Low-income working immigrant families in Quebec: Exploring their challenges to well-being

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ABSTRACT

OBJECTIVES: To identify low-income working families' health challenges and understand their barriers and facilitators to navigating those challenges.

METHODS: We conducted a focused ethnographic study in a food bank in Montreal, Quebec. Using purposeful sampling, we recruited participants who had at least one employed family member and one live-in child. Sensitizing concepts included social determinants of health (SDH) and family strengths. Participant observation, focus groups and in-depth interviews constituted the primary means of data collection. Thematic and contextual analyses were conducted iteratively.

RESULTS: We recruited 25 participants, 22 clients (15 women and 7 men with up to 5 children per family) and 3 members of staff. All clients were immigrants, having been in Canada for a range of 2 months to 23 years, thus reflecting the ethnic demography of the site. Families described health as physical, mental and socio-cultural well-being. Challenges to well-being included insufficient finances, non-standard work, hurdles in professional equivalency, isolation, children's acculturation, inadequate access to health care and the Canadian winter. Personal and structural barriers and facilitators to navigating challenges centred on parents' sense of the challenges being finite, control over discrete dimensions of life and hope of children's future success. Families who incorporated these perceptions into their narratives seemed to describe the challenges as navigable. Importantly, the SDH model did not anticipate the degree to which challenges would be defined by immigration factors.

CONCLUSION: In order to help low-income working immigrant families face diverse challenges to well-being, community workers and policy-makers must consider the specific challenges of immigration and the importance of individual families' outlooks as they navigate them.

KEY WORDS: Low income population; social determinants of health; family health; immigration; food insecurity; employment

La traduction du résumé se trouve à la fin de l'article.

Can J Public Health 2015;106(8):e539–e545
doi: 10.17269/CJPH.106.5028

In Canada, 39% of one-earner households live under the low income cut-off (LICO), a commonly used low-income measure.¹ This prevalence of working poverty is due in large part to a low minimum wage and the pervasiveness of “non-standard work”,^{2,3} meaning non-full-time, non-permanent work characterized by difficult working conditions and a lack of benefits beyond universal coverage.² Non-standard work has been linked to anxiety, depression, sleep disturbance and higher mortality rates than for those with permanent work;⁴ further, poverty is associated with the poorest health outcomes for most diseases and causes of death.⁵ Recent immigrants (in Canada ≤5 years) are often in non-standard work and living under the LICO,¹ therefore at particular risk of adverse health outcomes. Our objective was to shed light on income–health pathways by asking low-income working immigrant families in Quebec about their challenges.

Since 2001, Canada has received 250,000 new immigrants annually.⁶ Most are “economic class”, selected because they are expected to contribute on the basis of their age, professional experience, education and English/French proficiency.⁶ Although immigrants tend to be highly educated, they face obstacles in obtaining equivalent professional certification to practise within their domain⁷ and so are more likely to work in non-standard positions than their Canadian-born counterparts.^{3,8} Accordingly,

the poverty rate of recent immigrants is almost twice the national rate.¹ Further, discrimination against immigrants is seen in racialized workers' decreased employment mobility and job security,⁹ unemployment among highly qualified immigrants³ and a waning perception that immigration has a positive impact on Canadian culture or the economy.¹⁰

Peter provides a social justice framework for judging and addressing health inequalities, encouraging a particular examination of the unjust economic, social and political institutions that underlie inequalities and render them inequities.¹¹ For low-income working populations, these institutions support policies that maintain a low minimum wage and a surfeit of non-standard work positions.⁸ Further, the long process that immigrants undergo to acquire professional equivalency and, in Quebec, the legislation enforcing French proficiency in the

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Acknowledgements: The authors are grateful to the food bank administration, staff, volunteers and clients for their support of and participation in this project. We thank the reviewers and Dr. Jacob Burack for their helpful comments on the manuscript.

Conflict of Interest: None to declare.

workplace impede integration into Canadian society and can lead to persistent low income.⁷ According to de Sousa Santos, inequities are based not only on unjust institutions but also on cognitive injustice: “Without establishing a more balanced (neither relativistic nor imperialist) relationship among rival knowledges, all the policies aimed at promoting social justice will end up furthering social injustice.”^{12,p.14} For low-income working immigrants, “rival knowledges” may underlie race-based discrimination and a negative public perception of immigration.

The growing prevalence of working poverty in Canada has been acknowledged,³ and the potential health risks have been explored^{13,14} and confirmed.¹⁵ Studies on low-income immigrant workers’ health have focused on the employment–health relationship, particularly on the mental health effects of overqualification in employment.^{16,17} The social determinants of health (SDH) have not yet been explored more broadly.^{5,18} Our qualitative exploration of health challenges, using a conception of health articulated by immigrants themselves, thus contributes substantively to effective and relevant priority-setting in low-income working immigrant health policy.¹⁹ We asked the following: 1) What are the health challenges of low-income working families who access a Montreal food bank? 2) What are the barriers and facilitators for these specific families with regard to navigating those challenges?

METHODS

We used focused ethnography, a qualitative anthropological methodology, to guide data collection on a specific concept (health challenges) in a discrete community (low-income working families accessing an urban food bank) over a defined time period (September to December 2014). Focused ethnography also facilitated close consideration of the socio-political systems that constrain and/or enable the well-being of our population.²⁰ The setting of the study was a Montreal food bank that distributes food to over 800 low-income clients weekly, 12% of whom cite employment as their primary source of income. Health challenges were valued from within a constructivist paradigm, i.e., challenges were considered to be what participants said they were.²¹ In line with cognitive justice, this approach invited perspectives that challenged culturally biased assumptions of not only what the problems were but also how they could be addressed.¹²

The study was conducted with ethical approval from the McGill University Institutional Review Board and the food bank’s Board of Directors.

Conceptual frame

We used the SDH²² and a strengths-based nursing approach that understands families as having inherent capacities, competencies and resources to navigate challenges.²³ Focusing on family strengths takes the emphasis away from problems and instead highlights the potential to work through challenges. These conceptual frames deductively contributed to interview and observation guides but were themselves scrutinized as data were iteratively collected and analyzed.

Data collection

The primary researcher (RP) was a Masters Nursing student with 18 years of nursing experience. She aimed for prolonged

engagement by volunteering at the food bank for four months, using field notes to capture social context. Food bank clients who had at least one employed family member and one child at home were purposively recruited for a total of 10 semi-structured interviews and 3 focus groups in either English or French. Data collection took place during food distribution hours in designated rooms on site. Following preliminary analysis, interviews were conducted with three staff members to provide further contextual data. Interview and focus group duration was determined by the time constraints of the participants (30–60 minutes for interviews, 35–75 minutes for focus groups). All but two participants agreed to be audio-recorded; non-recorded interactions were captured through field notes. Interviews were transcribed for analysis. All quotations have been rendered in English.

To facilitate reflexivity, RP maintained a diary with an analytic narrative of personal and professional issues that affected recruitment, data collection and analysis; debriefing of these issues took place regularly among the research team.²⁰ For example, while many of the participants were professionals with relatively high social status in their home country, their standing had dropped to low-income, non-standard worker and food bank client at the time of the interview. Thus, issues of power were reflected upon throughout planning (e.g., confidentiality, positioning of interviewer/participant(s), timing, interview questions), and during and after interactions.

Analysis

Iterative analysis included thematic and contextual analysis.²⁰ For thematic analysis, deductive constructs guided an initial categorization of all data according to the SDH,²² with a focus on family strengths.²³ This was followed by the identification of emergent inductive codes. Abstraction occurred as relationships among codes converged.²⁰ Preliminary analysis was verified with client participants through follow-up e-mails to establish accuracy and completeness, and to enhance the relevance of the project to participants.²⁰ Analysis of contextual data (interviews with staff and field notes) employed deductive (e.g., local and public policy) and inductive (emergent) constructs. This analysis sought understandings of the social and political systems within which these low-income working families experience their health challenges.

RESULTS

All client participants ($n = 22$) were immigrants; most were categorized as “economic class” and had been living as a couple in Canada for less than five years. Eighteen had confirmed professions before coming to Canada; all were currently employed in non-standard employment (see Table 1).

What is health?

When directly asked the question “What does health mean to you?”, many responded in the negative, i.e., as the absence of a physical or mental symptom or illness. For example, participants said: “not having worries”, “your children are not sick”, “not having pain”. As the interviews progressed into topics such as “What makes life easier/more difficult for you?”, dimensions of social well-being became prominent, clearly broadening the conception of health beyond mind/body to include the

Table 1. Client participant demographics

Variable	Client (n = 22*)
Age	26–51 years [†]
Sex	7 men, 15 women
Countries of origin	Brazil, Venezuela, Haiti, El Salvador, Benin, Cameroon, Côte d'Ivoire, Algeria, Iran, Romania
Married: single parent	18:4
Time in Canada	Range: 0.25–23 years
0–4 years	18
≥5 years	4
Immigration status	Permanent resident: 19 Economic class: 15 Unknown: 4 [‡]
Visible minority [§]	Student visa (spouse): 3 20
Number of children	Average: 2.2 Range: 1–5
Age of children	Average: 8.5 years Range: 0.1–19 years
Prior profession in country of origin	Nurse (6), “professional” (4), graphic designer (2), human resources administrator (1), seamstress (1), “social educator” (1), administrative assistant (1), accountant (1), undisclosed (5)
Employment at time of study	Grocery store (2), print technician (2), factory (5), retail (2), daycare (2), cleaner (2), garbage disposal (1), patient care attendant (3), secretary (2), undisclosed (1)

* 22 client participants from 17 families (5 couples were interviewed). Demographic data of staff not provided to preserve confidentiality.

[†] 16 participants revealed their age; therefore only a range is provided.

[‡] Since we did not anticipate an exclusively immigrant sample, we did not initially collect baseline data on immigrant status.

[§] Defined in *Employment Equity Act* as “persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour”.

^{||} If participant was unemployed, participant’s spouse’s form of employment was counted.

well-being of family embedded in socio-cultural contexts. For example: “a state of the soul where you can affirm yourself, realize yourself”, “if you’re OK with your situation”, “having a job... enough income, keeping your mind relaxed”, “being positive, learning, singing, dancing...” The field notes detailed clients’ harried pace through the food bank line, many having travelled up to 32 km on public transportation to get food for their families. This pace reflected their busy lives, including commitments such as work, language classes and family schedules. One staff member described the importance of accessing the food bank in terms of clients’ overall family well-being:

“Children not being able to eat enough and therefore not being able to concentrate in school, and you think, all the emotional... consequences that come from that... The food bank makes things a little easier.”

Challenges to well-being

Participants described many challenges that mapped onto the SDH²² (Table 2); these included insufficient income, difficult work, work instability, disability and unemployment, food insecurity, inadequate housing and problematic access to health care. Insufficient income infused all narratives. Its importance as a health challenge, often accompanied by difficult work, was described aptly by a mother of five from Cameroon, in Canada for 17 months and working on-call nights: “With a budget that is very much below what is required to meet basic needs, we are always not sleeping at regular hours, not eating at regular hours... With all the effort in the world we won’t have good health.” Some of the “basic needs” she referred to were captured by other participants as adequate food, warm clothing and utilities

in winter, children’s over-the-counter medications, preventive dental care and tutoring for children experiencing difficulty in school.

Other challenges related specifically to work. A 48-year-old Cameroonian woman working on call for 0–25 hours per week was unable to find stable work despite a willingness to work for minimum wage outside of her field; she had been told she was overqualified for entry-level positions. Disability prevented a Beninian participant, and the husband of a Haitian participant, from providing for their families.

Food insecurity was a common challenge for all participants, as captured by one member of staff: “Some [clients] are forced, in the sense that they do not have a choice, to come here, because it’s the only resource they have. But some choose to make their lives easier – since the service is free.” Finally, challenges to health care access related to finding a family doctor, affording dental care and prescriptions, and navigating an unfamiliar health system.

Table 2 outlines how challenges were intertwined with the specific hurdles of the immigrant experience and whether these were anticipated by the SDH. Immigrant-specific concerns informed participants’ conceptions of health (physical or mental) as “well-being”, a broader term we will use from now on. One Cameroonian mother spoke of the inadequacy of her children’s school food program in solving her family’s food insecurity, because of the unfamiliarity of food served. A Venezuelan participant associated her husband’s decreasing weight with his strenuous work, contrasting the hard physical labour with his sedentary occupation in their country of origin. Finally, an Ivoirian woman spoke of the racism her daughter experienced at school. They had rented their home without realizing it was in a predominantly White neighbourhood. She related that their focused intent on integration had hindered them from properly assessing their daughter’s experience until it was too late; she lost an entire school year.

Challenges to well-being that did not fit an SDH model included difficulties with professional equivalency, language acquisition for employment, decreasing social status, children’s educational equivalency, family unity in the context of children’s acculturation, and climate. The prevalence of immigrant-specific challenges was summed up by one concerned staff member with personal migration experience:

“We want qualified immigrants, but when they arrive, we don’t give them the tools to evolve and make this society a dynamic one, and a better one. Because this is the purpose of selecting qualified immigrants. I stress a lot on that because I see this every week – I don’t want to say every day – but every week I see this.”

Barriers and facilitators to navigating challenges

Participants described both personal and structural barriers and facilitators to navigating their challenges to well-being. Barriers were signaled by the SDH model, including minimum wage (income); insufficient or irregular hours, lack of benefits or practical skills to find work (employment/working conditions); difficulty securing a family doctor (health services); proximity/facility of transport to work (housing); unstable work (unemployment/job security); physical or mental compromise – pain, sleeplessness,

Table 2. Resettlement aspects of select challenges to well-being

Challenge to well-being	SDH ²²	Immigration-specific aspect(s)	Verbatim
Insufficient income to meet basic needs	Income	Expenses related to climate	"We haven't yet bought winter jackets for ourselves, because if I buy... maybe there won't be enough left to eat." (Algerian father of 3, in Canada 7 months, commuting 3 hours daily for minimum wage employment)
Inadequate housing	Housing	Timing of migration	"We didn't have much luck. We got a house that didn't heat well, because we arrived in June, so we didn't know. And when winter arrived, there was no heat, and there was humidity..." (47-year-old mother of 3 from Cote d'Ivoire, in Canada 17 months)
Isolation	Social safety network	Removal from established social support system; cultural differences	"[My children] must move on, to adjust to the people, to make new friends... And us too, we want to have friends too, but for now we're kind of isolated." (36-year-old mother from Romania, in Canada 2.5 months)
Lowered social status from country of origin	No category	Professional equivalency; working below skill level	"He's an engineer... When he went to work and he had to work in garbage, he said to me, 'Never in my life did I think I would do this'." (speaking of Ivoirian husband)
Professional equivalency/ language proficiency to work	No category	Incoherence of pre-immigration expectations and post-immigration reality	"I have 14 years experience in a special unit... And these days they don't accept me because of the language, but in my country your government told us you can find a good job, a good situation." (42-year-old Iranian nurse, in Canada 5 months)
Family unity in the context of acculturation	No category	Cultural and societal differences in behavioural norms	"[Our daughters have] adopted another mentality. I don't know whether it's a Quebec mentality, but they don't do any more what they used to do in our country. We have some difficulty to manage this side." (51-year-old father of 3 from Cote d'Ivoire)
Unknown Canadian winter	No category	Unfamiliar climate	"Today, I worry about the weather... the temperature... because it's our first winter here and we don't know anything." (38-year-old father of 2 from Romania)

anxiety – affecting work, study or family life (disability); high school education or lack of technological expertise (education); food bank accessibility and limited food options (food insecurity); social isolation (social safety network); and neighbourhood factors such as the racialization of geographic spaces (race).

Difficulty with professional equivalency was a frequent barrier to meeting challenges. Many spoke of the unanticipated steps and duration of the equivalency process; one related failing a nursing equivalency course because she was required to enter vital signs on a computer – technology she had never used. A staff member described the common disillusionment that results from the hurdles of equivalency:

"Some immigrant families ... who are able to work, who had a rough time at the beginning, they may just give up and say... 'I'll just stay on welfare, I'm able to eat, pay my rent, and the government is just giving us money... it's not a lot, but...' "

The primary facilitator to meeting challenges to well-being, anticipated by the SDH model but defined by an immigrant experience, was social support. This was characterized by cultural/ church group membership and friendships developed through work, children's academic integration programs and language courses. A Romanian participant, in Canada two months, spoke of a work colleague who helped with anticipating the winter:

"I say, 'what are we going to do in winter?' and he says, 'we have the bus, we have the metro... what's the problem?'... I saw him so positive so it made me less worried. He's from India, it's colder in Romania than in India, so if he's OK, I say OK, I'll be fine too."

Notes taken during focus groups corroborated this supportive phenomenon: participants were strangers to each other, yet came together through the conversation in an empathetic manner, helping each other to express thoughts and congratulating one another on successes narrated.

The following three themes were particularly salient as participants described their challenges.

1. Temporality, uncertainty and looking toward the future.

Whether expressed in terms of a definitive timeline for "success" or a general sense that the challenges were a temporary rite of passage to integration, framing experiences temporally had the effect of decreasing uncertainty for some participants. A father from Brazil, in Canada for one year, reflected on accessing a food bank: *"Yeah, I mean it's not the ideal... but we understand that... it's temporary."* This confidence can be contrasted to the destabilizing effects of uncertainty on a 44-year-old Beninian participant, who found his continued unemployment and inability to provide for his family six years after arriving in Canada difficult to accept: *"How much longer are we going to need [the food bank]?... The time that it goes on is important because we are always thinking about our situation... How will I manage? I am anxious all the time. Where will I end up?"*

Some participants used time to compare their progress with that of others. One woman recalled *"all of the waits and everything... It wasn't terrible because we knew of fellow Ivoirians who had come before us, who were not at all integrated, so compared to others it was better."*

2. A sense of control contributing to well-being.

The control over discrete dimensions of working poverty within the immigrant experience took on importance and seemed to help participants navigate challenges in multiple domains, including language acquisition, parenting, children's education, work schedule and the Canadian winter. Choice gave some participants a perception of active decision-making even in the context of deprivation, thus enabling a sense of control over their situation. Two mothers with casual work emphasized their choice to work less so that they could be at home with their children, despite persistent low income and a continued reliance on the food bank. One couple spoke of their decision to rent a larger apartment surrounded by parks: *"If we choose to live in another place, we would have a bit more money... but we choose to stay here and*

do less things.” Another participant dealt with her lack of control over finances through spiritual means: “I’ve passed to another mode of being positive in the head and to believe that God will do a miracle and to continue like that... You can’t understand it. For three weeks you don’t have more than \$10 in your bank account, but you live.”

3. Children’s well-being as a path towards parental well-being. Increased opportunity for children was the dominant long-term goal for which parents expressed a willingness to endure their challenges: *“We had a car, house, jobs... We came here for [the children’s] future, not for ours.”* A nurse related her story of moving to a different neighbourhood to address discrimination against her daughter – a move that increased her daily work commute by over two hours. Finally, a participant whose husband had been off work for three months because of disability summed up the day-to-day utility of a long-term perspective: *“It’s that desire to succeed that makes that the morning is not, no, all is not lost, you’ve just started, don’t give up... The children are motivated to stay, they’re doing better than we are, and when we see them, we want to stay.”*

DISCUSSION

Low-income working families are more likely to be immigrants,³ supported through non-standard work,^{3,24} food insecure,¹³ and with poor access to health services.²⁵ To date, exploration of the health challenges faced by these families has focused primarily on employment, income and food insecurity as factors affecting health.^{2,13,15–17} While these studies shed light on some roots of the problem of working poverty, a broader exploration of health and its determinants can drive more creative, relevant and effective research and policy initiatives to improve health outcomes for this population.

Our study asked low-income working families to describe their health challenges and the barriers and facilitators to meeting these challenges. Overall, three salient findings are especially interesting: first, that our sample was exclusively immigrants, although recruited from a setting largely frequented by but not intended specifically for immigrants. Second, through listening to participants’ stories, we had to expand our own conception of health into what participants were clearly describing as a broader conception of “well-being”. Finally, our work corroborates the literature showing how the immigration experience is itself the root of many of their challenges (e.g., relocation and integration,²⁶ acculturation,¹⁸ professional equivalency,^{7,27} lowered social status²⁸ and difficulty finding stable employment^{3,8}) but furthers this evidence by showing how their challenges to well-being, though not exclusive to an immigration experience (e.g., low income, difficult employment and food insecurity), were still greatly informed by it.¹⁸

Exclusively immigrants

“Economic-class” immigrants are selected on the basis of criteria believed to represent “flexibility” and “adaptability” for “find[ing] success in Canada’s labour market.”⁷ With Canadian immigrants forming a growing proportion of the low-income, working population,³ it is not clear that this selective economic immigration strategy is justifiable. The majority of families in

our study were economic-class immigrants trying valiantly to integrate; however, personal and structural barriers such as minimum wage, work instability, and hurdles in professional equivalency and language acquisition complicated employment and income²⁷ and contributed to their reliance on food bank services.¹⁵ Further, some participants described mental health issues as they dealt with uncertainty related to professional equivalency and employment.

From Peter’s health equity and social justice perspective, food banks may “make things easier”, but they do not address inequities.¹¹ Truly addressing inequities requires transparency and navigability of the equivalency process, providing access to language classes, improving pre-immigration communication, and finally – in line with cognitive justice – fostering a socio-cultural climate intent on acknowledging and uncovering racial discrimination.^{12,27,29}

Health and “well-being”

Participants in our study described a broad conception of health, which we labeled “well-being”.³⁰ This conception encompassed physical, mental and socio-cultural aspects, thus challenging a narrow biomedical or culturally biased construct of health^{12,31} and confirming the validity of our SDH framework.²²

A strengths-based approach frames experience in positive terms, whereby families are encouraged to identify and use their strengths to foster resilience in the face of challenges to well-being.²³ Resilience research with vulnerable populations emphasizes the dynamic, day-to-day process of engaging with one’s cultural context, living with and interpreting challenges in a way that fosters “an ongoing commitment to move on, dealing with a series of challenges through time”.^{32,p.649} Many participants in our study revealed insights into challenges that appeared to foster such resilience: 1) a sense of the temporality of challenging situations; 2) a sense of control in the discrete aspects of life, including finances, work, language learning and the professional equivalency process, housing, and children’s education and acculturation; and finally 3) a perspective of children’s successful integration as a pathway to parents’ own integration. The presence of each of these insights was linked to a positive outlook as participants spoke of navigating challenges to well-being.

This broad conception of health was given substance and meaning through the voiced experiences of participants. Where they articulated the everyday rhythm of life and struggle as a low-income working immigrant, there was also strength, resilience and a steadfast focus on integration. By going to a place where low-income working families go and being welcomed to explore their stories, we were able to orient ourselves to experiences that we could not know or fully anticipate by frameworks alone. This approach enabled consideration of a diversity of knowledge and socio-cultural experiences, thereby facilitating richer understandings of a low-income, immigrant experience.¹²

Importance of immigration experience

Finally, our findings suggest that immigration is itself the root of many challenges of low-income working families. The importance of immigration as a determinant of health in its

own right^{18,26} is corroborated by the degree to which immigration both implicitly and explicitly infused the challenges narrated in our study. With the goal of addressing persistent health inequities within and across populations, the Final Report to the World Health Organization Commission on the Social Determinants of Health called for “narrative accounts of the impacts of policies from the household perspective”.^{5,p.42} Few if any studies to date have responded to that call among those living in working poverty, particularly the immigrant population in that cohort and particularly in Canada, where a selective immigration policy does not appear to facilitate integration, and public support for immigration has been waning.^{10*}

Future directions

The main strengths of our study lie in the contributions it makes to the growing literature on immigration as an SDH^{16–18,26} and the family narratives it provides to suggest useful directions in practice, policy and research aimed at helping low-income working families face challenges to their well-being.¹⁹ Notwithstanding these strengths, as with any study there are limitations. First, our cross-sectional design meant that we only glimpsed challenges at a single point in time; second, because low-income working families are busy, we experienced recruitment and data collection challenges.

Future studies on low-income working families, immigrant or otherwise, should aim for a longitudinal design. This would help to broaden an understanding of what allows some families to overcome their challenges while others struggle more. Independent evaluation of specific government and community immigration assistance programs might accompany such research, both through interviews and by monitoring health and social indicators of integration.²⁹ Our study could contribute both substantive and procedural guidance to such evaluations. Substantive contributions would be at the level of identifying potentially helpful services, such as those related to easing the process of professional equivalency and working in one's field (e.g., internship programs), language training, learning unfamiliar technologies necessary for the practice of one's profession, finding a social community, and adapting to and budgeting for a different climate (e.g., clothing, heating).^{12,19} Procedural contributions would involve encouraging individual mentorship of families according to their strengths and establishing a realistic timeline for both short-term and long-term goals toward integration.²³

CONCLUSION

Low-income working immigrant families in Canada are a growing population at risk of immigration-specific challenges. These families have a broad conception of well-being, and their insights provide valuable information for future practice, research and policy directions for programs aimed at helping them face their particular challenges.

* The authors would like to note that this article was submitted prior to the recent, highly publicized Canadian response to the Syrian refugee crisis.

REFERENCES

1. Statistics Canada. *Income in Canada, 2011*. CANSIM Table 202-0804 – Persons in Low Income Families, Annual. Ottawa, ON: Statistics Canada, 2012. Available at: <http://www5.statcan.gc.ca/cansim/a26?lang=eng&id=2020804> (Accessed February 24, 2014).
2. Benach J, Muntaner C. Precarious employment and health: Developing a research agenda. *J Epidemiol Community Health* 2007;61(4):276–77. doi: 10.1136/jech.2005.045237.
3. Stapleton J, Murphy B, Xing Y. *The Working Poor in the Toronto Region*. Toronto, ON: Metcalf Foundation, 2012. Available at: metcalffoundation.com/publications-resources/publications/ (Accessed February 24, 2014).
4. Lewchuk W, de Wolff A, King A, Polanyi M. From job strain to employment strain: Health effects of precarious employment. *Just Labour* 2003;3:23–35.
5. Kelly M, Morgan A, Bonnefoy J, Butt J, Bergman V. *The Social Determinants of Health: Developing an Evidence Base for Political Action*. Final Report to World Health Organization Commission on the Social Determinants of Health, 2007, pp. 677–90. Available at: http://www.who.int/social_determinants/resources/mekn_report_10oct07.pdf (Accessed February 24, 2014).
6. Citizenship and Immigration Canada. *Backgrounders – 2014 Immigration Levels Planning: Public and Stakeholder Consultations*. 2014; Available at: <http://www.cic.gc.ca/english/departement/media/backgrounders/2013/2013-06-21.asp#annexD> (Accessed October 23, 2014).
7. Renaud J, Cayn T. *Un emploi correspondant à ses compétences?: Les travailleurs sélectionnés et l'accès à un emploi qualifié au Québec*. Montréal, QC: Ministère de l'immigration et des communautés culturelles, 2006. Available at: <http://www.midi.gouv.qc.ca/publications/fr/recherches-statistiques/AccesEmploiQualifie-RapportRenaudCayn.pdf> (Accessed January 3, 2015).
8. Fleury D, Fortin M. *When Working Is Not Enough to Escape Poverty: An Analysis of Canada's Working Poor*. Ottawa: Human Resources and Social Development Canada, 2006. Available at: <http://publications.gc.ca/site/eng/294745/publication.html> (Accessed January 24, 2014).
9. Wilson RM. *Working Rough, Living Poor: Employment and Income Insecurities Faced by Racialized Groups and Their Impacts on Health*. Toronto, ON: Access Alliance Multicultural Health and Community Services, 2011. Available at: http://www.wellesleyinstitute.com/wp-content/uploads/2011/12/Access-Alliance_Working-Rough-Living-Poor-Final-Report-June-2011-E-version.pdf (Accessed July 15, 2015).
10. Canadians less enthusiastic about immigrants, survey finds. *Vancouver Province*, 2012 October 30. Available at: <http://oppenheimer.mcgill.ca/Canadians-less-enthusiastic-about?lang=en> (Accessed July 20, 2015).
11. Peter F. Health equity and social justice. *J Appl Philos* 2001;18(2):159–70. doi: 10.1111/1468-5930.00183.
12. de Sousa Santos B. *The Rise of the Global Left: The World Social Forum and Beyond*. London: Zed Books Limited, 2006; 13–34.
13. McIntyre L, Bartoo AC, Herbert Emery JC. When working is not enough: Food insecurity in the Canadian labour force. *Public Health Nutr* 2014; 17(1):49–57. doi: 10.1017/S1368980012004053.
14. Muirhead VE, Quiñonez C, Figueiredo R, Locker D. Predictors of dental care utilization among working poor Canadians. *Community Dent Oral Epidemiol* 2009;37(3):199–208. doi: 10.1111/j.1600-0528.2009.00471.x.
15. McIntyre L, Pow J, Emery JCH. A path analysis of recurrently food-insecure Canadians discerns employment, income, and negative health effects. *J Poverty* 2014;19(1):71–87. doi: 10.1080/10875549.2014.979462.
16. Chen C, Smith P, Mustard C. The prevalence of over-qualification and its association with health status among occupationally active new immigrants to Canada. *Ethn Health* 2010;15(6):601–19. doi: 10.1080/13557858.2010.502591.
17. Asanin Dean J, Wilson K. ‘Education? It is irrelevant to my job now. It makes me very depressed...’: Exploring the health impacts of under/unemployment among highly skilled recent immigrants in Canada. *Ethn Health* 2009; 14(2):185–204. doi: 10.1080/13557850802227049.
18. Castañeda H, Holmes SM, Madrigal DS, Young ME, Beyeler N, Quesada J. Immigration as a social determinant of health. *Annu Rev Public Health* 2015;36:375–92. doi: 10.1146/annurev-publhealth-032013-182419. Available at: <http://www.annualreviews.org/doi/abs/10.1146/annurev-publhealth-032013-182419> (Accessed December 15, 2014).
19. Ottawa Charter, World Health Organization. *The Ottawa Charter for Health Promotion*. Geneva, Switzerland: WHO, 1986. Available at: <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index.html> (Accessed July 22, 2015).
20. Polit DF, Beck CT. *Nursing Research: Generating and Assessing Evidence for Nursing Practice*, 9th ed. Philadelphia, PA: Lippincott Williams & Wilkins, 2009.
21. Annells M. Hermeneutic phenomenology: Philosophical perspectives and current use in nursing research. *J Adv Nurs* 1996;23(4):705–13. doi: 10.1111/j.1365-2648.1996.tb00041.x.
22. Mikkonen J, Raphael D. *Social Determinants of Health: The Canadian Facts*. Toronto: School of Health Policy and Management, York University, 2010.
23. Feeley N, Gottlieb LN. Nursing approaches for working with family strengths and resources. *J Fam Nurs* 2000;6(1):9–24. doi: 10.1177/10748407000600102.

24. Chung L. Low-paid workers: How many live in low-income families? *Perspect Labour Income* 2004;16(4):23–32.
25. Quiñonez C, Figueiredo R. Sorry doctor, I can't afford the root canal, I have a job: Canadian dental care policy and the working poor. *Can J Public Health* 2010;101(6):481–85. doi: 10.17269/cjph.101.1964.
26. Davies AA, Basten A, Frattini C. Migration: A social determinant of the health of migrants. *Eurohealth* 2009;16(1):10–12.
27. McCoy L, Masuch C. Beyond “entry-level” jobs: Immigrant women and non-regulated professional occupations. *J Int Migrat Integrat* 2007;8(2):185–206. doi: 10.1007/s12134-007-0013-0.
28. Dunn JR, Dyck I. Social determinants of health in Canada's immigrant population: Results from the National Population Health Survey. *Soc Sci Med* 2000;51(11):1573–93. doi: 10.1016/S0277-9536(00)00053-8.
29. Organization for Economic Cooperation and Development. *Indicators of Integration of Immigrants and Their Children 2012*. Paris, France: OECD, 2012. Available at: <http://www.oecd.org/migration/integrationindicators/> (Accessed March 2, 2015).
30. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948). Available at: www.who.int/about/definition/en/print.html (Accessed July 18, 2015).
31. Emery JCH, Kneebone R. *The Challenge of Defining Medicare Coverage in Canada*. Calgary, AB: The School of Public Policy – University of Calgary Publications Series, 2013. Available at: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2341234 (Accessed March 3, 2014).
32. Lenette C, Brough M, Cox L. Everyday resilience: Narratives of single refugee women with children. *Qualit Soc Work* 2013;12(5):637–53. doi: 10.1177/1473325012449684.

Received: May 3, 2015

Accepted: October 11, 2015

RÉSUMÉ

OBJECTIFS : Cerner les difficultés relatives à la santé des familles ayant un faible revenu de travail et comprendre les éléments qui entravent ou qui favorisent leur capacité de surmonter ces difficultés.

MÉTHODE : Nous avons mené une étude ethnographique ciblée dans une banque alimentaire de Montréal (Québec). Nous avons recruté par échantillonnage intentionnel des participants dont au moins un membre de la famille avait un revenu de travail et dont au moins un enfant vivait à la maison. Les concepts sensibilisants étaient les déterminants sociaux de la santé (DSS) et les forces familiales. Nos principales méthodes de collecte de données ont été l'observation des participants, les groupes de discussion et les entretiens en profondeur. Des analyses thématiques et contextuelles ont été menées de façon itérative.

RÉSULTATS : Nous avons recruté 25 participants, soit 22 clients (15 femmes et 7 hommes ayant jusqu'à 5 enfants par famille) et 3 membres du personnel. Tous les clients étaient immigrants et étaient au Canada depuis 2 mois à 23 ans, ce qui reflète la répartition ethnique du lieu. Les familles ont décrit la santé comme englobant le bien-être physique, mental et socioculturel. Les obstacles au bien-être étaient le manque d'argent, le travail non conventionnel, les exigences d'équivalences professionnelles, l'isolement, l'acculturation des enfants, l'accès inadéquat aux soins de santé et l'hiver canadien. Les éléments personnels et structurels entravant ou facilitant la capacité de surmonter les obstacles étaient centrés sur le sentiment parental de la finitude des difficultés, de contrôle sur différents aspects de la vie et d'espoir que leurs enfants réussissent un jour. Les familles qui intégraient ces perceptions dans leurs récits semblaient décrire les obstacles comme étant surmontables. Il est important de noter que le modèle des DSS n'avaient pas prévu la mesure dans laquelle les obstacles seraient définis par des facteurs d'immigration.

CONCLUSION : Afin d'aider les familles immigrantes ayant un faible revenu de travail à composer avec divers obstacles au bien-être, les travailleurs communautaires et les responsables des politiques doivent tenir compte des difficultés propres à l'immigration et de l'importance de la façon dont chaque famille perçoit ces difficultés pour les surmonter.

MOTS CLÉS : population à faible revenu; déterminants sociaux de la santé; santé de la famille; immigration; insécurité alimentaire; emploi