ask any questions prior to starting the discussion. Participants were also asked to complete a short demographic questionnaire. Their permission to audiotape the discussion was taken at this time.

A total of eight focus groups were conducted (one male and one female focus group for each ethnic group). 8 to 10 people were invited to attend each of the focus groups. Various channels were used to recruit participants. Residents were informed about the project through flyers posted in the buildings, through the project website, through community partners, and through word of mouth. All focus groups were arranged in St. James Town Community Centre, which is a neutral place and within the neighbourhood. During each focus group, there was one moderator and one facilitator. The focus group discussions were audiotaped and later transcribed and translated. Extensive notes were also taken to supplement the recordings. Refreshments and lunch were provided, and a small compensation was given to the participants.

7.4 Interviews

Individual interviews were done with select residents from the focus groups and with service providers representing various organizations in the neighbourhood. We understood from the outset that some focus group participants may not feel comfortable about openly sharing their personal views in the group; therefore, individual interviews were conducted with a subset of focus group participants. Individual interview participants were selected based on two criteria. During each focus group, the facilitator and the PI (observer) kept notes on (1) the quieter

people in the group and (2) people who had a lot to say but did not have the opportunity to expand on their views because other participants were not in agreement. Based on these two observations, two participants from each group were contacted and invited to participate in an individual interview. All interviews were done at a time and a place convenient for both the facilitator and each participant. Most of the interviews were done in a private (study) room in the community library. The interviews were conducted in the participant's preferred language (Chinese, Tamil, or English) and were audiotaped with the participant's consent.

A total of 16 individual interviews were conducted with newcomer immigrants and non-immigrants: 12 newcomer-immigrant interviews were conducted (6 female and 6 male; 4 from each cultural group), and 4 non-immigrant interviews were conducted (2 female and 2 male) as a comparison group. A semi-structured interview method was used for these interviews. The interviews with residents provided a more in-depth understanding of the issues of interest and focused on personal experiences of health, living in SJT, as well as how neighbourhood factors influence health.

Ten service providers representing various organizations and providing health and social services in the neighbourhood were invited to participate in the study. The interviews with service providers focused more on system-level issues related to place and health, such as accessibility, availability, and quality of health services to the public. The interviews were conducted in English, and a semi-structured interview method was used to conduct these interviews. Each of these interviews lasted for about an hour. Consent for interviewing and audiotaping the conversation was taken. A few participants requested to review the interview notes and give their approval before their data was entered in the database.

8. Ethical Considerations

This project was approved by the Research Ethics Board (REB) of York University. At the beginning of each focus group and interview, the project, the roles and contributions expected of participants, and the expected outcomes of the project were presented and explained to participants. Participants were then asked to read and sign a consent form that outlined their role in the project and granted permission to the researchers to use their responses without individual identification in reports and policy briefs. Individuals had the option to stop their participation at any time during the research process. They were ensured that their identity will not be released at any stage.

9. Analyses

9.1 Data Cleaning

Data cleaning involved (1) removing all identification and allocated identification numbers to participants; (2) arranging all transcripts according to the focus groups and service provider discussion guideline; (3) removing any judgmental language in the transcripts (neutral language used); (4) recording coded identification in an excel spreadsheet; and (5) formatting and entering data into qualitative analysis software NVivo 8.

9.2 Data Coding and Analysis

Schatzman and Strauss (1973) claim that qualitative data analysis primarily entails classifying things, persons, and events and the properties that characterize them. Typically throughout the data analysis process, ethnographers code their data using as many categories as possible. They seek to identify and describe patterns and themes. In this study, data analysis was also assisted by qualitative analysis software NVivo 8. The data from individual interviews, focus groups, and service provider interviews were analyzed for similarities, differences, and relationships to construct themes. Quotes or phrases from individual interviews and focus groups that represented similar ideas or themes were grouped together. The data were also explored in NVivo using data matrices and models that assemble organized information and relationships between themes. The conceptual framework developed in Figure 1 illustrates the relationships between the themes and concepts.

The demographic data were entered in a spreadsheet and analyzed. The analysis of the qualitative data involved (1) the use of computer software for qualitative analysis, NVivo 8, and (2) discussions among team members on emerging findings and the conceptual framework.

A multi-step thematic analysis of the data was conducted. Findings from focus groups informed the interviews with individual participants. General principles of qualitative descriptive analysis guided the data analysis (Sandelowski, 2000; Sullivan-Bolyai, Bova, & Harper, 2005). The credibility of the study was enhanced through triangulation of data sources and investigators (Streubert & Carpenter, 1999) and followed Farmer et al.'s (2006) intuitive and inter-subjective approaches to triangulation. The dependability of the data was assessed through stepwise replication (Lincolin & Gupta, 1985). Applying Wilms et al.'s (1990) approach to qualitative analysis, content analysis was conducted using an iterative process to identify major themes and concepts that are both descriptive themes ("code driven") and interpretive themes ("context or culturally driven"). During the analysis, specific attention was paid to the ways in which health and neighbourhood experiences vary by individual-level factors (e.g., gender, age, and ethnicity).

10. Results

A total of 63 participants from three ethno-racial groups (Chinese, Filipino, Tamil) as well as non-immigrants took part in the study. The age of the participants ranged from 18 to 74 years with a mean of 44 (SD = 12.5). The residency of the ethnic groups in Canada ranged from 10 months to 19 years with a mean of 6.1 (SD = 3.7) however, the average number of years living in St. James Town is 5 years. Tamils appear to have moved straight into SJT upon arrival in Canada, whereas Chinese and Filipinos have spent some time outside of SJT. In the non-immigrant comparative group, males have been living in SJT significantly longer than females (an average of 14 years for the former compared with 4 years for the latter). Immigrant groups had slightly higher educational levels than non-immigrant groups, and males were more educated than females. Only 55% of ethnic participants reported having paid jobs. More men reported having a job as compared to women. In the non-immigrant group, more females (40%) reported working as compared with males (20%). See Table 3 in the Appendix for demographic information on study participants.

The findings of the qualitative study are summarized according to the questionnaire/interview guidelines for focus groups and interviews: (1) perceptions of health and wellbeing; (2) the impact of migration and settlement on newcomers; (3) place-based characteristics of St. James Town (physical and social environment); (4) availability and quality of health and social services; and (5) service provider interviews which capture the challenges faced by service providers in providing quality services to an ethnically diverse population. The findings below represent the outcomes of both focus groups and individual interviews. We found that similar responses were given in both contexts; new information was not discovered in individual interviews.

10.1 Perceptions of Health and Wellbeing

Newcomer immigrants demonstrated an understanding of the factors in their social and physical environment that impact their health and wellbeing. The following themes emerged during discussions with newcomer immigrants about their understanding of health and wellbeing: the absence of disease; the impact of living conditions on health (e.g., quality of housing, socio-economic status, and neighbourhood context); the availability of "good" medical services; psychosocial health; and family and friend support. Most participants in the focus groups and individual interviews stated that physical health (the absence of disease in the body) was important to being in good health. Being healthy was referred to not only in the physical body but also in the ability to participate in Canadian society through employment.

The concept of wellbeing was discussed in focus groups and interviews in a more personalized manner, as "individual satisfaction" and "psychological balance," and shaped by social networks and social support. A Chinese female participant said that wellbeing is "family harmony." According to her, family harmony referred to a family that gets along and helps each other.

Newcomer Immigrants' Understanding of Health and Wellbeing

- The absence of disease in the body
- The availability of "good" medical services
- The ability to participate in society and the workforce
- Being productive
- Individual satisfaction and psychological balance
- Family harmony

Definitions of *health* and *wellbeing* differed slightly across the ethnic groups. Across the ethnic groups (as well as the comparison group of non-immigrants), *health* was defined as the absence of "physical illness" or illness existing in the body. Chinese and Tamil participants stated that mental health is important to a person's overall health and wellbeing, while very few Filipino participants mentioned mental health. In contrast to Tamil and Chinese participants, Filipino participants (mostly males) reported the importance of "being productive" or having able bodies to work and contribute to society every day. Canadian-born participants also reported the importance of being productive as contributing to health and wellbeing. Lastly, Tamil and Canadian-born participants frequently reported living conditions as an important contributor to health and wellbeing.

10.2. The Impact of Migration and Settlement on Newcomers

10.2.1 Employment Barriers

Participants were asked to describe their experiences with migration and the impact of migration on their health. Participants described that migration shaped their social and economic lives, and negatively affected their health and wellbeing. One Tamil male participant talked about how his qualifications and credentials that he accrued in his home country are not recognized in Canada, which has resulted in difficulties in finding employment.

Working two jobs with low pay is a common experience for newcomer immigrants. The inability to fully integrate into the labour force upon arrival in Canada was attributed mainly to a lack of competence in both official languages, difficulty in getting credentials and accreditations recognized in Canada, and a lack of Canadian work experience. Since the educational experiences of immigrants are acquired outside of Canada, the earnings of Canadian immigrants are lower than native-born Canadians with similar educational qualifications. These barriers can be overcome after a longer period of stay in the host country. However, younger immigrants are more likely to enroll in school or professional training programs compared with middle-aged immigrants. Those who come to Canada with children as dependants are more concerned about finding any job to support their family.

One Filipino female participant said, "*... [it's] hard to find a job. They ask for your experience. How do you get experience if [you] just came here?"* Similar to the male participants, females across the ethnic groups also described experiences of barriers to labour-market participation, including limited or low employment.

In an individual interview, a male Tamil participant described the impact of his working experience on his health:

> *The working condition is not the same here as back home. Over there I used to work Monday to Friday and would leave at 8 in the morning and be off by 3 p.m. But here it's not so. I'd have to work day and night. There is a possibility of our health being affected.*

Similarly, a male Chinese participant described the impact of his working hours on his health and wellbeing :

> *As immigrants, since we are forced to improve our living standards we are in a situation to do two jobs. So we could be in a position to be unable to take good care of the family and kids. We have to face the consequences such as falling sick, being unable to visit the doctor on right time, etc., and we have to put up with the effects.*

Tamil, Chinese, and Filipino newcomers all expressed difficulties with finding employment and the barriers to entering similar professions they had in their home country. However, experiences with unemployment and low wages are not attributed to immigrants alone. Non-immigrant participants in the study expressed the stress and complications with their health associated with being poor and having an absence of money to buy necessities. The following

quotes by two non-immigrant female participants illustrate their experiences of being poor. Their narratives also show their internalization of societies' perceptions of the poor and low-income groups:

> *OK, I'll tell you what affects my health, is knowing that I will be poor until the day I die … and that when I die, somebody will probably go in, clear out my apartment, and my family won't even get my stuff because I'll die here in SJT like an animal. (Non-immigrant female participant)*

> *I think it's the lack of money to do what I want. Because with money you can, say, buy a metro pass, you can go around here and there, buy more food, maybe go out to do things with people. Because how can you go out and do things with people—they invite you to come out to events, but you don't really have the money to go. (Non-immigrant female participant)*

10.2.2 Language Barriers

Language was described by several participants in the three ethnic groups as a barrier to seeking employment and a healthcare provider. In an individual interview, a Chinese male participant explained his difficulty with acculturation into Canada because of his limited ability to speak English:

> *The language barrier is a major problem for me. It is very difficult to find a professional job if you have problem with English which is official language in Canada. I am sure that if I had no problem with English, I could find professional job here.*

The Importance of Language

English language proficiency plays a crucial role for SJT residents in terms of their ability to find employment, successfully integrate into mainstream society, and understand their rights.

While there are neighbourhood organizations (e.g., community programs) that offer English language training to immigrants, some participants perceive their time constraints as a barrier to using community services. One Chinese male participant said, *"I cannot continue learning English because I am busy with my work."*

10.2.3 Physical Environment

Participants expressed concern about the effect of St. James Town's physical environment on their health and wellbeing. A Tamil male participant talked about the lack of recreational space:

> *There is no good park for bringing kids over to play in this neighbourhood. There are [a total of] two parks for about twenty buildings in this area. The kids trouble the parents asking them to take them outside since there's no place where they could go and play on their own; so we go through a lot of stress due to that.*

Participants also expressed concerns about the sanitation in the residential buildings in the neighbourhood. Another Tamil male participant talked about the lack of hygiene of residents

and that the residential buildings were never clean. A Chinese female participant complained of bedbugs in her room, which she believed was the result of the poor maintenance of buildings. Non-immigrant participants expressed similar concerns about sanitation and the problem of waste in the buildings. Non-immigrant female participants complained about the disregard of residents in keeping her building clean and not disposing of their personal waste down the garbage chute in the building.

10.2.4 Social Support

The loss of social networks and social support upon immigration to Canada was an important concern addressed by residents in individual interviews and focus groups. A Chinese male participant described the stress associated with adapting to a new environment:

> *Immigrants may not have big problems with physical and mental health, but everyone experience stress which are not possible to be avoided. There is relationship between stress and health. Most time, based on my experience, I believe that my physical condition is not good like before in China and become worse year by year. The stress is from psychological pressure, feeling not be accepted by the society, change of life style, different food choice and etc. Overall, our health conditions are not as good as before. But some people thought it is much better here than in China, such as cleaner air, not so crowded, not so busy and simple personal relationship, they feel much healthier. Then, they can work and study with good health condition, the stress they are facing create positive effect. But I believe that most of immigrants are not facing positive stress but negative stress, such as cultural shock, pressure from life and work.*

Similarly, a Chinese female participant described how the loss of social support and her experiences of adapting to a new environment have been stressful and impacted her wellbeing:

> *We face many problems: no relativities and friends, new environment, no financial foundation, and how to support ourselves. We are not familiar with environment and people here. Being in a bad mood affected our physical health directly.*

A Filipino male participant described the consequences of the change in physical environment on the ability to adapt:

> *Anybody, even plants, you pluck the plant from where it belongs and bring it somewhere else, sometimes the plant dies if the environment is not suitable for a plant. So also with animals. Especially people… … Like for example, an immigrant you pluck out from his country, where let's say tropical country, send him to 4 season weather, so he doesn't know how things work.*

Sentiments of inadequate social support were prominent among non-immigrant groups who described residents in St. James Town as *"untrustworthy"* and *"unreliable."* A non-immigrant female participant stated that *"people sell you out"* and *"they will stab you in the back."* Non-immigrant participants described their distrust of other residents resulting from the economic circumstances and daily struggles that low-income people experience. One non-immigrant

female participant described how her economic circumstances have affected her relationship with her family, friends, and boyfriend: *"Poverty makes it difficult to have a relationship …"* The stress associated with poverty and the result of poor living conditions can cause a disruption in social relationships.

10.2.5 Availability of Health and Social Services

A Tamil male participant explained that the limited availability of health and social services has had an impact on his health and that of his family. He notes that the space for new patients at health centres and in community and recreational programs is limited:

> *[T]here aren't any proper medical facilities over here. There are just two doctors' offices. Also we get to hear that there are programs for kids at the library and when we go there to register there aren't any spaces left. They pick up only limited and specific people. And when we line-up with tax papers etc., we don't get any registrations for our kids. There aren't any sufficient programs for them either. I have been affected by bad health after arriving in this neighbourhood.*

Discrimination in accessing health

Non-immigrant participants described experiences of discrimination in receiving care in the health clinic or hospital by healthcare providers, which create a barrier of access for the group.

Non-immigrant participants described experiences of discrimination in receiving care in the health clinic or hospital by healthcare providers, which create a barrier of access for this group. According to one Canadian-born female participant:

> *[T]hey [doctors] practice a low-intensity model of medical care, because they think "oh she's poor so we're going to give her this [treatment] and she's probably going to be ok with it because she's poor" … it's a shame that something that is publicly funded is like this [unfair].*

While there are health and social services in the neighbourhood, residents often express the view that these services are not available to them. What they mean by this is that existing services are of poor quality and do not address cultural differences, there are limited spaces in health facilities as well as recreational and community programs, and the services do not meet their needs. These issues, which can make services unavailable, reflect utilization patterns across the ethnic and non-immigrant groups.

10.3. Place-Based Characteristics of St. James Town

Questions regarding newcomer-immigrant perceptions of SJT were asked in order to address their views of the physical and social environment (the neighbourhood) and identify the link to resident health and wellbeing. Newcomer-immigrants varied in their perceptions of SJT varied from SJT's recreational and community activities, its safety, and its housing conditions.

10.3.1 Housing

A major concern among participants was the maintenance and upkeep of their building. Many were concerned about pests such as cockroaches and bedbugs that could infest the building

and their apartment. Participants spoke about what they did like about their apartments. The cheap rent and affordable housing in SJT attracted a lot of newcomer immigrants to the neighbourhood. One of the salient features that participants spoke about was the affordable rent for apartments and being able to have money left over to meet their daily needs. A Tamil male participant stated: *"with my income I could not afford to run my family with three kids and my wife. Only St. James Town would suit that kind of income."* This participant is referring to the difficulties of financially providing for his family given his low salary. The cheap rent in SJT is affordable for families with low socio-economic status.

Positive Aspects of the Neighbourhood

- Low cost-of-living and cheap rent in apartment high rises
- Proximity to grocery stores, healthcare facilities, social and community services, and place of work
- Accessibility of public transportation
- Proximity to ethnic grocery stores
- Proximity to residents and communities of similar ethnic background
- Presence of community services and programs to assist newcomer immigrants to adapt to their new environment
- Availability of programs and services, including language training, recreational programs, social workers, parenting programs, and health services

10.3.2 Location

Participants, including non-immigrant participants, spoke positively about the convenient location of ST. James Town. Residents are close to their place of work, local grocery and ethnic food stores, and community services. The following quote from a Tamil male participant describes the benefits of the location of SJT in the city of Toronto:

> *St. James Town [is] very convenient for me; like I could reach my work place in about 25 minutes from here by subway. That was one main reason for choosing to stay here. I looked at that convenience due to work.*

Similarly, a Tamil female participant in an individual interview explains:

> *This place is very convenient. School is close by; there is a library, doctor's office and many facilities nearby. We can move on our own by walk.*

10.3.3 Cultural Connections

Another positive characteristic of St. James Town expressed by immigrant participants is the presence of cultural affinities. For instance, in SJT and the surrounding area there are many groups of similar ethnic origin to whom people can relate and establish friendships and social support. A Chinese male participant reported:

> *[T]here are many newcomers who are similar to us. When my wife takes my son to go out for play, she can share information and have common topics to talk with others. There are not only Chinese but also Asian people here. There are some Asian food supplies at No Frill and Food Basics which consider different residents' needs.*

10.3.4 Crowdedness

Participants expressed their dislike of the crowdedness of the St. James Town neighbourhood, which can result in problems with sanitation, hygiene, and safety. In the Tamil male focus group, one participant explained his concerns about the impact of crowdedness on health and illness:

> *Since we are living in such a densely populated area we have to be prepared and accept the fact. People come here from all parts of the world and bring in all kinds of diseases that they are immune to. These diseases spread fast in such a populated area. People live different kinds of lifestyles here. They eat and cook different kinds of food and the tolerance level would be different for each person. We can't always stand other odours!*

Another participant in the Tamil male focus group described how the crowdedness of SJT contributes to traffic congestion in the city:

> *But it's too crowded and there's heavy traffic always. It's hard to get to Yonge Street; like it's packed every day. And while you are walking in a crowded area you might not know what will happen anytime. Someone might catch you and steal things from you any time; or they might stab you for random stuffs.*

In an interview, a Tamil female participant described how crowdedness resulted in the overutilization of and limited spaces for services in the community centre and health facilities in the neighbourhood:

> *I think [SJT] is one of the most populated areas in such a small space and it's not adequate if everybody wished to use the facility. If there were five children in each family in this building and everyone wanted to learn swimming, the pool wouldn't be big enough for that.*

Participants also expressed frustration with the level of noise in the neighbourhood. Some of this noise can be attributed to the city (e.g., ongoing construction and traffic congestion). Concern was also expressed about neighbours in the high-rise buildings who make a lot of noise. Residents described this as a disadvantage of living in a high-rise building; however, they did not have the option of moving since the cost of rent is low in SJT.

10.3.5 Safety

Safety concerns in the St. James Town neighbourhood were often talked about by all participants as an important issue on which they would like to see improvement.

A Tamil male participant described his experience with safety in the neighbourhood:

> *To mention the main problems here, I'd say the drug addicts pose a big pain over here. It's those people who consume drugs in this area. Sometimes we even hear some loud noises/sounds of shooting in the middle of the night (around 2 or 3 in the morning), and we wouldn't know what is it exactly. So this is the major issue in this neighbourhood and it happens now and then. These sounds of gunshots not only disturb our sleep but also give us a lot of tension (anxiety) about what could have possibly happened. We wouldn't know what might have happened to anyone. Any*

sound of gun shot could only be imagined but we didn't happen to see in through naked eyes.

A Chinese female participant described how she copes with her concerns about safety in the neighbourhood:

> *You have to pay attention to your own safety. I have been living here for three years. At the beginning, I was really worried about safety issue. I still avoid going out in the night and rarely take stairs.*

Moreover, perceptions of safety in SJT were influenced by stories told by other residents regarding danger in the neighbourhood:

> *My friend said that there are many drug addicts, prostitutes and homeless people in this neighbourhood." (Chinese female participant)*

Some participants spoke about public perceptions of crime or danger in SJT being associated with low-income people living in the neighbourhood. Newcomer-immigrant perceptions of SJT were shaped by their perceptions of what *"outsiders"* such as service providers or policy-makers thought of them. One Filipino male participant said that residents in SJT are referred to as *"low-income people."* This response demonstrates the internalization by newcomer immigrants of the stigma attached to low-income neighbourhoods. This observation may shed light on concerns about how the community and policy-makers respond to immigrant neighbourhoods.

Negative Aspects of the Neighbourhood Include:

- Language barriers and difficulty finding a healthcare provider of the same ethnic background
- Difficulty navigating the health system and access to social services because of a lack of available information to immigrant newcomers
- Difficulty sustaining social networks since residents do not stay in SJT for a long period
- Concerns about trust and reliability of other residents and neighbours
- Drugs, prostitution, and crime
- Overcrowded and densely populated
- Lack of physical space in buildings
- Concerns about poor hygiene and sanitation
- Noise and other pollution
- Residential building not adequately maintained
- Landlord neglect of building repairs
- Disregard for cleanliness by other residents
- Garbage in the neighbourhood and buildings
- Limited recreational programs for families

10.3.6 Social Networks and Support

Several questions were asked in focus groups and individual interviews to understand social networks and supports for newcomer immigrants living in St. James Town. Participants were asked if they rely on family members for support, and in times of crisis who they can turn to for help (e.g., family members, neighbours, or friends).

A Tamil male participant in the focus group described how his experience with migration changed his family dynamic and social network:

> *[S]ince we used to live a life of "joined" or "extended family" together with all our people and here we live nuclear family lives; we have to face the effects. There's no help here. We cannot depend on anybody. We've got to be independent here. It's a big struggle to live here all by myself. So we're affected a bit on that issue. We feel some loneliness.*

One of the impacts of immigration is a loss of social networks and family ties. Some participants described that most of their family, including parents and extended family members, are still in their home country.

Those who did have family members living in Toronto explained that they would go to their family for financial support. A strong emphasis was placed on approaching family for support, whether it be for financial assistance, personal advice, child care, or favours. Some participants explained that they sought information about available services in the area from neighbours or friends they had made in the neighbourhood. According to a Chinese male participant in an interview:

> *If family member can help me, I will go to family member. If family member cannot help me, I will go to friends. I will discuss about family issues with my wife and talk about work problem with colleagues. I do not talk about my work problem with my wife, because she cannot help me to resolve the problem and may feel stressed. I do not want to bring too much stress to home. It is not necessary and not helpful.*

The preceding quote reflects the Chinese group's perception that wellbeing includes *"family harmony."* Friendships with neighbours or residents in SJT were usually formed within ethnic groups. For instance, Chinese immigrants spent time with and conversed with other Chinese residents. Chinese participants said that cultural similarities and shared language made it easier to communicate with other Chinese residents. There was also some concern expressed about trust and reliability of other residents. In an interview, a Tamil male participant stated:

> *One cannot expect any respect from the people residing in this area because no one is aware what others might talk or behave. So there isn't any good relationship between neighbours in this area. People live with their problems all the time and don't have time for socializing with neighbours.*

Other participants spoke about how they generally kept to themselves but found that people were friendly. Some participants in interviews and focus groups spoke about the absence of time to socialize with their neighbours and to establish friendships. Participants described that they found it difficult to meet new people and form any friendships once they arrived in the neighbourhood, but this changed after a year or longer living in the neighbourhood. Similarly, non-immigrant participants described their difficulties with sustaining friendships because of the stress of being poor.

Responses did vary among Filipino, Chinese, and Tamil participants on the value of friendships. Most Filipino participants (both male and female) reported having a strong network of friends

who offered them support. Having friends appeared to be more important to Filipinos than to Chinese and Tamil groups.

10.4 Availability and Quality of Health and Social Services

Participants expressed concerns about the availability of quality health and social services in St. James Town. Several participants across the ethnic groups felt that there were not enough services available in the neighbourhood and surrounding area, especially services that met their needs. Several participants said that they had difficulty finding a family physician upon arrival. The Chinese group expressed a strong preference for family physicians who were also of Chinese origin. A Chinese female participant explained the difficulty immigrant families have in accessing services:

> *Some family doctors do not accept any new patients. It is very difficult for new immigrants to find a family doctor. [The] Health Centre provides health care services, but did not disseminate information in the neighbourhood well. Many residents do not know the centre's services. Most staffs of this health centre only speak English. Chinese residents have language barriers with communication in English.*

Participants expressed strong concerns about the language barrier when accessing services. Also, limited information was disseminated in the neighbourhood regarding available services. Some residents expressed that they weren't informed of community services or programs offered in the neighbourhood, and they experienced difficulty navigating community and health services. According to a Chinese female participant:

> *More information about services and programs should be provided. The notices and flyers should be posted and distributed; let residents get information. Dissemination of information is not sufficient. The residents are isolated and do not know where they can find information.*

New immigrants to Canada who do not speak the language and are not familiar with using the Internet, generally have a harder time accessing information on available services or finding support in their area.

10.5 Service Provider Interviews

The service providers interviewed were staff in organizations offering a range of services, including literacy programs, child development programs, parenting programs, and health services. Service providers in SJT and the surrounding area expressed the important challenges they face in providing services to newcomer-immigrant populations. They discussed the differing needs of newcomer immigrants and the inability to meet the needs of all ethnic groups. Service providers were also aware of the barriers that newcomer immigrants face in accessing community and health services.

A staff member at the neighbourhood's Parent Literacy Centre described some of the challenges:

[T]he community is complex, there are lots of special needs in the community … some parents with mental health issues—lower functioning adults with depression; complicated family dynamics … many individuals come from war torn countries—individuals deal with a lot silently.

Another challenge is the engagement piece. We are talking about people who are stigmatized, marginalized—they have been made promises that have been broken, time and time again and it is very hard to try and build that trust and help people help themselves.

Service providers also explained that federal funding for the centre's program determines the services and programs it can offer. Other factors impact the centre's provision of programs and services: the limited number of spaces available, and the increased demand for services and programs as more newcomer immigrants arrive. In addition, service providers consider cultural norms as potential barriers to access and use of services by immigrant women. The staff member at the Parent Literacy Centre noted:

There are often a lot of pressures within households—men typically have more power and control in the relationship and make decisions for the family. Women are often not enabled to adjust—expected to take care of the family and play secondary role.

Similarly, a staff member at the Central Community Health Team explained the barriers that newcomer immigrants face:

It is extremely challenging to have people participate, when as a newcomer, they don't know what services are there, there's language barriers, there's them not knowing where their next meal is coming from.

The staff member at the Central Community Health Team also expressed concerns about the difficulty of engaging newcomer immigrants, and the lack of trust immigrants have toward community providers.

Service providers described that funding constraints affect the provision of programs and services and the sustainability of their organizations. According to a staff member at Growing Together:

Funding is a huge constraint for us. The bulk of our funding comes from the ministries, child and youth and children's mental health has not really got an increase in funding for years. We did have that newcomer funding from United Way which ended but we do get ongoing funding from United Way.

Service providers also said that language barriers represent a challenge and that they would like to employ more staff who speak the languages of ethnic groups in the community.

The services offered in the community are free. Service providers disseminate information (through flyers, program guides, workshops, information sessions, face-to-face communication, meetings with local community agencies) on how to get involved in community programs, the programs and services that are available, and how to register. They

provide information in different languages to prevent language from being a barrier to accessing programs.

11. Conceptual Framework

Our conceptual framework emerged from the data findings. The conceptual framework for analysis was adapted from an ecological model of health by McLeroy, Bibeau, Steckler, and Glanz (1988) and a conceptual model by Stockdale et al. (2007) that explores neighbourhood stressors on health. Ecological models view behaviours as being affected by and affecting the social environment. In McLeroy et al.'s ecological model for health promotion, behaviour is viewed as the outcome of interest, which is determined by the following: (1) intrapersonal factors—characteristics of the individual, such as education and attitudes; (2) interpersonal processes and primary groups—formal and informal social network and social support systems; (3) institutional factors—social institutions; (4) community factors—relationships among organizations, institutions, and informal networks; and (5) public policy—local, state, and national laws and policies.

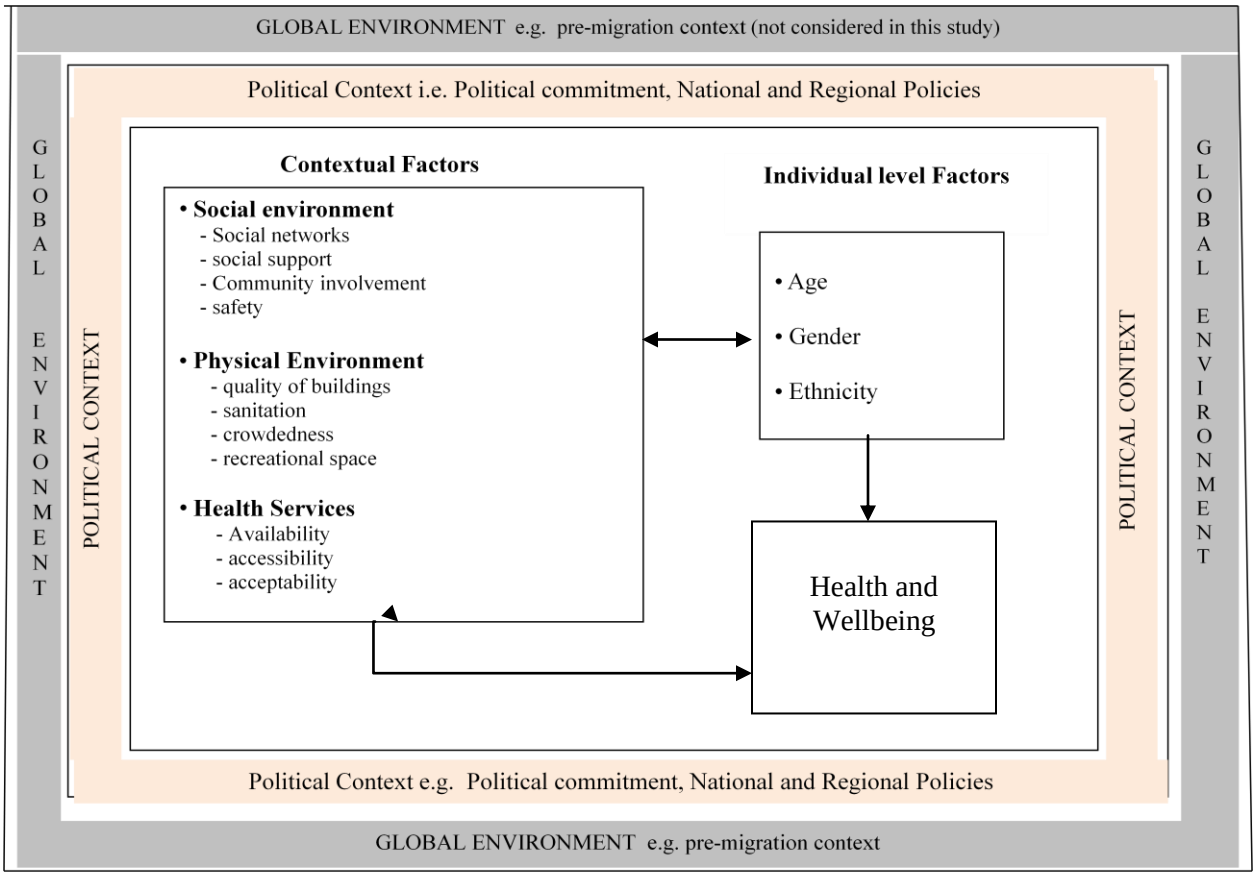
Stockdale et al.'s conceptual model of neighbourhood and health illustrates the pathways through which a neighbourhood's economic context (e.g., family income) impacts mental health, demonstrating a relationship between economic context and neighbourhood stressors (e.g., violent crime). A relationship also exists between a neighbourhood's economic context and "neighbourhood stress-buffering mechanisms," which include social networks and the available resources for social capital. The authors argue that social support can provide a protective function against psychological distress (Stockdale et al., 2007: 1870). Signs of neighbourhood disorders, including substance abuse and crime, contribute to the perception of disadvantaged neighbourhoods as dangerous and impact mental health.

The framework shown in Figure 1 illustrates our conception of the link between neighbourhood and health in St. James Town, and adequately represents the experiences of newcomers to that neighbourhood. This framework follows from the work of McLeroy et al. (1988) and Stockdale et al. (2007) to provide an understanding of how individual-level factors (e.g., age, gender, and ethnicity) can shape health and wellbeing and influence contextual or neighbourhood-level factors (e.g., social environment, physical environment, and health services). Thus, the model proposed for this study posits that the health and wellbeing of newcomer immigrants is a function of the interrelated effects of individual-level factors and contextual factors. At the contextual level, the key constellations of determinants are divided into three groups: social environment, physical environment, and health services. The framework recognizes that individuals and communities function within the bigger political and economic context of the country.

The outer frames labeled "political context" and "global environment" are not a specific focus of our study, but they are important factors that also shape immigrants' experience of migration. The "political context" frame represents the political commitments—such as national and regional policies—that shape the experiences (positive or negative) of newcomer immigrants. For instance, immigration policies in Canada affect the opportunities of immigrants to build social and economic capital. Newcomer immigrants' health and wellbeing are shaped by the loss of employment credentials and qualifications, which are not recognized

in the Canadian context. In the global environment, growing political and economic instability in many parts of the world is leading a large number of people to migrate (forced and voluntary). Pre-migration experiences may impact their health and wellbeing, depending on the prevailing policies and environment of receiving countries. Evidence indicates that the current trend of migration will probably continue and become an even greater global public health challenge.

Figure 1: Conceptual Framework for the Determinants of Health and Well-being



12. Discussion

St. James Town residents experience a range of physical, social, economic, and cultural factors in their neighbourhood that affect their physical, social, and mental health and wellbeing. This study has built on previous research providing detailed information on how "place" influences health among newcomer immigrants in SJT. Through a review of current literature on neighbourhood factors affecting health, social capital, supported housing, and immigration and health combined with information gathered from interviews and focus groups from residents and service providers, we developed a set of key place-based characteristics. It is important to note that service providers and residents of SJT highlighted many similar characteristics that influence the health and wellbeing of newcomer immigrants. Many

similarities in responses and shared experiences were also noted across the ethnic groups studied and between men and women in the focus groups. Differences between men and women across the ethnic groups primarily revolved around female participants' familial responsibilities in the home and language barriers that make it difficult for them to access health and social services and find employment.

Our study produced a number of themes regarding newcomer-immigrant experiences with immigration to SJT. These themes are categorized according to contextual factors: social environment, physical environment, and health services.

> New immigrants contend not only with their daily survival struggles but also with barriers to accessing services, social stigma, isolation, and marginalization, which add to their vulnerability to poor health and wellbeing.

Social Environment: Newcomer-immigrant participants, along with Canadian-born participants, experience income inequality, social exclusion, and barriers to labour-market participation as well as little or no job security. The working conditions of some low-paying jobs can affect residents' health and wellbeing. Language barriers contributed to the challenges of finding employment and accessing health and social services. Participants expressed some positive and many negative experiences of interaction with neighbours in SJT. Several participants spoke about how they generally kept to themselves but found that people were friendly. In the Filipino group, participants stated the importance of family and friends, and described that they had some friends in SJT that they could rely on in times of crisis.

Beyond interactions with neighbours, participants discussed the impact of drugs and crime on the overall neighbourhood. Even though some participants felt safe in their buildings, several noted that they had safety concerns about the neighbourhood as a result of street drugs and other criminal behaviour. Participants described the effects living in a neighbourhood infested with drugs, addictions, and crime could have on their own health and wellbeing and the safety of their family. Some participants said that the sounds of gunshots in the neighbourhood not only instilled fear and concern in residents but also disrupted their lives.

Residents are more likely to find stability and a sense of wellbeing in safe, clean, and comfortable environments and in neighbourhoods that have access to public transit and local amenities. Unfortunately, some participants across the ethnic groups associated such environments with "low-income" groups. Recent literature has identified the importance of neighbourhood safety. Specifically, safe neighbourhoods seem to help individuals cope with problems that may come up in housing (Wong et al., 2006) and are associated with increased stress.

Non-immigrant participants appeared to have a more intuitive understanding of factors that influence their health and wellbeing. This may result from being Canadian-born, speaking the English language, and living in SJT for a longer period of time compared with newcomer immigrants. In contrast to the newcomer-immigrant group, the non-immigrant group was more aware of the political forces that constrain their opportunities and choices.

Physical Environment: Participants offered positive and negative responses about SJT physical environment. Participants spoke positively about having access to public transit and amenities such as grocery stores and social and health services. Several Chinese participants noted that they wanted to be close to their family physician.

Several negative aspects of living in SJT were described. Participants across the ethnic groups raised concerns about the absence of recreational space and the limited number of spaces for community programs and new patients at health facilities. Participants expressed their dislike for the crowdedness in SJT and the disruptive noise in the high-rise residential buildings. Moreover, some participants complained about the lack of physical space in the high-rise apartments.

Health Services: Access to services, social support, and resources was associated with improved health outcomes in SJT. Many immigrants are unable to access healthcare services because of language barriers. Chinese participants indicated a strong preference for a family physician that is also of Chinese origin who could speak Chinese. It is important to recognize that immigrants' concerns over unavailable health services stem from the fact that newly arrived immigrants to Canada have to wait three months to be eligible for OHIP. Although health and social services are present in SJT, residents indicated that these services are not enough, of poor quality, and do not meet the needs of the diverse ethnic groups in the neighbourhood.

Non-immigrant participants described experiences of discrimination by healthcare providers that deter them from accessing medical care.

There are cultural acceptability barriers for immigrant groups. Immigrants generally come from communities that have different health practices or approaches to healthcare. Service providers face a number of constraints in trying to meet the needs of the immigrant communities they serve. Service providers described the challenges of meeting the demands of their funders while trying to design services that are accessible and appropriate to immigrants.

We know from the literature that the experiences of immigration for immigrant women are different from that of immigrant men. Immigrant women face the double jeopardy of oppression on the basis of their gender and being an immigrant (Oxman-Martinez, Abdool, and Loiselle-Leonard, 2000). Very little is known about the specific needs of immigrant women, and only few community-based organizations in Toronto focus exclusively on health and social services for immigrant women. Women entering Canada under dependent status often come with male relatives, and may not be as well educated, and therefore unable to find suitable employment (Khanlou, 2009a).

13. Study Limitations

The findings of this study should be considered in the context of certain limitations. This study is a snapshot of the St. James Town neighbourhood and, therefore, its demographic, physical, social, and economic conditions may change over time. It is also important to note the limitations of sampling and analysis due to the qualitative design of the study. In order to ensure inclusion of immigrant residents from specific ethno-racial backgrounds, purposive

sampling was used. Through this sampling technique, it is likely that we captured information from only those residents who had social networks and were more connected to the community, possibly excluding hard-to-reach marginalized residents from the three ethno-racial groups. However, the goal of qualitative research is not to generalize findings but to provide in-depth and sufficient information on the topic of interest to make the findings transferable (Khanlou, Koh, and Mill, 2008). In order to address the sampling limitation, a number of steps were taken to ensure the rigour of the study: (1) triangulation of data was undertaken; (2) several strategies were applied to recruit participants to capture a wide range of participants from the ethno-racial groups; (3) all focus groups and interviews with residents were conducted in their ethnic languages; and (4) the authors and interviewers involved in data collection and analysis were not from any of the participating groups.

14. Conclusion

This study examined both the "place-based" characteristics of St. James Town and individual-level factors, including newcomer immigrants' perceptions of the neighbourhood, their social relations, and their access to health and social services in the neighbourhood. The study captured the experiences of three ethno-racial immigrant populations: Tamil, Filipino, and Chinese. It compared their experiences with those of Canadian-born neighbourhood residents.

Findings indicate that SJT newcomer-immigrants experience a range of manifestations relating to physical, mental, and social health and wellbeing. The physical environment of SJT shapes health and wellbeing through a variety of experiences. The quality of infrastructure of housing, unclean residential buildings, and the presence of trash that serves as a breeding ground for pests and rodents are all perceived as constant stressors and threats to residents' physical and emotional health and wellbeing.

> "Among the myriad of issues that factor into the health and wellbeing of urban immigrant neighbourhoods are poverty, concerns surrounding built environment such as overcrowding, poor maintenance of high-rise buildings, sanitation, solid waste management, and lack of green and open spaces that compounds all these problems."
>
> (WHO, 2008)

Newcomer immigrants in SJT place a high value on open and green spaces in their neighbourhood. However, the poor quality and inadequate number of neighbourhood parks and recreational space limits their opportunities for social interaction with other residents.

Interviews with service providers revealed a number of challenges and barriers to providing services and care to newcomer immigrants who have diverse needs. Funding constraints do

not provide service providers with the flexibility to design and administer services and programs to accommodate the different needs of the ethnic groups.

15. Recommendations and Policy Implications

Our recommendations are organized according to the level of government intervention deemed necessary, based on our findings.

The following recommendations address issues that require actions at a level upstream from the community. Response to these issues may require intersectoral and cross-government actions because many are related to social and economic inequities that affect individuals as well as neighbourhoods. The roots of these issues lie deeper than the SJT neighbourhood and affect the opportunities newcomer immigrants have inside outside their communities.

All Levels of Government (Local, Provincial, and Federal)

1. **Provide political empowerment and reduce health inequities among newcomer immigrant populations by ensuring their fair representation and active participation in all phases of the health decision-making process as an integral feature of the right to health.**

   More immigrants are becoming vocal about health as an integral part of how they and their families go about their everyday lives, and about the way their society deals with health and healthcare. The WHO Commission on Social Determinants of Health stresses that inclusion and full participation in the society in which individuals settle is vital to the material, psychological, and political empowerment that form the basis for social wellbeing and equitable health (Commission on Social Determinants of Health, 2008).

Federal and Provincial Governments

2. **Emphasize multiple and simultaneous interventions. Foster intersectoral and cross-government collaboration and initiatives to address inequities and the social determinants of newcomer immigrant health.**

   Many of the issues highlighted in this study would not be considered to be directly within the realm of the health sector. However, these issues influence the behaviours, attitudes, and exposure to risks and resources experienced by newcomer immigrants in SJT and therefore play an important role in their health and wellbeing.

   Evidence suggests that interventions concerning the physical environment, housing, urban governance, and urban planning—in that order—are the proven priorities (WHO, 2008). A World Health Organization Report (2008) stresses that improving sanitation, solid waste management, housing, and the physical environment leads not just to physical wellbeing but to deeper consideration by policy-makers for social concerns, such as employment, productivity, education, social opportunities, and peace and order.

3. Develop policy as well as innovative practices to address the specific barriers leading to the underuse of social and health services by newcomer immigrants.

Language Barriers

Significant improvements in the accessibility, quality, and relevance of language programs are required to ensure that newcomer immigrants reach proficiency in English.

- Enhanced Language Training (ELT) has shown potential in helping newcomer immigrants obtain jobs in their fields, but the programs are not widely available. Many newcomer immigrants are on waiting lists before entering the program, and many are unable to access the program. Federal funding for ELT programs should be increased. However, community organizations should be given the flexibility to design their programs according to the needs of the community.
- Most newcomer-immigrant males take up several part-time jobs to support their families. Thus, it is not possible for them to register for ELT classes, which are usually offered between 9 a.m. and 5 p.m. Extended hours of services and some flexibility in scheduling should be built into these programs to encourage immigrants to take full advantage of these services. A combination of in-class and web-based teaching is one possibility that needs to be pilot-tested.

Accessibility Barriers to Quality Services

Given the numerous barriers newcomer immigrants face, Health Canada (2002) released a special report on access to health services for underserved populations and highlighted the needs of this population specifically. Barriers impeding access to and use of services among newcomer-immigrant populations are now recognized as a major problem requiring immediate policy attention (Khanlou, 2009b).

- A specific challenge for ethnic groups is underuse of health and social services. The reasons are multiple and include the following: cultural barriers, religious differences, language barriers, lack of finances, difficulty in finding family doctors, and long waiting periods for health insurance (Khanlou, 2009b).
- Newcomer Immigrants that settle in poor urban neighbourhoods encounter increased stressors and adverse life events, such as overcrowded and polluted environments, poverty, dependence on precarious jobs, and reduced social support. All these factors are known to have deleterious consequences on mental health. There needs to be a prioritization of services that target the mental health problems of marginalized and vulnerable populations, including problems of co-morbidity (i.e., where mental health problems occur jointly with other problems such as physical illness or substance abuse).

4. Address newcomer immigrants' underemployment and poverty, which are significant risk factors for their health and wellbeing.

Since Canada has an active immigration policy, its future and its economic strength are strongly tied to its diversity. The country must ensure successful integration of its diverse population. The best indicator of the success of immigrant integration is immigrants' ability to establish themselves in the workforce. However, the problem of immigrant underemployment is a dynamic one, and overlapping jurisdiction makes it challenging to overcome these barriers (The External Advisory Committee on Cities and Communities, 2006). To overcome multiple barriers, immigrant poverty cannot be dealt with sector by sector; it must be addressed holistically through the Government of Ontario's development policy. The province's development policy should include upgrading: physical upgrading through improvements to housing, infrastructure, and the environment; social upgrading through improved education, health, and equal employment opportunities; and governance upgrading through participatory processes, community leadership, and empowerment.

5. Address the lack of opportunities for newcomer immigrants to develop adequate social networks, which is a significant risk factor for their health and wellbeing.

As Canada's cities and neighbourhoods change demographically over the next decades, we will need to move towards greater inclusiveness. Social supports and networks are important for the wellbeing of immigrants, especially in the first few years upon their arrival in Canada. Lack of family and friendship networks can create a sense of isolation for newcomer-immigrant families. Moreover, as newcomer immigrants tend to have lower incomes, low- or no-cost places for social activities are particularly valuable for developing social networks. Green and open spaces, community centers and libraries facilitate social interactions which can provide relief from daily stresses and improve mood (Haque, Moriarty & Anderson, 2008). Public green spaces have been identified as playing a significant role in inter-ethnic youth engagement and relationship building (Seeland, Dubendorfer & Hansmann, 2009).

> "Strong cultural engagement can substantially improve the cohesiveness, confidence … and attractiveness of places."
>
> (The External Advisory Committee on Cities and Communities, 2006)

Municipal Governments

6. Strengthen intergovernmental collaboration so that municipal governments are engaged in decision making over the design, organization, delivery, and management of social and health services at the local level.

Canadian municipal governments receive financial transfers from federal and provincial governments to provide services such as protection (fire, police), transportation, environment (water, sewage, solid waste), recreation and culture, general services, conservation/development, and regional planning (Young & Leuprecht, 2006). Approximately half of the transfers are directed to transportation services and housing. The principle underlying the role of municipalities is that responsibility for services should be assigned to the lowest level of government capable of providing the service effectively. Municipalities are often affected by actions and decisions of the provincial and federal governments. Fiscal constraints and the decline in federal and provincial transfers affect the ability of municipalities to adequately administer and manage services.

References

Agyemang C, van Hooijdonk C, Wendel-Vos W, Lindeman E, Stronks K, Droomers M. (2007a). The association of neighbourhood psychosocial stressors and self-rated health in Amsterdam, The Netherlands. *J Epidemiol Community Health, 61*(12), 1042–1049.

Agyemang C, van Hooijdonk C, Wendel-Vos W, et al. (2007b). Ethnic differences in the effect of environmental stressors on blood pressure and hypertension in The Netherlands. *BMC Public Health, 7*, 118.

Ali J. (2002). Mental health of Canada's immigrants. *Health Reports, 13*(Suppl), 1–11.

Aneshensel CS, Sucoff CA. (1996). The neighbourhood context of adolescent mental health. *Journal of Health & Social Behavior, 37*(4), 293–310.

Asanin J, Wilson K. (2008). "I spent nine years looking for a doctor": Exploring access to health care among immigrants in Mississauga, Ontario, Canada. *Soc Sci Med, 66*(6), 1271–1283.

Beiser M. (2006). Longitudinal research to promote effective refugee resettlement. *Transcult Psychiatry, 43*(1), 56–71.

Beiser M, Hou F, Hyman I, Tousignant M (2002). Poverty, family process, and the mental health of immigrant children in Canada. *Am J Public Health,* 92(2):220-227.

Benoit C, Shumka L, Vallance, K, Hallgrimsdottir, H, Phillips, R, Kobayashi, K, Hanivsky, O, Reid, C, Brief, E. (2009). Explaining the health gap experiences by girls and women in Canada: A social determinants of health perspective. *Sociological Research Online, 14*(5). Retrieved from http://www.socresonline.org.uk/14/5/9.html

Bernard P, Charafeddine R, Frohlich KL, Daniel M, Kestens Y, Potvin L. (2007). Health inequalities and place: A theoretical conception of neighbourhood. *Soc Sci Med, 65*(9), 1839–1852.

Borg, M., Sells, D., Topor, A., Mezzina, R., Marin, I., & Davidson, L. (2005). What makes a house a home: The role of material resources in recovery from severe mental illness. *American Journal of Psychiatric Rehabilitation, 8*(3), 243–256.

Bowling A, Barber J, Morris R, Ebrahim S. (2006). Do perceptions of neighbourhood environment influence health? Baseline findings from a British survey of aging. *Journal of Epidemiology & Community Health, 60*(6), 476–483.

Brown J.B (1999). The Use of Focus Groups in *Clinical Research in Doing Qualitative Research.* Second Edition. Sage Publications, pp109-126.

Browne, G., & Courtney, M. (2005). Housing, social support and people with schizophrenia: A grounded theory study. *Issues in Mental Health Nursing,* 26(3), 311–326.

Bryant T, Raphael D, Travers R. (2007). Identifying and strengthening the structural roots of urban health in Canada: Participatory policy research and the urban health agenda. *Promotion and Education, 14*(1), 6–11.

Carpiano, R. (2006). Towards a neighbourhood resource based theory of social capital for health; Can Bourdieu and sociology help? *Social Science & Medicine, 62*(1), 165–175.

Carter T, Polevychok C, Friesen A, Osborne J. (July 2008). The Housing Circumstances of Recently Arrived Refugees: The Winnipeg Experience. *Prairie Metropolis Centre*. Pp 1-146

Cattell V. (2001). Poor people, poor places, and poor health: The mediating role of social networks and social capital. *Soc Sci Med, 52*(10), 1501–1516.

Caughy MO, O'Campo PJ, Muntaner C. (2003). When being alone might be better: neighbourhood poverty, social capital, and child mental health. *Soc Sci Med, 57*(2), 227–237.

Cerin E, Leslie E, du Toit L, Owen N, Frank LD. (2007). Destinations that matter: Associations with walking for transport. *Health & Place, 13*(3), 713–724.

Chapman MV. (2005). Neighbourhood quality and somatic complaints among American youth. *Journal of Adolescent Health,* 36(3), 244–252.

Chen H and Boore J. (2009). Translation and back-translation in qualitative nursing research: Methodological review. *Journal of Clinical Nursing, 19*, 234–239.

Chen J, Ng E, Wilkins R. (1996). The health of Canada's immigrants in 1994–95. *Health Rep, 7*(4), 33–45, 37–50.

Chen J, Wilkins R, Ng E. (1996). Health expectancy by immigrant status, 1986 and 1991. *Health Rep, 8*(3), 29–38(Eng), 31–41.

CIHI. *Improving the health of Canadians: An introduction to health in urban places*. Ottawa: Canadian Institute for Health, Information (CIHI) 2006a. Retrieved from http://www.cihi.ca/cphi

CIHI. Improving the health of Canadians: Promoting healthy weights. summary report. Ottawa: Canadian Institute for Health Information (CIHI) 2006b. Retrieved from http:// www.cihi.ca/cphi

Cohen DA, Farley TA, Mason K. (2003). Why is poverty unhealthy? Social and physical mediators *Soc Sci Med, 57*(9), 1631–1641.

Cohen DA, McKenzie TL, Sehgal A, Williamson S, Golinelli D, Lurie N. (2007). Contribution of public parks to physical activity. *Am J Public Health*, *97*(3), 509–514.

Collins P, C., Hayes M, V., Oliver L, N. (2009). Neighbourhood quality and self-rated health: A survey of eight suburban neighbourhoods in the Vancouver Census Metropolitan Area. *Health & Place, 15*(1), 156–164.

Commission on Social Determinants of Health. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health*. Geneva: World Health Organization.

Crabtree B. and Miller W. (1999). *Doing qualitative research* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Creswell, J.W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Cummins S. (2007). Commentary: investigating neighbourhood effects on health—avoiding the "local trap." *Int J Epidemiol, 36*(2), 355–357.

Cummins S, Curtis S, Diez-Roux AV, Macintyre S. (2007). Understanding and representing "place" in health research: A relational approach. *Social Science and Medicine, 65*(9), 1825–1838.

Diez-Roux AV. (2001). Investigating neighbourhood and area effects on health. *Am J Public Health, 91*(11), 1783–1789.

Dunn JR, Dyck I. (2000). Social determinants of health in Canada's immigrant population: Results from the National Population Health Survey. *Soc Sci Med, 51*(11), 1573–1593.

Dunn JR, Hayes MV. (2000). Social inequality, population health, and housing: A study of two Vancouver neighbourhoods. *Soc Sci Med, 51*(4), 563–587.

Dunn JR, Hayes MV, Hulchanski JD, Hwang SW, Potvin L. (2006). Housing as a socio-economic determinant of health: Findings of a national needs, gaps and opportunities assessment. *Can J Public Health, 97*(Suppl), s11–s23.

Dunn JR, Veenstra G, Ross N. (2006). Psychosocial and neo-material dimensions of SES and health revisited: Predictors of self-rated health in a Canadian national survey. *Soc Sci Med, 62*(6), 1465–1473.

Dyck I and Dossa P. (2007). Place, health and home: Gender and migration in the constitution of healthy space. *Health & Place,* 13, 691–701.

Edmondson R. (2003). Social capital: A strategy for enhancing health? *Soci Sci & Med, 57*, 1723–1733.

Ellaway A, Macintyre S. (1996). Does where you live predict health related behaviours: A case study in Glasgow. *Health Bulletin, 54*(6), 443–446.

Ellaway A, Macintyre S, Kearns A. (2001). Perceptions of place and health in socially contrasting neighbourhoods. *Urban Studies, 38*(12), 2299–2316.

Evans GW, Wells NM, Moch A. (July 2003) Housing and Mental Health: A Review of the Evidence and a Methodological and Conceptual Critique. *Journal of Social Issues*, 59(3):475-500.

The External Advisory Committee on Cities and Communities. (2006, June). *Final report. From restless communities to resilient places: Building a stronger future for Canadians*.

Feldman PJ, Steptoe A. (2004). How neighbourhoods and physical functioning are related: The roles of neighbourhood socioeconomic status, perceived neighbourhood strain, and individual health risk factors. *Annals of Behavioral Medicine, 27*(2), 91–99.

Farmer T., Robinson K., Elliott S., Eyles J. (2006) Developing and Implementing a Triangulation Protocol for Qualitative Health Research. *Qualitative Health Research*, 16; 377.

Fenta H, Hyman I, Noh S. (2004). Determinants of depression among Ethiopian immigrants and refugees in Toronto. *J Nerv Ment Dis, 192*(5), 363–372.

Galea S, Ahern J, Rudenstine S, Wallace Z, Vlahov D. Urban built environment and depression: a multilevel analysis. *J Epidemiol Community Health.* Oct 2005;59(10):822-827.

Gary TL, Stark SA, LaVeist TA. (2007). Neighbourhood characteristics and mental health among African Americans and whites living in a racially integrated urban community. *Health & Place, 13*(2), 569–575.

Gee EM, Kobayashi KM, & Prus SG. (2004). Examining the healthy immigrant effect in mid-to later life: Findings from the Canadian Community Health Survey. *Canadian Journal on Aging*, *23*, 1–69.

Geller, G., & Kowalchuk, J. (2002). Supportive housing needs of women with mental health issues in Regina. *Prairie Forum, 27*(1), 83–100.

Gordon-Larsen P, Nelson MC, Page P, Popkin BM. (2006). Inequality in the built environment underlies key health disparities in physical activity and obesity. *Pediatrics, 117*(2), 417–424.

Guruge S, Khanlou N. (2004). Intersectionalities of influence: Researching the health of immigrant and refugee women. *Can J Nurs Res, 36*(3), 32–47.

Health Canada. (2001). *The population health template: Key Elements and actions that define a population health approach*. Ottawa: Health Canada. Retrieved from http://www.phac-aspc.gc.ca/ph-sp/phdd/determinants/index.html

Herb, M., Miller, E., & O'Hara, A (2003). *A housing toolkit: Information to help the public mental health community meet the housing needs of people with mental illness*. Arlington, VA: National Alliance for the Mentally Ill.

Hill TD, Angel RJ. (2005). Neighbourhood disorder, psychological distress, and heavy drinking. *Social Science & Medicine, 61*(5), 965–975.

Hill TD, Ross CE, Angel RJ. (2005). Neighbourhood disorder, psycho-physiological distress, and health. *J Health Soc Behav, 46*(2), 170–186.

Hird S. (2003). *What is Wellbeing? A brief review of current literature and concepts*. Glasgow, Scotland: Public Health Institute of Scotland.

Hyman I. (2001). *Immigration and health*. Health Policy Working Paper Series. Working paper 01-05. Ottawa: Health Canada. Retrieved from http://www.hc-sc.gc.ca/iacb-dgiac/arad-draa/english/rmdd/wpapers/wpapers1.html

Hyman I. (2006). *Determinants of immigrant health: A literature review*. Report to Public Health Agency of Canada, Ottawa (unpublished working paper). Toronto: Independent Consultant.

Jackson S and Riley B. (2007). Health Promotion in Canada 1986-2006. *IUHPE Promotion and*

Education, 14(4), 214-218.

Jacobs, J. (1961). *The death and life of great American cities*. New York: Random House and Vintage Books.

Kawachi I, Berkman LF. Social ties and mental health. *Journal of Urban Health*. Sep 2001;78(3):458-467.

Kazemipur A, Halli S. (2000). The invisible barrier: Neighbourhood poverty and integration of immigrants in Canada. *Journal of International Migration and Integration, 1*, 85–100.

Keller-Olaman SJ, Eyles JD, Elliott SJ, Wilson K, Dostrovsky N, Jerrett M. (2005). Individual and neighbourhood characteristics associated with environmental exposure. *Environment and Behavior, 37*(4), 441–464.

Khanlou N. (2009a). *Equity in health and human services strategic initiative: Immigrant health in Ontario*. Final Report submitted to Ministry of Health and Long-term Care.

Khanlou N. (2009b). *Immigrant mental health policy brief*. Ottawa: Public Health Agency of Canada and Metropolis Canada.

Khanlou N, Koh J, and Mill C. (2008). Cultural identity and experiences of prejudice and discrimination of Afghan and Iranian immigrant youth. *International Journal of Mental Health Addiction, 6*, 494–513.

Lalonde M. (1974). *A new perspective on the health of Canadians: A working document*.

Latkin CA, Curry AD. (2003). Stressful neighbourhoods and depression: A prospective study of the impact of neighbourhood disorder. *J Health Soc Behav*, *44*(1), 34–44.

LIFT. (2006). *The St. Jamestown L.E.A.D Project. Local empowerment and access to democracy. A project for human rights and a healthy community*. Toronto: Low Income Families Together (LIFT), Ryerson University, Wellesley Central Corporation.

Lincoln Y, Guba E. (1985) Naturalistic inquiry. Sage: Thousand Oaks, California

Lindenbaum S. (2005). The value of a critical ethnographic engagement: Comments on the social production of health. *Soc Sci Med, 61*(4), 751–753.

Maas B, Fairbairn N, Kerr T, Li K, Montaner JS, Wood E. (2007). Neighbourhood and HIV infection among IDU: Place of residence independently predicts HIV infection among a cohort of injection drug users. *Health & Place, 13*(2), 432–439.

Macintyre S., Ellaway, A., & Cummins, S. (2002). Place effects on health: How can we operationalise, conceptualise and measure them? *Social Science & Medicine, 55*, 125–139.

McIntyre D, Thiede M, Birch S. (2009). Access as a policy relevant concept in low-and-middle income countries. *Health Economics Policy and Law*, 4:179-193

McLeroy K.R, Bibeau C, Steckler A, Glanz K. (1988). An ecological perspective on health promotion programs. *Health Educ Behav, 15*, 351.

Medeiros (1991). Family Service For All: A Study of Family Services for Ethno-cultural and Racial Communities in Metropolitan Toronto. *Toronto Multicultural Coalition for Access to family Services.*

Mertan RK, Kendall PI. (1946). The focused interview. *American Journal of Sociology, 51*.

Newbold B. (2005). Health status and health care of immigrants in Canada: A longitudinal analysis. *J Health Serv Res Policy, 10*(2), 77–83.

Newbold KB, Danforth J. Health status and Canada's immigrant population. *Soc Sci Med.* Nov 2003;57(10):1981-1995.

Newbold KB, Filice JK. (2006). Health status of older immigrants to Canada. *Can J Aging, 25*(3), 305–319.

Ng E, Wilkins R, Gendron F, Berthelot J-M. (2005a). The changing health of immigrants. *Canadian Social Trends, 78*, 15–19.

Ng E, Wilkins R, Gendron F, Berthelot J-M. (2005b). *Dynamics of immigrants' health in Canada: Evidence from the National Population Health Survey*. Ottawa: Statistics Canada. Catalogue no. 82-618-MWE2005002.

Odoi A, Wray R, Emo M, et al. Inequalities in neighbourhood socioeconomic characteristics: potential evidence-base for neighbourhood health planning. *Int J Health Geogr*. Aug 10 2005;4:20.

Oxman-Martinez J., Abdool S., Loiselle-Leonard M. (2000). Commentary: Immigration, Women and Health in Canada. *Canadian Journal of Public Health*, 91(5), 394-395.

Pampalon R, Hamel D, De Koninck M, Disant MJ. (2007). Perception of place and health: Differences between neighbourhoods in the Quebec City region. *Soc Sci Med, 65*(1), 95–111.

Parkes A, Kearns A. (2006). The multi-dimensional neighbourhood and health: A cross-sectional analysis of the Scottish Household Survey, 2001. *Health & Place, 12*(1), 1–18.

Phongsavan P, Chey T, Bauman A, Brooks R, Silove D. (2006). Social capital, socio-economic status and psychological distress among Australian adults. *Social Science & Medicine, 63*(10), 2546–2561.

Poortinga W, Dunstan FD, Fone DL. (2007). Perceptions of the neighbourhood environment and self-rated health: A multilevel analysis of the Caerphilly Health and Social Needs Study. *BMC Public Health, 7*(147), 285.

Poortinga W, Dunstan FD, Fone DL. (2008). Neighbourhood deprivation and self-rated health: The role of perceptions of the neighbourhood and of housing problems. *Health & Place, 14*(3), 562–575.

Prus S, Lin Z. (2005). Ethnicity and health: An analysis of physical health differences across twenty-one ethnocultural groups in Canada. Social and Economic Dimension of an Aging Population (SEDAP) Research Program SEDAP. Retrieved from http://socserv2.mcmaster.ca/sedap/p/sedap143.pdf

Putnam RD. (2001). Social capital measurement and consequences. *ISUMA: Canadian Journal of Policy Research, 2*(1), 41–51.

Raphael D. (2009) "Social Determinants of Health: An Overview of Key Issues and Themes." In *Social Determinants of Health.* Second Edition. (eds. Dennis Raphael). Pp. 2-20.

Rosenberg MW, Wilson K. (2000). Gender, poverty and location: how much difference do they make in the geography of health inequalities? *Soc Sci Med, 51*(2), 275–287.

Ross CE, Mirowsky J. (2001). Neighbourhood disadvantage, disorder, and health. *Journal of Health & Social Behavior, 42*(3), 258–276.

Sampson RJ. The neighborhood context of wellbeing. *Perspect Biol Med*. Summer 2003;46(3 Suppl):S53-64.

Sandelowski M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health, 23*, 334–240.

Schatzman L. & Strauss A.L. (1973). Field Research: Strategies for a Natural Sociology. Prentice Hall, Englewood Cliffs, New Jersey.

Sooman A, Macintyre S. (1995). Health and perceptions of the local environment in socially contrasting neighbourhoods in Glasgow. *Health & Place, 1*(1), 15–26.

Statistics Canada. (2003). *Longitudinal survey of immigrants to Canada: Process, progress and prospects*. Ottawa: Statistics Canada.

Statistics Canada. (2006). *Census tract profile for 0065.00, Toronto and Ontario*. Ottawa: Statistics Canada.

Statistics Canada. (2010). *Projections of the diversity of the Canadian population 2006–2031*. Ottawa: Statistics Canada. Catalogue no. 91-551-X.

Steele LS, Lemieux-Charles L, Clark JP, Glazier RH. (2002). The impact of policy changes on the health of recent immigrants and refugees in the inner city. A qualitative study of service providers' perspectives. *Can J Public Health, 93*(2), 118–122.

Steptoe A, Feldman PJ. (2001). Neighbourhood problems as sources of chronic stress: development of a measure of neighbourhood problems, and associations with socioeconomic status and health. *Ann Behav Med, 23*(3), 177–185.

Stockdale SE, Wells KB, Tang L, Belin TR, Zhang L, Sherbourne CD. (2007). The importance of social context: Neighbourhood stressors, stress-buffering mechanisms, and alcohol, drug, and mental health disorders. *Social Science & Medicine, 65*(9), 1867–1881.

Streubert H.J., and Carpenter D.R. (1999). *Qualitative Research in Nursing: Advancing the Humanistic Imperative*. (Second Edition) Philadelphia: Lippincott.

Sullivan-Bolyai S, Bova C, Harper D. (2005). Developing and refining interventions in persons with health disparities: The use of qualitative description. Nursing Outlook, 53(33), 127-133.

Surtees PG, Wainwright NW, Khaw KT, Day NE. (2003). Functional health status, chronic medical conditions and disorders of mood. *Br J Psychiatry, 183*, 299–303.

Tang TN, Oatley K, Toner BB. (2007). Impact of life events and difficulties on the mental health of Chinese immigrant women. *J Immigr Minor Health, 9*(4), 281–290.

Thurston WAE, Vissandjee B. (2005). An ecological model for understanding culture as a determinant of women's health. *Critical Public Health, 15*(3), 229–242.

Toronto Community Health Profiles Partnership (2005). City of Toronto Neighbourhood Profiles. Toronto, Canada. Available online at: http://www.torontohealthprofiles.ca/a_resources.php

Truelove M. (2000). Services for immigrant women: An evaluation of locations. *Canadian Geographer, 44*(2), 135–151.

Truong KD, Ma S. (2006). A systematic review of relations between neighbourhoods and mental health. *The Journal of Mental Health Policy & Economics, 9*(3), 137–154.

United Nations. (1948). *Universal declaration of human rights*. Geneva: United Nations, 1948. Retrieved from http://www.un.org/en/documents/udhr/index.shtml

Veenstra G. (2005a). Location, location, location: Contextual and compositional health effects of social capital in British Columbia, Canada. *Soc Sci Med, 60*(9), 2059–2071.

Veenstra G. (2005b). Social status and health: Absolute deprivation or relative comparison, or both? *Health Sociology Review, 14*, 121–134.

Veenstra G. (2007). Social space, social class and Bourdieu: Health inequalities in British Columbia, Canada. *Health & Place, 13*(1), 14–31.

Veenstra G, Kelly S. (2007). Comparing objective and subjective status: Gender and space (and environmental justice?). *Health & Place, 13*(1), 57–71.

Veenstra G, Luginaah I, Wakefield S, Birch S, Eyles J, Elliott S. (2005). Who you know, where you live: Social capital, neighbourhood and health. *Soc Sci Med, 60*(12), 2799–2818.

Wang MC, Cubbin C, Ahn D, Winkleby MA.(Sept 2007) Changes in neighbourhood food store environment, food behaviour and body mass index, 1981-1990. *Public Health Nutrition,* 1-8.

Warr DJ, Tacticos T, Kelaher M, Klein H. (2007). "Money, stress, jobs": Residents' perceptions of health-impairing factors in "poor" neighbourhoods. *Health & Place, 13*(3), 743–756.

Wayland S. (2006). *Unsettled: Legal and policy barriers for newcomers to Canada*. A joint initiative of Community Foundations of Canada and the Law Commission of Canada.

Weich S, Blanchard M, Prince M, Burton E, Erens B, Sproston K. (2002). Mental health and the built environment: Cross-sectional survey of individual and contextual risk factors for depression. *Br J Psychiatry, 180*, 428–433.

Wen M, Hawkley LC, Cacioppo JT. (2006). Objective and perceived neighbourhood environment, individual SES and psychosocial factors, and self-rated health: An analysis of older adults in Cook County, Illinois. *Social Science & Medicine, 63*, 2575–2590.

Wilson K, Elliott S, Law M, Eyles J, Jerrett M, Keller-Olaman S. (2004). Linking perceptions of neighbourhood to health in Hamilton, Canada. *J Epidemiol Community Health, 58*(3), 192–198.

Wilson K, Eyles J, Elliott S, Keller-Olaman S. (2009). Health in Hamilton neighbourhoods: Exploring the determinants of health at the local level. *Health & Place, 15*(1), 374–382.

Wong, YI, Hadley, TR, Culhane, DP, Poulin, SR, Davis, MR, Cirksey, BA, et al. (2006). *Predicting staying in or leaving permanent supportive housing that serves homeless people with serious mental illness*. Philadelphia, PA: U.S. Department of Housing and Urban Development, Office of Policy Development and Research.

World Health Organization. (1946). *Constitution of the World Health Organization*. New York: Author. Retrieved from http://www.who.int/governance/eb/who_constitution_en.pdf

World Health Organization. (2003). International migration, and human rights. *Health & Human Rights Publication Series*, no. 4.

World Health Organization. (2008). *Our cities, our health, our future: A synopsis of the report of the Knowledge Network on Urban Settings to the WHO Commission on Social Determinants of Health*. Geneva: World Health Organization.

Yen IH, Yelin EH, Katz P, Eisner MD, Blanc PD. (2006). Perceived neighbourhood problems and quality of life, physical functioning, and depressive symptoms among adults with asthma. *American Journal of Public Health, 96*(5), 873–879.

Young AF, Russell A, Powers JR. (2004). The sense of belonging to a neighbourhood: Can it be measured and is it related to health and well being in older women? *Social Science & Medicine, 59*(12), 2627–2637.

Ziersch AM, Baum FE, Macdougall C, Putland C. (2005). Neighbourhood life and social capital: The implications for health. *Social Science & Medicine, 60*(1), 71–86.

Zunzunegui MV, Forster M, Gauvin L, Raynault MF, Douglas Willms J. (2006). Community unemployment and immigrants' health in Montreal. *Soc Sci Med, 63*(2), 485–500.

Appendix

Table 1: Definitions of Themes

Themes	Definition
Community Involvement	Use of social and community services by newcomers is influenced by factors such as personal time, distance, family responsibilities, relationships and networks with residents in SJT
Health and Social Services: Availability	Distance to a health facility, hours of operation
Accessibility	Language barriers, quality of care (discrimination)
Acceptability	Cultural acceptability (cultural views and practices of health)
Physical Environment	Sanitation, crowdedness, quality of residential buildings, noise, space hygiene, and cheap rent
Resiliency	How well newcomers' cope with the changes they experience from immigration and in their new lifestyle and environment
Safety	Newcomers' perception of crime, drug users, and violence in SJT. Safety concerns have elicited fear and anger by the residents
Social Network/Social Support	Includes social capital., social isolation, trust and reliability of residents, and cultural connections to residents of similar ethnic backgrounds
Underemployment	Loss of previous employment/career in home country, different qualifications in Canada, change in socio-economic status (SES), and language barriers

Table 2: Participant Perceptions of SJT

Key Findings of Participant Statements about St. James Town

Negative Aspects of Neighbourhood

Availability and Accessibility of services

1. Limited recreational programs for families
2. Limited space available for recreational and social programs
3. Language barriers and the difficulty of finding a healthcare provider of the same ethnic background
4. Difficulty navigating the health system and access to social services because of a lack of available information to immigrant newcomers

Crowded

1. Densely populated
2. Lack of physical space in residential buildings
3. Concerns about poor hygiene and sanitation
4. Noise pollution

Quality of Housing

1. Residential buildings are not adequately maintained
2. Landlord neglects building repairs
3. Disregard for cleanliness by other residents

Safety

1. Drugs and Crime

Sanitation

1. Garbage in the neighbourhood and the residential buildings
2. Pollution

Social Networks

1. Difficulty sustaining social networks since residents do not stay in SJT for a long period
2. Concerns about trust and reliability of other residents and neighbours

Positive Aspects of Neighbourhood

Affordable Rent

1. Low-cost of living and cheap rent in apartment high rises

Community services

1. Presence of community services and programs to assist newcomer immigrants to adapt in their new environment
2. Programs and services offered include: language training, recreational programs, social workers, parenting programs, and health services

Cultural connections

1. Ethnic grocery stores
2. Residents and communities of similar ethnic background

Location

1. Close to grocery stores, health care facilities, social and community services, and place of work
2. Accessible by public transportation

Table 3: Characteristics of Participants in the Qualitative Study

	Ethnic Female Groups				Ethnic Male Groups				Ethnic Groups Total	Canadian-born Comparative Group		Native Total	Total sample
Description	**Total Female** (n=28)	**Chinese Female** (n=11)	**Filipino Female** (n=10)	**Tamil Female** (n=7)	**Total Male** (n=24)	**Chinese Male** (n=9)	**Filipino Male** (n=6)	**Tamil Male** (n=9)	**Total Pop.** (n=52)	**Native Female** (n=6)	**Native Male** (n=5)	**Total Pop.** (n=11)	**Total Pop.** (n=63)
Age in Years													
- Average	45	39	56	40	40	39	45	37	43	48	53	50	44
- Range	(24-74)	(24-55)	(31-74)	(35-47)	(18-72)	(33-47)	(33-55)	(18-72)	(18-74)	(34-58)	(39-58)	(34-58)	(18-74)
Years Lived in SJT													
- **Average**	4	2	4	7	6	2	5	10	5	4	14	9	6
- **0 – 4 years**	54%	82%	60%	---	57%	100%	66%	---	55%	50%	---	22%	50%
- **5 – 9 years**	46%	18%	40%	100%	30%	---	17%	75%	39%	50%	---	22%	37%
- **10 + years**	---	---	---	---	13%	---	17%	25%	6%	---	100%	56%	13%
Years in Canada													
- **Average**	6	5	6	7	7	4	5	10	6	44	48	46	13
- **0 – 4 years**	38%	55%	40%	---	43%	78%	50%	11%	40%	---	---	---	33%
- **5 – 9 years**	48%	27%	40%	100%	35%	22%	33%	67%	46%	---	---	---	38%
- **10+ years**	14%	18%	20%	---	21%	---	17%	22%	13%	100%	100%	100%	28%
Highest Education													
- **No High School**	14%	9%	30%	---	4%	---	---	11%	10%	17%	40%	27%	13%
- **High School/Apprentice**	18%	18%	10%	29%	26%	---	---	67%	21%	17%	20%	18%	21%
	32%	18%	30%	57%	8%	---	33%	---	21%	---	---	---	17%
- **College**	35%	55%	30%	14%	63%	100%	67%	22%	48%	67%	40%	55%	49%
- **University & Above**													
Currently Working	37%	45%	30%	33%	77%	78%	100%	57%	55%	40%	20%	30%	51%

<u>Focus Group Guide</u>: Newcomer Immigrants & Non-Immigrants

1) **Perceptions and experiences of health and wellbeing**
   i. How do you define health? (Probe if stress and depression are health issues)
   ii. When you hear the word "wellbeing" what does it mean to you?

2) **Health impact of migration and settlement**
   i. Do you perceive any changes in your health since arriving in St. James Town? (If yes, then what kind of changes)
   ii. Why did you choose to live in St. James Town?
   iii. What do you like and dislike about this neighbourhood?

3) **Characteristics of St. James Town which impact health and wellbeing**

   a) Quality of buildings
   i. What things stand out to you about the physical and social characteristics of St. James Town?
   ii. How can the buildings and physical space in St. James Town be improved?
   iii. What do you like and dislike about the place you live in St. James Town?
   iv. How does the condition of your housing in St. James Town affect your health?

   b) Recreational space
   i. Do you feel there are adequate and appropriate recreational spaces in St. James Town?
   ii. What are some barriers and challenges that you face in using these spaces? (Do you face problems in accessing and utilizing these recreational spaces?)
   iii. In what ways can the recreational spaces be improved?

   c) Availability and quality of services
   i. Do you feel there are adequate and appropriate health services and supports in St. James Town?
   ii. What are some barriers and challenges that you face in using these services?
   iii. In what ways can these services be improved?

   d) Social networks and supports
   i. Do you feel you can rely on your family members for support? Your neighbours?
   ii. In times of crisis, who would you turn to for help?
   iii. For what kind of help do you rely on your: a) neighbours, b) family members, c) friends

   e) Safety
   i. Do you have any safety concerns as a resident in St. James Town?
   ii. How can safety be improved in the neighbourhood?

   f) **Are there any other concerns in the neighbourhood that are important for your health and wellbeing and you would like to speak about?**

Interview Guide

a. RESIDENTS:

1. Perceptions of health & wellbeing and experiences of migration & settlement

i. How do you define health?
ii. How stressful was the migration and settlement process for you and your family? How did it impact your overall health?
iii. Do you perceive any changes in your health since arriving in St. James Town? (If you were to choose one issue, which issue would you say had the greatest effect on your health?)
iv. Why did you choose to live in St. James Town?

2. Characteristics of St. James Town which impact health and wellbeing

a) Quality of buildings

i. How does the condition of your housing in St. James Town affect your health?
ii. What do you like and dislike about the place you live in St. James Town?
iii. How can the buildings and physical space in St. James Town be improved?

b) Recreational space

i. Do you feel there are adequate and appropriate recreational spaces in SJT?
ii. What are some barriers and challenges that you face in using these spaces?
iii. In what ways can the recreational spaces be improved?

c) Availability and quality of services

i. Do you feel there are adequate and appropriate health services and supports in St. James Town?
ii. What are some barriers and challenges that you face in using these services?
iii. In what ways can these services be made more accessible?

d) Social networks and supports

i. Do you have any extended family in SJT?
ii. What is your relationship like with your neighbours in SJT?
iii. In times of crisis, who do you turn to for help?
iv. Why do you turn to this person?

e) Safety

i. What safety concerns do you have as a resident in St. James Town?
ii. How do you feel walking around St. James Town during the day? At night?

f) Employment and income

i. How easy was it for you to find employment in Canada? (How long did it take you to find your first job in Canada?)
ii. Do you have the same kind of job as you had working in your country?
iii. Do you think employment and income has any affect on your health and wellbeing?
iv. In what ways can the government assist newcomers in finding appropriate employment?

Interview Guide

b. SERVICE PROVIDERS:

a) Describe your organization's health services or programs targeted at newcomers:
   i. Elements of the program/services;
   ii. Objectives of the program/services;
   iii. Strong points of the program/services;
   iv. Challenges or weaknesses in the program/services?

b) Are there gaps in services/programs for newcomers in St. James Town that you can identify?

c) How could the overall health services/programs for immigrants in St. James Town be improved?

d) What health challenges do you think newcomers in St. James Town face?
e) Are the challenges different for various ethnic groups?

f) What role do you think neighbourhood's play in making people feel good and healthy?

g) How important do you think neighbourhood attributes are to one's health?

h) What physical and social characteristics of St. James Town do you think influence the health and wellbeing of its residents?

Probes:

- Quality of buildings
- Recreational space
- Availability and quality of services (including food)
- Social networks and supports
- Safety
- Economic issues

45 Charles St. East,
Suite 101
Toronto, ON, Canada
M4Y 1S2

Tel 416.972.1010

www.wellesleyinstitute.com

www.sjtinitiative.com

The Wellesley Institute advances urban health through rigorous research, pragmatic policy solutions, social innovation, and community action.

St. James Town Initiative is the signature project of the Wellesley Institute.

Media and Publications inquiries, please contact us by phone at 416-972-1010 or by e-mail at contact@wellesleyinstitute.com