

Health Profile on Immigrant and Refugee Children and Youth in Canada

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Contributors:

Writing and editing:

Govinda Dahal, Researcher, University of Ottawa
Louise Hanvey, Research Director, Canadian Institute of Child Health
Meghan Marcotte, Research Analyst, Canadian Institute of Child Health
Kevin Pottie, Chair, Canadian Collaboration for Immigrant and Refugee Health

Project development, research, and review:

Expert Advisory Committee

Rukhsana Ahmed, Associate Professor, University of Ottawa
Paula Brauer, Associate Professor, University of Guelph
Yvonne Chiu, Executive Director, Edmonton Multicultural Health Brokers Cooperative
Govinda Dahal, Researcher, University of Ottawa
Anita Gagnon, Professor, McGill University
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Linda Ogilvie, Professor, University of Alberta
Kevin Pottie, Chair, Canadian Collaboration for Immigrant and Refugee Health

For more information about the Expert Advisory Committee members, [click here](#).

Other

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Shelley Callaghan, Project Coordinator, Canadian Institute of Child Health
Meghan Marcotte, Research Analyst, Canadian Institute of Child Health
Janice Sonnen, Executive Director, Canadian Institute of Child Health
Robin Walker, Co-chair, Canadian Institute of Child Health

Graphic design:

Meghan Marcotte, Research Analyst, Canadian Institute of Child Health
Bert Schopf, Graphic Designer, Blackbird

Website development:

[Accel Web Marketing](#)



Canadian Institute of Child Health
Institut canadien de la santé infantile



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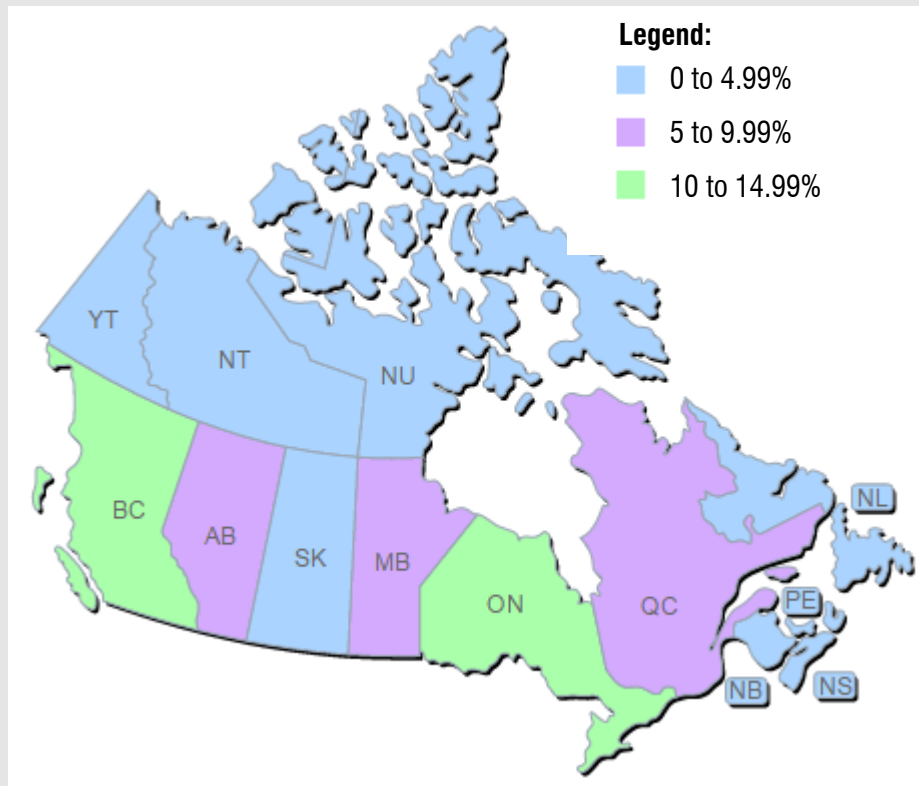
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1.1.1 Proportion of Children and Youth under 25 Who Have Immigrated to Canada, by Province and Territory, 2011



Note: The proportion for Canada overall was 9.5%.

Source: Adapted from Statistics Canada, 2011 National Household Survey, Statistics Canada Catalogue no. 99-010-X2011027.

Canada	NL	PE	NS	NB	QC	ON	MB	SK	AB	BC	YK	NT	NU
9.5	1.2	3.3	3.0	2.5	6.9	12.1	9.7	4.4	8.9	12.2	4.6	2.9	0.4

In 2011, there were 945,130 children and youth under age 25 living in Canada who had immigrated from another country. Immigrant children represented 9.5% of the total population of children and youth in Canada. 376,915 immigrant children were between birth and 15 years, and 568,215 were aged 15 through 24 years.

There were differences between provinces and territories in these numbers and proportions. More immigrant children and youth lived in Ontario—almost 500,000, or 12.1% of the total population of children and youth in the province. British Columbia had over 150,000 children and youth who had immigrated to Canada, accounting for 12.2% of the province's total population of children and youth.



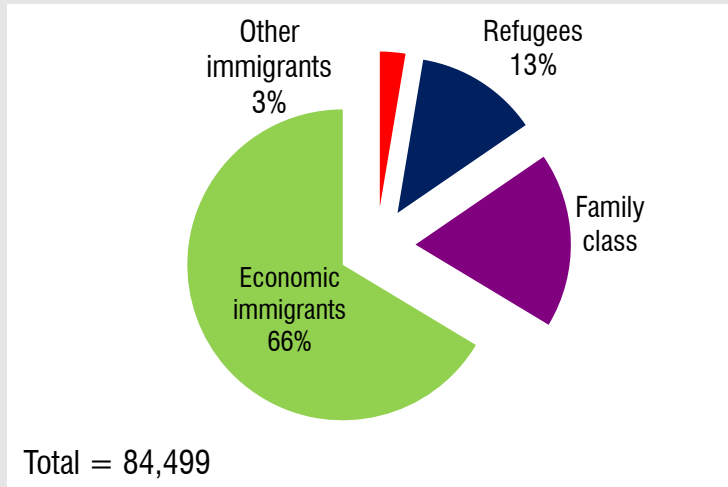


The Health of Canada's Children and Youth: A CICH Profile

Health Profile on Immigrant and Refugee Children and Youth in Canada

Section 1 - Immigrant and Refugee Children and Youth in Canada

1.2.1 Permanent Residents of Canada, 0 to 24 Years of Age, by Immigration Category, 2012



Graphic created by CICH using data adapted from Citizen and Immigration Canada. Facts and Figures 2012 – Immigration Overview: Permanent and Temporary Residents.
<http://www.cic.gc.ca/english/resources/statistics/facts2012/index.asp>

In 2012, 257,887 immigrants became permanent residents of Canada. Of those, 84,499 were children and youth between birth and 24 years of age. Of the permanent residents under age 25, the majority, or 66% (56,085) received residency status under the economic immigration class. Of those who immigrated to join family members already living in Canada (family class immigrants), there were 15,368 children and youth – making up 18% of children and youth. Another 10,810 people under age 25 obtained permanent residency status in Canada as refugees after fleeing their home countries (13% of all child and youth immigrants).

Immigrants to Canada are grouped into four classes: Economic, Family, Refugee and Other.

Economic Immigrants: “Permanent residents selected for their skills and ability to contribute to Canada’s economy.”¹

Family Immigrants: “Permanent residents sponsored by a Canadian citizen or a permanent resident living in Canada who is 18 years of age or over. Family class immigrants include spouses and partners (i.e., spouse, common-law partner or conjugal partner); parents and grandparents; and others (i.e., dependent children, children under the age of 18 whom the sponsor intends to adopt in Canada, brothers, sisters, nephews, nieces, and grandchildren who are orphans under 18 years of age, or any other relative if the sponsor has no relative as described above, either abroad or in Canada). Fiancés are no longer designated as a component of the family class under the *Immigration and Refugee Protection Act*.”¹ The definition of ‘dependent child’ changed in 2014 to include children under 19 rather than children under 22.²

If an economic immigrant sponsors his or her spouse and children to immigrate to Canada once he or she has already arrived, the spouse and children are considered family class immigrants.

Refugees: “Permanent residents in the refugee category include government-assisted refugees, privately sponsored refugees, refugees landed in Canada and refugee dependants (i.e., dependants of refugees landed in Canada, including spouses and partners living abroad or in Canada).”¹

Other: “Permanent residents in the other immigrant category include post-determination refugee claimants in Canada, deferred removal orders, retirees (no longer designated under the Immigration and Refugee Protection Act), temporary resident permit holders, humanitarian and compassionate cases, sponsored humanitarian and compassionate cases outside the family class, and people granted permanent resident status based on public policy considerations.”¹

¹Citizenship and Immigration Canada. *Facts and figures 2011 – Immigration overview: Permanent and temporary residents*.
<http://www.cic.gc.ca/english/resources/statistics/facts2011/glossary.asp>

²Citizenship and Immigration Canada. *Notice - Changes to the definition of a dependent child*. <http://www.cic.gc.ca/english/department/media/notices/2014-06-23.asp>



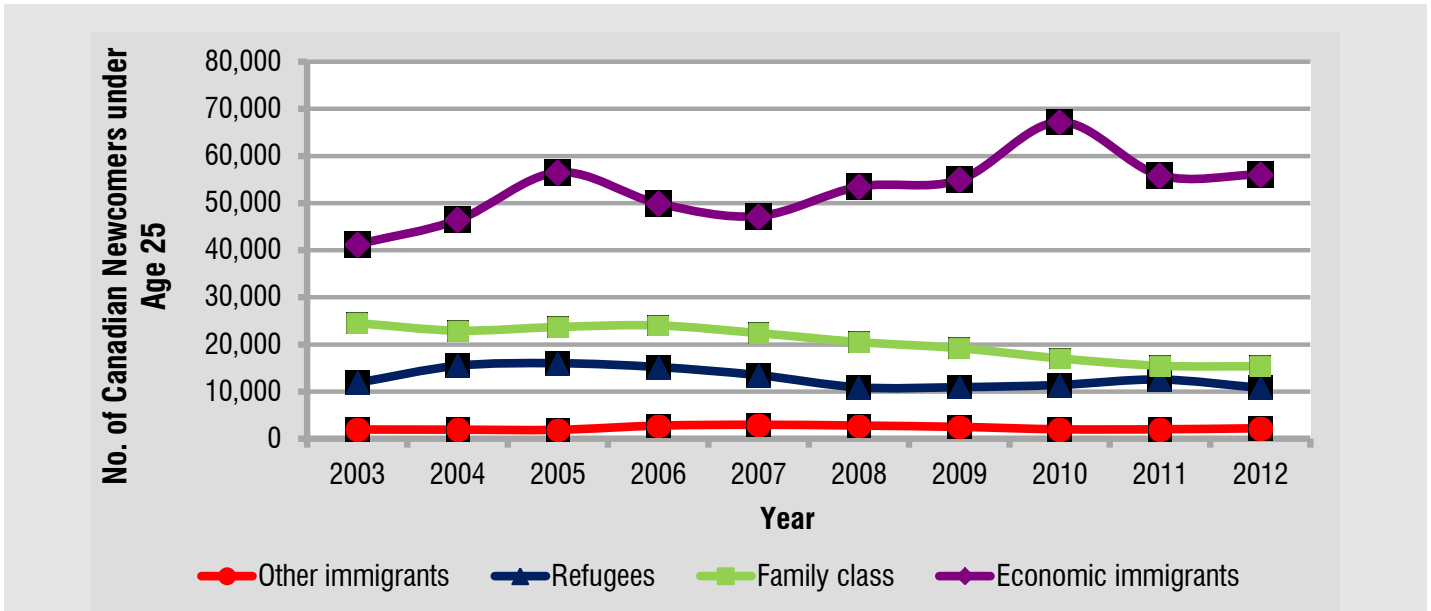


The Health of Canada's Children and Youth: A CICH Profile

Health Profile on Immigrant and Refugee Children and Youth in Canada

Section 1 - Immigrant and Refugee Children and Youth in Canada

1.2.2 Trends in the Number of Canadian Newcomers under Age 25 Who Are Permanent Residents, by Immigration Category, 2003 to 2012



Graphic created by CICH using data adapted from Citizen and Immigration Canada. Facts and Figures 2012 – Immigration Overview: Permanent and Temporary Residents. <http://www.cic.gc.ca/english/resources/statistics/facts2012/index.asp>

Since 2003, the number of children and youth aged 0 to 24 years who entered Canada as economic immigrants has increased. The number of children and youth who entered Canada as family class immigrants declined over that same time period.

Immigrants to Canada are grouped into four classes: Economic, Family, Refugee and Other.

Economic Immigrants: “Permanent residents selected for their skills and ability to contribute to Canada’s economy.”¹

Family Immigrants: “Permanent residents sponsored by a Canadian citizen or a permanent resident living in Canada who is 18 years of age or over. Family class immigrants include spouses and partners (i.e., spouse, common-law partner or conjugal partner); parents and grandparents; and others (i.e., dependent children, children under the age of 18 whom the sponsor intends to adopt in Canada, brothers, sisters, nephews, nieces, and grandchildren who are orphans under 18 years of age, or any other relative if the sponsor has no relative as described above, either abroad or in Canada). Fiancés are no longer designated as a component of the family class under the *Immigration and Refugee Protection Act*.”¹ The definition of ‘dependent child’ changed in 2014 to include children under 19 rather than children under 22.² If an economic immigrant sponsors his or her spouse and children to immigrate to Canada once he or she has already arrived, the spouse and children are considered family class immigrants.

Refugees: “Permanent residents in the refugee category include government-assisted refugees, privately sponsored refugees, refugees landed in Canada and refugee dependants (i.e., dependants of refugees landed in Canada, including spouses and partners living abroad or in Canada).”¹

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¹Citizenship and Immigration Canada. Facts and figures 2011 – Immigration overview: Permanent and temporary residents.

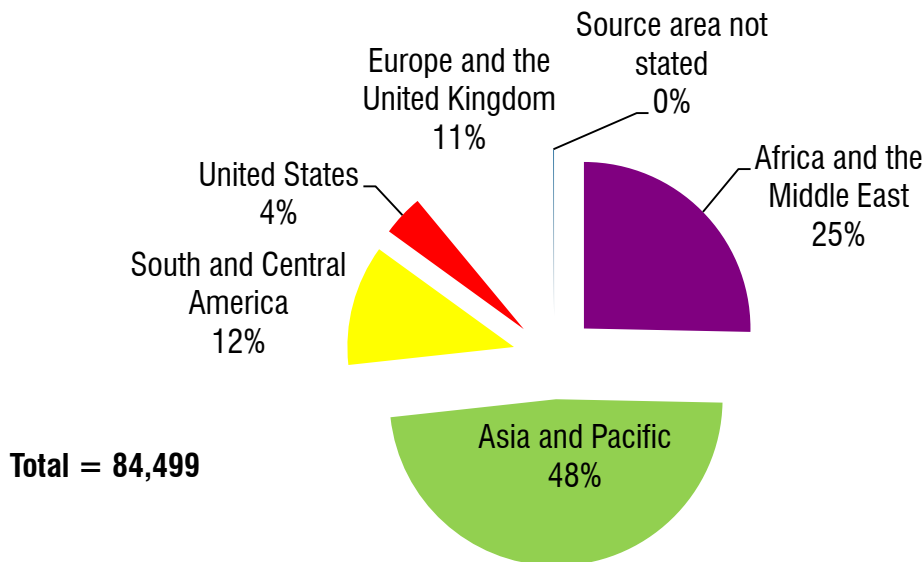
<http://www.cic.gc.ca/english/resources/statistics/facts2011/glossary.asp>

²Citizenship and Immigration Canada. Notice - Changes to the definition of a dependent child. <http://www.cic.gc.ca/english/department/media/notices/2014-06-23.asp>





1.3.1 Distribution of Permanent Canadian Residents under Age 25 by Region of Origin, 2012



Graphic created by CICH using data adapted from Citizen and Immigration Canada. Facts and Figures 2012 – Immigration Overview: Permanent and Temporary Residents. <http://www.cic.gc.ca/english/resources/statistics/facts2012/index.asp>

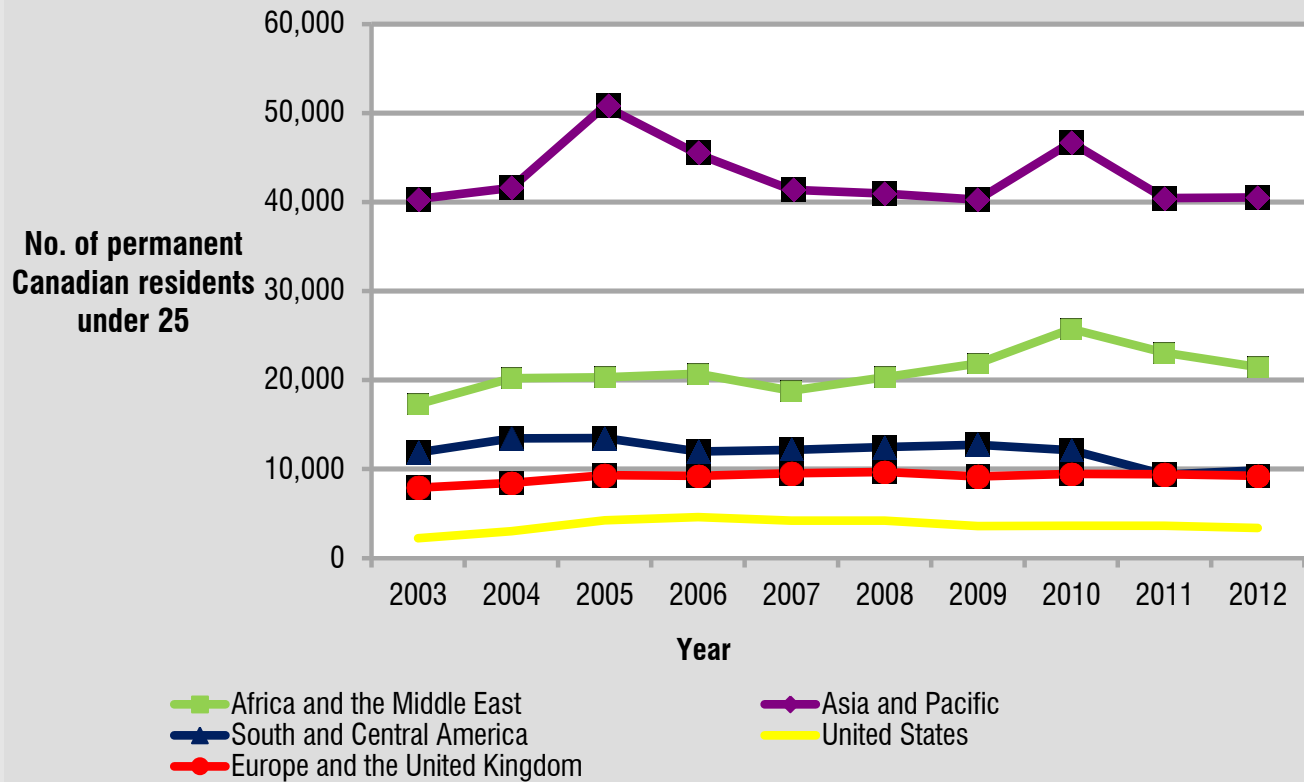
In 2012 almost half of the immigrants under 25 years who became permanent residents in Canada came from the Asia and Pacific Region. A further 25% came from Africa and the Middle East. A child's or youth's region of origin is not necessarily their place of birth. For example, research had found that many Jamaicans immigrate first to the United Kingdom, and then to Canada.¹ These individuals would technically be considered immigrants from the United Kingdom.

¹ Takenaka, A. (2007). Secondary Migration: Who Re-Migrates and Why These Migrants Matter. Migration Policy Institute. <http://www.migrationpolicy.org/article/secondary-migration-who-re-migrates-and-why-these-migrants-matter>





1.3.2 Trends in the Number of Permanent Residents under Age 25 by Origin, 2003 to 2012



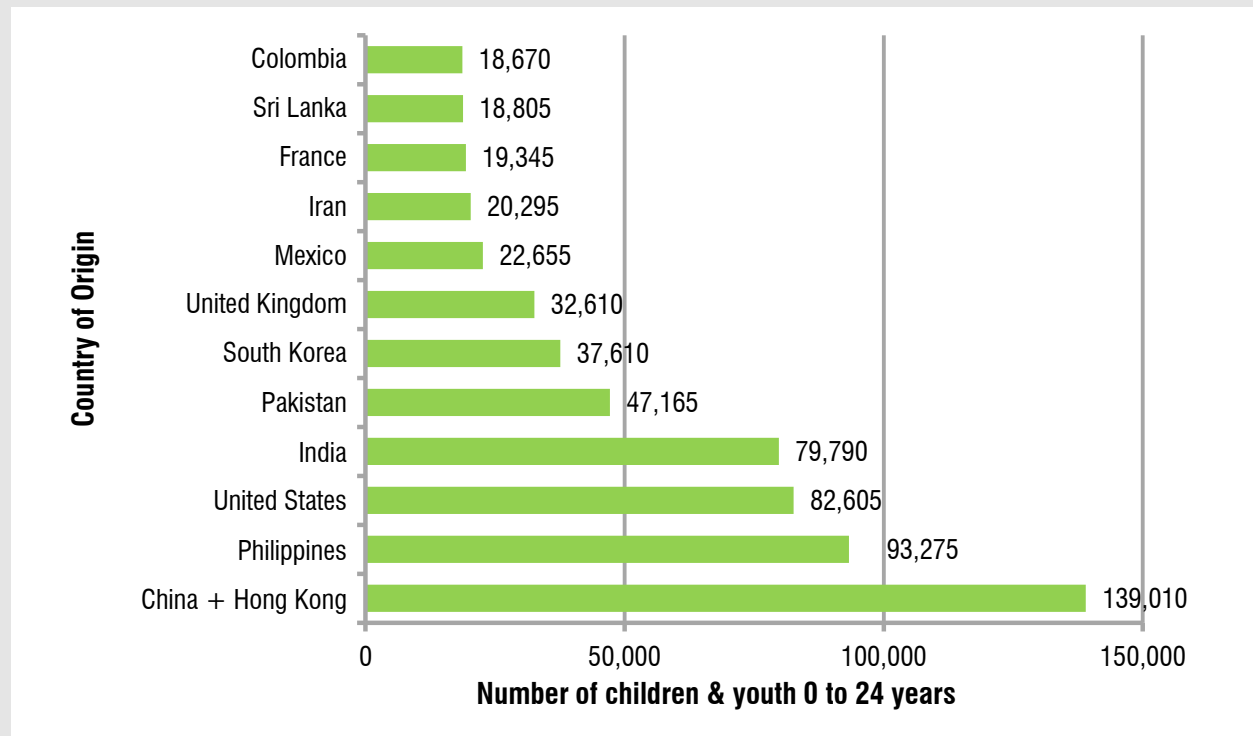
Graphic created by CICH using data adapted from Facts and figures 2012 – Immigration overview: Permanent and temporary residents. Canada – Permanent residents by age and source area. www.cic.gc.ca/english/resources/statistics/facts2012/index.asp

Between 2003 and 2012 the number of permanent residents under age 25 who immigrated from Asia and the Pacific Region stayed stable overall – after some fluctuation. The number of permanent residents under age 25 who immigrated from Africa and the Middle East increased during that time period.





1.3.3 Immigrants and Refugee Children and Youth, Ages 0 to 24 Years, Top Twelve Countries of Origin, Canada, 2011



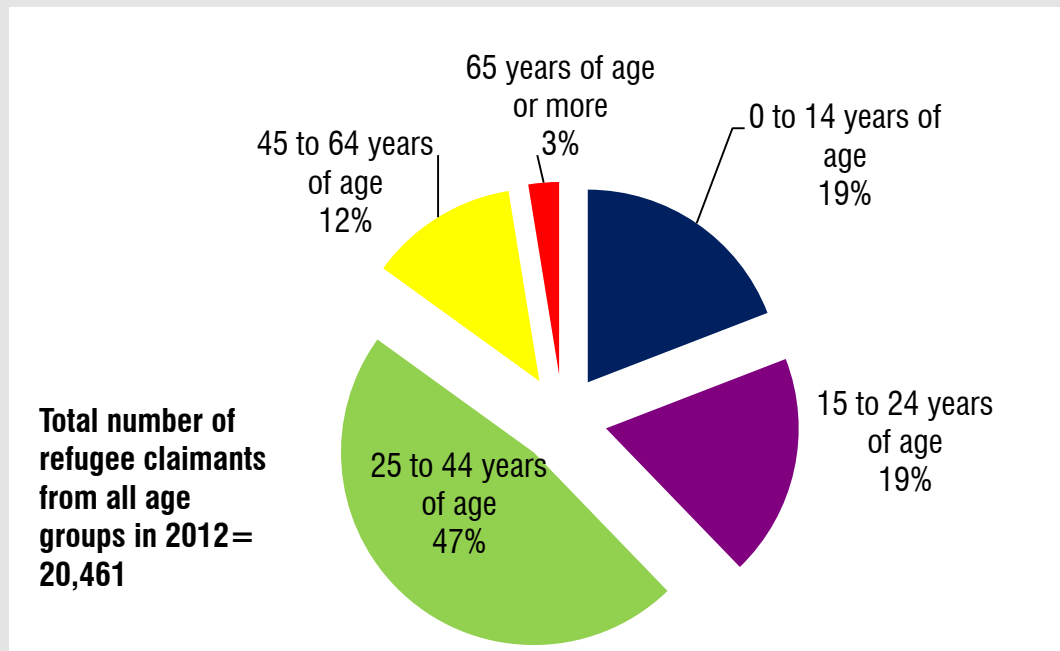
Graphic created by CICH using data adapted from Statistics Canada, 2011 National Household Survey, Statistics Canada Catalogue no. 99-010-X2011027.

In 2011, the largest group of immigrant children and youth came from China and Hong Kong. A large number of immigrant children and youth came from low and middle income countries.





1.4.1 Distribution of Refugee Claimants* by Age Group, Canada, 2012



* Refugee claimants are defined by Citizenship and Immigration Canada as “Temporary residents in the humanitarian population who request protection upon or after arrival in Canada...A refugee claimant whose claim is accepted may make an application in Canada for permanent residence.” <http://www.cic.gc.ca/english/pdf/research-stats/facts2010.pdf> .

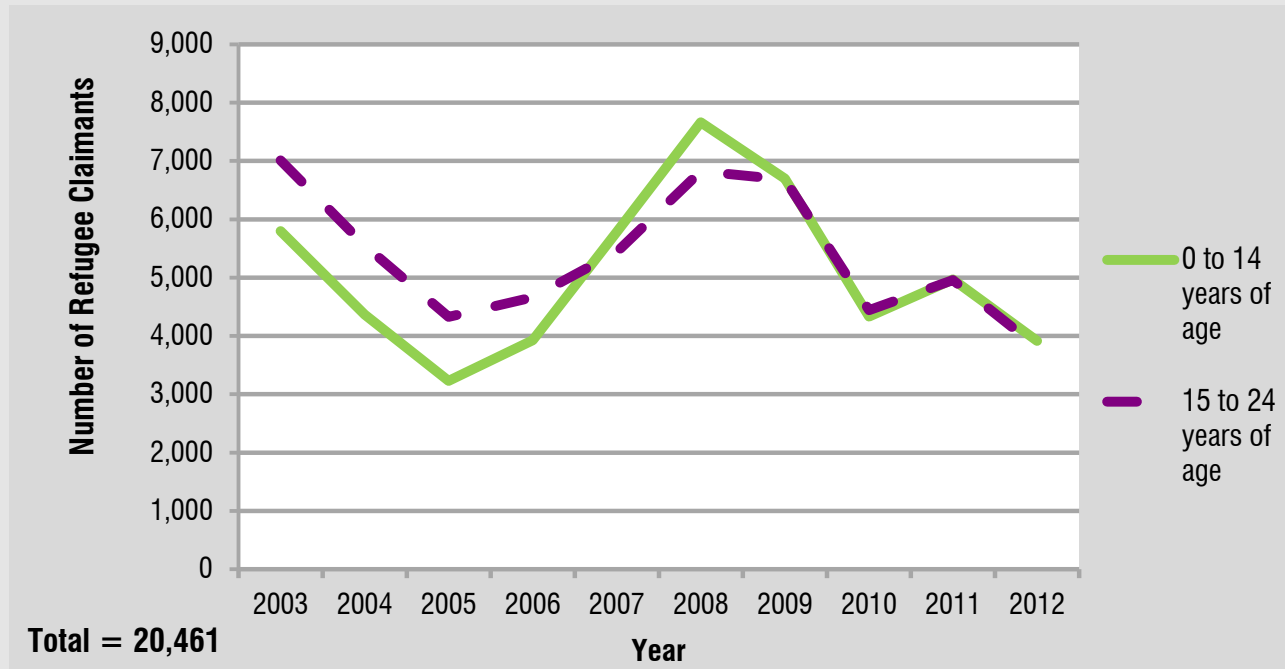
Graphic created by CICH using: Facts and figures 2012 – Immigration overview: Permanent and temporary residents. Temporary residents. Canada – Total entries of refugee claimants by gender and age Number. <http://www.cic.gc.ca/english/resources/statistics/facts2012/index.asp>

In 2012, of the 20,461 refugee claimants who arrived in Canada, 19% of them were 0 to 14 years of age and a further 19% were 15 to 24 years of age.





1.4.2 Number of Refugee Claimants* under 25 Years (total entries) by Age Group, Canada, 2003 to 2012



* Refugee claimants are defined by Citizenship and Immigration Canada as "Temporary residents in the humanitarian population who request protection upon or after arrival in Canada [...] A refugee claimant whose claim is accepted may make an application in Canada for permanent residence." <http://www.cic.gc.ca/english/pdf/research-stats/facts2010.pdf>.

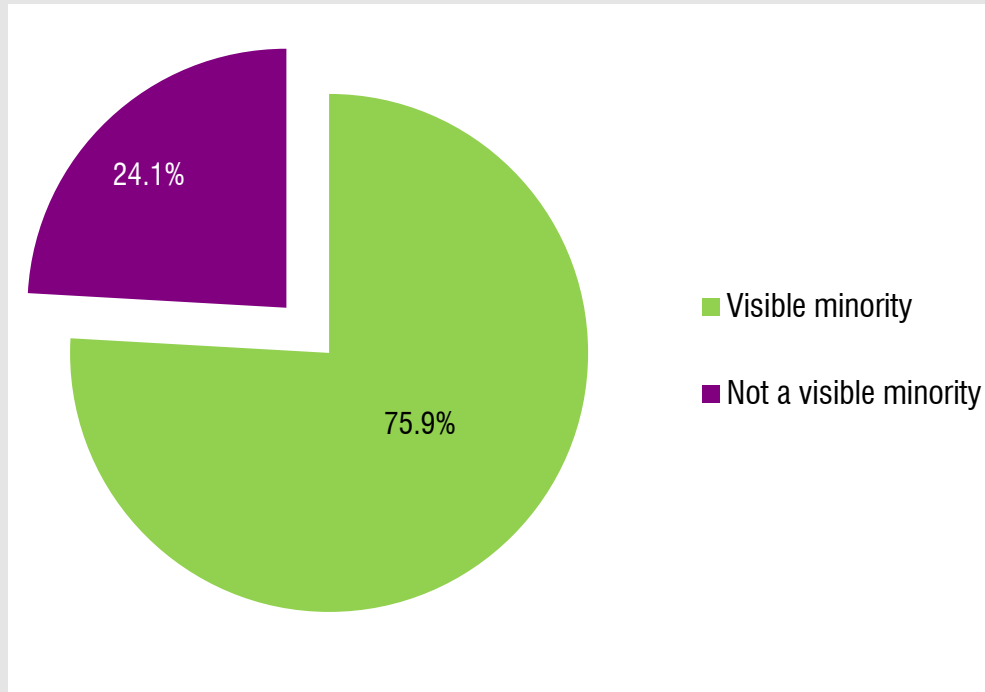
Graphic created by CICH using data from Facts and figures 2012 – Immigration overview: Permanent and temporary residents. Temporary residents. Canada – Total entries of refugee claimants by gender and age. <http://www.cic.gc.ca/english/resources/statistics/facts2012/index.asp>

The number of individuals under 25 years who claim refugee status in Canada varies from year to year. The number of claimants was high in 2003, with almost 6,000 claimants from 0 to 14 years and roughly 7,000 from 15 to 24 years. By 2005, these numbers dropped significantly to just over 3,000 claimants aged 0 to 14 years and roughly 4,500 claimants from 15 to 24 years. After peaking again in 2008, the number of refugee claimants under 25 years fell substantially until 2012 to under 4,000 for both 0 to 14 and 15 to 24 year olds.





1.5.1 Immigrant Children under 25 Years of Age by Visible Minority Status, Canada, 2011



Graphic created by CICH using data from Statistics Canada, 2011 National Household Survey, Statistics Canada Catalogue no. 99-010-X2011030.

The majority (more than three-quarters) of immigrant children and youth under 25 years belong to a visible minority group. The most prevalent ethnic groups with visible minority children and youth are South Asian, Chinese and Black.¹

¹Black immigrant and refugee children and youth have immigrated to Canada from various nations, mainly Caribbean and African nations. Examples include Jamaica, Haiti, Somalia, and Trinidad and Tobago. <http://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-010-x/99-010-x2011001-eng.pdf>



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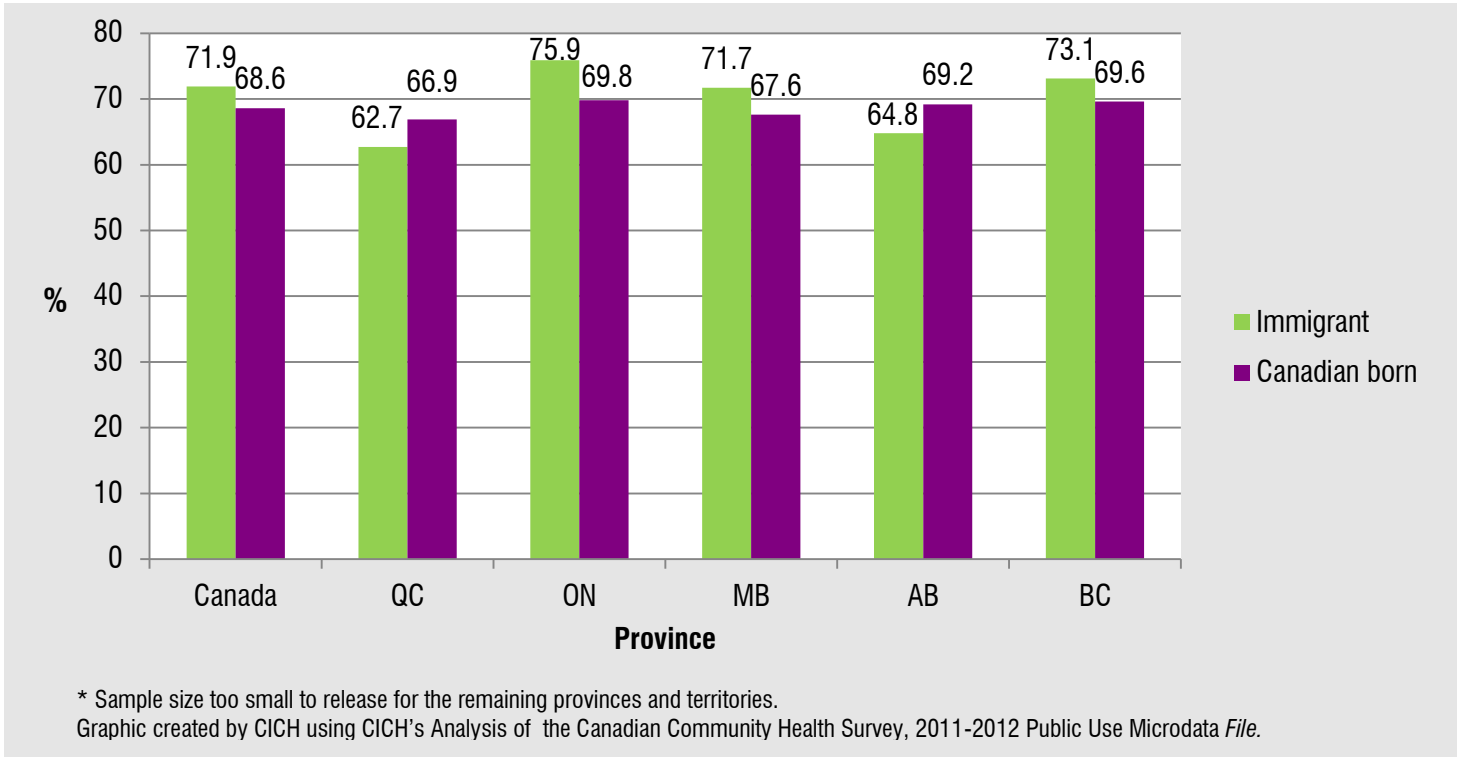


The Health of Canada's Children and Youth: A CICH Profile

Health Profile on Immigrant and Refugee Children and Youth in Canada

Section 2 - General Health Status of Immigrant Children and Youth

2.1.1 Proportion of Youth 12 to 19 Years of Age Who Report Their Health to Be Excellent/Very Good, by Immigrant Status and Province*, Canada, 2011-2012



Almost three-quarters (72%) of immigrant youth aged 12 to 19 years report that their health is excellent or very good. This is slightly higher than their Canadian born counterparts. Young men who are immigrants are more likely than are young women to say that this is the case – 75% compared with 68% respectively.

In Québec and Alberta immigrant youth are slightly less likely than their Canadian born counterparts to report that their health is excellent or very good.

In this data, the term 'immigrant' groups all types of immigrants together. However, refugee children's health is often not as good as that of other immigrants.¹ This is likely due in part to refugees receiving insufficient health care and living in substandard conditions in their countries of origin and having greater difficulty meeting their basic needs upon their arrival in Canada due to financial reasons.

¹DesMeules, M., Gold, J., Kazanjian, A., Manuel, D., Payne, J., Vissandjée, B., McDermott, S., & Mao, Y. (2004). New Approaches to Immigrant Health

Implications

Immigrant children and youth and their families come from a wide variety of cultural and linguistic backgrounds. Upon arrival, new immigrants tend to be healthier than the Canadian-born population, both because of immigrant-selection processes and because of certain socio-cultural aspects of health behaviours. However, refugees are more vulnerable and not able to enjoy the same measure of good health at the time of arrival. However, at least for adults, there is a decline in this "healthy immigrant effect" soon after arrival.





2.1.2 The 'Healthy Immigrant Effect'



Graphic created by CICH using images from fotolia and Big Stock Images.

Research on a broad sample of immigrants has shown that when immigrants arrive to Canada they are generally in better health than their Canadian born counterparts.¹ Even refugees, overall, have lower mortality rates than do Canadian citizens.¹ This is known as the 'healthy immigrant effect'.² It should be noted that the majority of Canadian research on the healthy immigrant effect has been on adults and not on children and youth. Whether or not this phenomenon occurs among younger Canadian newcomers should be examined.

Despite their initial relative good health, the health of immigrants often starts to decline sometime after their arrival to Canada. For example, research has found that those who had been living in Canada for 10 years or less had fewer chronic illnesses and less chance of disability than immigrants who had been living in Canada for longer and Canadian born citizens.³

Other research has shown that immigrants aged 20 to 59 years reported better health shortly after arrival to Canada than they did two years later.⁴ The greatest declines in self-reported health were among women and non-European immigrants (including West Asian, South Asian and Chinese individuals) as opposed to men and European immigrants.⁴

The cause or causes of this decrease in health status are not entirely known, but there are many possible explanations. For example:

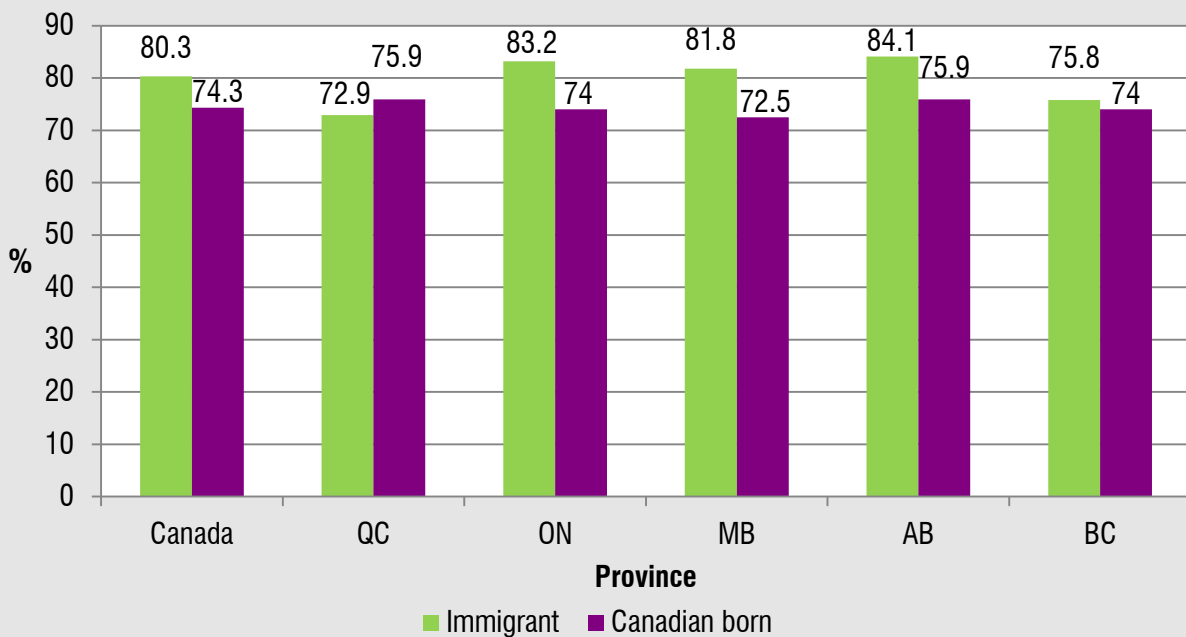
- There may be inadequate policies and services to help immigrants settle and maintain optimal health in Canada.¹
- Immigrants are more likely to be affected by unemployment, poverty, and difficulty accessing services for various reasons including language barriers.¹
- Immigrants become exposed to the same stressors and pollutants as Canadians and may adopt unhealthy habits such as smoking, drinking alcohol, and eating unhealthy foods.¹

¹Beiser, M. (2005). *The Health of Immigrants and Refugees in Canada*. *Canadian Journal of Public Health*, 96 (2), S30-S44.; ²Caring for Kids New to Canada. (2013) *Adaptation and Acculturation*. <http://www.kidsnewtocanada.ca/culture/adaptation#resilience>; ³Newbold, K.B., Danforth, J. (2003). *Health status and Canada's immigrant populations*. *Soc Sci Med*, 57, 1981-95.; ⁴Li-Ho, Kim, Carrasco, C., Muntaner, C., McKenzie, K., & Noh, S. (2013). *Ethnicity and Postmigration Health Trajectory in New Immigrants to Canada*. *American Journal of Public Health*, 103, (4), e96-e104.





2.2.1 Proportion of Youth 12 to 19 Years of Age Who Report Their Mental Health to Be Excellent/Very Good, by Immigrant Status and Province*, Canada, 2011-2012



* Sample size too small to release for the remaining provinces and territories.

Graphic created by CICH using data from the Canadian Community Health Survey, 2011-2012. CICH Analysis on Public Use Microdata File

The majority, 80%, of immigrant youth aged 12 to 19 years report that their mental health is excellent or very good. That compares to 74% of Canadian born youth. Those proportions are the same for young men and young women in both groups. Immigrant youth in Québec and BC are less likely to report that their mental health is excellent or very good compared to their counterparts in Ontario, Manitoba and Alberta.

Implications

These data indicate that immigrant youth are somewhat more likely to report that they have excellent or very good mental health, but the data also show that this is not consistent across the country. Research based on the New Canadian Children and Youth Study indicated that children in immigrant families from Hong Kong, Mainland China, and the Philippines living in Toronto and Montreal were at higher risk of emotional problems than were children in immigrant families in Winnipeg, Calgary, Edmonton, and Vancouver.¹ The study found that predictors of the mental health of immigrant youth are complex – immigrant human and social capital, home-school relationships, marginalization and lack of community supports were predictors – but their effect varied across regions. The authors conclude that “Although the expectations may not be unreasonable, simply admitting immigrants and then forgetting about them, or even punishing them by withdrawing support, is not only unreasonable, but bad for mental health”.²

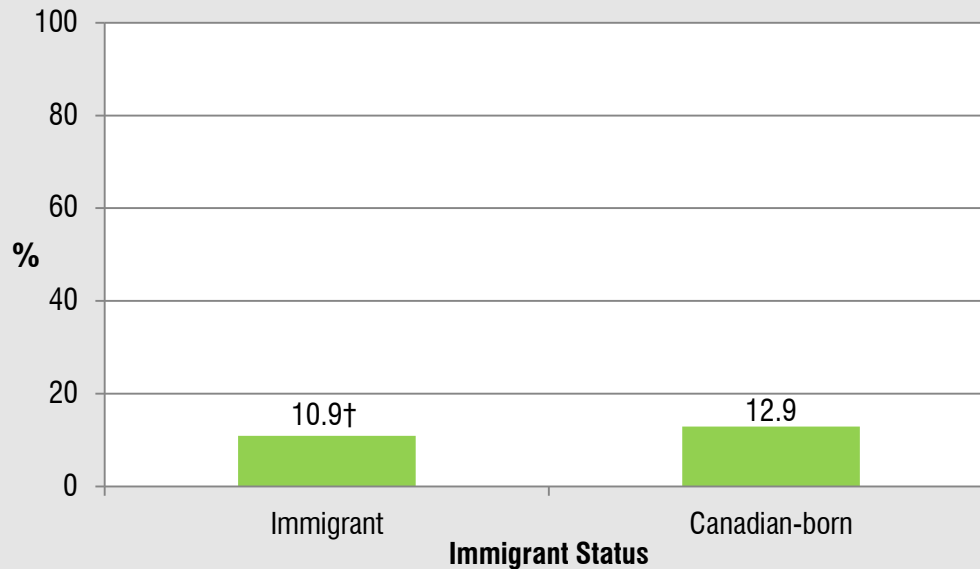
¹Beiser M, Zilber N, Simich L, Youngmann R, Zohar BT and Hou F. Regional effects on the mental health of immigrant children: Results from the New Canadian Children and Youth Study (NCCYS). *Health & Place* 17 (2011) 822-829.

²Ibid, p. 828.





2.2.2 Proportion of Youth 12 to 24 Years of Age Who Have Been Diagnosed with a Mood Disorder*, by Immigrant Status, Canada, 2011-2012



* Meet the CCHS - Mental Health/WHO-CIDI criteria for any of the measured mood disorders (Major Depressive Episode, Bipolar I, Bipolar II, Hypomania) in their lifetime.; † This is a marginal estimate that must be interpreted with caution.

Graphic created by CICH using data from the Canadian Community Health Survey, 2011/2012, CICH Analysis on Public Use Microdata File

Just over one-in-ten youth aged 15 to 24 years have been diagnosed with a mood disorder. That proportion is slightly higher for Canadian-born youth (13%) than immigrant youth (11%).

Implications

The causes of mood disorders in youth are complex – including factors relating to biology, genetics, social and psychological influences. These are compounded by the experiences of immigrant youth, which can include the loss of family and friends, language barriers among the children, youth and their parents; discrimination; difficult relationships between the children, youth, families and the schools and the quality of the neighbourhood in which the children, youth and families live.¹ Certain factors can protect young people from suffering with mood disorders – such as living in stable families, living in safe neighbourhoods and having support from a community of their peers.¹ It is important that health care providers recognize cultural barriers that might preclude immigrant children and youth and their families from recognizing and seeking help for mood disorders.

¹Depression in Children and Youth. Caring for Kids New to Canada: A Guide for Health Professionals Working with Immigrant and Refugee Children and Youth. <http://www.kidsnewtocanada.ca/mental-health/depression>





2.2.3 School and Mental Health



Graphic created by CICH using an image from Big Stock Photo.

According to the New Canadian Children and Youth Study (children aged 4 to 6 and 11 to 13), immigrant parents' perceptions of their children's school is important to the well-being of their children. Children were less likely to be physically aggressive – for example, to get into fights and bully other children – if their parents had positive perceptions of the school environment. This relationship existed in spite of the child's gender and age; the parents' education, ethnicity or depressive symptoms; the family's income and level of dysfunction; and factors related to the family's acculturation – e.g., the length of time they had been in Canada, their language spoken and their relative living conditions.¹

¹Hamilton HA, Marshall L, Rummens JA, Fenta H and Simich L. Immigrant parents' perceptions of school environment and children's mental health and behavior. *Journal of School Health* June 2011; 81(6): 313

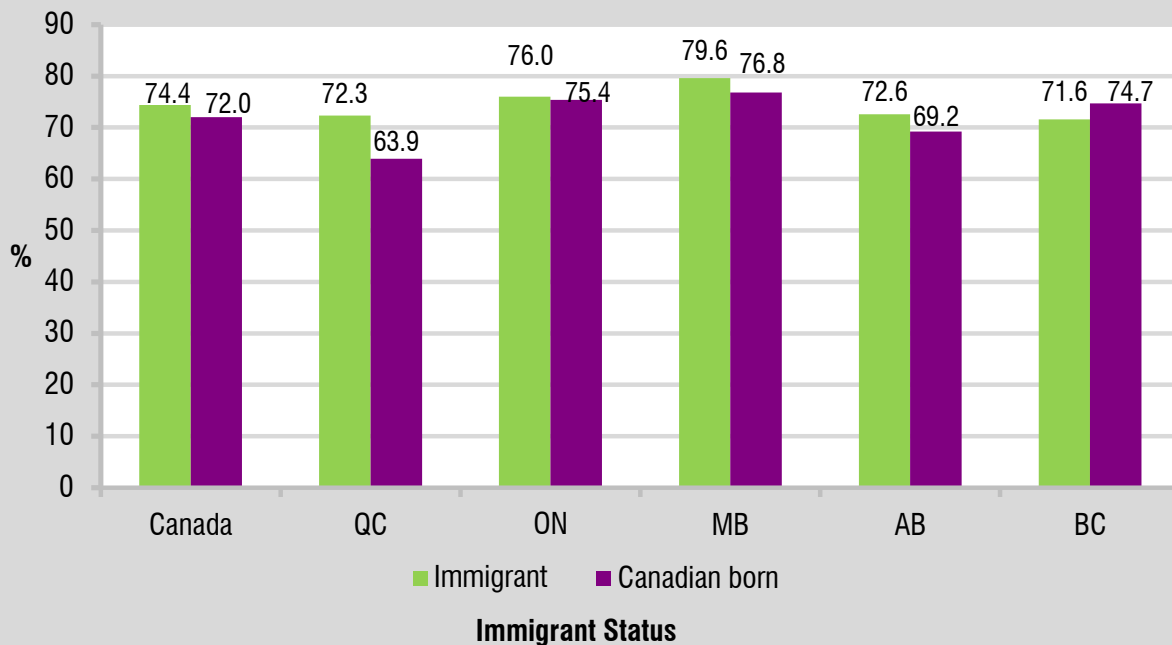
Implications

The school environment is critical to the health and well-being of immigrant children and youth. Focusing on the relationship between parents and schools – whereby parents develop a positive relationship and perception – can contribute to the social supports needed to help parents promote healthy choices to their children. These findings must be considered when developing collaborative policies in education, public health and social services.





2.2.4 Proportion of Youth, 12 to 19 Years of Age, Who Have a Very-Somewhat Strong Sense of Belonging to Their Local Community, by Immigrant Status and Province*, Canada, 2011-2012



* Sample size too small to release for the remaining provinces and territories.

Graphic created by CICH using data from the Canadian Community Health Survey, 2011/2012, CICH Analysis on Public Use Microdata File.

The majority of both immigrant and Canadian born youth are likely to report that they have a very or somewhat strong sense of belonging to their local community – almost three-quarters in both cases. Canadian born youth in Alberta and Québec are somewhat less likely to report that this is the case – 69% and 64% respectively.



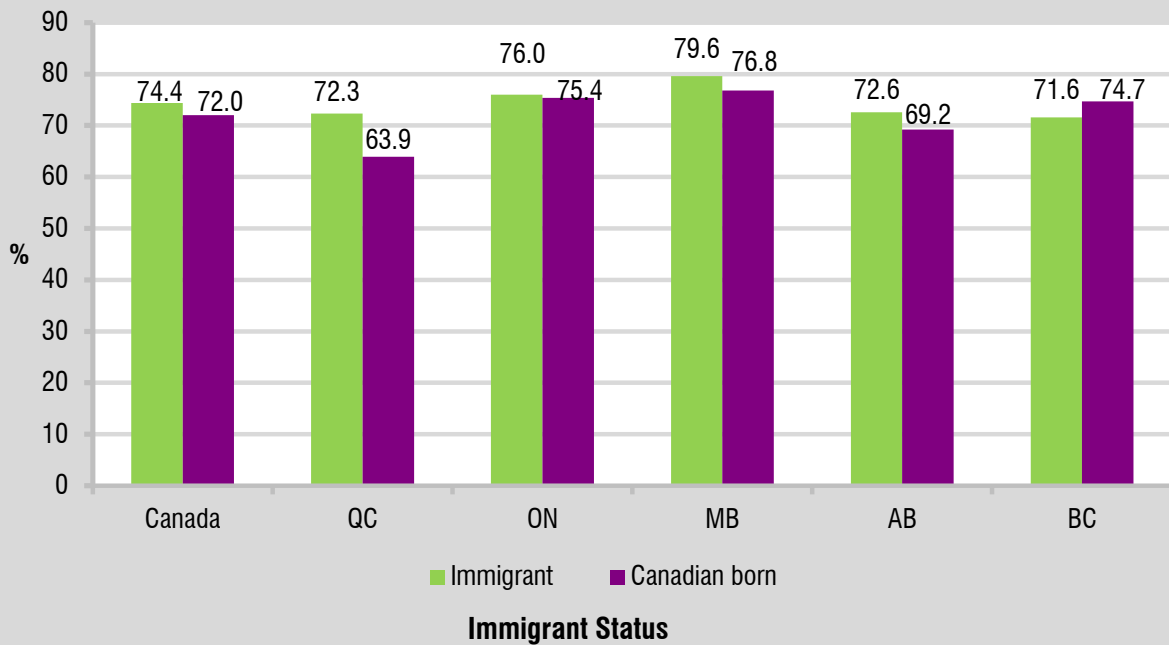


The Health of Canada's Children and Youth: A CICH Profile

Health Profile on Immigrant and Refugee Children and Youth in Canada

Section 2 – General Health Status of Immigrant Children and Youth

2.2.5 Proportion of Youth, 12 to 19 Years of Age, Who Have a Very-Somewhat Strong Sense of Belonging to Their Local Community, by Age Group and Immigrant Status, Canada, 2011-2012



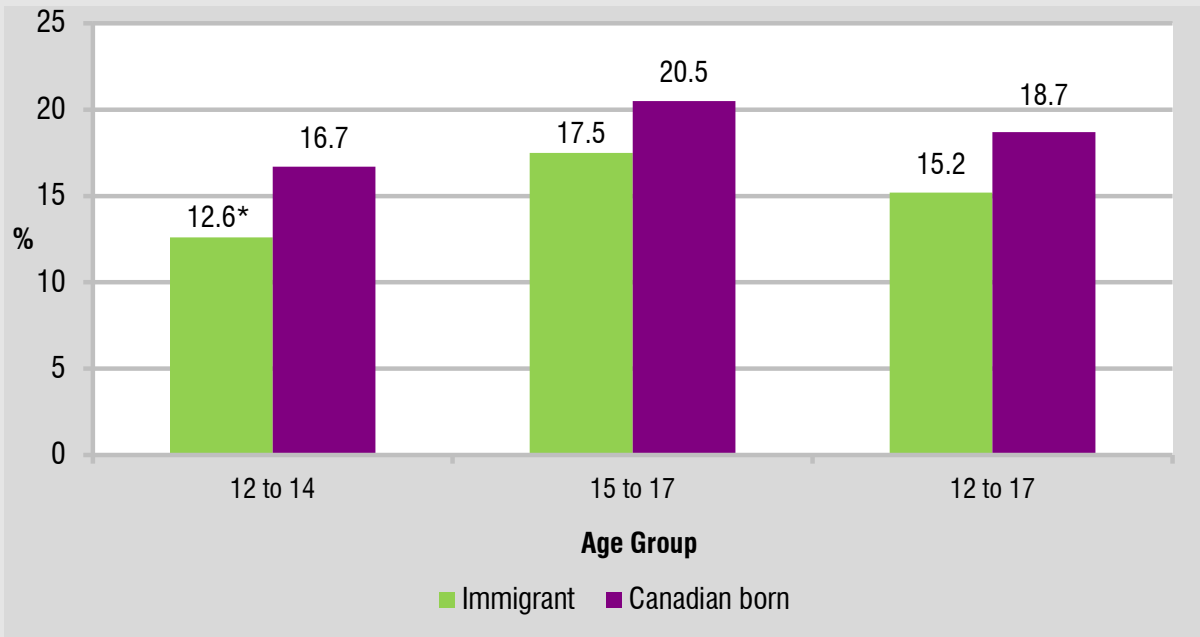
Graphic created by CICH using data from the Canadian Community Health Survey, 2011-2012, CICH Analysis on Public Use Microdata File.

Older youth are less likely than younger youth to report that they have a very or somewhat strong sense of belonging to their local community – both among immigrant youth and Canadian born youth. Eighty-eight percent of immigrant youth and 82% of Canadian youth aged 12 to 14 years reported this was the case – compared with 63% of immigrant youth and Canadian born youth aged 18 to 19 years





2.3.1 Proportion of Youth 12 to 17 Years of Age Who Are Overweight or Obese, by Age Group and Immigrant Status, Canada, 2011-2012



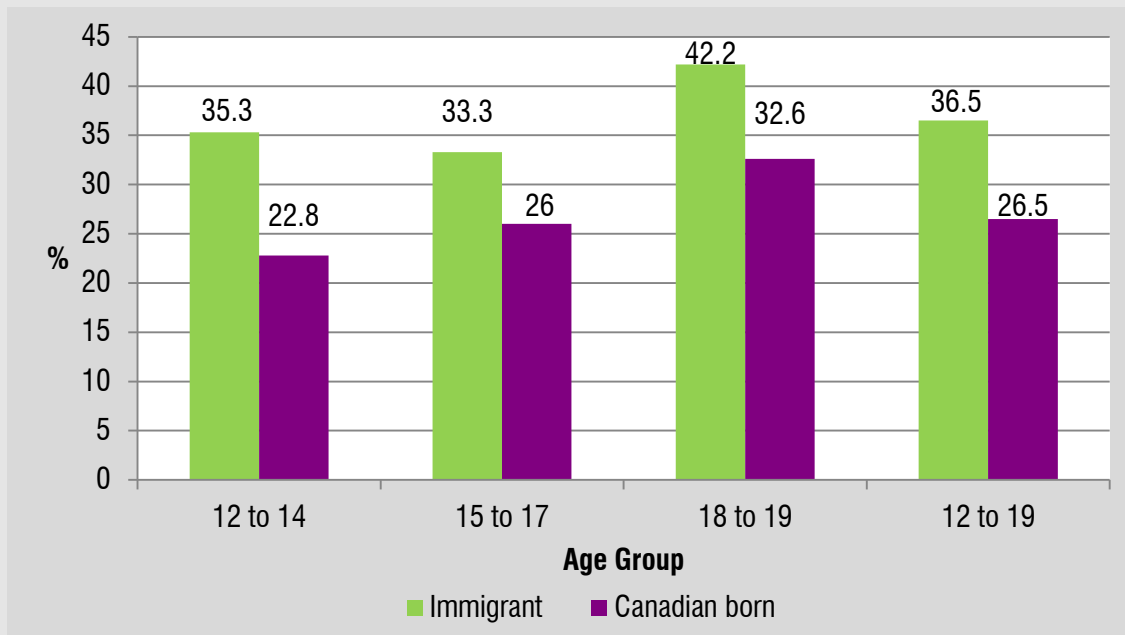
* This is a marginal estimate that must be interpreted with caution; Graphic created by CICH using data from the Canadian Community Health Survey, 2011-2012, CICH Analysis on Public Use Microdata File.

Canadian born youth between the ages of 12 and 17 are more likely to be overweight or obese than are their peers who are immigrants. In 2011-12, 19% of Canadian born youth were overweight or obese compared to 15% of immigrant youth. Older youth are more likely to be overweight or obese than are younger youth. Among both immigrant and Canadian born youth, young men are more likely to be overweight or obese than are young women.





2.4.1 Proportion of Youth 12 to 17 Years of Age Who Are Considered Inactive Based on Their Energy Expenditure Values, by Age Group and Immigrant Status, Canada, 2011-2012



* This is a marginal estimate that must be interpreted with caution; Graphic created by CICH using data from the Canadian Community Health Survey, 2011-2012, CICH Analysis on Public Use Microdata File.

Canadian born youth between 12 and 19 years are less likely to be inactive than are their peers who were born outside of Canada. Just over one-quarter (27%) of Canadian born youth are considered inactive compared with 37% of youth who are foreign born. Among both groups, young women are more likely to be inactive than are young men. Forty-five percent of young immigrant women (12 to 19 years) are considered to be inactive compared with 28% of young men. Those figures are 31% and 22% respectively for Canadian born youth. Older youth are more likely to be inactive than are younger youth – among both groups.

Implications

An important determinant of health for young people is involvement in regular physical activity. These findings are substantiated by analysis of the Canadian Health Behaviour in School-Aged Children's survey data, which found that youth born outside of Canada were less likely to be active than peers born in Canada.¹ This study also found that time since immigration and ethnicity were associated with participation in physical activity – specifically that the longer the youth were in Canada the more likely they were to have physical activity levels that were close to their Canadian born peers. In addition, East and South-East Asian youth were less likely to be physically active than Canadian born youth.

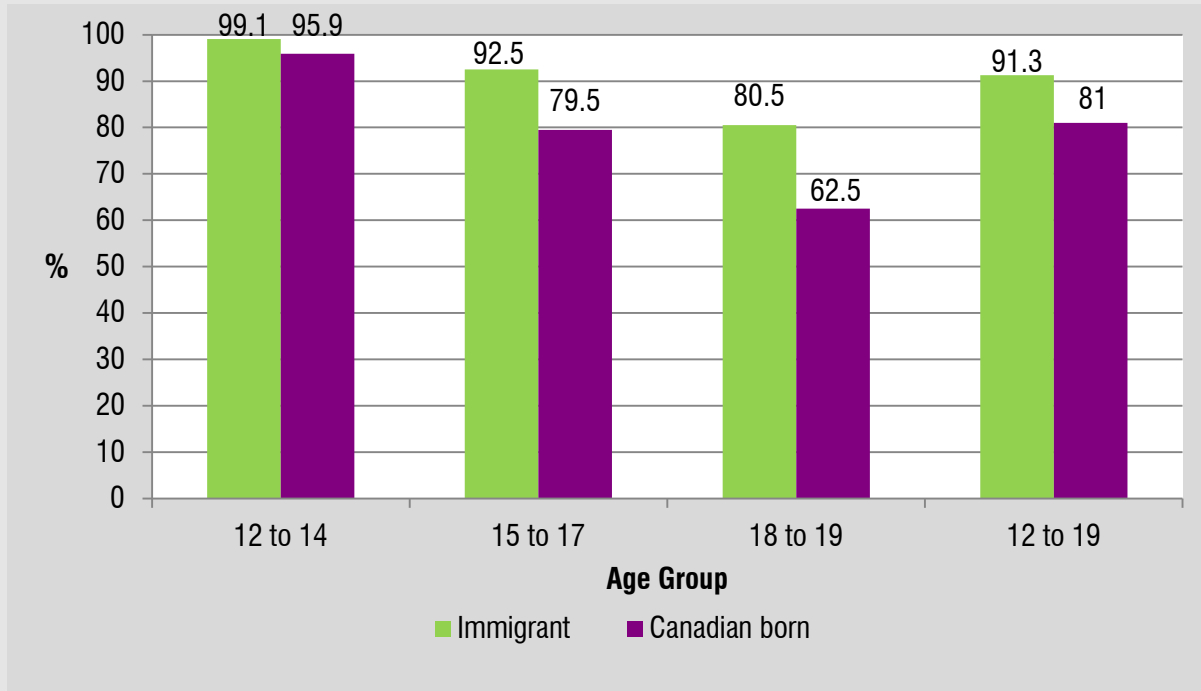
¹Kukaswadia A, Pickett W and Janssen I. Time Since Immigration and Ethnicity as Predictors of Physical Activity among Canadian Youth: A Cross-Sectional Study. PLOS ONE February 2014;

9:2.<http://www.plosone.org/article/abstract?uri=info%3Adoi%2F10.1371%2Fjournal.pone.0089509&representation=PDF>





2.4.2 Proportion of Youth 12 to 17 Years of Age Who Report They Have Never Smoked, by Age Group, and Immigrant Status, Canada, 2011-2012



Graphic created by CICH using data from the Canadian Community Health Survey, 2011/2012, CICH Analysis on Public Use Microdata File.

In 2011-2012, 91% of immigrant youth aged 12 to 19 years reported that they had never smoked cigarettes. The proportion was lower for Canadian born youth – at 81%. These proportions were similar for young men and women. Younger youth were more likely to report that they had never smoked than were older youth. Among 18 and 19 year old immigrant youth, 81% reported that they had never smoked compared with only 63% of Canadian born youth.



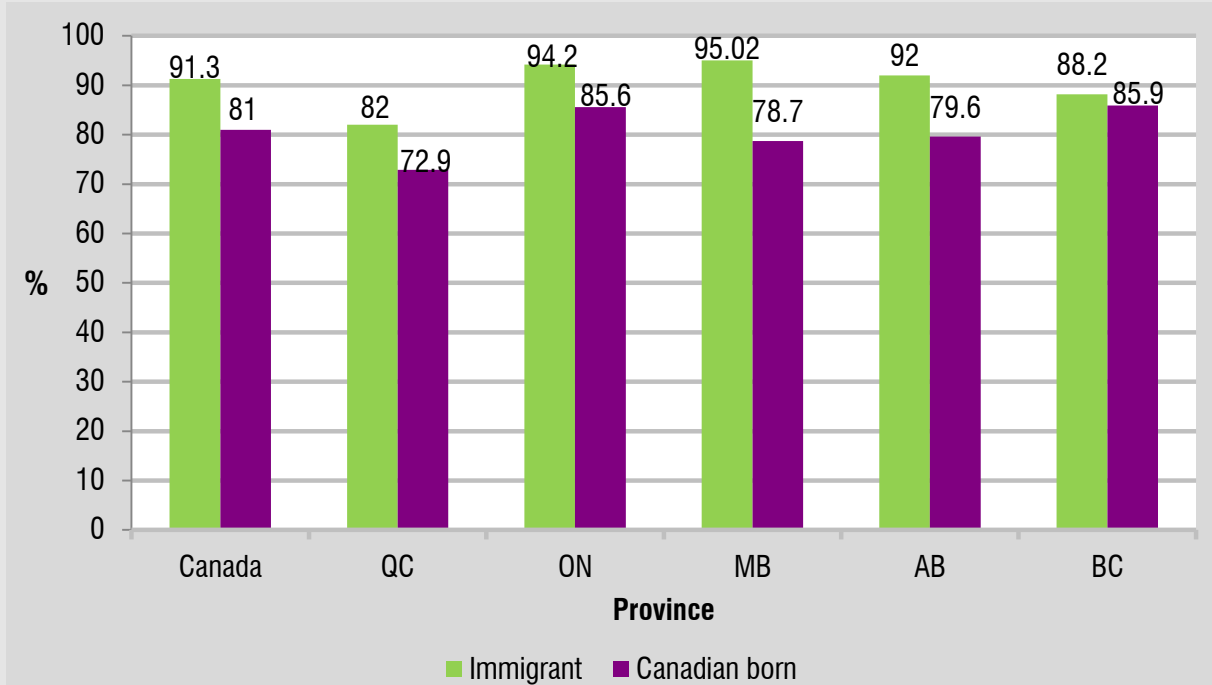


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2.4.3 Proportion of Youth 12 to 19 Years of Age Who Report They Have Never Smoked, by Province* and Immigrant Status, Canada, 2011-2012



* Sample size too small to release for the remaining provinces and territories; Graphic created by CICH using data from the Canadian Community Health Survey, 2011/2012, CICH Analysis on Public Use Microdata File.

The proportion of youth who had never smoked – both immigrant and Canadian born youth – were lower in Québec, at 82% and 73% respectively.



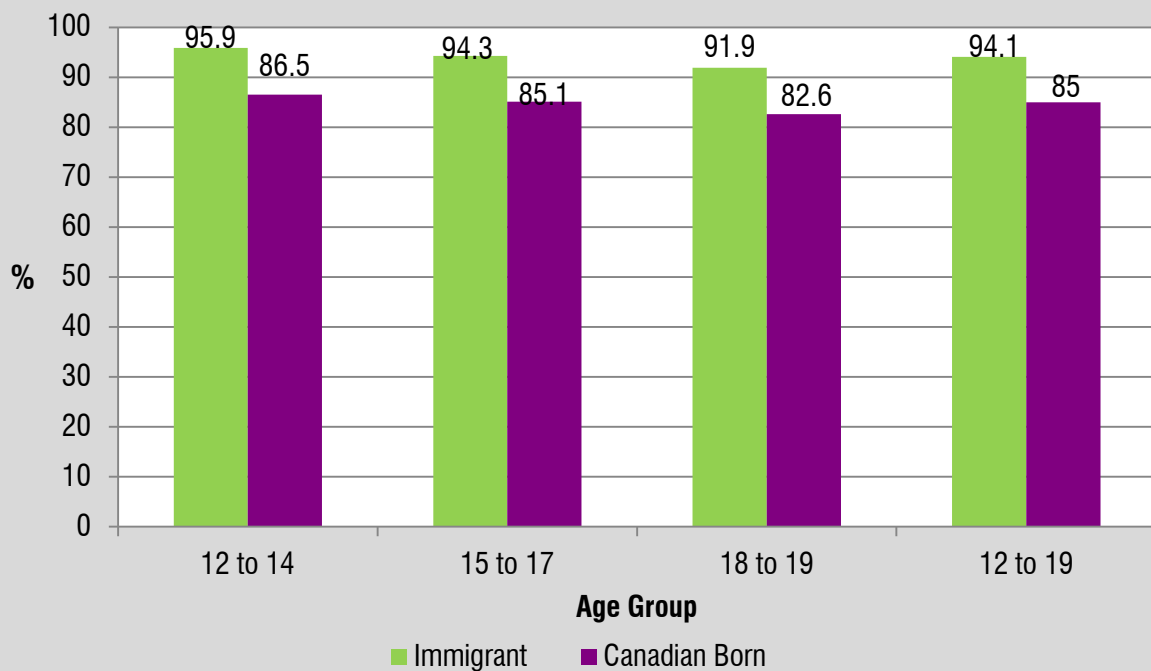


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2.4.4 Proportion of Youth 12 to 19 Years of Age Who Are Not Exposed to Second Hand Smoke in Their Homes Every Day or Almost Every Day, by Age Group and Immigrant Status, Canada, 2011-2012



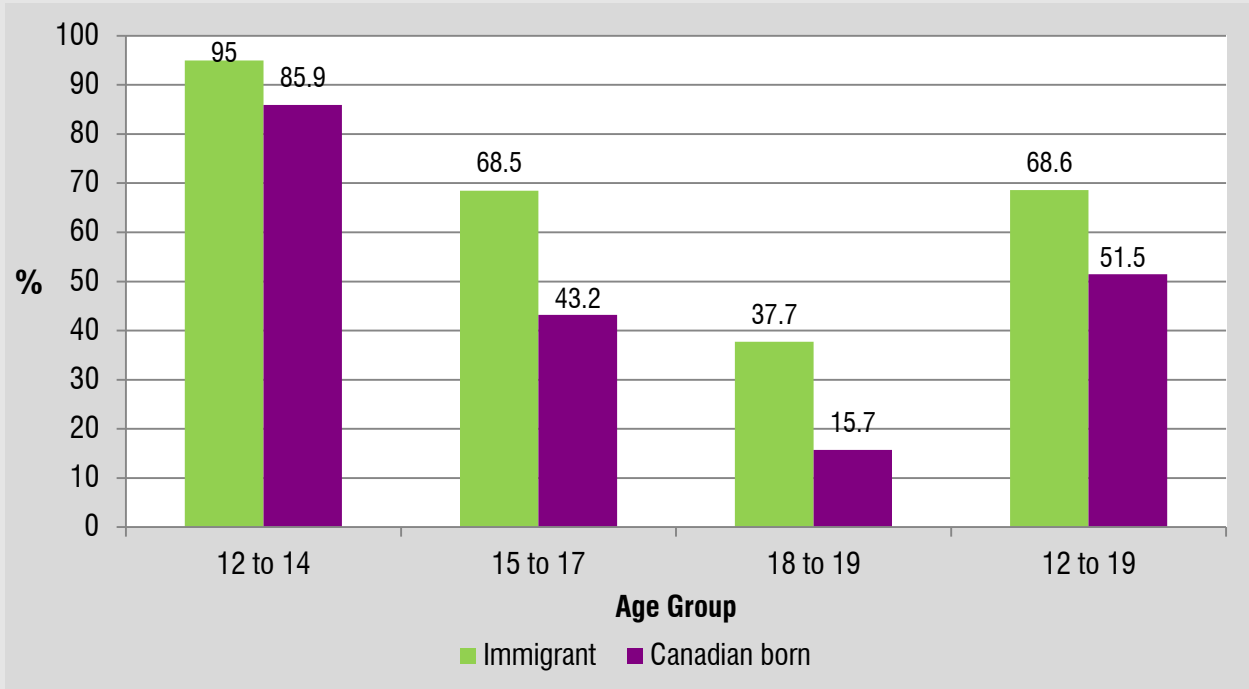
Graphic created by CICH using data from the Canadian Community Health Survey, 2011-2012, CICH Analysis on Public Use Microdata File.

The vast majority of children and youth in Canada are not exposed to second hand smoke in their homes regularly. However, immigrant children and youth are somewhat less likely to be exposed than are Canadian born children and youth. Ninety-four percent of immigrant children and youth 12 to 19 years of age reported they are not exposed to second hand smoke every day or almost every day – compared to 85% of Canadian born children and youth.





2.4.5 Proportion of Youth 12 to 19 Years of Age Who Report They Did Not Drink Alcohol in the Last Year, by Age Group and Immigrant Status, Canada, 2011-2012



Graphic created by CICH using data from the Canadian Community Health Survey, 2011-2012, CICH Analysis on Public Use Microdata File.

Immigrant youth were more likely than their Canadian born peers to report that they did not drink alcohol. In 2011/12, two-thirds of immigrant youth 12 to 19 years reported that was the case, compared to 52% of Canadian born youth. Older immigrant youth, those who were 18 and 19 years of age, were twice as likely as their Canadian born counterparts to report that they did not drink alcohol. Young women who are immigrants are somewhat more likely to report that they do not drink alcohol compared with young men – 71% compared with 66%. However, Canadian born young men and women are equally likely to report that they have never drank alcohol – that being the case for 52% of young men and 51% of young women.



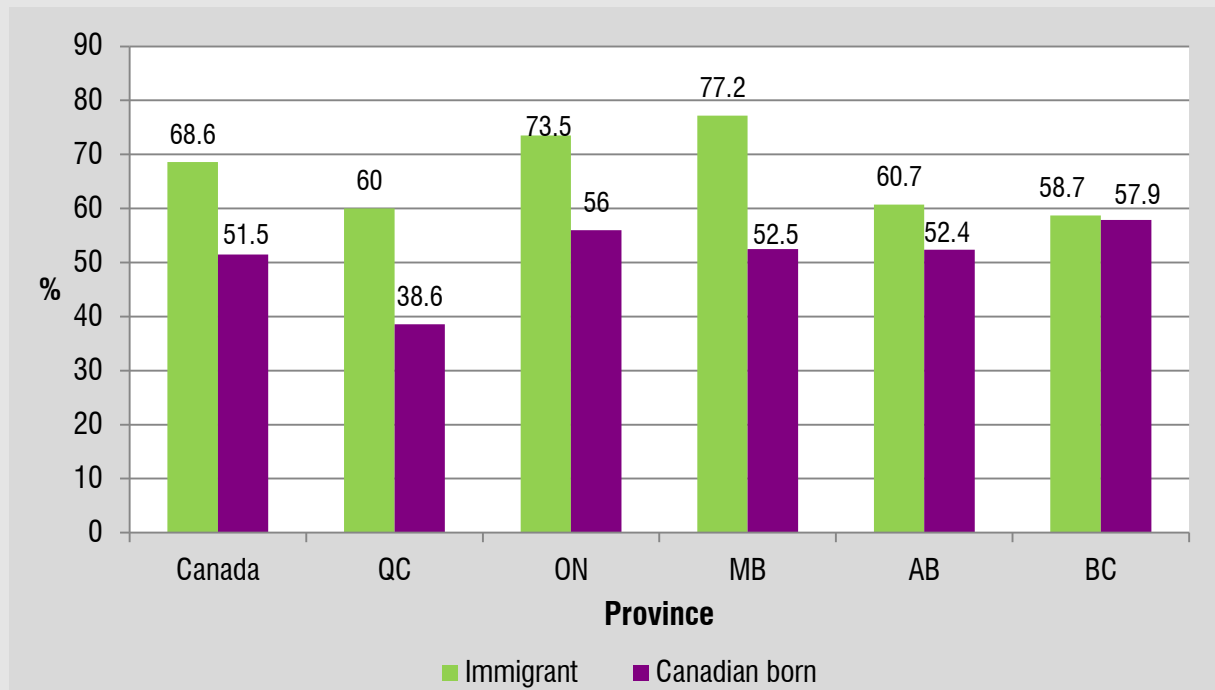


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2.4.6 Proportion of Youth 12 to 19 Years of Age Who Report They Did Not Drink Alcohol in the Last Year, by Province* and Immigrant Status, Canada, 2011-2012



* Sample size too small to release for the remaining provinces and territories; Graphic created by CICH using data from the Canadian Community Health Survey, 2011-2012, CICH Analysis on Public Use Microdata File

While 69% of Canadian immigrant youth aged 12 to 19 years report that they do not drink alcohol, that proportion is higher in Manitoba (77%) and Ontario (74%).



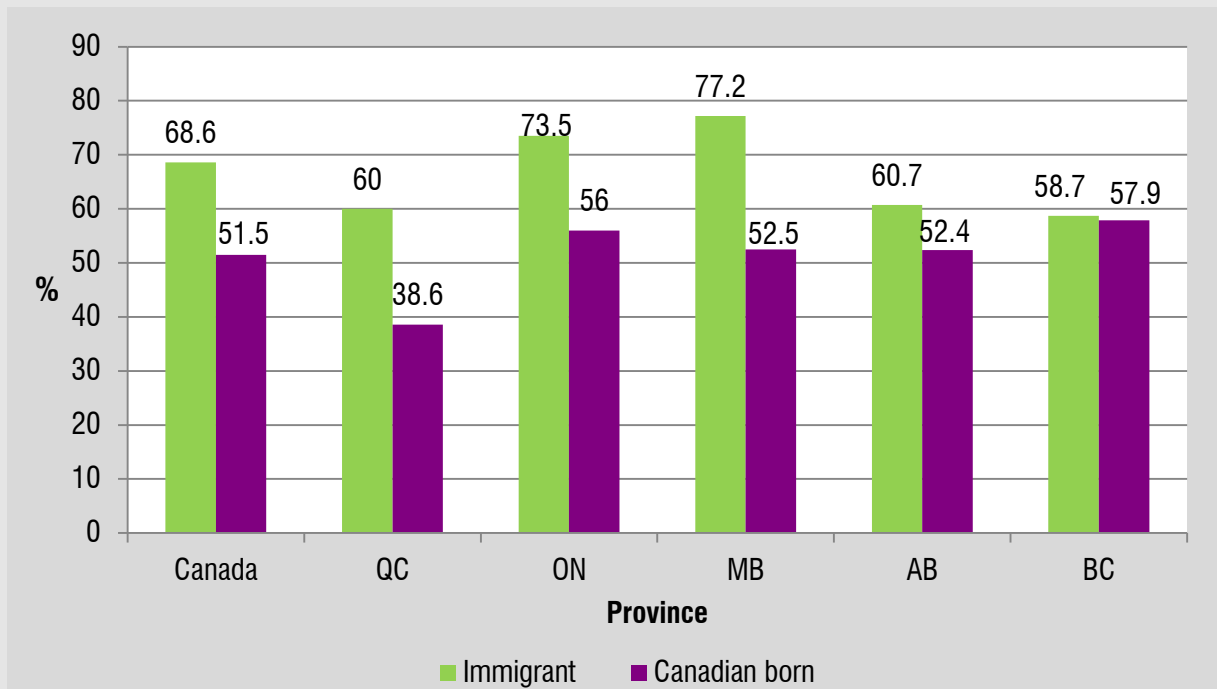


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2.4.7 Proportion of Youth 12 to 19 Years of Age Who Report They Eat Fruits and Vegetables at Least 5 Times a Day, by Province* and Immigrant Status, Canada, 2011-2012



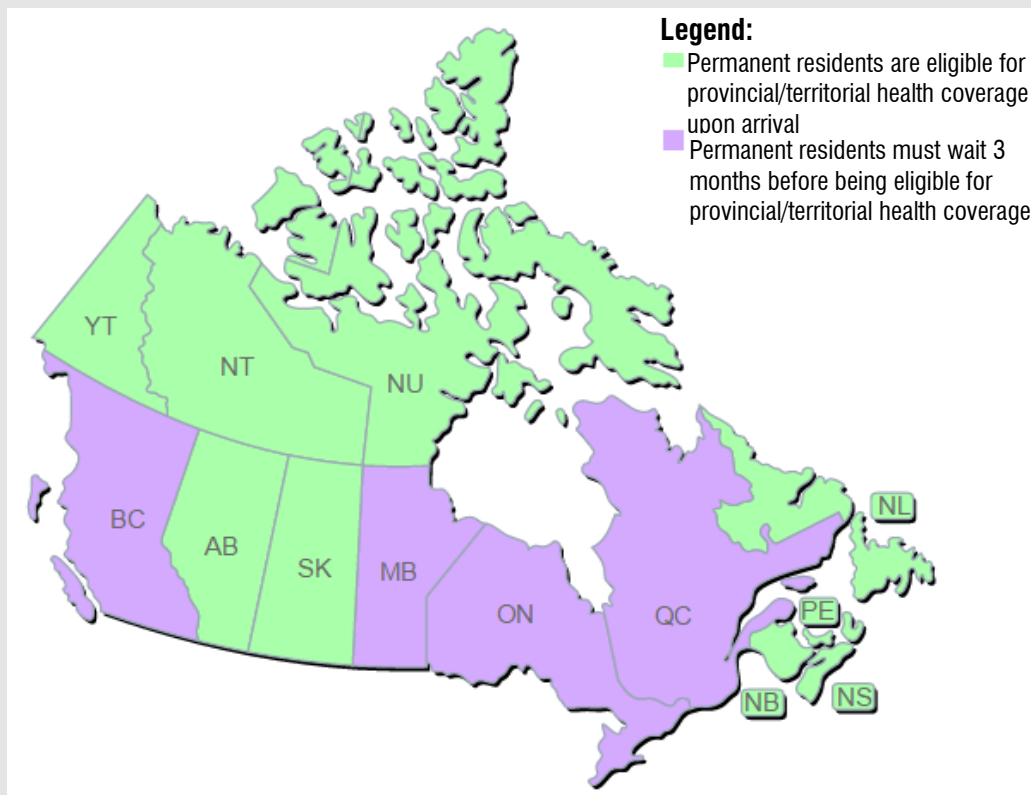
* Sample size too small to release for the remaining provinces and territories.; † This is a marginal estimate that must be interpreted with caution; Graphic created by CICH using data from the Canadian Community Health Survey, 2011-2012, CICH Analysis on Public Use Microdata File.

Less than half of Canadian children and youth report that they eat fruits and vegetables at least five times a day. Canadian born youth are somewhat more likely than immigrant youth to do so – 42% compared with 36%. Immigrant children and youth living in Québec are more likely to eat fruits and vegetables at least five times a day than are children and youth in other parts of Canada.





2.5.1 Health Coverage for New Child and Youth Permanent Residents in Canada



Not all immigrant and refugee children and youth have exactly the same health coverage across Canada. In most provinces and territories, new permanent residents are provided with full public health coverage from the time they arrive.¹ However, in Ontario, British Columbia, Manitoba, and Québec, permanent residents must wait 3 months before being eligible for provincial coverage.¹ In some cases this waiting period is waived. For example, a child under 16 years who is adopted and brought to Ontario will be eligible for health coverage right away.² Those who do not receive coverage from the time they arrive are encouraged to apply for private health insurance until their provincial/territorial coverage begins.¹

It is important for newcomers to Canada to know that although public health insurance is similar across the provinces and territories, there are some differences in the services and products that are covered by provincial/territorial coverage. As many immigrants and refugees do not remain in the province or territory where they first arrived, they will likely be confronted with various provincial/territorial health care systems.

For more information on health care coverage for new permanent residents, visit the [Kids New to Canada](http://www.kidsnewtocanada.ca/care/insurance) website and the [Health Canada](http://www.health.gov.on.ca/en/public/publications/ohip/ohip_waiting_pd.aspx) website describing the provincial and territorial roles in health care and information about applying for a health card.

¹<http://www.kidsnewtocanada.ca/care/insurance>;

²http://www.health.gov.on.ca/en/public/publications/ohip/ohip_waiting_pd.aspx





2.5.2 Health Coverage for Child and Youth Refugee Claimants* in Canada



* Refugee claimants are defined by Citizenship and Immigration Canada as “Temporary residents in the humanitarian population who request protection upon or after arrival in Canada... A refugee claimant whose claim is accepted may make an application in Canada for permanent residence.” <http://www.cic.gc.ca/english/pdf/research-stats/facts2010.pdf> .; Graphic created by CICH using an image from Big Stock Photo.

There are six types of health coverage available to refugees arriving to or living in Canada. These differ by the health services that are covered. Eligibility is based on several criteria such as the claimant's age, whether or not he or she is a government-assisted refugee, and the status of his or her refugee claim.¹

Child and youth refugees are eligible for the most comprehensive type of coverage available to refugees in Canada – Basic, Supplemental and Prescription Drug Coverage. This coverage includes most health care services covered under the provincial/territorial health insurance plans available where the child is residing. Among the included services are in-patient and outpatient hospital services; care provided by medical doctors, nurses, and other licensed health care professionals; laboratory and ambulance services; some dental and vision care; and prescription medications included in the provincial/territorial drug plan. For a complete description of the coverage available to refugee children and youth in Canada, visit the [Government of Canada](http://www.governmentofcanada.ca) website describing the Interim Federal Health Program.

¹<http://www.cic.gc.ca/english/refugees/outside/arriving-healthcare/individuals/apply-who.asp>



Health Profile on Immigrant and Refugee Children and Youth in Canada: Section 3

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Contributors:

Writing and editing:

Govinda Dahal, Researcher, University of Ottawa
Louise Hanvey, Research Director, Canadian Institute of Child Health
Meghan Marcotte, Research Analyst, Canadian Institute of Child Health
Kevin Pottie, Chair, Canadian Collaboration for Immigrant and Refugee Health

Project development, research, and review:

Expert Advisory Committee

Rukhsana Ahmed, Associate Professor, University of Ottawa
Paula Brauer, Associate Professor, University of Guelph
Yvonne Chiu, Executive Director, Edmonton Multicultural Health Brokers Cooperative
Govinda Dahal, Researcher, University of Ottawa
Anita Gagnon, Professor, McGill University
Louise Hanvey, Research Director, Canadian Institute of Child Health
Anna Kirova, Professor, University of Alberta
Edward Ng, Senior Analyst, Statistics Canada
Linda Ogilvie, Professor, University of Alberta
Kevin Pottie, Chair, Canadian Collaboration for Immigrant and Refugee Health

For more information about the Expert Advisory Committee members, [click here](#).

Other

Denise Alcock, Co-chair, Canadian Institute of Child Health
Shelley Callaghan, Project Coordinator, Canadian Institute of Child Health
Meghan Marcotte, Research Analyst, Canadian Institute of Child Health
Janice Sonnen, Executive Director, Canadian Institute of Child Health
Robin Walker, Co-chair, Canadian Institute of Child Health

Graphic design:

Meghan Marcotte, Research Analyst, Canadian Institute of Child Health
Bert Schopf, Graphic Designer, Blackbird

Website development:

[Accel Web Marketing](#)



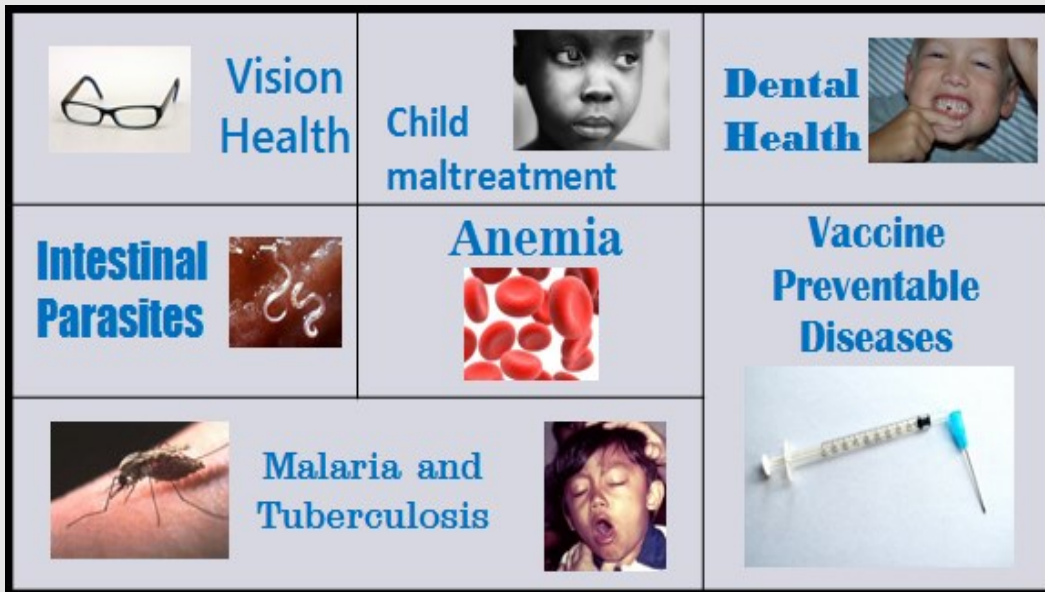
Canadian Institute of Child Health
Institut canadien de la santé infantile



uOttawa



3.1.1 Introduction: Priority Health Conditions Among Immigrant Children and Youth



Graphic created by CICH using images from Microsoft PowerPoint and Big Stock Photo.

The health needs of newly arriving children and youth who are immigrants and refugees often differ from those of Canadian born children. The prevalence of disease differs with exposure to disease, migration patterns, living conditions, and genetic predispositions. Health care professionals, teachers, community workers and other citizens may be interested to know what some of the key preventable and treatable health issues are for immigrant and refugee children.

The priority health conditions among immigrant children and youth in this section were based on evidence-based guidelines developed by the [Canadian Collaboration for Immigrant and Refugee Health](#).

For a description of the methodology used to identify these conditions, [click here](#).

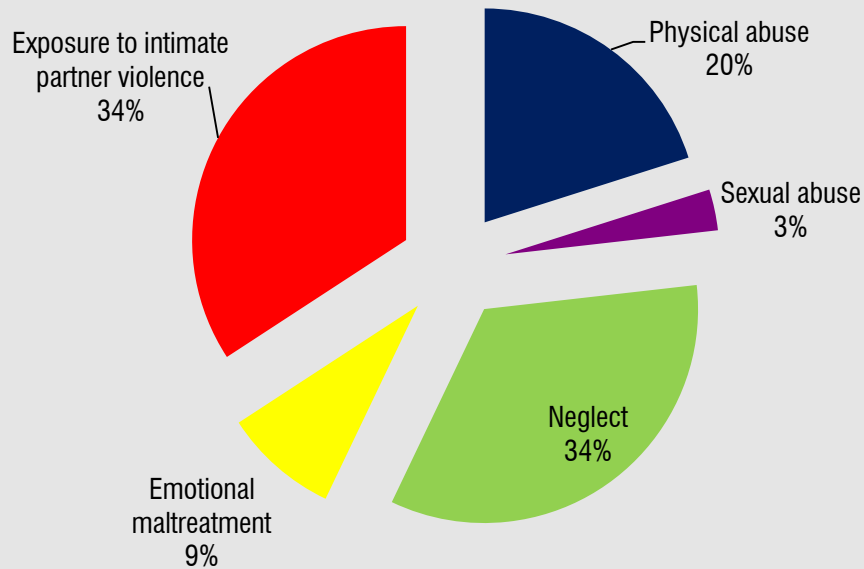


The [Canadian Collaboration for Immigrant and Refugee Health](#) (CCIRH), is a six year old interdisciplinary collaboration involving over 150 primary care practitioners, specialists, researchers, immigrant community leaders, and policy makers that shines an evidence-based lens on the emerging new discipline of migrant health. CCIRH began with an ambitious project aimed at producing evidence based guidelines for primary care practitioners that cover a broad range of infectious diseases; mental health and physical and emotional maltreatment; chronic noncommunicable diseases; and women's health; conditions identified by practitioners working with new immigrants.





3.2.1 Type of Child Maltreatment, Children 15 Years and Younger, Canada, 2008



Graphic created by CICH using data Adapted from the Public Health Agency of Canada. Canadian Incidence Study of Reported Child Abuse and Neglect – 2008: Major Findings. Ottawa, 2010.

Child maltreatment is an important public health issue. The prevalence and incidence of child maltreatment among immigrant and/or refugee children in Canada are unknown.

While not specific to immigrant and refugee children and youth, the Canadian Incidence Study of Reported Child Abuse and Neglect (2008) found a total of 85,440 substantiated cases of child abuse and neglect out of a total of 235,842 investigations. This was 14.19 cases per 1,000 children. An additional 8% of investigations – an additional 17,918 investigations or 2.98 investigations per 1,000 children – found that there was insufficient evidence to substantiate maltreatment; however, maltreatment remained suspected by the worker at the completion of the intake investigation. Thirty percent of investigations were unfounded (i.e. the child had not been maltreated) and 26% were due to concerns about the risk of future maltreatment rather than actual cases of maltreatment.

Of the 85,440 total cases of maltreatment among children that were substantiated, 34% involved neglect, 20% involved physical abuse, 34% involved exposure to intimate partner violence, 3% involved sexual abuse and 9% involved emotional maltreatment.¹

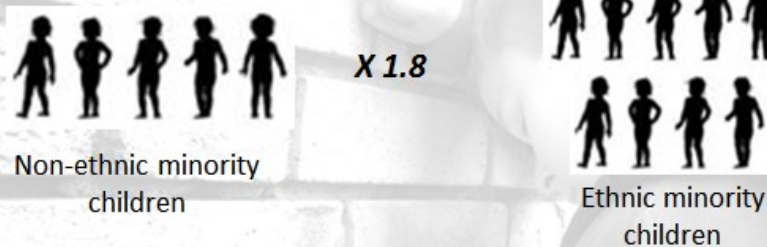
¹Public Health Agency of Canada. Canadian Incidence Study of Reported Child Abuse and Neglect – 2008: Major Findings. Ottawa, 2010





3.2.2 Child Maltreatment – Immigrant and Refugee Children

In 2003, ethnic minority children from 0 to 15 years had a 1.8 times greater likelihood to be over-represented in child protection services.



For every 5 non-minority Canadian children in child protection services, there were 9 ethnic minority children in these services.

Graphic created by CICH using data from Trocmé N, Fallon B, MacLaurin B, et al. Canadian incidence study of reported child abuse and neglect — 2003: major findings. Ottawa: Minister of Public Works and Government Services Canada; 2005.
Graphic created by CICH using an image from Vector Stock.

While the prevalence and incidence of child maltreatment among immigrant and/or refugee children in Canada are unknown, the evidence on maltreatment among ethnic minority children in the United States and Canada suggests that some ethnic minority children are disproportionately over- and under-represented in child protection services.¹

The Canadian incidence study of reported child abuse and neglect (2003) found that ethnic minority children 0 to 15 years of age had a 1.8 times greater likelihood to be over-represented in child protection services, whereas white and Arab children were under-represented. The higher rates were found among Aboriginal, Black, Latino and Asian children (the latter group for only physical abuse).² Yet, there was no evidence that child maltreatment was higher in immigrant families. Immigrant and refugee families may be particularly vulnerable to the harms that can occur because of legal and institutional interventions consequent to false-positive screening results, such as over-reporting for child maltreatment and unnecessary separation of the child from his or her family.

¹Pottie K, Greenaway C, Feightner J, Welch V, Swinkels H, Rashid M, Narasiah L, Kirmayer LJ, Ueffing E, MacDonald NE, Hassan G, McNally M, Khan K, Buhrmann R, Sheila Dunn S, Dominic A, McCarthy AE, Gagnon AJ, Rousseau C, Tugwell P, and coauthors of the Canadian Collaboration for Immigrant and Refugee Health. Evidence-based clinical guidelines for immigrants and refugees. CMAJ 2011; 183(12): E824 – E925.

²Trocmé N, Fallon B, MacLaurin B, et al. Canadian incidence study of reported child abuse and neglect — 2003: major findings. Ottawa (ON): Minister of Public Works and Government Services Canada; 2005. Cited in Pottie K, Greenaway C, Feightner J, Welch V, Swinkels H, Rashid M, Narasiah L, Kirmayer LJ, Ueffing E, MacDonald NE, Hassan G, McNally M, Khan K, Buhrmann R, Sheila Dunn S, Dominic A, McCarthy AE, Gagnon AJ, Rousseau C, Tugwell P, and coauthors of the Canadian Collaboration for Immigrant and Refugee Health. Evidence-based clinical guidelines for immigrants and refugees. CMAJ 2011; 183(12): E824 – E925

Implications

Immigrant children and youth and their families come from a wide variety of cultural and linguistic backgrounds. Upon arrival, new immigrants tend to be healthier than the Canadian-born population, both because of immigrant-selection processes and because of certain socio-cultural aspects of health behaviours. However, refugees are more vulnerable and not able to enjoy the same measure of good health at the time of arrival. However, at least for adults, there is a decline in this “healthy immigrant effect” soon after arrival.





3.3.1 Why Are Vaccinations against Common Childhood Disease Important for Immigrant and Refugee Children, Youth and Families



Graphic created by CICH using an image from Big Stock Photo.

In the past 30 years the majority of Canadians who were born outside of Canada (more than 70%) have originated from countries where vaccination coverage may be suboptimal or where several of the childhood vaccines that are routine in Canada are not part of the national vaccination schedule.¹ These include vaccines against illnesses such as varicella (chickenpox), rubella (also known as German Measles), diphtheria, pertussis (whooping cough), and tetanus. Immigrant children are therefore at risk for these vaccine preventable diseases with their associated morbidity and mortality.² Children and youth (and adults) who are susceptible to vaccine-preventable diseases must be identified and vaccinated to protect them and maintain herd (community) immunity and prevent outbreaks.

¹Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. *CMAJ* 2011;183:E824-925.

²Organization WH. WHO Vaccine- Preventable Diseases: Monitoring System. Geneva: The Organization; 2004.

Implications

There are many obstacles facing immigrant children, youth and their families regarding access to immunization. These are commonly low socioeconomic status, low parental education, younger maternal age, lack of knowledge about the illnesses and immunization, negative beliefs about immunization and fear of bad effects, lack of transportation, clinic hours and cost.³ Effective interventions must be utilized to enable immigrant children and youth to gain access – including education, reducing out-of-pocket costs, reminder systems and providing clinics in non-traditional places such as schools and places of worship.

³Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. *CMAJ* 2011;183:E824-925





3.3.2 Chickenpox (Varicella)



A large proportion of immigrant youth are susceptible to chickenpox (varicella). Evidence indicates that up to 50% of youth at age 15 who are immigrants from tropical countries are at risk – and particularly at increased risk of severe illness. The average age at which chickenpox develops varies for different world regions: older children/youth are more likely to get chickenpox in tropical countries – the average age of onset is 15 years – while in temperate and cold countries the average age of acquiring chickenpox is 5 years.

Implications

Pregnant immigrant women and their babies are at particular risk for complications of chickenpox – up to 50% of babies born with congenital varicella are likely to die and survivors may have congenital anomalies.¹ For most children, being immunized against chickenpox means that they will never get the disease. For others, being immunized means that if they do get chickenpox, it will be very mild, and they will recover quickly.²

Canadian Immigrant Health Guidelines recommend that all immigrant children younger than 13 years be vaccinated with the chickenpox (varicella) vaccine without prior blood testing. It is also recommended that all immigrant and refugee children, youth and adults from tropical countries over 13 years be screened for serum varicella antibodies, and that those found to be susceptible (not yet immune) be immunized.³

For the Canadian Immigrant Health Guidelines [click here](#).

¹Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. CMAJ 2011;183:E824-925.

²Public Health Agency of Canada. What you need to know about varicella (chickenpox). <http://www.phac-aspc.gc.ca/im/ivc-vve/faq-dis-mal/varicell-eng.php>

³Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. CMAJ 2011;183:E824-925





3.3.3 Measles, Mumps and Rubella



32% to 54% of immigrant children and youth are susceptible to vaccine-preventable diseases such as measles, mumps, and rubella upon arrival in Canada.

Source: Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. CMAJ 2011;183:E824-925.; Graphic created by CICH using an image from Big Stock Photo.

Many immigrant children and youth are susceptible to vaccine-preventable diseases upon arrival in Canada – such as measles, mumps and rubella (German Measles). Evidence indicates that 32%–54% are susceptible to these three diseases.¹ While routine childhood vaccination began in the mid-seventies in most developing countries – and many include measles - rubella and mumps vaccines are not administered routinely in most of these developing countries.² Most recent reported cases of congenital rubella syndrome and neonatal tetanus have occurred in children who were born to women who were not immunized and were foreign born.³

¹Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. CMAJ 2011;183:E824-925.

²World Health Organization. WHO vaccine-preventable diseases: monitoring system. 2004 global summary. Geneva; The Organization; 2004. Cited in Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. CMAJ 2011;183:E824-925.

³Danovaro-Holliday MC, LeBaron CW, Allensworth C, et al. A large rubella outbreak with spread from the workplace to the community. JAMA 2000;284:2733-9. And Craig AS, Reed GW, Mohon RT, et al. Neonatal tetanus in the United States: a sentinel event in the foreign-born. Pediatr Infect Dis J 1997;16:955-9 cited in Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. CMAJ 2011;183:E824-925

Implications

Measles, mumps and rubella are highly contagious diseases that can have serious consequences. Measles infection can cause encephalitis in 1/1,000 children⁴; mumps can cause deafness and meningitis⁵ and a baby born to a mother with no protection against rubella who has come in contact with the disease during her pregnancy could be born deaf, blind, or with heart or brain damage.⁶ Measles-mumps-rubella vaccine is extremely effective against measles and rubella – protecting almost 100% of children immunized. While the mumps vaccine effectiveness is lower – it still protects the majority of children immunized.

Canadian Immigrant Health Guidelines recommend that all immigrant and refugee children and youth with missing or uncertain vaccination records be vaccinated for measles, mumps and rubella using age-appropriate vaccination.⁷

For the Canadian Immigrant Health Guidelines [click here](#).

⁴Public Health Agency of Canada. What you need to know about measles. <http://www.phac-aspc.gc.ca/im/lyc-vve/faq-dis-mal/mumps-oreillons-eng.php> ; ⁵Public Health Agency of Canada. What you need to know about mumps. <http://www.phac-aspc.gc.ca/im/lyc-vve/faq-dis-mal/mumps-oreillons-eng.php> ; ⁶Public Health Agency of Canada. What you need to know about rubella. Public Health Agency of Canada. What you need to know about varicella (chickenpox). <http://www.phac-aspc.gc.ca/im/lyc-vve/faq-dis-mal/varicell-eng.php>

⁷Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. CMAJ 2011;183:E824-925





3.3.4 Diphtheria, Pertussis (Whooping Cough), Tetanus and Polio



Graphic created by CICH using an image from Big Stock Photo.

Many immigrants are susceptible to vaccine-preventable diseases upon arrival in Canada. Evidence indicates that 30%–50% of new immigrants are susceptible to tetanus. Immunity against diphtheria is low among immigrants – 35% to 50%.¹ Vaccinating children against diphtheria, pertussis, tetanus and polio have dramatically reduced the incidence of these illnesses (92% to 99.9%) and have almost completely eliminated resulting deaths.¹

¹Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. CMAJ 2011;183:E824-925.

Implications

Canadian Immigrant Health Guidelines recommend that all immigrant children with missing or uncertain vaccination records be vaccinated using age-appropriate vaccination for diphtheria, pertussis, tetanus and polio.³

For the Canadian Immigrant Health Guidelines [click here](#).

³Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. CMAJ 2011;183:E824-925





3.3.5 Hepatitis B



Graphic created by CICH using an image from Big Stock Photo.

In Canada, the rates of hepatitis B infection are low (less than 0.5%). During the past four decades most Canadian immigrants have come from countries with relatively high rates of hepatitis, including hepatitis B, and their rate of chronic infection is about 4%. Most of these people do not have symptoms for a long time. The mortality rate from chronic viral hepatitis is higher among immigrants than among those who are Canadian born – most likely because they have a higher rate of untreated, undiagnosed illness. Young children who live with someone with chronic hepatitis B virus are at increased risk of acquiring the infection. This puts immigrant children at higher risk as they are more likely to be living with someone with infection and no symptoms. Many immigrant children have not been immunized against hepatitis B.¹Evidence indicates that immigrant children, youth and families do not have knowledge regarding the seriousness of hepatitis B infection and less than 50% have been screened.²

¹Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. CMAJ 2011;183:E824-925.

²Hislop TG, Teh C, Low A, et al. Hepatitis B knowledge, testing and vaccination levels in Chinese immigrants to British Columbia, Canada. Can J Public Health 2007;98:125-9. cited in Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. CMAJ 2011;183:E824-925

Implications

Hepatitis B vaccine is an effective vaccine that significantly reduces the risk of getting the infection. Canadian Immigrant Health Guidelines recommend that susceptible children and youth from countries where Hepatitis B [seroprevalence](#) is moderate to high (i.e., > 2% HBsAg positive) be screened and vaccinated if susceptible.³

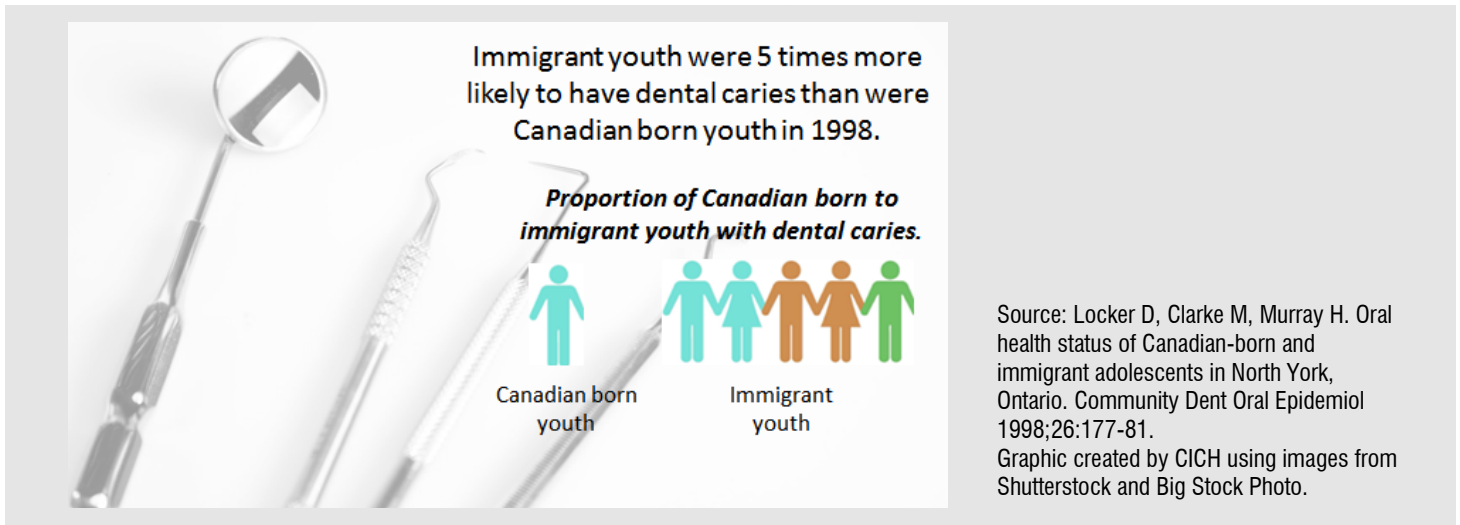
For the Canadian Immigrant Health Guidelines [click here](#).

³Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. CMAJ 2011;183:E824-925





3.4.1 Dental Diseases among Immigrant Children and Youth



Evidence indicates that immigrant youth are at greater risk of having dental disease – in fact they were five times more likely to have dental caries than were Canadian born youth. One in five immigrant youth required restorative dental care for these caries – compared to less than 4% of Canadian born youth.¹ While the longer immigrant children and youth live in Canada, the less likely they are to have dental disease, they continue to have higher rates than Canadian born young people. Recent evidence shows that the development of dental caries is increasing in African and Asian countries – it is thought that this is due to increasing consumption of sugar and lack of topical fluorides in toothpastes and professional dental products.² Poor oral health among immigrant children and youth may result from poor nutrition and diet, lack of fluoridated water, poor dental hygiene practices and limited dental care in the past. This is particularly true for refugee children and youth who are less likely than children and youth from other immigrant classes to have received dental care in the native countries.

¹Locker D, Clarke M, Murray H. Oral health status of Canadian-born and immigrant adolescents in North York, Ontario. *Community Dent Oral Epidemiol* 1998;26:177-81. Cited in Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. *CMAJ* 2011;183:E824-925.

²Petersen PE, Bourgeois D, Ogawa H, et al. The global burden of oral diseases and risks to oral health. *Bull World Health Organ* 2005;83:661-9. Cited in Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. *CMAJ* 2011;183:E824-925

³Caring for Kids New to Canada. Oral Health Screening. <http://www.kidsnewtocanada.ca/screening/oral-health>

Implications

Children and youth arriving from countries with limited dental care and where diets are high in sugar are at the highest risk for dental disease. Screening and referral for dental disease can facilitate treatment and prevention. Patients are twice as likely to go for dental treatment when they are actively examined and referred by a physician. Tooth-brushing twice daily with fluoridated toothpaste is effective in reducing the risk of dental decay.

Canadian Immigrant Health Guidelines recommend that clinicians screen all immigrant children and youth for dental pain by asking, “Do you have any problems or pain with your mouth, teeth or dentures?”. All immigrant children and youth should be screened for obvious dental caries and oral disease by examining their mouth with a penlight and tongue depressor. Children and youth with obvious dental disease should be referred to a dentist or oral health specialist. The guidelines recommend that primary care practitioners treat dental pain with nonsteroidal anti-inflammatory drugs (such as aspirin and ibuprofen) and refer patients to a dentist.³

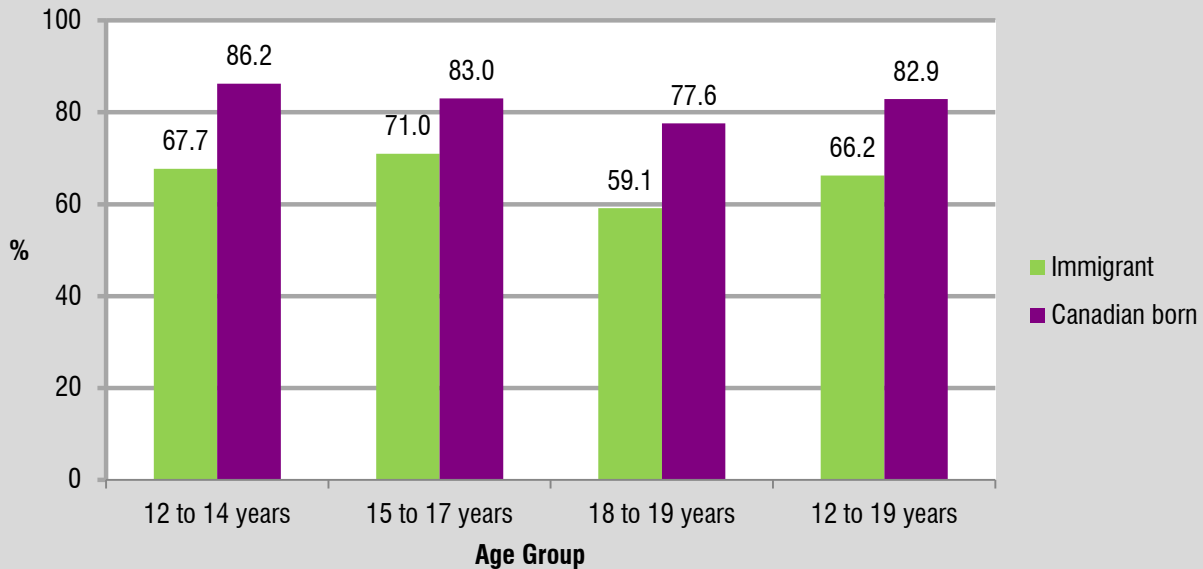
³Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. *CMAJ* 2011;183:E824-925





3.4.2 Access to Dental Care – Immigrant Children and Youth

Children and youth who consulted a dentist/orthodontist in the last year, by age group and immigrant status, Canada, 2011-2012



Graphic created by CICH using CICH's Analysis of the Canadian Community Health Survey, 2011-2012 Public Use Microdata File.

The proportion of immigrant children and youth aged 12 to 19 years and 15 to 17 years who had consulted a dental professional in the last year (2009/2010) was lower than the proportion of Canadian-born children and youth.

There are a number of factors that decrease access - lower income/financial priorities, language barriers, past experiences, fear and history of inadequate care; and embarrassment about dental disease.¹

¹Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. CMAJ 2011;183:E824-925

Implications

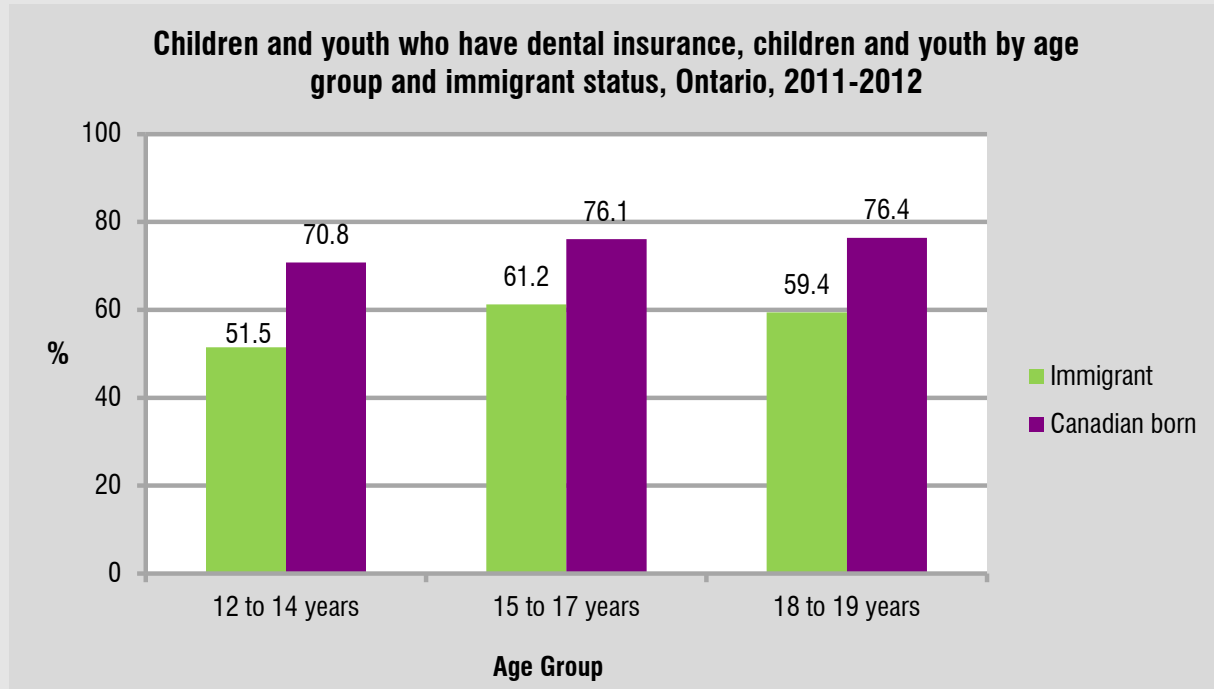
Immigrant children and youth who are new to Canada are likely to see a medical doctor before seeking dental care. Since these newcomers to Canada often have unmet dental care needs, physicians and paediatricians should screen these youth and refer them to a dentist when needed.²

²Caring for Kids New to Canada. Oral Health Screening. <http://www.kidsnewtocanada.ca/screening/oral-health>





3.4.3 Access to Dental Insurance – Immigrant Children and Youth



Graphic created by CICH using CICH's Analysis of the Canadian Community Health Survey, 2011-2012 Public Use Microdata File.

Dental care is not insured by the Canadian health care system in each province and territory. In Ontario (the only province for which data are available), immigrant children and youth aged 12 to 19 years were less likely than were Canadian-born children and youth to have dental insurance. This is certainly a barrier to accessing care.





3.5.1 Strongyloidiasis and Schistosomiasis



Graphic created by CICH using an image from Big Stock Photo.

Many immigrant and refugee children may have been exposed to intestinal parasites either in their country of origin or during time spent in refugee camps. Most types of intestinal parasites will resolve naturally once a child or adult has left the region where the parasites are commonly found, but two will not. Refugee children and youth, in particular, are at potential risk for strongyloidiasis and schistosomiasis.

Strongyloidiasis is disease caused by an intestinal parasite, usually spread through contact with infected soil. Schistosomiasis is a disease also caused by parasitic worms – spread through contaminated water. These diseases can persist for years to decades and consequently can cause serious suffering or death long after an immigrant resettles in a new country.

The burden of strongyloidiasis appears greatest in refugee populations originating from Southeast Asia and Africa, whereas the burden of schistosomiasis is greatest in refugee populations from Africa. Detection of strongyloidiasis or schistosomiasis is limited because infection can persist below the clinical detection level and because detection by stool microscopy is difficult. Serologic blood testing substantially enhances diagnostic sensitivity for these intestinal parasites.

Implications

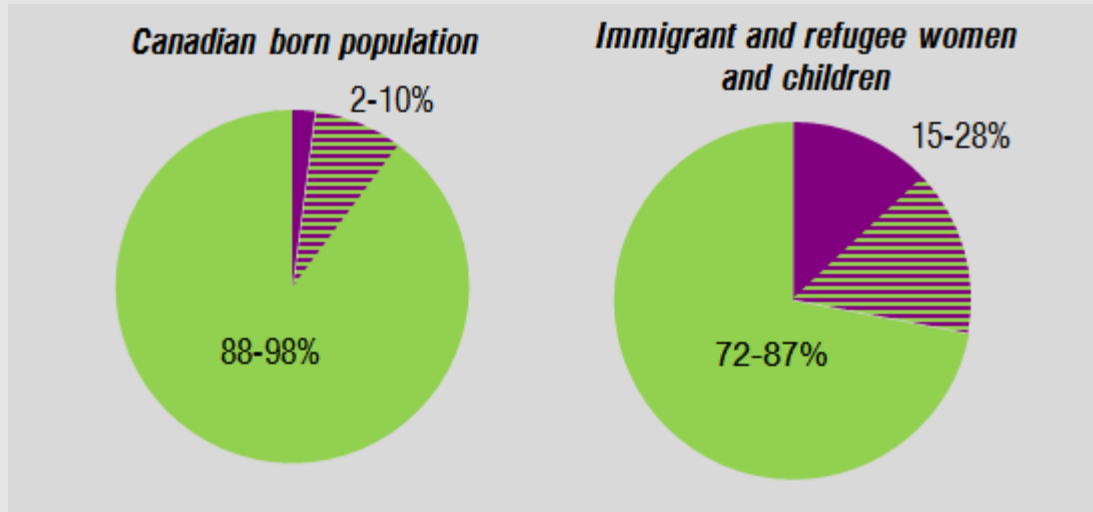
Canadian Immigrant Health Guidelines recommend that a blood test for strongyloidiasis should be offered to all recently arrived African and Southeast Asian refugees and a blood test for schistosomiasis should be offered to all recently arrived African refugees.

For the Canadian Immigrant Health Guidelines [click here](#).





3.6.1 Iron-Deficiency Anemia



Graphic created by CICH using data from Bindra GS, Gibson RS. Iron status of predominantly lacto-ovo vegetarian East Indian immigrants to Canada: a model approach. *Am J Clin Nutr* 1986;44:643-52.

Anemia is a condition where the blood lacks adequate healthy red blood cells that carry oxygen to the tissues of the body. Iron-deficiency anemia is due to a lack of iron. It is the most common kind of anemia and the most common nutritional illness in the world. Iron-deficiency anemia can result in poor pregnancy outcomes and impaired physical and cognitive development in children. No routine iron-deficiency screening or supplementation program is offered in Canada for immigrants, either before or after their arrival.¹ Immigrant and refugee women and children have a higher prevalence of anemia (15%–28%) than the Canadian-born population (2%–10%), excluding First Nations populations.² According to the World Health Organization the prevalence of iron-deficiency anemia among preschool children ranges from 21% to 68% and for women of childbearing age it is 18% to 48%.³ It can occur for several reasons including intestinal parasitic infections, dietary iron deficiency, menstrual blood loss, and pregnancy. Immigrants and refugees coming from regions with limited access to iron-rich foods, higher rates of infectious disease and higher numbers of births are at risk for iron deficiency.

Implications

Canadian Immigrant Health Guidelines recommend that to improve their cognitive development, growing children aged one to four years should be screened for iron deficiency by means of hemoglobin measurement. They also recommend that to improve hemoglobin levels and work productivity, immigrant and refugee women of reproductive age should also be screened by means of hemoglobin measurement.

¹Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. *CMAJ* 2011;183:E824-925.

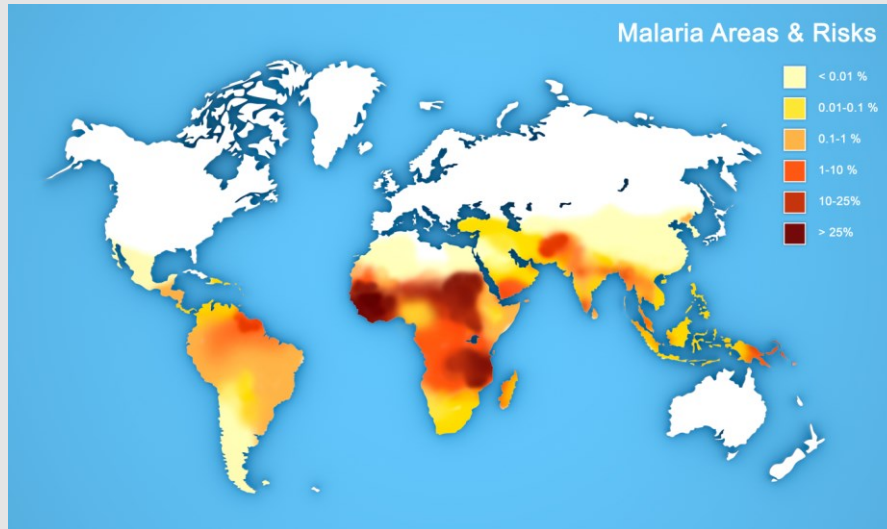
²Bindra GS, Gibson RS. Iron status of predominantly lacto-ovo vegetarian East Indian immigrants to Canada: a model approach. *Am J Clin Nutr* 1986;44:643-52.

³World Health Organization. Worldwide prevalence of anaemia 1993–2005. Geneva (CH): The Organization; 2008. Available: http://whqlibdoc.who.int/publications/2008/9789241596657_eng.pdf (accessed 2008 Sept. 10).





3.7.1 Malaria



Graphic created by CICH using an image from Big Stock Photo.

Malaria causes hundreds of millions of infections and an estimated one million deaths per year worldwide, many of which occur in children. Sub-Saharan Africa bears a significant proportion of the worldwide burden of malaria. The intensity and seasonality of malaria transmission varies significantly both within and among countries in the region and thus risk of malaria will vary between geographical locations, the age and ethnicity of the child and the time of year.

The symptoms of malaria (malaise, myalgia, headache and fever) are not exclusive to malaria and thus primary care practitioners may not readily recognize them as symptoms of malaria. Delays in the diagnosis and treatment of *P. falciparum* infection (the most dangerous type of malaria) may lead to severe disease and even death. Migrants who have lived or travelled in malaria-endemic areas are vulnerable to acute malaria, particularly within the first three months after arrival in Canada.

Implications

Routine screening of immigrant children and youth (and adults) for malaria is not recommended in the Canadian Immigrant Health Guidelines, but clinicians should be vigilant for symptoms of malaria – particularly when caring for children who have lived or traveled in malaria-endemic regions within the previous three months – particularly if they have fever. They should perform timely diagnostic inquiry and testing.¹

Improved surveillance for malaria is needed in Canada, as well as more research related to the utility of screening immigrants and refugees for this disease.

For the Canadian Immigrant Health Guidelines [click here](#).

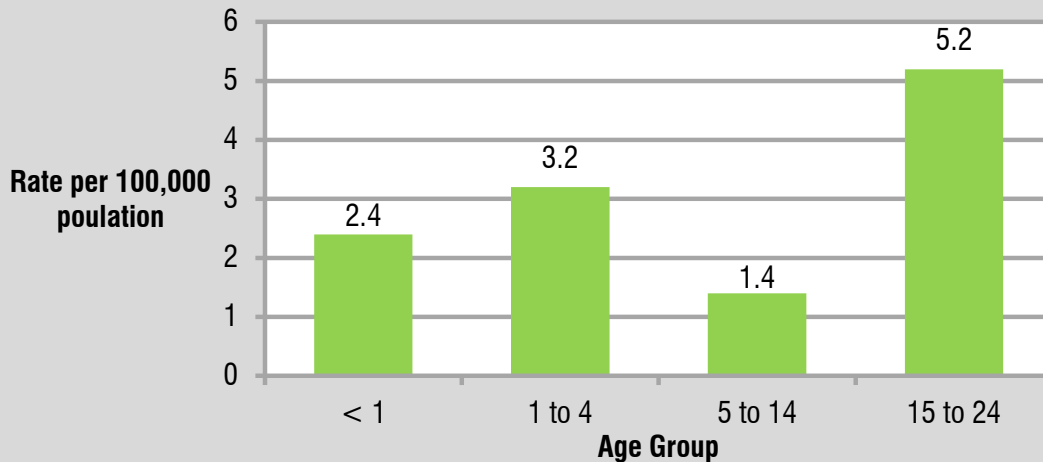
¹Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. CMAJ 2011;183:E824-925.





3.7.2 Tuberculosis (TB) among Immigrant and Refugee Youth

Incidence of new and re-treatment tuberculosis cases among children and youth per 100,000, by age group, Canada, 2012



Graphic created by CICH using data adapted from Public Health Agency of Canada. Tuberculosis in Canada 2012: Pre-Release. <http://www.phac-aspc.gc.ca/tbpc-latb/pubs/tbcan12pre/tab-eng.php#tab2>

Tuberculosis is an infection that is transmitted through airborne particles. It is an uncommon infection in Canada, but is still seen in indigenous populations and populations who are homeless. Immigrant and refugee children who have come from regions in the world where TB remains common are more likely to have TB. Foreign-born children, youth and adults account for 65% of all people with active tuberculosis in Canada, and some subgroups have up to a 500-fold greater risk of active tuberculosis relative to the non-Aboriginal Canadian-born population.¹

In 2012 the rate of TB among children and youth ranged from 2.4 to 5.2 per 100,000 – depending on the age group. The rate of TB in the entire Canadian population in 2012 was 4.8 per 100,000 population. It was 13.6 among foreign-born children and adults, 29.4 among Canadian-born Aboriginal people and 0.7 among Canadian-born non-Aboriginal people.¹

¹Public Health Agency of Canada. Tuberculosis in Canada 2012: Pre-Release. <http://www.phac-aspc.gc.ca/tbpc-latb/pubs/tbcan12pre/tab-eng.php#tab2M>

Implications

Canadian Immigrant Health Guidelines recommend that immigrant children and youth under 20 years of age from countries with a high incidence of tuberculosis should be screened for TB with a tuberculin skin test as soon as possible after their arrival in Canada. It is recommended that they be treated for latent tuberculosis infection if the results are positive and active tuberculosis is ruled out. It is recommended that all newly arrived refugees, including children, should be assessed for latent

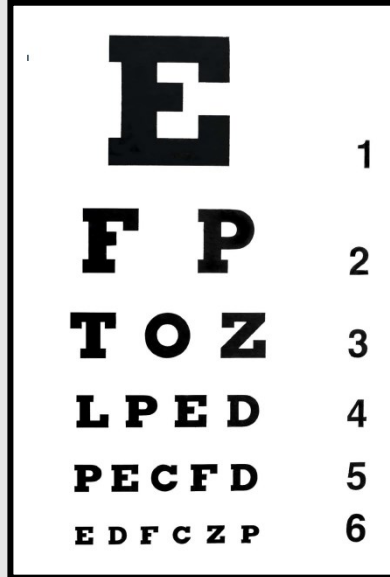
TB infection – with the exception of those with past tuberculosis disease documentation.²

¹Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. CMAJ 2011;183:E824-925.





3.8.1 Vision Assessment



Graphic created by CICH using an image from Big Stock Photo.

All immigrant children and youth can benefit from having their visual acuity (vision) assessed soon after arriving in Canada. Loss of vision and undiagnosed sight-threatening eye diseases are more common among new immigrants and refugees than in the general population. Preventive screening by an optometrist or ophthalmologist can help identify visual impairment and strabismus for children younger than five years of age. Assessing for a red reflex and inspecting the external eye can begin when a child is a newborn.

Regionally prominent “tropical” eye diseases, such as onchocerciasis (river blindness), active trachoma and xerophthalmia, have not been reported in immigrants or refugees to Canada. Asymptomatic forms of these diseases should resolve or stabilize after the children arrive in Canada.

Implications

New immigrant children and youth should be screened for vision loss within their first year in Canada and should be referred to an optometrist or ophthalmologist if their vision is less than 20/40.¹

¹Pottie K, Greenaway C, Feightner J, et al. Evidence-based clinical guidelines for immigrants and refugees. CMAJ 2011;183:E824-925.





3.9.1 Caring for Kids New to Canada



A guide for health professionals working with
immigrant and refugee children and youth

[Caring for Kids New to Canada](#) is a web portal that helps health professionals provide quality care to immigrant and refugee children, youth and families. It was developed by the Canadian Paediatric Society with experts in newcomer health. The site has a number of key resources including: medical assessment, using interpreters, travel related illness, cultural competence, case studies and community resources.





3.9.2 Metropolis



[Metropolis](#) is an international network for comparative research and public policy development on migration, diversity, and immigrant integration in cities in Canada and around the world.





3.9.3 New Canadian Children and Youth Study



[The New Canadian Children and Youth Study](#) is a longitudinal study of more than 4,000 children and youth of various ethnocultural backgrounds who have immigrated to Canada. The families of these children are also included in the study. The NCCYS focuses on the physical and mental health of these immigrant children and other factors that affect their health and development. The findings shed light on the challenges encountered by this population and how these children may be able to overcome these challenges and thrive in Canada.

The website presents several reports, publications, and projects stemming from this research.



Health Profile on Immigrant and Refugee Children and Youth in Canada: Section 4

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Contributors:

Writing and editing:

Govinda Dahal, Researcher, University of Ottawa
Louise Hanvey, Research Director, Canadian Institute of Child Health
Meghan Marcotte, Research Analyst, Canadian Institute of Child Health
Kevin Pottie, Chair, Canadian Collaboration for Immigrant and Refugee Health

Project development, research, and review:

Expert Advisory Committee

Rukhsana Ahmed, Associate Professor, University of Ottawa
Paula Brauer, Associate Professor, University of Guelph
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Govinda Dahal, Researcher, University of Ottawa
Anita Gagnon, Professor, McGill University
Louise Hanvey, Research Director, Canadian Institute of Child Health
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Meghan Marcotte, Research Analyst, Canadian Institute of Child Health
Janice Sonnen, Executive Director, Canadian Institute of Child Health
Robin Walker, Co-chair, Canadian Institute of Child Health

Graphic design:

Meghan Marcotte, Research Analyst, Canadian Institute of Child Health
Bert Schopf, Graphic Designer, Blackbird

Website development:

[Accel Web Marketing](#)



Canadian Institute of Child Health
Institut canadien de la santé infantile



uOttawa



4.1.1 What is Cultural Discordance?



Graphic created by CICH using an image from Big Stock Photo.

Immigrant and refugee children and youth living in Canada may experience the phenomenon of 'cultural discordance or dissonance'. This is defined as the perceived conflict or disagreement between the child/youth's culture of origin and the culture in Canada when it comes to social norms, behaviours and maintenance of one's heritage culture in the host society/country.¹

Often this happens when families come to Canada with young children – the children grow up learning and following Canadian culture, which may be different from their parents' heritage or home culture.¹ Two important areas of safety and security in the lives of immigrant children and youth are examined in the context of cultural discordance – bullying and peer aggression and suicide thoughts and attempts. In addition, sexual and reproductive health and cultural discordance are considered. These findings are based on a systematic review – [review the methodology here](#).

¹Rohmann A, Florack A, Piontkowski U. The role of discordant acculturation attitudes in perceived threat: An analysis of host and immigrant attitudes in Germany. *Int J Intercult Rel* 2006; 30:683-702.





4.1.2 Adaptation and Acculturation



Graphic created by CICH using an image from Stockvault.

Caring for Kids New to Canada tells us that immigrant youth move through four stages when they adapt to their new country. These steps are happiness and fascination; disappointment, confusion, frustration and irritation; gradual adjustment or recovery; and acceptance and adjustment. This process does not happen along a straight path – youth move forward and backward along the way. Cultural discordance can occur at any step along the way.

Learn more about adaptation and acculturation from [Caring for Kids New to Canada](#).





4.1.3 The Influence of Cultural Discordance



Graphic created by CICH using an image from Big Stock Photo.

The influence of cultural discordance is complex. The family environment of immigrant children and youth may differ from their school and social environment, which can lead to contradictory familial and societal expectations. It is possible that the tension that these children and youth feel from the differences in their home life compared to their lives in the greater community, especially at school, may be a concern for them. This situation may influence their sense of well-being and resultant behaviours, and may also influence their future-life-success.¹ On the other hand family ties and social resources could also buffer adversity, thereby protecting their well-being.²

¹Wilkins R, Tjepkema M, Mustard C, Choiniere R. The Canadian census mortality follow-up study, 1991 through 2001. *Health Rep* 2008;19:25-43.

²Child Health System Indicator Summary. 2006. (Accessed 2011, at <http://pcmch.on.ca/LinkClick.aspx?fileticket=0bn1d-jiVU%3D&tabid=64>)

Implications

The context of children's lives, especially the influence of cultural discordance has not been extensively studied in Canada. This can result in a lack of information upon which to base effective services designed for immigrant and refugee children.





4.2.1 Safety and Security: Bullying and Peer Aggression



← 1st generation and non-native English speaking immigrants are more likely to report being victims of violence at schools than are their native English speaking counterparts.

Refugee status and advanced parental age are associated with increased parent to child aggression among immigrants from South East Asia.



← Parent to child aggression is lower in first generation immigrant families compared to White and Black American families (in the U.S.).

Source: Pottie K, Dahal G, Georgiades K, Premji K and Hassan G. (2014). Do First Generation Immigrant Adolescents Face Higher Rates of Bullying, Violence and Suicidal Behaviours Than Do Third Generation and Native Born? *J Immigrant Minority Health*. doi: 10.1007/s10903-014-0108-6 <http://link.springer.com/article/10.1007%2Fs10903-014-0108-6#page-1>
Graphic created by CICH using images from Big Stock Photo and fotolia.

The findings depicted in this infographic suggest that experiences of bullying and peer aggression are higher among immigrant youth who are first generation and do not speak the country's official language(s) when compared to third generation and native-born youth. This suggests that the risks related to violence are greater when immigrant youth speak a language other than the primary language of their new country.¹ While this review only revealed findings based on American studies, the implications for Canadian immigrant youth are important. Studies showed that in most cases, a supportive, cohesive family – where all members live together – is associated with less violence.

¹Pottie K, Dahal G, Georgiades K, Premji K and Hassan G. (2014). Do First Generation Immigrant Adolescents Face Higher Rates of Bullying, Violence and Suicidal Behaviours Than Do Third Generation and Native Born? *J Immigrant Minority Health*. doi: 10.1007/s10903-014-0108-6; <http://link.springer.com/article/10.1007%2Fs10903-014-0108-6#page-1>





4.2.2 Safety and Security: Suicide Attempts and Ideation



1st generation immigrant youth have lower suicide attempt rates than non-immigrant youth and 3rd generation immigrant youth.



Immigrant youth who are not living with their biological parents reported higher levels of life stress and suicidal thoughts than their counterparts who were living with parents.



Source: Pottie K, Dahal G, Georgiades K, Premji K and Hassan G. (2014). Do First Generation Immigrant Adolescents Face Higher Rates of Bullying, Violence and Suicidal Behaviours Than Do Third Generation and Native Born? *J Immigrant Minority Health*. doi: 10.1007/s10903-014-0108-6 <http://link.springer.com/article/10.1007%2Fs10903-014-0108-6#page-1>
Graphic created by CICH using images from Big Stock Photo.

The findings depicted in this infographic indicate that immigrant youth who were living with their biological parents had lower rates of suicide attempts and ideation than native-born or second- and third generation youth. In addition, studies showed that in most cases, a supportive, cohesive family – where all members live together – is associated with less suicide ideation. Conversely, immigrant youth who are not living together with their biological parents experience higher levels of life stress and resultant suicidal thoughts than those living with intact families.



Implications

In spite of the stress of adjusting to a new culture and cultural dissonance within families, immigrant youth appear to benefit from cohesive families. It also appears that uncommonly high rates of family violence may contribute to higher suicidal thoughts and attempts. Despite risks, the likelihood of suicide appears to be low. Researchers have suggested that this is due to cultural values and supportive families.





4.3.1 Sexual and Reproductive Health

	Cultural discordance, immigrant youth and sexual and reproductive health	
Sexual activity	Young people who are confused about their cultural identity are more likely to engage in risky sexual behaviour.	
Teenage pregnancy	Young people who are integrated into the culture of their new country are more likely to engage in early sexual behaviour and view single parenthood as a viable option. They also have higher education and occupational aspirations.	
HIV prevention	In general young people are aware that unprotected sexual behaviour could lead to both pregnancy and sexually transmitted diseases.	

Sources: Goodenow C, Espin OM. Identity choices in immigrant adolescent females. *Adolescence* 1993;28:173-84.; Blake SM, Ledsky R, Goodenow C, O'Donnell L. Recency of immigration, substance use, and sexual behavior among Massachusetts adolescents. *American journal of public health* 2001;91:794-8.; DeSantis L, Thomas JT, Sinnett K. Intergenerational concepts of adolescent sexuality: Implications for community-based reproductive health care with Haitian immigrants. *Public Health Nurs* 1999;16:102-13. Graphic created by CICH using an images from Shutterstock and fotolia..

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Canadian Institute of Child Health
Institut canadien de la santé infantile



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Summary



There are nearly 1 million immigrant children and youth living in Canada, making up one tenth of Canada's children and youth. Overall they fare well in Canada – a greater proportion of immigrant youth report being in good physical and mental health and having a strong sense of belonging to their community compared their Canadian born counterparts. Immigrant youth smoke less, drink less, have less suicidal behaviors and have a smaller likelihood of being obese compared to those born and raised in Canada. This successful adaptation and general good health may be reflective of the majority of immigrant children and youth being of economic rather than refugee class – refugees may have more difficulty establishing a good, healthy life in Canada, at least initially.

Despite this, life is not easy for all immigrant youth in Canada. Roughly a tenth of these youth have been diagnosed with a mood disorder and one quarter report not having a strong sense of belonging to their community. With the current push towards increasing accessibility to mental health services in Canada, the specific needs of immigrant and refugee youth should be considered so that these populations may not only receive care, but receive care that is culturally sensitive and effective.

There are certain areas where immigrant and refugee children and youth do not fare as well as their Canadian born counterparts. Immigrant youth engage in less physical activity and eat fewer fruits and vegetables than do Canadians. They have relatively poor dental hygiene, a high prevalence of iron-deficiency anemia, an increased prevalence of eye diseases and vision problems, and, depending on their country of origin, a high risk of contracting malaria and tuberculosis before arriving to Canada. Due to the lack of available vaccines in tropical and developing countries from which some immigrants and refugees originate, these children and youth are up to 54% more likely to contract various illnesses such as chickenpox, measles, mumps, rubella, tetanus and Hepatitis B – even upon arrival in Canada. The consequences of these illnesses can be debilitating, costly, and fatal. Furthermore, having large numbers of unvaccinated children and youth compromises herd immunity in Canada, and is a major public health concern. The barriers to immunization faced by immigrant and refugee families, including lack of transportation and access to clinics and insufficient knowledge about vaccinations should be considered in the development of public health strategies to increase immunization levels across the country.

Continued...





Summary (Page 2)

...Continued

On other important topics, there is simply a lack of information. Some health and well-being data about immigrant youth is available, but it is difficult to access population statistics on immigrant infants and children. Furthermore, there is a lack of information about the prevalence of child maltreatment within immigrant families. In the past, certain ethnic minorities were almost twice as likely to be over-represented in child protection services while white and Arab children were under-represented in these services. Ethnic minority children, including immigrants, are over-screened and over-reported for child maltreatment, as compared to general population children. While physicians are encouraged to refrain from incorporating maltreatment screening into their routine care, they should be alert for signs of maltreatment in all paediatric patients.

In addition to health concerns, children and youth new to Canada will experience a plethora of emotions, including happiness, disappointment, gradual adjustment, and acceptance. In addition, they will also experience some degree of cultural discordance – the perceived conflict between a child's or youth's culture of origin and the Canadian culture into which he or she has been immersed. This discordance can lead to serious repercussions – bullying, peer aggression, suicidal thoughts and attempts, tension between youth and their parents, and sexual and reproductive health issues. Generally, living with one's biological parents and siblings in a cohesive and supportive family environment can help children avoid some of these problems. However, not all immigrant children and youth are lucky enough to live with their biological family upon arrival to Canada, and not all families offer the support that children need. It is thus very important for care and service providers, and for all those in the social circles of these immigrant children and youth, to understand the emotions and challenges that these children and youth will likely face. Offering support and guidance can facilitate newcomers' adjustment to their new lives.

It is critical that our Canadian public health system is aware of the priority health conditions and challenges that might prevent immigrant children and youth from achieving the high quality of life that is possible in Canada. Public health initiatives and high quality medical care can help to reduce the prevalence of these issues. Furthermore, other service providers and systems that immigrant families encounter, such as the education system and child care services, should consider the cultural differences and the obstacles that immigrants face in Canada. Initiatives and services should be developed and provided with the diversity of newcomers in mind – newcomers from different countries and experiences have different expectations and beliefs and will experience different barriers and challenges in Canada.

In addition to this module, visit the [CCIRH Migrant Health Knowledge Exchange Network](#), the [Caring for Kids New to Canada](#), and the [Metropolis](#) websites for more information and guidelines on immigrant and refugee health and well-being in Canada.

