The Immigrant Experience, Child Feeding and Care:

An Examination of The Determinants of Children’s Health and Nutrition in Newcomer Families

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy

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This study aims to examine how the migration experience influences newcomer mothers’ young child feeding and care practices and their children’s overall health. The thesis comprises three separate manuscripts, each of which examines one of the three intermediate determinants of the nutritional status of young children (UNICEF 1990): access to healthcare, household food insecurity, and child feeding and care practices. The research was conducted in Toronto’s Jane-Finch neighbourhood, a suburban neighbourhood home to a high density of newcomers. Thirty-two participants (16 Sri Lankan Tamil and 16 Latin American) who had migrated to Canada within the past five years as refugee claimants or family sponsored immigrants participated in the study. Data collection consisted of semi-structured interviews with women from low-income households who had a child between the ages of 1 and 5 years. Spanish and Tamil speaking interviewers interviewed each participant two or three times. Data was analyzed using a mid-level approach in which broad analytical themes are determined prior to analysis and specific themes were then generated based on participants’ perspectives and are grounded in the data.
The first manuscript examines newcomer mothers’ experiences accessing physicians for their children and identifies the major gaps between mothers’ expectations and their actual experiences that lead to barriers in communication and overall patient dissatisfaction. The second manuscript demonstrates that mothers’ past experiences with food insecurity affect two aspects of the construct of food insecurity: its managed aspect and its temporal nature. This finding has implications for the measurement of food insecurity in newcomer populations. The third manuscript reveals that newcomer mothers are exposed to several parallel and often conflicting systems of knowledge concerning health and nutrition for their children, and that their utilization of Canada’s Food Guide is impeded by its failure to acknowledge alternate parallel knowledge systems. These findings can be applied to the development of social and health policy aimed at improving cultural competency in healthcare and nutrition education and at ameliorating the income constraints leading to household food insecurity.
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Co-Authorship Statement

Laura Anderson independently led all aspects of the research, in consultation with the following individuals at specific stages of the project.

Design of the research project as a whole was done primarily by Laura Anderson, with support and guidance from Dr. Dan. Sellen and Dr. Jennifer Levy at Sick Kids’ New Immigrant Support Network. Laura Anderson and Dr. Dan Sellen worked together to procure funding for this study.

Participant recruitment and data collection for the study was performed by Laura Anderson, along with interviewers Laura Mandelbaum and Wasi Sivakumar. Laura Anderson also managed the data and developed coding strategies for analysis.

Data analysis and interpretation was performed by Laura Anderson with guidance from Dr. Catherine Mah.

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Chapter 1
Introduction

1.1 Overview

Each year over 230,000 immigrants arrive at their new home in Canada (Citizenship and Immigration Canada, 2012). Individuals make the decision to immigrate to Canada for a variety of economic, social, political, and other personal reasons. Regardless of the specific reason for their migration, their overall aim in coming to Canada is to move to a place where their families will have a better quality of life and more opportunities than they would have had in their country of origin. However, upon arrival newcomers to Canada face a wide range of challenges to their own and to their children’s health: as substantial research has shown, newcomers’ (immigrants who have arrived in Canada within the last five years) health deteriorates upon arrival in Canada (Newbold, 2009; McDonald & Kennedy, 2004). This deterioration in health can be described in part by the “healthy immigrant effect” (Hyman, 2001; Beiser, 2005), which proposes that immigrants lose their health advantage on arrival in Canada due to acculturative factors, including shifts towards a more Western diet and sedentary behaviours, in addition to several factors associated with the stress of resettlement. The negative health impacts of the immigration experience itself, as well as factors such as unemployment, poverty, food insecurity, social isolation, and the lack of access to services which newcomers are likely to face all contribute to this deterioration in health (Beiser, 2005).

While this deterioration in health has been well documented, there has been limited research to date on the health and diet of newcomer children in Canada. A better
understanding of the determinants of their health and diet is particularly important because shocks from illness and stress within the household due to migration can have a significant impact on children’s health and well-being over their life course (Beiser et al.). Because children are at a critical stage of growth and development, a good quality diet, especially for children under 5 years, improves growth, mental development, physical health, and school performance, and is necessary to ensure a healthy and productive future (Pollitt et al., 1995; Skalicky et al., 2006; Schroeder et al., 1995). In addition to the developmental importance of children’s health and diet, migration has the potential to affect parental child care practices. The stresses associated with migration, including newcomers’ documented higher risk of poverty and their potentially higher risks of mental health challenges in their first years living in a new country may compromise their child care and feeding practices (Dunn & Dyck, 2000; Bhugra, 2004), and they therefore may need extra social and programmatic support to help ensure the well-being of their children.

This thesis examines three intermediate determinants of the nutritional status of young children of newcomer parents in Canada, as defined by UNICEF’s (1990) conceptual framework: access to healthcare, household food insecurity, and child feeding and care practices. To date, no research has evaluated factors influencing young children’s diets and feeding practices among newcomer families in Canada, and no published studies have assessed household food insecurity or constraints to children’s diet among immigrants and refugees in Canada (Patil et al. 2012). Furthermore, while researchers and health systems are increasingly concerned with cultural competency in healthcare, (Betancourt et al. 2003) no studies to date have assessed how cultural and
linguistic barriers affect newcomer mothers’ ability to access health care for their children in Canada.

My analysis uses the UNICEF framework alongside methods in nutritional anthropology to develop an in-depth understanding of these health and nutrition-related experiences and practices in the context of migration and of being a newcomer. The experience of migration inherently involves significant changes in an individual’s social, cultural, political, and physical environment: Using an ecological perspective commonly employed in nutritional anthropology (Himmelgreen, 2002), this thesis aims to examine how these changes and the experiences of migration influence: the experiences mothers have accessing healthcare for their children; their experiences with household food insecurity; and their conceptualizations of the relationships between their children’s diets and their health, and how this affects the utility of one of Health Canada’s most widely used nutrition education tools: Canada’s Food Guide (Health Canada, 2007). The UNICEF conceptual framework suggests that care, along with food security and health care services, is critical for children’s survival, growth, and development (UNICEF, 1990). Care refers to a child’s caregivers’ behaviors and practices that provide food, health care, stimulation, and the emotional support necessary for children’s growth and development (Engle, Bentley, & Pelto, 2000). Newcomer parents are at higher risk of being exposed to several factors that may negatively influence their child care and feeding behaviours.

Throughout this thesis, the concept of cultural competency – the ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients’ social, cultural, and linguistic needs (Betancourt et al.,
2003)—is used to examine the utility of current healthcare practices, measurement tools, and health promotion materials. In each of Chapters 4-6, gaps in cultural competency are identified and are applied to develop recommendations to improve both service delivery and the development of health promotion tools for newcomer populations. Additionally, this thesis adopts a social determinants of health perspective, which acknowledges that the primary determinant of health status is socioeconomic status (Hayes & Dunn, 1998). Within anthropology, this approach is often referred to as an analysis of structural violence, a perspective that views social, economic, political, religious and cultural structures as determinants of individuals’ health and well-being (Farmer 2004). Regardless of terminology, both of these perspectives acknowledge that social structures as the local, national and international level are the primary predictors of health status, rather than individual behavioural or psychological factors. Chapters 4 and 5 directly address several of these structural barriers to well-being, examining specifically how low income and migration status are primary determinants of health and well-being in the context of primary health care and household food insecurity.

For this research I targeted the inner-suburban neighbourhood of Jane-Finch in Toronto. I selected this neighbourhood first because it is home to a high density of newcomers from a variety of backgrounds. Second, the area has a higher proportion of low-income households than the City of Toronto as a whole, and we wanted to target low-income households to examine the experience of household food insecurity. In this neighbourhood, I targeted Spanish speaking Latin American mothers and Sri Lankan Tamil mothers because during the formative stage of this research key informants identified them as two of the dominant groups in the area. I chose to sample two
different groups not for direct comparative purposes, but to increase the range of
variation within our sample. The following section provides contextual information on
the Jane-Finch neighbourhood.

1.2 Background: Jane-Finch Neighbourhood, Toronto, Ontario

Toronto is a highly diverse, multi-ethnic city with a very high density of
immigrants: In 2006, 50% of the city’s population was born outside of Canada, and 11%
of the population had immigrated to Canada within the last five years (Toronto Public
Health and Access Alliance Multicultural Health and Community Services, 2011). The
fieldwork for this thesis was conducted in the Jane-Finch neighbourhood, which is an
area of approximately 80,000 residents located in the Northwest corner of the city. The
neighbourhood has attracted newcomers to Canada since the 1960’s when high-density,
social and affordable housing was first developed. The area has since faced
overcrowding in schools, a dearth of community services, high crime rates, and
subsequent stigmatization. In recent years, however, there has been a backlash against
the stigmatization that the community faced for decades and renewed pride has surfaced
in the neighbourhood.

Jane-Finch is home to proportionately more recent newcomers and low-income
families than the City of Toronto as a whole: 2006 census data indicates that 24% of
households have incomes below the federal low income cut-off, and 12% of residents
arrived in Canada within the last five years (City of Toronto, 2008). In 2005, the City of
Toronto and United Way of Greater Toronto designated the area as one of 13 “Priority
Areas” in the city to be targeted for investment in infrastructure and community services,
although high poverty rates in the neighbourhood continue (City of Toronto, 2008; United Way Toronto, 2011; Hulchanski, 2010). This designation has benefitted these areas and allowed for an expansion of community services, which is an additional factor in attracting newcomers to this area. A recent report from United Way Toronto reported that 41% of private sector tenants identified social connections as the primary reason they moved to the neighbourhood, while 25% cited the convenience and accessibility of the area (United Way Toronto, 2011).

Jane-Finch is an ethnically diverse neighbourhood. An estimated 70 countries of origin are represented within its population, and over 100 languages are spoken in residents’ homes. The current top two regions of origin for recent immigrants are South Asia and South America (City of Toronto, 2008). I sampled two of the largest linguistic/cultural groups in the area: Sri Lankan Tamils, and Spanish-speaking Latin Americans.

The majority of the approximately 400,000 Sri Lankan immigrants living in Canada are Tamils who arrived in Canada following the outbreak of civil war in 1983 (La 2004). Canada’s Sri Lankan Tamil population is the largest outside of Sri Lanka, and Toronto is home to one of the largest Tamil communities outside of South Asia (Foster, 2007). While the largest concentration of Tamils in Toronto is in Scarborough, a suburban area in the Eastern end of the city, Tamils are dispersed throughout the city, and a significant number live in the Jane-Finch neighbourhood (City of Toronto, 2008). The Tamil community in Toronto has a strong presence and a high level of community involvement: there are 10 weekly Tamil newspapers, four Tamil language radio stations and three cinemas that show Tamil language films (Hyndman, 2003). Despite the
strength of this community it experiences high levels of poverty: In 1996 the prevalence of poverty among Tamil families was 53.5%, over twice the prevalence in the general population (22.7%; Ornstein, 2000).

Jane-Finch is home to the highest concentration of Latin Americans in Toronto. In this thesis, “Latin American immigrants” refers to individuals from Spanish-speaking countries in North, Central, and South America; this excludes immigrants from the Caribbean or any other non-Spanish speaking countries. While migrants from Latin America are a relatively new population in the context of Canadian migration, there have been several waves of immigrants, including political refugees, arriving in Canada since the late 1950s (Veronis, 2006). Since the mid-1990s most Latin American immigrants have arrived as skilled workers, although other classes of Latin American immigrants continue to arrive in Canada (Veronis, 2006; Citizenship and Immigration Canada, 2012). Overall, the prevalence of poverty among Latin American immigrant families in 1996 was 42%, compared with 22.7% in the general population (Ornstein, 2000). Although Latin Americans in Toronto do not form one united community, there are several community programs run by and tailored to Latin American immigrants in the Jane-Finch neighbourhood. Generally, divisions within the group fall along national lines, although there are also differences as a result of class, political, and ethnic differences (Veronis, 2006).

1.3 Thesis Structure

This thesis comprises three distinct but interrelated manuscripts all of which are drawn from fieldwork conducted between June 2010 and March 2011 in the Jane-Finch
neighbourhood in Toronto, Ontario. Each manuscript examines a different determinant of child health and nutrition, and explores the effect that the circumstances of migration and subsequent acculturation have on these determinants of child health. Each of these analyses focus broadly on the experiences of mothers of young children, and how migration affects their child care decision making and the resources they have available to care for their children.

Chapter 2 provides a review of the literature regarding immigration and immigrant health in Canada. The first section of the review outlines methods in nutritional anthropology and the conceptual framework used in this study. The next section of the review summarizes research on factors affecting immigrant health, including a review of “the healthy immigrant effect” and the concept of acculturation. The review also explores how migration affects parents’ ability to care for their children, and also how it might affect their caregiving decision-making. The remainder of the review describes UNICEF’s (1990) ecological framework for examining factors affecting children’s nutrition and health, and reviews the three intermediate determinants of health and nutrition which are further examined in this thesis: access to healthcare, household food insecurity, and parental child feeding knowledge and practices.

Chapter 3 describes the research collaborations, study design, and methods applied in the fieldwork for this study.

Chapter 4 examines newcomer mothers’ experiences accessing and utilizing healthcare for their children. This analysis applies Goddard and Smith’s (Goddard & Smith, 2001) theoretical framework for assessing equity in access to healthcare services
to analyze the means through which mothers access care, and to explore the barriers preventing them from access. These findings are discussed in terms of improving both outreach to newcomer families and improving cultural competency in healthcare.

Chapter 5 examines newcomer mothers’ experiences with household food insecurity. This analysis aims to contribute to a deeper understanding of the varied experiences of household food insecurity in Canada and to the development and use of tools to quantitatively measure household food insecurity.

Chapter 6 examines newcomer mothers’ cultural conceptions of food and health and how they change with migration to Canada. This paper applies Jordan’s (1993) model of authoritative knowledge to identify the different forms of knowledge and how they influence child feeding practices, as well as to identify what shifts are causing some forms of knowledge to be devalued in favour of others. This paper focuses on how this diversity of knowledge might influence the appropriateness and applicability of Canada’s Food Guide as a nutrition education tool for newcomer populations.

Chapter 7 discusses the findings of Chapters 4-6 within the context of the healthy immigrant effect and acculturation, as well as in the context of cultural competency in healthcare and social programs. It also examines the policy and program implications of this study, and makes recommendations for further research.
1.4 References


Chapter 2
Literature Review

2.1 Literature Review Overview

This chapter provides a review of research regarding immigration and health. It aims to provide a larger overview of the factors that determine immigrant health, and to provide an understanding of the particular health risks that newcomers and their children face on arrival to Canada. Furthermore, it identifies that there has been limited research assessing how various factors associated with migration affect children’s health. It begins with a review of the conceptual framework for this thesis, which is characteristic of ecological frameworks commonly used in nutritional anthropology. An overview of immigration trends in Canada follows, along with an examination of the “healthy immigrant effect”, which seeks to explain the phenomenon of the deterioration of immigrant health upon arrival in Canada. The review then examines several of the factors known to influence immigrant health and which help to explain the healthy immigrant effect. The next section examines the particular case of immigrant child health, and identifies several gaps in our understanding of the determinants of children's nutritional and health outcomes, particularly in the Canadian context. Finally, it identifies the three key determinants of newcomer children’s health and nutrition of interest to this thesis: access to healthcare, household food insecurity, and child feeding practices.
2.2 Biocultural Approaches in Nutritional Anthropology

Nutritional anthropology as a field focuses on the biological and cultural variability in human populations (Johnston, 1987). Specifically, Pelto and colleagues (2000) define nutritional anthropology as “fundamentally concerned with understanding the interrelationships of biological and social forces in shaping human food use and the nutritional status of individuals and populations.” The biocultural perspective employed by nutritional anthropologists, then, bridges the gap between biomedical and social science perspectives (Cosminsky, 1993). Anthropology as a discipline employs a holistic approach; for any outcome there are many interrelated contributing factors (de Garine, 2004; Jerome, Pelto, & Kandel, 1980; Pelto & Pelto, 1996). Biocultural anthropologists build on these traditional ethnographic anthropological approaches by applying a mix of qualitative and quantitative methods (Pelto et al., 2000). Recently, applied anthropologists working in the US and the UK have extended this biocultural approach to studies in newcomer health and nutrition (Hadley, Zodhiates, & Sellen, 2007; Himmelgreen et al., 2007; Sellen, Tedstone, & Frize, 2002).

2.2.1 Ecological Models in Nutritional Anthropology

Biocultural anthropologists commonly use ecological models to study nutrition and health outcomes because they focus on the intersection of the social and physical environments and their effects on human dietary behaviour (Himmelgreen, 2002; McLeroy et al., 1988). Pelto and colleagues (2000) describe an ecological framework for analyzing the factors affecting child diet. This framework integrates biological, social, cultural, psychological, physical and economic factors into the analysis of food systems,
and explores human adaptations (or resource management strategies) to these environments (Himmelgreen & Crooks, 2005; Messer, 1984; Quandt, 1996):

i. **Biological needs** refer to children’s need for nutrients, a well balanced diet and protection against disease.

ii. **The social environment** refers to the many factors that influence healthcare access as well as food availability, access and consumption in an urban environment. This includes division of labour within a household, decision-making between individuals within the household regarding types and amounts of foods for children, and social support from outside the household.

iii. **The cultural environment** refers to knowledge and attitudes regarding child feeding, including beliefs regarding the association between health and diet for children.

iv. **The economic and political environments** include government support for newcomers, access to employment and other sources of income.

v. **The physical environment** includes the neighbourhood in which the household is located, its environmental contaminants, its proximity to healthcare resources, and its access to safe, affordable, appropriate, and nutritious foods.

UNICEF (1990) has adopted a similar biocultural framework for assessing the determinants of nutritional status in children (Figure 2.1). This thesis comprises three sections, each of which assesses one of the three underlying determinants of children’s health and nutrition in this model: 1) the home environment and access to health services; 2) household food insecurity; and 3) child care and feeding practice.
2.3 Immigration Trends in Canada

Since 1988, Canada has on average accepted 230,000 immigrants annually (Citizenship and Immigration Canada, 2012). In 2011, the foreign-born population in Canada was approximately 6.8 million people, or 20.6% of the total population. Canada’s immigrant population continues to grow: In 2011, 17.2% of the foreign-born population and 3.5% of the total population in Canada had arrived in Canada within the last five years (Citizenship and Immigration Canada, 2012). Immigrants to Canada arrive from over 200 countries, and thus comprise an extremely ethnically and culturally diverse group. Over the past 40 years, the source countries of Canada’s immigrants have dramatically changed. Before the 1970s, most immigrants came from Europe or the United States, with Asia accounting for fewer than 10% of all immigrants, and Africa, the Middle East and the Caribbean collectively representing 5%. In 2012, almost half (49%) of immigrants to Canada arrived from Asia, 23% came from Africa and the Middle East, 15% from Europe, and 10% from South and Central America (Citizenship and Immigration Canada, 2012).

The vast majority of immigrants live in urban areas. Of the 6.8 million immigrants living in Canada in 2011, 91% lived in an urban area. In particular, Canada’s three largest metropolitan areas – Toronto, Vancouver and Montreal – account for almost two thirds (62.5%) of recent arrivals. Toronto, in turn, is home to 37.4% of Canada’s total foreign born population. In 2011, about 2,537,400 immigrants lived in Toronto, and accounted for 46% of Toronto’s total population. Furthermore, in 2011 just over 381,000 newcomers were living in Toronto, comprising 6.9% of Toronto’s total population (Citizenship and Immigration Canada, 2012).
2.3.1 Immigrant Classes in Canada

Immigrants to Canada arrive through several different institutional pathways, or immigrant classes. While research on immigrant and refugee health often refers to “immigrants” as a homogeneous group (Murdie, 2005) acknowledgement of the variation between immigrant classes is essential to understanding how the migration experience and economic and social resources can influence health outcomes. In Canada, there are three main classes of immigrants; economic immigrants, family class immigrants, and refugees.

**Economic Immigrants**

Economic immigrants are selected according to their skills and ability to contribute to Canada’s economy. This class includes skilled workers as well as business immigrants who intend to be self-employed or invest their money in a Canadian venture. Since 2003 over 60% of immigrants arriving in Canada annually arrive as economic immigrants, and in 2012, 62% of arrivals were economic immigrants (Citizenship and Immigration Canada, 2012). Although there is concern that economic migrants struggle to find work commensurate with their skill sets and experience, as a group they are more likely to find employment and have higher incomes than other immigrant classes (DeVoretz, Pivnenko, & Beiser, 2004).

**Family Class Immigrants**

Family class immigrants are sponsored by family members already living in Canada. These family members must live with and support their sponsored family member for at least two years after their arrival in Canada. In 2012, 25% of immigrants
arriving in Canada were family class immigrants (Citizenship and Immigration Canada, 2012).

Refugees

The United Nations High Commissioner for Refugees defines “refugees” as individuals who are unable to return to their country of origin because of a well-grounded fear of persecution. There are three channels through which refugees can acquire landed immigrant status in Canada: Government assisted refugees (GARs), privately sponsored refugees (PSRs) or as refugee claimants. In 2012, nine percent of newcomers arriving in Canada arrived as refugees (Citizenship and Immigration Canada, 2012). Over 325,000 GARs, PSRs, and refugee claimants entered Canada between 1999 and 2008, of whom over 10% now live in the Greater Toronto Area (Citizenship and Immigration Canada, 2008).

2.4 Immigrant Health Research: An Overview

2.4.1 The Healthy Immigrant Effect

Upon arrival in their new country, immigrants as a group are generally healthier than the host country population. However, as they spend more time in their new country, their health deteriorates to levels at or below that of the general population. The “healthy immigrant effect” describes this observation (Beiser, 2005). This paradigm is most strongly supported by a series of studies conducted on individuals from the Hiroshima region in Japan, who were being tracked by organizations interested in radiation exposure following the nuclear bombings. A portion of these individuals immigrated to California, another portion immigrated to Hawaii, and the remainder stayed in Japan (Marmot et al.,
This series of studies found that individuals in California had the highest rates of chronic disease and mortality, followed by those in Hawaii, with those in Japan having the lowest rates. A particularly important finding of these studies was that these morbidity and mortality rates approximated the rates of the regions to which the individuals had immigrated (Marmot & Syme, 1976; Marmot et al., 1975).

While the evidence in Canada supporting the healthy immigrant effect is somewhat mixed (Beiser, 2005), in general, immigrants tend to be healthier than the Canadian born population upon arrival to Canada. Four main factors may explain the health advantage that immigrants have on arrival in Canada (Kennedy, McDonald, & Biddle, 2006; McDonald & Kennedy, 2004). First, the screening process by host country authorities may result in an overall healthier immigrant population. This explanation may not apply in Canada, however, as few individuals are refused entry to Canada due to health reasons (Laroche, 2000). Second, individuals who are able to and choose to immigrate self-select, and may be more likely to be physically and financially able to immigrate (McDonald & Kennedy, 2004). Third, immigrants may practice more favourable health habits and behaviours than the average host country inhabitant. For example, individuals from low- and middle-income countries may have had pre-migration lifestyles that included more physical activity and lower consumption of calories (Abraido-Lanza et al., 1999; Khlat & Darmon, 2003). Finally, immigrants may under-report health conditions and may not in fact be healthier; this may be in part because immigrants tend to under-utilize health services (McDonald & Kennedy, 2004).

Several analyses of national and provincial surveys in Canada have found evidence to support the healthy immigrant effect (for a detailed review see Beiser, 2005).
Based on national surveys in Canada, Chen and colleagues (1996) found that immigrants had a longer life expectancy and lower levels of disability and dependency than Canadian born individuals. Other research by Newbold and Danforth (2003) found a pattern of decreased self-assessed health status with duration of residence in Canada. Most noteworthy is that health status among immigrants was found to be lower than the general Canadian population, although among new arrivals it was higher (Newbold & Danforth, 2003). McDonald and Kennedy (2004) identified similar trends, finding that immigrants were less likely to have been diagnosed with a chronic condition than native-born Canadians, but that over time in Canada there is a gradual decrease in health status. Gee and colleagues (2003) analyzed data from the 2000-2001 Canadian Community Health Survey, and found that among later mid-life immigrants, self-rated health was higher among recent immigrants than those who had been in Canada longer than 10 years. Others, however, have found less consistent findings. Analysis of the 1994-1995 National Population Health Survey (Dunn & Dyck, 2000) found that immigrants as a group were more likely than non-immigrants to report poor health status. However, they did find that those who had lived in Canada for more than ten years were more likely to report poor or fair health status than more recently arrived immigrants.

As outlined in Section 2.2, the aim of this thesis is to examine the underlying determinants of newcomer children’s health and nutrition, and to examine how these are affected by migration and migration-related experiences. Children as a group are at a particularly vulnerable stage of development and thus shocks from illness, lack of access to food, poverty and the stress that may be present in a family due to migration can have a greater impact on them than on the adults in a household (Beiser et al., 2005; Petterson
& Burke Albers, 2001). In the United States, immigrant children have been found to use program benefits less than American-born children (Hagan et al., 2003) and are also more likely to report poor health (Capps et al., 2004).

2.5 Explanations for Deterioration in Immigrant Health

A substantial body of research has focused on explaining the healthy immigrant effect, both in Canada and in other countries. Evidence suggests several mechanisms contribute to these declines, including diet and lifestyle change (Frisbie, Youngtae, & Hummer, 2001), loss of socioeconomic status (Bauder, 2003), social exclusion (Omidvar & Richmond, 2003), and a medical system that does not provide culturally competent care (Betancourt et al., 2003). Here, the proposed mechanisms are broadly divided into two sections: 1) Convergence/acculturation, and 2) Resettlement stress.

2.5.1 Convergence/Acculturation

The convergence framework (Beiser, 2005) posits that exposure to the environmental, social, cultural, and physical ecology of Canada drives a pattern that causes immigrants’ health outcomes to shift towards those of native-born Canadians (Dunn & Dyck, 2000; Kleiwer & Smith, 1995). These changes can be due to environmental toxins and pollutants, but are largely attributed to changes in behaviours, including diet, smoking, drinking, and sedentary behaviours (Franzen & Smith, 2009; Kim & Chan, 2004; Unger et al., 2004). McDonald and Kennedy (2004) suggest that while there is convergence in physical health status, there is not convergence in screening and detection of existing health problems. This could help explain the shift that
immigrants experience from higher health status than that of Canadian born residents, to similar or often lower health status (Newbold & Danforth, 2003).

Many migration researchers describe the social, cultural and behavioural convergence that takes place as “acculturation”, defined as:

Those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups (Redfield, Linton, & Herskovits, 1936).

This definition emphasizes that the process of acculturation can lead to change for both groups and individuals involved in the cultural contact, and is reflected in much of the current theoretical constructions of acculturation developed in recent years (Berry, 1997; Hazuda, Stern, & Haffner, 1988). Berry (1997) further distinguishes between acculturation as a collective or group-level phenomenon, and as an individual or psychological phenomenon. Following these distinctions, group level acculturation is a result of social and economic factors, while individual acculturation is influenced by attitude and behaviour changes, along with individual level factors such as social support, coping strategies, cultural distance and personality.

Researchers employ a wide variety of scales to measure acculturation. The two most common models of acculturation theory are the unidirectional model and the bidirectional model. The unidirectional (or unilinear) model of acculturation describes the process of acculturation as losing one’s native cultural traits while simultaneously taking on a new culture (Flannery, Reise, & Yu, 2001). Essentially, this model proposes that in order for individuals to adopt characteristics of their new culture, they must simultaneously lose the same aspects of their native culture. This model of acculturation
is widely applied in many studies exploring the relationships between measures of health and acculturation, often using single measures, such as language use or length of time a migrants have been in their new country (Gibson-Davis & Brooks-Gunn, 2006; Harley, Stamm, & Eskenazi, 2007).

The bidirectional (or bilinear) model of acculturation (Berry, 1997) describes the process of acculturation in terms of an individual’s relation to her culture of origin, as well as an individual’s relation to her new culture. In contrast to the unidirectional model, the bidirectional model views these two relationships as conceptually independent, resulting in four possible acculturation outcomes. These four outcomes are marginalization (negative attitudes toward both cultures), separation (positive home culture attitudes and negative host culture attitudes), assimilation (negative home culture attitudes and positive host culture attitudes), and integration (positive attitudes toward both cultures). In sum, there is a vast range of measures used, and a complete lack of standardization, which critics argue prevents comparison of data between studies and effective translation of research into policy and programs (Hunt, Schneider, & Comer, 2004; Patil, Hadley, & Nahayo, 2009; Broesch, & Hadley 2012).

A few Canadian studies have examined the association between various measures of acculturation and health outcomes among immigrants. These studies have all employed a unidirectional method of measuring acculturation, using length of time in Canada or English fluency as a measure of acculturation. Changes in behaviour following migration to Canada have been found to affect health outcomes. McDonald and Kennedy (2005) found that acculturation might accelerate the transition to Canadian lifestyle norms that account for the increased weight gain and chronic disease risk
immigrants experience after arrival to Canada. Similarly, Kaplan and colleagues (2002) found a significant association between Asian immigrants' length of time in Canada and the risk of hypertension. Longer length of time living in Canada has also been associated with increased consumption of alcohol among Chinese college students (Li & Rosenblood, 1994), and English language fluency was associated with a increased risk of low birth weight among Asian women in Canada (Hyman & Dessault, 1996). This trend towards poorer health outcomes with higher levels of acculturation is consistent with many studies conducted in other countries (Himmelgreen et al., 2004; Maskarinec, 2000; Cardoso et al., 1997; Scribner & Dwyer, 1989).

2.5.2 Dietary Acculturation

Although understudied in Canada, there is a significant body of recent literature examining dietary change experienced by newcomers to the United States and other Northern countries (Hadley et al., 2007; Patil et al., 2009; Satia-Aboura et al., 2002; Novotny et al., 2009). This change is referred to as dietary acculturation, defined as the process of a minority group adopting the eating patterns of the host country. Immigrants’ exposure to their new country’s culture involves both psychological changes as well as changes in preferences in taste (Satia-Aboura et al., 2002). These changes in taste, along with changes in the environment and food preparation and procurement options lead to changes in dietary intake.

The process of dietary acculturation has been documented in several immigrant populations, and is particularly relevant to the Canadian public health context considering the over 230,000 newcomers who arrive in Canada each year from a variety of cultures.
However, it is important to note that the process of dietary acculturation is not linear; immigrants often develop new strategies to integrate their traditional foods or ways of cooking with their new country’s food cultures (Satia-Abouta et al., 2002). There is evidence to suggest that the process of dietary acculturation is not as straightforward as simply adopting a more Western-style diet characteristic of higher rates of obesity and chronic disease. Research on South Asian immigrants in Glasgow found that their eating patterns did not significantly change after arrival in Scotland, although they often chose “healthier” versions of food items they used before, such as margarine instead of butter (Anderson & Lean, 1995).

Despite the non-linear nature of dietary acculturation, the changes in diet over time among immigrants are associated with a trend towards a Western-style diet characterized by higher energy density and lower nutrient density. Himmelgreen and colleagues (Himmelgreen et al., 2007) examined dietary and lifestyle changes before and after migration among Latinos in Florida, and found that in most cases, post-immigration food consumption and behaviours represented unhealthy changes, including weight gain, lack of physical activity, and greater consumption of processed foods. This dietary change may in turn put immigrants at higher risk of obesity and chronic disease (Fuentes-Afflick & Hessol, 2008; Yeh et al., 2009).

2.5.3 Resettlement Stress

Beyond convergence and acculturation, the resettlement stress framework explains the substantial decreases in immigrant health outcomes over time as a result of two related factors: First, the impacts of the immigration experience itself can negatively
affect both physical and psychological health. Second, immigrants as a group are a particularly vulnerable population because immigration and resettlement increases the chances individuals will face challenges such as unemployment, poverty, social isolation, and lack of access to services (Beiser, 2005).

The stress associated with the process of immigration may have significant health impacts. Sudden changes in diet, exposure to new pathogens, and catastrophic events such as war and natural disasters that can lead to anxiety and post-traumatic stress disorder have all been found to associate with poor health outcomes among immigrants (Hyman, Vu, & Beiser, 1997). Furthermore, immigrants may be at a higher risk of depression and anxiety during their first years in Canada: Beiser and Hou (2001) report a dramatic decrease in depression among Southeast Asian refugees during their first decade in Canada. Qualitative research on immigrants in Canada has also found that among those who perceived their health to deteriorate over time, the immigrants themselves perceived this deterioration to be a result of aging and the stresses associated with migration (Asanin Dean & Wilson, 2010).

The stress and anxiety newcomer mothers experience have the potential to impact their children's health. Maternal depression has been shown to negatively associate with the use of available preventive services for children, such as well-child visits and vaccinations, and positively associate with the use of emergency room care for their children (Minkovitz et al., 2005). Similarly, maternal behaviors impacting child health (e.g. smoking, not administering vitamins to a child, not restraining children in appropriate car seats, and early cessation of breastfeeding) are positively associated with maternal depression (Leiferman, 2002). Maternal depression is also inversely associated
with children’s psychological development and intelligence (Petterson & Burke Albers, 2001; Weinberg & Tronick, 1998).

More broadly, the resettlement stress framework addresses the fact that immigrants face structural, socioeconomic inequalities upon arrival in Canada that put them at risk of poor health outcomes. Dunn and Dyck (2000) found that socioeconomic factors strongly predict both self-rated health status and chronic disease in both immigrants and non-immigrants in Canada, although they have a stronger effect on immigrants. The financial challenges, changes in social support, and discrimination and social exclusion immigrants face on arrival are examined in the next two sections.

2.5.3.1 Financial Challenges

It has been well established that immigrants to Canada have considerably less financial resources than Canadian-born individuals. While 86% of Canadian-born residents are employed, only 77% of recent immigrants are employed, and only 79% of immigrants with graduate or professional degrees are employed (Schellenberg, 2004). Those who are unable to secure employment will often recourse to the Ontario provincial social assistance program, Ontario Works. Ontario Works has a "work first" approach to social assistance, which combines financial assistance with mandatory participation in job searches and other employment-related activities. These "work first" activities offer little to immigrants to help them overcome the disadvantages they face in the labour market (Mitchell, Lightman & Herd, 2007). The income disparity between Canadian-born men in Toronto and recent immigrant men in Toronto is particularly striking: while Canadian born men have an average annual income of $61,678, recent immigrant men have an average income of $35,202 (Schellenberg, 2004). Among newcomers, there is
considerable disparity in economic integration between immigrant classes. Analysis of immigrant cohorts in Canada throughout the 1990s found individuals arriving as family class immigrants and refugees had significantly lower incomes than those arriving as skilled workers. Family class immigrants and refugees earned an average of $19,532 and $20,117 respectively, while skilled workers earned almost twice as much, slightly over $45,000 annually (DeVoretz et al., 2004). Previous research has found that the employment newcomers are able to find is generally part time, lacks security, and does not utilize newcomers’ skills and education (Access Alliance 2013; Bauder & Cameron, 2002; Brouwer, 1999). Skilled workers also have higher fluency in either English or French: In 2012, 78% of skilled workers spoke either English or French, compared to 63% for refugees, and 58% for family class immigrants (Citizenship and Immigration Canada, 2012). This lower fluency among refugees and family class immigrants in particular, presents greater challenges for finding employment and accessing social and health services.

Research has consistently established that poverty, unemployment, and low-income are associated with poor health outcomes in the general population (Raphael, 2006; Wilkinson & Marmot, 2003; Wilkinson & Pickett, 2006). However, there has been limited research to date in Canada on the influence that the socioeconomic challenges immigrants face has on their health. Recent research in Toronto (Asanin Dean & Wilson, 2009) identified mental health impacts among immigrants arriving under the skilled worker program due to a lack of income, loss of employment-related skills, and loss of social status. This research also found that their physical health was affected through employment circumstances via stress and strenuous employment conditions.
The impact of these financial challenges on newcomer parents may have an impact on their caregiving practices. Although studies examining the effects of poverty on immigrant children are limited, economic disadvantage has been found to be associated with ineffective parenting and a strained family environment that can negatively affect child well-being (Elder, Van Nguyen, & Caspi, 1985; McLeod & Shanahan, 1993; McLoyd et al., 1994). In some ways, however, poverty appears to be less of a risk factor for poor health among immigrants than among non-immigrant populations (Beiser et al., 2002). This is likely due to the fact that risk factors such as low education levels are not associated with low income in immigrant populations (Zhou, 1997). Furthermore, there appear to be some social aspects of immigrant family life that may protect against the effect of poverty (Edwards & Beiser, 1994).

2.5.3.2 Social Support

For newcomers to Canada, social networks are essential for accessing information, services and programs, and also for maintaining relationships both in Canada and in their countries of origin (McMichael & Manderson, 2004). The dramatic shifts in the social support network accessible to immigrants after migration to Canada influence health outcomes. A study examining the social support networks of Chinese and Somali newcomers found that they experienced substantial unmet support needs, and that these limited resources and social networks impede their ability to cope with the challenges of settlement (Stewart et al., 2008). For many newcomers to Canada, their primary sources of social support come from their new community in Canada, i.e. from other immigrants of similar ethnic origin; seeking support from individuals of the same background is especially helpful due to commonality of experience (Simich, Beiser, & Mawani, 2003).
Research in Canada has not linked this support to any health outcomes. Internationally, although some studies have found mixed results (Algeria, Sribney, & Mulvaney-Day, 2007), tightly knit social groups have been found to have lower levels of stress, perceived discrimination, household food insecurity and better overall health (Finch & Vega, 2003; Galea et al., 2004; Oppedal, Roysamb, & Lackland Sam, 2004).

### 2.5.3.3 Racial Discrimination and Social Exclusion

Although public prejudice against racialized groups appears to be declining, significant levels of privately held prejudice still exist in Canada (Galabuzi 2006; Opoku-Dappah, 1994). For refugee claimants in particular, racist sentiments may be exaggerated due to speculation over the credibility of their claims (Opoku-Dappah, 1994). In Toronto and in other urban areas racialized groups have almost twice the rate of low income as the general Canadian-born population (31% vs. 17%; Statistics Canada, 2001). Visible minority recent immigrants to Canada often experience discrimination and are undervalued in the workplace (Li, 2001; Simich et al., 2005; Access Alliance, 2013). Furthermore, social and linguistic isolation and experiences of racism and discrimination have been found to contribute to immigrants’ feelings of disillusionment experienced with resettlement to Canada (Hyman, 2001).

### 2.6 Intermediate Determinants of Newcomer Children’s Nutrition and Health

The remainder of this literature review will examine three specific determinants of newcomer children’s nutrition and health, as outlined in Figure 2.1: access to healthcare, household food insecurity, and caregiver child feeding practices\(^1\). Within this

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\(^1\) Sections 2.6.1, 2.6.2, and 2.6.3 are adapted from sections of Chapters 4, 5, and 6.
review is a discussion of two factors that affect both access to healthcare and child feeding practices. The first is the concept of cultural competency, which has been identified as an essential component of both healthcare and health education within a multicultural society such as Canada’s (Betancourt et al., 2005; Johnson Vaughn, 2008). The second is the concept of authoritative knowledge (Jordan, 1993), which is applied in Chapter 6 as a framework for understanding mother’s conceptualizations of the relationships between food and health.

2.6.1 Access to Healthcare

Newcomers face multiple barriers in accessing healthcare for their children in Canada. For documented residents of Canada (this excludes those without status, including those whose refugee claims have been rejected, and those who arrived in Canada with no status and did not make a refugee claim), the Canada Health Act aims to ensure that all Canadians are able to access medical services (Health Canada, 2006). Despite the intended effects of this act, huge disparities in healthcare access exist within the Canadian population. In particular refugee claimants and family sponsored immigrants may be at higher risk of barriers to accessing healthcare services and other programs because of higher levels of unemployment and low-income in this group (Yu, Ouellet, & Angelyn, 2007). The family sponsorship program in Canada allows permanent residents to sponsor close kin to Canada. These permanent residents are responsible for ensuring there is support for that family member during his or her first year in Canada. Provincial government health insurance is also provided to the sponsored family member. Family class immigrants thus have some family members who have lived in Canada for at least a few years, and who may be able to help introduce them to Canada’s healthcare
system. They do not, however, necessarily have job qualifications and are not required to have official language skills. Those who arrive as refugee claimants arrive in Canada with only temporary status, and have access to federally funded healthcare through Interim Federal Health (IFH) coverage. In June 2012 several cuts were made to the IFH, including funding for extended healthcare such as medications and dental coverage (Access Alliance Multicultural Health and Community Services, 2012). Although these cuts were made subsequent to data collection for this study, these changes are currently relevant to a discussion of the barriers to healthcare newcomer families face.

Before even accessing the healthcare system, there are many contextual barriers that newcomer mothers may face, including limited social networks and lack of knowledge of services available (Simich et al., 2005). Furthermore, geographical barriers to accessing care have been documented in suburban Toronto areas (Asanin & Wilson, 2008; Wang, Rosenberg, & Lo, 2008). Both Canadian born residents and newcomers face difficulty finding a family physician who accepts new patients; if physicians in their neighbourhoods will not accept them they often have to travel long distances to access a physician. This can be burdensome for newcomers, and particularly for refugee claimants and family sponsored immigrants, because they are more likely to face economic constraints which may limit transportation options (Yu et al., 2007).

2.6.1.1 Cultural Competency in Healthcare and Health and Nutrition Education

Major aspects of resettlement stress are the cultural and linguistic barriers that prevent newcomers from accessing or effectively utilizing healthcare and social services. The cultural competence movement in healthcare acknowledges and incorporates the importance of culture, cross-cultural relations and cultural differences into healthcare
(Betancourt et al., 2003; Karmali et al., 2011). Previous research has indicated that language barriers between patients and healthcare providers leads to decreased use of health services (Timmins, 2002), decreased patient satisfaction (David & Rhee, 1998), and poorer health outcomes in patients (Wang et al., 2008). Access to professional interpreters can address this problem and although interpreters are sometimes available in Ontario hospitals they are not usually available in clinics. Interventions offering interpreters or a phone-in translation service have been found to both increase both patient satisfaction and adherence to follow up visits (Karmali et al., 2011). Beyond language, cultural differences between patients and healthcare providers can impede the quality of patient-provider interactions and create barriers to effective treatment. Discrepancies between patients and physicians in health beliefs, values and behaviours can lead to under-utilization of the healthcare system as well as to decreased adherence to preventive measures and medications, and a mismatch between expectations and actual experience of care (Gornick, 2000).

While much of the focus in the cultural competency movement has been on primary healthcare delivery, the development and delivery of culturally competent health and nutrition education materials and programs is equally important to ensure the health of diverse populations. In the United States, the American Association for Health Education published a position statement on cultural competency in health education in 2006 (American Association for Health Education, 2006); no such statement exists in Canada. Furthermore, despite this position statement, Johnson Vaughn (2008) identifies that in the United States too little attention has been given to cultural competency in the context of health education. There has been some progress in the development of
culturally competent health education and promotion tools in Canada: Health Canada’s key nutrition education tool, Canada’s Food Guide has been adapted for increased cultural competency for Canadian First Nations, Inuit, and Métis populations. Not only has it been translated into four First Nations languages, but the foods depicted reflect staples in these populations. Furthermore, it is depicted in a circular format, rather than the “rainbow” used in the general food guide, which was determined to be a more meaningful layout for this population (Health Canada, 2010a).

Related to the concept of cultural competency is the effect that patient expectations of care have on their perceptions of their healthcare experiences. For immigrants, various aspects of the standard of care in their new country may differ from the care they received in their countries of origin. These differences can also be exacerbated by patients’ expectations of care, which may not be in line with the standard of care in their new country of residence. The disconnect between expectations and experience has been examined in the context of healthcare and quality of life: individuals with different expectations will report a different quality of life even when they have the same clinical condition (Carr, Gibson, & Robinson, 2001). Clark and Redman’s (2007) examination of Mexican immigrant mothers’ expectations for children’s healthcare found that immigrant mothers had expectations of interpersonal warmth and friendly interactions from physicians, and also struggled with the lack of Spanish language fluency among healthcare providers. Chapter 4 will explore the concept of healthcare access for newcomer children, and will discuss the influence that this failure to meet expectations of healthcare has on mothers' perceptions of the care their children receive.
2.6.2 Household Food Insecurity

Household food insecurity is experienced when appropriate, nutritious and safe foods required for a healthy and productive life are not available and/or the ability to acquire such foods is uncertain due to financial constraints (Bickel et al., 2006). A central component of the concept of household food insecurity is that it is the result of income constraints, and is therefore distinct from the inverse of a commonly-used definition of food security – which is the assurance of healthy and safe food for all (McIntyre, 2011). Household food insecurity is a strong determinant of health for children: it negatively affects the quality of children’s diets and nutritional status (Bhattacharya, Currie, & Haider, 2004), children’s physical health (Casey et al., 2005) and mental health and development that is necessary for a child’s healthy and productive future (Perez-Escamilla & Pinheiro de Toledo Vianna, 2012). Additionally, beyond being a determinant of health, household food insecurity is a significant social problem. Low income-families reliant on social assistance programs are at a high risk of food insecurity in Canada, reflecting the inadequacy of these programs to alleviate poverty (McIntyre, Connor, & Warren, 2000; Che & Chen, 2001; Vozoris & Tarasuk, 2003).

Newcomers are known to be at a higher risk of household food insecurity than the general population: In 2007 12.6% of newcomer households reported food insecurity compared to 7.5% of non-immigrant households (Health Canada, 2010b). Studies within the last decade have documented very high rates of economic hardship, mental stress and food insecurity among refugees and other non-economic forced migrants in several high-income countries, including the United States (Patil et al., 2010). Among newcomers to the US and other high-income countries, low income, unemployment, and recent arrival
are predictors of food insecurity (Anderson et al., in press; Hadley & Patil, 2010; Hadley et al., 2007). Many immigrant families spend almost all their resources in order to arrive in their new country, and it often takes several months to find employment; for refugee claimants who have not yet had their claims approved this can be particularly challenging as they may be discriminated against due to their lack of permanent status (Canadian Council for Refugees, 1999). This lack of savings or income source places newcomer families at high risk of food insecurity in the first years following immigration (Quandt et al., 2004; Quandt et al., 2006). Studies in the UK and US have found food insecurity in more than half of all refugee families with children under five years, and a study of Latin American immigrants in Toronto found a similar prevalence (Hadley et al., 2007; Sellen et al., 2002; Vahabi et al., 2011).

In addition to the inherent challenges of low-income families, newcomers’ individual experiences in their countries of origin and during migration (e.g. in areas of conflict, of persecution, financial and personal insecurity, etc.), combined with the challenges and risk of mental distress they face on arrival in Canada, influence their subjective experience of food insecurity. Refugees in particular are at high risk of experiencing anxiety and depression when they arrive in Canada, and research has found this can affect their help-seeking behaviours in a healthcare context (Simich et al., 2006). Furthermore, newcomers arriving from areas of conflict and high levels of household food insecurity may be likely to view food insecurity in the Canadian context differently because of their past experiences. They may also have different expectations of services available to support them. While to date no research has examined differing expectations of support in relation to household food insecurity, in the health services literature
individual expectations of care received in a healthcare setting have been found to affect utilization and satisfaction with care received (Clark & Redman, 2007; Cristancho et al., 2008).

Two studies have examined household food insecurity among immigrants in Toronto, finding that income limitations, inadequate public and private sector responses (including food banks), poor knowledge of available resources, and cultural differences in food preferences all contributed to household food insecurity (Koc & Welsh, 2002; Vahabi et al., 2011). A third study (Lessa and Rocha 2012) examining food insecurity among immigrant women in Toronto identified the importance of food relations in the lives of immigrants, emphasizing the importance of focusing on food in settlement programs. Furthermore, this research found that limitations to access and availability are both central aspects of the experience of food insecurity for immigrant women. Building on this research, further conceptual work is needed to examine how the experience of household food insecurity is affected by migration, particularly among families with young children, who are at a higher risk of household food insecurity. Furthermore, no published studies have assessed food insecurity or constraints to child diet among immigrants and refugees in Canada (Patil et al., 2012; Beiser et al., 2005). Chapter 5 aims to address this gap by examining the experience of food insecurity among newcomer mothers and their families.

2.6.3 Child Feeding Practices

An ecological framework assessing the determinants of health and nutrition incorporates environmental, material, and political considerations in explanations of individual behaviours, but it does not discount the importance of knowledge and attitudes
to health outcomes (Pelto & Pelto, 1997). Outside the context of migration, caregivers’
level of nutrition knowledge, access to nutrition information and attitudes to child diet
and health have been found to strongly influence feeding practices and the types of foods
children are fed (Coveney, 2005). Parents’ child feeding decisions are based on a wide
range of factors, including financial, political, social and environmental forces, along
with their knowledge and understanding of the relationships between food and health.
Many of these factors have a particularly strong impact on child feeding in the context of
international migration, which often puts children at risk of limited access to a nutrient-
dense diet and also leads to high levels of stress on families (Hadley et al., 2007).
Furthermore, individuals’ knowledge of health and diet is constructed through social
interaction and negotiations, and has potential to change with migration to a new country
(Jovchelovitch & Gervais, 1999; Hadley & Patil, 2010). Individuals may conceptualize of
“healthy eating” in many different ways, which will vary both between cultures as well as
between individuals within a culture (Lappalainen, Kearney, & Gibney, 1998; Falk et al.,
2001; Povey et al., 1998). Recent research on health and nutrition knowledge among
newcomer groups has demonstrated that frameworks for understanding health and
nutrition vary significantly between different cultural groups in Canada (Ristovski-
Slijepcevic, Chapman, & Beagan, 2008).

One model for examining the changes in diet with migration to the West is
Brigitte Jordan’s work on authoritative knowledge, which examines how particular
health-related practices and ways of knowing are legitimized in a “community of practice”
in specific situations, such as childbirth (Jordan, 1993). This framework posits that in any
particular domain of human understanding, there are several different ways of knowing,
but very often some are ultimately more powerful than others (Irwin & Jordan, 1987). Although parallel knowledge systems can and do exist equally, usually one kind of knowledge gains authority over the others (Jordan, 1993). Jordan terms this type of knowledge as “authoritative knowledge”; it is the knowledge that “counts” in a particular society. This model describes the ways through which different forms of knowledge are distributed hierarchically. This type of knowledge is often associated with a stronger power base, and the authoritative knowledge is validated and accepted through both practice (medical or otherwise) and social interaction (Sargent & Bascope, 1997; Irwin & Jordan, 1987). Jordan’s initial work examined the interplay between parallel cultures, in particular between traditional birthing practices and Western/medicalized birthing practices. Other scholars have also applied the concept of authoritative knowledge in a variety of settings to further explore parallel forms of knowledge in the areas of reproductive health and nutrition (Saravanan et al., 2012; Ellison, 2003; Kingfisher & Millard, 1998; Fiedler, 1996). These parallel cultures are the result of the introduction of Western medical knowledge and practice to areas with other traditional knowledge forms.

The framework of authoritative knowledge is equally applicable to migration, a process through which individuals are exposed to new ways of knowing. In this sense, we are applying Jordan’s framework to acculturation theory, which posits that at the individual level acculturation occurs with migration to a new cultural context and is influenced by attitude and behaviour changes, along with social support, coping strategies, and other individual level factors (Berry, 1997). This process of acculturation is driven by individual (and group level) changes in behaviour and value systems. Jordan’s model is well suited as a framework to understand the process of changes in valuation of parallel
knowledge forms as demonstrated by recent research applying Jordan’s framework to an analysis of infant feeding practices among immigrant mothers in Canada (Chadwick, 2010). Analysis of these changes in valuation of parallel knowledge forms is particularly useful to assess the utility of nutrition education programs and materials in particular populations. Chapter 6 will apply this framework to assessing the limitations of Canada’s Food Guide for newcomer populations, and subsequently identify areas for potential improvement to this tool.

2.7 References


Asanin Dean, J., & Wilson, K. (2010). 'My health has improved because I always have everything I need here…": A qualitative exploration of health improvement and decline among immigrants. *Social Science & Medicine*, 70, 1219-1228.


Figure 2.1: Conceptual Framework: Determinants of Nutritional Status in Children

Outcome

Immediate Determinants

Dietary Intake → Health Status

Underlying Determinants

Household Food Insecurity → Child Care and Feeding Practice → Home Environment and Health Service Access

Basic Determinants

Household access to quantity and quality of resources

Financial, human, physical & social capital

Sociocultural, economic, political context

Adapted from UNICEF 1990
Chapter 3
Methods

This chapter describes in detail the methods employed for all elements of the study design, data collection, and data analysis. In Chapters 4, 5 and 6 specific details pertaining to the methods outlined in this chapter are repeated. Procedures for obtaining and recording informed consent, maintaining confidentiality and anonymity and for data management and protection followed current standard guidelines provided by the Office of Research Ethics at the University of Toronto, which approved the study protocol.

3.1 Study Development and Collaborations

The data in this thesis derives from fieldwork I conducted in the Jane-Finch neighbourhood in Toronto, Ontario between May 2010 and April 2011. This work was conducted with the collaboration and support of several partners: Access Alliance Multicultural Health and Community Centre (Access Alliance), The New Immigrant Support Network (NISN) at Toronto’s Sick Kids Hospital, and several community centres and organizations in the Jane-Finch neighbourhood.

In early 2010 I began the first stage of research design in collaboration with Access Alliance. Access Alliance is a community health centre in downtown Toronto that provides health and social services to immigrants and refugees from across Toronto. I was interested in researching refugee mothers’ experiences with food insecurity and other aspects of their children’s diet and health. Using principles of a community-based approach (Baker et al., 1999) I consulted with service providers working with these populations prior to developing specific research aims. I met several times informally
with Access Alliances’ community dietitians and research associates to identify the challenges that they perceived newcomers face in ensuring children’s diet and health. These meetings were instrumental to the development of my broad research objectives.

In March 2010 I began a research collaboration with the Hospital for Sick Children’s New Immigrant Support Network (NISN), which funded a significant portion of the project. Funded by Citizenship and Immigration Canada since 2009, NISN aims to improve access to health care and health information for newcomer children and families through the provision of culturally competent care. One of the project’s early aims was to conduct community-based research on healthcare access for the children of newcomers, and I assumed the role as lead investigator for this project. With NISN, I developed a relationship with a director and two settlement counselors at a community-based agency which provides a range of services to all immigrant communities, new Canadians, and individuals in need of assistance in Toronto.

With the help of staff at the community-based agency we identified the Jane-Finch neighbourhood, an area of approximately 80,000 residents in the Northwest corner of the city, as an ideal setting for this research. We targeted the Jane-Finch neighbourhood for several reasons. First, it was designated in 2005 as one of the City of Toronto’s 13 “Priority Areas” which were targeted for investment in infrastructure and community services (City of Toronto, 2008). This designation has benefited these areas and allowed for an expansion of community services, which is an additional factor in attracting newcomers to this area. We were interested in targeting a priority area for two reasons: first, we wanted to target low-income households, and these areas have a higher proportion of low-income households than the City of Toronto as a whole. Second,
because these areas have benefitted from investment in infrastructure and community services, they have a higher density of services from which we would be able to conduct service-based sampling. We specifically targeted Jane-Finch because it has a high density of newcomers compared to the rest of the City of Toronto, and also because the neighbourhood was served by our original partner agency, which was relevant from a practical perspective for the purposes of recruitment.

Throughout this thesis, I switch between using the pronouns "I" and "we" to describe the actors in this research. This inconsistency reflects the fact that while I conceptualized of the study and was the principal investigator, study design was conducted in collaboration with my community partners, data collection was carried out by myself and two interviewers, and parts of the analysis were conducted with academic collaborators.

### 3.2 Formative Research: Key Informant Interviews

I identified and interviewed 12 key informants prior to the development of specific research questions and tools. These individuals were chosen using snowball sampling techniques, and also by directly contacting organizations serving individuals in the Jane-Finch Priority Area. These key informants included dietitians, settlement counselors, social workers, and early years professionals, all of whom worked in Jane-Finch. I conducted introductory, semi-structured interviews with each of them in which I asked them to identify the greatest challenges their newcomer clients faced, generally, as well as specific to children’s health and diet (see Appendix 1 for the key informant interview guide). Additionally, I discussed with key informants which linguistic and
cultural groups would be most feasible to study in this area. Language constraints and the number of interviewers we could hire were limiting factors so we decided to choose two language groups to capture a broader range of experiences than we would with one alone. Based on the information gathered in key informant interviews, we decided to focus our study on Sri Lankan Tamil and Spanish speaking Latin American newcomers, as both groups had high numbers of recent newcomers arriving as either refugees or family class immigrants. At each stage of the research design (e.g. development of specific research questions, methods of data collection, inclusion criteria, sampling strategies, recruitment, and development of interview guides) we consulted several of our key informants. This strategy aims to develop research which is relevant to the study population, and is commonly used in a community-based research approach (Baker et al., 1999; Khanlou & Peter, 2005),

3.3 Interviewer Selection

Based on information from our key informants, we decided to conduct our interviews in Spanish and in Tamil due to the expected limited English fluency of our participants. We elected to hire interviewers to conduct the interviews directly in Spanish and Tamil rather than hiring interpreters to perform direct interpretation. This decision was based on consultations with our research partners who had experience with qualitative research with newcomer groups. Conducting interviews in the participants' first language decreases participant burden by decreasing the length of the interviews, and it also allows for a more fluid, conversational style, which is conducive to collecting rich data on participants' experiences. We hired two interviewers, one Spanish-speaking and one Tamil-speaking. Our Tamil interviewer had migrated from Sri Lanka to Canada.
as an adult eight years prior to data collection, and our Spanish-speaking interviewer had immigrated from Argentina to Canada as an adolescent thirteen years prior to data collection. Our Spanish-speaking interviewer, Laura Mandelbaum, had an MA in Cultural Anthropology and had qualitative interviewing experience prior to involvement in our study. Our Tamil-speaking interviewer, Wasi Sivakumar, had experience in conducting quantitative surveys but did not have prior experience in qualitative methods. Along with the Senior Project Manager at NISN, Dr. Jennifer Levy, who is a medical anthropologist with extensive qualitative research experience, I designed and conducted a two-day training session for our interviewers on in-depth interviewing following Legard and colleagues' (2003) guidelines. We conducted mock interviews with the study team in English, in addition to pre-testing the guides with participants in the community.

3.4 Interview Design

Following the key informant interviews I developed a research plan that aimed to examine three separate but inter-related components of newcomer children’s health: 1) newcomer mothers’ experiences accessing healthcare for their children; 2) the experience of food insecurity for newcomer mothers of young children and their families, and 3) how newcomer mothers conceptualize “healthy” foods for their children, and in particular the applicability and use of Canada’s Food Guide for newcomer families.

As a nutritional anthropologist using a biocultural approach to examining factors influencing children’s health and nutrition I incorporated methodologies developed by applied medical anthropologists Gretel Pelto, Margaret Bentley and colleagues (Bentley et al. 1988) in rapid ethnographic assessment. These techniques eliminate the need for
lengthy participant observation common to classic ethnography, and use consistent semi-structured interview guides to examine individual knowledge, practices and experiences of particular diseases, as well as social and cultural information which could facilitate the development of interventions targeting the diseases (Bentley et al., 1988). The methods used in this study draw on these approaches, with the similar aim of developing recommendations for policy and practice. We elected to conduct individual in-depth semi-structured interviews rather than using group methods, such as focus group discussions, because of the sensitive nature of several of the interview questions, which covered the precarious migration status of several of the participants (particularly those who were currently going through the refugee claims process), migration experiences, and experiences with income and household food insecurity. Furthermore, the goal of the research was to explore participants’ experiences and decision-making strategies regarding seeking healthcare and food for their children. This in-depth exploration of each participant’s experiences would not have been possible in a group interview setting.

Because of the breadth of topics covered in the study aims I determined that two interviews would be necessary to allow for sufficient interview depth. I developed two interview guides following Legard and colleagues' (2003) guidelines for in-depth interviews that explored participants’ experiences accessing healthcare, accessing food and the experience of household food insecurity, and mothers' dietary choices and their understandings of health and illness for their children. The interview questions were informed both by key informant interviews, and drew from other previously used interview guides aimed at exploring the experiences of household food insecurity and ways of knowing about food and health (M. DeMarco, personal communication, April 29,
I consulted with key informants as I developed the guides, and we pre-tested the guide in English with two participants who met inclusion criteria and spoke fluent English.

While this is a primarily qualitative study, in addition to the semi-structured interviews, we asked participants at the beginning of the first interview several structured demographic questions, including questions on family members’ ages, employment, income, education and migration. Following completion of the final interview, we also used a questionnaire derived from the Radimer-Cornell Food Security Module to quantitatively measure household food insecurity and compare these results to our qualitative results. This scale was chosen over the Canadian Household Food Security Survey Module because it has been used in several studies of refugee groups in Northern countries (Hadley & Sellen, 2007; Anderson et al., in press; Sellen, Tedstone, & Frize, 2002), although we did not validate it against any dietary measures in this study population. We translated the scale into Spanish and Tamil and back-translated it into English, and pre-tested it on two Spanish and Tamil speakers prior to conducting interviews with participants.

I made minor language adjustments to the interview guides and the food security scale following pre-testing, and also changed some of the probing questions that the interviewers felt were unnatural. I also continued to adjust the interview guide throughout the period of data collection in response to interviewer feedback, and as I learned what might be helpful to probe based on the previous interviews. This was an especially useful method to use with our Tamil interviewer, who did not have prior experience with the semi-structured format of qualitative interviewing, and who found it
very helpful to have several probes included on the interview guide. I maintained consistency between both the Tamil and Spanish interview guides; if I added probes in the Tamil guide as a result of questions raised in a previous Tamil interview, I also added these to the Spanish guide. Appendices 2-4 contain the final iterations of each of the two interview guides, and the food insecurity module.

3.5 Recruitment

We adopted a service-based, purposive sampling approach. We identified potential participants and recruited them through community service providers in the area, including settlement counselors and home visitors, as well as through drop-in programs such as the Ontario Early Years Centres, and nutrition and cooking programs targeting newcomers and their children. I left recruitment flyers and sign up sheets with service providers, and some suggested I recruit participants during their drop-in programs, which I did on mutually agreed-upon dates. Volunteers interested in participating were screened for the following inclusion criteria before consenting (see Appendix 5 for the English version of the study consent form) and enrolling:

1. *Arrival in Canada either as a refugee claimant, Government Assisted Refugee (GAR), or family class immigrant.* We chose these groups because they are at higher risk of unemployment and low-income, and we hypothesized that they might face more barriers accessing services, programs, and other social supports. However, although we had initially hoped to sample from each group evenly, we faced great difficulty finding mothers who had arrived as GARs who met the criteria for our study. We recruited and interviewed two Latin American mothers who had arrived as GARs, but
we were unable to locate any more participants who met these criteria. Because of the limited size of the sample, we omitted these two interviews from our analysis.

2. *Arrival in Canada within the last five years.* We recruited mothers who had arrived in Canada within the last five years because we were interested specifically in the experiences of newcomers.

3. *Sri Lankan Tamil or Spanish-speaking Latin American origin.* Both these groups have high rates of refugee claims and family sponsorship, and are also among the five most numerous linguistic groups in Jane-Finch. In addition to the Sri Lankan Tamil group we had initially tried to focus on a single country of origin (Colombian), but due to recruitment challenges we expanded the criteria to Spanish speakers from mainland Spanish-speaking Latin America.

4. *Mothers of children age 1-5 years.* Mothers are more likely than any other family member to be the primary caregivers of a child. This is particularly true for newcomers, because they are often geographically separated from extended family (grandmothers, aunts, sisters) who might otherwise take on a caregiver role (Rossiter, 1992). For this research, we were interested in mothers' responses to a resource-constrained environment. We selected an age range of 1-5 years because of the critical importance of nutrition, child care and healthcare for early child growth and development (Pollitt et al., 1995).

5. *Household income below the Federal low-income cut-off (LICO).* We chose to select individuals below the Federal LICO because of our focus on individuals at risk of household food insecurity.
I gave our interviewers potential participants’ names and contact information, and they contacted them and re-screened to ensure they met inclusion criteria. If they met inclusion criteria, they scheduled their first interview.

3.6 Interview Process

To ensure privacy and comfort, participants were given the choice of being interviewed in their own homes, or else in a private room at the Black Creek Community Health Centre. Each participant was interviewed two or three times, in interviews that ranged from 45 minutes to 2.5 hours in length. Interviews were conducted in either Spanish or Tamil (with the exception of one interview with a participant who spoke fluent English, and who I interviewed in English) by trained interviewers who were research assistants for the study. I was present for all of the first interviews with each participant, and all but two of the follow-up interviews. I do not speak or understand Tamil or Spanish, but I instructed interviewers to ask me during the interviews if I wanted them to follow up on particular comments participants made. Particularly during the first few interviews, the interviewers asked me for this type of feedback several times. After each interview, the interviewer and I discussed the interview and any questions the interviewer had about types comments and stories to follow up on during interviews.

Prior to scheduling follow-up interviews with each participant, I read the transcript from the first interview and made a list of follow-up questions for the interview to ask in the second interview if any further explanation or clarification was required.
3.7 Data Analysis

Each interview was audio recorded and later translated and transcribed by a third party. Transcripts were checked and edited for accuracy with the recordings by the interviewers. Data analysis of in-depth interviews was conducted using qualitative content analysis (Hsish & Shannon, 2005). Coding began after the completion of all interviews, and was conducted using NVivo 9 software. I used a mid-level approach to analysis (Miles & Huberman, 1992), a technique in which broad analytical themes are determined prior to analysis and specific themes are then generated based on participants’ unique perspectives and are grounded in the data. This technique involves an inductive approach, examining the data for links between pre-determined concepts, and generating themes after data analysis was completed to generate theory. Theoretical approaches and frameworks for each specific analysis are outlined in Chapters 4, 5, and 6.

3.8 References


Chapter 4
Accessing Primary Healthcare Providers for Children of Immigrants: Experiences of Latin American and Sri Lankan Tamil mothers

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4.1 Introduction

This paper explores recent immigrant mothers’ experiences accessing and utilizing primary healthcare for their young children. Our analysis examines the disconnects between patients’ needs and expectations of healthcare and perceived healthcare delivery with the aim of identifying key areas to improve access and increase cultural competency in healthcare for the study population. The concept of “access” to healthcare in Canada, where all permanent and temporary residents have the right to what are considered to be basic healthcare services, is more nuanced than in, for example, the United States, where many newcomers do not have health insurance (Durden & Hummer, 2006). Rather than conceptualizing of access as whether or not a given service is available, we use Goddard and Smith’s (2011) concept of access, which argues that variations in access to healthcare offered might arise due to differences in availability and quality of services, the cost incurred to patients in order to access the service, and information available to communicate availability of services to patients. Within this framework, a key component of immigrant healthcare quality is healthcare provider and service cultural competency. Furthermore, our analysis acknowledges the importance of mothers’ expectations of healthcare for their children, and how the disconnect between these expectations and their actual experience in Canada affects their perception of quality of care and their own stress levels.
Newcomers face multiple barriers in accessing healthcare for their children in Canada. For documented residents of Canada (this excludes those without status, including those whose refugee claims have been rejected, and those who arrived in Canada with no status and did not make a refugee claim), the Canada Health Act aims to ensure that all residents are able to access medical services (Health Canada, 2006). Despite the intended effects of this act, huge disparities in healthcare access exist within the Canadian population. In particular refugee claimants and family sponsored immigrants may be at higher risk of barriers to accessing healthcare services and other programs because of higher levels of unemployment and low-income in this group (Yu, Ouellet, & Angelyn, 2007; DeVoretz, Pivnenko & Beiser, 2004). The family sponsorship program in Canada allows permanent residents to sponsor close kin to Canada. These permanent residents are responsible for ensuring there is support for that family member during his or her first year in Canada; these sponsored family members also receive provincial government health insurance. Family class immigrants thus have some family members who have lived in Canada for at least a few years, and who may be able to help introduce them to Canada’s healthcare system. They do not, however, necessarily have job qualifications and are not required to have official language skills. Those who arrive as refugee claimants arrive in Canada with only temporary status, and have access to federally funded healthcare through Interim Federal Health (IFH) coverage.

Before even accessing the healthcare system, there are many contextual barriers that newcomer mothers may face, including limited social networks and limited knowledge of services available (Simich et al., 2005). Furthermore, geographical barriers to accessing care have been documented in suburban Toronto areas (Asanin & Wilson,
Both Canadian born residents and newcomers face difficulty finding a family physician who accepts new patients, and if physicians in their neighbourhoods will not take them they often have to travel long distances to access a physician. This can be particularly burdensome for newcomers, and in particular for refugee claimants and family sponsored immigrants, because they are more likely to face economic constraints which may limit transportation options (Yu et al., 2007; DeVoretz, Pivnenko & Beiser, 2004).

Language barriers between patients and healthcare providers lead to decreased use of health services (Timmins, 2002), decreased patient satisfaction (David & Rhee, 1998), and also poorer health outcomes in patients (Wang et al., 2008). Access to professional interpreters can address this problem, but interpreters are not usually available in clinics, although they are sometimes available in community health centres and hospitals in Ontario. Interventions offering interpreters or a phone-in translation service have been found to increase patient satisfaction and adherence to follow up visits (Karmali et al. 2011). Beyond language, cultural differences between patients and healthcare providers can impede the quality of patient-provider interactions and create barriers to effective treatment. Previous research has shown that discrepancies between patients and physicians in health beliefs, values and behaviours can lead to under-utilization of the healthcare system, decreased adherence to both preventive measures and medications, and a mismatch between expectations and experience of care received (Gornick, 2000; Williams & Rucker, 2000). These differences can be exacerbated by patients’ expectations of care, which may not be in line with the standard of care in their new country of residence. Recognition of these issues has led to an increased awareness of
the importance of the cultural competence movement in healthcare, which acknowledges and incorporates the importance of culture, cross-cultural relations and cultural differences into healthcare (Betancourt et al., 2003; Karmali et al., 2011).

While there is a growing literature on access to healthcare for adult newcomers, there has been limited research assessing caregivers’ experiences accessing healthcare for their children. Recent research has documented that adult newcomers to Canada often under-utilize the healthcare system (Stephenson, 1995; Wang et al., 2008), but it is unknown whether the same happens when they seek care for their children. Newcomer children (and the children of recent newcomers) are an extremely vulnerable population. Newcomers as a group experience a significant decline in health status as little as two years after arrival in Canada (Newbold, 2009). Evidence suggests several mechanisms contribute to these declines, including diet and lifestyle change (Frisbie, Youngtae, & Hummer, 2001), loss of socioeconomic status (Bauder, 2003), social exclusion (Omidvar & Richmond, 2003), and a medical system that does not provide culturally competent care (Betancourt et al., 2003). Children are at a particularly vulnerable stage of development as shocks from illness, lack of access to food, and stress that may be present in a family due to migration can have a greater impact on them than on the adults in a household (Beiser et al., 2005; Hyman, Beiser, & Vu, 2000; Pollitt et al., 1995). In the United States, immigrant children have been found to use program benefits less than American-born children (Hagan et al., 2003) and are also more likely to report poor health (Capps et al., 2004).

Previous research in Northern countries has identified disconnects between expectations of and experiences with accessing healthcare among immigrants. There are
several key domains of healthcare access and utilization in which this mismatch has been found, including cost, time spent and types of interaction with healthcare providers, geographical access, language and communication, understandings of health and illness, and expectations of type of care received (Bates, Rankin-Hill, & Sanchez-Ayendez, 1997; Clark & Redman, 2007; Gannotti, Kaplan, Penn Handwerker, & Groce, 2004; Lawrence & Kearns, 2005). This paper aims to further explore newcomer mothers’ experiences accessing and utilizing healthcare for their children. Specifically, this analysis uses Goddard and Smith’s (2001) framework for healthcare access, by assessing how availability, cost, access to information, and quality (both perceived and objective) affect access to healthcare for newcomer mothers. Additionally, we propose a modification to Goddard and Smith’s framework to also include cultural and linguistic competency of healthcare, and mother’s expectations of care as moderating factors in newcomer mothers’ perceived quality of healthcare received (Figure 4.1).

4.2 Methods

4.2.1 Research Partners and Coordination

The research was conducted in partnership with the Hospital for Sick Children’s New Immigrant Support Network along with the support of several community centres and programs in the Jane-Finch neighbourhood, including the Black Creek Community Health Centre. This study was approved by the Research Ethics Board at the University of Toronto, and followed standard ethics guidelines regarding informed consent, confidentiality and anonymity.
4.2.2 Data Collection Overview

Data were collected through in-depth, semi-structured interviews. We chose this method because of the sensitive nature of several of the interview questions, which covered the precarious migration status of several of the participants (particularly those who were currently going through the refugee claims process), migration experiences, and experiences with income and household food insecurity. Furthermore, the goal of the research was to explore participants’ coping mechanisms and decision making strategies regarding seeking healthcare and food for their children; this in-depth exploration of each participant’s experiences would not have been possible in a group interview setting. To ensure privacy, participants were given the choice of being interviewed in their own homes, or else in a private room at the Black Creek Community Health Centre.

4.2.3 Inclusion Criteria

Specific inclusion criteria for participation in this study were: (i) arrived in Canada either as refugee claimants or through the family sponsorship program; (ii) arrived in Canada within the last five years; (iii) of Sri Lankan Tamil and Spanish speaking Latin American origin; (iv) mothers of at least one child age 1-5 years; (v) household income below the Federal Low Income Cut-Off.

We focused our analysis on those who had arrived as refugee claimants or through the family sponsorship program because they are at a higher risk of unemployment and low-income than other groups and therefore a more vulnerable population (Yu et al., 2007; DeVoretz, Pivnenko & Beiser, 2004). We recruited mothers who had arrived in Canada within the last five years because we were interested
specifically in their experiences navigating a new healthcare system. We targeted Sri Lankan Tamils and Latin Americans because both these groups have high rates of refugee claims and family sponsorship, and are both in the top five linguistic groups in Jane-Finch. We had initially tried to focus on a particular country of origin (Colombia), but due to recruitment challenges we expanded the criteria to Spanish speakers from mainland Spanish-speaking Latin America. We aimed to explore a range of experiences among newcomer mothers living in Jane-Finch, and so selected these two cultural/linguistic groups to help ensure we collected a breadth of data. We targeted mothers of children age 1-5 years based on both theoretical and practical concerns. Mothers are more likely to be the primary caregivers of a child than any other family member. This is particularly true for newcomers, because they are often geographically separated from extended family (grandmothers, aunts, sisters) who might otherwise take on a caregiver role (Rossiter, 1992). For this research, we were interested in mothers’ coping strategies in an unfamiliar, resource-constrained environment. We selected an age range of up to 5 years because of the importance of nutrition and healthcare for growth and development, but excluded infants (age 0-1 years) because of high rates of breastfeeding and formula feeding at this age range (Pollitt et al., 1995).

4.2.4 Recruitment and Interviews

Participants were recruited through community service providers in the area, including settlement counselors and home visitors, as well as through drop-in programs such as the Ontario Early Years Centres, and lunch programs targeting newcomers and their children. Each participant was interviewed two or three times, in interviews ranging in length from 45 minutes to 2.5 hours in length. Interviews were conducted in either
Spanish or Tamil (with the exception of one interview with a participant who spoke fluent English) by trained interviewers who were research assistants for the study. The principal investigator was present for all of the first interviews with each participant, and all but two of the follow up interviews and took field notes on parent-child interactions within the participants’ homes.

4.2.5 Data Analysis

Each interview was audio recorded and later translated and transcribed by a third party. The principal investigator reviewed the first interview transcripts with interviewers and identified any potential clarification needed in subsequent interview(s). Transcripts were checked and edited for accuracy with the recordings by interviewers. We used a modified version of Goddard and Smith’s (2011) theoretical framework for assessing equity in access to healthcare services as a means of framing the ways in which mothers were able to access care, and the barriers which they faced preventing them from accessing healthcare. We examined how mothers’ expectations of care matched with their perceptions of care received. This framework builds upon ecological frameworks used by biocultural anthropologists (Pelto & Pelto, 1996) and combined health service and health-seeking approaches (Obrist et al., 2007). Each transcript was coded for themes relating to accessing and choosing healthcare providers. The coding process identified common themes within and between groups.
4.3 Results

We conducted interviews with 32 individuals who had arrived in Canada as either refugee claimants or family class immigrants (16 Sri Lankan Tamil and 16 Latin American) living in Jane-Finch. All participants completed both the initial interview and follow-up interview, and three participants completed a third interview due to time constraints during the first and/or second interviews. About half (44%) of all families were receiving Ontario Works, and 75% of Tamil families and 83% of Latin American families rented their apartments. The majority of children had OHIP coverage (75% of Tamil, and 61% of Latin American), while 25% of Tamil children and 28% of Latin American children were covered under the Interim Federal Health Plan. Two Latin American participants (11%) reported that their children had no health coverage because they were making humanitarian claims. In almost all of the interviews, participants expressed that they were very concerned about having enough money for rent and for affording medications and healthy food for their children. Almost half of the families reported no income other than Ontario Works, and most families had experienced precarious employment situations.

4.3.1 Accessing Information on Available Health Care Providers

Most participants had found their child’s physician through either friends or family members, with some reporting referrals from community services. None had difficulty locating a family physician who was currently taking patients. However, several participants who were not satisfied with their children’s current physicians indicated that they did not know how to find a new physician, and none reported knowing
how to locate a physician through the College of Physicians and Surgeons of Ontario. Furthermore, two Tamil participants articulated that it would be inappropriate to ask their current physician for referrals to specialists, such as pediatricians or gynecologists, as it would be an insult to that physician or they would be perceived as critiquing that physician:

I never knew that I could ask, so I never asked…I thought what would a doctor think about me if I approach him for another doctor? *(Tamil, Refugee Claimant)*

Several Tamil participants in particular felt they could not ask follow-up questions of their physicians, or ask about other healthcare services available, explaining that they had respect for the physician and did not want to question the physician’s authority. In describing their perceptions of physicians, two participants directly compared them to god. When one participant was asked whether she felt the physician spent adequate time with her, she responded:

I don’t know what to say…I should say that doctors are like God. *(Tamil, Family Class)*

In describing a physician as “like God”, this participant was indicating that she deferred to physicians and did not feel it would be appropriate to question the care she received. Several others echoed this feeling when prompted to describe concerns they had about the care their children were receiving. This particular expectation of their patient-physician interactions – that their physicians would be unwilling to discuss their diagnoses or any alternatives – resulted in many participants failing to clarify their questions with their children’s physicians.
4.3.2 Perceived Appointment Availability

Participants experienced many more challenges regarding appointment availability than with initially finding a physician for their child. Some Latin American participants reported they had been able to find physicians who spoke Spanish in the area, but many of these participants reported that it was very difficult to secure appointments. One described trying to get an appointment with her Spanish-speaking physician:

To make an appointment with my family doctor is a lottery…. because, wow, if I call right now, they give me an appointment in two months’ time. *(Latin American, Refugee Claimant)*

Several described experiences in which their child was sick and they had not been able to get an appointment. In these cases, participants felt their only option was to take their child to the emergency room; over half of participants had taken their children to the emergency room. In contrast, no participants who went to nearby English speaking physicians reported any difficulty in making appointments.

Tamil participants reported physician availability problems largely when they went to see Tamil speaking physicians across the city in the suburb of Scarborough. These participants often scheduled appointments several months ahead of time, although many expressed satisfaction with their Tamil-speaking physicians once they were able to secure an appointment. Participants who took their children to English-speaking physicians in the area were largely happy with their ability to get appointments and the amount of time the physician spent with them. One participant reported that she had waited for an entire day to see a physician at a walk in clinic:

We went to the walk in clinic in the morning and we got through at only four in the evening. *[We arrived at] around 9:30 in the morning
and we were waiting and waiting the whole day. Because of that I didn’t go to the mall; I was completely exhausted. \textit{(Tamil, Refugee Claimant)}

Other key informants and participants reported similar experiences regarding waiting to see the Tamil speaking family physician. Most participants expected to be able to make same-day appointments with their child’s physician; in cases where they were unable to do so they reported feeling helpless and unsatisfied with the healthcare they were receiving.

\textbf{4.3.3 Perceived Quality of Patient-Physician Encounters}

\textbf{4.3.3.1 Language}

Successful communication with the physician was one of the most prominent issues regarding quality of care for their children. Almost all Tamil participants reported poor or no English speaking ability, while one third of Latin American participants reported poor or no English ability (Table 4.1). Those with limited English skills who went to physicians who only spoke English reported they could understand most of what their children’s physician told them, but felt they had inadequate English proficiency to speak to the physician and ask questions. One participant described this situation:

\begin{quote}
I would love to ask them and get information from them…but as I don’t know English it is difficult for me…For us since we don’t have enough English knowledge, we don’t get services, but they are doing their job. \textit{(Tamil, Family Class)}
\end{quote}

A few Tamil participants who did not have access to interpreters when visiting their child’s physician described using hand gestures to communicate concerns about their children’s health:
I can usually understand what he speaks…but if there is something which I couldn’t understand, then I show them actions. (*Tamil, Refugee Claimant*)

Tamil participants were particularly hesitant to complain about the quality of their interactions with their physicians, and would generally describe interactions like the participant above, indicating that while language was a barrier, they were able to generally communicate with their physicians. These descriptions, however, indicate that there were likely significant communication gaps during these participants’ interactions with physicians.

Several participants took their children to physicians who spoke their native language. In the case of Tamil participants, this meant they travelled across the city to Scarborough (where there is a large Tamil population, but is a minimum of one hour on public transportation from Jane-Finch) to receive medical care. Participants often felt this route was their only option; they were concerned that miscommunication with the physician would lead to a misdiagnosis of their child. One participant expressed concern that:

If I didn’t explain the sickness correctly, if I tell them some of the symptoms wrong, they might prescribe the wrong medication…that is my fear. (*Tamil, Refugee Claimant*)

Some Latin American participants found Spanish-speaking physicians near Jane-Finch, and others were willing to travel far to be able to communicate clearly with their child’s physician. One participant had formerly lived across the city near a community health centre with a Spanish-speaking physician; she continued to travel an hour and a half to get to that physician. She explained that her physician told her she needed to find
another clinic because she lives out of their catchment area, but she cannot see another option:

She [the physician] has already told me that I have to change to [a closer clinic] but I tell her that if there isn’t a doctor who speaks Spanish, what is she going to change me for? Because I don’t have an interpreter. *(Latin American, Refugee Claimant)*

For participants like this one who have no family members or friends who can come to appointments to act as interpreters, they often have no choice other than to travel long distances.

### 4.3.3.2 Access to Interpreters

The vast majority of participants who were registered with English speaking-only physicians had never used an interpreter during a healthcare visit at a clinic. There were notable differences in the experiences of accessing interpreters between Latin American and Tamil participants. While Latin American participants were aware of interpreter services and expected some form of language support during encounters, many Tamil participants were unaware that they were available at all.

*Latin American Participants*

Although Latin American participants were generally aware of interpreters, most had not used them either because they thought it was not necessary or because the $10/hour rate participants reported at some clinics was prohibitive. Participants were only aware of interpreters available at the local community health centre. The Latin American participants who did not know that interpreters were available generally relied on family members to interpret for them. One of the three Latin American participants
who reported using an interpreter explained how important she felt it was to have an interpreter:

> It is really good over there [at the clinic] because we can have an interpreter. You know that medical terminology is difficult. If you need an interpreter, you request him in advance and he interprets for you. (*Latin American, Refugee Claimant*)

Some participants reported that after a few years their English had improved enough that they felt they were able to communicate without interpreters. One remembered trying to communicate in English when she first arrived in Toronto, and not understanding what the physician said:

> At the beginning it was difficult for me to understand, and I would have liked to have an interpreter. Now it is easier, so I don’t mind. (*Latin American, Refugee Claimant*)

**Tamil Participants**

Only one Tamil participant reported knowing about interpreters at clinics or having been offered interpreters. While some said that they could manage in English, others expressed that they would like to be able to ask their physicians more questions, but were not able to. Many Tamil participants said that they would like to have interpreters, but since they are not offered at their clinic, they have to bring their own interpreters (e.g. family members, friends) or go without. One Tamil participant, when asked whether she had thought of asking for an interpreter while staying at the hospital for four days after giving birth, responded:

> Yes, at that time, when the doctor came, I didn’t understand what they said…at those times I thought of [asking for an interpreter]. (*Tamil, Family Class*)
4.3.3.3 Length and Perceived Thoroughness of Patient-Physician Encounters

In our sample, the majority of both Latin American and Tamil participants felt that they and their child received inadequate attention from their child’s physician. Several Latin American participants expressed frustration that their child’s physician did not spend as much time with them as they were used to having with physicians in their country of origin. These problems were expressed only with physicians who did not speak their native language. One participant described:

The pediatrician sees you very fast and asks me “anything else?” and I can’t answer. Since he goes very fast, because there are a lot of people, I can’t answer him and I forget things. *(Latin American, Refugee Claimant)*

Many were also concerned that physicians were not adequately examining their children. Among Tamil participants, a common theme was their concern that the physician did not touch their child during an appointment:

I went once for my daughter and they didn’t even touch the patient, they just prescribed the medicine…they didn’t even touch the baby. *(Tamil, Refugee Claimant)*

Another concern among three Latin American participants was that physicians did not adequately follow up with their patients following tests.

We as patients have to ask them, what’s wrong with me? What were the test results? Because they don’t tell you. In my country, if the diagnostic is positive or negative they call me anyway. They don’t do that here. I am getting used to this culture, but I always doubt. *(Latin American, Family Class)*
The same participant was upset that her child’s physician had not prescribed anything to increase her child’s appetite:

In [my home country] if a kid doesn’t eat, we buy something to make him eat. (*Latin American, Family Class*)

Some participants who had similar experiences explained that there wasn’t much point in taking their children to the physician most of the time because they would only say their child had a virus and not give them any treatment.

Those who went to physicians who spoke their native language and who went to community health centres were generally quite satisfied with the quality of care received. Participants who felt they had the most positive experiences with their physicians emphasized the number of questions that they were able to ask their physicians, and the detailed responses they received:

[The Tamil doctor] is so patient and soft….she gives me more advice. I will ask so many questions, and she will sometimes laugh and then advise me well. (*Tamil, Family Class*)

The doctor spends enough time with us; she only feels satisfied if she examines us completely. If she does not thoroughly check then the patients would feel dissatisfied; they feel that if the doctor spends time to listen then the sickness can be cured. (*Tamil, Refugee Claimant*)

Tamil participants were particularly satisfied with the quality of health care that they received here in Canada in comparison with what they had received in Sri Lanka. Several explained that they were not accustomed to preventative medicine; rather they had only gone to visit physicians in Sri Lanka when their child had been ill or injured:

When we were there, we never went to the doctor. We went to the doctor in case of emergency…only that. Here when we go to the doctor, the child’s physical health is being checked…in comparison to back home this is much better. (*Tamil, Family Class*)
This theme of wanting to convey gratitude for the healthcare and other services they were able to access in Canada recurred throughout most participants’ discussions of patient-provider interactions.

### 4.3.4 Geographic Accessibility of Physicians

All participants reported that they could access an English-speaking family physician for their children near to their home. Among Tamil participants who did not go to Tamil speaking physicians in Scarborough, several expressed a wish that they could find a nearby Tamil physician.

> I really prefer to communicate in Tamil…but have never found a Tamil doctor. Some say they are here in Scarborough, but we cannot afford to travel to Scarborough. It will consume a whole day for us to travel that far…we would need to take a bus, a subway and then a bus again and to walk there…(*Tamil, Refugee Claimant*)

Additionally, several women (both Latin American and Tamil) explained that they did not like to travel on public transportation alone in the city. One woman had found a Tamil-speaking physician downtown who she liked for her children, but moved to a clinic nearby because she did not feel comfortable travelling downtown alone:

> If it’s nearby then they can help me. I don’t know where to go, so that’s why [I don’t go downtown]. I am scared to meet people of other nationalities; I do not even go on the road by myself. (*Tamil, Refugee Claimant*)

Like others in our sample, this participant expressed anxiety over interactions with people on the street who didn’t speak Tamil (e.g. “people of other nationalities”). Many of the Tamil participants described extremely high levels of isolation, and their husbands often discouraged or prohibited them from taking their children out for activities, or from inviting others to their home. This isolation limited many participants’ opportunities to
improve their English and learn about services available to their families, thus further impeding their ability to seek out culturally competent care for their children.

The large geographic distances between home and clinic were also exacerbated for most of the study participants due to their limited economic resources for transportation. Less than half of participants (7/16 Tamil families and 7/16 Latin American families) owned a car. Among car owners many did not have access to their vehicle during the day and several car-owning families reported that they could not afford to insure the car throughout the year. Furthermore, several participants reported that they often could not afford public transportation or taxis. One participant recalled being unable to afford bus fare while walking home in the snow from a hospital while pregnant. Another participant described two similar situations:

Today I went by bus and I returned with the same transfer because I didn’t have money to come back… there are some bus drivers who are really nice and some others who aren’t.

When my baby got really sick I didn’t even have the money for the taxi to go to the hospital. I don’t have a car and I don’t drive. *(Tamil, Refugee Claimant)*

Other participants described depending on family and friends for transportation help to access health care services:

I went there even though I had only one token. One daycare sister [friend from a parent-child drop in centre] said she would drop me…but last Friday that sister didn’t come to the school. Then I had no money for the bus to return home. Then, my Indian friend gave me some money. *(Tamil, Refugee Claimant)*

Several women employed budgeting strategies in which they would save a few dollars at a time to create an emergency fund for the bus, in case they needed to take their children to the physician or to the hospital in an emergency, or to avoid situations such as
those described above. Walk-in clinics in two of the local malls were often chosen because of their close proximity, which allowed participants to walk their children to them, although this was perceived as a trade-off due to long waits.

4.3.5 Trade-off: Geography vs. Quality of Care

Overall, participants described a situation in which they are forced to choose between language, location, perceived quality of care, and their own time costs. Often the choice is made to find a physician who is far away but who speaks the language, but other times not. Several participants described an alternate solution: using different physicians for different purposes. These participants, particularly those with Tamil-speaking physicians in Scarborough, used local walk-in clinics for child health issues they determined were less serious. For more complicated matters, or when parents had more concerns which they needed to communicate to family physicians, they would travel across the city to their Tamil-speaking physician. Some participants expressed that they did not want to go to an English-speaking physician when they might be prescribing medication, for fear that the physician would prescribe the wrong medication because they had communicated ineffectively.

4.3.6 Economic Costs

In addition to the time and transportation costs outlined above, participants described economic costs as a concern for accessing the medications prescribed for their children. For participants who were not covered under Ontario Works or Interim Federal Health (IFH) drug plans, the cost of medication was a cause of stress and made them less
inclined to visit a physician. Many expressed concern about what they would do if they were required to medical costs:

So far she hasn’t been sick much, but when she is, I know that my budget will be unbalanced. (*Latin American, Refugee Claimant*)

For those who have had to pay for medications, they often described it as a trade-off from their weekly food budget, and sometimes had to go into debt to pay for them.

I took [the money for prescription medications] from the rent and from the money I have to pay for the bills…we had to cut down on food and those things a little bit. (*Latin American, Refugee Claimant*)

Participants whose families were covered under Ontario Works or IFH drug plans expressed much less concern about affording medications, although they were uncertain about what was and was not covered. Some had had to pay for medications that weren’t covered under the plan. Several also reported having to pay for expensive medicines because they had not renewed their coverage.

4.3.6.1 Coverage under the Interim Federal Health (IFH) Plan

Most participants who were refugee claimants and whose families were covered under the IFH reported that they had no difficulty in accessing healthcare. This is in contrast to other reports that have found that clinics often do not accept IFH-covered patients (*Yu et al., 2007*). In Jane-Finch, it appears that clinics are willing to serve these patients.

Several participants were unsure about what the IFH program covered, and were worried about what would happen if they had a serious problem:

I think that if you have a serious problem, such as a heart attack, it is not completely covered. (*Latin American, Refugee Claimant*)
I am worried that the medicine is too expensive and the (IFH coverage) doesn’t cover it. Oh my God, what would I do? (Latin American, Refugee Claimant)

Many of these participants were accessing services in a community health centre, where patients without any health coverage are treated. Because the community health centres do not require any coverage, some of the families had let their IFH coverage expire, and had not felt it was necessary to apply for it again.

4.4 Discussion

The aim of this analysis was to explore the experience of primary healthcare access and utilization for children of newcomers to Canada. Among recent newcomer Latin American and Sri Lankan Tamil mothers in Jane-Finch, we analyzed the experience of accessing and utilizing primary healthcare for their child using Goddard and Smith’s (2001) framework. Access to information, availability (both geographic and time), perception of quality (both linguistic and cultural), and costs incurred to families (both financial and time) were all found to affect children’s access to family physicians. While previous research indicates that a shortage of family physicians in Canada affects all residents (Ontario Medical Association, 2007), barriers to access are exacerbated by factors associated with being a newcomer. Specifically, a lack of knowledge of services available, limited cultural and linguistic competency among healthcare services and providers, and economic barriers associated with travel and affording medications all impede access in our study sample. Furthermore, the mismatch between mothers’ expectations of the healthcare system and their experience led to patient-provider miscommunication, frustration, and overall decreased satisfaction with Canada’s healthcare system.
4.4.1 Access to Information on and Locating a Primary Care Provider

Before mothers and their children enter the healthcare system itself, there are other contextual barriers to accessing care. Newcomers to Canada face significant hurdles because they have often left their families and social networks behind and arrive in Canada with limited social support (Simich et al., 2005). Among newcomers in Canada, levels of social support have been found to directly influence an individual’s ability to access community programs and services (Neufeld et al., 2002). Recent newcomers are thus at risk of being unable to access information regarding services which may be available to them. More broadly, social exclusion of newcomer families is a growing concern in Canada (Omidvar & Richmond, 2003), and is a key determinant of newcomers’ ability to navigate the healthcare and social services systems. This social exclusion was evident especially among several of the Tamil participants in our sample, and as a result many of them were unaware of services available in their neighbourhood and in the city more generally.

Contrary to the findings of previous qualitative analysis conducted in Toronto (Asanin & Wilson, 2008) in our study no participant had difficulty locating a family physician who was currently taking patients. Generally, participants reported receiving referrals from friends, family, or community services. None, however, reported using the physician registry, and found it difficult to transfer from physicians if they were unhappy with the care they were receiving. Many participants expressed a reluctance to question physicians and the healthcare system which prevented them from accessing other resources, such as a pediatrician, a female physician, a specialist, or an interpreter. Research in the United States on visible minorities has found that African-American and
Latino patients perceive that the power differentials between patients and physicians decrease the quality of care received (Napoles-Springer et al., 2005). Tamil mothers’ comparison of their physicians to God exemplifies the power differential and physician inaccessibility that patients perceive during appointments. Interventions to incorporate cultural sensitivity into physician training programs, including a focus on effective communication and culturally sensitive individualized treatment may help physicians adjust their behaviour to become more approachable to their patients (Tucker et al., 2003). Furthermore, programs targeted at informing patients of their rights to healthcare, and of the services they have access to in the healthcare system may help address some of these barriers.

4.4.2 Linguistic Barriers

The reported lack of shared language and lack of interpretation between patients and physicians was a major barrier to finding acceptable healthcare for newcomer children. Particularly among the Tamil participants, many reported that they had experienced encounters with physicians during which there were no options for translation, which is particularly concerning given that physicians tend to overestimate patients’ ability to comprehend English during a medical encounter (Jackson et al., 1997). Thus, these interactions are characterized by a lack of comprehension by the patient, which has the potential to cause them anxiety regarding the quality of care they received, making them less likely to access other specialists or to follow up on care, and negatively affects overall health outcomes (Roberts & Crockford, 1997; Stuart et al., 1996; Trauer, 1995).
To cope with the linguistic and geographical challenges in access to care, participants reported a strategy of finding two physicians for their child. The strategy involved having a family physician/pediatrician who spoke their language but was geographically difficult to access, along with either using a nearby walk-in clinic or taking the child to their own local physician for minor concerns. Ontario does not have a province-wide electronic medical records system, and so while this strategy allows mothers to access physicians potentially more easily, the lack of continuity of care has the potential to increase emergency room utilization (Christakis et al., 2001), and leads to poor patient health outcomes (Cabana & Lee, 2004).

4.4.3 Economic Barriers to Healthcare

Scholarship on immigrant and refugee health often fails to differentiate between immigrants of different ethnic and linguistic origins, or by their immigration class (Murdie, 2005). In Canada, there are three different immigration categories that can lead to permanent residency: Economic, Family Class, and Humanitarian/Refugees (and within refugees there are those who made their claim in Canada, and those who were either government assisted or privately sponsored to come to Canada). Economic class immigrants have the highest rates of economic assimilation, and refugees have the lowest (Yu et al., 2007; DeVoretz, Pivnenko, & Beiser, 2004). In Ontario, the Ontario Health Insurance Program (OHIP) covers permanent residents, and for those who are temporary residents, the Interim Federal Health (IFH) Program provides health coverage and extended coverage such as medications and dental coverage (which is offered to low-income families and welfare recipients, but not the general Canadian population). As federally funded health insurance, IFH is designed as a temporary source of health
insurance for individuals who do not yet have access to provincial health insurance. However, in June 2012 several cuts were made to the IFH, including funding for extended healthcare such as medications and dental coverage (Access Alliance Multicultural Health and Community Services, 2012).

While healthcare was technically available to all of our participants through federal and provincial health insurance, there were clearly a number of economic constraints that affected participants’ ability to access healthcare. While families receiving Ontario Works (provincial welfare) benefits and also those covered by the Interim Federal Health Program had access to insurance for medications, the remaining study participants did not. Among those who did not have coverage, access to medications was a major source of stress, and was often only possible by decreasing food expenditures or going into debt. The extent of the difficulties faced by low income newcomer families in our study is particularly relevant given the subsequent changes made to the Interim Federal Health program after data collection was completed. Our results indicate that these cuts could very seriously impact refugee claimants’ ability to access medications, and could also impose other economic hardship on these families.

4.4.4 Quality: Mismatch Between Expectations and Experience of Healthcare

In our sample of newcomers navigating the Canadian healthcare system for the first time, many participants felt their experiences accessing primary healthcare for their children did not meet their expectations. One of the factors leading to these disconnects between expectations and actual experience was the perceived insufficient time spent in patient-physician interactions, as participants reported they were accustomed to longer
appointments in their countries of origin. Among participants who were already experiencing anxiety about how to communicate with their child’s physician, the added time pressure limited their ability to address all their concerns and to fully understand the physician. Several previous studies have found that extending appointment time by two or three minutes can improve screening and health education activities, and increase patient satisfaction (Dugdale, Epstein, & Pantilat, 1999; Roland et al., 1986; Wilson et al., 1992). Improving this dimension of patient-physician interactions is an important component to increasing cultural competency, and may also prevent miscommunication and the need for follow-up visits.

Other disconnects surround participants’ cultural expectations of physicians, and their hesitation to question healthcare professionals, such as by asking for referrals, or by asking follow-up questions. A few participants described preferring physicians who treated them “like a friend”. Some of these participants explained that they felt their child’s physician could not fully understand the cause of their child’s illness if they did not perform a tactile examination. This expectation is an example of a fundamental difference in patients’ expectations of physicians that can result in patients losing trust in the physician, and can negatively affect care-seeking behaviour and health outcomes (Whetten et al., 2006). Given that previous research has indicated that physicians perform poorly at identifying patients’ expectations of care (Perron et al., 2003), further work is needed to identify strategies to improve physicians’ patient communication strategies.

Several participants indicated that they were concerned they might be perceived to be critiquing physicians. In our sample, the Tamil participants in particular
experienced more anxiety concerning questioning physicians’ decisions; similar barriers in communication with physicians have been reported among Latino parents of special needs children living in the United States (Gannotti et al., 2004). This concern is also consistent with previous research that found recent immigrants are less likely to utilize services, and fear being too much of a burden on the healthcare system (McDonald & Kennedy, 2004). Several of our participants wanted to clarify that they were very grateful for all of the services available to them in Canada, and many also indicated that in their country of origin they did not have access to the same level of care. Previous research on recent Vietnamese refugees in Victoria B.C. reported participants similarly wanting to appear grateful in a hospital setting, and subsequently not reporting symptoms of nausea brought on by hospital food, further complicating diagnosis (Stephenson, 1995). Similarly, participants were aware that they generally received higher quality health care in Canada than they would have in their country of origin. This difference between their past and current health care systems may be affecting health-seeking behaviours in our study population.

In all cases, these disconnects between expectations and experiences have the potential to decrease both perceived and actual quality of care received. The disconnect between expectations and experience has been examined in the context of healthcare and quality of life: people with different expectations will report that they have a different quality of life even when they have the same clinical condition (Carr, Gibson, & Robinson, 2001). Clark and Redman’s (2007) examination of Mexican immigrant mothers’ expectations for children’s healthcare found that immigrant mothers had similar expectations of warmth and friendly interactions from physicians to mothers in our
sample, and also struggled with the lack of Spanish language fluency among healthcare providers. These unmet expectations and barriers to accessing healthcare have implications not only for children: Research on Somali immigrant women living in the United States has found that the experience of unmet expectations of health provider interactions both increased their frustrations and diminished their perceived quality of healthcare (Pavlish, Noor, & Brandt, 2010). This increased level of anxiety among mothers may have implications for both maternal and child health (Leiferman, 2002; Minkovitz et al., 2005).

**4.4.5 Study Limitations**

There are several limitations to this study. First, all participants were recruited through community partners who helped us with recruitment, including Ontario Early Years Centres, the Black Creek Community Health Centre, settlement counselors, community dietitians, and nutrition programs. These participants were already accessing programs and services in the community; we have therefore not included individuals who have not yet accessed these services in our sample. It is thus possible that we have not sampled the newcomers in Jane-Finch who are most vulnerable to barriers to accessing healthcare. Second, we sought to include participants from the range of Latin American and Sri Lankan Tamil newcomer mothers, including those who arrived in Canada as family class immigrants, and those who arrived as refugee claimants. However, while our results represent a wide range of experiences in our sample population, we do not attempt to draw conclusions about the study population as a whole. Although we sought to minimize interviewer bias by creating a standardized interview guide, it is possible that differences between our Spanish and Tamil interviewers’ experiences and perspectives
may have influenced follow-up questions and the content of parts of the interviews. Finally, our data collection did not include any interviews with physicians or patient-physician observations, and so we can only discuss patients' experiences.

### 4.4.6 Conclusions and Recommendations

This analysis has identified several levels of barriers to accessing primary care physicians for young children of recent newcomers in the Jane-Finch area. While geographical and financial barriers to accessing primary healthcare for newcomer children exist, the linguistic and cultural barriers that newcomer families face pose a significant risk to their children’s health. While limited access to family physicians is a problem facing many families with children living in Canada, newcomers are particularly vulnerable due to the limited linguistic and cultural competency of healthcare services and providers, combined with their limited social networks and awareness of available services, and their higher likelihood of facing economic constraints. Our analysis suggests that many newcomers may not be aware of the healthcare services available to them in Canada, or how to access these services. Participants in our study often reported feeling that they did not have the right to ask for services, and also that they have very limited social networks through which to find information regarding access to health care. It is particularly notable that although our sample was service-based (e.g. all participants had either accessed settlement counselors, early years programs, or other community programs), there was still very limited knowledge of how to navigate the healthcare system in Canada. An orientation to health care services upon arrival would help newcomers access services in the first months and years in Canada.
This analysis contributes to the literature on newcomer access to healthcare in its framing of cultural and linguistic competency and understanding of patient expectations as essential to ensuring access to healthcare for newcomer children. An increased focus on cultural competency in health clinics is essential to address many of the problems in perceived quality of care reported by participants in this study. Specifically, our findings indicate that patients have limited knowledge of their healthcare options and do not feel comfortable asking physicians or other healthcare providers for further information. Furthermore, patient and physician expectations of care may differ significantly, and cultural competency training programs are essential to help provide physicians with tools to support their newcomer patients. The demographic changes in Canada, and Toronto specifically, necessitate a greater focus on the disparities in health and health care between immigrants and the Canadian-born population. Our study found that the model of care at community health centres led to high levels of patient satisfaction and access to interpreters; this model could be extended throughout the health care system.

4.5 References


Neufeld, A., Harrison, M., Stewart, M., Hughes, K., & Spitzer, D. (2002). Immigrant women: Making connections to community resources for support in family caregiving. *Qualitative Health Research*, 12(6), 751-768.


<table>
<thead>
<tr>
<th></th>
<th>Sri Lankan Tamil participants (n=16)</th>
<th>Latin American participants (n=16)</th>
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<tr>
<td><strong>Mother’s age</strong></td>
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<td>31 (21-46)</td>
</tr>
<tr>
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<td>4.5 (0.5-5.5)</td>
<td>2.6 (1.5- 3.5)</td>
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<td><strong>Mother’s country of origin</strong></td>
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<td>Colombia (1) Ecuador (2) El Salvador (2) Honduras (1) Mexico (7) Nicaragua (1) Peru (1)</td>
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<td><strong>Mother’s immigration status on arrival in Canada</strong></td>
<td>Permanent resident (family class) 10 (63%)</td>
<td>5 (31%)</td>
</tr>
<tr>
<td></td>
<td>Refugee claimant 6 (37%)</td>
<td>11 (69%)</td>
</tr>
<tr>
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<td>Citizen 1 (6%)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Permanent resident 11 (69%)</td>
<td>7 (44%)</td>
</tr>
<tr>
<td></td>
<td>Refugee claimant 4 (25%)</td>
<td>7 (44%)</td>
</tr>
<tr>
<td></td>
<td>Humanitarian claimant 0</td>
<td>2 (13%)</td>
</tr>
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<td><strong>Mother’s highest level of education</strong></td>
<td>Primary 1 (6%)</td>
<td>1 (6%)</td>
</tr>
<tr>
<td></td>
<td>Highschool 8 (50%)</td>
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</tr>
<tr>
<td></td>
<td>Some college/university 2 (13%)</td>
<td>1 (6%)</td>
</tr>
<tr>
<td></td>
<td>College/university 5 (31%)</td>
<td>7 (44%)</td>
</tr>
<tr>
<td><strong>Mother’s English Speaking and Understanding Self-Assessment</strong></td>
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<td></td>
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<td>4 (25%)</td>
</tr>
<tr>
<td></td>
<td>Fairly well 13 (81%)</td>
<td>6 (38%)</td>
</tr>
<tr>
<td></td>
<td>Well 0</td>
<td>4 (25%)</td>
</tr>
<tr>
<td></td>
<td>Very well 0</td>
<td>1 (6%)</td>
</tr>
<tr>
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<td>1 (6%)</td>
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<tr>
<td></td>
<td>Poor 1 (6%)</td>
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<tr>
<td></td>
<td>Fairly well 13 (81%)</td>
<td>6 (38%)</td>
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<tr>
<td></td>
<td>Well 2 (13%)</td>
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<td></td>
<td>Very well 0</td>
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</tr>
<tr>
<td>---------------------------------------</td>
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</tr>
<tr>
<td></td>
<td>4 (25%)</td>
<td>2 (13%)</td>
</tr>
<tr>
<td>Husband’s highest level of education</td>
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</tr>
<tr>
<td>Primary</td>
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<td></td>
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<tr>
<td>High school</td>
<td>13 (81%)</td>
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<td>Some college/university</td>
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<tr>
<td>College/university</td>
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<td>13 (81%)</td>
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<tr>
<td>Has car</td>
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<td># Children in household (Median (range))</td>
<td>2 (1-3)</td>
<td>2 (1-3)</td>
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<tr>
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<td>3(1-5)</td>
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<tr>
<td>% Index children born in Canada</td>
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<tr>
<td>OHIP</td>
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<td>Interim Federal Health</td>
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<tr>
<td>None</td>
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Figure 4.1: Factors affecting access to healthcare for children of newcomers (adapted from Goddard & Smith, 2001)
Chapter 5
Experiences of Food Insecurity and Migration
Among Newcomer Mothers in Toronto

Anderson L.C., Mah C.L., and Sellen, D.W.

5.1 Introduction

Household food insecurity is experienced when appropriate, nutritious and safe foods required for a healthy and productive life are not available and/or the ability to acquire such foods is uncertain due to financial constraints (FAO, 2006; Bickel et al., 2000). A central component of the concept of household food insecurity is that it is the result of income constraints, and is therefore distinct from the inverse of a commonly-used definition of food security – which is the assurance of healthy and safe food for all (McIntyre, 2011). Household food insecurity is a strong determinant of health for children. It negatively affects the quality of children’s diets and nutritional status (Bhattacharya, Currie, & Haider, 2004), children’s physical health (Casey et al., 2005) and mental health and the development that is necessary for a child’s health and a productive future (Perez-Escamilla & Pinheiro de Toledo Vianna, 2012). Beyond a determinant of health, household food insecurity is also a significant social problem. Low-income families reliant on social assistance programs are at a high risk of food insecurity in Canada, reflecting the inadequacy of these programs in the alleviation of poverty (McIntyre, Connor, & Warren, 2000; Che & Chen, 2001; Vozoris & Tarasuk, 2003).

The concept of household food insecurity as it is used in Canada today was adopted in the early 1990s as a framework for describing, researching and designing
policies aimed at addressing poverty-related food problems (Cook, 2002). Early research on household food insecurity was largely qualitative and focused on the experience of hunger and food insecurity among low-income women in New York State (Radimer, Olson, & Campbell, 1990). This formative qualitative research identified quantitative, qualitative, psychological and social dimensions of food insecurity at both the individual and household levels (Radimer et al., 1990; Radimer et al., 1992; Kendall, Olson, & Frongillo, 1995). Furthermore, this work found that food insecurity is a managed process, and has an important temporal aspect, meaning the experience of food insecurity is a sequence of events that develop over time. These developments can sometimes be controlled, and some members of a household may experience food insecurity differently than others (Radimer et al., 1992; Tarasuk, 2001). This qualitative work was the foundation for the development of a quantitative measure of food insecurity, the Radimer/Cornell scale (Kendall et al., 1995). This scale, along with the Community Childhood Hunger Identification Project (CCHIP; Wehler, Scott, & Anderson, 1992), laid the groundwork for the development of the US and Canadian Household Food Security Survey Modules (HFSSM). The HFSSM has been used to monitor food security in the US annually since 1995, and has been a supplement to the national Canadian Community Health Survey since 2004 (Health Canada, 2007). It is currently used to measure household food insecurity in Canada both for the CCHS and has also been used in smaller, targeted samples (Health Canada, 2007; Vahabi et al., 2011).

Newcomers are known to be at a higher risk of household food insecurity than the general population: In 2007 12.6% of newcomer households reported food insecurity compared to 7.5% of non-immigrant households (Health Canada, 2010). Studies within
the last decade have documented very high rates of economic hardship, mental stress and food insecurity among refugees and other non-economic forced migrants in several high-income countries, including the United States (Patil et al., 2010). Among newcomers to the US and other high-income countries low income, unemployment, and recent arrival are predictors of food insecurity (Anderson et al., in press; Hadley & Patil, 2010; Hadley, Zodhiates, & Sellen, 2007). Many immigrant families spend almost all their resources in order to arrive in their new country, and it often takes several months to find employment; for refugee claimants who have not yet had their claims approved this can be particularly challenging as they may be discriminated against due to their lack of permanent status (Canadian Council for Refugees, 1999). This lack of savings or income source places newcomer families at high risk of food insecurity in the first years following immigration (Quandt et al., 2004; Quandt et al., 2006). Studies in the UK and US have found food insecurity in more than half of all refugee families with children under five years, and a study of Latin American immigrants in Toronto found a similar prevalence (Hadley et al., 2007; Sellen, Tedstone, & Frize, 2002; Vahabi et al., 2011).

In addition to the inherent challenges of being a low income family, newcomers’ individual experiences in their countries of origin and during migration (e.g. in areas of conflict, of persecution, financial and personal insecurity, etc.), combined with the challenges and risk of mental distress they face on arrival in Canada, influence their subjective experience of food insecurity. Refugees in particular are at high risk of experiencing anxiety and depression when they arrive in Canada, and this can affect their help-seeking behaviours in a healthcare context (Simich et al., 2006). Furthermore, newcomers arriving from areas of conflict and high levels of household food insecurity
may be likely to view food insecurity in the Canadian context differently because of their past experiences. They may also have different expectations of services available to support them. While there has been no research to our knowledge examining differing expectations of support in relation to household food insecurity, in the health services literature individual expectations of care received in a healthcare setting have been found to affect utilization and satisfaction with care received (Clark & Redman, 2007; Cristancho et al., 2008).

Much of the early qualitative work designing the current HFSSM was based on U.S. and Canadian-born families with children (Hamelin, Beaudry, & Habicht, 1998; Radimer et al., 1990). Two studies conducted in the past decade examined household food insecurity among immigrants in Toronto using qualitative methods, finding that income limitations, inadequate public and private sector responses (including food banks), poor knowledge of available resources, and cultural differences in food preferences all contributed to household food insecurity (Koc & Welsh, 2002; Vahabi et al., 2011). A third study (Lessa and Rocha 2012) examining food insecurity among immigrant women in Toronto identified the importance of food relations in the lives of immigrants, emphasizing the importance of focusing on food in settlement programs. Furthermore, this research found that limitations to access and availability are both central aspects of the experience of food insecurity for immigrant women. Building on this research, further conceptual work is needed to examine how the experience of household food insecurity is affected by migration, particularly among families with young children, who are at a higher risk of household food insecurity. No published studies have qualitatively assessed children's food insecurity or constraints to child diet among immigrants and
refugees in Canada (Patil et al., 2012; Beiser et al.. This analysis directly responds to calls for more qualitative research on the experience of food insecurity (Power, 2004), and aims to contribute to the understanding of the experience of food insecurity in Canada by examining the experience of low-income, recently arrived refugee claimants and family class immigrants living with young children. The experience of household food insecurity for Canadian newcomers as a group is currently under-studied and under-theorized and this study aims to build upon the current knowledge of the qualitative experience of food insecurity. An understanding of the experience of food insecurity in this group is relevant to the development and use of tools to quantitatively measure and monitor household food insecurity, and has the potential to inform programs and policy targeting household food insecurity among immigrants and other vulnerable groups in Canada.

5.2 Methods

5.2.1 Research Partners and Coordination

The research was conducted in partnership with the Hospital for Sick Children’s New Immigrant Support Network along with the support of several community centres and programs in the Jane-Finch neighbourhood, including the Black Creek Community Health Centre. This study was approved by the Research Ethics Board at the University of Toronto, and followed standards ethics guidelines regarding informed consent, confidentiality and anonymity.
5.2.2 Qualitative Data Collection

Data were collected through in-depth, semi-structured interviews. We chose this method because of the sensitive nature of several of the interview questions, which covered the precarious migration status of several of the participants (particularly those who were currently going through the refugee claims process), migration experiences, and experiences with income and household food insecurity. To ensure privacy, participants were given the choice of being interviewed in their own homes, or else in a private room at the Black Creek Community Health Centre.

5.2.3 Quantitative Data Collection

The household food security questionnaire was derived from the Radimer-Cornell Food Security module. This scale was chosen over the Canadian Household Food Security Survey Module because it has been used in several studies of newcomer groups in Northern countries (Sellen et al., 2002; Hadley & Sellen, 2007; Anderson et al., in press). These previous studies found very high levels of household food insecurity in recently arrived refugee households with young children and in several contexts these levels correlated with measures of acculturation. This study is an extension of this work, as we aim to examine household food insecurity both quantitatively and qualitatively, while exploring the experiences of migration and the process of acculturation.

5.2.4 Inclusion Criteria

Specific inclusion criteria for participation in this study were: (i) arrival in Canada either as refugee claimants, government assisted refugees (GARs) or through the family sponsorship program; (ii) arrival in Canada within the last five years (iii) of Sri Lankan
Tamil and Spanish speaking Latin American origin; (iv) mothers of at least one child age 1-5 years; (v) household income below the Federal Low Income Cut-Off.

We selected refugee claimants and family class immigrants because they are at high risk of unemployment and low-income and through formative research we learned that there were high numbers of both groups living in Jane-Finch (Yu, Ouellet, & Angelyn, 2007; DeVoretz, Pivnenko & Beiser, 2004). We recruited participants who had arrived in Canada within the last five years because we were interested specifically in newcomers’ experiences with household food insecurity in their first years in Canada. We targeted mothers of children age 1-5 years based both on theory and practical concerns. Mothers are more likely to be the primary caregivers of a child than any other family member. This is particularly true for newcomers, because they are often geographically separated from extended family (grandmothers, aunts, sisters) who might otherwise take on a caregiver role (Rossiter, 1992). We selected an age range of up to 5 years because of the importance of nutrition for growth and development, but excluded infants (age 0-1 years) because of high rates of breastfeeding and formula feeding at this age range (Pollitt et al., 1995).

5.2.5 Recruitment and Data Collection

Participants were recruited through community service providers in the area, including settlement counselors and home visitors, as well as through drop-in programs such as the Ontario Early Years Centres, and lunch programs targeting newcomers and their children.
Each participant was interviewed two or three times, in interviews that ranged from 45 minutes to 2.5 hours in length. Interviews were conducted in either Spanish or Tamil (with the exception of one interview with a participant who spoke fluent English) by trained interviewers who were research assistants for the study. The principal investigator was present for all of the first interviews with each participant, and all but two of the follow up interviews and took field notes on parent-child interactions within the participants’ homes.

We targeted Sri Lankan Tamils and Latin Americans because both these groups have high rates of refugee claims and family sponsorship, and are both in the top five linguistic groups in Jane-Finch. Due to language constraints we limited our sample to two language groups, which enabled us sample a greater diversity of ethno-cultural groups.

5.2.6 Data Analysis

Each interview was audio recorded and later translated and transcribed by a third party. The study coordinator reviewed the first interview transcripts with interviewers and identified any potential clarification needed in subsequent interview(s). Transcripts were checked and edited for accuracy with the recordings by interviewers. We analyzed data inductively using codes both developed prior to analysis, and those developed inductively through the progression of data analysis.

Data analysis of in-depth interviews was conducted using qualitative content analysis. We used a “mid-level approach” to analysis (Miles & Huberman, 1994), a technique in which broad analytical themes are determined prior to analysis and specific
themes are then generated based on participants’ unique perspectives and grounded in the data (Hsieh & Shannon, 2005). For this research, we were particularly interested in using the existing frameworks of household food insecurity (Radimer et al., 1990; Tarasuk, 2001) to explore newcomer mothers’ experiences of household food insecurity, and also to understand how their migration experience might affect their perception of their own household food insecurity and their management strategies. We used an inductive approach examining the data for links between migration and food insecurity, and generated themes after data analysis was completed to develop theory on the relationships between food insecurity and migration in this sample. Coding began after the completion of all interviews, and was conducted using NVivo 9 software.

5.3 Results

5.3.1 Participant Demographics

Our eligibility criteria required that participants have a family income below the Federal Low-Income Cut-Off (LICO). During recruitment there were no potential participants who were ineligible due to their self-reported income on recruitment, which was expected due to the low-income demographics of the area, particularly among recent newcomers. During interviews, three families were discovered to have incomes above the LICO, but we have included their interviews in this analysis as they still share many similar experiences to lower-income families. About half (44%) of all families were receiving Ontario Works, and 75% of Tamil families and 83% of Latin American families rented their apartments while the rest owned theirs. Using the Radimer-Cornell scale (Appendix 4) we found that 66% of participants had experienced some level of
household food insecurity within the month prior to the interview. Fifty percent of participants personally had experienced household food insecurity, while 41% reported food insecurity for their children, and 13% reported their children had experienced hunger. Other participant demographics are outlined in Table 4.1.

5.3.2 Experiences of Food Insecurity

During analysis, we identified two aspects of the experience of food insecurity (Radimer et al. 1992; Tarasuk 2001; Hamelin et al. 2002) as central to the food insecurity experience which may be unique to the migrant experience: food insecurity as a managed process, and the temporal aspect of food insecurity. We present our results here according to these two aspects.

5.3.2.1 Food Insecurity as a Managed Process

Migration’s Impacts on the Family Economic Situation:

Unemployment and unreliable employment were the most common explanations for concerns about household food insecurity. Many participants experienced high levels of household food insecurity in their first months or years in Canada, when family members were unable to find work. These first months in Canada were often described by participants as being extremely socially isolating, and as a time of doubt. One participant described the impact on her family when her husband had difficulty finding work:

He couldn’t find a job for a while and it was difficult. Though at that time we were getting some money from the government, but it wasn’t enough. It was a bit hard and we went to the Food Banks and to the benefit programs. There was a time when he said we should go back to Mexico, but we managed to get by. (Latin American, Family Class)
Most participants expressed concern because their partners did not have permanent, full
time employment. Two participants’ husbands had recently lost their jobs, and they both
expressed concern about where money for food and for rent would come from:

I’m worried about…the rent and the food, right? Yeah. For the
food I can, ah, save some money from this month, that my husband
receives, okay? So I’m gonna be okay. But I’m worried about the
rent. Because is like $900, so. Where I’m gonna get the $900? I
don’t know if I can apply for welfare. I don’t know. (Latin
American, Family Class)

We always have to bear in mind that we need to have enough food.
We can’t always have everything, you see? We know that some
days we can have more or some days less. But we usually try to
have the minimum for the rent and for the food. (Latin American,
Refugee Claimant)

Many described lengthy job searches with limited success for both themselves and their
partners. Participants reported that the main barriers to finding work were the lack of
recognition of their credentials in Canada, their lack of social connections, their limited
English capability, and a lack of child care support. One Tamil participant described the
difficulties they had affording food because their claim had not been accepted, making it
harder for her husband to find work:

Now we have not been accepted and when we do not have enough
money to pay for rent, even today we gave them whatever we had
and told them that we will give the balance later and they said ok.
So it gives me some worries. We manage ourselves with the fruits
and milk, and if we don’t have the money I’ll manage with
whatever we have. When we have the money we give them
nutritious food; usually these difficult situations will not last for
more than a short period (Tamil, Refugee Claimant)

This woman emphasized that she was only worried about giving her children nutritious
food. In comparison to her experiences in Sri Lanka, when they would go to bed without
any food, in Canada they were at least able to afford some bread for their children.
Only two Latin American participants were employed (both part time), and no Tamil participants were currently working. A few participants reported that they had been employed in Canada, but none had been able to keep their jobs, largely because of the difficulty in finding childcare.

I would like to go to work but there is no option of leaving her and going to work. I did not come over here because I didn’t have anything over there [in Sri Lanka]. I feel here is harder than over there. I never depended on anyone for anything [in Sri Lanka]. That is a worry for me….And coming over here, even though government is paying, I am feeling bad getting this money… If my husband comes over here we can both go to work alternatively. How long will they provide welfare? It’s not like it will never stop, right? (Tamil, Refugee Claimant)

This participant explained a different but related tension than the one described previously: while she was grateful for the opportunities she and her children could have in Canada, she found that in some ways life was more difficult in Canada than in her home country. As indicated above, she did not want to be dependent on welfare, and she was anxious about how much longer she would qualify for that support.

*Household Budgeting Strategies*

The primary response by participants experiencing household food insecurity was to cut back on household expenses, including cutting back on clothing purchases as well as decreasing their household food budget. Strategies for the latter included reliance on staple foods, avoiding restaurants, avoiding more expensive foods such as fresh fruits, cheeses, and meats. This was often described as occurring at the end of the month. One participant described her experiences:

I buy a bag of rice and it lasts, then I don’t buy anything else. The day I buy all that, soup, oil, that day I spend more. Let’s say that it is once per month that I do that. The rest of the time is as if, how
can I tell you, I try to manage it, to make it last. *(Latin American, Refugee Claimant)*

Since most participants were unemployed, they depended on their partners for financial resources. While some indicated that their husbands saved for emergencies, others described saving parts of their weekly budget from their husband in case of an emergency:

Thank God, I have never had an emergency. My husband is not a person who says “Here you have 20 dollars this week in case of an emergency”. He used to give it to me before but now he doesn’t. So if he ever gives me something, I keep it saved for those days when I have an emergency. Let’s say that every week he leaves 20 or 50 dollars and I know that I can’t spend that money just like that (laughter), but I also know the money is there in case of an emergency. *(Latin American, Refugee Claimant)*

Several food insecure participants buffered their children against food insecurity by eating less themselves. They recalled skipping meals, and drinking only tea or broth during meals to ensure their children had food. One described how she stretches the foods purchased at the supermarket by eating food from the food bank, which she considered to be less desirable, so that her children did not have to eat it.

Sometimes I go to the food banks, but very few times because they give you canned food, which my daughters don't eat, but they don’t give you the essentials, such as milk, yogurt or those things. But I try to get that just for them. *(Latin American, Refugee Claimant)*

Thirteen participants reported that they were actively concerned at the time about how they would be able to feed their child in the next week. One participant experienced such acute household food insecurity that she explained she was grateful the interview team could come interview her that day because she was depending on the $25 gift card to a grocery store that we offered as an honorarium for participation. She explained that this was the only way she would be able to get food that day. As she explained “if there is no
money, then [my daughter’s] food items are gone…I worry this might happen each and every day” (Tamil, Refugee Claimant).

**Seeking Assistance from Friends, Family Members and Food Banks**

Most participants had borrowed small amounts of money from friends and family members in Canada and felt that they would be able to borrow money in an emergency. A few participants sent their children to family members’ and neighbours’ apartments for meals at the end of the month when they faced more financial constraints. One participant, who experienced a high level of household food insecurity described her strategies for asking for assistance when she ran out of food:

> I go door to door asking for a bottle of milk…It is embarrassing. I can do that for one day, but for the rest of the days my daughter doesn’t drink milk. And I think that is bad for her development not to drink milk…I just tell them that I forgot to buy milk, but my sisters in law know that it is because I don’t have money (Latin American, Refugee Claimant)

Among Latin American families, food banks were frequently cited as a reason for why participants did not worry about child hunger; all but two had used them, and all knew where to find food banks. These food banks were often part of community programs that these women attended. While some reported they felt there was a stigma, among these families this was never a reason not to go: as one Latin American participant explained, even though her husband had initially not supported her food bank use, once he saw how much food she received from there, he conceded it was a useful service. This was in stark contrast to Tamil families, of which five did not know where to find a food bank, and none reported that they had found them to be particularly helpful. This lack of knowledge was consistent with many Tamil participants’ general descriptions of limited
social networks, social isolation, and lack of knowledge of available services. Tamil participants cited the belief that food was expired, and also that they did not want to eat canned food as the reasons for which they were uninterested in food banks. While several Latin American participants shared these concerns, many of them explained that they were a reliable resource in case of emergencies.

Sometimes I need to borrow but we can’t always, so we adjust the budget…at least here, thank God, we can go to the Salvation Army [food bank] (Latin American, Refugee Claimant)

Many who regularly accessed food from food banks felt that they were not able to access the food bank enough times each month.

5.3.2.2 Temporality: Experiencing Varying Degrees of Food Insecurity over the Life Course

In interview discussions regarding their current experience of food insecurity, over one quarter of participants (including both Latin American and Tamil participants) felt compelled to explain that the food insecurity situation was much worse for family and friends in their home countries and elsewhere in the world, and that they themselves had experienced much more extreme levels of food insecurity prior to arrival in Canada. Although many indicated that they were currently experiencing food insecurity in Canada, they indicated that they felt that in Canada they would not starve, and that others fared worse than them. One participant explained it as such:

I have never worried any day as such…when I was back in Sri Lanka I used to worry but not even a day after coming here…I have experienced so many bad things, and when I think about that now I will worry as I had to come across so much trouble. (Tamil, Family Class)
The stories of challenges family members faced and are currently facing due to flooding and civil war in Sri Lanka and very often violence in Latin America were a driving force in framing what the participants considered to be hardship. Another participant was acutely aware of her situation in the global context, and explained that she felt that she could not justify asking for anything more for herself because she knew at the time that Haitian earthquake victims faced more need than she did:

I don’t go to the food bank because the Salvation Army is helping Haiti, that’s why I don’t want to go there…they were taking food for them. *(Latin American, Refugee Claimant)*

Some participants’ lengthy migration experiences put them in a highly food insecure position, which made their situation in Canada seem relatively secure. Several who arrived as refugee claimants spent weeks or months in transit getting to Canada, often with limited access to food and little control over their situation. One participant described her migration to Canada from Sri Lanka, which took her through the United States:

When I was in America, I didn’t have any money with me…I had no food, I had a very tough time. Most of the days I was starving and just drinking water. *(Tamil, Refugee Claimant)*

When describing the difficult situations their friends and family faced in their countries of origin, several participants explained that they tried to send remittances home whenever possible. Through this direct comparison between themselves and these family members in more difficult situations these participants framed themselves as less insecure. The same Tamil participant quoted above explained that she sent remittances home to her husband who could no longer work because people were coming to his house and beating him, asking where his wife was and how she left:
He is in fear, he cannot go to any job. They say that the war is over but he is still in fear; he got a beating two times. The army will call him, beat him, and send him back. They ask ‘where is your wife?’…if he goes out the army will get him. I want to send him money but the money I receive on welfare is not even enough for me. I want to find a job for this reason (Tamil, Refugee Claimant)

Like several others, this participant discussed at length her desire to send money to support family at home. In the formative stages of this research, key informants indicated that remittances were a major burden for Tamil participants in particular. Thus, prior to interviews, we had expected to find that sending remittances home was a significant burden on household budgets. Among Latin American families, we found that this was not a common practice. While some families reported sending money home, it was never discussed as a burden, and if they did not have extra money they did not send it.

A few participants noted that while they were in fact having challenges in Canada, they were still grateful for what they had in Canada, and felt that they should not complain. This theme encompassed both participants’ general feelings of gratitude for the freedoms they are afforded living in Canada compared to their countries of origin, as well as their gratitude for services and government support provided. One participant described this tension between the stress she and her family currently experience in Canada and her gratitude for living in Canada:

Sometimes I feel bad about it but I am grateful to this country because of the opportunity he is being given. We are going through this now…this is the situation and we need to get adjusted to it. We can’t do any other thing. But this country is great. God blesses this country and God blesses you too because we are very happy, very happy. It is a chance that we are being given. (Latin American, Refugee Claimant)
When this woman referred to “the situation”, she was referring to the high levels of household food insecurity she and her family were experiencing at the time. She discussed her inability to absorb any emergency household expenses, and relied on the food bank. Nonetheless she repeatedly emphasized how grateful she was to live in Canada.

Three participants specifically explained that they felt that they could not in fact have a legitimate claim to food insecurity because of the government programs and food banks available to address issues of hunger in Canada. One participant who received Ontario Works benefits explained her perception of the government’s role in addressing hunger in Canada:

In our country [Sri Lanka], there were many poor people who had difficulty getting food, but after they come to Canada, government gives money for food for everyone. But the government will only give money for those who have welfare right? If they are not on welfare and if they work, and if the income is not enough, I think those people have problems. Those people can go to the food banks (Tamil, Family Class)

In sum, this participant and others tended to feel that since there is support they should not complain. Nonetheless, later in the interview this woman went on to describe what meets our definitions of household food insecurity, and indicated she was very worried about her children being at risk of food insecurity as well. Embarrassment regarding borrowing money and asking for food was an additional common related theme, and many participants were frustrated that they were dependent on the help of others, when they had been self-sufficient in their countries of origin. Several Tamil participants expressed this concern regarding food banks.
5.4 Discussion

This analysis aims to expand upon existing qualitative work on the experience of food insecurity in North America by examining the experience of food insecurity among newcomer mothers of young children. We examined both determinants and outcomes of food insecurity, and explored in particular how these mothers’ migration experiences influenced the determinants of food insecurity in their households, and also how migration affected their subjective experience of household food insecurity. Here we analyze these experiences using two existing frameworks for the analysis of the conditions and experiences of household food insecurity: food insecurity’s managed aspect, and its temporal dimensions (Tarasuk 2001; Radimer et al. 1992; Hamelin et al. 2002). We identified two key distinctions between the experience of food insecurity in newcomers’ countries of origin and Canada which in turn impact how they perceive their experience of household food insecurity here in Canada. First, for many newcomers their ability to manage the situation of household food insecurity has decreased due to limitations in finding employment and decreased levels of social support. Second, for most participants the relative deprivation experienced in Canada has also decreased upon arrival in Canada, which affects their subjective experience of household food insecurity.

5.4.1. Food Insecurity as a Managed Process

The managed aspect of food insecurity includes strategies to obtain food or money in the context of resource scarcity (Tarasuk, 2001). While securing employment is often not considered part of the managed process of food insecurity, we include it here
because it was central to our participants’ explanations of how they would ideally choose to manage their current situation.

5.4.1.1 Securing Reliable Income

Consistent with the definition of household food insecurity (McIntyre, 2011), participants indicated that increased income was the primary factor that would improve their ability to feed their children. Food insecure participants indicated that their inability to secure sufficient reliable income through employment or through Ontario Works was the primary factor driving their food insecurity. Refugee claimants and family sponsored immigrants, the two immigration classes chosen for this sample, often do not have the qualifications and language skills that economic migrants require to enter Canada, and so they have more difficulty integrating into Canadian society. These groups have significantly lower incomes during the first 18 years after arrival than skilled workers (DeVoretz, Pivnenko, & Beiser, 2004). While several of our participants’ husbands came to Canada as skilled workers, those who arrived as refugee claimants had major challenges securing employment, and for those still going through the refugee claims process, their precarious migration status caused further stress. Among the families not receiving Ontario Works, work was very gendered; only four participants (three Latin American and one Tamil) in our sample were employed outside the home, while the rest stayed home and cared for children. Several of these women expressed frustration that without family members such as mothers and aunts living nearby, they were unable to find the childcare required in order to find work. This feeling of helplessness was felt acutely by participants on welfare, who were frustrated by the fact that they had greater relative earning potential in their countries of origin. Furthermore, it was evident from
interviews that many of our participants were trying very hard to avoid dependence social services. This was particularly frustrating for participants who had been accustomed to supporting themselves in their countries of origin, and this disconnect between how they perceived themselves, and how they felt they were perceived in Canada was a significant cause of stress.

5.4.1.2 Resource Augmentation Strategies

The resource augmentation strategies employed by food insecure families, particularly the child buffering and food bank use, are consistent with findings among families experiencing high levels of household food insecurity in other contexts (McIntyre et al., 2003; Himmelgreen et al., 2000; Jacobs Starkey, Gray-Donald, & Kuhnlein, 1999). Previous work examining food insecurity and food bank use by Latina women in the United States has also found that the stigma surrounding food bank use can be a limitation to utilization, but that food banks combined with other social support networks fill the gaps created by insufficient income and welfare support (Mares, 2013). In our sample, several Latin American participants described a similar situation, using a strategy of combining support from friends, community nutrition programs, and private sector supports such as food banks to procure sufficient food. This strategy was less evident among Tamil participants, likely partly due to the social isolation many Tamil women experienced, which led to their lack of knowledge of either food banks or public sector services available. Lemke and colleagues (2003) suggest that larger social networks may increase an individual's ability to manage resources in difficult situations, and our results suggest that the social isolation several Tamil women described affected their ability to manage the process of household food insecurity. These findings lend
support to quantitative analysis reporting that higher levels of social capital decrease the risk of food insecurity (Martin et al., 2004), although recent analyses have found no definitive link between social support and household food insecurity (De Marco & Thorburn, 2008). This difference in social isolation between Latin American and Tamil participants is one of the greatest distinctions between the two groups, and is a component of household food insecurity that is not easily quantifiable nor is it measured in the current Household Food Security Survey Module.

5.4.2 Temporality

An essential component of the concept of food insecurity is that it is dynamic. Food insecure households and individuals experience a distinct sequence of events and experiences which is an essential aspect of the concept of food insecurity as a managed process (Tarasuk 2001). Previous research has indicated that food insecure families tend to experience periods of acute food shortages (often in the days preceding receipt of pay cheques or welfare cheques, or during the winter for seasonal workers) followed by periods when they may be slightly more food secure (Hamelin, Beaudry, & Habicht, 2002). This pattern has been documented among food insecure immigrant populations in the United States (Hadley & Sellen, 2007), and several participants in our sample described similar experiences. Beyond these monthly or annual temporal patterns, we found that the temporal shifts in the experience of food insecurity through the life course were particularly relevant to this sample of recently arrived newcomers. Almost all participants in our study described higher levels of food deprivation in their countries of origin. This early life deprivation and subsequent migration to Canada affected participants’ subjective experience of food insecurity in two distinct ways. While several
participants were highly food insecure, their security relative to their past situation (and also relative to family members’ current situations) made them feel relatively secure. Furthermore, the experience of hardship including food insecurity in their home countries and during transit to Canada affected their perceptions of their current food insecure status. We propose that the experience of household food insecurity in distinct periods of time can influence perceptions and experience throughout the life course.

5.4.2.1 Framing of Food Insecurity in Canada as Minimal due to Past Experiences

During interviews over half of study participants shared stories of extreme hunger in their countries of origin and during their migration to Canada. It is noteworthy that while many of these participants were highly educated (Table 5.1), Sri Lankan participants had experienced a civil war and its aftermath which exposed them to hardship, and many of the Latin American participants had experienced poverty, particularly in rural areas, while growing up. Among Tamil participants in particular it was very common for them to describe the acute hunger, and skipping meals that they had grown accustomed to in their youth. Furthermore, many of them still had family members who were suffering from these forms of extreme food insecurity. These experiences include trauma that may have long lasting effects. Individuals in resource constrained environments are more likely to experience higher levels of household food insecurity if they report symptoms of stress and anxiety (Anderson et al., 2012; Hadley et al., 2008). The anxiety caused by past trauma may affect individuals’ resource augmentation strategies and also their perceptions of their current situation.
5.4.2.2 Perceived Lack of Right to Complain

A second outcome of participants’ past experiences with more extreme levels of food insecurity was evident in how they used comparisons between their home country and their current situation in Canada to indicate that they felt that their problems in Canada were not significant enough to warrant complaint, or to expect any help or support. The social dimension of household food insecurity, as outlined originally by Radimer and colleagues (1990) and as conceptualized for the HFSSM, refers to the deviations from social and cultural norms that food insecure individuals are compelled to make in order to acquire and to consume food. Newcomers are in a unique position in that they begin the process of acculturation (Berry, 1997) upon arrival in their new countries. Thus, to varying degrees, these individuals are affected by the social and cultural norms of both their countries of origin as well as Canada.

These effects of migration on the subjective experience of food insecurity present a challenge for service provision and support of these communities, as newcomers experiencing income and food insecurity are expected to access services available to them. Participants in our sample widely indicated that they felt that they should be grateful for being in Canada, and because of this gratitude they felt that they did not have a right to expect a higher quality of life. Participants’ discussions of a private sector response to household food insecurity, food banks, exemplify this feeling of gratitude. The continued focus on food banks and other community responses as a solution to household food insecurity masks the social inequalities that cause families to be food insecure (McIntyre, 2011). This construct of food banks as a solution to the “problem” of hunger and food insecurity has a tendency to suggest to the general public that sufficient
supports exist to address the problem of hunger. This framing may be one reason why newcomers in our study feel they should be grateful for any support that they receive in Canada.

An unexpected finding in this research is that in comparing the results of participants’ responses to the Radimer-Cornell module, we found several discrepancies between the qualitative and semi-quantitative questionnaire responses from individual participants. Qualitative interviewing is widely considered to offer more in-depth insight into participants’ experiences and beliefs, and so it was based on this understanding that we aimed to explore experiences of household food insecurity using in-depth interviews. We found that two participants, however, who indicated high levels of household food insecurity in the module, did not indicate any concern about food during the interviews. For example, when asked in several ways about concerns about food, one Tamil participant who arrived as a family class immigrant simply responded, “I don’t think about that much”, and another explained:

I want to give him good food… I haven’t thought about food in the future. I think about feeding them well but not thought about food scarcity (Tamil, Family Class)

Both these participants were Tamil, and throughout our interviews we found that the Tamil participants were less likely to go into great detail and as a result there was less richness to the data. This may have been because our Tamil interviewer had less previous experience in qualitative interviewing than our Spanish interviewer. Or, it may also be due to cultural barriers; one of our key informants anticipated prior to data collection that many of our Tamil participants would likely not be comfortable discussing household financial matters with us.
5.4.3 Limitations

There are several limitations to this study. First, all participants were recruited through community partners who helped us with recruitment, including Ontario Early Years Centres, the Black Creek Community Health Centre, settlement counselors, community dietitians, and nutrition programs. These participants were already accessing programs and services in the community; we have therefore not included individuals who have not yet accessed these services in our sample. It is therefore likely that we have not sampled the newcomers in Jane-Finch who are most vulnerable to barriers to accessing healthcare. Second, we sought to include participants from the range of Latin American and Sri Lankan Tamil newcomer mothers, including those who arrived in Canada as family class immigrants, and those who arrived as refugee claimants. However, while our results represent a wide range of experiences in our sample population, we do not attempt to draw conclusions about the study population as a whole. Finally, although we sought to minimize interviewer bias by creating a standardized interview guide, differences between our Spanish and Tamil interviewers’ experiences and perspectives may have influenced follow-up questions and the content of parts of the interviews.

5.4.4 Conclusions and Implications

Food insecurity is currently conceptualized as a chronic condition that varies in severity over time (Tarasuk, 2001). This analysis contributes to the existing literature on food insecurity by examining the case of a vulnerable group – recently arrived refugee claimants and family class immigrants – who arrive in Canada having already experienced food insecurity and other forms of deprivation, and continue to experience
food insecurity in Canada in a different way. Here we expand the concept of the temporality of food insecurity to include the experience of household food insecurity through the life course as well as the migration process. Among newcomers who have experienced high levels of deprivation in their countries of origin, the relatively low levels of food insecurity experienced in Canada, combined with their gratitude for the opportunity to live in Canada, may affect their own perception of need and make them less likely to report food insecurity and to seek programmatic support. Furthermore, barriers to adequate and consistent income through employment including language barriers and a lack of Canadian training and experience make it challenging to procure sufficient food. Social isolation and past trauma may further limit their options for resource augmentation strategies.

Currently, household food insecurity among Canadian newcomers is monitored using the HFSSM. This tool was developed based on extensive qualitative data on the experience of household food insecurity and has been validated in many settings. However, none of this qualitative work was conducted on immigrant populations, and there are still gaps in our understanding of household food insecurity among many vulnerable populations in Canada, including newcomers. Our research indicates that there are several aspects of the experience of household food insecurity that may be unique to newcomer populations that should be taken into consideration when measuring food insecurity in these groups. These aspects include their challenges in managing household food insecurity due to migration-related unemployment and limited social networks, as well as their experiences with high levels of food insecurity at different periods throughout the life course, which can affect their perception of the situation here in
Canada. We suggest further research to examine how past experiences of household food insecurity, acculturation, challenges in securing reliable employment, and social isolation may affect experiences with other vulnerable groups of newcomers in Canada. This research can be applied to help develop a food security module aimed at measuring these particular aspects of newcomer food insecurity in Canada. Furthermore, it could inform the development of programs and policy to support food insecure newcomer families, with the aim of ultimately ensuring they have sufficient income to protect them against food insecurity.

5.5 References


understanding of underlying causes for food and nutrition insecurity. *Public Health Nutrition, 6*(8), 759-764.

Mares, T. (2013). "Here we have the food bank": Latino/a immigration and the contradictions of emergency food. *Food and Foodways, 21*, 1-21.


Table 5.1: Participant Demographics

<table>
<thead>
<tr>
<th></th>
<th>Sri Lankan Tamil participants (n=16)</th>
<th>Latin American participants (n=16)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mother’s age</strong></td>
<td>31 (23-44)</td>
<td>31 (21-46)</td>
</tr>
<tr>
<td><strong>Years mother has been in Canada</strong> (median (range))</td>
<td>4.5 (0.5-5.5)</td>
<td>2.6 (1.5-3.5)</td>
</tr>
<tr>
<td><strong>Mother’s country of origin</strong></td>
<td>Sri Lanka (16)</td>
<td>Colombia (1) Ecuador (2) El Salvador (2) Honduras (1) Mexico (7) Nicaragua (1) Peru (1)</td>
</tr>
<tr>
<td><strong>Mother’s immigration status on arrival in Canada</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent resident (family class)</td>
<td>10 (63%)</td>
<td>5 (31%)</td>
</tr>
<tr>
<td>Refugee claimant</td>
<td>6 (37%)</td>
<td>11 (69%)</td>
</tr>
<tr>
<td><strong>Mother’s current immigration status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citizen</td>
<td>1 (6%)</td>
<td>0</td>
</tr>
<tr>
<td>Permanent resident</td>
<td>11 (69%)</td>
<td>7 (44%)</td>
</tr>
<tr>
<td>Refugee claimant</td>
<td>4 (25%)</td>
<td>7 (44%)</td>
</tr>
<tr>
<td>Humanitarian claimant</td>
<td>0</td>
<td>2 (13%)</td>
</tr>
<tr>
<td><strong>Mother’s highest level of education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>1 (6%)</td>
<td>1 (6%)</td>
</tr>
<tr>
<td>High school</td>
<td>8 (50%)</td>
<td>7 (44%)</td>
</tr>
<tr>
<td>Some college/university</td>
<td>2 (13%)</td>
<td>1 (6%)</td>
</tr>
<tr>
<td>College/university</td>
<td>5 (31%)</td>
<td>7 (44%)</td>
</tr>
<tr>
<td><strong>Mother’s English Speaking and Understanding Self-Assessment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can’t speak or understand</td>
<td>0</td>
<td>1 (6%)</td>
</tr>
<tr>
<td>Poor</td>
<td>3 (19%)</td>
<td>4 (25%)</td>
</tr>
<tr>
<td>Fairly well</td>
<td>13 (81%)</td>
<td>6 (37%)</td>
</tr>
<tr>
<td>Well</td>
<td>0</td>
<td>4 (25%)</td>
</tr>
<tr>
<td>Very well</td>
<td>0</td>
<td>1 (6%)</td>
</tr>
<tr>
<td><strong>Mother’s English Reading and Writing Self-Assessment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can’t read or write</td>
<td>0</td>
<td>1 (6%)</td>
</tr>
<tr>
<td>Poor</td>
<td>1 (6%)</td>
<td>3 (19%)</td>
</tr>
<tr>
<td>Fairly well</td>
<td>13 (81%)</td>
<td>6 (38%)</td>
</tr>
<tr>
<td>Well</td>
<td>2 (13%)</td>
<td>5 (31%)</td>
</tr>
<tr>
<td>Very well</td>
<td>0</td>
<td>1 (6%)</td>
</tr>
<tr>
<td><strong>Husband’s current immigration status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citizen</td>
<td>7 (44%)</td>
<td>4 (25%)</td>
</tr>
<tr>
<td>Permanent Resident</td>
<td>4 (25%)</td>
<td>2 (13%)</td>
</tr>
<tr>
<td>Refugee Claimant</td>
<td>2 (13%)</td>
<td>5 (31%)</td>
</tr>
<tr>
<td>Humanitarian Claimant</td>
<td>0</td>
<td>2 (13%)</td>
</tr>
<tr>
<td>Does not live in Canada</td>
<td>2 (13%)</td>
<td>0</td>
</tr>
<tr>
<td>No husband</td>
<td>1 (6%)</td>
<td>3 (19%)</td>
</tr>
</tbody>
</table>

| Husband’s highest level of education | | |
| Primary | 0 | 2 (13%) |
| High school | 13 (81%) | 5 (31%) |
| Some college/university | 0 | 3 (19%) |
| College/university | 3 (19%) | 3 (19%) |

| Household annual income, $CAD (Median (range)) | 23,700 | 20,640 |
| | (12,480-44,000) | (14,400-62,000) |

| % Receiving Ontario Works | 7 (44%) | 7 (44%) |
| % Renting house/apartment | 12 (75%) | 13 (81%) |
| % Have car | 7 (44%) | 6 (38%) |
| # Children in household (Median (range)) | 2 (1-3) | 2 (1-3) |
| Age of index child (Median (range)) | 3 (1-5) | 3 (1-5) |
| % Index children born in Canada | 12 (75%) | 8 (50%) |

| Household Food Insecurity | | |
| Food secure | 6 (38%) | 5 (31%) |
| Household food insecurity | 10 (63%) | 11 (69%) |
| Individual Insecurity | 10 (63%) | 6 (38%) |
| Child hunger | 1 (6%) | 3 (19%) |
Chapter 6
Eating Well with Canada’s Food Guide: Authoritative knowledge about food and health among newcomer mothers

Anderson, L.C., Mah, C.L., and Sellen, D.W.

6.1 Introduction

The Canadian federal government has developed nutrient requirement recommendations for Canadians through food guides since 1942, when “Canada’s Official Food Rules” was published by the federal Health Department in 1942 (Bush et al., 2007; Katamay et al., 2007). Since then, these recommendations have evolved from prescriptive diets to the current 2007 version, Eating well with Canada’s Food Guide (Canada’s Food Guide; Appendix 1), which aims to be a “description of a healthy pattern of eating intended to reduce the risk of chronic disease and obesity, and meet nutrient requirements for most Canadians [which] focuses on the amount and type of food to eat.” (Bush et al., 2007). Importantly, it aims to translate the science of nutrient requirements into a practical pattern of food choices. As the primary health promotion tool used to disseminate knowledge concerning the ideal food intake pattern as determined by Health Canada’s Office of Nutrition Policy and Promotion, its effectiveness depends on individual Canadians’ exposure to and response to these guidelines. The current version of Canada’s Food Guide is based on substantial nutritional epidemiological evidence, with a strong focus on preventing chronic disease through decreasing salt and saturated fat intake, increasing fruit and vegetable intake, and increasing physical activity (Bush & Kirkpatrick, 2003; Katamay et al., 2007). Furthermore, in addition to reflecting
epidemiological evidence, upon release of the new guide, the Office of Nutrition Policy and Promotion stated that it “reflects Canada in 2007” (Bush et al., 2007). This statement implies that because Canada is a multicultural country in which all Canadians are exposed to a diversity of foods and cuisines, the new guide reflects a multicultural range of foods.

Dietary guidelines such as Canada's Food Guide are designed to help with individual feeding decisions, including those that parents make for their children. Parents’ child feeding decisions are based on a wide range of factors, including financial, political, social and environmental forces, along with parental knowledge and understanding of the relationships between food and health. Many of these factors have a particularly strong impact on child feeding in the context of international migration, which often puts children at risk of limited access to a nutrient-dense diet and also leads to high levels of stress on families (Hadley, Zodhiates, & Sellen, 2007). In particular, outside of the context of migration, caregivers’ level of nutrition knowledge, access to nutrition information and attitudes to child diet and health have been found to strongly influence feeding practices and the types of foods their children are fed (Coveney, 2005).

Individual knowledge of health and diet is constructed through social interaction and negotiations, and has the potential to change with migration to a new country (Jovchelovitch & Gervais, 1999; Patil et al., 2010). Individuals may conceptualize “healthy eating” in many different ways, which will vary between cultures as well as between individuals within a culture (Lappalainen, Kearney, & Gibney, 1998; Falk et al., 2001; Povey et al., 1998). Recent research on health and nutrition knowledge among newcomer groups has demonstrated that frameworks for understanding health and
nutrition vary significantly between different cultural groups in Canada (Ristovski-Slijepcevic, Chapman, & Beagan, 2008). While the 2007 version of *Eating Well with Canada's Food Guide* aims to reflect Canada’s cultural diversity (Bush et al., 2007), it is limited in two respects. First, while the depiction of foods on online resources reflect a slightly greater diversity of foods by cultural preference, the guide itself features foods generally associated with a Western/European diet. Furthermore, the framework of the guide focuses exclusively on food from a Western/biomedical perspective, thus failing to acknowledge other frameworks for understanding health and nutrition. Such cultural and contextual interpretive frameworks are not explicitly incorporated into the design of the versions of Canada’s Food Guide. Therefore, public health strategies for enhanced promotion of the guidelines must be informed by additional information pertaining to the way Canada's Food Guide is apprehended and comprehended, information that is currently not well understood.

This paper aims to explore the diversity in the interplay between newcomers’ previous dietary knowledge and practice and how their exposure to Canadian dietary guidelines via Canada's Food Guide, dietitians, physicians, and other sources influences dietary change on arrival to Canada. There is a significant body of recent literature outlining dietary change experienced by newcomers to the United States and other Northern countries (Hadley et al., 2007; Satia-Abouta et al., 2002; Perez-Escamilla, 2009; Novotny et al., 2009). Dietary acculturation has been well documented in several newcomer populations, and is particularly relevant from a health perspective given that changes in diet over time are associated with a trend towards a Western-style diet characterized by higher energy density and lower nutrient density. In turn, this dietary
change may put individuals at higher risk of obesity and chronic disease (Fuentes-Afflick & Hessol, 2008; Yeh et al., 2009).

One model for examining the changes in diet with migration to the West is Brigitte Jordan’s work on authoritative knowledge, which examines how particular health-related practices and ways of knowing are legitimized in a “community of practice” in specific situations, such as childbirth (Jordan, 1993). This framework posits that in any particular domain of human understanding, there are several different ways of knowing, but very often some are more powerful than others (Irwin & Jordan, 1987). Although parallel knowledge systems can and do exist equally, usually one kind of knowledge gains authority over the others (Jordan, 1993). Jordan terms this type of knowledge as “authoritative knowledge”; it is the knowledge that “counts” in a particular society. This model describes the ways through which different forms of knowledge are distributed hierarchically. This type of knowledge is often associated with a stronger power base, and the authoritative knowledge is validated and accepted through both practice (medical or otherwise) and social interaction (Sargent & Bascope, 1997; Irwin & Jordan, 1987). Jordan’s work examines the interplay between parallel cultures, in particular between traditional birthing practices and Western/medicalized birthing practices. Other scholars have also applied the concept of authoritative knowledge to a variety of settings to further explore parallel forms of knowledge in the areas of reproductive health and nutrition (Ellison, 2003; Fiedler, 1996; Kingfisher & Millard, 1998; Saravanan et al., 2012). These parallel cultures are the result of the introduction of Western medical knowledge and practice to areas with other traditional knowledge forms.
This framework of authoritative knowledge is equally applicable to migration, in which individuals are exposed to new ways of knowing. In this sense, we are applying Jordan’s framework to acculturation theory, which posits that at the individual level acculturation occurs with migration to a new cultural context and is influenced by attitude and behaviour changes, along with social support, coping strategies, and other individual level factors (Berry, 1997). This process of acculturation is driven by individual (and group level) changes in behaviour and values. Jordan’s model is well suited as a framework to understand the process of changes in valuation of parallel knowledge forms, as a recent analysis applying Jordan’s framework to an analysis of infant feeding practices among immigrant mothers in Canada has demonstrated (Chadwick, 2010). We extend our analysis from this work and apply the concept of authoritative knowledge to examine the types of knowledge that participants possess concerning the relationships between food and health, and to assessing how these types of knowledge have changed with migration to Canada.

There is currently a gap in the literature on the cultural conceptions of food and health, and of caregivers’ knowledge, attitudes, and practices regarding optimal child diets among recently arrived immigrants in Canada. Using Jordan’s model of authoritative knowledge we aim not only to identify the different forms of knowledge and explore how these influence child feeding practices, but also to examine what shifts are causing some forms of knowledge to be devalued in favour of others. We apply this model to the context of migration, using it as a tool to examine the overlapping and potentially competing forms of knowledge to which individuals are quickly exposed through the process of migration. This paper focuses first on identifying the ways that
this diversity of knowledge might influence the appropriateness of Canada’s Food Guide as a tool, and the applicability of Canada’s Food Guide to this population. Second, we aim to identify the different types of knowledge about food and health. This research will contribute to narrowing these gaps and will help to inform the design of culturally competent programs aimed at improving young child diet in newcomer families in Toronto, and will also assist providers and policymakers in understanding how caregivers use and interpret nutrition recommendations.

6.2 Methods

6.2.1 Research Partners and Coordination

The research was conducted in partnership with the Hospital for Sick Children’s New Immigrant Support Network along with the support of several community centres and programs in the Jane-Finch neighbourhood, including the Black Creek Community Health Centre. The study was approved by the Office of Research Ethics at the University of Toronto, and followed standard guidelines for best practice in research ethics regarding informed consent, confidentiality and anonymity.

6.2.2 Rationale for Methodology

Data were collected through in-depth, semi-structured interviews. We chose this method over group-based methods such as focus group discussions because of the depth of information required to examine the individual experiences of household food insecurity and migration. Individual interviews were also necessary because of the sensitive nature of several of the interview questions, which covered the precarious migration status of several of the participants (particularly those who were currently
going through the refugee claims process), migration experiences, and experiences with income and household food insecurity. To ensure privacy, participants were given the choice of being interviewed in their own homes, or else in a private room at the Black Creek Community Health Centre.

### 6.2.3 Inclusion Criteria

Specific inclusion criteria for participation in this study were: (i) mothers of at least one child age 1-5 years; (ii) of Sri Lankan Tamil and Spanish speaking Latin American origin; (iii) household income below the Federal Low Income Cut-Off; (iv) arrived in Canada either as refugee claimants or through the family sponsorship program; (v) arrived in Canada within the last five years.

We selected refugee claimants and family class immigrants because they are at higher risk of unemployment and low-income (Yu, Ouellet, & Angelyn, 2007; DeVoretz, Pivnenko & Beiser, 2004). We recruited participants who had arrived in Canada within the last five years because we were interested specifically in recently arrived newcomers’ exposure to public health nutrition messaging and their conceptualizations of the relationship between food and their children’s health in their first years in Canada. We targeted mothers of children age 1-5 years based both on theory and practical concerns. Mothers are more likely to be the primary caregivers of a child than any other family member. This is particularly true for newcomers, because they are often geographically separated from extended family (grandmothers, aunts, sisters) who might otherwise take on a caregiver role (Rossiter, 1992). We selected an age range of up to 5 years because of the importance of nutrition for growth and development, but excluded infants (age 0-1
years) because of high rates of breastfeeding and formula feeding at this age range (Pollitt et al., 1995).

For this research, we were particularly interested in mothers’ conceptualizations of the relationships between food and health in a new country, and we differentiated between two broad ethno-cultural groups. We targeted Sri Lankan Tamils and Latin Americans because both these groups both have high rates of refugee claims and family sponsorship, and are both in the top five linguistic groups in Jane-Finch. Due to language constraints we limited our sample to two language groups, which enabled us to sample two groups of high known vulnerability as determined during the formative research stage, but also provided insight into the more general experiences of newcomers and their knowledge of food and health, including their interpretation of and application of Canada’s Food Guide.

6.2.4 Recruitment and Data Collection

Participants were recruited through community service providers in the area, including settlement counselors and home visitors, as well as through drop-in programs such as the Ontario Early Years Centres, and lunch programs targeting newcomers and their children.

Each participant was interviewed two or three times, in interviews that ranged from 45 minutes to 2.5 hours in length. Interviews were conducted in either Spanish or Tamil (with the exception of one interview with a participant who spoke fluent English) by trained interviewers who were research assistants for the study. The principal investigator was present for all of the first interviews with each participant and all but
two of the follow up interviews, and took field notes on parent-child interactions within the participants’ homes during the interviews.

6.2.5 Data Analysis

Each interview was audio recorded and later translated and transcribed by a third party. The study coordinator reviewed the first interview transcripts with interviewers and identified any potential clarification needed in subsequent interview(s). Transcripts were checked and edited for accuracy with the recordings by interviewers. We analyzed data inductively using codes both developed prior to analysis, and also those developed inductively through the progression of data analysis. Our codes were informed by Jordan’s (1993) model of authoritative knowledge. Each transcript was coded for themes relating to caregivers’ ways of knowing about food and health and their experience with Canada’s Food Guide. The coding process identified common themes within and across groups.

6.3 Results

6.3.1 Participant Demographics

We interviewed 32 participants who had arrived in Canada within the last five years, of which 16 were Spanish-speaking from Latin America, and 16 were Tamil-speaking from Sri Lanka. Among the Tamil participants, 10 arrived in Canada as family class immigrants, and six arrived as refugee claimants. Among the Latin American participants, five arrived as family class immigrants, and 11 as refugee claimants. The median age of the index child was 3 (range = 1-5), and the median number of children in
each household was 2 (range = 1-3). Other participant demographics are outlined in Table 6.1.

6.3.2 Awareness and Application of Dietary Guidelines and Canada’s Food Guide

Latin American participants were generally very familiar with Canada’s Food Guide, while less than half of Tamil participants were aware of it. The high level of exposure to Canada’s Food Guide among Latin American participants is likely due to the community nutrition programs that most of these participants attended, many of which were either run in Spanish or had Spanish staff. While some Tamil participants were exposed to Canada’s Food Guide in community programming, there were fewer programs specifically targeting this language group.

Among Latin American participants the concepts of the four food groups, balance and variety, and focus on the nutritional components of foods were widely expressed, and all but one participant indicated that they had learned this from Canada’s Food Guide. Among Tamil participants, these concepts were less widely used when describing their decisions making process regarding their children’s food.

When describing the utility of Canada’s Food Guide, several participants expressed regret that they perceived that they did not know anything about how to feed their children before being exposed to the guide and other nutrition messaging:

Before perhaps I didn’t give them food with nutrients. Now I have changed. Instead of giving them canned food I give them natural food…here you end up understanding what’s good and what’s bad. (Latin American, Refugee Claimant)
For example, with the program about nutrition I realized everything I had done was done badly (laughter). So I told myself “If I have another child, I know what things to do right”. For example, if I am doing something wrong with them, what can I do to change that. There are things or tips that can help you (Latin American, Refugee Claimant)

Others indicated that they believed that they weren’t giving their children foods with nutrients, despite the fact that they reported giving them fresh, whole foods. They devalued their own previous knowledge (“non authoritative knowledge”; Jordan, 1993) in favour of the authoritative knowledge learned from dietitians and other community service providers. Over a quarter of participants indicated that they felt that they had obtained limited knowledge in their countries of origin about how they should feed their children:

The bad thing was that my mom perhaps didn’t know much and you said you didn’t want something and then you didn’t eat. (Laughter). She didn’t oblige us to eat. For example, if you didn’t like milk, you didn’t have it. I think that is [bad] because I think that somehow milk is good because of the calcium and so on. (Latin American, Family Class)

### 6.3.2.1 Representation of Food Types in Canada’s Food Guide

Several participants explicitly explained that because their traditional foods were not represented in Canada’s Food Guide, they were not sure how they could follow the guide. They felt they were unable to follow the recommendations of the guide because their staple foods were not included in it:

Because [people from my country]…., well, I can’t stop eating rice and a small portion of rice is very little for me. (Laughter). I serve the plate by eye and if we do that, [my husband] is from [another Latin American country] and he can’t stop eating tortilla. Then, I haven’t been able to eliminate rice and tortillas. (Latin American, Refugee Claimant)

Some explained that the types of flours they used were not healthy because they were not
in the food guide, and this made them feel guilty about not following what they were perceived to be best practices. Others indicated that they did not know how to prepare the types of food listed in Canada’s Food Guide, and they did not understand how they could substitute traditional foods.

6.3.3 Conceptualizing the Relationship Between Food and Health

We identified three dominant, sometimes overlapping discourses that participants used to conceptualize the relationship between health and food for their children. First, a discourse focusing on the importance of “natural foods” as the healthiest food options for their children. Second, a discourse focusing on food’s influence on illness susceptibility, which includes a sub-category focusing on hygiene and food safety. Third, a discourse focused on the nutritional components of food, including the concept of “balance” in the diet. These discourses derived from both their home country and Canadian influences.

6.3.3.1 Natural Foods

This was the most widely used discourse concerning food choice among both Tamil and Latin American participants. The concept of “natural foods” includes a lack of pesticides, other chemicals, and hormones in foods, and also includes an emphasis on food that is fresh and locally grown. When discussing produce in Canada, over three quarters of participants were concerned about the presence of pesticides and hormones in fruits, vegetables and animal products. This framework was employed by most participants from both groups (Tamil and Latin American) to explain their beliefs about the relationship between the food their children eat and their overall health.
Many participants felt that in their home countries pesticides were not a concern, while they believed the produce available in Canada generally has high levels of chemicals. Further, some participants indicated they were concerned about the original source of foods from particular grocery stores, and were aware of the lack of fresh produce available at discount grocery stores. Several Tamil participants indicated concern that the food at local grocery stores (which they perceive to be Chinese owned although this is often not the case) has higher amounts of chemicals:

Then, they used to say not to buy in Chinese stores… because it has many chemicals… Price Choppers and No Frills are okay… if I get any vegetables, they want me to buy from Price Choppers… if I buy fruits, they want me to buy from Price Choppers… they say it is good… fresh… even if it is costly… it is good for kids’ health. (Tamil, Family Class)

Over half of participants explained that processed foods were much more widely available in Toronto than they were in their countries of origin, and as a result they were more concerned about ensuring that their children ate “natural foods” in Canada than they would have been at home. In particular, participants expressed concern at the wide availability and consumption of canned and frozen foods, and processed meats in Canada, including in schools and in community programs. Several participants brought up this comparison between fresh foods in their home countries and processed foods in Canada:

[The food in my home country is] much fresher. If you want to eat chicken in the evening, the chicken is still alive in the morning (laughter). You go to the markets and everything is fresh, they have just cut the vegetables. Over here everything is more processed. (Latin American, Refugee Claimant)

This participant not only expressed her concern about the processed nature of foods, but also about the fact that she perceived meat and produce in her country of origin to be freshly killed or picked. Most participants
reported similar concerns and felt that the produce available to them was not sufficiently fresh.

Many participants felt that food in Canada was less healthy because of the perceived lack of nutritional value of frozen and preserved foods. One Tamil participant felt that foods in Canada were less fresh and had less taste, which she linked directly to nutritional content:

We eat freshly cooked food there… here when we eat, fridge food. There we eat fresh food every time, right? Now, we eat food without any nutrients, and without any taste (Tamil, Family Class)

Participants’ explanations for why they felt that “natural foods” were better for their children’s health fall into three categories. The first category encompasses worries that the effects of chemicals from processed and non-organic foods have on their children’s health. The second category encompasses worries that food that wasn’t fresh lacked sufficient nutrients to ensure proper growth and development. The third category encompasses concerns about the effects of hormones on their children’s growth and development.

There is a difference between the chicken they sell there and the chicken they sell here. There, they grow and give there. Here, they grow in farms right, so there is difference in both the chickens…There is something in it, which would affect the kids’ hormonal growth. (Tamil, Refugee Claimant)

Among both Latin American and Tamil participants, several also explained that the children specifically did not have a taste for their traditional foods. One Latin American mother explained that once her child had been exposed at schools and community programs to processed “Canadian” foods such as macaroni and cheese and pizza, they developed a taste for those foods in particular. She felt that she felt his diet
would have not been the case in her country of origin because he wouldn't have been exposed to foods like macaroni and cheese:

[His diet would be better if we were still living in our home country] because he wouldn't know about macaroni and cheese...he would be used to eating the food over there. I don't know. He has eaten this type of food here in the [community centre drop in program]. So it is very difficult because he is used to that type of food.

6.3.3.2 Protection Against Illness

Participants’ discussions about the relationship between health and food included concerns about both infectious and chronic disease and illness, using both traditional and Western discourses. All Tamil participants used aspects of a traditional humoral discourse in discussing the relationships between health and illness. In particular, many Tamil participants explained that they fed their children in Canada differently than they would have at home because of the difference in climate. Furthermore, they explained that animal products, particularly meat and cheese, protected against illness brought on by the cold climate in Canada.

In cold places we have to take meat so that we can bear cold and be strong. He says that then only we could bear with the cold. So I started eating it and got adjusted to it. (Tamil, Family Class)

Both Tamil and Latin American participants conceptualized a healthy diet as a means of avoiding acute, or infectious illness and also as a means of preventing chronic disease. Several identified sugars, fats, and cholesterol as causes of cardiovascular disease, diabetes, and obesity in general. This was often, though not always, framed in
terms of concern for their children based on experiences with chronic disease among family and friends.

Besides this, all my family have diabetes precedents, my mum and my older sister suffer from diabetes, so my children are prone to it. Everybody says that too much sugar is bad and wherever I go, for example in the school, they tell me not to give them chocolate or this or that. *(Latin American, Refugee Claimant)*

Several Latin American participants were concerned about preventing overweight and obesity in their children, while this was not a direct concern of any Tamil participants. Concerns about strength, growth, and preventing underweight were concerns among many participants of both groups. Two participants explained their concerns about their child’s strength and how they linked it to their diet:

Because from what I have learnt and I know, food is very important for the child’s development. Since he was born very small, he has always been very skinny. In comparison to other children with his same age, he has less energy and strength. Therefore, I think food is important to improve those things. *(Latin American, Refugee Claimant)*

For me the food I give should be healthy and it should make her bones strong. *(Tamil, Refugee Claimant)*

The theme of cleanliness and food safety as important determinants of children’s diets was very common among Tamil participants. The majority of participants identified hygiene as the most important factor in ensuring that food was healthy for their children.

While Tamil participants discussed hygiene at length, it was only mentioned in passing by two Latin American participants:

We don’t go out to eat, for example, to fast food restaurants. I am not going to lie, sometimes we go out and the children feel like eating there, but we don’t eat French fries or stuff like that. They
eat at home. They are here. [Because we are concerned about] the hygiene. We don’t know how they prepare the food. *(Latin American, Refugee Claimant)*

Tamil participants primarily identified eating food outside the home as a major health concern. While most Tamil participants identified hygiene as one of the most important determinants of whether a food was healthy or not, a few said they felt that they did not need to worry about hygiene in Canada as much as they had in Sri Lanka.

**6.3.3.3 Nutritional Components of Food**

*Balance/Variety*

Latin American participants widely employed the concept of balance or variety to describe their understanding of a healthy diet. Canada's Food Guide emphasizes variety by focusing on eating from all four food groups, with a key message to “enjoy a variety of foods from the four food groups” *(Health Canada, 2007)*. Participants generally used this term to indicate that they were eating from the range of food groups outlined in Canada’s Food Guide, and many ensured their children ate foods containing a range of macro- and micronutrients. Almost all Latin American participants indicated that they had learned about this concept in Canada, but several also said that they had learned about the concept of balancing food in their home countries. One participant explained why she focused on ensuring balance in her child’s diet:

> Besides the fact that I was fed in that way, at the school and in the programs I have attended the [drop-in program for children and caregivers], I have been told that all those foods mean a balance and healthy diet. They have nutrients and proteins and everything our body needs, so they are healthy…I remember being taught about food groups since I was at school. *(Latin American, Refugee Claimant)*

Others, however, had only encountered this concept since arriving in Canada. Many were
familiar with the term “balanced diet” used by dietitians and physicians. Although all Latin American participants indicated that they understood that a “balanced” diet was considered to be healthy in Canada, not all chose foods for their children accordingly, or could identify precisely what this concept meant. One participant explained that rather than following Canada’s Food Guide's approach, she was more traditional:

It is not that I consider it bad, but perhaps in Mexico we are not used to following a food guide. We are very traditional and we eat what we are used, no matter if you eat pork or the same vegetables every day. We don’t try to complement meals (Latin American, Refugee Claimant).

**Macro- and micronutrients**

Many Tamil participants employed the concept of balance or variety, although indirectly, through discussions of various nutritional components of foods (micronutrients and macronutrients) as important to consider for health. One Tamil participant discussed the importance of feeding her children a range of foods to ensure protection against illness:

Add more vitamins, then the children don’t get sick fast. Sick means, like, if they eat more cheese or more carbohydrates, they get disease, or if vitamins gets reduced in food, they get disease, so everything should be in equal (Tamil, Family Class)

Both Latin American and Tamil participants widely employed the concepts of nutrients, vitamins and macronutrients to varying degrees.

Similarly, all participants in both groups mentioned the importance of eating fruits and vegetables to some extent. Most participants felt that fruits and vegetables were an integral part of their traditional diets, and cited their own childhood exposure to fruits and
vegetables and their own mothers’ focus on their health benefits as reasons for their belief. Some Latin American participants, however, explained that they had only learned in Canada about the nutritional importance of fresh fruits and vegetables. In particular, this focus came in the form of a focus on the consumption of raw vegetables, especially salads. These participants explained that they had learned that this was what “healthy food” was in Canada. Several felt that their families at home would be perplexed by their salad consumption, but they had felt it was a healthier way to eat. One participant explained how she and her husband had decided that salads were healthier:

My husband learned it from, uh, I think that he had a friend…and he always said, her skin is very nice…he said that everybody that lives here, the skin, they are more healthy, because here they eat more salad, more lettuce, tomatoes, more vegetables, right. He said “no, no, no, we are going to eat salad” It’s better for our body (Latin American, Family Class)

6.4 Discussion

This analysis provides strong evidence of a variety of conceptualizations of the relationship between food and health in this group of Latin American and Sri Lankan Tamil newcomer mothers. Furthermore, this range of conceptualizations limits the utility of Canada’s Food Guide as a tool for dietary guidance. Table 6.2 identifies the key limitations to Canada’s Food Guide’s effectiveness among newcomer groups: These limitations lie in its representations of recommended foods, its exclusive utilization of biomedical concepts of nutrition, and its limited exposure to some groups of newcomers. Despite these limitations we emphasize that Canada’s Food Guide has the potential to provide valuable, generalizable guidance which has been found to effectively communicate some basic guidelines that can improve overall health and prevent chronic
disease (Bush et al., 2007). Canada’s Food Guide must be recognized as a useful tool, but our analysis identifies that its potential to improve dietary outcomes is limited by the fact that its messages are not being translated effectively for all newcomer groups. In response to these limitations, we recommend that its role and limitations for Canada’s diverse population be more clearly communicated both in the guide itself and by health professionals and other service providers promoting key nutritional guidelines. Furthermore, modifications to the guide and the development of separate guides for particular dietary cultures have the potential to further improve its utility.

Using Jordan’s (1993) framework of authoritative knowledge we examined how participants in our sample negotiated between different constructions of the relationships between food and health, and how this influenced their child feeding practices. Several caregivers indicated that they felt guilty that they weren’t able to feed their children according to dietitians’ recommendations and Canada’s Food Guide. There was a distinctive differentiation between what Latin American and Tamil participants considered to be authoritative knowledge, which among Latin American participants was largely the knowledge system outlined in Canada’s Food Guide. When participants were asked to contrast between the foods they ate at home and what they fed their children in Canada there was a tendency to explain that in their countries of origin they “didn’t know anything” about how to feed their children. It is noteworthy that as researchers with affiliation with the University of Toronto and The Hospital for Sick Children, participants may have viewed us as part of the structures that govern the dominant discourse on food and health, thus biasing their responses. Nonetheless, the knowledge participants learned
through Canada's Food Guide, dietitians and nutrition programs was prioritized, and in doing so traditional models of thinking about food and health were devalued.

We found indications of a marked difference in exposure to Canada’s Food Guide between the Tamil and Latin American groups. Previous research (Jacobs Starkey et al., 2001) has documented very low use of Canada’s Food Guide in several groups across Canada. In our sample, most of the Tamil participants are no exception. However, the high level of knowledge and application of Canada’s Food Guide among the Latin American participants indicates there are effective programs in Jane-Finch exposing newcomers to these dietary guidelines. This finding suggests that these programs provide participants with spaces to negotiate different ways of knowing as they are exposed to Canada’s Food Guide. Many participants described their introduction to Canada’s Food Guide through nutrition programs as a turning point in their child feeding decisions. The way they compare their knowledge acquired since arrival in Canada with that of their family at home, where “no one knows anything” about nutrition is strongly indicative of the shift in their perceived hierarchy of knowledge types. As Jordan (1993) found in her work on birth in Mexico, when there are competing forms of knowledge, one type often gains authority over the others. While participants would have had exposure to traditional child feeding knowledge and practice in their home countries, their failure to identify it as “knowledge” indicates that they devalue this form of knowledge in favour of Canada’s dietary guidelines. The acculturative process as outlined by Berry (1997) is influenced in particular by their exposure to nutrition programs and guidelines, which leads to a shift in newcomers' conceptions of the hierarchy of forms of knowledge. Following the framework of authoritative knowledge, several types of knowledge can
exist at once, but one type of knowledge – in this case, knowledge derived from nutrition education programs based on Canada’s Food Guide – gains authority. This authoritative knowledge from the guidelines is complemented by other forms of knowledge which, while utilized are not identified by participants as “knowledge”, in particular their conceptualizations of healthy food as necessarily fresh food.

Among Latin American participants in our sample, Western constructs of nutritional science are central to how the participants themselves conceptualize what constitutes healthy food for their children. In contrast, among Tamil participants this was not the primary construction of their knowledge. While many Tamil participants focused on including macro- and micronutrients in their diet – focusing generally on vitamins, and on limiting fats – overall a focus on protection against illness, and a focus on the cleanliness of food was the dominant discourse used. Among the Latin American participants, the concept of balance/variety was widely employed to explain how they chose to feed their children. However, it appeared that many of the participants had learned the term “balance” from health and nutrition professionals, and were not sure exactly what the term meant. Keane and Willets (1996) similarly found in their UK sample that while participants were aware that using the language of “balance” indicated that they were applying key concepts from nutritional science, they were unsure how to define it. This disconnect between their language and knowledge may suggest the beginning of a shift toward valuing knowledge from a nutritional science perspective. Particularly in the context of recent migration, this tension between valuation of the Western/medical concept of balance as authoritative knowledge and the lack of clarity on the exact definition suggests a desire to adopt the knowledge systems perceived to hold
authority in Canada. However, lack of clarity in applying the key concept of “balance” suggests that a more in-depth assessment of the cultural competency of these nutritional education messages conveyed in Canada’s Food Guide is warranted.

The concept of “natural foods” was the most widely used framework for linking food and health in both groups. This is consistent with previous work in this field (Falk et al., 2001; Povey et al., 1998) that has found a focus on organic, pesticide-free and unprocessed foods to be an important component of Americans’ conceptualization of what makes up healthy food. In fact, recent work in Canada with newcomers found that a focus on natural foods was important among only some newcomer groups (Ristovski-Slijepcevic et al., 2008). This strong focus on “natural foods” as essential to ensuring children’s health is consistent with other Latin American newcomer groups in the United States that has found newcomers often find it very stressful when they are unable to find the fresh foods they are accustomed to eating in their home countries (e.g. Himmelgreen et al., 2007). This is relevant to our population because it challenges the widely held perception that food insecure families should be grateful for whatever food they are able to get, whether from food banks or through social assistance (Tarasuk & Eakin, 2003).

Within our analytical category of “natural foods” there is an overlap between the concepts of “fresh” and otherwise “natural” (e.g. organic, GMO-free) food; however the two concepts are also in competition. The definition of what constitutes quality in the context of food, particularly fresh produce, involves a “social process of qualification” (Sonino & Marsden, 2006). That is, the meaning of high quality, healthy foods varies depending on a number of factors, including cultural traditions, consumer perceptions and institutional and policy support. Cross-cultural research in Europe has indicated that
a divide in European conceptualizations of food quality between the South (e.g. Italy, Spain and France), which more highly values the terroir – the local, traditional context of production -, and the North (UK, Germany and the Netherlands), which more highly values qualities focusing on environmental sustainability or animal welfare. Sonino and Marsden (2006) suggest that one underlying cause of this difference is that in these Northern European countries, economic efficiency and health and safety legislation are considered to be the most effective means of delivering quality food, whereas in the southern countries similar legal and institutional systems have not been developed. In our sample, the particularly strong focus on “freshness” of foods among Latin American participants is likely partially attributable to a similar difference in institutional focus on food delivery and safety in their countries of origin.

Tamil participants conceptualized the relationship between food and illness using concepts widely used in the ancient Indian medical tradition of Ayurveda, which describes three humors in the body: wind, bile, and phlegm (Obeyesekere, 1977). Ayurveda is a humoral medical system, which characterizes certain foods as producing heat and others producing cold. Similarly, illness results from relative excess or deficiency in one or more of the humors (Helman, 2007). Although Latin American folk medicine uses similar humoral models (Logan, 1973), none of our Latin American participants described relationships between food and health in this manner. In Sri Lanka and India the Ayurvedic system operates alongside biomedicine (Pugh, 2006) as a parallel, complementary form of medical knowledge. The strength of the Ayurvedic tradition in Sri Lanka alongside Western biomedicine may explain the continued pull of the Ayurvedic tradition among Tamil participants, which makes them resist adopting the
knowledge systems proposed in Canada’s Food Guide.

For these groups of newcomers, their migration status may also affect these shifts in authoritative knowledge. All participants had arrived in Canada within five years prior to recruitment as either refugee claimants or family class immigrants. As the discourse concerning refugees in particular has shifted in Canada since the 1970s to embrace ideological elements including “we are being invaded”, and “they will not integrate”, individuals who arrive in Canada on non-economic grounds are positioned in a situation of limited power (Lacroix, 2000). For an individual newcomer, this positioning may have implications increasing acculturation and shifting perceived authoritative knowledge.

Utility of Canada’s Food Guide

One of the key messages of Canada’s Food Guide - that of eating from all four food groups, and ensuring “balance” – was widely understood among Latin American participants. This concept of “balance” in the diet comes from a largely Western biomedical discourse around food (Keane & Willets, 1996), and is one about which the majority of participants expressed lack of familiarity prior to arrival in Canada. However, many participants were interpreting the guide extremely literally. Specifically, they felt that the foods that were not pictorially represented did not fall under the umbrella of what the guide determined to be “healthy” foods. While the guide is available in both Spanish and Tamil (and in ten other languages including English and French), the guide has not been adapted to include foods more commonly eaten by these ethnocultural groups, nor has it been adapted to include differences in their conceptions of meals, servings, or other implied constructs used in the guide. While the stated aim was to create a food guide that
is “of our times” and reflects the multiplicity of food cultures in Canada (Bush et al., 2007), our findings indicate a different reality. Many of our participants felt that their staple foods were not depicted in the images of the food guide. To date, there has been progress in improving Canada's Food Guide's cultural competency for Canadian First Nations, Inuit, and Metis populations. Not only has it been translated into four First Nations languages, but the foods depicted reflect staples in this population. Furthermore, the adapted guide is arranged in a circular format, rather than the “rainbow” used in the general food guide, which was determined to be a more meaningful layout for this population (Health Canada, 2010). Similar adaptations for large newcomer groups in Canada would be extremely useful, and could emphasize rather than devalue non-biomedical constructions of health and nutrition, which can then be applied to complement the biomedical models currently used in Canada’s Food Guide.

This study aimed to explore a major factor in determining caregiver child feeding decisions: their conceptualizations of which foods are healthiest for their children. Of course, there are many other factors driving these decisions, including socioeconomic factors, geographical access to food, and children’s preferences. Of particular note in our sample is that participants described changes in their children’s food preferences since arriving in Canada, and identified these changes as primary determinants of their children’s diets.

Beyond exposure, it is possible that many of these children were also at risk of teasing and tormenting if they brought traditional foods to drop in programs or to school. Other recent research examining food in the lives of Toronto immigrants has documented that newcomer women found school and work environments to be non-accepting of those
who ate foods outside mainstream “Canadian” foods (Lessa & Rocha, 2009). These children are likely to play a larger role in determining feeding decisions than those of Canadian born parents as children of immigrants are often used by their parents as both linguistic and cultural translators and therefore often have active involvement in family decision-making processes (Orellana, Dorner, & Pulido, 2003). While we had anticipated that the preferences of preschool-aged children would have only a minimal impact on their parents’ feeding decisions, it was clear that many of the children in our study were quickly acculturating to a Canadian style diet.

The discrepancy between the two groups in terms of exposure to Canada’s Food Guide is consistent with our findings that Tamil participants were unaware of how to access dietitians, experienced more limited access to social support, and as a group were much less likely than Latin American participants to know how to access social programs and had more limited access to social support. Previous research indicates that there are systematic challenges to providing social support for immigrants and refugees in Canada, and issues such as lack of integration of services limits service providers’ ability to meet newcomers' needs (Simich et al., 2005). This lack of access to services, including those that would provide information concerning Canada’s Food Guide is, after affordability of foods, another barrier.

This study has several implications to policy and further development of Canada’s Food Guide and other nutritional materials. Several of the key messages concerning healthy eating are effectively transmitted in some newcomer groups: Messages about limiting oils and fats are well understood, and the message to eat vegetables and to eat a variety of foods is fairly well transmitted. However, we have identified three key
domains of Canada’s Food Guide and its delivery that limit its effectiveness in newcomer groups. First, the pictorial representation of foods currently in the guide do not depict the dietary staples typical of many newcomer groups. Second, the guide utilizes only biomedical concepts of nutrition of health and neglects to integrate parallel nutritional knowledge systems espoused by many newcomer groups. Third, some newcomer groups are not exposed to the guide and its messages. We propose further research to examine the guide’s limitations in other ethnocultural groups in Canada. This formative research could then guide the development of new, culturally competent versions of Canada’s Food Guide for several of Canada’s largest ethnocultural groups. These new versions could engage with concepts of natural foods and traditional links between food and illness in specific newcomer groups. We also propose the development of culturally competent nutrition education programs aimed at supplementing the guide's messages, and targeted outreach to ensure the transmission of dietary messages to newcomer groups across Canada.

6.5 References


Table 6.1: Participant Demographics

<table>
<thead>
<tr>
<th></th>
<th>Sri Lankan Tamil participants (n=16)</th>
<th>Latin American participants (n=16)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mother's age</strong></td>
<td>31 (23-44)</td>
<td>31 (21-46)</td>
</tr>
<tr>
<td><strong>Years mother has been in Canada (median (range))</strong></td>
<td>4.5 (0.5-5.5)</td>
<td>2.6 (1.5-3.5)</td>
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<tr>
<td><strong>Mother’s country of origin</strong></td>
<td>Sri Lanka (16)</td>
<td>Colombia (1) Ecuador (2) El Salvador (2) Honduras (1) Mexico (7) Nicaragua (1) Peru (1)</td>
</tr>
<tr>
<td><strong>Mother's immigration status on arrival in Canada</strong></td>
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<td></td>
</tr>
<tr>
<td>Permanent resident (family class)</td>
<td>10 (63%)</td>
<td>5 (31%)</td>
</tr>
<tr>
<td>Refugee claimant</td>
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<td>11 (69%)</td>
</tr>
<tr>
<td><strong>Mother’s current immigration status</strong></td>
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<td></td>
</tr>
<tr>
<td>Citizen</td>
<td>1 (6%)</td>
<td>0</td>
</tr>
<tr>
<td>Permanent resident</td>
<td>11 (69%)</td>
<td>7 (44%)</td>
</tr>
<tr>
<td>Refugee claimant</td>
<td>4 (25%)</td>
<td>7 (44%)</td>
</tr>
<tr>
<td>Humanitarian claimant</td>
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<td>2 (13%)</td>
</tr>
<tr>
<td><strong>Mother’s highest level of education</strong></td>
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<td></td>
</tr>
<tr>
<td>Primary</td>
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<td>1 (6%)</td>
</tr>
<tr>
<td>High school</td>
<td>8 (50%)</td>
<td>7 (44%)</td>
</tr>
<tr>
<td>Some college/university</td>
<td>2 (13%)</td>
<td>1 (6%)</td>
</tr>
<tr>
<td>College/university</td>
<td>5 (31%)</td>
<td>7 (44%)</td>
</tr>
<tr>
<td><strong>Mother’s English Speaking and Understanding Self-Assessment</strong></td>
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<tr>
<td>Poor</td>
<td>3 (19%)</td>
<td>4 (25%)</td>
</tr>
<tr>
<td>Fairly well</td>
<td>13 (81%)</td>
<td>6 (37%)</td>
</tr>
<tr>
<td>Well</td>
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<td>4 (25%)</td>
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<tr>
<td>Very well</td>
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<td>1 (6%)</td>
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<tr>
<td><strong>Mother’s English Reading and Writing Self-Assessment</strong></td>
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<td>Can’t read or write</td>
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<td>1 (6%)</td>
</tr>
<tr>
<td>Poor</td>
<td>1 (6%)</td>
<td>3 (19%)</td>
</tr>
<tr>
<td>Fairly well</td>
<td>13 (81%)</td>
<td>6 (38%)</td>
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<tr>
<td>Well</td>
<td>2 (13%)</td>
<td>5 (31%)</td>
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<tr>
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<td>------------------</td>
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<td></td>
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<td>High school</td>
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<td>College/university</td>
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<tr>
<td></td>
<td>(12,480-44,000)</td>
<td>(14,400-62,000)</td>
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<tr>
<td>% Receiving Ontario Works</td>
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<td>7 (44%)</td>
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<tr>
<td>% Renting house/apartment</td>
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<td>% Have car</td>
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<tr>
<td># Children in household (Median (range))</td>
<td>2 (1-3)</td>
<td>2 (1-3)</td>
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<tr>
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<td>3 (1-5)</td>
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<tr>
<td>% Index children born in Canada</td>
<td>12 (75%)</td>
<td>8 (50%)</td>
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Table 6.2: Key limitations to Canada’s Food Guide’s effectiveness in newcomer groups

<table>
<thead>
<tr>
<th>Domain</th>
<th>Limitation</th>
<th>Proposed Action</th>
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<tr>
<td></td>
<td>Adaptations to Canada’s Food Guide</td>
<td>Health and Community Service Provider</td>
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<tr>
<td>Representation of recommended foods</td>
<td>Foods represented are not staples of diets typical of many newcomer populations</td>
<td>Development of new versions targeted at specific cultural groups</td>
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<td></td>
<td></td>
<td>Community and individual-level education from dietitians and nutrition educators re the guide is not to be taken literally</td>
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<td>Utilization of biomedical concepts of nutrition</td>
<td>Focus on concepts of “balance” and micronutrients do not integrate parallel nutritional knowledge systems</td>
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<td>Limited exposure among some groups</td>
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Chapter 7
Discussion and Conclusions

7.1 Overview

This study’s findings contribute to an important topic in Canadian public policy. Given the 230,000 newcomers who arrive in Canada each year, their health and the health of their children is of great concern. Because research has found that newcomers’ health deteriorates upon arrival in Canada, an understanding of the processes that lead to this outcome is essential to the development of policy and programs dedicated to helping prevent this decline in health status. This study examined how the migration experiences of newcomer mothers influence several dimensions of their child care and feeding practices. As described in Chapter 2, an ecological approach in nutritional anthropology takes a holistic approach to determining influences on children’s health and nutrition. We used UNICEF’s (1990) conceptual framework on the determinants of children’s nutrition as an ecological model to frame this study. This model acknowledges the broader social, economic and political contexts that determine nutritional status and health in children. Furthermore, it identifies three underlying determinants of children’s nutritional status and health, each of which we address in this study: The home environment and health service access, household food insecurity, and child care and feeding practice.

A central thematic finding of this study is that the experience of migration and of being a newcomer has a multitude of influences on mothers' child feeding and care practices. Chapter 4 found that the gaps in expectations and experience regarding the types and duration of patient-provider interactions decrease mothers’ satisfaction with the
care they receive for their children. In another domain of health and well-being, we found in Chapter 5 that expectations of household food insecurity are determined by past experiences with household food insecurity; the higher levels of household food insecurity many newcomers faced in their countries of origin had implications for their help-seeking behaviours. Finally, in Chapter 6 we found that the parallel and sometimes conflicting forms of knowledge affected the utility of Canada’s Food Guide for many newcomer mothers, and also that the process of acculturation in Canada had an impact on how they determined what is the healthiest, or best food to feed their children.

Each of Chapters 4-6 examined one of three interrelated aspects of children’s health and diet. The chapters examined mothers’ experiences and expectations accessing primary health care for their children; their experiences with household food insecurity; and their conceptualizations of the relationship between food and health for their children and their experiences using Canada’s Food Guide. While the implications of each individual analysis are outlined in the respective manuscript-style chapters, this chapter will examine several crosscutting themes that emerge from this body of work.

7.2 Crosscutting Analytical Themes

7.2.1 Shifting Expectations: A Dimension of Acculturation

The three analyses in this thesis uncover several ways that the process of recent newcomer mothers' acculturation interacts with their children’s health. As outlined in Chapter 2, acculturation is the phenomena that result when groups of individuals with different cultures come into contact and the subsequent changes that occur in the cultural patterns of either or both groups, either at the group level or individual level (Berry,
1997; Redfield, Linton, & Herskovits, 1936). In this analysis we focus on individual acculturation, which is influenced by attitude and behaviour changes, as well as by changes in support, coping strategies, and other individual level factors (Berry, 1997). Chapter 4 found a significant disconnect between newcomers' expectations of healthcare for their children and their actual experience in Canada. We propose that this is an important aspect of the acculturation process, i.e. this disconnect is characteristic of immigrants with low levels of acculturation. Conversely, as immigrants acculturate they experience a shift in expectations in many domains, including their expectations of healthcare and their expectations of quality of life. These shifts in expectations, then, are an important and understudied aspect of the changes in attitudes that are central to Berry's (1997) definition of the process of acculturation.

Chapter 5 provides a new perspective on newcomer mothers' experience of household food insecurity. Among newcomers who have experienced high levels of deprivation in their countries of origin, the relatively low levels of food insecurity experienced in Canada may affect their own perception of need and make them less likely to seek support. While this study is limited by its cross-sectional design, this finding has implications for our understanding of acculturation in the context of household food insecurity. Further research to examine how immigrants' perception of their own need and household food insecurity changes over time in Canada will contribute to the theoretical understanding of these acculturative processes.

Chapter 6 applies Jordan's (1993) framework of authoritative knowledge to acculturation theory with the aim of understanding the process of changes in valuation of parallel forms of health and nutrition knowledge among newcomer mothers. The
authoritative knowledge framework provides a useful means for understanding the shifts in behaviour that take place in the acculturation process by determining how newcomers determine which knowledge systems gain authority and in turn influence behaviours. This analysis applied Jordan's framework to examine newcomer mothers' child feeding knowledge and practice, but a further extension of this work could apply it to other dimensions of health behaviour including healthcare seeking behaviours and treatment of illness.

7.2.2 Cultural Competency

Chapters 4 and 6 identify ways that improved cultural competency in healthcare and other services has the potential to improve newcomer children’s health. As examined in Chapter 4, an increased focus on cultural competency in clinics in Toronto is essential to help address many of the problems in perceived quality of care reported by participants in this study. Patient and physician expectations of care may differ significantly, and cultural competency training programs are essential to help provide physicians with tools to support their newcomer patients. The demographic changes in Canada necessitate a greater focus on the disparities in health and health care between immigrants and the Canadian-born population. Our study found that the model of care at community health centres led to high levels of patient satisfaction and access to interpreters; this model could be extended throughout the health care system.

Chapter 6 identified several gaps in the cultural competency of the most widely used nutrition education tool in Canada: Canada’s Food Guide. While Canada’s Food Guide was widely recognized among newcomer participants in our service-based sample
we identified several ways in which the key messages are not being effectively transmitted. This reveals a major limitation in population health messaging: very often an overarching “one size fits all” approach is not the most effective way of transmitting the same message to very different sub-populations. We propose two complementary strategies that may help translate the messages outlined in Canada’s Food Guide. First, because diets and the notion of what constitutes healthy food are both culturally specific, we propose that further work be undertaken to revise Canada’s Food Guide for several of the dominant ethno-cultural groups in Canada. Second, further work is needed to identify the most effective ways to translate this knowledge at a community level. Misinterpretations of the guide identified by our participants could have been avoided by consultations with community dietitians or in sessions with other health practitioners.

7.2.3 **Expression of Gratitude and Reluctance to Accept Support**

This study identifies several ways in which newcomers’ past experiences in their countries of origin and during the migration process affect their behaviours and perceptions of their situation here in Canada. In Chapter 5 we found that participants often minimized their experiences of household food insecurity here in Canada through comparisons to their experiences of poverty in their countries of origin, where in many cases they experienced higher levels of household food insecurity. In many cases, these participants felt they did not have a right to complain, because they felt that the public and private support they received in Canada far exceeded anything they would have received in their countries of origin. In short, they wanted to avoid appearing ungrateful. Participants echoed these feelings in their descriptions of experiences with family physicians in Chapter 4: Tamil participants in particular reported that they were hesitant
to question healthcare professionals, for example by asking for referrals, or by asking follow-up questions. These concerns may be a result of their migration status; individuals who have arrived in Canada recently are in a position of limited power (Lacroix, 2000), and this may affect their perception of their rights to health in Canada. Further research on the implications of newcomers' perceived positioning and their health seeking behaviour is warranted.

7.2.4 Economic Barriers to Health

It is widely understood that socioeconomic factors – including income, employment and social status- are the strongest determinants of population health (Raphael, 2006; Wilkinson & Marmot, 2003). Our study examined several economic barriers to health, and found that the experience of household food and income insecurity was a cause of stress among newcomer families in our sample. Chapter 5 explores the challenges newcomer families face with household food insecurity, and their inability to find reliable income through secure employment. The insufficiency of Ontario Works was perceived to be the greatest barrier to achieving household food security. These results are consistent with the conceptual definition of household food insecurity as a phenomenon resulting from limited income (McIntyre, 2011). In Chapter 4, we found that while healthcare was technically available to all of our participants through federal and provincial health insurance, there were clearly a number of economic constraints that affected participants’ ability to access healthcare. While families benefitting from Ontario Works and those covered by the Interim Federal Health Program had access to insurance for medications, the rest (like most residents of Canada) did not. Among those who did not have coverage, access to medications was a major source of stress, and was
often only achieved by decreasing food expenditures or going into debt. The extent of the difficulties faced by low income newcomer families in our study is particularly relevant to cuts made to the Interim Federal Health program in June 2012, after data collection was completed (Access Alliance Multicultural Health and Community Services, 2012). Our results indicate that these cuts could very seriously impact refugee claimants’ ability to access medications, and could also impose other economic hardship on their families. These findings indicate that changes in health and social policy are needed to ensure newcomer and other low-income families are able to afford sufficient food and access to medicines for their household.

7.3 Between-Group Comparisons

7.3.1 Comparison Between Latin American and Tamil Participants

Our rationale for selecting two different language groups for this study was to examine the experiences of a range of newcomers, rather than to compare between groups directly. In fact, explicit comparison between the two groups would lead to challenges in interpretation because Spanish-speaking Latin Americans in particular are a very heterogeneous group. Nonetheless, we identified two key distinctions between these groups that are relevant to our research aims and analysis.

First, overall Latin American participants reported higher levels of social engagement and greater access to information, services and programs. There were several not-for-profit community associations and programs that specifically targeted Spanish speaking individuals, and many of the Latin American participants in this study were recruited from these programs. As previous research has shown, the primary
sources of social support available to newcomers to Canada are from individuals of similar ethnic origin (Simich, Beiser, & Mawani, 2003); these individuals have had similar experiences and can help newcomers access programs and services that can help them settle in Canada. Latin American participants benefitted from these networks: As discussed in Chapter 6, Spanish-language programs helped participants learn how to apply Canada’s Food Guide. Furthermore, Latin American participants were more likely to know how to access interpreters at health clinics, as discussed in Chapter 4. Tamil participants had access to a few local programs staffed by Tamil speaking service providers, but there was less cohesion between these groups, and for the most part Tamil participants had less knowledge of services available. Several of the Tamil participants explained that their husbands preferred them to not speak to other women, or to have them in their house, which may account for their more limited social networks. These gendered limitations on social interactions have been documented elsewhere among Sri Lankan Tamil women in Toronto (Morrison, Guruge, & Snarr, 1999). Thus, this isolation in an area with a high density of Tamil newcomers is worthy of note, and relevant to outreach efforts for social services and programs.

The second major difference identified between these two groups is in their conceptualizations of health and diet. Latin American participants largely espoused biomedical medical models concerning health, diet and nutrition. While they were exposed to new concepts here in Canada (e.g. Canada’s Food Guide), these ways of knowing about health were often consistent with their understanding of health from their countries of origin. Tamil participants reported a mix of these Western medical models alongside Ayurvedic/ humoral models, which are typical of South Asian groups (Helman,
Jordan’s (1993) model of authoritative knowledge provides a useful framework for understanding how these participants negotiate between several different, parallel forms of knowledge. Latin American participants prioritized the biomedical knowledge learned both in their home countries and also through Canada’s Food Guide, dietitians and nutrition programs, and in doing so devalued the models of thinking about food and health many of them had learned in their countries of origin. Tamil participants, in contrast, exhibited stronger ties to their non-Western medical forms of knowledge, and they were less inclined to give authority to the Western medical and nutritional knowledge proposed in Canada’s Food Guide. This dynamic may also extend to other aspects of children’s health – e.g. illness unrelated to nutrition, and other care behaviours – and further research to understand the dynamics of these parallel forms of knowledge could be useful in developing culturally competent models for program delivery and health care.

7.3.2 Comparison Between Refugee Claimants and Family Class Immigrants

In Canada, there are three classes of immigrants: Economic class, family class, and humanitarian/refugees (and within refugees there are those who made their claim in Canada, and those who were either government assisted or privately sponsored to come to Canada). Economic immigrants have the highest rates of economic assimilation, and refugees have the lowest (DeVoretz, Pivnenko, & Beiser, 2004; Yu, Ouellet, & Angelyn, 2007). We selected participants who had arrived in Canada as refugee claimants and family class immigrants because we were interested in targeting those immigrants who were more likely to face challenges in economic and social assimilation into Canada; for this reason we eliminated any economic immigrants from our sample (Yu et al., 2007).
While we had initially anticipated that family class immigrants would face fewer challenges than refugee claimants due to the family support that, by definition, they had in Canada, we found that this was not the case. Among both ethnocultural groups, there has been significant migration to Canada over the past two decades, and as a result many refugee claimants also had some family members or friends living in Canada when they arrived. In contrast, even though family class immigrants had support, several identified that there was tension between them and the family members who had sponsored them. One appreciable difference between the two groups was the high levels of stress experienced by refugee claimants still going through the lengthy refugee claim process. Furthermore, many Latin American participants were aware that refugee claims from several Latin American countries are increasingly less likely to be successful in Canada, which further exacerbated their stress.

7.4 Limitations

There are a number of limitations to this study, many of which are common in qualitative research. First, one major inconsistency in the interviews was the different interviewers who conducted the Tamil and Latin American interviews. While the use of native-speaking interviewers conducting interviews entirely in Spanish and Tamil was in many ways a strength of this study, it inherently resulted in differences in the interview flow between the two groups. We made efforts to minimize the inconsistencies through interviewer training, and also through several mock and pilot interviewers. Additionally, because I was there for all but three of the 67 interviews we conducted, I was able to troubleshoot with interviewers when they had a question, and I also provided them with feedback after reading each interview transcript. Additionally, the nature of this and
much qualitative research is exploratory and it does not attempt to characterize the experience of all individuals in any group described in this study. Rather, it documents the range of experiences of participants in our sample. We aimed to achieve information saturation in our sample, but this does not mean that all the experiences described applied to all participants. Another limitation of this study was the sampling strategy, which was entirely service-based. While this was a strength as it allowed us to examine the experience accessing these services, it was also a limitation in that those who are not accessing services in the neighbourhood are likely the most isolated and likely more vulnerable.

7.5 Recommendations

The results of this study contribute to our understanding of several interrelated aspects of the migration experience that affect newcomer mothers' child care and feeding practices, and subsequently influence their children's health. These findings can be applied to inform the development of health and social policy. We have identified several key areas in service delivery and policy that require attention to improve health outcomes for newcomers and their children.

First, improvements in cultural competency of healthcare delivery are needed to ensure equitable access to healthcare for newcomers and their children. Cultural competence training for healthcare providers can take a variety of formats: A review of 34 studies evaluating the effect of cultural competency training for healthcare providers found that even one four hour session, including case scenarios, and interviewing members of another culture, can improve provider knowledge and patient satisfaction.
(Beach et al., 2005). Other more intensive trainings can take several weeks, and include international travel to offer healthcare providers with exposure to healthcare in different cultural contexts (Haq et al., 2000). In areas of Canada such as Toronto with a high density of immigrants, at minimum day-long trainings such as these to improve providers' awareness of the impact of culture on patient-provider encounters are needed. Furthermore, our study identified that language barriers were a major issue for many newcomer mothers. Programs to make in-person and phone-in interpreters available for all non-English speaking patients are needed at health clinics and hospitals.

This study has identified a need for the development of several culturally competent versions of Canada’s Food Guide targeting Canada’s most populous ethnocultural communities. Currently, the guide is translated into ten languages in addition to English and French. This study's findings suggest that the variety of knowledge systems regarding food and health in Canada's multicultural population necessitate the development of food guidelines that incorporate these other systems of knowledge in parallel with the biomedical nutritional knowledge currently promoted in Canada's Food Guide. In addition, we recommend the development of culturally competent nutrition education programs aimed at supplementing Canada’s Food Guide’s messages. We also suggest that these findings could be applied to the development of other widely used health promotion tools and programs.

Finally, we have identified that the experience of household food insecurity is dramatically influenced by the migration experience. We suggest further research to examine how past experiences of household food insecurity, acculturation, challenges in securing reliable employment, and social isolation may affect experiences with other
vulnerable groups of newcomers in Canada. This research can help develop a household food security module aimed at measuring these particular aspects of newcomer food insecurity in Canada. Furthermore, it can inform the development of programs and policy to address the barriers to employment, the insufficiency of income offered by Ontario Works, and the unavailability of affordable housing to support food insecure newcomer families. These changes in policy would aim to ultimately ensure newcomers have sufficient income to protect against household food insecurity.

7.6 References


Lacroix, M. (2000). *The road to asylum. Between the fortress Europe and Canadian refugee policy: The social construction of the refugee claimant subjectivity.* (PhD thesis), McGill University, Montreal.


Appendix 1: Key Informant Interview Guide

1. What is your current job? And how do you work with newcomers?

2. Describe the populations you work with (country of origin, immigration status, income level, family composition, gender)

3. What do you think are the greatest challenges facing the newcomers you work with?

4. How do you think these challenges impact newcomers’ health? Diet?

5. What are the health issues you are most concerned with?

6. Do you have concerns about children’s diets in these families?
   a. What are they?
   b. What do you think are the causes of these circumstances you describe?

7. How do the families you work with address these problems?
   a. What sort of coping strategies do you see?
   b. Where do they go for help? (food bank, friends, other community organizations, etc)

8. Do you/your organization have any ways to address these problems?
   a. What do you do? (referrals, community kitchen programs, etc)
   b. What would you like to be able to do/ what gaps do you see in services provided?
Appendix 2: Interview Guide #1

Introduction

We’re first going to ask you some general demographic questions, about your age, where you live, your income, and things like that.

1. How old are you?

2. What is your current immigration status? (Probe: Are you a Canadian citizen, permanent resident/landed immigrant, refugee, refugee claimant, other/specify)
   a. What was your immigration status when you first arrived in Canada?

3. In what country were you born?
   a. Did you and your family move to Canada from a rural or urban area?
   b. What part of the country did you move from?

4. What is your highest level of education?
   a. Primary
   b. Secondary
   c. Post-Secondary (College/University)
   d. Certificate/training program

5. How well can you speak and understand English?
   a. poorly
   b. fairly well
   c. well
   d. very well
   e. cannot speak and understand this language

6. How well can you read and write English?
   a. poorly
   b. fairly well
   c. well
   d. very well
   e. cannot read and write this language

7. What is your postal code?
8. Do you rent your home? (or own, live with family/friends, etc)
   a. [IF NOT IN HOME] Is it a house, high-rise/low-rise apartment, basement, etc?
   b. How many bedrooms does it have?
   c. If rent, how much rent do you pay?
   d. Do you find it difficult to pay your rent?
   e. Why?
   f. Are there particular months when it is more difficult than others?
9. What is your marital status?
   a. [If relevant] where was your husband born?
   g. If married or common-law, do you live with your husband?
   h. If no, where does he live?
   i. What is your husband’s current immigration status?
   j. When did your husband first come to Canada?
   k. What was your husband’s immigration status when he first arrived in Canada?
   l. What is your husband’s highest level of education?
   m. How well can your husband speak and understand English?
      i. poorly
      ii. fairly well
      iii. well
      iv. very well
      v. cannot speak and understand this language
   n. How well can your husband read and write English?
      i. poorly
      ii. fairly well
      iii. well
      iv. very well
      v. cannot read and write this language
10. How many children do you have?
a. For each child:
   i. What is the child’s name?
   ii. How old is the child?
   iii. Is the child a boy or a girl?
   iv. Where was the child born?
   v. Where does the child live?
   vi. Is the child in school?

   1. If in school, which grade?

<table>
<thead>
<tr>
<th>Child Name</th>
<th>Age</th>
<th>Gender</th>
<th>Place of Birth</th>
<th>Place of Residence</th>
<th>In School? (Grade)</th>
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11. Is there anyone else who lives with you?
   a. If yes, who? What is your relationship to them? Age (if child/youth)? Gender?

12. What is your religion?
   a. Do you practice? / Are you active?
   b. Do you attend a temple/church? How regularly?
   c. What is the temple/church’s name? Where is it located? Are there other people from Sri Lanka who go there?

13. What language do you speak at home?
   a. What language does your child speak at home?
Immigration

We would now like to learn more about your experience coming to Canada.

14. How long have you been in Canada?

15. Where did you live before coming to Canada?

16. Other than your home country, were you in any other countries before you arrived in Canada?

17. What made you come to Canada?

18. Who moved with you to Canada?

19. Were family members living in Toronto before you came here?
   a. Did they sponsor you/your family? If yes [AND NOT HUSBAND]: how does this affect your relationship?
   b. Have you sponsored any family members? How does this affect your relationship with them?

Income and expenses

20. What is your household’s/family’s source(s) of income? (Probe: do you have employment income (including from children who work and contribute to the household), social assistance/welfare/family benefits, employment insurance, compensation/disability, retirement pension, old age security, family members, Do you have any additional sources of income?)
   a. What is your household income from each of these sources (go through list)

<table>
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<tr>
<th>Earner name</th>
<th>Source</th>
<th>Part time/full time/welfare benefit</th>
<th>Hours worked at job</th>
<th>Amount (Weekly or Monthly)</th>
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b. Does anyone in your household have paid employment? Is it full time, part time, or temporary? How much does each job pay (weekly or monthly)? How many hours do they work on that job? (Ask for each employed household member)

c. For each job:

   vi. How long did it take you/your family member to find that job?

   vii. Can you tell us about how you/your family member got that job?

1. What difficulties did you encounter while finding this job?

d. If not employed, have you been looking for a job?
viii. Why/why not? (probe for need for benefits of welfare)

e. [If participant receives support from government income source]

ix. Do you find it easy to get your money?

x. What steps do you go through to get your money?

xi. Does this provide enough money to support your family?

1. (if no) what do you do to supplement?

21. What are your major monthly expenses? (probe for food, housing, insurance, RESP, loan repayment, supporting family)

22. Do you know how much savings your family has? Can you tell me approximately how much they are?

a. In Canada?

b. In home country?

23. Does your family have any outstanding debts? What are they?

a. In Canada?

b. In home country?

Money and Transportation

24. How do you usually get around (i.e. public transportation, do you walk, do you have a car, do you borrow a car?)

25. Do you worry about not having enough money for transportation?

a. [if they have worries], how do you manage to get by without money for transportation?

b. Are there things you avoid spending money on in order to save money for transportation?

Social Support

26. Where do you go for

a. Emotional support? (Can be either people living in Toronto or elsewhere)

i. How do this person help you? Can you give an example of a time you received emotional support?
ii. Can you give an example of a time you received emotion support?
iii. Is there anyone else you receive emotional support from? (if yes, repeat probes)

b. Practical support? (i.e. child care, transportation)
c. Financial support?
   i. Can you give me an example of a time you asked for financial support from this person?
   ii. Is there anyone else you can go to for financial support?

27. Are there people you can go to for help if you don’t have enough food for your family? Who are they?

   a. Can you tell me about a situation in which you asked someone for help?

   b. What sort of help did you ask for?

      a. How does asking them for help make you feel?

      b. How does it affect your relationships?

28. Do you help other people/family members who do not live in your household? (Probe: do you send money to your “home” country?)

   a. If yes, what kind of help?

   b. How does helping these people affect your household?

      a. How does it affect your household budget when you need to send money to them?

29. Are there people who you help out when they don’t have enough money for food?

   a. Can you tell me about a situation in which you helped someone out?

**Health and Illness**

For the following questions, I’d like to specifically talk about the health of [NAME], your youngest child between age 2 and 5 years.

First I would like to talk about the prenatal care you received when you were pregnant with [NAME] and your delivery

30. Did you receive any prenatal care when you were pregnant with [NAME]?
a. IF YES: how many months pregnant were you when you started prenatal care?

b. Who did you go to for prenatal care?

c. Where were they located?

d. How long did it take you to get there each time?

e. What was your prenatal care experience like?

f. [IF OTHER CHILDREN] did you receive prenatal care when pregnant with your other children?

31. Where did you deliver [NAME] {e.g. hospital, home, etc}

32. Who was there for the delivery? (clinician type, family members)

33. [IF OTHER CHILDREN] where did you deliver your other children?
   a. Can you tell me about the deliveries of your other children?

34. Did any one take care of you in the first weeks of [NAME]’s life?
   a. Who was it?
   b. How long did they take care of you?
   c. What did they do to care for you?
   d. Is there any care you would have liked to receive, but didn’t?
      i. Why didn’t you receive this care?

35. How would you describe the health of [NAME]?
   a. What makes you think that?

36. Do you have any worries or concerns?

37. How would you describe the health of your other children? Do you have any concerns about them?

38. What do you do to help make [NAME] healthy?
   a. What else do you do?

39. What things do you think are bad or do you avoid because you think it’s not good for [NAME]’s health?
a. What is it about those things that you think are bad for [NAME]’s health?


41. What questions do you have about [NAME]’s health or illnesses?
   a. Where do you go to try to find answers to your questions?
   b. Is there anyone you ask for advice on your child’s health?

42. What vaccinations has [NAME] received?
   a. Where did you learn what vaccinations he/she needed?
   b. Do you have any questions about his/her vaccinations?

43. Since you’ve been in Canada, has [NAME] ever been sick?
   a. [IF YES], please describe that time? Did you do anything to try to make [NAME] better?

44. Do you or have you ever used alternative or complementary [Probe: traditional / non-hospital / Ayurvedic medicine] to improve [NAME]’s health, prevent illness, or treat illness?
   a. If yes, can you describe the alternative and/or complementary medicine you have used?
   b. Where do you go to get it? (for Tamil who don’t use: probe for if they used Ayurvedic medicines at home, and why they don’t use them here)

45. Does [NAME] have a doctor?
   a. IF YES
      a. How did you find your doctor?
      b. Is it a family doctor or a pediatrician or other?
      c. Where is the doctor’s office?
      d. What is it like going to the doctor?
      e. Do you find the doctor helpful?
      f. Does he/she address your needs and your child’s needs?
b. IF NO

   a. Have you ever tried to get a doctor?

      i. IF YES: what problems did you encounter trying to get a doctor?

46. When talking to doctors, etc., in which language do you feel most comfortable communicating?

47. Does [NAME] have a dentist he/she sees regularly?

   a. IF YES

      i. When was the last time [NAME] went to the dentist?

      ii. [IF OTHER CHILDREN] When was the last time your children went to the dentist?

      iii. How do you decide when to take your children to the dentist?

   b. IF NO

      i. Do you have concerns about your children’s dental health?

      ii. Why do your children not have a dentist?

      iii. Is there something you would like to change so that your children would go to a dentist?

      iv. When was the last time you went to a dentist? Do you have any concerns about your dental health?

48. Have you ever met with a dietician for [NAME] or for yourself? A dietitian is a person with a qualification in nutrition and diet and who counsels clients individually or in groups on their diet and food choices.

   a. What did you talk to them about?

   b. Were you able to make the changes they recommended?

   c. Do you think that meeting with them was helpful?

      i. Why/ Why not?
49. If [NAME] or another member of your family was sick in the future and needed health care, what would you do? Where would you go for care?

50. Do you know what 9-1-1 is?
   a. Have you used it before?
   b. Can you tell me about your experience using it?

51. Do you know how to access walk-in clinics?

52. Do you know where the nearest emergency department is?
   a. How would you get there if you needed to use it?
   b. If you have used it, can you tell me about your experience using the emergency department?
   c. What have you gone there for?

53. Do you have an OHIP card for [NAME]?
   a. If no, why not?
   b. IF REFUGEE: do you have Interim Federal Health coverage?

54. Do you worry about not having enough money for health care, medicine or medical supplies?
   a. If yes, can you tell me more about your worries?

55. Would you like to learn more about how to access health care for your child?
   a. What would you like to learn? (Probe: how to find a doctor, interpreter services, when to use the emergency room, what is covered and what isn’t covered by OHIP)

56. Do you feel healthcare providers in clinics (doctors, nurses, dietitians) are people you can talk to and ask questions of?
   a. Do you feel they give you enough time?
   b. Are you able to get appointments?
   c. Are you able to get interpreters?

57. Do you feel healthcare providers in hospitals are people you can talk to and ask questions of?
a. Do you feel they give you enough time?

b. Are you able to get appointments?

c. Are you able to get interpreters?

58. How do you see the role of healthcare providers?

Health and Diet

59. What do you remember being fed as a child by your mother/caregiver? What are the good/bad things about the way you ate as a child?

a. Do you feed [NAME] in the same way now?

b. Is this the way you would feed [NAME] if you were still in your home country?

c. Are the snack foods [NAME] eats the same as he/she would eat if you were still in your home country?

   a. How are they different?

d. What are the good/bad things about the way you feed [NAME] now?

e. Who do you go to for advice now on how to feed [NAME]? (can be here or in country of origin)

f. What sort of conversations do you have with these people about feeding your children?

60. When you think about [NAME]’s diet, what factors influence it most?

61. What have you learned about “healthy eating” for [NAME]?

   a. What does “healthy eating” mean to you”?

   b. Do you ever think about food from this perspective?
c. Do you talk to [NAME] or other children about “healthy eating”? What do you tell them? Do you find this useful?

d. Has your idea of healthy eating for children changed over time?

e. Did you think about healthy eating before you came to Canada?

f. What do people in your home country think about the way you feed your children now?
   a. Would they approve of/ not approve of?

g. Do you know what Canada’s Food Guide is?
   a. Do you find it useful?
   b. What have you learned from it?

h. What would you like to learn about “healthy eating”?

i.

Closing

We really appreciate that you have taken time to speak with us today.

62. Is there anything else you would like to tell us about your life, your child’s health and diet, or your experience accessing care?

53. Do you have any friends who also meet the study criteria who you think would like to participate?

- Give recruitment sheet with phone numbers to contact
- Ask if we should follow up with them in a few days to see if they have had a chance to ask their friends
Appendix 3: Interview Guide #2

Question Guide #2

During the first interview we talked a lot about your household and your child’s health. Now we would like to talk to you more about how you get food for your family and what your child[ren] eat[s]. Do you have any questions before we start?

1. Where do you buy or get food from? (store name and type). Any others?
   a. Why do you go to these stores?

2. Who goes to shop for food most of the time? How often do you go to shops?

3. How do you get to the shops? How far do you have to go/ how much time does it take?

4. Do you consider the prices high or low or just right at the store(s) where you usually shop?
   a. Do you choose to go to stores because they advertise sales?
   b. How do you hear about these sales (e.g. flyers, word of mouth, etc)?
   c. What items do you find expensive?
      i. Do you avoid these items because of the price?
      ii. Are there any others you find expensive? Any others?
   d. What items do you find to be good value?
      i. Are there any other items you find to be good value? Any others?

5. Does the store where you usually shop carry fresh fruits and vegetables?
   a. Do you find fruits and vegetables to be affordable?
   b. How often do your children eat fruits and vegetables?
   c. Would you like them to eat more fruits and vegetables?
   d. What would make them eat more fruits and vegetables?
      i. Could you do anything to make them eat more?
      ii. Could anyone else do anything to allow them to eat more?
6. Who decides in your households how much is spent on food?

7. Who decides what kind of food is bought?
   a. (If not in charge) if you were in charge, would you do things differently?
   b. Why is this other person in charge of making spending decisions?

8. Are there certain foods you would like to eat but you find difficult to get? What are the problems? (probe for cost, availability, acceptability, religious foods)

9. Do you think the foods you get are of good quality?
   a. Do you think they are fresh enough?

10. Do you grow any of your own food?

11. In many families, people argue about who should cook, who should clean up, etc. What kinds or arguments or disagreements are there in your household around feeding and taking care of your child?

12. Do you sometimes get food from other sources than shops? (Probe for community kitchens, food banks, community gardens etc)
   c. Where and how from?
   d. How regularly?
   e. Do you get the type of food you want from these sources?
   f. How do you feel about getting foods from these sources?

13. Are there foods you always have in the house? What are they? Why?
   g. Do you buy in bulk? Do you worry about wasting food?

14. Do you worry about not having enough money for food?
   a. IF YES, can you tell me more about your worries?
   b. Can you tell me about a specific time when you had trouble paying for food? What caused it and what did you do about it?
   c. Do you think you will be worried about having enough money for food in the future?
Child Food Security/Hunger

For the next set of questions, I’d like us to talk particularly about [NAME] (your youngest child between age 2 and 5):

15. Do you ever worry there will not be enough food for him/her?
   a. What makes you worry? Can you tell me about a time when you were worried about there not being enough food for [NAME]?

16. Are you ever not able to give [NAME] food if he/she is hungry?
   b. How often does this happen?
   c. How does [NAME] react when this happens?
   d. How does this make you feel?

17. If you experience times of sufficient food and then too little food, does it affect the way you eat?
   a. How does it affect the way you eat?

18. What strategies do you use to get enough for [NAME] to eat when income/food is scarce?
   a. Do you feed him/her cheaper/less desirable foods?
   b. Do you ever eat less food? Do you ever skip meals?
   c. What advice do you have for other families who have trouble getting enough food for their children to help make their situation better?

19. Are there foods you think [NAME] should eat more often but you can’t afford? Or you can’t find? (Probe: grains, other traditional foods…)
   d. Which ones?
   e. Why?

20. Whose responsibility is it to look after your children:
   a. Who gives them food?
   b. Who watches them?

19a Do your children eat food anywhere else other than in your home?
c. Where?
d. What do they eat there?
e. How often?

21. What do you think would improve your situation regarding food for your family?

Social Support

22. How often do you meet with friends, relatives, and neighbours?
   a. What do you do with them?

23. Do you socialize with people from [country of origin]?
   a. [IF NO] Why not?
   b. Do you socialize with people from other countries?
      i. [IF NO] Why not?

Community Services in the area

24. How did you come to live in your neighbourhood?
   a. Do you plan to stay here?
   b. What do you like about your neighbourhood?
   c. What do you not like about your neighbourhood?
   d. Do you know people in your building?
      i. Do you socialize with them?
      ii. Do you ever ask them for help with anything? (child care, food, advice, etc)
      iii. Can you give me an example of a time you got help from someone in your building?
      iv. Has someone in your building ever asked you for help? Can you tell me about that time?
25. Have you attended any programs or classes that have taught you about children’s nutrition and health (e.g. prenatal classes, parenting classes, OEYC, Healthy Baby Healthy Children, community kitchen)?

   a. How did you learn about these programs?

   b. Are these services helpful?

   c. Do you like going to these programs?
      i. Why?
      ii. What do you find good/useful about what you learn in these programs?
      iii. Is there any information that is not useful??
         1. Do you disagree with any of the advice? What in particular?

**Settlement Services and Employment**

26. Have you been enrolled in LINC or ESL classes?

   a. IF YES
      i. How have these classes helped you settle in to Canada?

   b. IF NO
      i. Would you like to take these classes?
      ii. Why are you not taking these classes?

27. Have you met with a settlement counselor? How often do you meet with him/her?

   a. Do you find the settlement counselor helpful?

   b. What does she/he help you with?

28. Have you or a family member met with an employment counselor or used job training services?

   a. Have these services (language and employment) helped you and your family members find jobs?
      i. Can you tell me about a time they helped?

   b. Have you encountered any other problems when you or other family members have tried to find a job?
      i. [IF YES] Can you tell me about these problems?
Mother’s Daily Routine

29. Can we walk through yesterday (or the last weekday) and go through your different activities (e.g. work, childcare, shopping, household chores)
   a. Are there things you would like to do that you do not have time for?

Feeding

30. Let’s talk about what [CHILD NAME] ate yesterday or the last weekday.
    What was the first thing [CHILD NAME] ate yesterday?
    a. What time did [CHILD NAME] eat that?
    b. Where did [CHILD NAME] eat that?
    c. Who gave [CHILD NAME] that food?
    d. How did you decide to give this food?
    e. Who else was around?
    f. What was the next thing [CHILD NAME] ate yesterday? [repeat a-e for each food] [repeat f until bedtime]

31. Yesterday, were there any foods you would have liked [CHILD NAME] to eat, but s/he didn’t?
    a. Why didn’t she/he eat these foods?

32. How do you decide how much food to give [CHILD NAME]?

33. How do you know if [CHILD NAME] has had enough to eat?

34. Do you worry all about [CHILD NAME]’s weight?
    a. What are your concerns?
    b. What do you do about those concerns?

35. Can you tell us where you heard about this study? From which organization/person/poster?

Closing

36. Is there anything else you would like to tell us about how you feed your child, or how you buy and find food for your family?

Thank you very much for your time.
Appendix 4: Household Food Insecurity Supplement

*Which if any of these has taken place within the last month?*

1. I worry whether my food will run out before I get money to buy more
   - Not True  Sometimes True  Often True

2. I worry about where the next day’s food is going to come from
   - Not True  Sometimes True  Often True

3. We eat the same thing for several days in a row because we only have a few different kinds of food on hand and don’t have money to buy more
   - Not True  Sometimes True  Often True

4. The food that I bought didn’t last and I didn’t have money to buy more
   - Not True  Sometimes True  Often True

5. I ran out of foods that I needed to put together a meal and I didn’t have money to get more
   - Not True  Sometimes True  Often True

6. I can’t afford to eat the way I should
   - Not True  Sometimes True  Often True

7. I can’t afford to eat properly
   - Not True  Sometimes True  Often True

8. I am often hungry but I don’t eat because I can’t afford enough food
   - Not True  Sometimes True  Often True

9. I eat less than I think I should because I don’t have enough money for food
   - Not True  Sometimes True  Often True

10. I cannot afford to feed my child(ren) the way I think I should
    - Not True  Sometimes True  Often True

11. I cannot give my children a balanced meal because I can’t afford that
    - Not True  Sometimes True  Often True

12. My children are not eating enough because I just can’t afford enough food
    - Not True  Sometimes True  Often True

13. I know my children are hungry sometimes, but I just can’t afford more food
    - Not True  Sometimes True  Often True
Appendix 5: Consent Form

DATE: _____________

LETTER OF INFORMATION / CONSENT

A Study about Access to Food and Health Care for Young Children

Principal Investigators:  Ms. Laura Anderson Dr. Jennifer Levy
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Research Sponsor:
New Immigrant Support Network, The Hospital for Sick Children, funded by Citizenship and Immigration Canada
Joint Centre of Excellence for Research in Immigration and Settlement (CERIS)
Canadian Institutes of Health Research (CIHR)
Purpose of the Study

The purpose of this study is to look at access to food and healthcare for young children of mothers new to Canada.

You are invited to take part in this study on access to food and healthcare for young children. We want to explore mothers’ experiences. We are hoping to learn about problems and solutions that mothers have in feeding their children and in finding healthcare for them in Canada. We also hope to find out about mothers’ attitudes towards and experiences with our health care and social service systems.

What will happen during the study?

You will be invited to participate in two interviews that will take about two hours each. We will interview you in a private room. With your permission, we would like to audio-tape the interview and record written notes.

In the interviews we will ask you questions about yourself, your household, and your child. Here are some examples of the types of questions we will ask:

a) Do you have any concerns about what you and your children eat?

b) If your child is sick in the future, where would you go for care?

c) Do you ever have a hard time getting food, or foods that are good for your child?

You will be offered food and drink, TTC tokens to cover transportation costs, and a $25 grocery gift certificate after each interview for your time. At the end of the research process we will provide you with information about health and nutrition.

Are there any risks to doing this study?

The risks involved in participating in this study are low. Some of the questions are sensitive in nature and you may feel uncomfortable answering. You may worry about how others will react to what you say.

You do not need to answer questions that you do not want to answer or that make you feel uncomfortable. And you can stop taking part at any time. We describe below the steps we are taking to protect your privacy.

Are there any benefits to doing this study?
We hope to learn more about how mothers new to Canada make sure their children get the food and the healthcare they need, as well as any barriers they face. We hope that what is learned as a result of this study will help us to better understand what kinds of needs mothers new to Canada have in terms of access to food and healthcare resources, along with the health messages available to them and how this information affects attitudes and child care practices. This could help both public health programs and social and health service programs to be more effective. There may be no direct benefits to you from participating in the study.

Payment or Reimbursement

In compensation for your participation in these interviews, you will receive a $25 grocery gift card. Additionally, you will be given TTC tokens for transportation costs to get to the interview.

Who will know what I said or did in the study?

We will try to protect your privacy in this study. Throughout the interviews we will use only your first name. In our notes and in any reports we write we will not use your name. Nor will we include information that would allow you to be identified. Your privacy will be protected.

The information you provide will be kept in a locked and secure office where only we (the researchers) will have access to it. Information kept on a computer will be protected by a password. Once the study is finished, the interview notes and audiotapes will be destroyed after five years.

What if I change my mind about being in the study?

It is your choice to be part of the study or not. If you decide to be part of the study, you can decide to stop (withdraw) at any time, even after signing the consent form or part-way through the study. If you decide to withdraw, there will be no consequences to you. If you chose to withdraw, you can decide whether you would like us to keep some, all or none of the information you have given us. If you do not want to answer some of the questions, you do not have to, but you can still be in the study. Your decision whether or not to be part of the study will not change or stop the way you use services at ________________________________.

How do I find out what was learned in this study?

We expect to have this study completed by approximately May 2012. If you would like a brief summary of the results, please let us know and we will send it to your home address. We will also be sharing some of the main points of the group discussion with COSTI, The Centre for Spanish Speaking People, and Ontario Early Years Centres. We will not include any names or identifying information in this report.

Questions about the Study
If you have questions or require more information about the study itself, please contact Laura Anderson (647.822.1153) or Dr. Daniel Sellen (416.978.8112) at the Department of Anthropology, University of Toronto or Jennifer Levy (416.813.7654 ext 28324) at the Hospital for Sick Children.

This study has been reviewed and approved by the University of Toronto Research Ethics Board and received ethics clearance. If you have concerns or questions about your rights as a participant or about the way the study is conducted, please contact:

University of Toronto Office of Research Ethics
General Phone: 416-946-3273
E-mail: ethics.review@utoronto.ca
I have read the information presented in the information letter about a study being conducted by Ms. Laura Anderson and colleagues, of the University of Toronto. I have had the chance to ask questions about my involvement in this study and to receive additional details I asked for. I understand that if I agree to participate in this study, I may leave the study at any time. I have been given a copy of this form. I agree to participate in the study.

Signature: ______________________________________

Name of Participant (Printed) ___________________________________

Date: _______________________________________________

...Yes, I would like to receive a summary of the study’s results. Please send them to this email address ______________________________ or to this mailing address ______________________________.

.....No, I do not want to receive a summary of the study’s results.