ACCESSING CANADIAN HEALTHCARE FOR IMMIGRANTS: EMPOWERMENT, VOICE AND ENABLEMENT (ACHIEVE)

Setareh Ghahari
Queen's University

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INTRODUCTION

Healthcare services are an essential right provided to all Canadians; however the level of accessibility may vary across user groups. One of the groups with lower level of access are immigrants to Canada. Currently, immigrants constitute a growing proportion of Canadians, being responsible for two-thirds of Canada's population growth in recent years [1]. In 2019 alone, Canada is projected to welcome 330,000 newcomers [2].

It is believed that immigrants enter Canada with better health than native-born Canadians because mandated health screening during immigration is assumed to generate healthier-than-average newcomers [3]. However, literature has demonstrated a "healthy migrant effect", in which immigrants' higher-than-average health deteriorates when measured after 4 years of living in Canada and newcomers' health declines to mirror Canadian-born residents' poorer health [4 5 6]. This phenomenon has also been established, for not only physical health, but also mental health [7]. For example, research has shown that the migration process may select for personality traits such as "psychological hardiness" [8] but self-perceived mental health later deteriorates with longer residency in Canada [7]. While poor living conditions and inattention to health make newcomers susceptible to declined long-term physical and mental health, literature has highlighted specific barriers that prevent adequate healthcare access in immigrants [9,10]. Healthcare access can be defined as the ability to navigate health services and communicate effectively with healthcare providers [11]. Adequate access is important for immigrants to ensure they and their families are protected from worsening health over time and can receive sufficient resources to support wellbeing. However, there is strong evidence that immigrants do not access services because of a lack of knowledge, skills and confidence to find, access and navigate heath services. To overcome this barrier, literature suggests education programs for immigrants to enable timely access to health services and effective navigation of the healthcare system.

METHODS

The aim of this study was to pilot test the Accessing Canadian Healthcare for Immigrants: Empowerment, Voice & Enablement (ACHIEVE) program to address barriers that immigrants face accessing healthcare eservices in Canada. We hypothesized that immigrants who receive the ACHIEVE program will report better self-reported communication with healthcare providers and have improved confidence in navigating healthcare services in comparison to their baseline.

*Participant*s

Immigrants were included in the study if they were adults (over age 18) and had an English level of 3 or above according to Canadian Language Benchmark standards which is the ability to comprehend short and simple conversation [12]. All immigrants who showed interest in participating in this program received ACHIEVE program. However, data were collected only from those who consented to participate in the study.

Immigrants were recruited in Kingston through two organizations: KEYS Job Centre and Loyola School of Adult and Continuing Education. KEYS offers specialized services to immigrants, including a mentoring program, refugee resettlement services ESL (English as a Second Language) classes. The Loyola School supports the return of former students to the education system and also offers ESL classes. Students were allocated to different ESL classes according to English proficiency testing prior to commencing classes measured using Canadian Language Benchmark Standards. The research team recruited individuals for the study who were already involved in these classes. This project was approved for ethics at the Queen's University review board.

Measures

Demographic information was collected once at the beginning of the program to record participant age, type of immigration, family status, and years lived in Canada. Two questionnaires were also used to pilot test the efficacy of the program through participants' understanding and confidence in healthcare access.

1. The Health Education Impact Questionnaire (heiQ) by Osborne et al.[13], measures self-reported understanding and confidence in communicative ability with health organizations and health professionals. The heiQ Health Navigation Scale ($\alpha = 0.82$) and Program Evaluation Scale will help test validity in the results as the questionnaire is proven high in construct validity and reliability of measuring health education programs (Osborne, Elsworth, & Whitfield, 2007). The Health Navigation Scale will be conducted in a pre-post study format in which participants' self-perceived confidence in navigating health services before and after ACHIEVE will be assessed. This scale consists of 5 items on a 4-point Likert scale ranging from 1 (strongly disagree) to 4 (strongly agree).
   The Program Evaluation Scale was conducted solely after completion of the ACHIEVE program to measure participant satisfaction with the program overall in successfully teaching health literacy. This scale consists of 9 items on a 4-point Likert scale ranging from 1 (strongly disagree) to 4 (strongly agree), with a maximum score of 36. Permission to use the tool was obtained from the authors.

2. The second questionnaire entitled "Confidence in Health Access" was created by the research team using an exhaustive literature review and consultation by immigrant experts. Questions are based on the ACHIEVE program content with 2-3 questions ranked 0-5 (maximum scores on questionnaires therefore ranging between 10-15). Questionnaires were administered at the beginning and end of each weekly session to assess comprehension of course concepts.

Analysis

A paired samples *t*-test using Statistical Package for Social Sciences (SPSS) was calculated to test the effectiveness of the program in improving confidence and thus access to healthcare ($p<.05$). The heiQ questionnaire was used to measure participant satisfaction in the program using the Program Evaluation Scale. As the data violated assumptions of normality, Wilcoxon Signed Rank tests were calculated to determine the effectiveness of each individual session.

RESULTS

In total, 46 participants gave consent to participate in our research. Of these participants, 21 were females, 21 were male, and 4 did not fill out the demographic questionnaire indicating gender. The age range was between 20-74 with 10 participants between the ages of 20-30, 13 participants between the ages of 31-40, 9 participants between the ages of 41-50, and 7 participants between the ages of 51-74. 4 participants did not fill out the demographic questionnaire and 3 chose not to reveal their age.

Of the 46 consented participants, 20 completed both the pre-test and the post-test heiQ. The primary analysis of pre-post heiQ Health Navigation Scale scores met all assumptions including normality. Scores were summed and a paired samples t-test was conducted to examine if there was a difference in health navigation before and after the 7-week long ACHIEVE program. The test demonstrated that post-test scores (M=17.00) were significantly higher than pre-test scores (M=14.20, t(19)= -3.907, p = 0.001).

Self-report scores indicating participants' perceptions of the ACHIEVE program was completed by 22 participants using the heiQ Program Evaluation Scale, with a potential maximum score of 36. As this scale measured participants' satisfaction in the program, it was only distributed post-session. Descriptive statistics were as follows, M=32.454, Min= 24.00, Max= 36.00, SD=3.826.

LIMITATIONS

The limitations of this study provide insight to the considerations that should be made in future studies of ACHIEVE as well as when designing and testing future health literacy programs for immigrant and related populations.

Firstly, while the study recruited and educated many participants, the heiQ pre-post tests only had complete data for 20 participants and secondary analyses on session knowledge had 22 participants. This was largely due to problems with attrition and gathering consent. Attrition was a noteworthy problem for data collection as many participants would miss classes or leave class early for a variety of circumstances which prevented the research team from gathering post-session scores. This is the nature of ESL classes and was not related to our research. Research on English literacy programs has demonstrated problems with program completion for a variety of

reasons especially among those with low- to intermediate-level language skills [14]. Secondly, consent was also a problem among low- to intermediate- level English participants. The research team was informed of issues with comprehension of the consent form in earlier trials of the ACHIEVE program and had made revisions to remove all identified "difficult" wording. Although consent was simplified prior to the current study, the form was still too difficult for some participants to complete. ESL teachers also later informed the research team that many immigrants, particularly refugees, are hesitant to sign any form of documentation. Further, there is potential for undocumented participants or visiting immigrants in the country to participate in ACHIEVE which may prevent some individuals from wanting to provide demographic information despite reassurance that this would be kept confidential. The research team plans to reduce the perceived invasiveness of the questionnaire by removing numerous questions regarding immigration status in future studies as our analysis is not concerned about personal information but rather reported effectiveness of the program and increases in knowledge post-program. Finally, a study on "then-test" questions highlight the flaws of retrospective, "then-assessment as participants are more likely to report favourable results after investing significant time and therefore expect to gain some benefits from the program which may be reflective in their questionnaire responses [15]. Also, post-test answers may be skewed by social desirability bias such that participants understand they are providing an assessment of change and thus attest improvement. Given the limitations, the research team may explore shorter sessions to account for attrition and study designs like wait-list controls to control for potential response biases. Future study designs may also explore including a baseline measure a few weeks prior to commencing ACHIEVE to better monitor the effectiveness of the program.

CONCLUSION

This pilot study has shown evidence of positive results for the effectiveness of ACHIEVE in improving confidence in healthcare access as well as increased knowledge in specific areas of CHC. The research team hopes to replicate the results in a larger sample to find reliable success in the program for nationwide implementation. Future directions for ACHIEVE are anticipated for the program to be distributed via online modules to improve accessibility of the program. The research team is also planning to create various editions of ACHIEVE tailored for different English proficiency levels.

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