RESPONDING BETTER TO THE NEEDS OF THE LINGUISTIC AND CULTURAL COMMUNITIES IN ESTRIE

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Production
Centre intégré universitaire de santé et de services sociaux de l'Estrie –
Centre hospitalier universitaire de Sherbrooke
Direction de santé publique
300 King Street East, suite 300
Sherbrooke, QC J1G 1B1

Telephone: 819 829-3400
Fax: 819 569-8894

Editing
Geneviève Baron, Direction de santé publique de l'Estrie
Mathieu Roy, Directions générales adjointes aux programmes sociaux et de réadaptation et aux programmes santé physique généraux et spécialisés
Natalie Stronach, Direction de santé publique de l'Estrie

Collaboration
Mélissa Généreux, Direction de santé publique de l'Estrie
Marie-Andrée Roy, Direction de santé publique de l'Estrie

Revision and layout
Marie-Eve Brière, Direction de santé publique de l'Estrie
Isabelle Mathieu, Direction de santé publique de l'Estrie

References

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- Carole Gendreau, CIUSSS de l'Estrie — CHUS
- Rachel Hunting, Townshippers' Association
- Julie Laflamme, CIUSSS de l'Estrie — CHUS
- Matey Mandza, Fédération de communautés culturelles de l'Estrie
- Gaétan Nadeau, CIUSSS de l'Estrie — CHUS
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A FEW WORDS FROM THE DIRECTOR

Last September, the first report ever by the Director of Public Health in Estrie on the mental health and well-being of the citizens in Estrie was published. This year, for its second edition, a subject of equal importance, specifically the health of the English-speaking and immigrant communities in Estrie, was chosen.

The need to draw a profile of our linguistic and cultural minorities became apparent to us once we learned of the results of the *Québec Survey of Child Development in Kindergarten* (QSCDK). That survey showed significant gaps in the general development of English and French-speaking children who attend kindergarten in Estrie. Why were there such differences? Were they the result of language or cultural barriers, or of other factors (e.g., poverty)? One thing is certain: we find such gaps unacceptable. We must therefore understand them better in order to take appropriate action.

At the same time, the massive influx of Syrian refugees over the past year reinforces our wish to grasp the health issues that are specific to immigrants, in particular recent immigrants and refugees, many of whom have endured hardship and trauma which could be lasting and affect both their physical and mental well-being.

Within the framework of this report, our intention was to distinguish the health needs of the English-speaking community and those of the immigrant community in Estrie, assuming that the respective realities of both communities were quite distinct.

The initiative taken to accomplish our goal was particularly rigorous. We first formed an advisory committee composed of partners and members of the English-speaking and cultural communities in Estrie. That committee assisted us at every stage of the process, from developing the work plan to interpreting the results. I sincerely thank all members of the committee for their commitment and invaluable contribution. In order to draw the most accurate findings, we have integrated to our study not only a quantitative component (i.e., the analysis of numerous sources of data), but also a qualitative one. No fewer than 48 people from the English-speaking and immigrant communities in Estrie participated in focus groups to share their experience with us and to improve our understanding. Finally, we completed our analyses by conducting individual, in-depth interviews with key actors in the municipal, education, and community sectors.

It is with a great sense of pride that I invite you to read this report and to become acquainted with the needs and realities that are specific to the English-speaking and immigrant communities in Estrie.

Best regards,

Mélissa Généreux, M.D.
Public Health Director for Estrie

INTRODUCTION

The field of public health is concerned not only with the health of individuals, but also with that of the broader, general population. Public health pays particular attention to health inequities within populations, especially those said to be *vulnerable* and which include persons who must manage less favourable situations in their everyday lives. Associations according to sex, age, socio-economic status, and health status are regularly compiled in Estrie. However, to this very day, few studies have been made on health status and state of well-being according to linguistic or cultural background.

Estrie has slightly more than 30,000 native English speakers and nearly 20,000 immigrants (persons born outside of Canada). That represents approximately 50,000 people out of a population nearing 500,000 (nearly 10% of the population). The scientific literature converges and shows that, in addition to reporting detrimental lifestyles and greater limitations in their activities of daily living, minority communities have a poorer perception of their physical and mental health. Furthermore, various studies have also established that recent immigrants have a better health status than that of the host population. This phenomenon, known as the ***healthy immigrant effect***, usually wears off as time passes following the date of immigration. Slowly, the prevalence of chronic diseases and mortality rates increase to reach that of the host population.

These questions and others will be addressed in this thematic surveillance report of which the specific objectives are to:

1. Describe the status of immigrant and English-speaking communities in Estrie and to establish the differences with the reference population (i.e., non-immigrants, French speakers).
2. Document the perceptions of English-speakers and immigrants regarding their social and health care needs.
3. Make recommendations to improve the health and well-being of both of these communities in Estrie.

In order to respond to these objectives, many health and well-being indicators gathered from surveys and administrative records were analyzed. Focus groups were held with local English-speakers and immigrants. Individual and group interviews were held with local community, municipal and education partners to qualify and substantiate the findings. Finally, local initiatives by the English-speaking and immigrant communities in Estrie are presented at the end of each section in order to pay tribute to the many positive contributions of our partners.

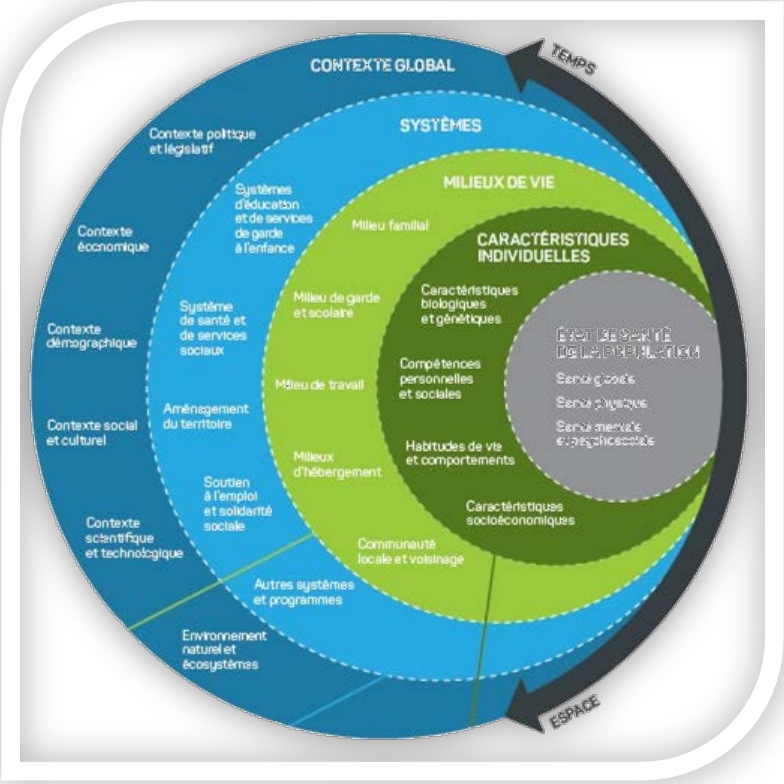
The recommendations in this report are addressed to the decision-makers, professionals and partners of the Direction de santé publique de l'Estrie, to the health care and social services network in Estrie, and to intersectoral organizations. Together, we must assume our mandate to the public, and adapt our offer of services so that it responds better to the social and health care needs of the linguistic and cultural communities in Estrie.

1. FRAME OF REFERENCE

The frame of reference chosen to orient the work for this report (Figure 1) is that of the *Programme national de santé publique 2015-2025* (national public health program for 2015-2025).[1] This frame of reference groups the determinants that need to be considered when conducting health studies. Health is defined as "the physical, psychic, and social ability of individuals to act within their environment and to fulfill their intended roles in a manner that they deem acceptable for themselves and for the groups to which they belong." [TRANSLATION][2] The determinants include the individual, social, economic, and environmental factors associated with health. These determinants are grouped into four broad categories, specifically: global context, systems, living environments, and individual characteristics. All determinants addressed in this report fall under one of these categories. The determinants are arranged in a circle around a central element which they influence, specifically the health status of the population.

The health status of the population can be measured in various manners. For example, the general health status can be obtained from indicators such as general mortality, life expectancy or personal health perception. The physical health status can be measured using data on diseases, whereas mental health status can be evaluated thanks to data on positive elements (e.g., resilience) and negative elements (e.g., mental disorders).

Figure 1
Carte de la santé et de ses déterminants. (Available in French only.)



Source: Ministère de la Santé et des Services sociaux (2016). Programme national de santé publique, 2015-2025.

The purpose of this report is to analyze the data gathered from studies and administrative records within the English-speaking and immigrant communities in Estrie. More specifically, our goal is to compare the health status of English speakers with that of French speakers, and the health status of immigrants with that of persons born in Canada. Here are the health status indicators as well as the health determinants which will be studied.

CATEGORY	SUBCATEGORY	INDICATOR
Global context	Political and legislative	An Act Respecting Health Services and Social Services Charter of the French Language
	Economic	---
	Demographic	Structure by age and sex Country of origin
	Social and cultural	---
	Scientific and technological	---
	Natural and ecosystem	---
Systems	Education and childcare	---
	Health care and social services	Participation in the Québec Breast Cancer Screening Program (QBCSP) Access to health care services Consultation with a health care professional
	Spatial planning	---
	Employment assistance and social solidarity	Unemployment rate Employment rate
Living environment	Family	Age and educational attainment of mothers Family composition
	School and childcare	Violence at school and cyberbullying Day care attendance
	Work	---
	Housing	Proportion of renters
	Local community and neighbourhood	Sense of belonging
Individual characteristics	Biological and genetic	Age and sex
	Skills-level	Childhood development in kindergarten Resilience Self-esteem, empathy, problem solving
	Lifestyle habits and behaviours	Physical activity, nutrition, tobacco use, alcohol, drugs, brushing teeth and flossing, unprotected sex, stress
	Socio-economic characteristics	Educational attainment Employment Income Proportion of income dedicated to housing
Health status	Overall health	Health perception Life expectancy
	Physical health	Premature births and low-weight births Dental caries among children Excess weight, obesity Chronic and infectious diseases Nutritional deficiencies Disabilities
	Mental and psychosocial health	Prevalence of selected mental disorders Presence of depressive symptoms Post-traumatic stress Positive mental health Psychological distress

2. THE ENGLISH-SPEAKING COMMUNITY

POLITICAL AND LEGISLATIVE CONTEXT

In Canada, language access in health care is based primarily on interpretations of the *Canadian Charter of Rights and Freedoms*, provincial and territorial human rights laws, the *Canada Health Act*, and provincial health care laws.[3] It is essential to mention that in Québec, the *Charter of the French Language* occupies an important place within the political and legislative spheres as it regulates the place of the English language in the province's public and institutional spaces. Section 15 of Québec's *Act Respecting Health Services and Social Services* furthermore mentions that "English-speaking persons are entitled to receive health services and social services in the English language, in keeping with the organizational structure and human, material and financial resources of the institutions providing such services (…)." The right to receive services in the English language also figures among the 12 rights of the users of the Centre intégré universitaire de santé et de services sociaux de l'Estrie — Centre hospitalier universitaire de Sherbrooke (CIUSSS de l'Estrie — CHUS).

The institutional committees for access to health services and social services in the English language were abolished regionally on March 31, 2015, at the time the health network was reformed. The Ministère de la Santé et des Services Sociaux (MSSS) is in the process of reviewing the composition and mandate of the various committees to be restructured following the merger of the institutions. Meanwhile, a transitional consultative body is maintained by the CIUSSS de l'Estrie — CHUS in order to provide a platform for exchange and discussion with the English-speaking community. In addition, programs of access to services in the English-language which existed in the former institutions of the health care network in Estrie remain in force. The Estrie Regional Committee for programs of access to health services and social services in the English language should be formed and operative once again in 2016-2017.

Moreover, the CIUSSS de l'Estrie — CHUS receives grants from the federal government to offer training aimed at improving the English-language skills of health professionals. The objective of the organization is to train 155 employees per year from 2015-2016 to 2017-2018.

DEMOGRAPHIC CONTEXT

In 2011, more than 32,000 Estrie residents born in Canada (non-immigrants) reported that English is the language they speak most often at home (Table 1). That represents 7.3% of the population of Estrie. Two local services networks (RLS) are notable for their high proportion of English speakers: La Pommeraie (21%) and Memphrémagog (15%). In fact, these two local services networks along with that of Sherbrooke cover nearly 75% of English-speakers living in Estrie. A map of the proportion of English speakers in the 96 communities in Estrie can be found in Appendix C. More than 75% of English speakers live in rural areas (outside of Sherbrooke, Magog, and Granby).

Table 1
Number, proportion, and distribution of non-immigrants whose language spoken most often at home is English, Québec, Estrie and RLS, 2011

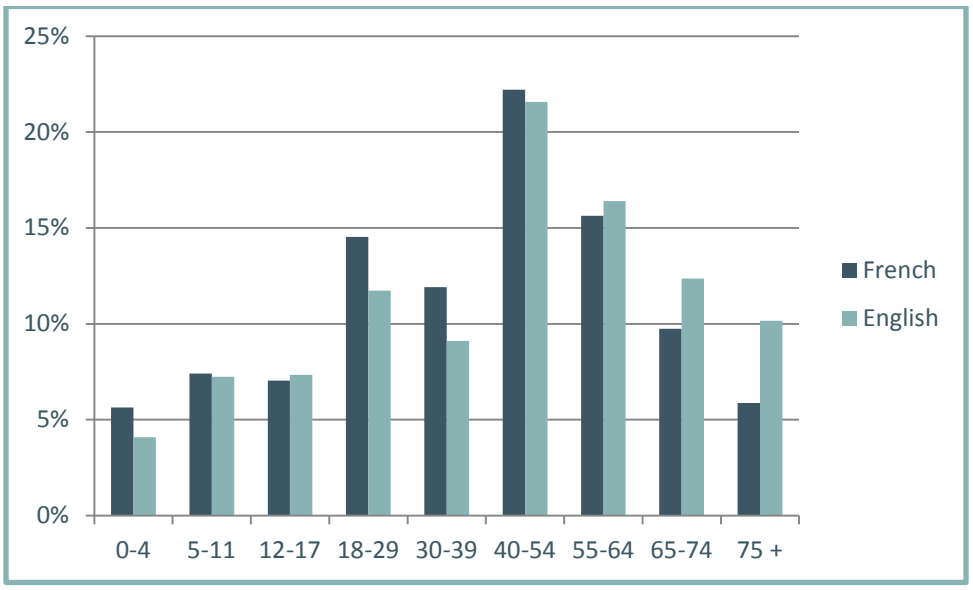
Local services network (RLS)	Number	Proportion of English speakers[1] (%)	Distribution of English speakers[1] in Estrie (%)
La Pommeraie	10,435	20.9	32.3
La Haute-Yamaska	2,645	2.9	8.2
Memphrémagog	7,075	15.0	21.9
Coaticook	1,810	9.8	5.6
Sherbrooke	5,805	3.9	18.0
Val Saint-François	1,950	6.7	6.0
Asbestos	380	2.7	1.2
Haut-Saint-François	2,065	9.6	6.4
Granit	120	0.6	0.4
Estrie	32,290	7.3	100
Québec	752,355	10.0	---

Source: Statistics Canada, Census, 2011

1: Language spoken most often at home = English (single response)

The English-speaking population is older than the French-speaking population of the region. The median age of English speakers is 48.1 years whereas that of French speakers is 43 years. The English-speaking community in Estrie is also older than the English-speaking population of Québec in general (39.5 years). In Estrie, 22.5% of the English-speaking population is aged 65 years and older (compared to 15.6% for French speakers; Figure 2). Young English-speaking adults aged 18 to 39 years are proportionately less numerous than French-speakers in the same age category.

Figure 2
Population age structure according to language most often spoken at home, Estrie, 2011



Source: Statistics Canada, Census, 2011.

The demographic structure of the English-speaking population in Estrie, characterized by an overrepresentation of seniors and an underrepresentation of young adults, affects the vitality of the community according to some community actors. In fact, the emigration of the English-speaking population to other Canadian regions was quite significant between 1976 and 1986. This phenomenon continues, but at a slower rate. Even today, a significant proportion of young English speakers leave the region, and they tend to be those most likely to have attained the university level and to be financially well off.[4] In contrast, as described in the paragraphs which follow, those who remain exhibit more significant signs of socioeconomic vulnerability.

FAMILIES AND YOUNG CHILDREN

In Estrie, there are approximately 1,300 English speakers aged 0 to 4 years.[5] In 2014, 224 children were born of an English-speaking mother (non-immigrant) in Estrie, which constitutes 4.8% of all births.[6] No difference in the proportion of premature and low-weight births was noted according to the language spoken at home. However, there were significant differences in certain health determinants. In particular, over the period of 2010-2014 in Estrie:

- 6.1% of English-speaking mothers were aged 19 years or less when they gave birth (compared to 2.9% for French speakers).
- 11.5% of English-speaking mothers had completed less than eleven years of education (no high school diploma) when they gave birth (compared to 8.8% for French speakers).

These results are different from the provincial data because, in Québec, the proportion of very young mothers is similar according to language used (approximately 3%), and English-speaking mothers exhibit an advantage in educational attainment (less than eleven years of education: 4.8% among English speakers and 7.3% among French speakers).

Childhood development in kindergarten

In 2012, the *Québec Survey of Child Development in Kindergarten* (QSCDK) measured the proportion of vulnerable children in various domains of development. When the data is cross-tabulated according to the mother tongue of the child (Table 2), we find that:

- Children in Estrie who have English (but not French) as a mother tongue are proportionately more likely to have a vulnerability than children who have at least French as a mother tongue and this, in every domain of development.
- The proportion of English-speaking children in Estrie who have a vulnerability is greater than that of their counterparts in the rest of Québec, and that, in every domain of development.

Table 2
Proportion of children who are vulnerable by mother tongue, Québec and Estrie, 2012

	Québec			Estrie		
	At least French (%)	English, but not French (%)	Difference by language	At least French (%)	English, but not French (%)	Difference by language
Physical health and well-being	8.6	12.8	Yes	8.9	23.6 (+)	Yes
Social skills	8.6	10.6	Yes	9.2	20.1 (+)	Yes
Emotional maturity	9.7	9.7	No	10.0	15.9 (+)	Yes
Cognitive and language development	9.3	10.6	Yes	9.8	17.1 (+)	Yes
Communication abilities and general knowledge	7.8	19.2	Yes	7.7	26.4 (+)	Yes
Vulnerability in at least 1 area	23.2	32.8	Yes	24.7	46.1 (+)	Yes

(+): Significant difference (0.05 threshold) between Estrie and Québec within the same linguistic subgroup.

Source: *Institut de la statistique du Québec. Special compilation of the data of the* Québec Survey of Child Development in Kindergarten *(QSCDK), 2012.*

In Estrie, nearly one out of every two English-speaking children has a vulnerability in at least one domain of development, which is nearly twice as many as among French speakers. It is possible to show the results by local services network (RLS) in the territories which have the largest English-speaking communities. Here is the percentage of children who are vulnerable in at least one domain respectively among English speakers and French speakers in the territories in which English speakers are the most numerous:

- La Pommeraie: 48.9% vs. 24.8%
- Memphrémagog: 51.0 % vs. 28.6 %
- Sherbrooke: 55.5% vs. 22.3%

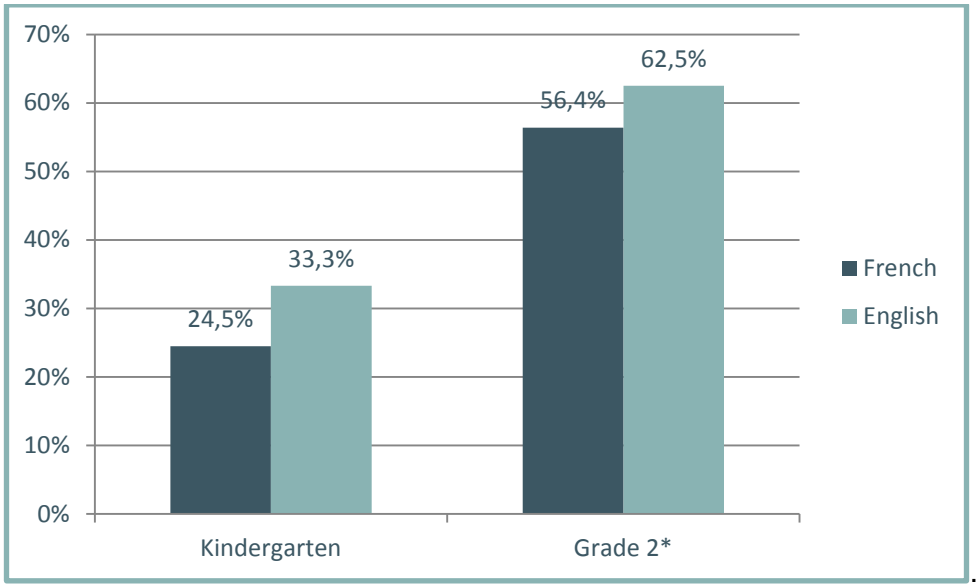
The association between a higher proportion of vulnerable children in at least one domain of development and the English language as a mother tongue is demonstrated at the provincial level.[7] The analysis of the Québec data of the QSCDK also sheds light on other characteristics associated with vulnerability in kindergarten: being a boy, being among the youngest in the cohort, and being born outside of Canada.

The QSCDK finally highlights two other elements linked to vulnerability: regular non-attendance of a childcare service before entering school, and material and social deprivation. The QSCDK makes it possible to obtain these characteristics according to mother tongue at the provincial level only, but it is possible to make approximations with the characteristics of the students of the Eastern Townships School Board. The proportion of disadvantaged schools in the ETSB (which reflects deprivation within the territory of the school) is similar to that of schools throughout Québec (31%). However, childcare service attendance before school is significantly lower for the client groups of the ETSB (32.8%) than in Québec (80.9%) and in the French school boards in Estrie (between 73.3 and 88.6%).[8] These findings may constitute hypotheses which could explain the vulnerability of English-speaking children in Estrie.

Oral health

In Estrie, children registered in kindergarten and in grade 2 benefit from screening for dental caries by a dental hygienist. Screening results are compiled and it is possible to cross-reference them with the language of instruction. As shown in Figure 3, students attending English schools have a higher incidence of dental caries than those attending French schools.

Figure 3
Children who have had dental caries by language of instruction, Estrie, April 1, 2011, to March 31, 2016 (5 years)



*The data exclude the RLS de la Haute-Yamaska and de la Pommeraie
Source: I-CLSC

A regional publication[9] provides the main risk factors associated with dental caries: availability of fluorides, eating and oral hygiene habits, the use of health services, and socio-economic status. Survey data among high school students and adults do not reveal any differences in tooth brushing, flossing, or the consultation of a dentist by language in Estrie.[10, 11, 12] However, as shown in the following paragraphs, English speakers exhibit differences in eating habits and socio-economic status.

ADOLESCENTS

Lifestyle habits and physical health

Many differences in eating habits have been observed among high school students according to language of instruction (Table 3). In Estrie, the students in English schools compare unfavourably to those attending French schools as regards the consumption of sweetened beverages, salty snacks, sweets, breakfast each morning, and junk food at the restaurant. Another interesting fact: French-speaking students in Estrie compare favourably to French-speaking students in Québec in three of the four food and nutrition indicators. That advantage is not present among students attending school in English.

As regards alcohol consumption, fewer students in Québec's English-language school network have consumed alcohol at least once in their lives (57.2% vs. 63.3%) and they are less likely to have consumed alcohol excessively over the past twelve months (33.3% vs. 42.0%). In Estrie, there is no such difference. English-speaking students consume alcohol at levels that are quite similar to those of their French counterparts (66.2% for alcohol use in lifetime and 45.3% for excessive use). No difference by language is noted as regards tobacco or drug use.

As regards sexual health, students aged 14 years and older who attend English schools in Estrie are more numerous to have reported having had sexual relations (43.0%) than did English-speaking students in the province generally (32.3%). French-speaking students in Estrie are no different from those in Québec in this matter (approximately 37%).

Table 3 Lifestyle habits and behaviours by language of instruction among high school students, Estrie, 2010-2011

	Québec			Estrie		
	French (%)	English (%)	Difference by language	French (%)	English (%)	Difference by language
Eating habits						
Consume at least one sweetened beverage, salty snack or sweet daily	30.0	32.6	Yes	23.9-	32.5	Yes
Generally consume the minimum serving of fruits and vegetables	33.5	27.9	Yes	34.3	28.0	No
Ate breakfast every morning over the past school week	60.6	52.6	Yes	65.3 (+)	52.7	Yes
Consume junk food at a restaurant or snack bar 2 times/week or +	19.5	26.1	Yes	14.6(-)	22.6	Yes
Physical Activity						
Proportion of sedentary students	23.9	23.9	No	24.4	23.5	No
Weight						
Overweight	20.5	24.9	Yes	19.0	21.6	No
Tobacco, drugs, alcohol						
Proportion of smokers	7.0	6.1	No	6.4	8.6	No
Alcohol consumption in lifetime	63.3	57.2	Yes	66.2	66.2	No
Excessive alcohol use within the past twelve months	42.0	33.3	Yes	45.1	45.3	No
Drug use in lifetime	27.4	25.1	No	28.8	30.3	No
Sexuality						
Students aged 14 years and older who have had at least one sexual relation	37.7	32.3	Yes	37.7	43.0 (+)	No
Students aged 14 years and older who have used a condom during their last sexual relation	67.9	71.5	No	65.6	63.5	No

(+)/(-): significant difference (0.05 threshold) between Estrie and Québec within the same linguistic subgroup

Source: Institut de la statistique du Québec. Québec Health Survey of High School Students, 2010-2011.

Mental health and well-being

Nearly twice as many students attending English schools than those French schools reported having been victims of violence (at school and on the way to school) or of cyberbullying. That difference is present at both the provincial and regional levels. At the same time, English-speaking students compare unfavourably to French-speaking students in many personal skills indicators in Québec and in Estrie (Table 4). In Estrie, the situation of English-speaking students is unfavourable for the two following indicators: problem solving and elevated psychological distress.

As regards the diagnoses of mental disorders, the prevalence of anxiety, depression, and eating disorders is higher among young English speakers than among French speakers in Québec, but not in Estrie. The reverse occurs for attention deficit disorder with or without hyperactivity (ADHD): young French speakers report more diagnoses and medication use to calm down or to focus than English speakers. In Estrie, the prevalence of ADHD is 17.2% among students in the French network whereas it is 11.2% among students who attend school in English. A difference of five percentage points is also present in medication use. It should be remembered that these are diagnosed disorders and, consequently, access to services has an influence on their prevalence.

Table 4
Bullying, personal skills and diagnosed mental disorders by language of instruction, Estrie, 2010-2011

	Québec			Estrie		
	French (%)	English (%)	Difference by language	French (%)	English (%)	Difference by language
Bullying						
Victims of violence at school or on the way to school or of cyberbullying	34.3	57.2	Yes	35.1	59.8	Yes
Personal skills						
High level of general self-efficacy	29.0	24.0	Yes	29.9	26.7	No
High level of problem-solving skills	32.3	25.2	Yes	34.9	28.2	Yes
Low self-esteem	18.3	22.9	Yes	19.1	22.4	No
Elevated psychological distress	20.4	24.1	Yes	19.9	27.3	Yes
Diagnosed mental disorders						
Medical diagnosis: anxiety, depression or eating disorder	11.6	15.0	Yes	12.0	13.5	No
Medical diagnosis: attention deficit with or without hyperactivity	12.9	10.3	Yes	17.1 (+)	11.2	Yes
Medication use to calm down or to focus (past two weeks)	8.3	4.5	Yes	12.1 (+)	7.5	Yes

(+)/(-): significant difference (0.05 threshold) between Estrie and Québec within the same linguistic subgroup

Source: Institut de la statistique du Québec. Québec Health Survey of High School Students, 2010-2011.

What the partners think

The English education partners would first like it to be recognized that the majority of English-speaking students do succeed quite well. However, these partners acknowledge that there are learning, stimulation, and academic success problems at the level of primary and secondary institutions within the English network. To explain this finding, they advance a series of hypotheses:

(1) The socio-economic situation of the English-speaking community in Estrie is less stellar than that of French speakers. The mean age is higher, and young educated English-speaking adults tend to leave the region to find work outside the province or country. Yet the academic success of children often depends on the education and socio-economic level of the mother. In fact, it is mainly the mother who gives her children a taste for school, notably through reading or early childhood stimulation exercises.

(2) There is no childcare center intended specifically to serve English speakers in Estrie. Evidently, many English-speaking children attend quality childcare services in a French-speaking environment. However, some parents prefer that their children be educated in their mother tongue and make arrangements accordingly. The educational strategy conceived by the parents is often successful, but sometimes, that strategy fails to generate the intended results. Thus, youth who would require more specialized education services start kindergarten with difficulties in one or more domains of development. It appears that this phenomenon is more frequent in rural areas.

(3) In a context of vulnerability, people want to communicate in their mother tongue. Yet health and social services in Estrie are mainly provided in French. This linguistic reality results in members of the English-speaking community using fewer services. If that is true for adults, then it is also true for children who have speech therapy and remedial education needs.

(4) There are services for the English-speaking community, but there are gaps in the alignment of the services offered with the needs of the community. It should not be imagined that all services must be provided in English. However, there needs to be adequate communication with persons belonging to the English-speaking community. For now, there are still disparities in this matter. The community therefore closes in upon itself and informal mutual assistance networks develop. While some informal networks are excellent, others are of lesser quality. Children with special needs may thus not have their needs met.

Interview with Mr. Christian Provencher, Director General of the Eastern Townships School Board, August 31, 2016.

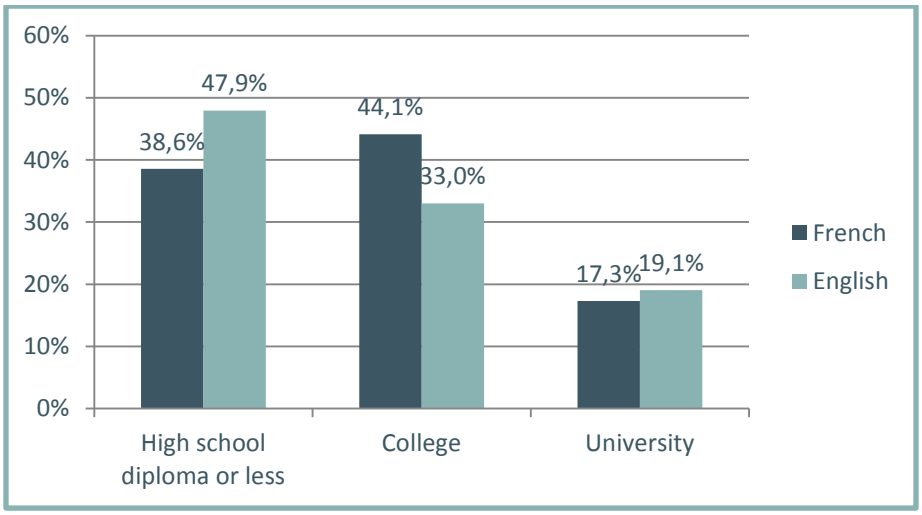
ADULTS

Socio-economic characteristics

In Estrie, nearly 50% of English speakers aged 25 to 64 have an educational attainment equivalent to or less than a high school diploma (DES). This proportion is greater than that observed among French speakers in

Estrie (38.6%) and English speakers in the rest of the province (32.2%). The local services networks (RLS) of Memphrémagog and of Coaticook compare unfavourably in this matter, the proportion of English speakers with low educational attainment (DES or less) being respectively 57.3% and 56.0%. French speakers are more likely than their English counterparts to have attained the college level (44.1% vs. 33.0%). As regards the population which has attained university level, there is no difference by language spoken in Estrie.

Figure 4
Highest educational attainment among 25-64 years old by language spoken most often at home, Estrie, 2011



Source: Statistics Canada. National Household Survey, 2011.

At the time of the 2011 census, the unemployment rate was slightly higher among the English-speaking community (6.9%) than among French speakers (4.8%) in Estrie. A similar difference was observed province-wide. The unemployment rate was approximately 8% among English speakers at the three following territories: La Pommeraie, La Haute-Yamaska and Memphrémagog.

In Estrie as in Québec, there are more English speakers than French speakers in the low-income bracket among those aged 18 to 64 years (22.4% vs. 15.5% in Estrie). This may be attributable to the lower educational attainment and to the higher unemployment rate among English-speaking adults compared to French speakers in the region. Among seniors, the trend is reversed and becomes less apparent in Estrie. When observing the net median income (after taxes) of people aged 15 years and older, it is practically identical to both French and English speakers in Québec; however, in Estrie, French speakers are advantaged compared to English speakers. Just as with low income, the median income after taxes among seniors is higher among English speakers than French speakers in Estrie and Québec, although the difference is much less pronounced in Estrie.

Table 5
Low income and median income by language spoken most often at home, Estrie and Québec, 2010

	Québec		Estrie	
	French	English	French	English
Low income in 2010 based on low-income measure (18-64 years)	14.1%	17.6%	15.5%	22.4%
Low income in 2010 based on low-income measure (65 years or +)	20.3 %	15.6 %	20.1 %	21.1 %
Median income after taxes in 2010 (15 years or +)	$26,530	$26,185	$24,798	$21,658
Median income after taxes in 2010 (65 years or +)	$20,258	$24,496	$19,798	$20,763

Source: Statistics Canada. National Household Survey, 2011.

Lifestyle habits and chronic diseases

Adult English speakers in Estrie are more likely than French speakers to smoke, less likely to consume five fruits and vegetables daily, and more likely to engage in excessive alcohol use. It is worth remembering that the eating habits of English-speaking adolescents also compared unfavourably. However, English-speaking adults are more likely than French speakers to do more than thirty minutes of exercise per day. As regards chronic diseases, the prevalence of hypertension is greater among English speakers (23.6% vs. 17.1%) as is the percentage of the population which suffers from at least one chronic disease (30.9% vs. 37.9%). However, this is attributable to the fact that the English-speaking population is older. When the rates are adjusted for age, the differences disappear. It should be noted that English speakers are more likely than their French-speaking counterparts to report backache (21.0% vs. 17.1%). As for body weight, more English speakers are obese (25.0% vs. 21.0%). Finally, it is interesting to note that 21.8% of English speakers describe their health status as fair or poor compared to 13.6% for French speakers.

Table 6
Prevalence of lifestyle habits, alcohol and drug use, and chronic diseases by language spoken most often at home among non-immigrant adults, Estrie, 2014-2015

	Language spoken most often		Difference by language
	French (n=9 456) (%)	English (n=623) (%)	
Lifestyle habits			
Tobacco use	16.5	19.6	Yes
Less than 30 minutes of physical activity daily	32.7	20.9	Yes
Less than 5 fruits or vegetables daily	56.3	61.8	Yes
At least one unhealthy lifestyle habit	70.9	62.9	Yes
Drugs and alcohol			
Drug use over the past year	12.1	14.0	No
Excessive alcohol use (5 glasses or more) once a week or more	10.1	13.5	Yes
Reported chronic physical diseases			
Asthma	6.7	7.1	No
Hypertension	17.7	23.6	Yes
Chronic obstructive pulmonary disease (COPD)	3.4	3.0	No
Diabetes	7.3	8.8	No
Heart disease	6.4	8.2	No
Cancer	2.3	2.9	No
At least one chronic physical disease	30.9	37.9	Yes
Other reported health problems			
Health perception (fair/poor)	13.6	21.8	Yes
Excess weight (BMI of 25 or above)	55.3	55.7	No
Obesity (BMI of 30 or above)	21.0	25.0	Yes
Back pain	17.1	21.0	Yes

Source: Direction de santé publique de l'Estrie. Enquête de santé populationnelle estrienne, 2014-2015.

As regards the themes of lifestyle habits and chronic diseases, the data was drawn from a regional survey, and there is no provincial comparison. However, data from other surveys show similar results to those obtained in Estrie.[13] In fact, English speakers eat fewer fruits and vegetables, and are more likely to be overweight, but are less sedentary than French speakers.

Moreover, the regional data of the 2011 National Household Survey (NHS)[14] indicate that 15.3% of English speakers aged less than 65 years and 45.5% of English speakers aged 65 years and older have a disability (difficulty with seeing, hearing, communication, and mobility), which is a higher proportion than that observed among French speakers (respectively 10.1% and 34.4%).

Mental health and well-being

The mental health and well-being of English speakers presents a mixed picture. English speakers are slightly more likely than French speakers to exhibit optimal mental health and to have a strong sense of belonging to the local community, two protective factors associated with higher levels of well-being. However, if rates are adjusted for age, no difference is observed within both language groups (both these elements are more frequent among seniors). As regards the indicators of mental disorders, psychological distress is less frequent among English speakers and this difference is particularly pronounced among seniors. The presence of depressive symptoms is more frequent among English speakers, and particularly among those aged 18-64 years. Finally, approximately 10% of the population has received a diagnosis of mood disorder or anxiety disorder, regardless of the language spoken most often at home.

Table 7
Indicators of mental disorders and of well-being according to language spoken most often at home by non-immigrant adults, Estrie, 2014-2015

	Language spoken most often		Difference by language
	French (n=9 456) **(%)**	**English** (n=623) **(%)**	
Indicators of well-being			
Most days are quite a bit or extremely stressful	20.3	21.1	No
Optimal positive mental health (decile 10)	9.7	12.4	Yes
Strong resilience (highest quartile)	22.3	25.2	No
Strong sense of belonging to the local community	57.0	64.7	Yes
Indicators of mental disorders			
Elevated psychological distress (quintile)	24.7	19.9	Yes
Depressive symptoms lasting two weeks or more	13.8	17.4	Yes
Anxiety disorders	7.3	6.1	No
Mood disorders	6.3	6.9	No
Anxiety or mood disorders	10.9	10.9	No

Source: Direction de santé publique de l'Estrie. Enquête de santé populationnelle estrienne, 2014-2015.

Health services

In Estrie, 86.0% of English speakers have a family physician (compared to 82.2% for French speakers). English speakers are also more likely to have consulted a family physician over the past year (76.4% vs. 72.4% for French speakers). However, when these results are adjusted to control for the effect of age, these differences disappear. For other types of health professionals, there are differences by language spoken (even when the age structure is taken into consideration). English speakers have consulted the following health professionals less frequently than French speakers over the past year:

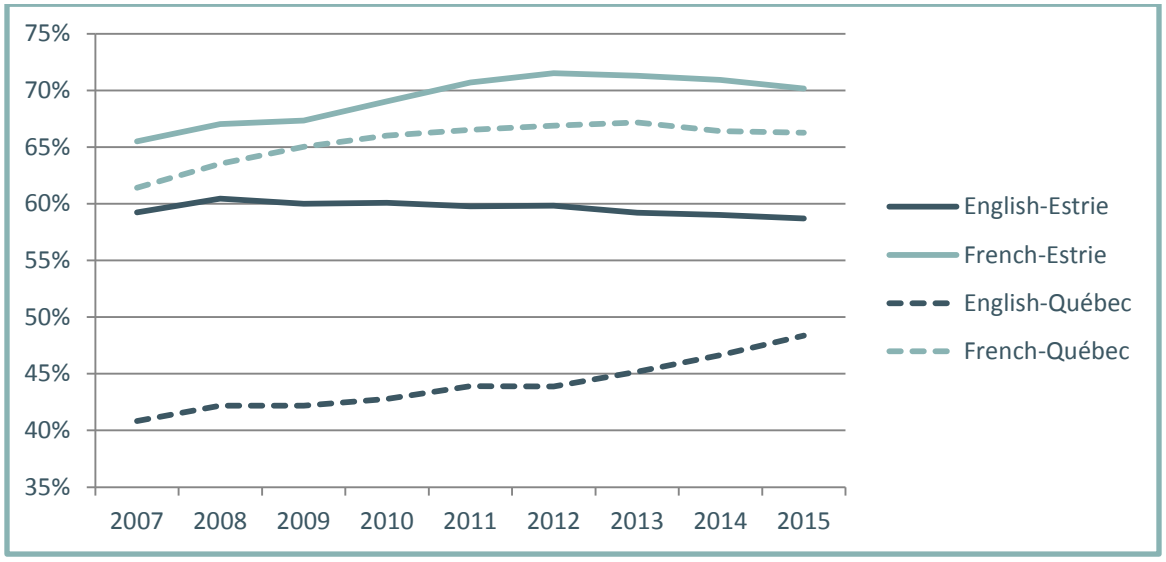
- Kinesiologist (3.4% vs. 6.7%)
- Pharmacist (57.5% vs. 66.2%)
- Psychologist or social worker (7.5% vs. 11.0%).

In Québec, 75.5% of English speakers and 80.3% of French speakers report having seen a family physician[15] and approximately 12.0% of English speakers and French speakers have consulted a social services professional over the past year.[16]

A survey of 293 English speakers in Estrie in 2015-2016, covered, among other subjects, the language in which services are received during consultations in the health network.[17] Thus, 73.0% of respondents were served in English by their family physician: 60.6% at the CLSC; 52.1% by Info-Santé; and 48.0% during a visit to the emergency room or an outpatient clinic, or during hospitalization.

Within the framework of the *Québec Breast Cancer Screening Program* (QBCSP), women aged 50 to 69 years are invited to take a mammography exam every two years. In 2015, more than 4,800 English-speaking women were invited to take this examination at one of the six designated screening centres in our region. At both the regional and provincial levels, English-speaking women participate less than French-speaking women with, in Estrie, participation rates of 58.7% and 70.2% respectively. The participation of English-speaking women in Estrie is nonetheless significantly higher than those of English-speaking women in the rest of the province (48.0%). However, the rate is stabilizing in Estrie (as much for the region as for each of its territories) while it is on the rise in the rest of Québec.

Figure 5
QBCSP participation rates by language of correspondence, Estrie and Québec, 2007 to 2015



Source: *Institut national de santé publique du Québec. Système d'information du PQDCS (SI-PQDCS). Extracted on April 19, 2016 from the INSPQ Infocentre. Indicator last updated on June 22, 2016.*

It is not easy to understand why English-speaking women participate less in breast cancer screening than French-speaking women. Among the potential explanatory elements to consider are factors which more globally influence the participation of women.[18, 19] These include: lack of knowledge of the language, lack of access to primary care, lack of information, the geographic accessibility of screening centres, recent immigration, and socio-economic variables such as low income, low educational attainment, not being married, and the unemployment. A study led in 2011 in Estrie regarding the participation and satisfaction of women who participated in the QBCSP[20] sheds light on certain factors also found in the literature such as a lack of awareness about breast cancer, its risk factors, and the benefits of screening; negative attitudes towards mammography exams (including various fears and anxiety); and lack of_awareness of services offered by the QBCSP (including the guarantee of a medical follow-up of the results regardless of whether women have an attending physician). Other further incentives include having a close friend or relative who has breast cancer, the presence of symptoms, as well as a very important factor – the presence of an attending physician and the latter's prescription for breast screening.

What the partners think

To improve access to local social services and health services among rural English speakers, the Massawippi Valley Health Centre, a local health cooperative, was opened in the municipality of Ayer's Cliff in April 2015. Since its opening, this health cooperative has helped to provide more than 3,000 medical consultations, as well as a variety of services offered by nurses, podiatrists, physiotherapists, psychotherapists, and naturopaths. The Massawippi Valley Health Centre enables all citizens (for a monthly fee of $8.70) to have access to local social services and health services in English. This local cooperative currently has 1,600 members (being unable to welcome more as demonstrated by its waiting list). The required monthly fees are used to cover a portion of the operating expenses of the cooperative such as rent, equipment, materials, and the salaries of the nurses, secretaries, administrators, and maintenance staff. Two general practitioners together work two-and-a-half days per week at the cooperative. This supply of local services responds to the needs of the citizens of Ayer's Cliff who admit unequivocally that they would not consult if they had to go elsewhere in Estrie to receive the same services.

Certain legislative requirements which arose from the reform of the health and social services network appear to diminish the provision of local services. For example, since the adoption of Bill 20, general practitioners in Québec will be required to respect a patient quota that is much higher than the one that is currently in effect in order to avoid being penalized financially. General practitioners are thereby more likely to think twice before providing local services in rural areas. The rural English-speaking communities which until then were mobilized to meet their local needs now fear that their health cooperative will need to be closed and that their access to services will deteriorate.

Interview with Mr. Alec Van Zuiden (Mayor of Ayer's Cliff) and Ms. Ghislaine Poulin-Doherty (Director General of the Massawippi Valley Health Centre) held on June 29, 2016.

LIFE EXPECTANCY AND MORTALITY

At the provincial level, a study confirms the advantage of English-speaking men and women for many avoidable causes of death for the periods of 1990-1994 and of 2005-2007.[21] However, these differences are diminishing over time. For the period from 2005 to 2011, the life expectancy at birth of English speakers remains greater than that of French speakers in Québec (excluding Estrie) for both men and women. In Estrie, life expectancy is greater for English-speaking men (80.4 years) than French-speaking men (78.6 years), but there is no difference for women. Moreover, French-speakers in Estrie have a greater life expectancy than francophone Quebecers both for men and women. English speakers in Estrie do not have this advantage.

Table 8
Life expectancy at birth and at 65 years by language spoken at home, Estrie and the rest of Québec, 2005-2011

	Rest of Québec			Estrie		
	French	English	Difference by language	French	English	Difference by language
Life expectancy at birth						
Men	77.8	79.7	Yes	78.6 (+)	80.4	Yes
Women	82.5	83.9	Yes	83.6 (+)	83.8	No

Source: *Ministère de la Santé et des Services sociaux. Deaths files, 2005 to 2011*
Statistics Canada. Census, 2006 and 2011.
Institut de la statistique du Québec. Population estimates, 2008

FOCUS GROUPS

Two focus groups (total of 21 participants, group descriptions in Appendix D) were held with English speakers in Estrie who live in the local services networks of Sherbrooke, Memphrémagog, La Pommeraie, and Val Saint-François. The groups were invited to express their health needs and social needs as well as to discuss their experiences with the health and social services network. Methodology details are found in Appendix B. The themes addressed during the discussions were grouped into five dimensions, which facilitated the articulation of the discourse of the English-speaking community in Estrie.

Health is multifactorial

Those who participated in the focus groups agree on a global vision of health. In conformity with the 1948 definition of the World Health Organization (WHO), English speakers state that the meaning of health goes well beyond the absence of disease or disability.

- *Health is not just one aspect. It is, at one and the same time, our emotional, physical, mental and spiritual state.*
- *Health is a package, a sense of well-being. It is much more than the absence of disease. It is the result of social conditions and of many experiences.*

A lack of accessibility in the supply of health and social services

Access to services is a major topic among the participants of the focus groups. Numerous English speakers who were met mentioned lack of accessibility in the supply of health and social services. They noted repeatedly the importance and difficulty in gaining access to a family physician locally, near their

residence. For these English speakers, local services carry a particular meaning. As many English speakers often live in small, "tightly knit" local communities, the social bonds which they develop and maintain with their fellow citizens are meaningful. These quality social bonds undoubtedly influence the need to have access to local health and social services.

- *My husband has had a heart condition for the last three to four years. Still no GP.*
- *When I moved here, I worked the phone for months and months and months [to find a doctor].*

Without a family physician to lead the way, gaining access to the health and social services system seems difficult for the participants. They acknowledge that French speakers share this problem. That said, they seem to find it hard to experience this reality.

- *As an English minority, we are disadvantaged in access to services. The services that are already thin on the ground are even thinner on the ground for us.*
- *The real big thing is to get into the system.*

One consequence of lack of access is an increase in the use of private services.

- *When I needed a physiotherapist or a psychologist, I went to the private sector, because I would still be waiting for the hospital to call me.*

Another consequence is psychological distress among some citizens who feel abandoned and who do not know how to deal with the situation.

- *It's fine to say that you've been on the list at Magog for five years, but in the meantime, what do you do? It's very distressing to hear that.*
- *If you are on a waiting list for two years, you put your life on hold all this time.*

Furthermore, the lack of access to services is exacerbated by the geographic situation of the citizens interviewed.

- *They tend to centralize everything. We're putting everything in a giant building in Sherbrooke for a 100-mile radius. If you live 80 miles away, then you're unlucky, because you don't have anywhere to go unless you get in your car and drive an hour or an hour and a half to Sherbrooke.*
- *Especially in rural communities, if you don't have a car, it is too bad for you.*

Cultural and linguistic barriers

The issue of access to services in English was also stated. The English speakers who were met described situations in which health and social services professionals showed a lack of knowledge of English. The participants emphasized the importance of communicating in one's mother tongue when placed in a situation of vulnerability.

- *Our French may be good, but when it comes to our health, we want to understand every single little thing.*
- *People who are bilingual often lose that second language as they age.*
- *When you're in a crisis situation, you revert to your mother tongue even though you are usually bilingual.*

Along the same line of thinking, it is difficult to access documents in English. The lack of written resources in English is experienced as an injustice.

- *They only had "Mieux vivre avec ton enfant" in French.*
- *Go to the website: not a single page in English, not a single link in English, none of the documentation in English. It's ridiculous!*

The importance of communicating in one's mother tongue is even stronger among seniors. The participants denounce the lack of health institutions dedicated to English-speaking seniors (despite the aging population).

- *There's only one recognized CHSLD, and there are two other homes for seniors that have an English mission. But outside of that, there's no option in Sherbrooke. And our population is not getting any younger.*

These language barriers generate anxiety, insecurity, distress, and plenty of frustration among the English speakers interviewed.

- *The language barrier makes everything more dramatic, more upsetting, and more stressful.*
- *One nurse came and gave me a pill. She didn't speak a word of English. I tried to talk to her, but she didn't understand anything. She gave me one pill and left. And that's all I had for 28 hours. I didn't see anyone. Nobody came to talk to me. I was stressed out. I couldn't sleep. I had no idea what was going on. I called my husband and asked him to come and get me out. I'm so scared, I don't know what's going on.*

The citizens consulted would appreciate it if professionals within the network had a certain level of cultural competency. Some said they had experienced language discrimination or cultural discrimination as the culture is different from that of the French-speaking community.

- *At the end of the day, it leaves people feeling like they're second-class citizens because of their language and their thoughts.*
- *It's the first time in my entire life I've ever felt like a second-class citizen, that I wasn't important.*

To overcome these barriers, the participants would like to benefit from the services of a translator. Others show an interest in learning and perfecting their French, but the requisite administrative hurdles block their attempts. It was even mentioned that the cost of French lessons is reimbursed for immigrants but not for English speakers.

- *These courses are available to newcomers, which is great, but they should be available to newcomers coming from within Canada. It just makes sense for everybody to learn French and to be able to interact with the whole society.*

A need for support and guidance

Participants in the focus groups mentioned that it is difficult to navigate the health and social services network. This problem is even truer for newcomers. The need for support and guidance to better navigate the system was cited.

- *When I came here, I had no idea where to go. I didn't know what a CLSC was. It would have been nice if there had been accessible information about Townshippers or any community organisations. Then I could have been connected.*
- *I'm frustrated, because I don't know where to go with that particular problem.*

Due to their geographic location, rural English speakers say they feel the effects of the lack of support more acutely. There is a desire for rural liaison officers and access to local services.

- *We made the suggestion for a pilot-nurse. And that's it! It died. It never got further. For all kinds of services, this kind of attitude, to me, would make a lot of sense, because those services are available in a centralized location. And people know about it. And there are professionals. But they don't relate back out into the community. And if the people that are affected in the community had somebody that they could relate to, who really cared about it, and could help them, I think a pilot-nurse would help a lot.*

Inadequate supply of services for the needs of the community

For the participants, the supply of health and social services is not adapted to the needs of their community. This discrepancy is amplified within the current context of the restructuring of the health care and social services system. The English speakers interviewed would like the population to be consulted before changes to service provision are implemented.

- *Before dividing up territories, they should ask for some input, because geographically and culture wise, we don't just get all chopped up and end up being in a group areas…*

The discourse held by the participants finally brings out the needs which are not sufficiently heard or fulfilled. For example, disease prevention and health promotion are important concerns among those interviewed, and they find that the services provided in that area are insufficient. A better articulation of the regional supply of services with community organizations also appears to be desired.

- *We do not feel like preventative health messages are tailored to our English community.*
- *There's many out there non-governmental institutions that can help and should be included in those other services.*

The community mobilizes

Since 2012, Phelps Helps in Stanstead has been offering one-on-one tutoring and help with homework twice a week in order to prevent students from dropping out. In 2015-2016, 28 primary school and 19 high school students benefited from this free program. A calm, safe, stimulating environment allows youth to develop a positive attitude and independence in learning. Participation is voluntary and there are no selection criteria. This program is funded through private donations, fund raisers, and the municipalities of Stanstead and Ogden. The tutors are volunteers.

The 2014-2015 results show that no participant dropped out of school and that 66% of participants improved their overall average. In addition, a 48% increase was noted among youth who believe they are capable of completing high school after participating in Phelps Helps.

Among the difficulties encountered, Ms. Katie Lowry, the project coordinator, noted that recruiting is more difficult among high school students. A summer camp as well as a mentoring program for students in grades 5 and 6 was set up in order to increase the sense of belonging to Phelps Helps and to increase high-school student retention. Another important issue is transportation. In order to encourage youth participation, ETSB school buses make a stop in front of the facilities of Phelps Helps, and Stanstead's R.-H. Rediker volunteer action centre offers a drive-home service to youth following the activity if their parents are unable to pick them up.

Phelps Helps is a fine example of community mobilization to encourage the academic success of English-speaking youth in the Stanstead region.

Written in collaboration with Ms. Katie Lowry, Program Director.

3. THE IMMIGRANT COMMUNITY

According to Statistics Canada, immigrants are "persons residing in Canada who were born outside of Canada, excluding temporary foreign workers, Canadian citizens born outside Canada and those with student or working visas."[22] Approximately 50,000 arrive in Québec each year.[23] Most immigration in Québec and in Estrie is economic. In fact, in 2015, 61.1% of immigrants fell under the economic immigrant class, 21.4% under the family class, while 15.5% were refugees, and 2.0% belonged to other immigrant categories.[24] The global political and economic context influences the origin of immigrants. Between 2011 and 2015, Africa was the birth continent of nearly a third (32.9%) of immigrants; Asia and America followed with 29.6% and 20.8% respectively, whereas 16.5% of immigrants were born in Europe. The five main countries of origin over this period were the following: China, France, Haiti, Algeria, and Morocco.[25] Finally, Estrie welcomes approximately 3% of all immigrants in the province each year, which corresponds to approximately 1,000 people.[26]

POLITICAL AND LEGISLATIVE CONTEXT

There is a distinction between landed immigrants and refugees as regards public health and social services coverage for newcomers. In fact, landed immigrants and refugees are entitled to a medical insurance card, and therefore to free health care and services. However, for landed immigrants, there is a waiting period of three months during which medical expenses are not covered (except for pregnancies, for victims of violence, and for patients who have an infection that could endanger public health). This measure, which does not exist for refugees, may present an obstacle to gaining access to services, particularly in emergency situations. Immigrants who fall under this restriction must purchase private health insurance in order to be covered during this waiting period.[27]

In Québec, the right to access to health services and social services in their own languages for members of the various cultural communities of Québec has been recognized since 1986 in the *Act Respecting Health Services and Social Services.* The act states that the organization of services should "foster, to the extent allowed by the resources, access to health services and social services in their own languages for members of the various cultural communities of Québec."[28] Every institutional board of directors must therefore take this into account when establishing its priorities, strategic orientations, and the organization of the supply of services.[29]

DEMOGRAPHIC CONTEXT

In 2011, there were approximately 20,000 immigrants in Estrie who made up 4.3% of the population. Of that number, 44% were recent immigrants (who arrived between 2001 and 2011). The highest concentration lives in Sherbrooke, where half the immigrant community in Estrie is found, as well as 65% of recent immigrants. The second most important immigration pole in Estrie is the RLS de la Haute-Yamaska (notably in Granby) which has 3,155 immigrants (Table 9), and 20% of recent immigrants. A map of the proportion of immigrants in the 96 communities of Estrie is shown in Appendix C.

Table 9
Number, proportion, and distribution of immigrants, Québec, Estrie and RLS, 2011

Local services network	Number of immigrants	Proportion of immigrants in the total population (%)	Distribution of immigrants in Estrie (%)	Proportion of recent immigrants (10 years) within the immigrant population (%)	Distribution of recent immigrants in Estrie (%)
La Pommeraie	2,095	4.2	11	12.6	3.2
La Haute-Yamaska	3,155	3.4	16.6	53.1	19.9
Memphrémagog	2,135	4.5	11.3	23.7	6.0
Coaticook	560	3.0	3.0	22.3	1.5
Sherbrooke	9,685	6.6	51	56.6	65.3
Val Saint-François	525	1.8	2.8	23.8	1.5
Asbestos	145	1.0	0.8	27.6	0.5
Haut-Saint-François	385	1.8	2.0	19.5	0.9
Granit	290	1.3	1.5	36.2	1.3
Estrie	18,980	4.3	100.0	44.3	100.0
Québec	880,035	11.7	---	38.1	---

Source: Statistics Canada. National Household Survey, 2011.

Generally, new immigrants are younger than people born in Canada.[30] In Estrie, the median age of all immigrants is identical to that of persons born in Canada (43 years). However, it is 31.6 years for those who arrived in Canada between 2001 and 2011, and 53.9 years for those who immigrated before 2001.

FAMILIES AND YOUNG CHILDREN

Among the 25,000 children living in Estrie in 2011 aged 5 years or less, 1.4% were immigrants. In 2014, 439 immigrant women gave birth in the region. The proportion of premature births and low weight at birth are comparable regardless of the place of birth of the mother. The proportion of young mothers (19 years or less) is also similar. However, over the period of 2010-2014, a higher proportion of immigrant women have an educational attainment level of less than 11 years at the time of the birth of their child (12.6% vs. 9.0% for non-immigrant women).

Childhood development in kindergarten

In 2012, the QSCDK made it possible to measure the proportion of children who are vulnerable in various domains of development. Children in Estrie who were born outside of Canada are more vulnerable than children born in Canada in two of the five domains of development: cognitive and language development (23.3% vs. 10.8%), and communication abilities and general knowledge (34.5% vs. 9.1%).

Immigrant children in Estrie also stand out upon examination of one indicator of vulnerability in at least one domain of development. In fact, this finding is worrisome. In Estrie, there is a difference between immigrant children and children born in Canada as regards the proportion of children who are vulnerable in at least one domain of development (44.7% vs. 26.2%), but that difference is also present when this comparison is made with other immigrant children in Québec (44.7% vs. 34.7%).

Table 10
Proportion of vulnerable children by place of birth, Québec and Estrie, 2012

	Québec			Estrie		
	Born in Canada (%)	Born outside of Canada (%)	Difference by place of birth	Born in Canada (%)	Born outside of Canada (%)	Difference by place of birth
Physical health and well-being	9.2	13.6	Yes	10.0	**8.9	No
Social skills	8.8	10.7	Yes	9.8	**5.7	No
Emotional maturity	9.6	10.6	No	10.1	**9.1	No
Cognitive and language development	9.6	14.5	Yes	10.4	23.3	Yes
Communication abilities and general knowledge	9.8	21.2	Yes	9.1	34.5 (+)	Yes
Vulnerability in at least one domain	24.7	34.7	Yes	26.2	44.7	Yes

(+)/(-): significant difference (0.05 threshold) between Estrie and Québec within the same linguistic subgroup
**: Coefficient of variation greater than 25%; imprecise estimate provided for reference purposes only
Source: Institut de la statistique du Québec. Special compilation, 2012.

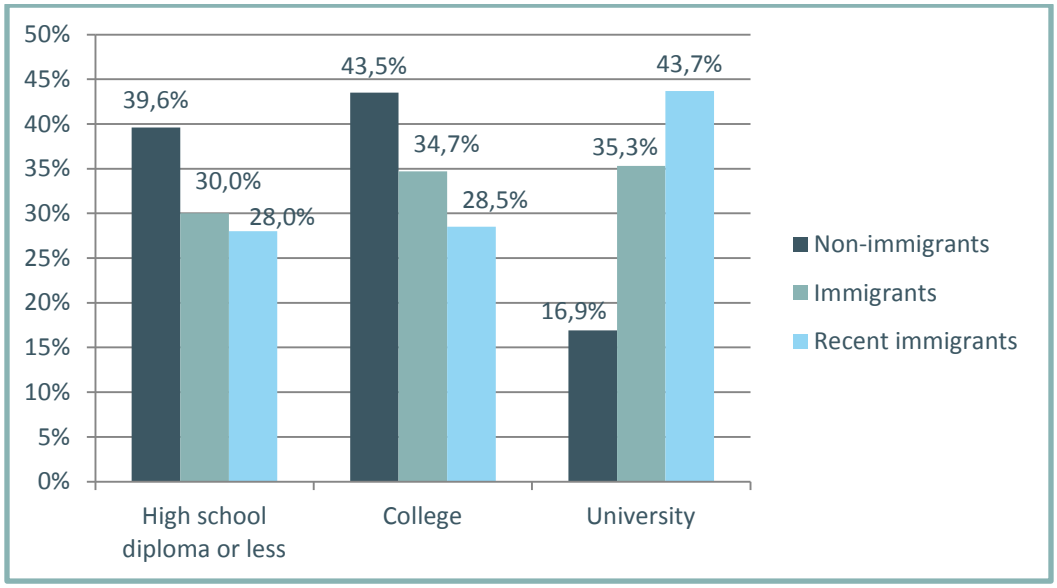
This disadvantage of immigrant children may be related to the migratory experience which, for many immigrant families with young children, is particularly stressful.[31] Children who do not master the language of instruction may also experience difficulty interacting with the teacher and other children in the classroom. They also face further challenges in understanding the instructions and assignments given to them, in communicating their needs, and in participating in classroom activities.[32]

ADULTS

Socio-economic characteristics

In Estrie, educational attainment among immigrants is higher than among those born in Canada (Figure 6). In fact, 35.3% of immigrants have a level of education equivalent to a bachelor's degree whereas this proportion is 16.9% among non-immigrants. The situation is even more favourable among recent immigrants (arrived within the last 10 years) because 43.7% among them have attained a university level of education.

Figure 6
Educational attainment by immigrant status, Estrie, 2011



Source: Statistics Canada. National Household Survey, 2011.

Even if Canadian selection policies favour educated immigrants, their degrees do not guarantee employment in the labour market, in particular for those who have arrived recently. The employment rate of recent immigrants in Estrie (63.0%), in spite of their higher educational attainment, is lower than that of non-immigrants (74.8%) and of immigrants who landed in Canada before 2001 (73.4%).[33] The unemployment rate evidently follows a reverse trend: recent immigrants have an unemployment rate of 11.4% compared to 5.0% within other groups (2011 data). Survey results show that lack of Canadian experience, lack of recognition of foreign degrees, and language difficulties are the main obstacles to immigrants gaining employment during their first years in Canada.[34] In addition, for those who find employment, the job is frequently inferior to what one might expect when considering their skills and level of education.[35]

Consequently, the data show that recent immigrants are highly disadvantaged as regards the different income indicators (Table 11). In fact, they are proportionately more likely to have low incomes, to be renters, and to spend 30% or more of their income on household expenses than Estrie residents born in Canada. Immigrants who arrived in Canada before 2001 exhibit a profile that is similar to or even favourable compared to that of non-immigrants (among seniors). Finally, a higher proportion of immigrants has been observed living in the most materially and socially disadvantaged communities in Estrie than in the most advantaged ones. This phenomenon has been noted on a regional scale (6.6% vs. 3.9%), but more particularly in Sherbrooke (9.9% vs. 4.0%).

Table 11
Income indicators by immigrant status, Estrie, 2011

	Non-immigrants	Immigrants who landed before 2001	Immigrants who landed between 2001 and 2011
Low income in 2010 based on low-income measure (18-64 years)	15.8%	17.8%	38.9%
Low income in 2010 based on low-income measure (65 years +)	20.5%	14.4%	34.8%
Median income after taxes in 2010 (15 years and +)	$24,589	$24,305	$17,482
Median income after taxes in 2010 (65 years and +)	$19,850	$22,436	$10,286
Proportion of renters	28.1%	24.8 %	59.8%
Owners who paid 30% or more of household total income towards shelter costs	10.7%	12.7 %	17.7 %
Renters who paid 30% or more of household total income towards shelter costs	28.5%	29.2 %	37.3 %

Source: Statistics Canada. National Household Survey, 2011.

What the partners think

La Grande Table is a Sherbrooke-based community organization which provides assistance and support services to users in two specific areas. First, food services are offered to persons with low incomes (popular restaurant and lunchbox service at schools). Second, *La Grande Table* offers job search assistance and support services. Within the framework of this second mission, *La Grande Table* wishes to express itself considering that a considerable part of its active job-seeking client base are members of the immigrant community in Estrie.

For *La Grande Table,* there is no doubt that access to employment is more difficult within the immigrant community than in the other communities in Estrie. Yet, what the partners in the field observe is a clientele that is capable and willing to work. Efforts must be made to remedy this situation and to publicly name the "blocking" at the hiring stage which seems to exist among employers. This difficulty in integrating immigrants to the labour market often nourishes a feeling of bitterness. Immigrant communities sometimes feel they are victims of discrimination and the targets of prejudice, especially when they objectively find that they work less than others despite often having a higher level of education.

Cultural difficulties appear to be at the source of this differential access to the labour market. The community partners state that the vision of work of the immigrant communities and of the other communities in Estrie is not the same. Thus, the value placed on the concept of productivity, interpersonal relations, and work climate differs among these communities. Furthermore, language barriers exacerbate cultural differences and may partially explain this "blocking" at the hiring stage.

According to the community partners, employers need to open up more to the immigrant community. Lots of awareness-raising to promote the hiring of immigrants remains to be done. Yet employers must know that the immigrant community is faithful, productive and punctual when hired. To this end, the preferred strategy is to emphasize immigrant success in the workplace. By focusing awareness-raising and intervention efforts on the positive achievements of the immigrant community in Estrie, employers in the region will understand that immigrants are good employees for whom work is often synonymous with pride, but also and above all, a vector of integration into society.

Interview with Ms. Ginette Valcourt (director general of *La Grande Table*) and Ms. Clothilde Stamm (worker at *La Grande Table)* held on September 8, 2016.

Lifestyle habits and chronic diseases

Many studies - Québec, Canadian, and international - mention the healthy immigrant effect.[36, 37] Thus it is observed that recent immigrants are generally in better health than the local population. This phenomenon is attributable, among others, to a selection process which privileges young, healthy and highly educated immigrants who have professional and language skills that enable a better social and economic integration. However, this effect tends to disappear over time. Therefore, even if there are differences which result in not all immigrant groups being equally exposed to this phenomenon, it is found that mortality rates and the prevalence of chronic diseases within this population tend to increase as more time is spent in Canada to finally reach, and sometimes even surpass, those of the host population.[38, 39] The underlying reasons for this decline are complex. Beyond the methodological difficulties associated with studies which examine this phenomenon, many reasons were invoked to explain the following: aging, the adoption of hazardous lifestyles, stress associated with the immigration process, difficult socio-economic conditions, the underutilization of health services, the loss of social ties, and discrimination against immigrants.[40, 41, 42]

The available data does not make it possible to draw a profile of the lifestyle habits and chronic diseases of immigrants in Estrie according to their stay in Canada. In fact, the data of the *Enquête de santé populationnelle estrienne* (ESPE) 2014-2015 makes it possible to identify responders who arrived in Canada within the past 5 years, but the low number of responders in this category does not provide reliable data (n=77). Furthermore, it was not possible to obtain information from immigrants who arrived in the country within the past 10 years using the survey data given that that question was not asked. However, it was observed that immigrants in general (regardless of the length of their stay in Canada) have lifestyle habits that are similar to and sometimes even better than those of Estrie residents born in Canada. In fact, excessive alcohol use and the prevalence of tobacco use is lower among immigrants than non-immigrants (respectively 7.3% vs. 10.3%, and 13.5% vs. 16.7%).

The immigrant population compares favourably to the Canadian-born population in having a lower prevalence of the following health problems: hypertension, chronic pulmonary obstructive disease (COPD), diabetes, and excess weight and obesity. However, when adjusted for age (immigrants are younger), the observed differences for hypertension and excess weight disappear.

Table 12
Prevalence of lifestyle habits, alcohol and drug use, and chronic diseases by place of birth among adults, Estrie, 2014-2015

	Place of birth		Difference by place of birth
	Canada (n=10,084) (%)	Outside of Canada (n=602) (%)	
Lifestyle habits			
Tobacco use	16.7	13.5	Yes
Less than 30 minutes of physical activity daily	32.0	29.6	No
Less than 5 fruits or vegetables daily	56.6	56.8	No
At least one unhealthy lifestyle habit	70.4	68.4	No
Drugs and alcohol			
Drug use over the past year	12.2	10.0	No
Excessive alcohol use (5 glasses or more) once a week or more	10.3	7.3	Yes
Reported chronic physical diseases			
Asthma	6.8	6.3	No
Hypertension	18.1	13.6	Yes
Chronic obstructive pulmonary disease (COPD)	3.3	1.8	Yes
Diabetes	7.4	3.8	Yes
Heart disease	6.5	4.8	No
Cancer	2.3	2.5	No
At least one chronic physical disease	31.3	23.5	Yes
Other reported health problems			
Health perception (fair/poor)	14.1	11.6	No
Excess weight (BMI of 25 or above)	55.3	48.4	Yes
Obesity (BMI of 30 or above)	21.2	15	Yes
Back pain	17.3	15.6	No

Source: Direction de santé publique de l'Estrie. Enquête de santé populationnelle estrienne, 2014-2015.

Finally, two Québec studies[43, 44] show that, with the exception of diabetes, recent immigrants (who landed within the past 10 years) are less likely to have a long-term health problem than those born in Canada. Established immigrants (10 years or more) are more likely to suffer from diabetes and hypertension than those born here.

Mental health and well-being

In the field of mental health, Canadian population studies tend to support the ***healthy immigrant effect***. In these studies, compared to their Canadian-born counterparts, recent immigrants report having better mental health and a lower prevalence of mental disorders including stress, depression, mood disorders and anxiety, suicidal ideation, and alcohol dependency. However, some of these studies report less favourable mental health among established immigrants. These studies also indicate that the reported mental health status among recent immigrants tends to deteriorate over time.[45, 46]

In Estrie, no difference was found in the indicators of well-being, psychological distress or the presence of depressive symptoms according to place of birth. That said, immigrants exhibited a lower prevalence of physician-diagnosed anxiety and mood disorders than non-immigrants. These regional findings are also true province-wide.[47]

Multiple factors influence the mental health of the immigrant population. These factors can be grouped into individual categories (age at arrival, sex, marital status, income, education, culture, and religion) or systemic categories (barriers to employment, service accessibility, prejudice, and discrimination.)[48, 49] Thus, many factors could explain the results shown concerning the mental health of immigrants in Estrie, but further studies are required in order to better identify them. However, as we will see in the section which follows, the immigrant population underutilizes the health and social services available. The lower prevalence of diagnosed mental health problems might likewise be explained, at least in part, by the lower use of health services by this population category.

Table 13
Indicators of mental disorders and of well-being by place of birth among adults, Estrie, 2014-2015

	Place of birth		Difference by place of birth
	Canada (n=10,084) (%)	Outside of Canada (n=602) (%)	
Indicators of well-being			
Most days are quite a bit or extremely stressful	20.4	20.1	No
Optimal positive mental health (decile 10)	9.9	10.3	No
Strong resilience (highest quartile)	22.4	19.6	No
Strong sense of belonging to the local community	57.5	56.7	No
Indicators of mental disorders			
Elevated psychological distress	24.4	23.2	No
Depressive symptoms lasting two weeks or more	14.0	13.3	No
Anxiety disorders	7.2	3.0	Yes
Mood disorders	6.3	4.3	Yes
Anxiety or mood disorders	10.9	6.6	Yes

Source: Direction de santé publique de l'Estrie, Enquête de santé populationnelle estrienne, 2014-2015.

Access to services

As mentioned earlier, studies report that immigrants use health services less than Canadians by birth.[50, 51] This low use of services might be attributable to a better health status (particularly among recent immigrants), lack of familiarity with the health system, language barriers, a misunderstanding of certain cultural aspects of disease, and also difficulty gaining access to services.[52]

In Estrie, among adults born outside of Canada, only 66.8% have a family physician, whereas this proportion rises to 82.4 % among those born in Canada.[53] Immigrant adults are also less likely than non-immigrants to have consulted a psychologist or a social worker within the last year (7.3% vs. 10.8%). These differences persist even when the rates are adjusted for age.

Similar findings are also found at provincial level[54]: 44.4% of recent immigrants (less than 10 years) and 75.2% of established immigrants (10 or more years) have a family physician (vs. 81% for Canadians by birth). In addition, 9.2% of recent immigrants and 9.9% of established immigrants have consulted a social services professional within the last year compared to 12.8% for those born in Canada. Québec survey results concerning unmet needs reveal that the probability of having an unmet need as regards a family physician is higher among immigrants, regardless of the duration of their residence. As regards the unmet need to consult a social services professional, only established immigrants compare unfavourably to Canadian-born citizens, with a higher probability of need.[55]

THE HEALTH STATUS OF REFUGEES AT A GLANCE

According to the Geneva Convention, a person who meets all of the following conditions may be considered a refugee[56]:

1. A person must be outside the country of which he is a national or, if he has no nationality, outside the country of habitual residence.
2. A person must have a well-founded fear of persecution because of his race, religion, nationality, membership in a particular social group, or political opinions.
3. In light of this fear, the person must be unable or unwilling to avail himself of the protection offered by that country or to return to that country.

Québec welcomed 23,405 refugees from 2010 to 2014, or 8.9% of immigrants admitted into the province.[57] Of that number, approximately 2,300 settled in Estrie.

Among those born outside of Québec, refugees make up a particularly vulnerable group, owing equally to their living conditions in their countries of origin or of transit, and to the difficulties related to adapting to Québec society. Notably, they are at greater risk of suffering from certain health problems such as infectious diseases (e.g., tuberculosis, malaria, other parasitic infections, and hepatitis B), certain types of chronic diseases (e.g., cardiovascular diseases, pulmonary diseases, and diabetes), as well as psycho-social and mental health problems (e.g., depression and post-traumatic stress disorder).[58, 59]

In order to evaluate the physical state of health and the well-being of refugees, thirteen clinics have been set up in thirteen host cities in Québec. The objective of these clinics is to assess the physical health and well-being of the refugees referred to them and to provide services which meet their needs (or to refer them to other pertinent services when required).[60] In Estrie, two refugee clinics were established, one in Granby (2013) and another one in Sherbrooke (2009). The targeted clientele consists of refugees who have arrived in Canada within the last six months and who have no attending physician.

Demographic and social context

This section examines a sample of 380 refugees who have consulted the Clinique de réfugiés de Sherbrooke (CDR) (refugee clinic) between July 2, 2013, and December 16, 2014.[61]

The refugees in the study consist of a young population compared to recent immigrants to Estrie (arrived within 10 years or less). In fact, the median age of the refugees at the time of their arrival is 21 years (compared to 31.6 years among recent immigrants). Within this sample, 10.5% are children aged 5 years or less, 29.7% are school aged, while 46.1% are aged 18 to 44 years. Those aged over 65 years make up 1.3% of the population studied, and there are slightly more men (52.9%) than women (47.1%).

In 2013 and 2014, 46.8% of refugees who were seen at the refugee clinic in Sherbrooke (CDR) were originally from Afghanistan, 17.9% were from the Democratic Republic of Congo, and 12.9% were from Iraq. The other countries of birth in the sample, by order of importance, are: Columbia (6.6%), Rwanda (4.7%), Burundi (3.2%), Iran (2.1%), Bhutan and Central African Republic (1.8% each), Côte d'Ivoire (Ivory Coast) (1.6%), and Cameroon (0.5%).

Refugees spend a great deal of time in exile before landing in Canada. In fact, the median duration of their transit before their arrival in Canada is 13 years, the shortest being less than one year and the longest being 32 years. During this period of transit, approximately one out of every five persons (17.4%) lived in a refugee camp, and, among the children and adolescents, one out of every two (49.7%) was born during this period.

At the time of their arrival in Canada, nearly nine out of ten refugees (86.3%) were accompanied by one or more members of their family. Among adults, nearly half are single (47.3%) and 44.1% are married. At the time of their visit to the refugee clinic, nearly a third of the adults knew one of the official languages (37%). Thus, 71.4% need an interpreter during their medical appointments. Finally, 10.5% of the adults report having no education, a situation that is more frequent among women (20%) than men (2.5%).

Lifestyle habits and chronic diseases

Among the adult refugees who consulted the refugee clinic (CDR) in 2013 and 2014, 13.4% smoked. The gross prevalence of tobacco use is therefore identical to that found among all immigrants to Estrie (13.5%), but lower than that of Estrie residents born in Canada (16.7%).[62] Problems associated with excess weight (BMI of 25 or more) are similar to those found among all immigrants in our region, but are less frequent than among Estrie residents born in Canada. In fact, the prevalence of excess weight among refugees is 48.4% compared to 44.3% among Estrie residents born in Canada.[63]

It was noted that few antecedents of hypertension (5.7%), diabetes (2.2%), or cardiovascular disease (0.4%) were self-reported by the patients examined at the CDR. However, at the time of the medical examination, 12.8% of adult refugees suffered from hypertension while 7.9% had an abnormal glycemic profile which could indicate potential diabetes.

Table 14
Lifestyle habits and chronic diseases among adult refugees by sex, Clinique des réfugiés de Sherbrooke, 2013 and 2014

	Adults		All adults (%)
	Men (%)	Women (%)	
Lifestyle habits and weight			
Tobacco use (n= 224)	24.0	1.0	13.4
Body Mass Index (BMI) (n=215)			
Overweight (BMI 25-30)	33.0	29.0	31.2
Obesity (BMI ≥30)	9.6	26.0	17.2
Chronic diseases			
Hypertension:			
Reported by the patient (n=227)	4.1	7.6	5.7
Screened during medical examination (n=227)[1]	13.1	12.4	12.8
Diabetes :			
Reported by the patient (n=227)	1.6	2.9	2.2
Abnormal glycemic profile (n=114)[2]	7.0	8.3	7.9
Heart disease:			
Reported by the patient (n=227)	0.8	0.0	0.4

1. Systolic blood pressure ≥ 140 mmHg and/or diastolic blood pressure ≥ 90 mmHg
2. Blood-glucose (non-fasting) of ≥ 11.1 mmol/L or HBA1c > 6,5%

Source: Community health externship report under the supervision of Dr. G. Baron and Desjardins, F. (2015). La santé des réfugiés à Sherbrooke. *Faculty of medicine and health sciences of the Université de Sherbrooke.*

Mental health and well-being

According to a 2005 meta-analysis, the frequency of depression among refugees is similar to that of the general population, but the frequency of post-traumatic stress disorder (PTSD) is much greater.[64] The risk factors for depression among immigrants and refugees may include stressful events, the lack of social support or isolation, physical health problems, the inability to speak the language of the host country, and being separated from children who remain in the country of origin.[65] The cumulation of torture and trauma are the most important predictors of post-traumatic stress disorder.[66]

Among the adult refugees who consulted at the CDR in 2013 and 2014, many exhibited risk factors which could affect their mental health. In fact, nearly two out of three (63.0%) speak neither French nor English, and slightly more than one out of two has no family that is already established in Canada (52.3%), or else is single, widowed, separated, or divorced (55%). When interviewed about this subject, 11.8% of men and 23.3% of women reported feeling isolated.

In addition, many refugees reported traumatic events during their migration In fact, a third of refugees (32.4%) reported the death of a family member, nearly one out of five (16.8%) reported having suffered physical abuse, and nearly one out of ten women (7.1%) reported sexual abuse.

Many refugees reported symptoms which could be associated with anxiety or mood disorders. In fact, a quarter of refugees (26.4%) reported that they were stressed or anxious, 16.3% reported sadness and crying, and 18.9% reported sleep disorders.

Finally, during the medical examination at the CDR, a diagnosis of post-traumatic stress disorder (PTSD) was given to 4.8% of patients. This prevalence is lower than that found in the meta-analysis of Fazel et al. (2005)[67], in which PTSD levels affected 9.0% of the adult refugee population welcomed in developed nations.

Table 15
Risk factors and mood or anxiety disorder symptoms among adult refugees by sex, Clinique des réfugiés de Sherbrooke, 2013 and 2014

	Adults		All adults (%)
	Men (%)	Women (%)	
Risk factors			
Speak neither French nor English (n=227)	62.3	63.8	63.0
Lack social support:			
Arrived in Canada alone (n=227)	18.0	8.6	13.7
No family already in Canada upon arrival (n=220)	53.4	51.0	52.3
Single, widowed, separated, or divorced (n=222)	55.4	54.4	55.0
Traumatic events:			
Death of a 1st degree family member (n=216)	29.1	36.4	32.4
Victim of physical violence (n=214)	15.7	18.2	16.8
Victim of sexual violence (n=214)	0.0	7.1	3.3
Symptoms reported by patients			
Sadness or crying (n=227)	11.0	21.9	16.3
Anxiety or stress (n=227)	23.0	30.5	26.4
Sleep disorders (n=227)	18.0	20.0	18.9

Source: Community health externship report under the supervision of Dr. G. Baron and Desjardins, F. (2015). La santé des réfugiés à Sherbrooke*. Faculty of medicine and health sciences of the Université de Sherbrooke.*

Anemia and nutritional deficiencies

Recent immigrants and refugees have a higher prevalence of anemia (15 to 28%) compared to the Canadian-born population (2 to 10%).[68] The WHO estimates that worldwide the prevalence of iron-deficiency anemia varies from 21 to 68% among children aged 0 to 5 years and from 18 to 48% among women of reproductive age.[69]

Among refugees who consulted the refugee clinic (CDR) in 2013 and 2014, anemia[i] affected 11.2% of the refugees examined (aged 2 years and older). The prevalence of this disease affected 5.6% of children aged 2 to 5 years, 8.8% of children aged 6 to 17 years, and slightly more than one in ten adults (13.4%), in particular women (27.1%). Iron-deficiency anemia[ii] affects primarily women of reproductive age (18 to 44 years) - 25% overall. Among the refugees examined, few children are affected by this disease (3.5% of those aged 6 to 17 years, and no child aged 2 to 5 years).

[i] Hemoglobin <120 g/L among women (18 year and older), <130g/L among men (18 years and older), <115 g/L among youth aged 6 to 18 years, and <105 g/L among children aged 2 à 6 years.
[ii] Iron deficiency: <22 ug/L

Infectious diseases

Some infectious diseases are frequent among the immigrant and refugee population. For example, a large proportion (20 to 80%) of immigrants from countries in which chronic hepatitis B is frequent is not immune or has not been vaccinated against this disease.[70] The prevalence of this chronic infection may reach 4% within this population compared to 0.5% within the Canadian-born population.[71] Furthermore, nearly two-thirds of active tuberculosis cases in Québec (62.3%) are found among persons born outside of Canada.[72] In addition, the screening and treatment of latent tuberculosis infections is particularly important among immigrants[iii] considering that the prevalence of the latent infection can reach up to 50% among adults and 25% among children, contrary to the Canadian-born population[iv] in which the prevalence is usually less than 10%.[73] Another frequent infectious problem within the immigrant and refugee population is intestinal parasites. Thus, nearly a quarter of the children born outside of Canada have intestinal parasites at the time of their arrival.[74]

Among the refugees who have consulted the CDR in 2013 and 2014, 1.6% had hepatitis B (chronic or acute), 35.3% were immunized against this disease (following a previous or resolved infection, or vaccination) and 59.7% were not immune or had not been vaccinated against this virus. Also, more than one out of every two adults (53.6%) tested positive for tuberculin, which could indicate a latent tuberculosis infection (26.5% among those aged less than 18 years). Finally, a quarter (25.0%) of preschool-aged children had pathogenic intestinal parasites at the time of their arrival. This prevalence reaches 20.5% among school-age children and drops to 13.7% among adults.

[iii] This is particularly true for immigrants from Sub-Saharan Africa, Asia, South America, and Central America.
[iv] Non-Aboriginal population born in Canada which has not received the BCG vaccine.

The community mobilizes

As of February 29, 2016, the governments of Canada and Québec had each respected their commitment to welcome 25,000 and 3,600 Syrian refugees respectively. Of this number, 292 were relocated to Estrie - 63 in Granby and 229 in Sherbrooke.

These massive arrivals required the rapid implementation of a strong and coordinated organizational structure which would enable the supply and provision of equitable, accessible, safe, and quality services. To meet this goal, the *Plan ministériel pour l'évaluation du bien-être et de l'état de santé physique des réfugiés en situation d'arrivées massives* was developed and implemented up to February 29, 2016.

In Estrie, these interventions were implemented under the helm of the Comité stratégique sécurité civile - Mission santé and under the co-responsibility of the Coordination régionale de la sécurité civile and the Direction des services généraux. Tactical and operational committees were set up in order to coordinate the initiatives of the five departments of the CIUSSS de l'Estrie – CHUS involved and of the non-government organizations (NGOs). The Direction de santé publique was actively involved, considering not only the potential of infectious diseases within the groups concerned and the issues of vaccine coverage for refugees, but also the future interventions required to meet the significant needs of the refugees such as their integration into their new communities. For that purpose, the Community Action Department maintains close ties with the host municipalities and with other organizations which have a role to play in integration.

Within the 72 hours following their arrival in Sherbrooke or Granby, the refugees were examined in a refugee clinic (CDR). During their examination, particular attention was paid to the presence of infectious disease symptoms and vaccine coverage. Over the next 28 days, subsequent interventions made it possible to complete the evaluation of their health and well-being, and to conduct a psycho-social follow-up, to initiate vaccination, if that had not already been done, and so on.

The workers of Service d'aide aux néo-canadiens (SANC) and of Solidarité ethnique régionale de la Yamaska (SERY), two significant partners, played and continue to play an essential role in the case management of Syrian refugees at the very time of their arrival. Finding an apartment, requesting medical insurance and social insurance cards, opening a bank account, and accompaniment for a first visit to a grocery store were among the services that needed to be provided to newcomers.

Written by Dr. Robert Pronovost, Direction de santé publique de l'Estrie

FOCUS GROUPS

Three focus groups (total of 27 participants, group description in Appendix D) were held with immigrants in Sherbrooke and in Granby. They were invited to voice their health and social needs as well as to discuss their experience of the health and social services network (see Appendix B). The themes discussed were grouped into six dimensions.

A global vision of health

There is no doubt among the immigrants who were met that health is much more than the absence of disease. For the participants, health refers to an equilibrium among many physical, psychological, spiritual, economic, and social factors.

- *Health is a global matter which encompasses physical, psychological, social, and religious dimensions. There are so many factors surrounding the well-being of the individual.*
- *The individual is just one within the system. He needs to be in harmony with his environment in order to be healthy.*

To maintain this equilibrium, eating habits and physical exercise are at the very centre of the concerns of the immigrants who were interviewed. They report having the most control over these two health determinants.

- *I try to have good eating habits with my children. We reduce our consumption of soft drinks and juice, and we try to decrease our consumption of fat. When we buy our groceries, we try to look at the nutrition facts and avoid trans fats.*

Other health determinants were reported. Those determinants can less easily be modified. Such is the case for employment, community involvement, and disposable income.

- *When a person doesn't work and has no money to feed his family, it's more difficult to pay attention to one's own health.*
- *The notion of usefulness to society is very important.*

Access to culturally appropriate mental health services

While health is multi-factorial, mental health occupies a particular dimension. The immigrants who were met consider mental health a major determinant of well-being.

- *It's being able to live. Before beginning to think about one's physical health, it is necessary to have a sound mind.*
- *Health and mental health go together, because when the mind goes, so does the body.*

Once this finding is established, it becomes easier to understand the need for this community to have access to mental health services. Furthermore, the immigrants interviewed report distress related to the immigration context (e.g., state of war, refugee camps). Yet, it appears difficult to access these services.

- *When I arrived in Canada, I was a refugee. I left Columbia when it was in a state of war. My daughter had just been shot to death. We arrived here and we needed psychological help. I left Columbia and everything there behind. I have lots of mourning to do.*
- *I was always on the CLSC's waiting list to meet a psychologist. I have never met one. Never. When one is in the middle of such a situation, can you imagine the impact it has on the person's health?*

Furthermore, the definition of mental health evoked by the participants differs from that of the host population. The offer of services must take into account these social and cultural subtleties. Immigrants do not talk about mental health in the same manner and language as do other Estrie residents. A strong stigma attached to mental illness in their countries of origin modulates their discourse. More humane and less medicalized intervention methods are also desirable.

- *Depression is not a disease where we come from. It is intellectual and human laziness.*
- *We are not used to taking anti-depressants. Nearly 90% of immigrants who are given anti-depressants will toss them into the trash bin.*

Social isolation and difficulty adapting to the host society

The feeling of being socially isolated is mentioned repeatedly. That feeling of being alone in a parallel universe is a major obstacle to adapting to the host society.

- *Our need is to break our isolation. We leave one place and we graft ourselves to another. That graft has to take. There needs to be interaction between the community and ourselves.*

- *We find ourselves completely isolated in an apartment. We don't know the language, we have no resources, and we don't know what to do. We are in an abyss.*

The immigration process appears likewise to be difficult. It is not without impact on the health of the immigrants interviewed.

- *When we arrive, we are physically fine, but then the mind starts to go. We have integration issues, we can't find work, we have lost our network, and we don't know the system. That is how we start no longer taking care of ourselves or of our health.*

Another aspect which may slow integration involves the ties between the host society and the family remaining in the country of origin.

- *Half my mind is here, the other is in Columbia. I always used to get news from my family. My sister was kidnapped and everyone else holds me accountable for what is happening there.*
- *My parents remained there. Even with them, I don't talk because it always involves problems.*

A lack of support after landing in the new country was mentioned by the immigrants who were met. This lack of support is perceived as an abandonment of the participants by Québec.

- *Immigration is something that was sold to us. The problem is that there is no after-sales service. When you go there, there will be this and that and that. When I landed at the airport, I was told "here is all of the information there is." It has already been two and half years, and I get by on my own.*
- *I feel cheated, because I was sold a life project. It is obvious that I legally have everything, that I can do whatever I want, that I can live my Canadian dream, that I can live my Québec dream, but there is nothing to help you or to guide you.*

A few solutions for overcoming isolation were proposed by the immigrant community. Community organizations which work with the community are to be privileged, as are interventions aimed at promoting the social participation of newcomers.

- *It is very important to invest in community organizations working with immigrant communities. It is important to develop projects, to help communities break their isolation.*
- *It is necessary to participate in activities. It is very important to interact with others.*

Access to an adequate job

Access to an adequate job is fundamental to all immigrants who were met. It is a non-negotiable need which is a health priority for them. Employment is a social integration factor which lowers stress and gives individuals greater control over their lives and environments.

- *If we find a job, then we are able to purchase medication, to eat well, to get out - but all of these things are not yet within my reach, and so I don't take care of my health they way I should. But what do you want? I have neither the time, nor the means.*

The loss of professional recognition and of social status upon landing in Québec are traumatic events which have had a major impact on the health of the immigrants who were met. Participants report having to accept jobs for which they are overqualified.

- *It's as if I had taken 18 years of experience and thrown it into the garbage.*
- *Those who had everything, who had a social status, came here and now are not even able to get into the system. This disillusionment is what ruins our health.*

Beyond the degree-recognition process, the immigrants interviewed noted great difficulties in hiring which they attribute to a type of discrimination.

- *It's a shame to talk about it, but there's lots of discrimination.*

- *Many organizations post jobs, but in fact, we don't have access to those positions. We soon realize that the jobs are given to Quebecers.*
- *Employers require me to have Québec experience. Where am I to get that experience if nobody gives me the opportunity to work?*

Access to health and social services

Access to health and social services is also a recurring need mentioned within the focus groups composed of immigrants to Estrie. Frontline access was named as was access to specialized services. The immigrants interviewed do not understand why waiting times are so long.

- *Family physicians are very important. Many people have no family physician.*
- *You need to be aware of the waiting times to meet specialists. I've been waiting for two years to meet the specialist to solve my problem.*
- *Even when you go to the emergency, you can end up waiting 18 hours before anyone pays attention to you. At home, I have never spent more than two hours waiting to see a physician. It's strange, but you wait much longer to see a physician here than in Africa.*

Once the immigrants have access to the desired services, they decry the lack of follow-up from the workers whom they have met.

- *We went to the hospital. They told us that she needed to have an operation on her sinuses. Now we've been on the waiting list for well over five months. We wait, but there is no follow-up.*
- *I undergo X-rays, but I receive no answer. I give urine samples. No answer - ever.*

These barriers to access lead to behaviours which hinder the social integration of the immigrants who were met. Some isolate themselves out of fear of becoming sick. Finally, when consultation becomes necessary, their reflex is to go to the emergency or to call an ambulance.

- *Who should I talk to when I don't feel well? I've been here for two and a half years, and I'm still wondering. I suppose that if I fall sick, I'll call an ambulance.*

Cultural barriers and health literacy

Cultural barriers are associated with differing visions of health - that of the immigrant and that of the host society.

- *Physicians here factor in the weather. If a child has a fever, he'll be treated. But if the child has no fever, they say he'll get over it. But you know that the child is sick: he's yours.*
- *When you meet a professional, you have to be able to talk to him and he has to be able to understand you. It's not just about listening. You can spend many hours explaining your problem and then realize he doesn't understand you. In the end, it's as if you asked for apples and were given bananas instead.*

It emerges from the focus groups that health and social services staff must develop cultural competency to interact with the immigrant community.

- *I was always wondering whether those dealing with immigrants received training to do so.*
- *I understand that they don't understand our needs because those needs come from elsewhere; however, there needs to be some open-mindedness or else what's the point?*

For example, the participants mentioned that some cultures tend to use medications whereas others are more accustomed to methods based on alternative medicines.

- *Sir would like to meet a homeopath. He would like to have the opportunity to receive alternatives to medications.*

- *Everybody believes that you'll get your health back by taking medications. For us, that's not the way it works. Before taking all kinds of medications, we'll try anything. We'll try all kinds of natural stuff before agreeing to take a medication.*

Incomprehensible information appears to exacerbate the cultural barriers named by the immigrants interviewed. According to them, we need to work on the information-seeking skills of immigrants and their ability to properly understand the information they find.

- *There are no documents in the mother tongues of those who are here.*
- *I come from a French-speaking country, and I don't understand the information that I read. Whom should we address? I don't know.*

The community mobilizes

Services may be available, but they are not necessarily accessible and adapted to the needs of immigrants. The *Comité d'adaptation des services aux personnes immigrantes* (CAPSI) (services adaptation committee for immigrants), set up in 2009 by SERY, aims to improve this situation by proposing an organization of services based on the genuine needs of immigrants.

CAPSI does not offer services directly to immigrants, but rather to the workers of various organizations and workplaces. The objectives are: awareness-raising; joint action and support in complex cases; competency and skills development; and support for workers who deal with immigrants and refugees. Information and awareness-raising activities, knowledge sharing, and the discussion of cases are the methods retained to achieve these objectives.

CAPSI does not receive specific funding. Its operations are based on human resources allocated by SERY and partner organizations (CUISSS de l'Estrie — CHUS, L'autre Versant, Université de Sherbrooke, and Commission scolaire du Val-des-Cerfs).

4. SUMMARY

THE ENGLISH-SPEAKING COMMUNITY

Some researchers suggest that just the fact of living in a linguistic minority context henceforth be considered a health determinant because of associated health and social disparities.[75] In fact, studies have shown that persons belonging to the French-speaking minority in the rest of Canada (living outside of Québec) perceive themselves to be in poorer health, older, less educated, and poorer; they report more chronic diseases and are more likely to smoke, drink and be obese. The English-speaking minority in Québec (excluding the English-speaking population of Montreal) exhibits a similar profile.[76]

In Estrie, the same profile can be drawn of members of the English-speaking community.

- At the demographic level, it is noted that there are proportionately fewer English-speaking adults than French-speaking adults aged 18 to 39 years (20.8% vs. 26.9%), but more seniors (22.5% vs. 15.6%). Over the past few decades, young adults who have left the region are more likely to have attained a higher level of education than those who have remained.[77]
- English-speaking adults are more likely to attain a lower level of education than French speakers (48% have a high school diploma or less vs. 39%). Furthermore, English speakers are more likely to be in the low-income bracket.
- English-speaking adults are more likely to smoke, to eat an insufficient number of fruits and vegetables on a daily basis, and to use alcohol excessively compared to French-speakers in the region.
- More adult English speakers report having poor health (21.8%) compared to French speakers (13.6%).

These preoccupying results affect the children and adolescents belonging to this community.

- English-speaking mothers are more likely than French-speaking mothers to be very young (less than 20 years old) or to have low educational attainment at the time of birth of their child.
- The proportion of kindergarten children who are vulnerable in one or more areas of development is twice as high among English speakers as among French speakers. The most significant differences between the two language communities (which compare unfavourably for English speakers) were observed in the following domains: physical health and well-being, social skills, and communication abilities and general knowledge.
- Kindergarten and grade two students who attend English schools are proportionately more likely than those attending French school to have one or more dental caries.
- In high school, English-speaking students exhibit poorer eating habits than their French-speaking counterparts. For example, 1/3 of English speakers report consuming sweetened beverages, salty snack, or sweets on a daily basis, whereas this proportion is 23.9% among students attending French schools.
- Among English students who attend high school, nearly 6 out of 10 claim they were victims of violence (at school or on the way to school) or of cyberbullying. That proportion is 35% among students who attend schools in French.

As regards the use of health services, it was noted that the proportion of adults who have a family physician and who have consulted the latter within the last twelve months is similar among both English

and French speakers. However, adult English speakers are less likely than French speakers to have consulted a psychologist or a social worker within the past year (7.5% vs. 11.0%) and English-speaking women participate less in the QBCSP (58.7% vs. 70.2%).

Studies show the effects of the effects of the language barrier, notably in the level of satisfaction with the care received.[78] Thus, in Québec, in spite of having comparable accessibility to a family physician, English speakers consider that health services respond less to their overall health problems (65% vs. 87.5%) and give them less control over their problems than French speakers (81.7% vs. 92.3%).[79] The results of these focus groups point in the same direction:

- A perceived lack of access to family physicians, notably in rural areas;
- A lack of knowledge of English by health professionals and of documents in English;
- A need for support and guidance to navigate the health system;
- A perception that insufficient attention is paid to the needs of English speakers and that these needs are not met, and that the restructuring of the health network exacerbates this phenomenon.

THE IMMIGRANT COMMUNITY

First, we find a shortage of data on the health status of the immigrant community which does not allow taking into account the heterogeneous nature of this population. In fact, the place of birth (Canada or outside of Canada) as well as the period of landing in Canada are not always compiled in administrative databanks or in surveys. Certain information on immigrant classes considered important as regards their vulnerability, for example that on refugees, is also missing. Finally, the low number of immigrant respondents reached by the health surveys does not always make it possible to obtain reliable results for this population group.

In Estrie, the majority of immigrants, especially recent immigrants, live in the RLS de Sherbrooke and in the RLS de la Haute-Yamaska. Compared to the host population, a greater proportion resides in the most materially and socially deprived communities. Recent immigrants (who have landed within the last 10 years) are younger than the Canadian-born population (median age of 31.6 years and 43.2 years respectively). Also noteworthy:

- The proportion of adults who have completed university studies is greater among immigrants than among those born in Canada.
- Despite their higher educational attainment, they face unfavourable economic situations: higher unemployment, low incomes, high proportion of renters, significant proportion of income spent on housing. These situations are particularly experienced by recent immigrants. Among immigrants who arrived before 2001, the economic indicators are comparable to those of the host population.

There are very little data on immigrant children and no data on immigrant adolescents in Estrie. However, the results of the QSCDK (2012) for Estrie are worrisome. Indeed, 44.7% of children in Estrie born outside of Canada are vulnerable in at least one area of development, whereas this proportion is at 34.7% for immigrant children in Québec and approximately 25.0% for Canadian-born children. Immigrant children are particularly vulnerable in the cognitive and language domain of development, and in the communication abilities and general knowledge domain of development.

The *healthy immigrant effect* seems to exist within the adult immigrant community in Estrie. Indeed, the situation of adult immigrants compares favourably as regards chronic diseases. They suffer less from hypertension, diabetes, chronic pulmonary obstructive disease (COPD), and obesity. It should be noted that these results are partly explained by the (younger) age structure of this population group. The situation of adult immigrants also compares favourably as regards their lifestyle habits: they smoke less and have lower alcohol use than the host population.

Even though the indicators of well-being and of depressive symptoms are similar among immigrants and those born in Canada, immigrants are less likely to have been diagnosed with anxiety or mood disorders (6.6% vs. 10.9%). However, there is an underutilization of health and social services by the immigrant population. The lower prevalence of diagnosed mental health disorders might be explained, in part, by the lower use of health services by this population category.

The underutilization of health services by immigrants may be attributed to many factors: a better health status (among recent immigrants), a lack of familiarity with the health system, language barriers, incomprehension of certain cultural aspects of disease, and difficulty gaining access to services.[80] In Estrie, as in Québec, there are barriers to accessing these services, notably frontline services, for this population. In fact, immigrants to Estrie are less likely to have a family physician compared to the Canadian-born population (66% vs. 82%). A province-wide study[81] shows that only 44% of recent immigrants (who landed within the past 10 years) have a family physician in Québec (vs. 81% for those born in Canada) and nearly four out of every ten (41%) report the need for being assigned a family physician as unmet (vs. 11% among those born in Canada).

Some researchers believe that there are social determinants which are unique to immigrants.[82] These social determinants are: (1) migration and adaptation to the host country, (2) discrimination based on race, and (3) underemployment and the poverty which accompanies it. Within the focus groups, the main issues which were raised concern social isolation and difficulties adapting to the host society as well as access to adequate employment. The participants highlighted the importance of having access to culturally appropriate health and social services, particularly mental health services.

- Isolation sets in upon landing in the host society and it constitutes a barrier to social integration. Access to adequate employment then becomes fundamental and is perceived to be more meaningful than health.
- Access to health and social services is difficult for the immigrants who were interviewed. In addition, even once they had access to services, the participants noted a lack of follow-up and cultural barriers.
- Mental health occupies a particular dimension in the definition of health by the immigrants who were met. According to them, mental health is more important than physical health. Access to culturally appropriate mental health services is therefore important.

5. RECOMMENDATIONS

This section presents recommendations addressed to the decision-makers, professionals and partners of the Direction de santé publique de l'Estrie, of the health care and social services network, and of other sectoral domains. These recommendations are formulated in order to pursue a common objective, specifically to improve the health status of the English-speaking and immigrant communities in Estrie. Without being prescriptive, we hope that these recommendations will guide the planning, implementation, and adaptation of services as well as of research, assessments, and evaluations.

1. Surveillance of health status and of its determinants

Recommendation # 1.1

Improve the medical and administrative databases (e.g., I-CLSC) by integrating variables which enable the identification and analysis of the health status of the English-speaking and immigrant communities (e.g., language spoken at home, place of birth) as mandatory fields to be completed.

Recommendation #1.2

When conducting population health surveys, consider the possibility of including a sufficient number of English speakers and immigrants in order to obtain reliable data for these populations.

Recommendation #1.3

Consider the fact of living in a minority language situation as a health determinant associated with social health inequalities, and as such, systematically analyze health data by language spoken at home when surveillance health status.

For the immigrant population, health status surveillance, whenever possible, should take into consideration additional social determinants such as the migratory process and discrimination based on race, and put emphasis on employment. In addition, it should take into account the heterogeneous nature of this population group and offer differentiated analyses by country of birth, the period of arrival in Canada, and immigration class.

Recommendation #1.4

Monitor the evolution of the health status and state of well-being of the English-speaking and immigrant communities in Estrie.

2. Health research and evaluation

Recommendation #2.1

Support research and health assessment and evaluation initiatives which focus on the English-speaking and immigrant communities. Health perceptions and beliefs (physical and mental), health and social services needs, barriers and facilitators to services, as well as cultural elements associated with the use of services should be prioritized.

3. Training of health professionals

Recommendation #3.1

Offer and promote access to training that is adapted both to the needs and expectations of those communities and to the needs of and work experience of the workers of the CIUSSS de l'Estrie — CHUS to health professionals who work with these population groups.

4. Accessibility, adaptation, and improvement of health and social services

Recommendation #4.1

That the CIUSSS de l'Estrie — CHUS foster the implementation of committees mandated to improve the adaptation and accessibility of services to the English-speaking and immigrant communities.

Recommendation #4.2

That the CIUSSS de l'Estrie — CHUS ensure an adequate representation of the English-speaking and immigrant communities at local and regional round tables.

Recommendation #4.3

That the CIUSSS de l'Estrie — CHUS improve the intercultural competency of the organization while considering the latter as one of the dimensions of service quality (e.g., access to interpreters, training of non-clinical staff, partnerships with cultural communities and community organizations, production of performance data differentiated by community). Enhancing the intercultural competency of the organization as a dimension of service quality as regards the English-speaking community could also be considered.

Recommendation #4.4

That the CIUSSS de l'Estrie — CHUS take advantage of the implementation of the *Plan d'action régional en santé publique 2015-2025* to review the health prevention and promotion strategies used with the English-speaking and immigrant communities in order to better reach out to them and to better respond to the needs of those communities. A multi-strategic approach that is evidence-based and specific to these communities could be contemplated and include, among others, social marketing and community development.

Recommendation #4.5

That the CIUSSS de l'Estrie — CHUS improve the hiring of staff from the English-speaking and immigrant communities in compliance with the regulations in force.

5. Communications

Recommendation #5.1

When producing and disseminating public information, ensure that the contents are translated or adapted culturally for the targeted communities in compliance with the legal framework.

Recommendation #5.2

Disseminate information to better equip the English-speaking and immigrant communities to navigate through the regional health and social services network.

6. Community development and intersectoral action

Recommendation #6.1

Capitalize on the strengths (e.g., strong sense of belonging to the local English-speaking community) of the English-speaking and immigrant communities of Estrie and support development initiatives for these communities.

Recommendation #6.2

Encourage the adoption of health policies which meet the needs of English-speaking and immigrant communities. For example, the future community development policy of the CIUSSS de l'Estrie — CHUS should focus on the needs and realities of both these communities.

Recommendation #6.3

Encourage intersectoral action to improve the health determinants in English-speaking and immigrant communities. For example, these actions may support the development of services which would help provide better access to employment to immigrants or a better alignment of services provided to pre-school and school-aged English speakers.

CONCLUSION

In light of the findings in this report and of the recommendations made therein, it is essential to monitor the evolution of the health status and state of well-being of the English-speaking and immigrant communities in Estrie. It is also fundamental to better document certain specific issues raised within the framework of this report, notably accessibility to health and social services (and their use) by minority communities, as well as the impact of language and cultural barriers in this matter. Considering that the differences in health and well-being observed between the groups studied in this report (i.e., English-speakers and immigrants) and the French-speaking majority in Estrie, it is crucial to adapt the offer of local and regional services in order to respond better to the needs of cultural and linguistic communities.

The parties met to bring this work to completion evidently brought to our attention many barriers and obstacles to health and well-being among the English-speaking and immigrant communities in Estrie. That being said, we have also noted successes, initiatives, strengths, and resources which characterize these communities. We believe that the communities concerned need to be mobilized so that they can utilize these health "assets" to undertake community development initiatives and thereby create health and well-being for their fellow citizens.

Finally, even though the Direction de santé publique has chosen to put emphasis on the needs of the cultural and linguistic communities in this report, other communities also have significant needs (e.g., persons living in poverty). We wanted, however, to shed light on the issues that are particular to both of these groups considering that they have been scantly documented to date in Estrie.

APPENDICES

APPENDIX A: METHODOLOGY

In order to identify the principle health and social services needs of the English-speaking and immigrant communities in Estrie, we have used a mixed-methods approach which includes a quantitative component and a qualitative component.

Quantitative component

The following table shows the data sources used in the quantitative part. They consist of surveys and medical and administrative files in which it is possible to categorize individuals by place of birth or language spoken at home. Given that there are various ways to measure language (e.g., mother tongue, spoken at home, most commonly used), we chose language spoken most often at home as a crosstab variable whenever possible.

SOURCE	PERIOD	TARGETED POPULATION	GEOGRAPHIC SCALE	DATA DESCRIPTION
Census National Household Survey *Statistics Canada*	2011	Entire population	Québec Estrie RLS	**Crosstab variables:** Immigrant status Language spoken most often at home (among non-immigrants) **Subjects covered:** Demographics (age and sex) Highest educational attainment Income Activity, employment, and unemployment rates Disabilities
Québec Health Survey of High School Students (QHSHSS) *Institut de la statistique du Québec*	School year 2010-2011	High school students (12-17 years)	Québec Estrie	**Crosstab variables:** Language of instruction **Subjects covered:** Lifestyle habits and risky behaviours Reported prevalence of selected mental disorders Social environment Personal skills
Québec Survey of Child Development in Kindergarten (QSCDK) *Institut de la statistique du Québec*	2012	Kindergarten children	Québec Estrie RLS	**Crosstab variables:** Place of birth Mother tongue **Subjects covered:** Vulnerability in 5 areas of development
Enquête de santé populationnelle estrienne (ESPE) *Direction de santé publique de l'Estrie*	2014-2015	18 years or older	Estrie	**Crosstab variables:** Place of birth Language spoken most often at home (among non-immigrants) **Subjects covered:** Lifestyles and chronic diseases Mental health and well-being Use of health services
Births files *Ministère de la Santé et des Services sociaux*	2005 to 2014	All births	Québec Estrie	**Crosstab variables:** Place of birth Language spoken at home (non-immigrants)

SOURCE	PERIOD	TARGETED POPULATION	GEOGRAPHIC SCALE	DATA DESCRIPTION
				Subjects covered: Prematurity and low weight at birth Age and educational attainment of the mother
Deaths files *Ministère de la Santé et des Services sociaux*	2005 to 2011	All deaths	Québec Estrie	**Crosstab variables:** Language spoken at home* **Subjects covered:** Life expectancy
I-CLSC *CIUSSS de l'Estrie — CHUS*	2011-2012 to 2015-2016	Kindergarten and grade 2 students at the primary level	Estrie	**Crosstab variables:** Language of instruction **Subjects covered:** Dental caries
Information system of the Québec Breast Cancer Screening Program (SI-PQDCS)	2007 to 2015	Women aged 50 to 69 years	Québec Estrie	**Crosstab variables:** Language of correspondence **Subjects covered:** Participation in the QBCSP
Clinical records *CIUSSS de l'Estrie — CHUS*	July 2, 2013, to December 16, 2014	Refugees who were seen at the Clinique de réfugiés de Sherbrooke	---	**Subjects covered:** Demographic, social, and economic features Lifestyle habits Chronic and infectious diseases Mental health and well-being

* With imputation when language data missing. Produced by the INSPQ.

Quantitative component

Samples and recruitment

Five focus groups were held (total of 48 participants). The first group brought together English speakers living in urban areas (i.e., Sherbrooke and Magog; n=6) whereas the second group was held with English speakers living in rural areas (i.e., Ayer's Cliff, Brome Lake, Hatley, Potton, Richmond, Stanstead; n=15). Three focus groups were also held with the immigrant community in Estrie. The 1st group consisted of sixteen established refugees who were considered immigrants. The two other focus groups were held in Sherbrooke (n=5) and in Granby (n=6). The selection of participants was made by community organizations (i.e., Service d'aide aux familles réfugiées et immigrantes de l'Estrie, Fédération des communautés culturelles de l'Estrie, Townshippers Association) and by partners of the CIUSSS de l'Estrie — CHUS.

Data collection

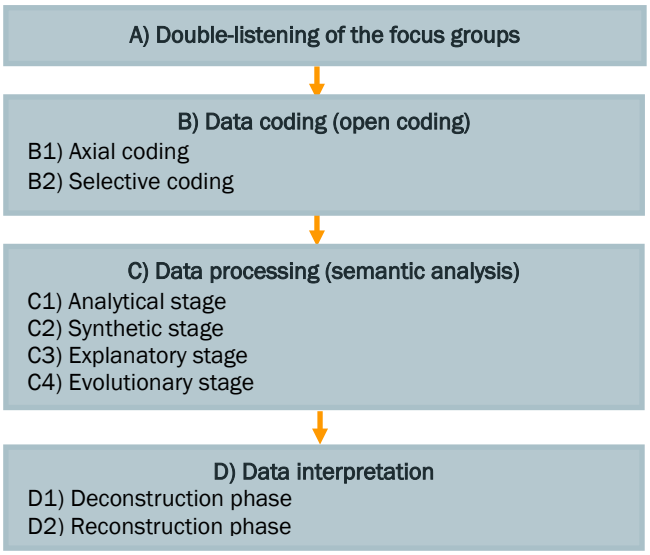
Four main themes were addressed in each focus group (see interview grid, Appendix B):

1) perceived health needs and social needs;
2) experience with the health and social services network;
3) adaptation of the health and social services network to the specific needs and concerns of each community;
4) work experience.

The interview grid was created based on a conceptual model. The focus groups were held between March 18 and April 16, 2016. They lasted approximately two hours and were recorded to analyze the discourse.

Data analysis

Two content analyses were completed using the following procedure, one for the discourse of English speakers and one for the immigrant community.



1st stage = Double-listening of each focus group

Each focus group was listened to twice. The 1st listening was one of appropriation to identify the main themes which characterize each focus group. Gross passages were positioned under the identified themes and became analytical subcategories. The 2nd listening was used to validate and enhance the appropriation listening and to increase the internal validity of the data gathered.

2nd stage = Data coding

In the coding stage, the gross data are classified in a grid composed of analytical categories.[83] These categories can be established during the data coding (open coding) or prior to it (closed coding). A two-stage approach to open coding (i.e., axial coding and selective coding) was performed. For the axial coding, analytical categories arose from listening to the focus groups[84] in which passages associated with one another are identified. These passages become subcategories which correspond to ideas or concepts associated with the analytical objectives. These subcategories are grouped into global dimensions. These dimensions, formed from the subcategories, are the analytical categories of the analytical grid. Next comes selective coding, which consists of ordering the categories of the analytical grid.

3rd stage = Data processing

In the data processing stage, processing may be semantic or statistical.[85] The semantic method was used: it is founded on a deep understanding of the discourse through the analytical grid. The semantic analysis is executed in four stages: (1) an analytical stage in which are studied the subcategories from which the categories of the analytical grid are created, (2) a synthetic stage in which the analytical categories point to a structure to construct a discourse; (3) an explanatory stage in which are studied the associations among the analytical categories, and (4) an evolutionary stage from which the qualitative discourse emerges.

4th stage = Data interpretation

The final stage of the content analysis consists of interpreting the coded and processed data. This stage is conducted in two phases: deconstruction and reconstruction. The deconstruction phase involves removal from the focus groups to reposition the data for the analytical objectives.[86] The reconstruction phase involves producing arguments in which one's own ideas are developed based on the qualitative discourse constructed.

APPENDIX B: INTERVIEW MODALITY

FOCUS GROUP (IMMIGRANTS)

WORD OF INTRODUCTION .....[+/- 5 minutes]

Hello everyone.

My name is Mathieu Roy. I am a scientific adviser with the Direction générale adjointe of the CIUSSS de l'Estrie — CHUS and I am currently working with the Direction de publique de l'Estrie to produce a thematic monitoring report on the health of cultural and linguistic communities. Without your participation today, this report would never be completed. Its completion is largely attributable to your presence. Therefore, on behalf of the Direction de santé publique, allow me to thank you.

The objective of the focus group is to identify your primary health and social services needs. To that effect, we will discuss four specific issues. They are: (1) your health needs and your social needs, (2) your experience with the health and social services network (3) how the network might better take into consideration your needs and concerns; and (4) your work experience. Each of these issues will be addressed through different questions. There will be a total of 14 questions and it will take approximately two hours to answer them.

My role today will be to ask you some questions and to listen to you. I will not take part in the discussion. However, I invite you to engage in discussion among yourselves, one person at a time, so that we can hear you better on the audio recorder in the middle of the table. During focus groups, some people tend to speak more than others. Because I would like to hear what everyone has to say and because everyone has had a pertinent experience, I might interrupt some people or ask others to speak more. Do not be offended if it happens to you. I might even intervene on occasion to follow a lead which seems promising to me. I ask that you write notes on the sheet of paper given to you to keep track of your thoughts while waiting for your turn to speak. (Remember that, as far as possible, only one person can speak at a time.) Finally, I wish to remind you that anything you say is strictly confidential. In no circumstance will it be possible to identify you.

During the focus group, I will give you a file which mentions your first and last name as well as your country of origin. I would appreciate it if you could add the following information:

- your age
- your city
- the number of months or years since you landed in Canada
- your signature and phone number (or email) where I can reach you if we ever needed to contact you again.

Thank you and may you have a pleasant conversation.

QUESTIONS DURING THE FOCUS GROUP..... [+/- 115 minutes]

Round table.....[+/- 5 minutes]

- Let's break the ice and introduce ourselves. One by one, we can give our last name and first and mention how long we have been in Canada.
- I'm Mathieu Roy. I'm 34 and I first arrived in Estrie 5 years ago. It is a pleasure to meet you today.

Opening question.....[+/- 10 minutes]

1) *Let's proceed with the first question. What does health mean to you?*
2) *Now that I have heard you define health, what do you or your family do to be or remain healthy?*

1st issue = Health and social needs.....[+/- 30 minutes]

3) *What are your health needs, those of your family, or those of your community? By health needs, I mean those which concern your body or mind.*
   Name body and mind independently in order to have two independent answers.
4) *Do you or your family have any social needs? Specifically, do you have needs which are not health-related but which would greatly improve your life in general?*
5) *Do you, your family or your community have needs other than health or social needs?*

2nd issue = Experience with the health and social services network .....[+/- 30 minutes]

6) *Talk to me about your experience with the health and social services network (or of the experience of people you know). By health and social services network, I am referring to any public institution which provides health care services or social services, and that is associated with physical health, mental health, or even well-being.*
7) *For you or your family, what would or does facilitate the use of health services or of social services in Estrie?*
8) *On the contrary, for you or your family, what would or does complicate the use of health services or of social services in Estrie?*
9) *Do you or any people you know currently use or have you used resources other than those of the health and social services network? Alternative resources?*

3rd issue = Adaptation of the network according to needs .....[+/- 15 minutes]

10) *How can the health and social services network offer care or services which better meet your needs, those of your family, or those of your community?*

4th issue = Employment issues .....[+/- 15 minutes]

11) *Can you talk to me about the issues or difficulties that you (or someone you know) currently experience or have experienced at your job (or at a job you once held)?*
12) *When you arrived and did not yet master the language, was it difficult to find work?*
13) *Do you have any suggestions for improving the occupational situation of immigrants, or what have you done to improve a situation that you experienced related to your job?*

Closing question.....[+/- 5 minutes]

14) *This is the final question. Is there anything you would like to add that has not been mentioned or overly discussed today?*

Closing remarks .....[+/- 5 minutes]

Once again, thank you for participating. I will listen to our conversation again in order to analyze it in depth. Do not worry. It will not be possible to identify you. As soon as my analysis is completed, I will destroy the recording of our conversation. If you have any further questions, I remain available. Thank you and have a nice day.

FOCUS GROUP (ENGLISH-SPEAKERS)

Introduction.....[+/- 5 minutes]

Hello everyone.

My name is Mathieu Roy. I am a scientific adviser with the Direction générale adjointe of the CIUSSS de l'Estrie — CHUS and I am currently working with the Direction de publique de l'Estrie to produce a thematic monitoring report on the health of cultural and linguistic communities. Without your participation today, this report would never be completed. Its completion is largely attributable to your presence. Therefore, on behalf of the Direction de santé publique, allow me to thank you.

The objective of the focus group is to identify your primary health and social services needs. To that effect, we will discuss four specific issues. They are: (1) your health needs and your social needs, (2) your experience with the health and social services network (3) how the network might better take into consideration your needs and concerns; and (4) your work experience. Each of these issues will be addressed through different questions. There will be a total of 14 questions and it will take approximately two hours to answer them.

My role today will be to ask you some questions and to listen to you. I will not take part in the discussion. However, I invite you to engage in discussion among yourselves, one person at a time, so that we can hear you better on the audio recorder in the middle of the table. During focus groups, some people tend to speak more than others. Because I would like to hear what everyone has to say and because everyone has had a pertinent experience, I might interrupt some people or ask others to speak more. Do not be offended if it happens to you. I might even intervene on occasion to follow a lead which seems promising to me. I ask that you write notes on the sheet of paper given to you to keep track of your thoughts while waiting for your turn to speak. (Remember that, as far as possible, only one person can speak at a time.) Finally, I wish to remind you that anything you say is strictly confidential. In no circumstance will it be possible to identify you.

During the focus group, I will give you a file which mentions your first and last name as well as your country of origin. I would appreciate it if you could add the following information:

- your age
- your city
- your signature and phone number (or email) where I can reach you if we ever needed to contact you again.

Thank you again…

QUESTIONS FOR THE FOCUS GROUP ..... [+/- 115 minutes]

Everybody's presentation .....[+/- 5 minutes]

- Let's break the ice and introduce ourselves. One by one, we can give our last name and first and mention how long we have been in Canada. I'm Mathieu Roy. I'm 34 and I first arrived in Estrie 5 years ago. It is a pleasure to meet you today.

Opening question .....[+/- 10 minutes]

1) *Let's proceed with the first question. What does health mean to you?*
2) *Now that I have heard you define health, what do you or your family do to be or remain healthy?*

1st issue = Health and social needs .....[+/- 30 minutes]

3) *What are your health needs, those of your family, or those of your community? By health needs, I mean those which concern your body or mind.*
4) *Do you or your family have any social needs? Specifically, do you have needs which are not health-related but which would greatly improve your life in general?*
5) *Do you, your family or your community have needs other than health or social needs?*

2nd issue = Experience with the health and social services network .....[+/- 30 minutes]

6) *Talk to me about your experience with the health and social services network (or of the experience of people you know). By health and social services network, I am referring to any public institution which provides health care services or social services, and that is associated with physical health, mental health, or even well-being.*
7) *For you or your family, what would or does facilitate the use of health services or of social services in Estrie?*
8) *On the contrary, for you or your family, what would or does complicate the use of health services or of social services in Estrie?*
9) *Do you or any people you know currently use or have you used resources other than those of the health and social services network? Alternative resources?*

3rd issue = How to adapt the system to individual needs?.....[+/- 15 minutes]

10) *How can the health and social services network offer care or services which better meet your needs, those of your family, or those of your community?*

4th issue = Issues related to work .....[+/- 15 minutes]

11) *Can you talk about issues or problems that you had in connection with your job? These could also be work-related issues that your friends or family have experienced.*
12) *How does language facilitate or complicate work-related issues?*
13) *Do you have any suggestions to improve your situation at work? Have you ever done anything to improve a situation that you experienced related to your job*

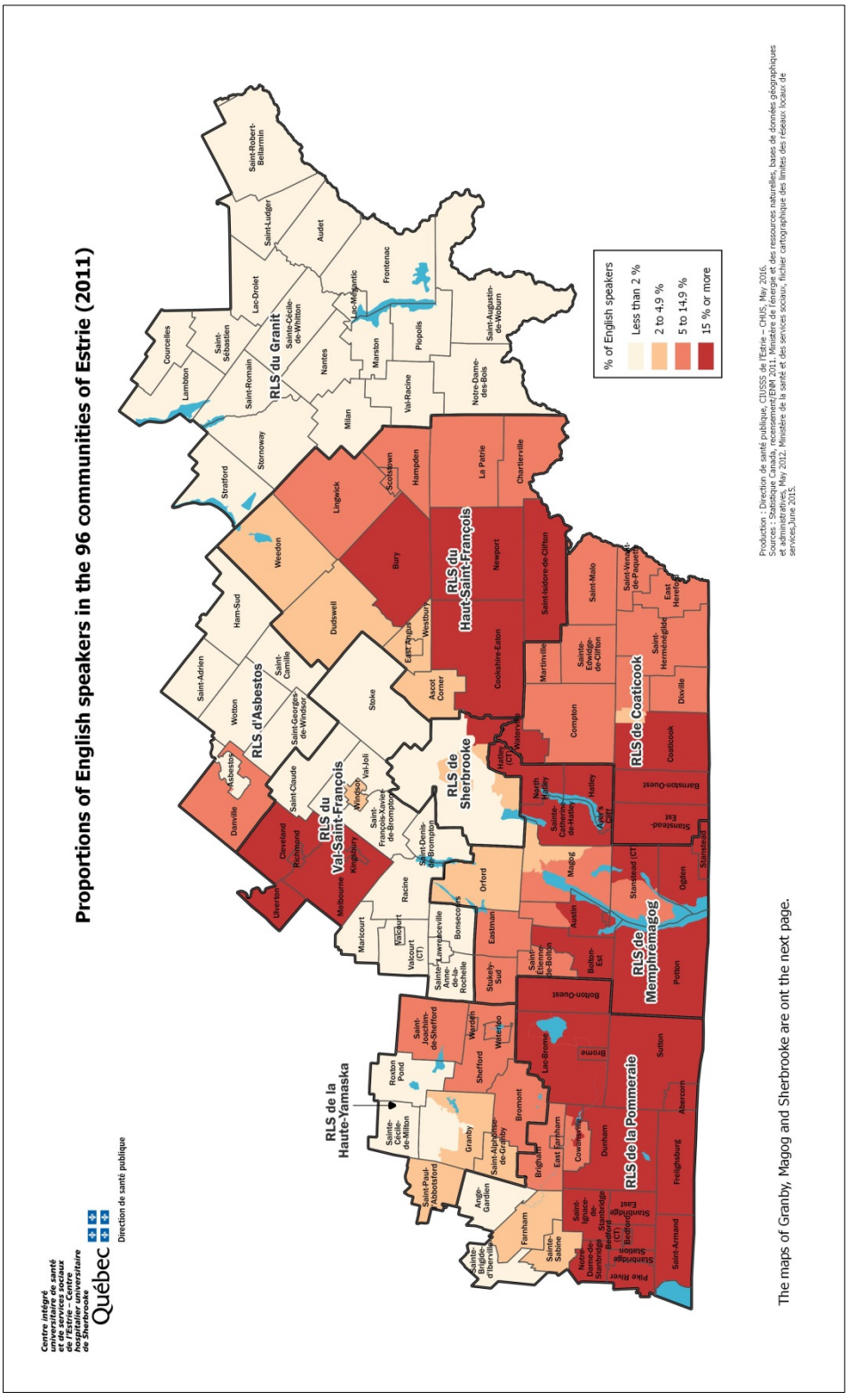
Closing question .....[+/- 5 minutes]

14) *This is the last question. Is there anything you want to add that has not been covered today?*

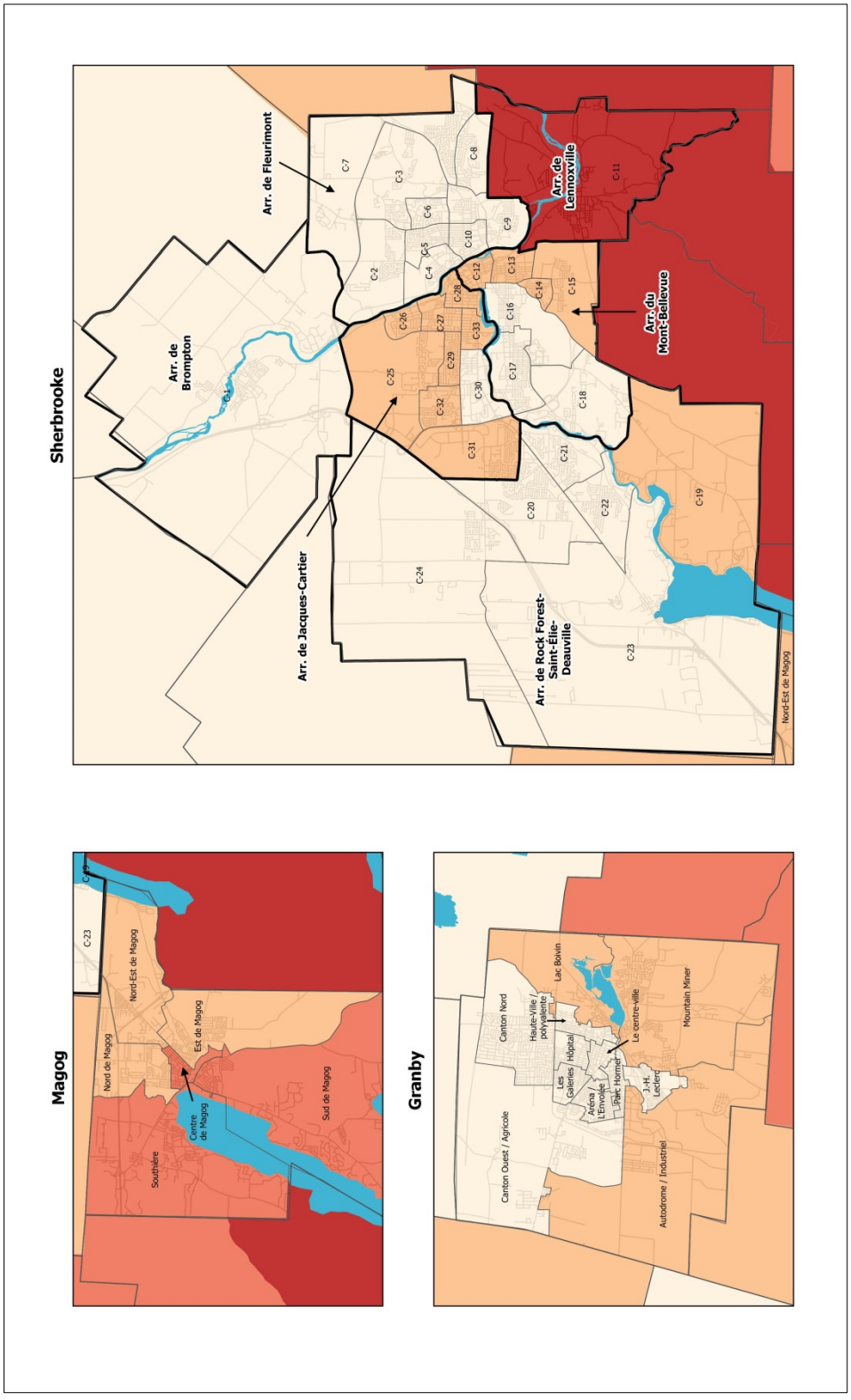
Closing remarks.....[+/- 5 minutes]

Once again, thank you for participating. I will listen to our conversation again in order to analyze it in depth. Do not worry. It will not be possible to identify you. As soon as my analysis is completed, I will destroy the recording of our conversation. If you have any further questions, I remain available. Thank you and have a nice day.

APPENDIX C: MAPS OF THE PROPORTIONS OF ENGLISH SPEAKERS AND OF IMMIGRANTS IN THE 96 COMMUNITIES OF ESTRIE



The maps of Granby, Magog and Sherbrooke are ont the next page.

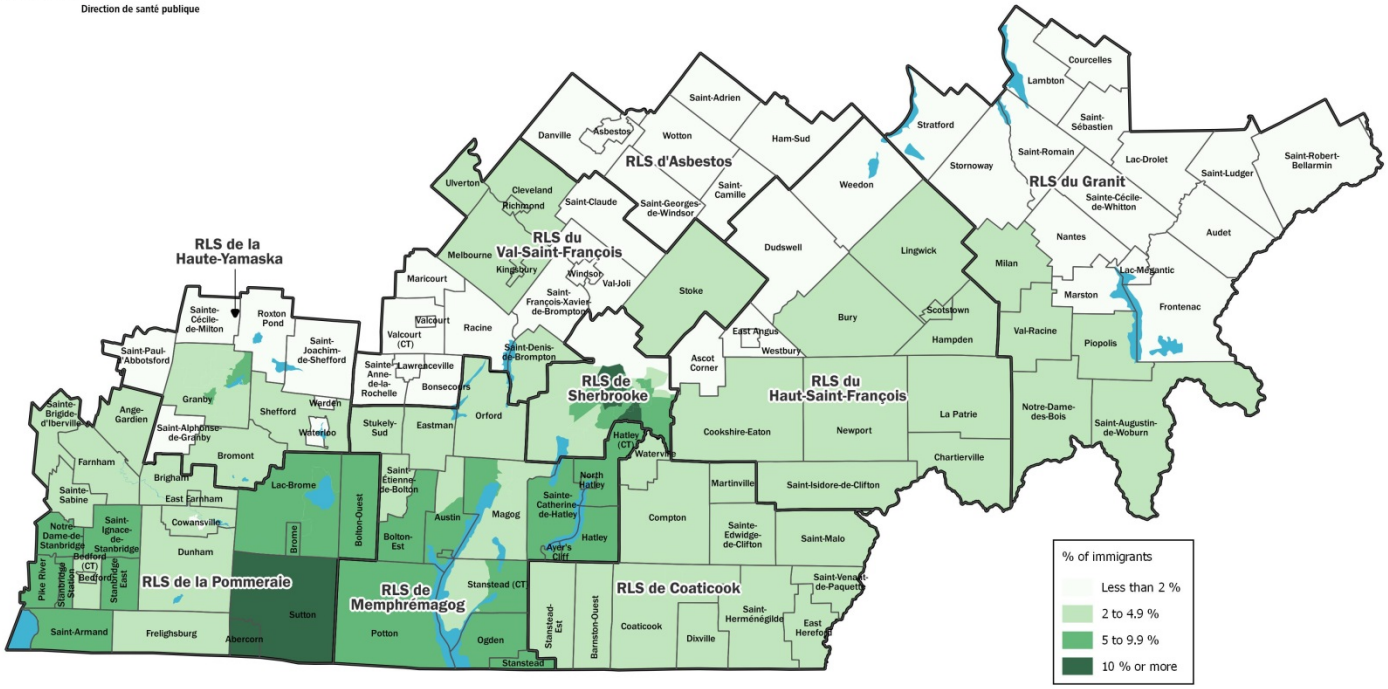

Sherbrooke
Arr. de Fleurimont
Arr. de Brompton
Arr. de Jacques-Cartier
Arr. de Rock Forest-Saint-Élie-Deauville
Arr. de Lennoxville
Arr. du Mont-Bellevue
Nord-Est de Magog
Magog
Nord de Magog
Nord-Est de Magog
Est de Magog
Centre de Magog
Sud de Magog
Southière
Granby
Canton Nord
Canton Ouest / Agricole
Haute-Ville / polyvalente
Lac Boivin
Les Galeries / Hôpital
Aréna / L'Envolée
Parc Horner
Le centre-ville
J.-H.-Leclerc
Mountain Miner
Autodrome / Industriel

Centre intégré universitaire de santé et de services sociaux de l'Estrie – Centre hospitalier universitaire de Sherbrooke

Québec

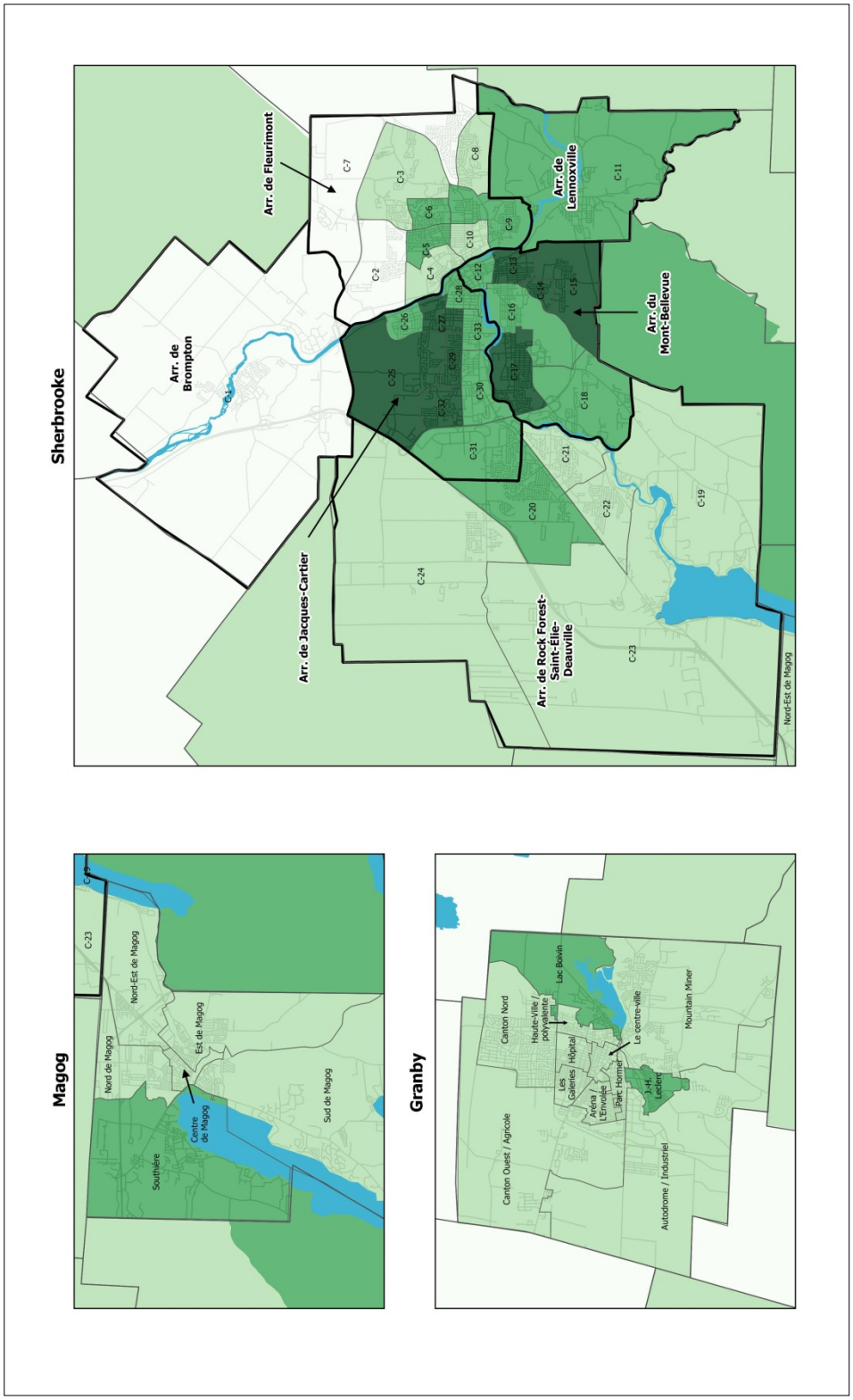
Direction de santé publique

Proportions of immigrants in the 96 communities of Estrie (2011)



The maps of Granby, Magog and Sherbrooke are on the next page.

Production : Direction de santé publique, CIUSSS de l'Estrie – CHUS, May 2016.
Sources : Statistique Canada, recensement/ENM 2011. Ministère de l'énergie et des ressources naturelles, bases de données géographiques et administratives, May 2012. Ministère de la santé et des services sociaux, fichier cartographique des limites des réseaux locaux de services, June 2015.


Sherbrooke
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Aréna / L'Envolée
Parc Horner
Le centre-ville
Mountain Miner
J.-H. Leclerc
Autodrome / Industriel

APPENDIX D: PROFILE OF FOCUS GROUP PARTICIPANTS

English-speaking community

Two focus groups with a total of 21 participants.

		Total	% of total
Sex	Men	5	23.8
	Women	16	76.2
Age	20-29	1	4.8
	30-39	2	9.5
	40-49	1	4.8
	50-59	2	9.5
	60+	15	71.4
Rural: urban		15: 6	

Rural: participants from Ayer's Cliff, Brome Lake, Hatley, Potton, Richmond, and Stanstead (n=15)

Urban: participants from Sherbrooke and Magog (n=6)

Immigrant community

Three discussion groups with a total of 27 participants.

		Total	% of total
Sex	Men	6	22.2
	Women	21	77.8
Age	20-29	7	7.4
	30-39	6	22.2
	40-49	8	29.6
	50-59	2	7.4
	60+	2	7.4
	Unknown	2	7.4

Country of origin of immigrants: Argentina, Belgium, Bhutan, Burundi, Colombia, Côte d'Ivoire (Ivory Coast), Senegal, Togo.

Average number of years since landing in Canada: 6.2 years.

LIST OF REFERENCES

1 MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX DU QUÉBEC (2016). “Pour améliorer la santé de la population du Québec.” *Programme national de santé publique*, 85.

2 MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX DU QUÉBEC (2011). Québec Official Publisher. *An Act Respecting Health Services and Social Services*, RSQ, chapter S-4.2, section 171. Retrieved on August 15, 2016 from http://legisquebec.gouv.qc.ca/en/ShowDoc/cs/S-4.2.

3 BOWEN, S. (2001). "Language Barriers in Access to Health Care," Health Canada, 141.

4 POCOCK, J. and B. HARTWELL (2010). *Profil de la communauté anglophone des Cantons-de-l’Est* (2nd ed.), 34.

5 STATISTICS CANADA (2011). 2011 Census.

6 MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX (2014). *Births files.*

7 INSTITUT DE LA STATISTIQUE DU QUÉBEC (2013). “Portrait statistique pour le Québec et ses régions administratives,” *Enquête québécoise sur le développement des enfants à la maternelle 2012,* 104.

8 INSTITUT DE LA STATISTIQUE DU QUÉBEC (2014). “Mise à jour du profil sociodémographique, scolaire et socioéconomique,” *Enquête québécoise sur le développement des enfants à la maternelle (EQDEM) 2012*. Retrieved from the INSPQ Infocentre.

9 DIRECTION DE SANTÉ PUBLIQUE DE L’ESTRIE (2014). “La santé buccodentaire en Estrie,” *Bulletin Vision Santé Publique,* no. 11, 1-7.

10 INSTITUT DE LA STATISTIQUE DU QUÉBEC (2008). *Enquête québécoise sur la santé de la population*. Retrieved from the INSPQ Infocentre. Indicator last updated on November 30, 2015.

11 INSTITUT DE LA STATISTIQUE DU QUÉBEC (2010-2011). *Enquête québécoise sur la santé des jeunes du secondaire*, Retrieved from the INSPQ Infocentre. Indicator last updated on September 6, 2016.

12 DIRECTION DE SANTÉ PUBLIQUE DE L’ESTRIE (2014-2015). *Enquête de santé populationnelle estrienne*.

13 INSTITUT NATIONAL DE SANTÉ PUBLIQUE DU QUÉBEC (2013). “Quelques habitudes de vie et indicateurs de santé des anglophones du Québec,” *La langue, déterminant de santé et de la qualité des services*, 52.

14 STATISTICS CANADA (2011). *National Household Survey.*

15 INSTITUT DE LA STATISTIQUE DU QUÉBEC (2010-2011). “Le médecin de famille et l’endroit habituel de soins : regard sur l’expérience vécue par les Québécois,” *Enquête québécoise sur l’expérience de soins,* vol. 2, 73.

16 INSTITUT DE LA STATISTIQUE DU QUÉBEC (2010-2011). “La consultation pour des services sociaux : regard sur l’expérience vécue par les Québécois.” *Enquête québécoise sur l’expérience de soins,* vol. 3, 49.

17 COMMUNITY HEALTH AND SOCIAL SERVICES NETWORK (2015). “L’accès aux soins de santé et aux services sociaux en anglais au Québec,” *Sondage sur la vitalité des communautés RCSSS/CROP,* 105.

18 INSTITUT NATIONAL DE SANTÉ PUBLIQUE (2011). “Est-ce que l'accessibilité géographique des centres de dépistage influe sur la participation des femmes au Programme québécois de dépistage du cancer du sein?”, 53.

19 SCHUELER, K.-M. et, autres (2008). “Factors associated with mammography utilization: A systematic quantitative review of the literature,” J Women’s Health, 17(9):1477-1498.

20 CARBONNEAU, M., et al. (2011). ”Perception et satisfaction des femmes ayant participé au Programme québécois de dépistage du cancer du sein en Estrie,” Direction de santé publique et de l’évaluation, Agence de la santé et des services sociaux de l’Estrie, 144.

21 INSTITUT NATIONAL DE SANTÉ PUBLIQUE DU QUÉBEC (2013). “La mortalité évitable des deux principales communautés linguistiques du Québec,” *La langue, déterminant de l’état de santé et de la qualité des services*, 52.

22 STATISTICS CANADA (2010). *Definition of immigrant.* Retrieved on May 5, 2016, from http://www.statcan.gc.ca/pub/81-004-x/2010004/def/immigrant-eng.htm].

23 MINISTÈRE DE L’IMMIGRATION, DE LA DIVERSITÉ ET DE L’INCLUSION DU QUÉBEC (2011-2015). “L’immigration permanente au Québec selon les catégories d’immigration et quelques composantes,” *Portrait statistique*, Direction de la recherche et de l’analyse prospective, 100.

24 Id. reference 23.

25 Id. reference 23.

26 Id. reference 23.

27 MUNOZ, M. and CHRIGWIN, J.C. (2007). ”Les immigrants et les demandeurs d’asile : nouveaux defis,” *Le médecin du Québec,* 42 (2), 33-43.

28 GOUVERNEMENT DU QUÉBEC. Québec Official Publisher. *An Act Respecting Health Services and Social Services*, RSQ, chapter S-4.2, sections 2.5 and 2.7. Retrieved on August 15, 2016 from http://legisquebec.gouv.qc.ca/en/ShowDoc/cs/S-4.2.

29 GOUVERNEMENT DU QUÉBEC. Québec Official Publisher. *An Act Respecting Health Services and Social Services*, RSQ, chapter S-4.2, section 171. Retrieved on August 15, 2016 from http://legisquebec.gouv.qc.ca/en/ShowDoc/cs/S-4.2.

30 HEALTH CANADA (2010). “Migration Health: Embracing a Determinants of Health Approach,” *Health Policy Research Bulletin*, no. 17, 10.

31 AGENCE DE LA SANTÉ ET DES SERVICES SOCIAUX DE LAVAL (2014) “Agir ensemble pour l’avenir des tout-petits Lavallois,” *Portrait Lavallois sur le développement global des jeunes enfants,* Direction régionale de santé publique, 54.

32 AGENCE DE LA SANTÉ ET DES SERVICES SOCIAUX DE MONTRÉAL (2014). “Portrait montréalais du développement des enfants à la maternelle,” Direction de santé publique de Montréal, 104.

33 STATISTICS CANADA (2011). National Household Survey.

34 SIMICH, L., and B. JACKSON (2010). “Social Determinants of Immigrant Health in Canada: What Makes Some Immigrants Healthy and Others Not?” *Health Policy Research Bulletin*, no. 17, 26-29.

35 Id. reference 34.

36 INSTITUT DE LA STATISTIQUE DU QUÉBEC (2015). "État de santé, utilisation des services de santé et besoins non comblés des immigrants au Québec," *Zoom santé*, 10.

37 INSTITUT DE LA STATISTIQUE DU QUÉBEC (2014). "L'état de santé des immigrants du Québec a-t-il changé au cours des années 2000 par rapport à celui des Canadiens de naissance? Une vue d'ensemble à partir d'indicateurs-clés," *Zoom santé*, 15.

38 HYMAN, I. (2001). "Immigration and Health," *Health Policy Working Paper Series*. Working Paper 01-05. Ottawa (Ontario): Health Canada.

39 HYMAN, I. (2007). "*Immigration and Health : Reviewing Evidence of the Healthy Immigrant Effect in Canada*." CERIS Working Paper No. 55. Toronto (Ontario): Joint Centre of Excellence for Research on Immigration and Settlement.

40 Ibid. reference 36.

41 Ibid. reference 37.

42 BEISER, M. (2005.) "The Health of immigrants and refugees in Canada," *Canadian Journal of Public Health, v*ol. 96 (suppl. 2), S30-S44.

43 Ibid. reference 36.

44 Ibid. reference 37.

45 EDWARD Ng. and WALTER, O. (2010). "Is there a healthy immigrant effect in mental health? Evidences from population-based health surveys in Canada." Statistics Canada: 23-28.

46 KHANDOR, E. and KOCH, A. (2011). "Newcomer Health in Toronto," *The Global City*. Toronto Public Health, 181.

47 Ibid. reference 37.

48 KHANLOU, N. (2010). "Migrant mental health in Canada." Faculty of Health, York University: 9-16.

49 Ibid. reference 45.

50 McDERMOTT, S. et, al. (2010). "Health services use among immigrants and refugees to Canada.", *Bulletin de recherche sur les politiques de santé*, No. 17, 37-40.

51 Ibid. reference 36.

52 Ibid. reference 50.

53 DIRECTION DE SANTÉ PUBLIQUE DE L'ESTRIE (2014-2015). Enquête de santé populationnelle estrienne.

54 Ibid. reference 36.

55 Ibid. reference 36.

56 MINISTÈRE DE L'IMMIGRATION, DE LA DIVERSITÉ ET DE L'INCLUSION (2016). Retrieved on August 1, 2016, from http://www.immigration-quebec.gouv.qc.ca/en/immigrate-settle/refugees-other/humanitarian-immigration/definitions.html.

57 Ibid. reference 23.

58 POTTIE, K. et al. (2011). "Evidence-based clinical guidelines for immigrants and refugees," *CMAJ*, vol. 183 (12), E824-E830.

59 NARASIAH, L. and De MARGERIE, G. (2007). "Le dépistage médical chez le nouvel arrivant," *Le Médecin du Québec*, vol. 42 (2), 55-61.

60 MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX (2012). Guide d'intervention de la tuberculose (2012 ed.). Québec, 148.

61 GUZMAN, C. et al. (2015). "La santé des réfugiés à Sherbrooke." Community health externship report under the supervision of Dr. G. Baron and F. Desjardins. Sherbrooke: Faculty of medicine and health sciences of the Université de Sherbrooke, 80.

62 Ibid. reference 53.

63 Ibid. reference 53.

64 FAZEL, M., et al. (2005). "Prevalence of serious mental disorder in 7,000 refugees resettled in western countries: a systematic review," *Lancet*, vol. 365, 1309-1314.

65 Ibid. reference 58.

66 Ibid. reference 58.

67 Ibid. reference 64.

68 Ibid. reference 58.

69 Ibid. reference 58.

70 Ibid. reference 58.

71 Ibid. reference 58.

72 Ibid. reference 60.

73 Ibid. reference 60.

74 AUGER, L.-T. and al. (2007). "Ces enfants venus d'ailleurs," *Le médecin du Québec*, Vol. 42, no 3, 55-63.

75 BOUCHARD, L. and DESMEULES, M. (2013). "Linguistic Minorities in Canada and Health," *Healthcare Policy*, 9, 38-47.

76 Ibid. reference 75.

77 Ibid. reference 4.

78 Ibid. reference 3.

79 Ibid. reference 15.

80 Ibid. reference 50.

81 Ibid. reference 15.

82 Ibid. reference 34.

83 ANDREANI, J.C., and CONCHON, F. (2005). “Fiabilité et validité des enquêtes qualitatives : Un état de l’art en marketing,” *Revue Française du Marketing,* vol. 201, 5-21.

84 STRAUSS, A., and CORBIN, J. (Ed.) (1998). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory* (2nd ed.). Thousand Oaks, USA: SAGE Publications.

85 Ibid. reference 83.

86 FELDMAN, M.S. (1994). *Strategies for Interpreting Qualitative Data*. Thousand Oaks, USA: SAGE Publications.