Does lack of health care information and literacy affect South Asian immigrants’ health in the greater Toronto area (GTA)?

Le manque d’information en soins de santé et le niveau d’alphabétisation affectent-ils la santé des immigrants sud asiatiques dans la région du grand Toronto (RGT) ?

ISLAM Tariqul S. M., ÉTONGUÉ MAYER Raoul

Abstract: Immigrant populations enter Canada hoping for a better quality of life and usually with higher health status because of the Canadian immigration process which screens out those who have health problems. However, visible minority immigrants experience barriers/challenges of lack of health information and literacy in accessing appropriate health care opportunities in the Greater Toronto Area (GTA). Using the SPSS software, this research conducted cross-tabulation, chi-square tests and Cramer’s V; the results show that there are statistically significant associations between South Asian immigrants’ self-rated health before and after coming to Canada as well as between self-rated health and health information and literacy variables. The results also show that South Asian immigrants’ self-rated health declined after living some time in Canada.

Résumé: Les populations immigrées entrent au Canada dans l'espoir d'y avoir une meilleure qualité de vie; elles jouissent généralement d'un bon état de santé en raison du processus de filtrage mis en place par Immigration Canada qui élimine tous ceux qui ont des problèmes de santé. Toutefois, dans la région du Grand Toronto (RGT) les immigrants, minorités visibles font face aux obstacles (défis) à cause du niveau d'alphabétisation et par manque d'information sur l'accès aux possibilités de soins de santé appropriés. En utilisant le logiciel SPSS, cette recherche qui s'appuie sur les tests de chi-carré et Cramer V et leurs résultats montrent qu'il y a statistiquement des associations significatives entre l'auto-évaluation de l'état de santé des immigrants sud-asiatiques avant et après leur arrivée au Canada ainsi qu'entre l'état de santé autoévalué, l'information sur la santé et les variables du niveau d'alphabétisation. Les résultats montrent également que l'auto-évaluation de l'état de santé des immigrants sud-asiatiques baisse après qu'ils aient vécu un certain temps au Canada.

Keywords / Mots clés

South Asian Immigrants, Health Information, Health Literacy, Access Barriers, Health Care.

INTRODUCTION

Immigration has been a key component in Canadian nation building and social development of Canada from the Confederation era. The state uses immigration to address the problems of labor shortage and economic development and population growth as well as to stimulate the economy and investment. The Canadian government has also been providing millions of dollars for immigrants’ settlement services: “This is all good news because Canada needs immigrants, and it needs them to succeed. Immigrants drive Canada’s economy, both as consumers and in the workforce. In 2012, immigration was responsible for two-thirds of Canada’s population growth” (Ryan, 2014). From this perspective, immigration settlement services have been introduced to help immigrants settle more easily and achieve full participation in Canadian life. However, the immigrants, especially the visible minority immigrants are facing challenges in accessing health care, education and employment services. This study analyzes health-care information and literacy challenges of South Asian immigrants in accessing the appropriate health-care opportunities in the Greater Toronto Area (GTA).
LITERATURE REVIEW

Canada is a multicultural society and English and French are the official languages spoken in the official settings. Although multiculturalism is the state policy, there are limited provisions to accommodate and communicate effectively across various cultural and language groups. The Ad Hoc Committee on Health Literacy (1999) describes health literacy as the ability to obtain, analyze and understand health information in order to make appropriate decisions about personal health (Simich, 2010).

In their article, Zanchetta and Poureslami (2006) provide examples of how health affects the communication between immigrants from different cultures, languages and health-care systems. Language is important because it is needed to accommodate different views of the world. The authors reported that there may be many reasons for low health literacy; however, low education, language, culture, traditional beliefs and other systemic factors do contribute to the low health literacy of immigrants (Zanchetta & Poureslami, 2006). They also found that visible minorities face barriers to access and service use, such as lack of information about certain health services available in Canada (Zanchetta & Poureslami, 2006). In another article, Kreps and Sparks (2008) explain that the need for effective communication about health risks and benefits is particularly important and complex. Immigrants who have difficulties in understanding health information face challenges in making sense of relevant health information which is also worsened by intercultural communication barriers.

Kreps & Sparks (2008) also argue that immigrant groups are “often confused and misinformed about health care services, early-detection guidelines, disease prevention practices, treatment strategies, and the correct use of prescription drugs, which can lead to serious errors and health problems” (p. 329). Members of vulnerable immigrant populations, such as the elderly, the less educated, and women, need culturally-relevant, accurate, and timely health-care information (Kreps & Sparks, 2008). These challenges necessitate adaptive, culturally-sensitive communication strategies. From that perspective, health literacy is a very important component of accessing appropriate health care. Simich (2010) explains in her article that without basic literacy skills, immigrants have difficulty managing health-related information. Reporting that low health literacy may have a long-term concern for immigrant populations, she also explains that even someone with higher educational attainment is not guaranteed the higher level of health literacy. Simich recommended health literacy intervention for immigrants (Simich, 2010). Pirisi’s (2000) article stated that low health literacy prevents patients from getting the full utilization of treatment, clinical information and equal access to care. The article reported that lower health literacy leads to poorer health outcomes (Pirisi, 2000). Given the literature review above, it is clear that visible minority immigrants, those coming from different cultural and linguistic backgrounds, have lower health literacy, which affects their access to health care.

SETTLEMENT SUPPORT SERVICES

In 1950, the Department of Citizenship and Immigration was created. From the very beginning, formal settlement services were provided, along with funding for a non-governmental organization to aid in the integration of newcomers (Tolley, Biles, Andrew, Esses, Victoria, Burstein, 2012). At the beginning the Welcome House and other settlement services were introduced throughout the 1960s and 1970s (Tolley et al., 2012). For integration of immigrants, the settlement services programs, integration policy, and governance were introduced in the 1970s.

In 1978, the Ontario Council of Agencies Serving Immigrants (OCASI) was established. The elements of the OCASI were federally funded immigration services and adaptation programs. In addition, the Metropolis project was introduced with the objective of determining whether the immigrant population could or would be integrated into Canadian society. The Metropolis project started in 1996 and functioned until 2013. Approximately 9000 policy makers, researchers and local community partners contributed to the project (Tolley et al., 2012). However, the question remains of how successful the various projects, program and policies and settlement services programs have been in fulfilling the immigrants’ need for better health and well-being.

The delivery of settlement services to newcomer immigrants involves both federal and provincial governments. The Ministry of Citizenship and Immigration Canada (CIC) does not provide services directly to the newcomers. Instead, it provides funding to the provinces, immigrant-serving organizations, and other community-based agencies. Three main funding programs are provided by the CIC: Language Instruction for Newcomers to Canada (LINC), the Immigration Settlement and Adaptation Program (ISAP) and the Host Program (The Fifth Report of the Standing Committee on Citizenship and
Immigration, 2003). The province of Ontario has a very rigorous immigration settlement services program in which municipalities play the major role with non-government settlement service providers named as neighborhood services. Other than municipalities and neighborhood service providers, the province provides information on its website regarding settlement and employment. Other settlement services agencies and community groups also provide some kinds of settlement services.

The Greater Toronto Area (GTA) includes the City of Toronto and the Regions of Peel, York, Durham and Halton. The City of Toronto and all of the regions have their public health and other community health service agencies according to the Province of Ontario. The City of Toronto also has a strategic Plan: A Healthy City for All (2010-2014). The foundation principles of the strategic plan are to ensure accountability, diversity, community engagement, health equity and commitment to excellence.

<table>
<thead>
<tr>
<th>Public Health Units</th>
<th>Hospitals</th>
<th>Community Care Access Centres</th>
<th>Community Health Centres</th>
<th>Nurse Practitioner-Led Clinics</th>
<th>Local Health System Networks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Province of Ontario</td>
<td>48</td>
<td>211</td>
<td>14</td>
<td>92</td>
<td>25 (plan)</td>
</tr>
<tr>
<td>GTA</td>
<td>10</td>
<td>64</td>
<td>4</td>
<td>30</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: Ontario Ministry of Health and Long Term Care, 2014.

Table 1: Organizations providing health-care services in the GTA

Table 1 shows that there are 64 Hospitals, 4 Community Care Access Centers, 30 Community Health Centers, 2 Nurse-Led Clinics and 5 Local Health Integration Networks (LHIN) in the GTA (Ontario Ministry of Health and Long-Term Care, 2014). There are also public health units for each of the regions and the City of Toronto. The health-care services and delivery systems were introduced for the emerging needs of immigrant populations living in the GTA.

RESEARCH METHODOLOGY

For this research, a cross-sectional research design was chosen. A total of 307 self-administered survey questionnaires were collected from South Asian immigrants living in the Greater Toronto Area (GTA). The data were collected by convenience sampling from five countries of South Asian: Bangladesh, India, Nepal, Pakistan, and Sri Lanka. Using the Statistical Package for the Social Sciences (SPSS) software, this research tested the study, conducting cross-tabulation, descriptive statistics and chi-square test to analyze and interpret the data. The measurements of the variables were: The dependent variables of the research—self-rated health, and access to health care—were collected by a questionnaire survey; and self-rated health was assessed with the Likert scale of the participants’ health as excellent, very good, good, fair, or poor. The independent variables of the study—the demographic and the socioeconomic characteristics of immigrants—were collected by a questionnaire survey.

DESCRIPTIVE RESULTS

GENERAL SOCIAL SUPPORT

Among the participants 42 percent acknowledged that they were informed by someone or some organization about the social support services and resettlement support services such as housing, employment, language training, education, access to health-care services, health-care information, etc., available for immigrants for their resettlement in their new country. The results show that 58 percent were not informed, although in Ontario, as soon as the immigrant lands here, an immigration officer provides a brochure regarding settlement services available in the cities (Figure 1). However, there is no health-related information brochure provided at the time of immigrants’ landing. In addition, other than in Ontario, no brochure was provided to earlier landed immigrants. Most of the immigrants reported they are not informed about the settlement services. The explanation is that when they land in Canada they are very excited about having an easy quality of life with employment and opportunities. They have a preconceived picture about Canada that as soon as they are here opportunities and employments are waiting for them. At the same time they do not understand about the settlement services and why they need those, what kind of services they are and why they need them; therefore, they do not even read those brochures.
Only 27 percent of the newcomer immigrants attended any information session regarding the available social support services for settlement in the GTA (Figure 2). Only 20 percent of the population received social support services in areas such as settlement, housing, information regarding services, and other basic needs in the GTA (Figure 3).

The general settlement support services for the immigrant population are very important for their resettlement in their host society. In the GTA, hundreds of neighborhood organizations, NGOs, the municipality’s own support services and other organizations are working to help newcomers. However, the data show that a very small number of the population reported receiving social support services. Although 42 percent were informed by relatives, friends or any other person and/or any organization about the social support services available for their settlement in the GTA, only 27 percent attended any information session regarding this availability and only 20 percent received any social support services in the GTA.
The data clearly show that the agencies failed to reach those people with their services; there may be a lack of communication between the immigrants and the service provider. Therefore, it can be said that there are challenges to accessing or receiving the social support services or perhaps the services are not convenient to immigrants and/or the services are not sufficient for their needs.

Only 30 percent of the participants attended Canadian official language classes after coming here to improve their communication skills. Although this percentage is not very high, it is a very good initiative on the part of the immigrants to gain valuable language training for their resettlement. However, among the population 41 percent of women went to the language proficiency class whereas only 20 percent of men attended. It is important to note that only 68 percent of the sample population had internet access immediately after they came to Canada.

HEALTH INFORMATION

South Asian populations have a very different home health-care system from Canada’s. For example, in South Asia there are public health-care systems and private health-care systems. People at any time can choose which one they want to use. The private health-care system is also affordable and readily available. In addition, there is less of a gate-keeping system in the South Asian health care system. For anyone wishing to visit a specialist the choice is open and they can see a specialist directly. On the other hand, the Ontario health-care system is very different from the South Asian system and is complicated to use from the South Asian population’s perspective. It is very important to know the health-related information, where to go for services and how to use and navigate the system. From that perspective, health information is very important for the newcomers and their better health and well-being. Many of the immigrants living in the GTA do not know the available health-care services and how the system works. The data also show that 30 percent of the participants do not know the needed information about the Ontario health-care services available to them (Figure 4). Among the population women are more informed about the available Ontario health care services than men.

In addition, almost 25 percent of the participants do not have information about the Ontario health-care system (Figure 5).
The data also show that 21 percent of the participants experienced difficulties getting the health information or advice they needed (Figure 6). Among them, women experienced more difficulties getting the health information or advice they needed.

**Figure 6: Participants who experienced difficulties getting health information**

However, of those who had lived less than two years in Canada, almost 31 percent experienced difficulties getting the health information or advice they needed. Among the difficulties they experienced: 35 percent of the participants were not receiving adequate information; 28 percent waited a long time to speak to someone; 20 percent did not know where to go/call; 18 percent did not know where to go/call; 18 percent experienced problems contacting a physician or nurse; 8 percent could not get through or have their call answered; 3 percent did not have a telephone number to call; and others, 3 percent.

Figure 7 shows that 53 percent of the participants did not have non-medical extended health insurance such as insurance for prescription drugs, eye care and glasses, dental care, chiropractic and so on. Among them half of the men had extended health care insurance; however, only 42 percent of the women had extended non-medical health insurance to support their prescription drugs, eye care, dental care and other services not covered by provincial health services.

**Figure 7: Participants who had extended health insurance**

HEALTH LITERACY

Health information and literacy are very important for accessing appropriate health care. More importantly, immigrant populations need proper information and literacy to access the Canadian health care system as well as to communicate and interact with health professionals to get decisions about the health care they need. Among the participants, 26 percent responded that they did not know how to use the Ontario health-care system; women are less comfortable with how to use the system (Figure 8).
In addition, of those who had lived less than three years in Canada, almost 41 percent did not know how to use the Ontario health-care system. This response is alarming. If someone has lived for almost three years in Canada and does not know how to use the health-care system, this is a very important barrier to accessing health care.

Among the participants 92 percent understood their physicians’ instructions and directions and only 8 percent had problems (Figure 9).

It is a concern that 17 percent do not know the basic information and services needed for making appropriate decisions about their personal health (Figure 10).
The participants also responded that 13 percent were not able to communicate effectively with their physicians to get information about their health (Figure 11); 17 percent of women were not able to communicate effectively with their physicians to get information about their health.

![Figure 11: Participants’ ability to communicate effectively](image)

However, of those who have lived less than three years in Canada almost 21 percent are not able to communicate effectively to get information about their health. The data show that almost 25 percent of the population are not familiar with how to use the Ontario health care system and do not know the basic information and services needed for making appropriate decisions about their personal health.

HEALTH STATUS AND BARRIERS TO HEALTH CARE

SELF-REPORTED HEALTH STATUS

The self-reported health was tested using cross tabulation and chi-square which compares South Asian immigrants’ health before and after they enter and live for some time in Canada. The chi-square test was conducted to determine how the two variables were associated. Cramer’s V was used for the strength of the association.

The cross-tabulation and a chi-square test were conducted and the results show that there is a statistically significant association between South Asian immigrants’ self-rated health before coming to Canada and their self-rated current health after living in Canada.

<table>
<thead>
<tr>
<th>Health on entering Canada</th>
<th>Health Now</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Good &amp; below</td>
<td>Very good</td>
</tr>
<tr>
<td>Good &amp; below</td>
<td>Count</td>
<td>56</td>
</tr>
<tr>
<td>% within Health Ago</td>
<td>88.9%</td>
<td>9.5%</td>
</tr>
<tr>
<td>Very good</td>
<td>Count</td>
<td>40</td>
</tr>
<tr>
<td>% within Health Ago</td>
<td>40.8%</td>
<td>55.1%</td>
</tr>
<tr>
<td>Excellent</td>
<td>Count</td>
<td>33</td>
</tr>
<tr>
<td>% within Health Ago</td>
<td>22.6%</td>
<td>26.0%</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>129</td>
</tr>
<tr>
<td>% within Health Ago</td>
<td>42.0%</td>
<td>31.9%</td>
</tr>
</tbody>
</table>

Table 2: Cross tabulation: Health on entering Canada/ Health Now

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>142.591</td>
<td>4</td>
<td>.000</td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>150.974</td>
<td>4</td>
<td>.000</td>
</tr>
<tr>
<td>Linear-by-Linear Association</td>
<td>99.096</td>
<td>1</td>
<td>.000</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>307</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 16.42.

Table 3: Chi-square test
The result of the bivariate analysis is $\chi^2 (4) = 142.59, p<.001$; Cramer’s V= .482. The chi-square test shows that there are statistically significant associations between self-rated health on entering Canada and after living a few years in Canada. Cramer’s V shows that there is a moderate to strong association between two of the variables. The result of the cross tabulation shows that, among the sample, 146 participants reported their health was excellent before coming to Canada, but after coming to Canada that self-reported health declined. Only 75 participants remained as excellent, 38 participants’ health decreased to very good, 33 to good and below category. The health of 98 participants who reported their health as very good also declined, as 54 reported remaining in the very good category, and 44 reported a decrease to good and below category. Among the participants, 54 reported their health before as good and 5 participants’ health increased to the excellent category; however, 6 participants’ health declined below category.

There is a statistically significant association between South Asian immigrants’ self-rated health before coming to Canada and their self-rated current health after entering Canada and living here for some time. The association between the variables is also strong. In addition, the cross-tabulation shows that the South Asian immigrants’ self-rated health declined after entering Canada.

### BARRIERS TO HEALTH CARE

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Self-rated health after entering Canada</th>
<th>Chi-Square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Good &amp; Below</td>
<td>Very Good</td>
</tr>
<tr>
<td>The South Asian immigrants who did not experience any difficulties getting the health information or advice had better health than those who had experienced difficulties.</td>
<td>No</td>
<td>92</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>37</td>
</tr>
<tr>
<td>Those who had the information about the health care system in the GTA had better self-rated health than those who did not have the information.</td>
<td>No</td>
<td>46</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>83</td>
</tr>
<tr>
<td>Those who did not have problems communicating their concern to their doctors had better self-rated health.</td>
<td>No</td>
<td>98</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>42</td>
</tr>
<tr>
<td>Those who did not have language barriers when trying to get routine or ongoing health care had better self-rated health than those who had language barriers.</td>
<td>No</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>80</td>
</tr>
<tr>
<td>Those who were familiar with using the Ontario health care system had better self-rated health.</td>
<td>No</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>85</td>
</tr>
<tr>
<td>Those who did not understand basic health information and the services needed to make appropriate decisions about their personal health had worse self-rated health.</td>
<td>No</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>90</td>
</tr>
<tr>
<td>Those who were able to communicate effectively with health professionals to get information about their health had better self-rated health.</td>
<td>No</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>102</td>
</tr>
</tbody>
</table>

P value, * ≤.05, ** ≤ .01, *** ≤ .001

Table 4: Statistical associations between self-rated health and barriers to access to health care services
The findings of Table 4 show that there are significant statistical associations between South Asian immigrants’ current self-rated health status and the variables of health information and literacy.

**DISCUSSION**

Many of the immigrants living in the GTA do not know the available health-care services and how the system works. The data also show that 30 percent of the participants do not know the needed information about the Ontario health-care services available to them. Among the population women are more informed about the available Ontario health care services than men; perhaps they need to use the system more frequently than men. In addition, almost 25 percent of the participants do not have information about the Ontario health-care system. Among the participants, 26 percent responded that they did not know how to use the Ontario health-care system; women are less comfortable with how to use the system. In addition, of those who had lived less than three years in Canada, almost 41 percent did not know how to use the Ontario health-care system. This response is alarming. If someone has lived for almost three years in Canada and does not know how to use the health care system, this is a very important barrier to accessing health care.

The findings of chi-square analyses supported the hypothesis that challenges/barriers to accessing health care affect the health status of South Asian immigrants negatively. The South Asian immigrants’ self-rated health declined after coming to Canada and living for some time in Canada. The results from the chi-square analyses supported the hypothesis that South Asian immigrants face significant challenges/barriers in accessing health care in the Greater Toronto Area (GTA).

There are significant associations between South Asian immigrants’ current self-rated health status and the variables involved in accessing barriers to health-care services. The South Asian community initially faces the challenges to enter into health-care services and information and how to use the system. The system is different from the one back home and along with other settlement challenges, they face challenges of health information, where to go, the entry point, how to get appropriate health services in their community and how to navigate the system.

**CONCLUSION**

Immigrants face multiple settlement challenges to their resettlement in their new society. Health information and literacy are very important for accessing appropriate health care. More importantly, immigrant populations need proper health information and literacy to access the Canadian health care system as well as to communicate and interact with health professionals to make decisions about the health care they need. For the lack of information, they do not know the basic information and services needed for making appropriate decisions about their personal health. From that perspective, health information is very important for the newcomers and their better health and well-being. South Asian is the fastest-growing immigrant group in the GTA. The results show that this population faced significant barriers in accessing appropriate health care opportunities in the GTA because of the lack of health information and literacy needed for their settlement period. Because of these challenges, their health declined.

**REFERENCES**


RYAN, PATTI (2014). "Newcomers to Canada". Maclean’s, 127, 53-56


Acknowledgement

This research was supported by the Social Sciences and Humanities Research Council of Canada.

To cite this article

Electronic reference

Tariqul Islam and Raoul Étongué Mayer, “Does lack of health care information and literacy affect South Asian immigrants’ health in the greater Toronto area (GTA)?” Canadian journal of tropical geography/Revue canadienne de géographie tropicale [Online], Vol. (1) 2, online in December 5, 2014, pp. 13-23. URL: http://laurentian.ca/cjtg

Authors

S. M. Tariqul ISLAM, Ph.D.
Interdisciplinary Human Studies
Laurentian University
Sudbury, Ontario, Canada
E-mail: sy_islam@laurentian.ca

Raoul ÉTONGUÉ MAYER, Ph. D.
Full Professor
Department of Geography
Laurentian University
Sudbury, Ontario, Canada.
E-mail: remayer@Laurentian.ca