

**SUPPORTING RECENT IMMIGRANTS IN THEIR EFFORT
TO ACCESS INFORMATION ON HEALTH AND
HEALTH-RELATED SERVICES: THE CASE OF 211 TORONTO**

by

Andrea Angelo Maria Cortinois

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

Graduate Department of Health Policy, Management and Evaluation
University of Toronto

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Abstract

The objectives of this thesis are to: 1) obtain a snapshot of callers of 211 Toronto, a free information and referral service, understanding how representative they are of Toronto's general population; 2) understand how 211 Toronto callers seeking health-related information use the information they obtain when contacting the service and their overall level of satisfaction, and; 3) better understand the experience and information needs of recent immigrants struggling to navigate an unfamiliar health care system.

The study had three phases: 1) a cross-sectional phone interview with 211 Toronto callers; 2) a follow-up phone interview of 211 Toronto callers who had asked health-related questions; and, 3) qualitative interviews with callers who were Spanish speakers from Latin American countries. Participants were randomly selected adult callers living within the boundaries of Toronto's Census Metropolitan Area (CMA). Respondents were compared with the general adult population living in Toronto's CMA, using 2001 Census data, to identify under- or overrepresented population groups. A sub-set of callers who had asked health-related questions was followed up to understand how they had used the information received and their level of satisfaction with the service. Qualitative interviews

were conducted with callers who were recent immigrants and native Spanish speakers from Latin America to explore their post-migration experiences.

Recent immigrants experience significant information challenges. Health-related questions reflect the multifaceted nature of the concept of health in the experience of users. Negative experiences with the health care system are common. Recent immigrants have access to disorganized, confusing, often poor quality information. 211 Toronto represents an efficient and effective way to gain access to information but does not achieve its full potential.

Newcomers should receive timely, appropriate, and reliable information on existing health and health-related services as soon as possible after they relocate to Canada. Appropriate information should also be made available to potential immigrants in their countries of origin. Information and communication technologies should be used to support newcomers, increasing the efficiency and effectiveness of services such as 211 Toronto.

“The greatest distance between people is not space, but culture.”

Highwater, J. (1981) *The Primal Mind: Vision and Reality in Indian America*.

New York: Meridian.

“In Mexico, I was blind. In Canada, I became blind, deaf and mute.”

Jimena, Interview #10

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Chapter I – Introduction

Over the past quarter of a century, globalization has resulted in an increasingly dramatic international division of labour. This, in turn, has prompted massive migratory movements (Castells, 2000).

Immigration is visibly changing Canada. Particularly in large cities, the Canadian demographic and social landscapes are being reshaped by this phenomenon. As immigration is expected to continue and even increase over time, Toronto, Montreal and Vancouver will become even more significant examples of highly multicultural or ‘globalized’ communities. They represent social laboratories where the importance and meaning of individual, ethnic, linguistic, and cultural boundaries is being re-constructed through the ongoing tensions between belonging and liminality, identity and hybridity, the empiric reality of multiculturalism and the lack of a real ‘culture of multiculturalism’ (Sandercock, 2005). These tensions will hopefully contribute to shape a new Canadian discourse on immigration and integration.

Over the next few decades, Canadian societal structures and institutions will have to continue to adapt to respond to the needs and demands of a new and diverse population. The health care system will not be an exception. Future changes will be quite significant, given the complexity of the system and its tendency to react relatively slowly to social changes. This research project is intended to contribute to the growing discourse on the challenges faced by health care systems in highly multicultural societies.

Access is an essential component of a health care system’s responsiveness. Many factors interact to influence access to and use of health services including, among others: the specific characteristics of the surrounding political, social, economic and cultural environments; the general features of the health care system itself; population characteristics; health needs; health-related behaviours; and health outcomes, including

consumer satisfaction (Andersen, 1995). Multiculturalism adds to the complexity of such interactions in many ways, from the obvious problems created by language barriers to the much more subtle challenges produced by different cultural interpretations of health, illness, and the process of care, and significantly impacts access to health care.

Access to relevant, timely, and appropriately presented information may become an increasingly important resource for recent immigrants who are learning to navigate and negotiate a largely unknown health care system and are at high risk of becoming underserved. Users' informational needs are also a powerful reflection of the complexity and multifaceted nature of their interactions with the immediate social surroundings and the health care system. Focusing on information needs, therefore, represents a potentially useful approach to better understand what is needed to build a health care system that is truly responsive to the needs of the population it aims to serve.

The main investigator's interest in issues of globalization, migration, multiculturalism, the impact of these phenomena on equity in health, and the role of information as an enabler of access to health care services are the result of experiences that cross the artificial separation line between personal and professional life. The main investigator is himself an immigrant and has been working for more than two decades across and in between cultures, mainly as an international public health practitioner. Since he moved to Canada, he has also witnessed one of the largest immigration waves in the history of this country and its profound effects on Toronto. He has contributed to research projects focusing on immigrants and other potentially underserved population groups. At the same time, through his work at the Centre for Global eHealth Innovation, a joint initiative of the University of Toronto and the University Health Network, the largest academic health science centre in Canada, he has also focused his attention on the role that both traditional and new information and communication technologies (ICTs), as well as information itself, play in the transformation of the health care system. Through this work, he has become

particularly interested in the complex challenges faced by recent immigrants who seek access to an unfamiliar health care system.

This study examines the importance of access to information about health and health-related services as an enabler of access to health care, in a highly multicultural setting. The study focuses on the experience of recent immigrants and tackles the question of whether the same factors that limit recent immigrants' access to and effective use of health care resources could also be responsible for a limited use of information and referral services explicitly designed to support them.

A. Case Study: 211 Toronto

The study focuses on 211 Toronto Community Connection Service (211 Toronto), an information and referral service financed in large part by the United Way of Greater Toronto and the City of Toronto (www.211toronto.ca). 211 Toronto has been chosen because it can be considered as an 'ideal' one-stop information and referral service, for reasons that will be detailed in Chapter II. Potentially, this service could support recent immigrants from a variety of backgrounds in their quest to access, understand, and appropriately use existing health and health-related services.

B. Research Goal and Objectives

The goal of this study is to better understand the experience of recent immigrants struggling to navigate and negotiate a largely unfamiliar health care system and identify barriers limiting in a significant way their access to information services.

The study has three main objectives. These are to:

1. obtain a snapshot of 211 Toronto users who contact the service by phone, understanding how representative they are of Toronto's general population;

2. understand how 211 Toronto callers seeking health-related information use the information they obtain when contacting the service and their overall level of satisfaction; and
3. gain a better appreciation of the experience of recent immigrants struggling to navigate and negotiate an unfamiliar health care system, focusing on their information needs, information seeking behaviour, knowledge of, attitude towards, and actual use of existing information sources, and barriers and facilitators experienced in the process of obtaining information.

The study includes three data collection phases, each one corresponding to one of the objectives:

1. a cross-sectional survey of 211 Toronto callers;
2. a follow-up survey of 211 Toronto callers seeking health-related information; and
3. qualitative interviews with 211 Toronto callers who are recent immigrants from Spanish-speaking Latin American countries.

C. Overview Of the Remaining Chapters

Chapter II presents and contextualises the rationale for this research project. It: analyzes the complex and heterogeneous array of observations and personal experiences that led the main investigator to focus on the topic of this dissertation; gives an overview of the immigration phenomenon in Canada, the forces that shape it, its dimensions and characteristics, and its impact on society; briefly describes the experience of newcomers who try to use health services; and offers an essential introduction to the role information plays in facilitating immigrants' access to health care. In addition, the chapter describes a research initiative known as 'Levelling the Playing Field', to which the main investigator contributed, that had a significant impact on the conceptualization of this study (Hohenadel et al., 2007). Finally, the chapter introduces 211 Toronto and explains why this service represents a particularly interesting case study and starting point for the development of this research project.

Chapter III presents the results of a review of the existing literature on immigration and health in Canada. The review includes three sections: immigration and health, focusing on the health status of newcomers and on the conditions that are particularly relevant to this population group; immigrants' access and use of health services; and newcomers' access to information services.

Chapter IV analyses the essential elements of the theoretical framework that oriented the study. It is organized in three parts. First, it offers a concise overview of a model known as 'Behavioral Model of Health Services Use' that was developed to describe and predict access and use of health services (Andersen, 1995). Second, it introduces the concept of 'information behaviour' and describes how it has evolved over time, in the field of information studies. It also presents a model developed by Wilson and colleagues that explains information behaviour (Wilson, 2005). Finally, the chapter shows how these two models, simultaneously assumed, may represent a useful theoretical background for this study.

Chapter V outlines the study methodology. It includes sections describing the review process undertaken to obtain approval for the study protocol from the University of Toronto Research Ethics Board and, for each of the three study objectives, it discusses the procedures followed to achieve them. These procedures include: the rationale for the methods used; a description of the setting, location, and relevant dates; recruitment procedures, including eligibility criteria, sources, and methods of selection of participants; data sources and measurement; potential sources of bias and efforts to address them; study size and its justification; handling of variables; statistical methods; and issues of integration of results from different phases of the study.

Chapter VI reports on the quantitative component of the study. It begins with a brief summary of the most important results. It then summarizes the data collection process, reports response and completion rates, and presents the descriptive analysis of the survey

data. The results of the comparison between survey data and 2001 Census data for Toronto's Census Metropolitan Area (CMA), aimed at identifying population groups who were either under- or overrepresented among 211 Toronto callers, are also summarized in this chapter. In addition, the analysis of data collected during the follow-up phase of the survey, which focused on issues of effectiveness and satisfaction are presented.

Chapter VII presents the results of the qualitative interviews analysis. It introduces the study participants and offers brief overviews of their lives before and after moving to Canada. It presents and discusses results with particular attention to respondents' experience with health and health-related services and with information sources. In addition, the chapter includes a tentative map of the information pathways followed by respondents in their effort to navigate and negotiate health and health-related services in Toronto.

To conclude, Chapter VIII brings together and discusses the results from the two components of the study, draws general conclusions, and examines their practical implications with particular emphasis on implications for policy and service provision.

D. References

Andersen, R.M. (1995) 'Revisiting the behavioral model and access to medical care: Does it matter?' *Journal of Health and Social Behavior*; 36 ; 1: 1-10.

Castells, M. (2000) *End of Millennium*. 2nd ed. Oxford (UK): Blackwell.

Hohenadel, J.; Kaegi, E.; Laidlaw, J.; Kovacik, G.; Cortinois, A.A.; Kang, R. et al. (2007) 'Leveling the playing field: The Personal Coach Program as an innovative approach to assess and address the supportive care needs of underserved cancer patients.' *Journal of Supportive Oncology*; 5; 4: 185-93.

Sandercock, L. (2005) *Migrations: Conflicts and Multiculturalism - Or, The Satanic Verses As Urban Manifesto*. Unpublished document.

Wilson, T.D. (2005) Evolution in Information Behavior Modeling: Wilson's Model. In: Fisher, K.E.; Erdelez, S.; McKechnie, L.E.F. (Eds.) *Theories of Information Behavior*. Pp. 31-36. Medford (NJ): Information Today.

Chapter II – Background and Rationale

This chapter presents and contextualises the rationale for this research project. It also describes and briefly analyzes the complex and heterogeneous array of observations and personal experiences that led the main investigator to focus on the topic of this dissertation.

Chapter II includes four sections. Section A presents an overview of the immigration phenomenon in Canada, the forces that shape it, its dimensions and characteristics, and its impact on society. It also includes a brief analysis of the tension existing, in highly multicultural societies, between the need for a new ‘culture of globalization’ and the reality of traditional interpretations of and responses to the immigration phenomenon. Section B presents an introductory analysis of newcomers’ experience with health services and of the role information plays in facilitating immigrants’ access to health care. Section C describes a research initiative known as ‘Levelling the Playing Field’, to which the main investigator contributed, that had a significant impact on the conceptualization of this study (Hohenadel et al., 2007). Finally, Section D presents a brief introduction to 211 Toronto (www.211toronto.ca) including an explanation of why this service represents a particularly interesting case study and starting point for the development of this research project.

A. Globalization, International Migration and Multiculturalism

Since pre-historic times, human populations have been on the move, progressively colonizing most of the globe in search of more favourable living conditions. Human flows have been the norm, not the exception, across centuries, spurred and shaped by a myriad of structural and contextual forces. Several modern states, including present-day Canada, have been created through such population movements. The most powerful force behind contemporary migration fluxes is almost certainly the increasingly dramatic international division of labour produced by the globalization phenomenon.

Over the past three decades, globalization has reshaped the world in which we live. In its more contemporary meaning, the term globalization defines a complex and multidimensional phenomenon, in constant evolution and only partially understood, involving radical and fast-paced changes in all major spheres of life, from the economic to the political, social, cultural, and technological ones (Cortinois et al., 2003). Globalization creates new forms of interconnection and interdependence and transforms the spatial organization of social relations and transactions, altering, among many others, concepts of nation state, democracy, citizenship, community, social capital, inclusion/exclusion, and cultural identity.

The globalization process, driven by powerful engines such as the revolutionary advances in transportation and information and communication technologies (ICTs), is having a major economic impact all over the world. While trade, migration, communication and dissemination of scientific and technical knowledge have undoubtedly been the basis of economic progress in the world, unfair and unequal resource development and allocation have also resulted from the skewed distribution of the benefits produced by this process (Oxfam, 2002). In particular, it has been suggested that in the information age, economic globalization represents a new phase in which capitalism has developed decentralized flexible networks of production that value innovation while excluding vast sections of humanity which simply find no place in the network (Castells, 2000). At the same time, the implementation of the neo-liberal economic agenda throughout the world has severely limited the capacity of governments to promote economic policies able to protect the vast majority of their own citizens (Crosby, 2006). The excluded, or at least those among them who can, move in search of a better life. In the process, they soon realize that borders are not as permeable to people as they are to goods, information, and capital.

Large numbers of international migrants choose Canada as their new home. According to the 2001 National Census, in that year almost 20% of all Canadian permanent residents, or 5.4 million people, were foreign born: the highest proportion in 70 years. Only in Australia

is the proportion of foreign-born population higher than it is in Canada even if, since the late 1980s, Canada has had a proportionally higher annual intake of immigrants than any other country (Statistics Canada, 2003).

For the first 60 years of the 20th century the overwhelming majority of immigrants came from a few European countries, particularly the UK, Italy, Germany, and the Netherlands, and from the United States. European immigrants accounted for 90% of all immigrants who arrived to Canada before 1961. More recently, however, due to changes in both Canadian immigration laws and the international landscape, the vast majority of immigrants originate from an increasing number of countries in continents other than Europe including Asia (58% of immigrants), the Middle East (20%), the Caribbean, Central and South America (11%), and Africa (8%) (Statistics Canada, 2003). Of all newcomers, in 2001¹ 73% lived in just three metropolitan areas: Toronto, Vancouver, and Montreal. Toronto attracted the largest share of new immigrants (43%), nearly three times greater than its share of the total population in Canada. That year, Toronto had a foreign-born population of 1.7 million, almost 44% of its total population, and had already become one of the most multicultural metropolises in the world, possibly the most multicultural if compared with other metropolitan areas that are the final destination for large numbers of international migrants: Miami (40%); Sydney (31%); Los Angeles (31%); and New York City (24%) (Statistics Canada, 2003).

A growing proportion of recent immigrants speak a language other than English or French most often at home. In 2001, 61% of the immigrants who had arrived during the previous decade used a non-official language at home. Also, the visible minority population is steadily increasing, growing much faster than the total population. In 2001, almost 4

¹ To maintain internal consistency and avoid confusions, all census-related statistics in this study refer to the 2001 Census, the most recent version for which data was available at the time the study was conducted.

million individuals identified themselves as visible minorities¹. Three quarters of immigrants who moved to Canada in the 1990s were members of visible minorities groups. Most of them lived in Ontario and British Columbia. More than 200 different ethnic origins² were reported in the 2001 Census, most of them represented in Toronto. The largest visible minority groups in Toronto were: Chinese, South Asians, Filipino, Korean, Arabs, and Latin Americans. With the growing cultural diversity of Canada, an increased number of relationships involve individuals from different groups. Of all unions, in 2001 3.1% involved either a visible minority person with a non-visible minority person or two persons from different visible minority groups. As a result of increasing intermarriage, many people now report multiple ethnic ancestries (Statistics Canada, 2003).

Immigration will most likely continue over the next decades and its effects will become even more evident. Canada is increasingly dependent on immigration to mitigate the combined effect on the labour market of birth rates at historic lows and the ageing of its largest demographic cohort, the 'Baby Boomers'. Immigration will likely account for all net labour force growth by 2011 and projections indicate it will account for total population growth by 2031 (Citizenship and Immigration Canada, 2001).

While there is increasing evidence that 30 years of globalization as a 'grand economic theory' might soon end in failure (Ralston Saul, 2004), other, possibly more important characteristics and consequences of this phenomenon will probably endure and even increase in significance. One of them is almost certainly the very rapid trans-national mixing of cultures due to the movement of large numbers of people across borders and to

¹ The *Employment Equity Act* defines visible minorities 'persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour' (Government of Canada, 1995).

² In the 2001 Census, 'Ethnic Origin' refers to the ethnic or cultural group(s) to which the respondent's ancestors belong. Respondents were asked to specify as many groups as applicable and four write-in spaces were provided. In the instructions, it was explained that ancestry should not be confused with citizenship or nationality and that the answer should make reference to an ethnic or cultural group, not to the language spoken. Twenty-five examples were given, including: Canadian, French, English, Chinese, Italian, German, Scottish, Irish, Cree, Micmac, Metis, Inuit (Eskimo), East Indian, Ukrainian, Dutch, Polish, Portuguese, Filipino, Jewish, Greek, Jamaican, Vietnamese, Lebanese, Chilean, and Somali (Statistics, 2007).

the impact of ICTs. The long-term results of these global fluxes are difficult to foresee but projections indicate that, for example, 50% of the languages spoken today in the world will disappear before the end of this century (BBC World Service, 2007). The type of ethno-cultural and linguistic mix we experience today in Toronto, sometimes defined as ‘globalization at home’ (University Health Network, 2001), is shared by several other metropolitan areas around the world and, over time, will become increasingly common. Soon, the impact of immigration will reach beyond large cities. We are currently witnessing an increase in multiculturalism in the traditionally white, largely Anglo-Saxon suburbs.

Immigration fluxes as significant as the ones we currently experience in Canada qualitatively change a society. Pervasive interactions among cultures influence its identity and the sense of belonging. As Foucault would write, ‘the fundamental codes of a culture – those governing its language, its schemas of perception, its exchanges, its techniques, its values, the hierarchy of its practices’ (Foucault, 1973) are all altered by massive immigration. The concept of community changes as it changes the way we perceive our needs and priorities with respect to the needs and priorities of both local and remote ‘others’. Terms such as ‘minorities’, ‘visible minorities’, ‘mainstream culture’, ‘us’ and ‘them’, and many others either lose their meaning or radically change it. Places like Toronto, whose demographic and cultural landscapes have already been dramatically reshaped by immigration, have become social laboratories where the importance and meaning of individual, ethnic, linguistic, and cultural boundaries will be re-construed through the ongoing tensions between belonging and liminality, identity and hybridity. A true culture of multiculturalism, able to keep up with the empirical reality of this phenomenon, will have to emerge to prevent the type of social unrest of which the 2005 violent clashes in the *banlieue parisienne* were a powerful example (Sandercock, 2005). At this stage, however, the lack of this new culture is quite evident. The ideal of multiculturalism dramatically clashes with the traditional concept of nation state and its interpretation of/response to the immigration phenomenon.

The countries in the north, even more after September 11, live in fear of being swallowed up by large masses hitting them as a human tsunami. The mainstream media, in fact, describe migration using almost exclusively water-related metaphors: as a wave or flood. International migration policies have created a 'gated world' where the privileged few live inside protected enclaves while the destitute majority is left outside. The first order of barriers is created by language itself. People on the move are categorized according to a terminology that powerfully influences their right to relocate and, often, their chances to survive. Terms like 'refugee', 'internally displaced person', 'economic migrant' belong to a categorization system that is used as a means of control. Of particular importance is the distinction between forced and voluntary relocation, as the 1951 Geneva Convention Relating to the Status of Refugees protects only migrants who are 'forced' to leave due to conflict or prosecution. Such distinction does not acknowledge the fact that the violence of poverty and the violence of war are deeply interrelated and leaves so-called economic migrants unprotected. To extend protection to this category of migrants, in 1990 the UN General Assembly adopted the United Nations Convention on the Protection of the Rights of All Migrant Workers and Their Families. Unfortunately, however, it took 13 years to obtain the required number of ratifications by UN member states to make the Convention come into force. As of 2006, no northern country had ratified the Convention and many, including Canada, actively oppose it (Crosby, 2006).

Behind the myth of Canada as a welcoming country a quite different reality looms. In the past, Canadian immigration policies have been openly racialized. For example, as vividly described by Karen Chow in her documentary 'In the Shadow of Gold Mountain', in the first half of the 20th century Canada was actively encouraging and rewarding European migration while at the same time discriminating against Chinese immigrants who came to build the Canadian Pacific railway. Laws such as the *Chinese Head Tax and Exclusion Act* plunged the Chinese Canadian community into decades of debt and family separation and threatened to eradicate the entire community (Cho, 2004).

Today, while open discrimination may have disappeared, clear indicators remain showing that Canada's immigration policies are shaped by domestic, self-serving priorities that do not necessarily favour those most in need. A clear example of such attitude is the 'Skilled Worker Class Immigration Program' modified in 1993 to encourage the immigration of more highly educated applicants (Citizenship and Immigration Canada, 2007) and the point system it uses, largely based on criteria such as formal education, professional experience, and knowledge of official languages. Applicants who achieve high scores, and are therefore accepted, usually belong to already privileged minorities in their countries of origin. Everybody else is left outside. Another example of the self-serving attitude is the active 'poaching' of certain professional categories, such as physicians and nurses, in countries that face major crises due to, among other factors, the loss of their skilled workers (Schrecker et al., 2004). The various 'guest workers' programs that attract to Canada, every year, tens of thousands of foreign workers represent a third and final example. Seasonal migrant workers support our economy, contribute out of their pay check to benefits they are not entitled to receive, but cannot apply for citizenship even if many of them spend the largest part of the year in Canada, each year, sometimes for decades (Pickard, 2005).

To make things worse, the 'brain drain' promoted by some of these policies is unfortunately accompanied, in Canada, by what could be called 'brain waste', often the result of a lack of coordination between policies at the federal level and those at the provincial and local levels. Recent studies denounce the contradiction between immigration policies that have successfully attracted increasingly larger numbers of highly educated and skilled immigrants and the poor indicators of family economic welfare among newcomers. For example, Picot and colleagues have analyzed the prevalence of low income among recent immigrants over the past decade (Picot et al., 2007). They define low income as family income below 50% of median income of the total population, adjusted for family size. They found that low income rates among recent immigrants have been

increasing after 2000. About 65% of immigrants enter low income at some time during the first ten years in Canada. 'Chronic' low income, defined as being in low income at least four of the first five years, is also increasing. The dramatic changes in education and skills levels after the 1993 modifications to the 'Skilled Worker Class Immigration Program' had only a small positive effect on chronic low-income rates as in the 2000 cohort, for example, 52% of those in chronic low income were skilled economic immigrants and 41% had university degrees. While 1.2 million children in Canada, almost one child out of every six, live in poverty, 49% of children in recent immigrant families are poor (Teelucksingh et al., 2005). Factors behind these figures include, among others, an overrepresentation of recent immigrants in low-paying jobs; the lack of recognition of international work experience and credentials, and racial discrimination in employment.

Visible-minority immigrants, in particular, are slower to integrate socially and economically into Canadian society than their white, European counterparts. They identify themselves less as Canadians, trust their fellow citizens less and are less likely to vote than white immigrants (Reitz et al., 2007). Also, their children exhibit a more profound sense of exclusion than their parents, feeling alienated by perceptions of discrimination and vulnerability. These perceptions stem from feeling uncomfortable in social situations due to their racial make-up and from fear of suffering a racial attack. Poverty rates among visible minority persons in Canada, particularly recent visible-minority immigrants, are particularly high, greater than 50% for some groups, such as recent black immigrants. The major causes of poverty include barriers to equal participation in the job market and lack of access to permanent, skilled, and reasonably well-paying jobs (Jackson, 2001). In a recent study on career development and advancement of visible minorities in corporate Canada (Tallarico et al., 2007), approximately 50% of visible-minority respondents with foreign educational credentials felt their employers did not recognize their educational background as being 'on par' with equivalent Canadian degrees, in comparison to only 23% of white/Caucasian respondents.

While the integration discourse recognises the value of diversity, at the same time it questions it on the premise that growing racial diversity and cultural differences weaken Canada's normative consensus and social cohesion. However, the view that massive migration will eventually result in the loss of cultural and national identity can be challenged by observing that Canada as we know it was built on immigration and that culture and identity are not static concepts but characteristics in continuous evolution. When listening to those who speak in defence of Canadian values and traditions it would be interesting to ask them which Canada they are referring to, whether the 1960 Canada, today's Canada, or Canada of 2040. It would be important to know as those are three very different places.

B. Access To Information and Access To Health Services

Over time, Canadian institutions, including the health care system, have to evolve and adapt to the new reality of multiculturalism. Culturally based systems of care have to develop to meet the values, expectations, needs, and practices of the population. In highly multicultural societies, in fact, health services face unprecedented challenges in reaching the population they are supposed to serve. An attempt to make immigrants 'fit' the existing system will not be the right answer. The 'one size fits all' approach will not work. Instead, services will have to be conceptualized, designed, and delivered while taking into consideration the new context (Cortinois et al., 2003).

In places like Toronto, where a 'global environment' already exists, hospitals are already caring for patients from increasingly heterogeneous ethno-cultural and linguistic backgrounds, with mixed experiences and expectations, presenting new patterns of disease. These characteristics add to the complexity of the clinical encounter, usually increasing uncertainty, asymmetry of information, and the relative weight of competing and often unspoken values (McKee et al., 2002). Health care institutions show the first signs of reaction to the new conditions and discussion has started on the need for enhanced cultural competency through education of the work force on the impact of socio-cultural factors on

the overall health of patients and staff. The University Health Network, for example, has formally acknowledged the need for ongoing data collection and participatory analysis to monitor the effectiveness of institutional efforts in responding to changing socio-demographic trends, as well as the central role of the promotion of culturally sensitive services provision in diverse languages (University Health Network, 2001). But these are still early steps.

The challenges faced by newcomers and by health care systems suggest the need for profound and comprehensive changes in the way health care provision is conceived in highly multicultural societies, a radical transformation process. The aim of the present study, whose goal is to better understand the experience of recent immigrants who are struggling to navigate and negotiate an unfamiliar health care system and identify barriers limiting their access to information services, may appear quite limited if seen against the background of the required radical transformation process. In the short term, however, an in-depth understanding of such barriers is a first, significant contribution to minimizing newcomers' odds of becoming underserved, reducing health disparities, and increasing the effective and efficient use of existing services.

Canadian studies have shown varying results regarding the health services utilization by recent immigrants. Similar or lower utilization by newcomers as compared to Canadian-born populations have been shown depending on the type of service, circumstances of migration, country of origin, sex and socio-economic status (Glazier et al., 2004).

Underutilization of certain types of health care services, particularly preventive and mental health services, may be interpreted as the reflection of the inadequacy of existing services in meeting immigrants' needs (Hyman, 2001). A comprehensive review of the literature on the subject of access to health care services by immigrants in Canada is presented in the next chapter.

There is no doubt that a large segment of the recent immigrant population struggles to understand an unfamiliar health care system and faces a daunting labyrinth of providers, institutions and services. Many of them are unable to understand, access, and optimally use appropriate services that could help them find solutions to their immediate and long-term needs. As a result, recent immigrants are at risk of becoming ‘underserved’, using this term the way it is conceptualized, for example, by the Association of Clinicians for the Underserved, in the US (www.clinicians.org), the organization that publishes the ‘Journal of Health Care for the Poor and Underserved’ (www.press.jhu.edu/journals/journal_of_health_care_for_the_poor_and_underserved). The underserved are disadvantaged individuals and communities who face daunting barriers due to contextual factors such as ethnicity, culture, language, disability and socio-economic status.

While access to health services is the ultimate result of the combined action of several related factors that will be presented and discussed in Chapter IV, in the case of recent immigrants it seems sensible to consider the availability of relevant and timely information on health and health-related services an essential precondition for the successful navigation and negotiation of the Canadian health care system. An increasing number of information and referral services have been created to support potentially marginalized groups, including recent immigrants. Several studies, however, have shown that reaching out and meeting the needs of those who might benefit the most from health information and referral services is a major challenge. Most commonly, users of these services are members of the mainstream culture and belong to middle to upper socio-economic groups. Conversely, non-dominant ethno-linguistic groups, lower socio-economic groups, rural populations, and people with low literacy skills, among others, are those who use health information and referral services the least (Demark-Wahnefried et al., 1998; Hoffman-Goetz et al., 1998; Montazeri et al., 1999; Underwood et al., 1994). The results reported in the published literature were validated by a study conducted at the Centre for Global eHealth Innovation, where the main investigator is based, called ‘Levelling the Playing Field’, that will be briefly analyzed in the following section. The formative evaluation

phase of this project concluded that people who face barriers such as low literacy/formal education, poverty, and social isolation, or whose linguistic, cultural or religious backgrounds are non-dominant, have significant unmet supportive care needs, including limited access to information (Jadad et al., 2002).

Some of the existing health information and referral services make use of ICTs, demonstrating how such technologies may become effective tools for the public to gain access to health information, people, and services. When information services are ICT-based, however, recent immigrants may experience additional barriers due to lack of access to the Internet and limited computer skills, among others. Once again, there is evidence in the literature that less advantaged population groups are those who benefit the least from ICT-based resources (Chang et al., 2004; Changrani et al., 2005; Cotten et al., 2004; Gustafson et al., 2005; Hsu et al., 2005; Lorence et al., 2006; Lorence et al., 2007; Miller et al., 2007; Miller et al., 2005; Renahy et al., 2006; Skinner et al., 2003; Willis et al., 2006).

A better understanding of the information needs of recent immigrants and of their attitudes towards and experience with ICT-based information services would help improve the appropriateness, adequacy and accessibility of those services. In turn, an increased use of those services could give newcomers access to relevant and timely information that would support them in their effort to navigate and negotiate the Canadian health care system. Information needs are also a reflection of the complexity of newcomers' experience, an additional key to better understand such experience.

C. Levelling the Playing Field

As previously mentioned, one of the most powerful incentives to initiate this study has been the main investigator's experience as a team member in a previous research initiative, known as 'Levelling the Playing Field' (LPF), developed at the Centre for Global eHealth Innovation and funded by CIHR, several other agencies, and philanthropic organizations. LPF was aimed at developing and testing an innovative model to help potentially

underserved cancer patients access, understand, and appropriately use community- and hospital-based supportive care services to enhance their health care and better manage their illness (Cortinois et al., 2005). LPF represents a useful opportunity for reflection on the challenges of multicultural health care and the need to explore innovative ways to confront them. LPF focused on ‘supportive care’ for patients and their families. Although LPF focused on cancer patients in an institutional setting, the definition of supportive care the study adopts, borrowed from the McMaster University’s Supportive Cancer Care Research Unit (McMaster University's Supportive Cancer Care Research Unit, 2007), and the lessons learned during the study, can be easily applied to a much broader context. Supportive care is defined as the provision of necessary services to meet the physical, informational, psychosocial, spiritual and practical needs of patients and their families.

The main goal of LPF was to assist patients at risk of being underserved due to five barriers: poverty; low literacy skills; language barriers; cultural issues; and social isolation. Trained individuals called ‘personal health coaches’ (coaches) worked one-to-one with patients to help them identify and meet their supportive care needs. Coaches acted as knowledge brokers, facilitating access and appropriate use of both community-based and institutional services. Of the 46 patients enrolled in the program, 43 were born outside of Canada and 37 did not speak English as their first language. Half of them required the help of an interpreter. Language, cultural issues, and poverty represented the most common barriers. Many patients, quite understandably, faced multiple barriers. Language was the easiest barrier to identify and the best predictor of unmet supportive care needs since patients had difficulty understanding most of the information provided to them by members of their health care team and hospital staff at large. Cultural barriers were harder to detect, although their effect was important. They affected, among other aspects: patients’ beliefs and attitudes toward technical care; their relationship with providers; their willingness to discuss personal health matters with ‘strangers’, including coaches, and sometimes even with family members; and their willingness to accept support from governmental and other ‘authorities’ (Cortinois et al., 2005).

LPF was followed by a very comprehensive and meticulous final evaluation. The main investigator was a member of the evaluation team and was strongly influenced by the experience at the very time he was conceptualizing and designing the present study. Some of the aspects of the LPF experience that are particularly relevant in this context and informed this study are briefly presented below.

First, the evaluation showed how individual patients face, at the same time, multiple and mutually interacting barriers of different natures. The broad, comprehensive operational definition of ‘supportive care’, as adopted in the context of the LPF intervention, helped to draw attention away from the challenges of clinical care and the limiting focus on the patient-provider interaction, often the only focus of interventions aimed at enhancing health services ‘cultural competence’, to highlight the intricate web of heterogeneous needs and barriers that shape newcomers’ experience with health care and the health system in general. The intervention highlighted the complexity of the experience of access and the need for a comprehensive approach to address patients’ needs in a highly multicultural society.

Second, coaches observed how difficult it was for patients to verbalize the barriers and problems they were facing. Presumably, an important reason for this was that problems and barriers were not perceived or even conceptualized as such by immigrant patients. Many of them had gone through challenging experiences in countries where health and social services are less developed than in Canada. What is perceived as a problem or barrier here might represent the norm somewhere else. Also, patients were often unaware of available services that would have been of fundamental importance to them, such as, for example, the Provincial Government Drug Plan (Trillium) available to all cancer patients. Not having ever used analogous services before, they could not even envision their existence. Coaches played a very active role in the problem identification process, ‘discovering’ barriers as patients would describe their life experiences. The active role of

coaches was acknowledged by LPF participants. Most patients, in fact, identified the help they received to understand their own needs and to connect them to services and resources as one of the most important functions played by coaches.

Third, patients reported difficulty communicating with their health care team. Often, such problems were due to language barriers but language wasn't the only obstacle they had to overcome. Poor communication practices of both patients and providers were also to blame. Many patients did not understand documents they were given and struggled with scheduling appointments. Finally, and perhaps more importantly, a myriad of other cultural barriers, less 'visible' than language but equally powerful, were clearly at work to limit patients' access to services. Cultural differences as barriers to access vary from situation to situation, may be difficult to appreciate, and their effect can be obscured by the emphasis given to language barriers. Nevertheless, they are omnipresent and sometimes work in quite surprising ways. For example, on at least two occasions people from non-Canadian backgrounds asked the main investigator whether having a 'family doctor' meant being married to a physician. While this question easily triggers a smile, it is a perfectly logical one for somebody who comes from a country where family doctors do not exist and the concept itself is unheard of. A second example may help understand how cultural barriers can qualitatively influence the use of services even for highly educated individuals with a good understanding of the health care system. Recently, the main investigator has witnessed the experience of a close friend, originally from South America, who had to make use of hospital services after a life threatening accident. He has been living in Canada for almost a decade, speaks English virtually perfectly, is a physician, and his research agenda focuses on improving patient-provider relationships. In spite of this all, his relationship with the health care team was extremely frustrating and his status as a foreign-trained physician and a member of a visible minority made things even more complicated, if possible. All along, he was constantly shocked by the realization of how dramatic the differences between practice here and in his home country are.

Fourth, LPF was an opportunity to realize how much work is still needed, in Canada, to move from a 'position of tolerance to a position of true acceptance, respect, inclusion, and the celebration of diversity', to borrow the words used by former Federal Minister of State for Public Health Carolyn Bennett in describing the first public health goal for Canada (Bennett, 2005). Health care providers are busy and ill-equipped to deal with a highly multicultural patient population. Large hospitals are decades behind, if the very limited number of trained interpreters available to help with patients from a variety of linguistic and cultural backgrounds can be used as a basic indicator of their levels of awareness and commitment. In this respect, the example of the University Health Network (UHN), a multi-site academic health sciences centre located in downtown Toronto and the largest hospital network in Canada, is particularly noteworthy. UHN has a catchment area that, as shown earlier in this chapter, represents one of the most, if not the most, multicultural geographic areas in the world. With an annual budget that exceeds one billion Canadian dollars, each year the UHN cares for more than 65,000 inpatients and performs almost a million outpatient clinical visits (University Health Network, 2007). Yet, it employs only eight interpreters, the remaining work being left to approximately 200 external freelancers who may not always be immediately available (Abraham, 2007). Even organizations working in the community have a long way to go. For example Interlink, a Toronto-based organization that, before recently becoming part of Princess Margaret Hospital, was independently offering home nursing services, did not employ a single professional whose first language was other than English and did not have any specific policy in place to hire nurses with specific language skills (Caldwell, 2007).

Finally, at a time when, on the one hand, the policy discourse is built around 'keywords' such as fiscal restraint and efficiency and, on the other hand, immigration results in an increasingly complex landscape, the clash between the need for efficiency and the need for accessibility could become increasingly dramatic as resource allocation might not match patients' needs and inequities might become increasingly significant. In this context, it is important to explore innovative ways of facilitating access to available resources and make

the most of services, such as 211 Toronto, that could become increasingly important in supporting a highly multicultural population (Cortinois et al., 2005).

The considerations outlined above have significantly influenced the conceptualization and design of this research project. This study, in fact, does not focus exclusively on clinical services but takes into consideration a myriad of other services that newcomers might need to use either in the process of learning how the Canadian health care system as a whole works or as the result of specific health problems. ‘Health-related services’¹ such as childcare and eldercare, transportation services, information and referral services, homemaking, insurance and legal support services, counselling, and spiritual support services, just to mention a few examples, should represent essential components of a comprehensive strategy aimed at addressing newcomers’ needs. In turn, satisfying such needs will hopefully result in improved access and more appropriate and effective use of clinical health services by recent immigrants. In addition, the study explicitly acknowledges the effects of cultural differences, well beyond language barriers, particularly with respect to their effects on expectations and the conceptualization of problems and barriers by newcomers. In the main investigator’s view, information services in highly multicultural settings cannot just respond to the demands of users but have to actively engage them and support their gradual understanding of an unknown health care system.

LPF is only one example of several research initiatives focusing on the challenges faced by patients who have to navigate through a maze of services and providers. In 2005, for example, the US National Cancer Institute announced more than 25 million dollars in grants to develop an innovative 5-year ‘Patient Navigator Research Program’ (PNRP). A

¹ Perhaps not surprisingly, no explicit and univocal definition of ‘health-related services’ exists in the literature. Most authors use ad hoc definitions that draw attention to the perceived and evaluated needs of a specific patient population to emphasize the complex issues related to caring for such population (Abe-Kim et al., 2007; Booth et al., 1999; Weller et al., 2003). This study adopts a loose and inclusive definition of what constitute ‘health-related services’ that is consistent with the supportive care model previously described in this chapter.

large part of this funding is being used to study the work of ‘navigators’ defined as ‘trained, culturally sensitive health care workers who provide support and guidance throughout the cancer care continuum’ (National Cancer Institute - Center to Reduce Cancer Health Disparities, 2007). LPF’s adopted perspective is broader than the PNRP’s as it challenges navigation problems beyond the realm of technical care to encompass all facets of supportive care. In addition, LPF prefers the term ‘coach’, instead of ‘navigator’, as one of the main objective of coaches is to support patients in building self-help skills and competencies to become able to make use of services independently in the future (Cortinois et al., 2005). The present study builds on this experience while broadening the focus of attention moving it from a specific group of patients to the general population of users and potential users of services.

D. 211 Toronto Community Connection Service

The study focuses on 211 Toronto as an example of an information and referral service potentially able to support recent immigrants from a variety of linguistic backgrounds in their quest to access, understand, and appropriately use existing health and health-related services. 211 Toronto has been chosen as a case study because it could be considered as the ‘ideal’ one-stop information and referral service. It is, in fact, a free of charge, confidential service available 24 hours a day, seven days a week. Without having to go through an automated answering system, users can reach by phone, directly, highly trained and experienced counsellors. 211 Toronto receives on average about 30,000 calls a month. The service can also be reached online and by email. Each month, approximately 2.5 million pages on the 211 Toronto web site are visited by both unique and repeated users, Email inquiries, however, are quite uncommon, between 20 and 30 per month (FindHelp Information Services, 2007). Given the large number of calls received each month by 211 Toronto and the intrinsic complexity of studying web usage, it was decided that phone interviews represented an efficient way to collect data in a limited amount of time. Therefore, the study focused exclusively on users who contact 211 Toronto by phone.

At the time of the study 211 Toronto employed 31 counsellors, 25 of whom were 'Certified Information and Referral Specialists' and six 'Certified Resource Specialists', all trained according to the accreditation standards set by the Alliance of Information & Referral Systems, a professional association that brings together over 1,000 community information and referral providers in Canada and the US (www.airs.org). As a group, counsellors speak approximately ten languages and can communicate with users, through interpreters, in virtually any language spoken in Toronto (FindHelp Information Services, 2007). Counsellors assess users' situations, help them find answers to questions, and provide them with options and appropriate referrals. Thanks to their training, 211 Toronto counsellors become 'knowledge brokers' and are able to help users break down complex queries into smaller components that can then be effectively addressed through a process of information needs identification and information retrieval. Considering the extremely heterogeneous linguistic and cultural background of 211 Toronto users, counsellors act, in practice, as cross-cultural knowledge brokers.

211 Toronto offers information about an extremely broad range of community, social, health, and government services operating in the city of Toronto, the Niagara Region, and Simcoe County, covering virtually any foreseeable information need recent immigrants might experience. Finally, 211 Toronto is available both by phone and on the Internet, which provides the opportunity to compare preferences regarding alternative ICT-based ways to access information. The Centre for Global eHealth Innovation and Findhelp Information Services, the coordinating agency responsible for 211 Toronto and for several other specialized services, have a long-term history of collaboration that was built particularly around the LPF experience.

This chapter has offered a high-level analysis of the broad and extremely complex issues that constitute the background for this research project. Emphasizing the nature of these issues assists in understanding the limitations of the study while situating it within a

broader context. The main investigator is aware of the intertwining economic, political, social, and cultural factors shaping this landscape and understands that none of the problems faced by recent immigrants and the health system in highly multicultural environments will be dealt with by means of simple technical solutions. Before moving on, in Chapter IV, to describe the theoretical framework that gives shape to the study, the next chapter will present the results of a review of the literature aimed at identifying the most important health issues experienced by immigrants in Canada and the barriers they face accessing health as well as information services.

E. References

Abe-Kim, J.; Takeuchi, D.T.; Hong, S.; Zane, N.; Sue, S.; Spencer, M.S. et al. (2007) 'Use of mental health-related services among immigrant and US-born Asian American: Results from the National Latino and Asian American Study .' *American Journal of Public Health*; 97; 1: 91-8.

Abraham, E. (7-3-2007) *Personal email communication*.

BBC World Service (2007) *The Noisy Planet*.
http://www.bbc.co.uk/worldservice/specials/1643_noisyplanet/page2.shtml.

Bennett, C. (2005) *Keynote Speech*. Ottawa, September 18-21 2005: Canadian Public Health Association 96th Annual Conference - Mapping the Future of Public Health: People, Places and Policies.

Booth, R.E.; Kwiatkowski, C.F.; Weissman, G. (1999) 'Health-related service utilization and HIV risk behaviors among HIV infected injection drug users and crack smokers.' *Drug and Alcohol Dependence*; 55; 1-2: 69-78.

Caldwell, B. (7-5-2007) *Personal email communication*.

Castells, M. (2000) *End of Millennium*. 2nd ed. Oxford (UK): Blackwell.

Chang, B.L.; Bakken, S.; Brown, S.S.; Houston, T.K.; Kreps, G.L.; Kukafka, R. et al. (2004) 'Bridging the digital divide: Reaching vulnerable populations.' *Journal of the American Medical Informatics Association*; 11; 6: 448-57.

Changrani, J.; Gany, F. (2005) 'Online cancer education and immigrants: Effecting culturally appropriate websites.' *Journal of Cancer Education*; 20; 3: 183-6.

Cho, K. (2004) *In the Shadow Of Gold Mountain*. Ottawa: National Film Board of Canada.

Citizenship and Immigration Canada (2001) *Pursuing Canada's Commitment to Immigration: The Immigration Plan for 2002*. Ottawa: Citizenship and Immigration Canada.

Citizenship and Immigration Canada (2007) *Skilled Worker Class Immigration Program*. <http://www.cic.gc.ca/english/skilled/index.html>.

Cortinois, A.A.; Downey, S.; Closson, T.; Jadad, A.R. (2003) 'Hospitals In a globalized world: A view from Canada.' *Healthcare Papers*; 4 ; 2: 14-32.

Cortinois, A.A.; Hohenadel, J.; Kaegi, E.; Kang, R.; Laidlaw, J.; Kovacik, G. et al. (2005) *Levelling the Playing Field For the Underserved In a Highly Multicultural Society*.

Cotten, S.R.; Gupta, S.S. (2004) 'Characteristics of online and offline health information seekers and factors that discriminate between them.' *Social Science & Medicine*; 59; 9: 1795-806.

Crosby, A. (2006) *The Boundaries Of Belonging: Reflections On Migration Policies Into the 21st Century*. Ottawa (ON): Inter Pares.

Demark-Wahnefried, W.; McClelland, J.; Campbell, M.K.; Hoben, K.; Lashley, J.; Graves, C. et al. (1998) 'Awareness of cancer-related programs and services among rural African Americans.' *Journal of the National Medical Association*; 90; 197-202.

FindHelp Information Services (2007) *About 211 Toronto*. http://www.211toronto.ca/about_211.jsp.

Foucault, M. (1973) *The Order of Things: An Archeology Of the Human Sciences*. New York: Vintage Books.

Glazier, R.H.; Creatore, M.I.; Cortinois, A.A.; Agha, M.M.; Moineddin, R. (2004) 'Neighbourhood recent immigration and hospitalization in Toronto, Canada.' *Canadian Journal of Public Health*; 95; 3: I30-I34.

Government of Canada (1995) *Employment Equity Act*. Number: c. 44, E-5.401.

Gustafson, D.H.; McTavish, F.M.; Stengle, W.; Ballard, D.; Jones, E.; Julesberg, K. et al. (2005) 'Reducing the digital divide for low-income women with breast cancer: A feasibility study of a population-based intervention.' *Journal of Health Communication*; 10; 1 (Suppl.): 173-93.

- Hoffman-Goetz, L.; Breen, N.L.; Meissner, H. (1998) 'The impact of social class on the use of cancer screening within three racial/ethnic groups in the United States.' *Ethnicity & Disease*; 8; 43-51.
- Hohenadel, J.; Kaegi, E.; Laidlaw, J.; Kovacik, G.; Cortinois, A.A.; Kang, R. et al. (2007) 'Leveling the playing field: The Personal Coach Program as an innovative approach to assess and address the supportive care needs of underserved cancer patients.' *Journal of Supportive Oncology*; 5; 4: 185-93.
- Hsu, J.; Huang, J.; Kinsman, J.; Fireman, B.; Miller, R.; Selby, J. et al. (2005) 'Use of e-Health services between 1999 and 2002: A growing digital divide.' *Journal of the American Medical Informatics Association*; 12; 2: 164-71.
- Hyman, I. (2001) *Immigration and Health*. Health Policy Working Paper Series 01-05. Ottawa: Health Canada.
- Jackson, A. (2001) 'Poverty and Racism.' *Perception*; 24; 4: 1-4. Ottawa (ON): Canadian Council on Social Development.
- Jadad, A.R.; Kaegi, E.; Laidlaw, J. (2002) *Levelling the Playing Field: The Personal Coach Program - Phase I Project Report*. Toronto: Ministry of Health and Long Term Care.
- Lorence, D.P.; Park, H. (2007) 'Study of education disparities and health information seeking behavior.' *Cyberpsychology and Behavior*; 10; 1: 149-51.
- Lorence, D.P.; Park, H.; Fox, S. (2006) 'Racial disparities in health information access: Resilience of the Digital Divide.' *Journal of Medical Systems*; 30; 4: 241-9.
- McKee, M.; Healy, J. (2002) Future Hospitals. In: McKee, M.; Healy, J. (Eds.) *Hospitals In a Changing Europe*. Pp. 281-284. Philadelphia (PA): Open University Press.
- McMaster University's Supportive Cancer Care Research Unit (2007) *Supportive Cancer Care*. <http://www-fhs.mcmaster.ca/slru/sccru/>.
- Miller, E.A.; West, D.M. (2007) 'Characteristics associated with use of public and private web sites as sources of health care information: Results from a national survey.' *Medical Care*; 45; 3: 245-51.
- Miller, K.S.; Bunch-Harrison, S.; Brumbaugh, B.; Kutty, R.S.; FitzGerald, K. (2005) 'The meaning of computers to a group of men who are homeless.' *American Journal of Occupational Therapy*; 59; 2: 191-7.

Montazeri, A.; Haghghat, S.; Vahdani, M.; Jarvandi, S.; Harirchi, I. (1999) 'Evaluation of a national breast cancer information service: The Iranian experience.' *Supportive Care in Cancer*; 7; 154-7.

National Cancer Institute - Center to Reduce Cancer Health Disparities (2007) *Patient Navigation Program* . <http://crchd.cancer.gov/pnp/pnrp-index.html>.

Oxfam (2002) *Rigged Rules and Double Standards: Trade, Globalisation, and the Fight Against Poverty*. Make Trade Fair Campaign. Oxford (UK): Oxfam.

Pickard, M. (2005) *In the Crossfire: Mesoamerican Migrants' Journey North.*: International Relations Center - Americas Program.

Picot, G.; Hou, F.; Coulombe, S. (2007) *Chronic Low Income and Low-Income Dynamics Among Recent Immigrants*. Research Paper: Analytical Studies Branch Research Paper Series. Statistics Canada, Business and Labour Market Analysis.

Ralston Saul, J. (2004) 'The end of globalism and the rebirth of nationalism.' *Hastings Center Report*; 34; 1: 34-41.

Reitz, J.G.; Banerjee, R. (2007) Racial Inequality, Social Cohesion, and Policy Issues in Canada. In: Banting, K.; Courchene, T.J.; Seidle, F.L. (Eds.) *Belonging? Diversity, Recognition and Shared Citizenship in Canada*. Pp. 489-545. Montreal (QC): Institute for Research on Public Policy.

Renahy, E.; Chauvin, P. (2006) 'Internet uses for health information seeking: A literature review.' *Revue D'Épidémiologie Et De Santé Publique*; 54; 3: 263-75.

Sandercock, L. (2005) *Migrations: Conflicts and Multiculturalism - Or, The Satanic Verses As Urban Manifesto*.

Schrecker, T.; Labonte, R. (2004) 'Taming the brain drain: A challenge for public health systems in Southern Africa.' *International Journal of Occupational and Environmental Health*; 10; 4: 409-15.

Skinner, H.; Biscope, S.; Poland, B. (2003) 'Quality of internet access: Barriers behind internet use statistics.' *Social Science & Medicine*; 57; 5: 875-80.

Statistics Canada (2003) *Canada's Ethno-Cultural Portrait: The Changing Mosaic*. 2001 Census: Analysis Series. Ottawa: Ministry of Industry.

Statistics, C. (2007) *2001 Census - Dictionary*.
<http://www12.statcan.ca/english/census01/Products/Reference/dict/pop040.htm>.

Tallarico, C.M.; Powderley, K. (2007) *Visible Minorities in the Workplace: Foreign Educational Credentials Not Seen as On Par With Canadian Equivalents*. Toronto (ON): Catalyst and The Diversity Institute in Management & Technology, Ryerson University.

Teelucksingh, C.; Galabuzi, G.E. (2005) *Working Precariously: The Impact of Race and Immigrant Status on Employment Opportunities and Outcomes in Canada*. Toronto (ON): Canadian Race Relations Foundation.

Underwood, S.M.; Hoskins, D.; Cummins, T.; Morris, K.; Williams, A. (1994) 'Obstacles to cancer care: Focus on the economically disadvantaged.' *Oncology Nursing Forum*; 21; 47-52.

University Health Network (2001) *Strategic Directions 2011: Exemplary Patient Care and Global Impact*. Toronto: University Health Network.

University Health Network (2007) *UHN Fast Facts 2005-2006*.
<http://www.uhn.ca/Media/facts/index.asp>.

Weller, W.E.; Minkovitz, C.S.; Anderson, G.F. (2003) 'Utilization of medical and health-related services among school-age children and adolescents with special health care needs (1994 National Health Interview Survey on Disability [NHIS-D] Baseline Data) .' *Pediatrics*; 112; 3 (Part 1): 593-603.

Willis, J.M.; Macri, J.M.; Simo, J.; Anstrom, K.J.; Lobach, D.F. (2006) 'Perceptions about use of a patient Internet portal among Medicaid beneficiaries.' *American Medical Informatics Association - Annual Symposium Proceedings*; 1145.

Chapter III – Review Of the Literature

This chapter includes the results of a two-part review of the literature. The first part focuses on immigration and health in Canada (Section A) and analyzes with particular attention the issue of immigrants' access to health services. The second part (Section B) deals with immigrants' access to information sources. The review includes publications, in English, identified by searching the following databases: Ovid Medline (1950-June 2008); Embase (1980-June 2008); HealthStar (1966-June2008); CINAHL (1982-June 2008); Scopus (uncertain-June 2008); Web of Science – Science Citation Index and Social Science Citation Index (1945-June 2008); and PsycINFO (1985-June 2008). The terms used to search the literature are included in Appendix 2.

A. Immigrants and Health in Canada

The literature on immigration and health is rich and complex. It is not easy to summarize it within the space limits imposed by a thesis chapter. For this reason, the review includes almost exclusively Canadian work published over the past 10 years and focuses on issues that are central to the debate on immigration and health in this country. In other words, it is not a comprehensive, systematic review of the literature on the subject. As the problem of access and use of health services is at the heart of this research project, the review does also lend particular attention to the literature on this topic.

From a policy and service provision perspective, one of the fundamental questions related to immigration and health is how immigrants fare in comparison to the health of the Canadian-born population (Ali et al., 2004).

Until the 1960s, after epidemics of measles, smallpox, cholera and syphilis had been brought to North America by centuries of European immigration, the so called 'sick immigrant' paradigm dominated the scientific literature on immigration and health in Canada. According to this view, the least healthy and fit individuals were those who chose

to emigrate and newcomers constituted a menace for native-born populations (Beiser, 2005).

In the 1960s, however, the common perception of the immigration phenomenon started to shift as a result of changes in societal attitudes and immigration policies. Canada began to accept immigrants from regions of the world other than Europe and introduced new selection criteria that focussed on individual characteristics such as language knowledge, level of education, and professional skills. At the same time, medical screening before entry became more comprehensive. As a result, the 'sick immigrant' paradigm was progressively replaced by a new one, virtually its opposite, known as the 'healthy immigrant effect.' This new paradigm is still perhaps the most commonly used one to summarize the health-related aspects of the immigration experience in Canada. The 'healthy immigrant effect' suggests that newcomers are, on average, healthier than Canadian-born residents and long-term immigrants (Beiser, 2005). Newcomers' superior health status would be the result of the combined effect of two different processes: self-selection; and the selection carried out by receiving countries (Hyman, 2001). Self-selection results in the relocation of people who are on average more able and motivated to move, and in better health. On the other hand, selection processes at the receiving country also result in the acceptance of applicants who, scoring high in terms of several factors that represent important socio-economic determinants of health, such as formal education, language abilities and job skills, are also, on average, in better health.

Newcomers' health advantage, however, does not last indefinitely. The longer immigrants live in Canada the more their health status becomes similar to the health status of the native-born population. This change is explained as the result of two mechanisms: convergence and resettlement stress (Beiser, 2005). The convergence model suggests that the health status of newcomers declines due to their ongoing exposure to the environment typical of the country of resettlement, until it equals that of the native-born population. Part of the shift is the result of both passive mechanisms, such as being exposed to the same

toxins, pollutants, and stressors, and more active ones, including adopting the bad habits of the receiving society and/or abandoning protective health behaviours (Beiser, 2005). Immigrants' declining health may also be due to stresses inherent in the resettlement process.

Several studies have produced results that seem to confirm the existence of the initial health advantage. Most of them are based on a few large databases developed and maintained mainly by Statistics Canada. These databases are large enough to offer the opportunity to produce meaningful comparisons and generalizations. In fact, even if the number of immigrants living in Canada is dramatically increasing, newcomers still represent a relatively small proportion of the general population. Among the most commonly used databases are: the National Population Health Survey (NPHS), a survey which includes approximately 20,000 respondents 12 years old and older, representing the whole Canadian population with the exception of the Territories, and has both cross-sectional and longitudinal components (<http://www.statcan.ca/english/concepts/nphs/>); the Canadian Community Health Survey (CCHS), a cross-sectional study including over 130,000 respondents in 133 health regions across Canada and focusing on health determinants, health status, and health system utilization (<http://www.statcan.ca/english/concepts/health/>); and the National Longitudinal Survey of Children and Youth (NLSCY), a long-term study of Canadian children that follows their development from birth to early adulthood (<http://www.statcan.ca/cgi-bin/imdb/p2SV.pl?Function=getSurvey&SDDS=4450&lang=en&db=imdb&dbg=f&adm=8&dis=2>) (Ali et al., 2004). Other important sources of data for Canadian studies are the Census (<http://www12.statcan.ca/english/census/index.cfm>) and the provincial databases of vital statistics.

In two studies published in 1996, Chen and colleagues used several different sources of data, including census data, vital statistics data, and data from the NPHS, to compare various measures of self-reported health status and health-related behaviour in immigrants and in the native-born population and to explore a possible link between time spent in

Canada and health outcomes. The authors concluded that immigrants had more disability-free years and longer life expectancies than Canadian-born respondents. However, differences were significant mainly in the case of recently arrived subjects from non-European countries. Also, they found that immigrants who had spent 10 years or more in Canada had a higher prevalence of chronic conditions and disabilities, and were more often smokers, than recent immigrants (Chen et al., 1996a; Chen et al., 1996b).

The Health Utilities Index (HUI), a complex indicator of health status and functionality, was used by Kopec and colleagues in a study published in 2001 to measure differences among several groups of respondents living in Canada, defined by language and place of birth. Making use of NPHS data, the authors calculated the age-standardized prevalence of dysfunction and concluded that immigrants speaking only English from North America, Europe, and Australia had better HUI scores than English-speaking Canadians. However, immigrants speaking other languages were less healthy than English-speaking Canadian-born respondents (Kopec et al., 2001).

In 2002, Perez analyzed the results of the 2000/2001 CCHS to examine differences in prevalence of chronic conditions between newcomers and the native-born population. When comparing age-, education-, and income-adjusted odds ratios for chronic conditions in general, by sex and years since immigration, he found that immigrants, particularly newcomers, did report significantly less conditions than Canadian-born respondents. Interestingly, however, the results were not consistent when analyzing various conditions individually, including heart disease, cancer, high blood pressure, and diabetes. For example, heart disease in men and cancer in women were associated with length of residence. However, this was not true for heart disease in women and cancer in men. (Perez, 2002).

Newbold and Danforth, in 2003, analyzed data from the NPHS Cycle 3 (1998/1999) and compared the health status of the immigrant and Canadian-born populations using

indicators such as self-assessed health, the HUI, and diagnosed conditions, including heart disease, asthma, diabetes, high blood pressure, and arthritis. The authors found that immigrants as a whole were more likely to report poor health status and less likely to report better states of health. However, immigrants who had spent less than five years in Canada would rank their level of health higher than native-born individuals. This difference steadily diminished over time. Data on diagnosed conditions showed a similar situation as immigrants, in general, were burdened with higher rates of chronic conditions, including arthritis, high blood pressure, and diabetes. Prevalence rates for all chronic conditions rose over time and, after about 10 years, became greater than those observed in the general population. (Newbold et al., 2003).

Ali and colleagues, in 2004, reviewed a significant number of studies based on Statistics Canada databases to summarize evidence supporting or denying the 'healthy immigrant effect.' They reported key findings organized in four main categories (physical health, mental health, health behaviours, and health care utilization) and concluded that most studies had produced evidence supporting the effect (Ali et al., 2004).

In 2004, DesMeules and colleagues analyzed the preliminary results of a Canada-wide initiative aimed at linking health and immigration databases. Their analysis focussed on mortality data and health services utilization. The study showed that recent immigrants had low mortality compared to the general Canadian population. This was true for all-cause mortality as well as mortality from the leading causes of death, including cardiovascular diseases, all-site cancer, most specific cancer sites, accidents, poisoning and violence, respiratory diseases, and diabetes. Significant differences in indirect standardized mortality rates were found between refugees and non-refugees, with the former showing higher mortality, and among immigrant groups from different regions of the world. The authors suggested that the results support the 'healthy immigrant effect' hypothesis (DesMeules et al., 2004).

In the same year, Gee and colleagues published the results of a study that adopted a population health perspective, analyzing socio-economic determinants of health and indicators of health status and health system utilization, to examine the relationship between length of residence in Canada and health status in mid- to later-life individuals. Using data from the 2000-2001 CCHS, the authors' analysis showed that recent immigrants, in both the 45-to-64 and 65-and-over age groups, were younger on average and more likely to be male, married, and post-secondary graduates than those in the Canadian-born population. It also showed strong support for the 'healthy immigrant effect' in the former group, with an initial advantage in terms of functional health among new immigrants that was gradually lost over time. Yet, data did not justify the initial advantage in terms of socio-economic determinants of health or lifestyle factors and, in the authors' opinion, more research is needed to better understand the phenomenon. Also, among older individuals, the 'healthy immigrant effect' did not show as, on the contrary, recent older immigrants had significantly poorer health compared to Canadian-born counterparts. However, when data were adjusted for socio-economic determinants of health and lifestyle differences, the immigrant and non-immigrant groups became more similar. (Gee et al., 2004).

McDonald and Kennedy, in 2004, published the results of a study that extracted data from multiple databases, including the NPHS and the CCHS, to test the 'healthy immigrant effect' hypothesis. The authors used two measures of health status: the incidence of chronic medical conditions as diagnosed by a health care professional; and self-assessed health status. They found clear evidence of a 'healthy immigrant effect' for diagnosed chronic conditions, in both men and women. However, they did not observe the same changes in the case of self-assessed health status, which remained relative constant over time. They also observed that convergence to the levels shown by the Canadian-born population was quite slow, in the case of some chronic conditions taking up to 20 years. They also confirmed the importance of the geographic area of origin as a determinant of

health in the immigrant population but notice that neither controlling for the year of arrival nor for geographic origin would substantially change the results (McDonald et al., 2004).

Beiser, in his excellent review published in 2005, identified several conceptual and methodological limitations that appear in many of the studies supporting the ‘healthy immigrant effect’ paradigm and analyzes contradictory results and epidemiological paradoxes that neither the ‘sick immigrant’ nor to the ‘healthy immigrant’ paradigms can fully explain (Beiser, 2005). His first observation was that most studies supporting the concept are not based on longitudinal follow-up of newly arrived immigrants, an approach that would permit to measure actual changes in health status over time, but instead make use of data from different cohorts of immigrants. Therefore, they compare the health of today’s recent immigrants with that of immigrants who came earlier. Differences between these two groups, such as, for example, country of origin, can be very significant. Also, he noticed that while the ‘healthy immigrant effect’ seems to apply to chronic conditions in general, when they are collectively considered, the analysis of specific conditions does not show significant differences between newcomers and the Canadian-born population (Perez, 2002). In addition, he observed that many authors tend to forget that the term ‘immigrant’ does not describe a homogeneous category but, instead, individuals with very different origins and histories who often display, in fact, quite different health profiles. For example, both Chen and colleagues and Newbold & Danforth found differences between the health status of immigrants from the Americas and Europe, on the one hand, and immigrants from Asia and Africa on the other, with the latter showing significantly better health (Chen et al., 1996b; Newbold et al., 2003). He also noticed that several studies make use of fairly small samples that considerably limit the possibility to compare subgroups of immigrants such as, for example, newcomers of different age, sex, immigration class, or coming to Canada from different regions of the world. Finally, he affirmed that the ‘healthy immigrant effect’ does not help to explain why, for certain conditions, such as obesity, diabetes and mental problems, studies have shown that long-term immigrants’ rates do not equal those of the receiving society but get worse, a phenomenon known as ‘immigrant

overshoot.’ Beiser concluded suggesting that an important research effort was still needed to understand the real impact of the ‘healthy immigrant effect’ on each category of immigrant and on each specific disease.

In recent years, as reported below, other authors have expressed similar ideas and have emphasized the importance of accounting for the complexity of the immigration experience. In particular, they have stressed the need to explore more in depth the role played by the broader socio-economic determinants of health in determining changes over time in immigrants’ health status, as convergence and resettlement stress might not tell the whole story.

For example, in a 1998 paper, Fowler reviewed experiences involving the provision of primary health care services to newcomers in the Hamilton area and identified a long list of factors that were particularly important in influencing the health status of immigrants and refugees. The list included, among others: demographic and socio-cultural characteristics; language; social isolation; lack of knowledge of existing resources and services; cross-cultural differences in information-seeking patterns; conflicting communication styles between users and providers; and different interpretations of what constitutes a health risk and of the meaning of the word ‘prevention’ (Fowler, 1998).

In 2000, Dunn and Dyck authored a paper, based on NPHS data, analyzing the impact of the social determinants of health on the health status of the immigrant population in Canada. Taking a population health perspective, the authors structured the study around three sets of comparisons: immigrants vs. non immigrants; immigrants from Europe vs. immigrants from other areas of the world; and recent immigrants (who had spent less than 10 years in Canada) vs. long-term immigrants. The authors did not find any significant pattern of association between socio-economic characteristics and immigration characteristics, on the one hand, and health status on the other. However, their statistical analysis suggested that socio-economic factors played a much more important role in the

case of immigrants than in that of native-born people. The authors interpreted the complexity of such relationships, which could not be explained in simple terms, as a reflection of the complexity of the immigration experience (Dunn et al., 2000).

A 2005 paper authored by Newbold offers mixed support for the ‘healthy immigrant effect.’ On the one hand, the author did not find any significant difference in terms of self-assessed health status between immigrants and native-born individual. On the other hand, however, a survival analysis he conducted showed that the Canadian-born were at a lower risk of transitioning to poor health than immigrants, over the study period. Also, the hazard function between the two groups was diverging over time, that is, the risk of transitioning to poor health increased over time, for immigrants, at a higher rate than for non-immigrants. Newbold did also analyze differences in health across different arrival cohorts and noticed that recent cohorts experienced an early and more dramatic decline in self-reported health status than earlier cohorts. He concluded that, as the decline in self-assessed health occurs over a very short period, it cannot be the result of convergence, as traditionally defined, but must be related to changes in *perceived* health. In turn, perception can be influenced by the challenges and barriers that are typical of the acculturation process and by the ‘deskilling’ of newcomers who cannot find jobs appropriate to their educational levels and professional experiences (Newbold, 2005).

In his 2005 paper, Beiser called for the development of a new, ‘interaction’ paradigm that would fully allow for the complexity of the immigration experience. Such model would take into account a much larger number of factors than those traditionally related to the ‘healthy immigrant effect’ paradigm. The central concept would be that resettlement should not be considered in itself the cause for deteriorating health. Instead, the negative and positive circumstances of resettlement are the factors that should be considered, including: the vast heterogeneity of immigrants’ characteristics in terms of country of origin, sex, age, entry class, previous exposure to illness, prior experience with the Western system of care, level of acculturation, and previous health habits; pre-migration

stressors, such as traumatic events, particularly in the case of refugees; post-migration stressors, such as acculturation and cultural retention, social exclusion, discrimination, unemployment, poverty; and coping strategies/protective mechanisms developed by individuals, families, and communities at large (Beiser, 2005).

Most studies supporting the 'healthy immigrant effect' have focused on chronic illnesses and disability including cancer, cardiovascular disorders, type 2 diabetes, hypertension, and others (Ali et al., 2004; Balzi et al., 1995; Beiser et al., 1997; Cairney et al., 1999; Chen et al., 1996a; Chen et al., 1996b; DesMeules et al., 2004; Gee et al., 2004; Kopec et al., 2001; McDonald et al., 2004; Newbold et al., 2003; Perez, 2002; Sheth et al., 1999). The situation, however, is different for infectious and parasitic diseases, which can be more prevalent among newcomers than long-term immigrants or non-immigrants (DesMeules et al., 2004; Hyman, 2001; Kinnon, 1999). DesMeules and colleagues, for example, found that while overall rates of infectious and parasitic diseases were similar among newcomers and non-immigrants, specific immigrant subgroups presented higher rates. Rates of transmissible diseases in newcomers tend to lower the longer they live in Canada.

Pottie and colleagues conducted a study at an immigrant-friendly family medicine facility located in Ottawa including a total of 112 refugees, mainly from Sub-Saharan African countries, who had recently arrived. Prevalence rates for several transmissible conditions, including tuberculosis (TB), HIV/AIDS, chronic hepatitis B and intestinal parasites, were significantly higher among refugees than in the general Canadian population. Latent TB, in particular, was the most common condition and was identified in approximately 50% of all study participants (Pottie et al., 2007).

Several studies have shown that prevalence rates of TB among immigrants are much higher than among non-immigrants (Dasgupta et al., 2005; Wilkins, 1994). Among various hypotheses suggested to explain high prevalence rates, the most commonly accepted is that

immigrants from countries where the disease is endemic may have inactive TB and go through a process of re-activation (Wilkins, 1994).

Mental health problems, particularly among refugees, have been also extensively studied as resettlement is considered a potentially important stressor whose effect might be felt by immigrants both immediately after relocation and over time. However, in a 2002 study by Ali, immigrants showed to have less mental health problems than the Canadian-born population, as measured by age-, sex-, marital-status-, income-, and education-adjusted odds ratios. Similarly to what has been shown for chronic conditions, recent immigrants showed the lowest rates while long-established ones had rates that were comparable to those of the general population. Differences remained even after controlling for knowledge of either Canadian official languages, employment status, and feeling of belonging to the local community. In addition, it was shown that regions of origin made a difference as immigrants from North America and Europe showed rates of mental health problems and alcohol dependence similar to those of the Canadian general population while Asian immigrants had the lowest prevalence of mental health problems and those from Africa the lowest for alcohol dependence (Ali, 2002).

In 2002, Beiser and Hou published one of the few available studies that focus specifically on immigrant children in Canada. Analyzing data from the NLSCY, they observed that while immigrant children between the age of 4 and 11 were more likely to be living in poverty, they enjoyed better mental health status than Canadian-born children, with lower rates of externalizing and internalizing behaviours. The explanation suggested by the authors is that poverty is experienced in very different ways in Canadian families as compared to immigrant families. While in Canadian families poverty is often associated with broken homes and family violence, this is not the case in immigrant families where children can find more often, on average, a strong, supportive environment (Beiser et al., 2002). This is a very significant example of the complexity of the immigration experience and shows how nuanced the analysis of such phenomenon should be, reaching well beyond

the appealing but perhaps excessive simplicity of models such as the ‘healthy immigrant effect.’

A rich international literature exists focussing on immigrants’ access to and use of health services. In Canada, studies conducted in the 1990s and at the dawn of the new century have shown both similar or lower services utilization rates among recent immigrants, when compared with rates in the general population, depending on a number of factors, including the type of services studied, participants’ demographic characteristics, immigration categories, countries of origin, and socio-economic status (Ali, 2002; Chen et al., 1996b; Chen et al., 2002; Dunn et al., 2000; Hyman et al., 2000; Hyman, 2001; Kinnon, 1999; Laroche, 2000; Perez, 2002; Roberts, 1997; Wen et al., 1996). In general, those studies have failed to clarify whether limited use was due to reduced levels of need or to societal and cultural barriers. More recently, the body of literature focusing on access to health services has significantly expanded and, over the past five years, the realization that relatively little was known about the specific access problems of the immigrant population has encouraged researchers to focus their attention on this group.

DesMeules and colleagues, in their 2004 paper analyzing the preliminary results obtained from linking Canadian immigration and health administrative databases, noticed that age-adjusted physician visits rates in British Columbia were lower for immigrants, as a group, than for the non-immigrant population. However, this was not true for all subgroups of immigrants, as refugees and newcomers from North Africa had rates similar to those of the general population. They also observed, in Ontario, a spike in physician visits three months after newcomers’ arrival. This dramatic increase was observed at the end of the waiting period that British Columbia, New Brunswick, Ontario and Quebec impose on newly arrived immigrants before they can register for the public health insurance plan. For the first three months in Canada, newcomers who resettle in those provinces either have to purchase private insurance or pay out of their own pockets for health care. The spike suggested that an economic access barrier existed for recent immigrants early after their

arrival (DesMeules et al., 2004). More recent research has confirmed this result (Asanin et al., 2008).

A study published in 2004 by Glazier and colleagues focused on recent immigrants who resettled in low-income inner city areas. The study used hospitalization data, as a means to measure health objectively, to explore the contextual effect of immigration at the neighbourhood level, that is, the effect that high rates of recent immigration would have on individual health and health behaviours. Glazier and colleagues found that neighbourhoods with the highest proportion of recent immigration were also the poorest. In addition, no matter in which neighbourhood recent immigrants were living, they were significantly poorer than non-immigrants living in the same neighbourhood. All of the categories of hospitalization by neighbourhood, with the exception of surgical hospitalization, showed significantly higher rates of admission as the proportion of recent immigrants increased. In particular, ambulatory care-sensitive (ACS) conditions, those for which timely ambulatory care may prevent the need for hospital admission, showed the highest relative rates of hospital admission. Interpreting these results was difficult because the effect of poverty and recent immigration were strictly entangled and, being this an area-level study, it was impossible to say who was hospitalized, whether recent immigrants or non-recent immigrants. In the former case, these results would contradict the 'healthy immigrant effect' and suggest that increased morbidity and barriers to accessing primary health care services were contributing factors (Glazier et al., 2004a).

A study conducted in Montreal by Leduc and Proulx, followed 20 families over a period of several years to understand how they used health services and changes in primary health care utilization patterns over time. The authors identified three separate phases in the experience of the participating families. During the first phase, they would contact services when they needed to address a specific needs. Services were identified through a variety of information sources and often selected in an unsystematic way. Continuity of care was minimal. During the second phase participants started to form opinions based on their

previous experiences, and developed preference. The last phase saw the families consolidate their choices and develop an ongoing relationship with selected sources of care. Participants' evaluation of the quality of health care was based on three basic elements: distance from home and time needed to reach the service; interpersonal skills of health providers and perceived technical skills; and language spoken by health care providers and their staff. Socio-cultural preferences and previous experiences in their countries of origin clearly influenced their judgement and preferences (Leduc et al., 2004).

McDonald and Kennedy, in their 2004 paper, discussed the hypothesis that the apparent decline over time in immigrant health could be due to chronic conditions going more often undiagnosed, among recent immigrants, due to social, cultural and linguistic barriers that would make access to services particularly challenging for this group. Over time, barriers would ease and existing chronic conditions would be eventually diagnosed. To test such hypothesis the authors measured differences between recent immigrants and the Canadian-born population with respect to three indicators that should represent good measures of access to basic health services: having a family doctor; having consulted with a doctor in the previous 12 months; and having had the blood pressure tested in the previous 12 months. For the first two indicators, recent immigrants showed lower rates at arrival that converged to native-born levels over a period of 6-8 years. For blood pressure testing, immigrant women had lower rates that would converge to Canadian general population's rates in 6-9 years while there was no significant difference between immigrant and native-born men. The authors concluded that immigrants' use of basic components of the health care system approaches native-born levels much faster than health outcomes converge. Access to health services, therefore, should not be considered as a potential explanation for the convergence phenomenon. However, they caution, there could still be differences in diagnosis and treatment that would result in worse health outcomes for immigrants (McDonald et al., 2004).

In 2005, Deri published a paper discussing the effects of social networks on access and use of health services. Comparing data from three cycles of the Canadian NPHS across groups of immigrants speaking different languages and coming from different areas of the world, the author found strong evidence that social networks affected utilization in many ways, such as providing information on services and the health care system as a whole and reducing the effort needed to locate an appropriate provider. One of the interesting results of this study was that utilization of health services by immigrants is directly correlated with the number of doctors practicing in the neighbourhood who speak the same language as newcomers (Deri, 2005).

In two 2007 papers, Lai and Chau published the results of a survey conducted in seven Canadian cities to study the effects of service barriers on the health status of elderly Chinese immigrants. They interviewed a random sample of more than 2,200 respondents 55 years of age or older. Their findings confirmed that a number of different barriers were significant predictors of both physical and mental health, after controlling for demographic factors. Among the most important barriers identified were: personal health beliefs and attitude towards western medicine; language; administrative problems; and services' geographic accessibility. Also, problems in communication contributed to the participants' perception that services and providers were not culturally sensitive (Lai et al., 2007a; Lai et al., 2007b).

In 2008, Asanin & Wilson published a paper reporting the results of a qualitative study conducted in a Mississauga (Ontario, Canada) neighbourhood where immigrants represent more than half of the entire population and where 51% of residents speak a non-official language. The study explored access to health care among a diverse group of immigrants to understand the most important barriers to health care as perceived by immigrants themselves. Eight focus groups were organized with participants showing a very broad range of ethnic, cultural and demographic characteristics. Study participants identified three broad categories of barriers that concerned them the most. The first one was

geographic accessibility, referring to the physical location of health care services and a person's ability to receive care in that location. Several participants complained for the lack of family physicians accepting new patients, in their neighbourhood. Patients relying on walk-in clinics or hospital emergency rooms for primary care were shocked by the long wait time. Accessing services in other neighbourhoods appeared very challenging, particularly for those respondents who had to rely on public transportation, because they did not know the city, nor the public transit system, and in many cases did not speak English. The second category was socio-cultural accessibility, including a wide range of concerns, from language to inappropriate medical treatment. Language represented a significant barrier. The lack of female providers was a second one. In addition, many respondents perceived the approach used by family physicians as rushed, impersonal, incomprehensive and lacking depth. Also, profound differences in conception of health and healing between immigrants and Canadian providers were emphasized and many participants thought that foreign-trained physicians would be an ideal solution. The third category of barriers included those related to economic accessibility. Immigrants complained about the three month waiting period before being covered by the provincial health plan. The cost of prescription medications represented another barrier and several participants said they would not go to see a doctor because they could not afford drugs (Asanin et al., 2008).

A large number of studies that focus on specific diseases and conditions, immigrant groups, types of health care services, and particular barriers have also been recently published. For example, several authors have explored the issue of immigrants' access to mental health services in Canada. While various circumstances related to the migration experience are considered by study participants major stress-inducing factors, and individual coping strategies seem to be insufficient, virtually all immigrant groups observed significantly underutilize mainstream mental health services. The two major barriers seem to be language and a different cultural interpretation of what constitutes mental health, but other cultural, social, geographic, and economic variables might also

contribute to underuse (Ahmad et al., 2004b; Chen et al., 2005; Kirmayer et al., 2007; Li et al., 2000; Schaffer et al., 2006; Whitley et al., 2006). Recent literature also includes a large number of publications focusing on immigrants' access to services, quality of care received, and health outcomes with respect to several other categories of health care services including screening and prevention services, health promotion, surveillance, mother and child care, dental services, and home care, among others (Ahmad et al., 2004a; Chan-Yip, 2004; Guttman et al., 2008; Hyman et al., 2002a; Hyman et al., 2002b; Lai, 2004; Lai et al., 2007c; Newbold et al., 2006; Pottie et al., 2007; Richards et al., 2005; Rush et al., 2007).

For various reasons, women represent a particularly interesting subgroup within the immigrant population. In the case of immigrant women, in fact, the factors most commonly influencing immigrants' access and use of health services are modified and compounded by additional determinants of access that are unique to women. A rich literature focuses on immigrant women's health and access to care.

One of the central research questions related to immigrant women's health is how to best influence their health behaviour through successful health promotion initiatives. New immigrant women represent a very diverse group facing multiple cultural, economic, linguistic, informational, and systemic barriers to adopting and maintaining healthy behaviours. Both their pre-migration habits and post-migration social context must be taken into consideration to achieve significant results (Hyman et al., 2002a; Hyman et al., 2002b). Studies focusing on specific ethno-cultural groups, such as women from Southern Asia or China, have shown that many commonly used health promotion strategies are not particularly effective with these groups because they find difficult to access and comprehend typical messages and are not used to receive formal institutional health information. More effective might be two-way dialogue models of informal health promotion (Ahmad et al., 2004a). On the other hand, there is evidence that well thought written socio-culturally tailored and language-specific interventions can achieve

satisfactory results, as shown by an experience aimed at promoting cancer screening among South Asian immigrant women (Ahmad et al., 2005).

Another area showing clear evidence of barriers for women is cancer screening and prevention. In Canada, while the proportion of immigrant and minority women who consult a family physician is similar to that of Canadian-born women, women belonging to these groups are less likely to be screened for breast and cervical cancer. In turn, breast cancer and cervical cancer are major contributors to morbidity and mortality among various immigrant groups, including for example Chinese and Vietnamese women (Brotto et al., 2008; Donnelly, 2008; Hislop et al., 2004; Hyman et al., 2001). Several studies have shown that the use of Pap smears, mammography, and clinical breast examination is lower among immigrant women, particularly recent immigrant women and those belonging to visible minorities, with low official language proficiency, low income, and low levels of formal education (Ahmad et al., 2004c; Donnelly, 2008; Glazier et al., 2004b; Hislop et al., 2004; Hyman et al., 2001; Lofters et al., 2007). Among the reasons for lower participation in screening activities are: lack of knowledge about the specific diseases and the importance of screening and prevention; misperception of low susceptibility to cancer among certain ethno-cultural groups; language barriers; and difficulties in the health care provider-patient relationship, particularly in the case of male providers (Ahmad et al., 2005; Donnelly, 2008; Hislop et al., 2004; Lofters et al., 2007; Oelke et al., 2007).

Finally, immigrant women may find particularly difficult to access mental health services. Given the common difficulties they experience in the relationship with providers, health care encounters fail to become for them opportunities to seek help and discuss mental health concerns (Ahmad et al., 2004b). In addition, the barriers described in the previous paragraphs as restricting access to health services in general, such as insufficient language skills, unfamiliarity with services, and cultural differences, also affect access to mental health services (O'Mahony et al., 2007a; O'Mahony et al., 2007b; Teng et al., 2007).

B. Information Sources for Immigrants

In the health field, the concepts ‘information’, ‘information sources’, and ‘barriers reducing access to information sources’ can be defined in very different ways, depending on the level of analysis. For example, information can be analyzed at a ‘macro’ level, in the context of international health and development, and the relationships between high and low & middle income countries, observing that results from scientific research in the ‘North’ are often not available to support evidence-based practices in the ‘South.’ Then, lack of access to scientific publications becomes one of the major barriers and the contribution of Information and Communication Technologies (ICTs) is seen in terms of development of virtual libraries and networks of knowledge repositories that would democratize information and promote global equity in health (Pellegrini Filho, 2002). At a ‘meso’ level, ‘information’ can be interpreted as the data needed for policy formulation, monitoring and evaluation or for health services management. At that level, examples of barriers can be: a lack of core data; underdeveloped health statistics systems; absence of population-based health information; limited coordination among data providers; lack of appropriate data dissemination tools, such as investigative reports and atlases; and limited analytical expertise. This research project, however, focuses on what could be considered a ‘micro’ level: health information available (or not) to individuals to understand their preventive, curative or rehabilitative needs, select and access services, and participate in shared clinical decision-making. More specifically, it focuses on information *on* health and health-related services, that is, information useful to increase potential users’ awareness of existing services, understanding of how such services work, sufficient appreciation of the structure and operations of the local health care system, and skills needed to navigate and negotiate it.

In the literature, very rarely a clear distinction is made between health information, usually conceptualized as information related to a condition or disease and preventive or curative interventions, and information on health services. Some exceptions exist, however. For example, Caidi and Allard suggest that the process of social exclusion of recent

immigrants may be interpreted as an information problem: when information needs related to resettlement, housing, employment opportunities, health services, or education are not met, then navigation through the system and consequent social inclusion become very difficult (Caidi et al., 2005). Sadavoy and colleagues, reporting the results of a Toronto-based study, write that one of the key barriers limiting access to mental health services for 'ethnic seniors' was the limited understanding they and their caregivers had of the health care system, and their limited capacity to negotiate it, because of systemic barriers and lack of information (Sadavoy et al., 2004). Sheikh-Mohammed and colleagues, studying the barriers that limit access to health care for refugees from Sub-Saharan Africa who had resettled in Sydney, Australia, found that, among others, language, lack of health information, not knowing where to seek help, and poor understanding of how to access services were fundamental (Sheikh-Mohammed et al., 2006). Several other authors indicated lack of awareness and understanding of existing services and lack of navigation and negotiation skills as barriers to health services utilization (Asanin et al., 2008; Demark-Wahnefried et al., 1998; Deri, 2005; Miller et al., 2004; O'Mahony et al., 2007a; O'Mahony et al., 2007b; Reynolds, 2004; Wu et al., 2005).

When offering information to newcomers, the fundamental challenge is represented by their language and cultural heterogeneity (Allen et al., 2004; Aspinall, 2007; Caidi et al., 2005; Changrani et al., 2005; Courtright, 2005; Finney Rutten et al., 2006; Helft et al., 2005; Kakai et al., 2003; Kralj et al., 2004; Lorence et al., 2006; Marks et al., 2004; Monnier et al., 2002; Morahan-Martin, 2004; Thorne, 2003). Barriers are not just linguistic but relate to other aspects of culture. Several studies, in fact, have shown the effect of culture on information seeking. For example, Finney Rutten and colleagues, analyzing questions asked on the phone at the US National Cancer Institute's 'Cancer Information Service', realized that patients, their families and friends would ask different types of questions depending on their ethno-cultural background and socio-demographic characteristics (Finney Rutten et al., 2006). Also, as several studies have pinpointed, sources of information, assessment of the quality of information collected, skills in

interpreting the information, and several other factors related to information seeking and utilization are influenced by users' characteristics, not just socio-economic and demographic, but also ethno-cultural (Helft et al., 2005; Marks et al., 2004). In a study on information seeking patterns among cancer patients, Kakai and colleagues observed that Caucasian patients preferred objective, scientific, and updated information such as the one offered by medical journals, newsletters from research institutions, phone information services, and the Internet. Japanese patients, instead, relied on the media and on commercial sources. Finally, non-Japanese Asian and Pacific Islanders chose person-to-person communication with their health providers, friends, and other patients (Kakai et al., 2003).

With respect to ICT-based means to disseminate information, in some authors' opinion, an actual 'cultural digital divide' exists, particularly in the case of information available on the Internet (Changrani et al., 2005). While developing a very interesting exploration of culturally competent approaches to cancer education, Thorne realized that even different 'cultures of use' of Internet communication tools exist. Different cultures, in fact, perceive the existence of these tools and constantly re-construct their meaning as artefacts in very distinctive ways. Internet communication tools are not neutral media but their use is influenced by individual and collective experience (Thorne, 2003). Lorence studied racial/ethnic characteristics associated with Internet use and online health information seeking, in the US, and concluded that wide gaps in the use of computers and access to the Internet still exist between the Caucasian population and the African American and Hispanic ones. These gaps have largely remained unchanged in spite of the efforts aimed at reducing the digital divide made by the American administration at the end of the 1990s (Lorence et al., 2006; Lorence et al., 2007). Other authors have shown the differences in knowledge and use of ICT-based information sources existing between the mainstream population and minorities (Monnier et al., 2002; Morahan-Martin, 2004).

A study by Courtright published in 2005, focusing on both purposive information seeking and accidental encountering of health information among Latin American newcomers to a small city in the US, showed the central importance of personal social networks as a source of information for this group of recent immigrants (Courtright, 2005). The relative importance of this information channel is a typical feature of social groups who are 'information poor' (Chatman, 1991). The 'information poor', by definition, are population groups living in an environment in which the emphasis is on immediate gratifications and satisfaction of basic needs. They usually belong to lower socio-economic classes and tend not to seek information outside of their most immediate and familiar environment, thinking that outside sources are not capable of addressing their concerns and are not trustworthy or credible. A large number of publications are available that confirm in various ways this aspect of newcomers' information-seeking behaviour (Ahmad et al., 2004a; Caidi et al., 2005; Deri, 2005; Dyck, 1995; Fisher et al., 2004b; Leduc et al., 2004; Sheikh-Mohammed et al., 2006).

Access to and use of information sources, whether ICT-based or not, is also shaped by several socio-economic and demographic factors that, not surprisingly, represent well-known broader determinants of health. These factors, which well describe a large proportion of recent immigrants, interact with each other and have the same impact on access to information sources that they have on access to health services. They include, among others: low income; low levels of formal education; living in a rural area; and being older. A large body of literature is dedicated to studying their role as information barriers (Carlson et al., 2006; Cotten et al., 2004; Fogel et al., 2002; Gustafson et al., 2005).

How should various levels of government, health care providers, agencies serving recent immigrants, information and referral organizations, and other institutions dealing with newcomers address the issue of access to information sources? The literature offers a few suggestions. Caidi and Allard, for example, encourage information services providers, particularly libraries, to play a more proactive role and reach out to newcomers to make

sure their information needs, from those related to the simple aspects of daily living to support for increased civic participation and social connections, are addressed. In their opinion, involving immigrants in the process of gathering and designing information resources and systems that are meaningful to them would be a particularly effective strategy (Caidi et al., 2005).

Other authors report on various community outreach experiences that focused not only on information dissemination itself but also on teaching skills to participants that they could use to access information more effectively, such as literacy skills, computer training, and use of online databases such as Medline Plus (Broering et al., 2006; Fisher et al., 2004a; Shipman et al., 2004; States et al., 2006; Suarez-Balcazar et al., 2005; Williams et al., 2005). For example, a partnership of libraries, community agencies, and academic institutions in Virginia created the 'Women's Health Network for Minority Consumer Health Outreach', an initiative that facilitated access to public computers in community locations where staff were trained to search for and evaluate health web sites to support Spanish-speaking immigrant women (Shipman et al., 2004). In New York, a program of community-based health education workshops was developed, in English and Spanish, to reach older people from diverse ethnic, cultural, and language backgrounds. The workshops included training on the use of computers and Internet navigation. Also, a web site was created to provide ongoing access to the instructional materials used during the workshops and to other useful resources and links (States et al., 2006). Finally, in Alberta, Canada, the Calgary and Area Child and Family Services Authority joined with several agencies working with newcomers to develop, as a pilot project, a call centre which provides staff from the Authority a one-stop phone contact for information about immigrant and refugee families, their cultures, and available, culturally-appropriate resources (Williams et al., 2005).

Finally, a few examples of interventions making use of alternative ICT-based information dissemination tools are described in the literature. Usually, these projects test the

feasibility of providing health-related information to ethnic minority groups who might have minimal access to the Internet using touch-screen computer kiosks. Information is delivered not just in writing but also in audio and visual formats, and in multiple languages. The technological interface is designed to maximize easiness of use and information kiosks are located in public high transit areas where the target population tends to converge. Examples of pilot studies exist both in the UK and in the US and initial results are encouraging. However, multimedia computerized information kiosks are still in the early stage of development and their full potential remains unexplored (Connell et al., 2003; Fintor, 1998; Jackson et al., 2003; Lewis et al., 1997; Nicholas et al., 2002a; Nicholas et al., 2002b; Nicholas et al., 2003; Nicholas et al., 2004; Peters et al., 2005).

The review presented in this chapter briefly summarizes the rich and somehow intricate literature on immigration and health in Canada. Past studies have well described the complexity of reaching users across languages and cultures and the major challenges policy makers and service providers face in highly multicultural societies. Published studies also emphasize the role played by information sources in supporting newcomers in their effort to navigate and negotiate the complex system of existing health and health-related services. The review represents a useful starting point for this research project as it stresses the need to explore more in depth the experiences and problems faced by specific groups of newcomers and to test novel strategies aimed at maximizing the impact of immigrant serving organizations' activities.

C. References

Ahmad, F.; Cameron, J.I.; Stewart, D.E. (2005) 'A tailored intervention to promote breast cancer screening among South Asian immigrant women.' *Social Science & Medicine*; 60; 3: 575-86.

Ahmad, F.; Shik, A.; Vanza, R.; Cheung, A.; George, U.; Stewart, D.E. (2004a) 'Popular health promotion strategies among Chinese and East Indian immigrant women.' *Women & Health*; 40; 1: 21-40.

Ahmad, F.; Shik, A.; Vanza, R.; Cheung, A.M.; George, U.; Stewart, D.E. (2004b) 'Voices of South Asian women: Immigration and mental health.' *Women & Health*; 40; 4: 113-30.

Ahmad, F.; Stewart, D.E. (2004c) 'Predictors of clinical breast examination among South Asian immigrant women.' *Journal of Immigrant Health*; 6; 3: 119-26.

Ali, J.S. (2002) 'Mental health of Canada's immigrants.' *Health Reports*; 13; (Suppl.): 101-11.

Ali, J.S.; McDermott, S.; Gravel, R.G. (2004) 'Recent research on immigrant health from Statistics Canada's population surveys.' *Canadian Journal of Public Health*; 95; 3: 19-13.

Allen, M.; Matthew, S.; Boland, M.J. (2004) 'Working with Immigrant and Refugee Populations: Issues and Hmong Case Study.' *Library Trends*; 53; 2: 301-28.

Asanin, J.; Wilson, K. (2008) "'I spent nine years looking for a doctor": Exploring access to health care among immigrants in Mississauga, Ontario, Canada.' *Social Science & Medicine*; 66; 6: 1271-83.

Aspinall, P.J. (2007) 'Language ability: A neglected dimension in the profiling of populations and health service users.' *Health Education Journal*; 66; 1: 90-106.

Balzi, D.; Gelides, A.; Branker, A. (1995) 'Cancer mortality in Italian immigrants and their offspring in Canada.' *Cancer Causes Control*; 6; 1: 68-74.

Beiser, M. (2005) 'The health of immigrants and refugees in Canada.' *Canadian Journal of Public Health*; 96; 2 (Suppl.): S30-S44.

Beiser, M.; Devins, G.; Dion, R.; Hyman, I.; Lin, E. (1997) *Immigration, Acculturation, and Health*. Ottawa: National Health Research and Development Program.

Beiser, M.; Hou, F. (2002) 'Poverty and mental health among immigrant and non-immigrant children.' *American Journal of Public Health*; 92; 2: 220-7.

Broering, N.C.; Gomes, S.L.; Chauncey, G.A. (2006) 'Outreach to public libraries, senior centers, and clinics to improve patient and consumer health care: An update.' *Journal of Consumer Health on the Internet*; 10; 3: 1-19.

Brotto, L.A.; Chou, A.Y.; Singh, T.; Woo, J.S. (2008) 'Reproductive health practices among Indian, Indo-Canadian, Canadian East Asian, and Euro-Canadian women: The role of acculturation.' *Journal of Obstetrics & Gynaecology Canada*; 30; 3: 229-38.

Caidi, N.; Allard, D. (2005) 'Social inclusion of newcomers to Canada: An information problem?' *Library and Information Science Research*; 27; 3: 302-24.

Cairney, J.; Ostbye, T. (1999) 'Time since immigration and excess body weight.' *Canadian Journal of Public Health*; 90; 2: I20-I24.

Carlson, B.A.; Neal, D.; Magwood, G.; Jenkins, C.; King, M.G.; Hossler, C.L. (2006) 'A community-based participatory health information needs assessment to help eliminate diabetes information disparities.' *Health Promotion Practice*; 7; 3 (Suppl.): S213-S222.

Chan-Yip, A. (2004) 'Health promotion and research in the Chinese community in Montreal: A model of culturally appropriate health care.' *Paediatrics & Child Health*; 9; 9: 627-9.

Changrani, J.; Gany, F. (2005) 'Online cancer education and immigrants: Effecting culturally appropriate websites.' *Journal of Cancer Education*; 20; 3: 183-6.

Chatman, E.A. (1991) 'Life in a small world: Applicability of gratification theory to information-seeking behavior.' *Journal of the American Society for Information Science*; 42; 6: 438-49.

Chen, A.W.; Kazanjian, A. (2005) 'Rate of mental health service utilization by Chinese immigrants in British Columbia.' *Canadian Journal of Public Health*; 96; 1: 49-51.

Chen, J.; Hou, F. (2002) 'Unmet needs for health care.' *Health Reports*; 13; 23-4.

Chen, J.; Ng, E.; Wilkins, R. (1996a) 'Health expectancy by immigrant status.' *Health Reports*; 8; 3: 29-37.

Chen, J.; Ng, E.; Wilkins, R. (1996b) 'The health of Canada's immigrants in 1994-95.' *Health Reports*; 7; 4: 33-50.

Connell, C.M.; Shaw, B.A.; Holmes, S.B.; Hudson, M.L.; Derry, H.A.; Strecher, V.J. (2003) 'The development of an Alzheimer's disease channel for the Michigan Interactive Health Kiosk Project.' *Journal of Health Communication*; 8 ; 11-22.

Cotten, S.R.; Gupta, S.S. (2004) 'Characteristics of online and offline health information seekers and factors that discriminate between them.' *Social Science & Medicine*; 59; 9: 1795-806.

Courtright, C. (2005) 'Health information-seeking among Latino newcomers: An exploratory study.' *Information Research*; 10; 2.

Dasgupta, K.; Menzies, D. (2005) 'Cost-effectiveness of tuberculosis control strategies among immigrants and refugees.' *European Respiratory Journal*; 25; 6: 1107-16.

Demark-Wahnefried, W.; McClelland, J.; Campbell, M.K.; Hoben, K.; Lashley, J.; Graves, C. et al. (1998) 'Awareness of cancer-related programs and services among rural African Americans.' *Journal of the National Medical Association*; 90; 197-202.

Deri, C. (2005) 'Social networks and health service utilization.' *Journal of Health Economics*; 24; 6: 1076-107.

DesMeules, M.; Gold, J.; Kazanjian, A.; Manuel, D.; Payne, J.; Vissandee, B. et al. (2004) 'New approaches to immigrant health assessment.' *Canadian Journal of Public Health*; 95; 3: I22-I26.

Donnelly, T.T. (2008) 'Challenges in providing breast and cervical cancer screening services to Vietnamese Canadian women: The healthcare providers' perspective.' *Nursing Inquiry*; 15; 2: 158-68.

Dunn, J.R.; Dyck, I. (2000) 'Social determinants of health in Canada's immigrant population: Results from the National Population Health Survey.' *Social Science & Medicine*; 51; 11: 1573-93.

Dyck, I. (1995) 'Putting chronic illness 'in place': Women immigrants' accounts of their health care.' *Geoforum*; 26; 3: 247-60.

Finney Rutten, L.J.; Squiers, L.; Treiman, K. (2006) 'Requests for information by family and friends of cancer patients calling the National Cancer Institute's Cancer Information Service.' *Psycho-Oncology*; 15; 8: 664-72.

Fintor, L. (1998) 'The Michigan health kiosk: Cancer info on the go.' *Journal of the National Cancer Institute*; 90; 809-10.

Fisher, K.E.; Durrance, J.C.; Bouch Hinton, M. (2004a) 'Information grounds and the use of needs-based services by immigrants in Queens, New York: A context-based, outcome evaluation approach.' *Journal of the American Society for Information Science and Technology*; 55; 754-66.

Fisher, K.E.; Marcoux, E.; Miller, L.S.; Sanchez, A.; Cunningham, E.R. (2004b) 'Information behaviour of migrant Hispanic farm workers and their families in the Pacific Northwest.' *Information Research*; 10; 1: Paper 199 [Available at <http://InformationR.net/ir/10-1/paper199.html>].

Fogel, J.; Albert, S.M.; Schnabel, F.; Ditkoff, B.A.; Neugut, A.I. (2002) 'Use of the Internet by women with breast cancer.' *Journal of Medical Internet Research*; 4; 2: Electronic paper #9.

Fowler, N. (1998) 'Providing primary health care to immigrants and refugees: The North Hamilton experience.' *Canadian Medical Association Journal*; 159; 4: 388-91.

Gee, E.M.; Kobayashi, K.M.; Prus, S.G. (2004) 'Examining the healthy immigrant effect in mid- to later life: Findings from the Canadian Community Health Survey.' *Canadian Journal on Aging*; 23; 1 (Suppl.): S61-S69.

Glazier, R.H.; Creatore, M.I.; Cortinois, A.A.; Agha, M.M.; Moineddin, R. (2004a) 'Neighbourhood recent immigration and hospitalization in Toronto, Canada.' *Canadian Journal of Public Health*; 95; 3: I30-I34.

Glazier, R.H.; Creatore, M.I.; Gozdyra, P.; Matheson, F.I.; Steele, L.S.; Boyle, E. et al. (2004b) 'Geographic methods for understanding and responding to disparities in mammography use in Toronto, Canada.' *Journal of General Internal Medicine*; 19; 9: 952-61.

Gustafson, D.H.; McTavish, F.M.; Stengle, W.; Ballard, D.; Jones, E.; Julesberg, K. et al. (2005) 'Reducing the digital divide for low-income women with breast cancer: A feasibility study of a population-based intervention.' *Journal of Health Communication*; 10; 1 (Suppl.): 173-93.

Guttmann, A.; Manuel, D.; Stukel, T.A.; DesMeules, M.; Cernat, G.; Glazier, R.H. (2008) 'Immunization coverage among young children of urban immigrant mothers: Findings from a universal health care system.' *Ambulatory Pediatrics*; 8; 3: 205-9.

Helft, P.R.; Eckles, R.E.; Johnson-Calley, C.S.; Daugherty, C.K. (2005) 'Use of the internet to obtain cancer information among cancer patients at an urban county hospital.' *Journal of Clinical Oncology*; 23; 22: 4954-62.

Hislop, T.G.; Teh, C.; Lai, A.; Ralston, J.D.; Shu, J.; Taylor, V.M. (2004) 'Pap screening and knowledge of risk factors for cervical cancer in Chinese women in British Columbia, Canada.' *Ethnicity & Health*; 9; 3: 267-81.

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

Hyman, I.; Guruge, S. (2002a) 'A review of theory and health promotion strategies for new immigrant women.' *Canadian Journal of Public Health*; 93; 3: 183-7.

Hyman, I.; Guruge, S.; Makarchuk, M.J.; Cameron, J.; Micevski, V. (2002b) 'Promotion of healthy eating among new immigrant women in Ontario.' *Canadian Journal of Dietetic Practice & Research*; 63; 3: 125-9.

Hyman, I.; Singh, M.; Ahmad, F.; Austin, L.; Meana, M.; George, U. et al. (2001) 'The role of physicians in mammography referral for older Caribbean women in Canada.' *Medscape Womens Health*; 6; 5: 6.

Hyman, I.; Stewart, D.E.; Cameron, J.I.; Singh, M. (2000) '*Physician-Related Determinants of Cervical Cancer Screening Among Chinese and Vietnamese Women in Toronto*'. Poster Presented at the Harvey Stancer Research Day, Centre for Addiction and Mental Health, Toronto.

Jackson, M.; Peters, J. (2003) 'Introducing touchscreens to black and ethnic minority groups: A report of processes and issues in the Three Cities project.' *Health Information & Libraries Journal*; 20; 3: 143-9.

Kakai, H.; Maskarinec, G.; Shumay, D.M.; Tatsumura, Y.; Tasaki, K. (2003) 'Ethnic differences in choices of health information by cancer patients using complementary and alternative medicine: An exploratory study with correspondence analysis.' *Social Science & Medicine*; 56; 4: 851-62.

Kinnon, D. (1999) *Canadian Research On Immigration and Health: An Overview*. Ottawa: Health Canada.

Kirmayer, L.J.; Weinfeld, M.; Burgos, G.; du Fort, G.G.; Lasry, J.C.; Young, A. (2007) 'Use of health care services for psychological distress by immigrants in an urban multicultural milieu.' *Canadian Journal of Psychiatry*. 52; 5: 295-304.

Kopec, J.A.; Williams, J.I.; To, T.; Austin, P.C. (2001) 'Cross-cultural comparisons of health status in Canada using the Health Utilities Index.' *Ethnicity. & Health*. 6; 1: 41-50.

Kralj, L.; Barriball, L. (2004) 'Online information on primary care services for refugees and asylum-seekers.' *British Journal of Community Nursing*; 9; 3: 115-21.

Lai, D.W. (2004) 'Use of home care services by elderly Chinese immigrants.' *Home Health Care Services. Quarterly*. 23; 3: 41-56.

Lai, D.W.; Chau, S.B. (2007a) 'Effects of service barriers on health status of older Chinese immigrants in Canada.' *Social Work*; 52; 3: 261-9.

Lai, D.W.; Chau, S.B. (2007b) 'Predictors of health service barriers for older Chinese immigrants in Canada.' *Health & Social Work*; 32; 1: 57-65.

Lai, D.W.; Hui, N.T. (2007c) 'Use of dental care by elderly Chinese immigrants in Canada.' *Journal of Public Health Dentistry*. 67; 1: 55-9.

Laroche, M. (2000) 'Health status and health services utilization of Canada's immigrant and non-immigrant population.' *Canadian Public Policy*; 26 ; 1: 51-73.

Leduc, N.; Proulx, M. (2004) 'Patterns of health services utilization by recent immigrants.' *Journal of Immigrant Health*; 6; 1: 15-27.

Lewis, D.; Nath, C. (1997) 'Feasibility of a kiosk-based patient education system in a busy outpatient clinic setting.' *Diabetes Educator*; 23; 577-86.

Li, H.Z.; Browne, A.J. (2000) 'Defining mental illness and accessing mental health services: Perspectives of Asian Canadians.' *Canadian Journal of Community Mental Health*; 19; 1: 143-59.

Lofters, A.; Glazier, R.H.; Agha, M.M.; Creatore, M.I.; Moineddin, R. (2007) 'Inadequacy of cervical cancer screening among urban recent immigrants: A population-based study of physician and laboratory claims in Toronto, Canada.' *Preventive Medicine*; 44; 6: 536-42.

Lorence, D.P.; Park, H. (2007) 'Study of education disparities and health information seeking behavior.' *Cyberpsychology and Behavior*; 10; 1: 149-51.

Lorence, D.P.; Park, H.; Fox, S. (2006) 'Racial disparities in health information access: Resilience of the Digital Divide.' *Journal of Medical Systems*; 30; 4: 241-9.

Marks, J.P.; Reed, W.; Colby, K.; Ibrahim, S.A. (2004) 'A culturally competent approach to cancer news and education in an inner city community: Focus group findings.' *Journal of Health Communication*; 9; 2: 143-57.

McDonald, J.T.; Kennedy, S. (2004) 'Insights into the 'healthy immigrant effect': Health status and health service use of immigrants to Canada.' *Social Science & Medicine*; 59 ; 1613-27.

Miller, S.T.; Schlundt, D.G.; Larson, C.; Reid, R.; Pichert, J.W.; Hargreaves, M. et al. (2004) 'Exploring ethnic disparities in diabetes, diabetes care, and lifestyle behaviors: The Nashville REACH 2010 community baseline survey.' *Ethnicity & Disease*; 14; 3 (Suppl. 1): S1-S38.

Monnier, J.; Laken, M.; Carter, C.L. (2002) 'Patient and caregiver interest in Internet-based cancer services.' *Cancer Practice*; 10; 6: 305-10.

Morahan-Martin, J.M. (2004) 'How internet users find, evaluate, and use online health information: A cross-cultural review.' *Cyberpsychology and Behavior*; 7; 5: 497-510.

Newbold, K.B. (2005) 'Self-rated health within the Canadian immigrant population: Risk and the healthy immigrant effect.' *Social Science & Medicine*; 60 ; 1359-70.

Newbold, K.B.; Danforth, J. (2003) 'Health status and Canada's immigrant population.' *Social Science & Medicine*; 57 ; 1981-95.

Newbold, K.B.; Patel, A. (2006) 'Use of dental services by immigrant Canadians.' *Journal of the Canadian Dental Association*; 72; 2.

Nicholas, D.; Huntington, P.; Williams, P. (2002a) 'An evaluation of the use of NHS touch-screen health kiosks: A national study.' *Aslib Proceedings*; 54; 372-84.

Nicholas, D.; Huntington, P.; Williams, P. (2002b) 'The impact of location on the use of information systems - Case study: Health information kiosks.' *Journal of Documentation*; 58; 284-301.

Nicholas, D.; Huntington, P.; Williams, P. (2003) 'Delivering consumer health information digitally: A comparison between the web and touchscreen kiosk.' *Journal of Medical Systems*; 27; 13-34.

Nicholas, D.; Huntington, P.; Williams, P. (2004) 'The characteristics of users and non-users of a kiosk information system.' *Aslib Proceedings*; 56; 48-61.

O'Mahony, J.M.; Donnelly, T.T. (2007a) 'Health care providers' perspective of the gender influences on immigrant women's mental health care experiences.' *Issues in Mental Health Nursing*; 28; 10: 1171-88.

O'Mahony, J.M.; Donnelly, T.T. (2007b) 'The influence of culture on immigrant women's mental health care experiences from the perspectives of health care providers.' *Issues in Mental Health Nursing*; 28; 5: 453-71.

Oelke, N.D.; Vollman, A.R. (2007) "'Inside and outside": Sikh women's perspectives on cervical cancer screening.' *Canadian Journal of Nursing Research*; 39; 1: 174-89.

Pellegrini Filho, A.P. (2002) 'Inequities in access to information and inequities in health.' *Pan American Journal of Public Health*; 11; 5-6: 409-12.

Perez, C.F. (2002) 'Health status and health behaviour among immigrants.' *Health Reports*; 13; (Suppl.): 89-100.

Peters, J.; Jackson, M. (2005) 'Accessibility and use of touchscreens by black and ethnic minority groups in the Three Cities project.' *Ethnicity & Health*; 10; 3: 199-211.

Pottie, K.; Janakiram, P.; Topp, P.; McCarthy, A. (2007) 'Prevalence of selected preventable and treatable diseases among government-assisted refugees: Implications for primary care providers.' *Canadian Family Physician*; 53; 11: 1928-34.

Reynolds, D. (2004) 'Cervical cancer in Hispanic/Latino women.' *Clinical Journal of Oncology Nursing*; 8; 2: 146-50.

Richards, B.; Kozak, R.; Brassard, P.; Menzies, D.; Schwartzman, K. (2005) 'Tuberculosis surveillance among new immigrants in Montreal.' *International Journal of Tuberculosis & Lung Disease*. 9; 8: 858-64.

Roberts, N.C.D. (1997) 'Psychiatric admissions of Asian Canadians to an adolescent inpatient unit.' *Canadian Journal of Psychiatry*; 42 ; 847-51.

Rush, T.J.; Ng, V.; Irwin, J.D.; Stitt, L.W.; He, M. (2007) 'Food insecurity and dietary intake of immigrant food bank users.' *Canadian Journal of Dietetic Practice and Research*; 68; 2: 73-8.

Sadavoy, J.; Meier, R.; Ong, A.Y. (2004) 'Barriers to access to mental health services for ethnic seniors: The Toronto study.' *Canadian Journal of Psychiatry*; 49; 3: 192-9.

Schaffer, A.; Cairney, J.; Cheung, A.H.; Veldhuizen, S.; Levitt, A.J. (2006) 'Use of treatment services and pharmacotherapy for bipolar disorder in a general population-based mental health survey.' *Journal of Clinical Psychiatry*; 67; 3: 386-93.

Sheikh-Mohammed, M.; MacIntyre, C.R.; Wood, N.J.; Leask, J.; Isaacs, D. (2006) 'Barriers to access to health care for newly resettled Sub-Saharan refugees in Australia.' *Medical Journal of Australia*; 185; 11-12: 594-7.

Sheth, T.; Nair, C.; Nargundkar, M.; Anand, S.S.; Yusuf, S. (1999) 'Cardiovascular and cancer mortality among Canadian of European, South Asian and Chinese origin from 1979 to 1993: An analysis of 1.2 million deaths.' *Canadian Medical Association Journal*; 61; 20: 131-8.

Shipman, J.P.; Daly, D.C.; Henry, J.K. (2004) 'Partnering with the community: A women's health network for multicultural communities.' *Journal of Consumer Health on the Internet*; 8; 4: 27-39.

States, R.A.; Susman, W.M.; Riquelme, L.F.; Godwin, E.M.; Greer, E. (2006) 'Community health education: Reaching ethnically diverse elders.' *Journal of Allied Health*; 35; 4: 215-22.

Suarez-Balcazar, Y.; Kinney, L.; Masi, C.M.; Cassey, M.Z.; Muhammad, B. (2005) 'A participatory internet initiative in an African American neighborhood.' *Journal of Prevention & Intervention in the Community*; 29; 1-2: 103-16.

Teng, L.; Robertson, B.E.; Stewart, D.E. (2007) 'Healthcare worker's perceptions of barriers to care by immigrant women with postpartum depression: An exploratory qualitative study.' *Archives of Women's Mental Health*; 10; 3: 93-101.

Thorne, S.L. (2003) 'Artifacts and cultures-of-use in intercultural communication.' *Language Learning & Technology*; 7; 2: 38-67.

Wen, S.W.; Goel, V.; Williams, J.E. (1996) 'Utilization of health care services by immigrants and other ethnic/cultural groups in Ontario.' *Ethnicity & Health*; 1 ; 1: 99-109.

Whitley, R.; Kirmayer, L.J.; Groleau, D. (2006) 'Understanding immigrants' reluctance to use mental health services: A qualitative study from Montreal.' *Canadian Journal of Psychiatry*. 51; 4: 205-9.

Wilkins, K. (1994) 'Tuberculosis.' *Health Reports*; 8; 1: 33-9.

Williams, M.; Bradshaw, C.; Fournier, B.; Tachble, A.; Bray, R.; Hodson, F. (2005) 'The Call-Centre: A child welfare liaison program with immigrant serving agencies.' *Child Welfare*; 84; 5: 725-46.

Wu, Z.; Penning, M.J.; Schimmele, C.M. (2005) 'Immigrant status and unmet health care needs.' *Canadian Journal of Public Health*; 96; 5: 369-73.

Chapter IV – Theoretical Framework

Access to health care services has been extensively studied since the 1960s. Over time, researchers have tackled this concept from both the health services and the users' perspectives, focusing on different types and levels of clinical and non-clinical services, as well as on their mutual interactions, and comparing access across population sub-groups and geographic areas both within countries and at the international level (Gulzar, 1999).

Historically, the Alma Ata Declaration of 1978 identified accessibility as one of the central pillars of Primary Health Care (World Health Organization, 1978). This emphasis resulted in an increased and ongoing effort to explore issues of appropriateness, adequateness, and acceptability of care. More recently, the impact of equitable access to services on the health status of populations has become a central component of the wider applied research effort aimed at understanding and challenging existing inequities in health (Evans et al., 2001, p. 4).

As a result, the understanding of the concept of health care accessibility has increased considerably. Over the years, several dimensions of access have been identified and measured, among others: population characteristics, health systems characteristics and the (mis)fit between these two categories; enabling or limiting factors impacting the use of existing services; service availability; utilization rates; users' levels of satisfaction; medical care outcomes; and health status of a population (Gulzar, 1999). These dimensions of access have been organized into predicting and/or explanatory models by a number of authors.

Of particular interest in the context of this study is the model commonly known as 'Behavioral Model of Health Services Use' developed by Andersen in the late 1960s (Andersen, 1968) and revised several times over the past three decades (Andersen, 1995). The model has been central to the debate on access to health care services for over thirty

years and may help contextualize the role of access to information as a precursor of access to care.

At the same time as Andersen's model was being developed, scholars in the field of information studies were learning how people access and use information. In this case, too, several models have been put forward to explain human behaviour. Among them, a remarkably comprehensive model was developed by Wilson in the early 1980s and subsequently modified and expanded (Wilson, 1981; Wilson et al., 1996). Wilson's model of 'information-seeking behaviour' identifies factors creating the need for information and describes how people react to those factors, seek information, access information sources, and use information in different contexts.

Andersen's and Wilson's models present significant analogies as they both focus on the complex interactions of environmental, contextual, socio-cultural, and individual factors explaining/predicting human behaviour, and organize them in comparable fashions. They also stress the dynamic and recurrent nature of these interactions, including feedback loops that link outcomes to the early stages of the process. In addition, the two models complement each other in illustrating how access to information on health and health-related services enables access to services. In fact, Wilson's model describes a process whose final step is the use of information sources and information sources are, in turn, one of the 'starting points' in Andersen's model: one of the factors that enable individuals to use health services. It seems therefore useful to make simultaneous reference to the two models as they might help identify factors that represent at the same time, for certain population groups, both barriers to the use of health services and barriers to the use of information and referral services explicitly designed to support these groups.

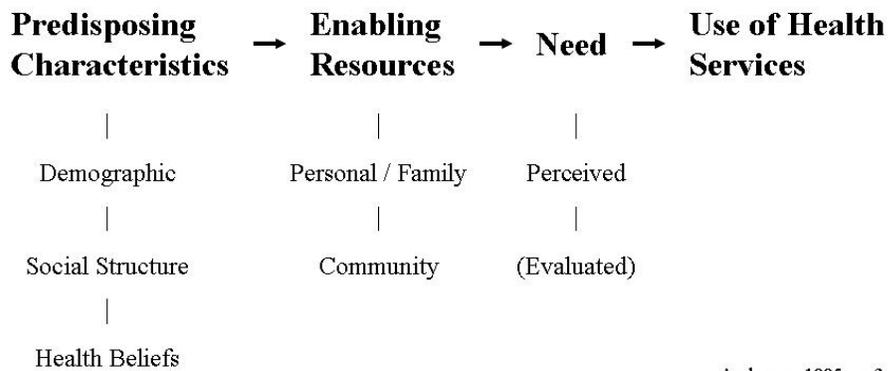
This chapter includes three sections. Section A is a concise overview of Andersen's model. Section B briefly describes how the concept of 'information behaviour' has evolved over time, in the field of information studies, and introduces Wilson's model. The final section

– Section C – shows how these two models, simultaneously assumed, may represent a useful theoretical background for this study.

A. *The Behavioral Model Of Health Services Use*

The ‘Behavioral Model of Health Services Use’ (Behavioral Model) presents a comprehensive and systemic perspective to study equity of access and efficient and effective use of health care services (Andersen, 1995). Since its original version (Figure 4.1), the model suggested that use of health services is a function of individual patients’ predisposition to use them, external factors that enable or impede use, and need for care. It is meant to be both a predicting and an explanatory model. On the one hand, in fact, each one of its components may be conceived as making an independent contribution to predicting use. On the other hand, the model suggests a causal order that includes exogenous predisposing factors, necessary but not sufficient enabling resources, and needs that have to be defined to prompt use of services.

Figure 4.1 – Original Version Of Andersen’s Behavioral Model



Under ‘Predisposing Characteristics’, the original model includes three broad categories: demographic factors, social structures, and health beliefs. Demographic factors, such as

age and sex, are biological imperatives influencing the likelihood that people will need health care. Social structures include a broad range of factors that shape the individual's status in his/her community, his/her ability to cope with problems, and the characteristics of his/her physical environment. Health beliefs include knowledge, attitudes, and values about health and health services that influence people's perception of health services and of the need to use them, and their actual use.

'Enabling Resources' are categorized into personal/family resources and community resources. The availability of health facilities and personnel, on the one hand, and people's means and know-how to identify, access, and appropriately use services, on the other hand, are all important elements that impact the actual use of health services. Regular source of care, income, perceived barriers, social support, travel and waiting times are some of the measures that can be adopted to explore this component of the model.

'Need' is conceptualized in terms of perceived and evaluated need. Perceived need relates to people's view of their own general health and their experience of the physical as well as psychological impact of their condition. Such experience, in turn, influences their assessment of the severity of their problem and of the need to seek professional help. The evaluated component of need, conversely, reflects professional judgment about people's health status and their need for health care.

As Andersen reports in his 1995 re-visitation of the Behavioral Model (Andersen, 1995), since its first conceptualization virtually every single component of the model has been critiqued, from a variety of perspectives. In some authors' opinion, the model does not pay enough attention to social networks, social interactions, and culture (Bass et al., 1987; Guendelman, 1991). Others believe the model does not offer enough support to meaningfully analyze the link between beliefs, needs, and type of use (Guendelman, 1991; Mechanic, 1979). A number of suggestions have been made to add new components to the list of predisposing characteristics, including genetic factors (True et al., 1994) and

psychological characteristics such as mental dysfunction (Rivnyak et al., 1989), cognitive impairment (Bass et al., 1992), and autonomy (Davanzo, 1994). With respect to enabling resources, some authors express concern about an apparent lack of attention to organizational factors within health services as potentially important predictors of use (Gilbert et al., 1993; Kelly et al., 1992; Patrick et al., 1988). Other authors believe little space is made within the model to include the extent and quality of an individual's social relationships as enabling resources to facilitate or impede health services' use (Bass et al., 1987; Counte et al., 1991; Freedman, 1993; Miller et al., 1991; Pescosolido, 1992). Finally, some commentators have suggested the Behavioral Model excessively emphasises need as the prime determinant of use while discounting the impact of health beliefs and social structure (Coulton et al., 1982; Gilbert et al., 1993; Mechanic, 1979; Wolinsky et al., 1991).

At the same time, over the past three decades, hundreds of studies have adopted the Behavioral Model as a basic framework to study access to and use of health services, both in the US and abroad. An examination of a small selection of recently published papers shows that this model has been applied to study a wide variety of services, population groups, and geographic areas, with a strong emphasis on the exploration of issues of equity of access by underserved populations.

The model has been adopted to study, among others, access to: screening services (Baker et al., 2005; Owusu et al., 2005); immunization services (Acosta-Ramirez et al., 2005); general and specialized physician care (Broyles et al., 2000; Honda, 2004; Kilbourne et al., 2002; Lim et al., 2002; Swanson et al., 2003); hospital outpatient, inpatient, and emergency services (Afilalo et al., 2004; Broyles et al., 2000; Desai et al., 2003; Jaynes, 2004; McCusker et al., 2003; Richardson et al., 2001); cardiac rehabilitation services (Grace et al., 2004); mental health services (Bazargan et al., 2005; Goodwin et al., 2002; Kimerling et al., 2005); ophthalmic care (Baker et al., 2005); oral health and dental care services (Doty et al., 2003; Heslin et al., 2001); prescription drugs (Xu et al., 2003); physical

therapy services (Walker, 2005); social work services (Auslander et al., 2005); and specialized services for children (Acosta-Ramirez et al., 2005; Borders et al., 2004; Kane et al., 2005; Wallace et al., 2004).

Most of the above-referenced publications adopt the Behavioral Model to explore issues of equity of access, focusing on population groups who face significant barriers and often comparing potentially underserved users to the general population. Immigrants, veterans, low income multiethnic minorities, the homeless, medically underserved communities, HIV patients, rural communities, women, and children with special needs are all examples of groups whose access to and use of health services have been studied making reference to this model. A large percentage of studies have been conducted in the US but the model has been adopted to study populations in other areas of the world including, among others: Canada (Afilalo et al., 2004; Grace et al., 2004; McCusker et al., 2003); Latin America (Acosta-Ramirez et al., 2005); Sub-Saharan Africa (Fosu, 1994); and the Middle East (Auslander et al., 2005).

Over the decades, Andersen and his collaborators have worked to improve and expand the Behavioral Model, stimulated by criticisms while encouraged by its wide adoption. The model has gone through several major revisions (Andersen, 1995) and its most recent version (Figure 4.2) shows important improvements. First, the expanded model incorporates two new and significant components considered as important inputs for understanding use of health services: the health care system itself, including national health policies and the organization of available resources; and the external environment, including its physical, economic, and political dimensions. Second, the new model acknowledges that use of services is a means to other ends therefore including an 'outcomes' component. Outcomes are defined in terms of both perceived and evaluated health status as well as users satisfaction. Taking outcomes into consideration offers the opportunity to include in the measurement of health services utilization dimensions such as effectiveness and efficiency. Third, the new model recognizes personal health practices

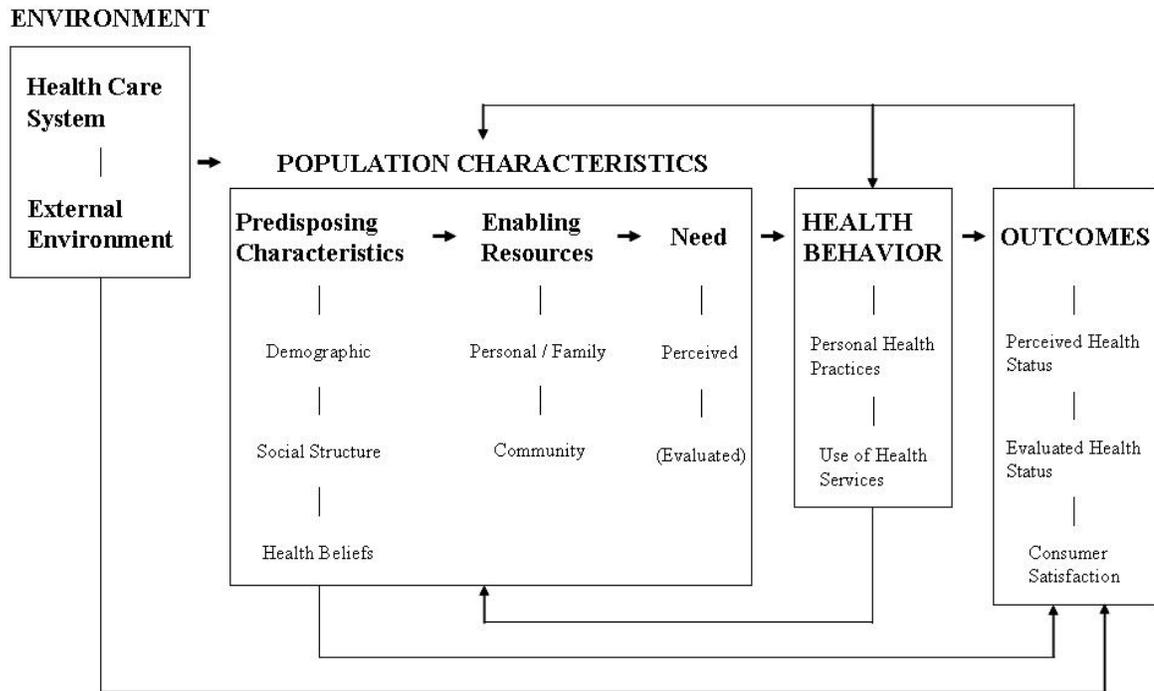
such as diet, exercise and self care as significantly interacting with use of services to produce outcomes. Finally, the most recent version of the Behavioral Model highlights the dynamic and recurrent nature of these interactions as well as their complexity. To this end, it includes alternative pathways of influence as well as feedback loops showing, for example, how environmental factors and predisposing characteristics such as health beliefs may directly influence outcomes and how health outcomes, in turn, may influence health behaviour and predisposing characteristics.

Andersen's model has several applications of interest. Two of them are particularly significant in the context of this analysis. First, the model articulates the elements needed to define access to services, a complex and multifaceted health policy measure, in a comprehensive and multidimensional way. Second, as stressed by Andersen himself (Andersen, 1995), it offers the opportunity to identify inequities in access to health services on the basis of which predictors of realized access are dominant.

Equity in health can be defined as the absence of systematic disparities in health, or in the major social determinants of health, between social groups who have different levels of underlying social advantage/disadvantage (Braveman et al., 2003). People who are already socially disadvantaged by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic, or religious group are systematically put at further disadvantage, with respect to their health, by inequities in health.

On the basis of this definition it is clear that inequities in access to and use of health services are just one component of inequities in health, as key social determinants of health include much more than just health care. In addition, health care considered as a social determinant of health is not limited to the receipt/utilization of health services only. On the contrary, it also includes social policies, the allocation of health care resources, the

Figure 4.2 – Expanded Version Of Andersen’s Behavioral Model



Adapted from Andersen, 1995, p. 8

financing of health care, and the quality of health care services offered (Braveman et al., 2003). Yet, equity of access remains an important component and cannot be discounted in the assessment of overall equity in health.

As previously observed, a large number of studies focusing on issues of equity of access adopt the Behavioral Model. The most important reason for such success is probably the categorization of predictors of access offered by the model. Such categorization, in fact, represents a particularly appropriate starting point for equity analysis. Inequitable access should be suspected every time dominant predictors belong to the social structure, health beliefs, and enabling resources categories. Conversely, demographic and needs variables accounting for most of the variance in utilization may be suggestive of equitable access. It

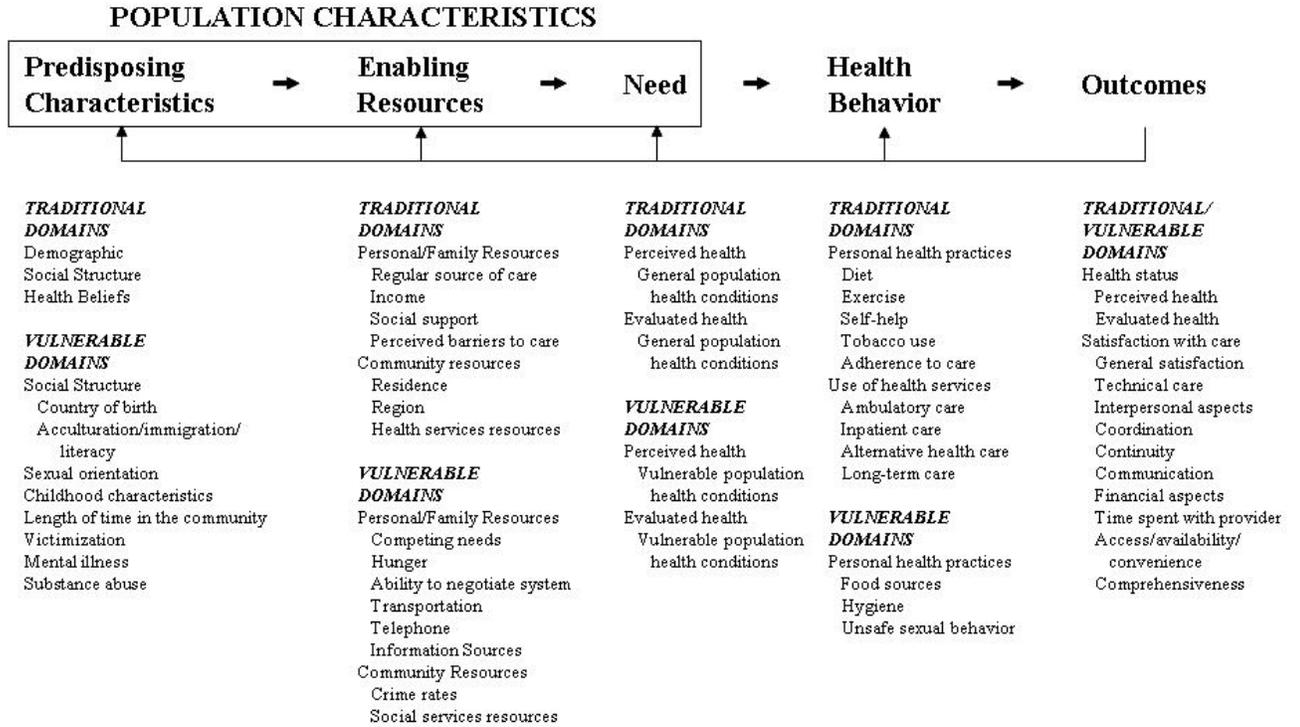
is worth repeating that this represents only a starting point for the analytical process. In most cases, a much more detailed and exhaustive analysis is needed to understand the mechanisms at work and the relative weight of each predictor.

Over time, several authors have developed modified versions of the Behavioral Model to study access to and use of specific health services or to focus on particular population groups. This research project makes reference to a version of the model Gelberg and colleagues (Gelberg et al., 2000) developed to gain a better understanding of the health and health-seeking behaviour of vulnerable populations, including, among others: minorities; undocumented immigrants; disabled persons; the elderly; the homeless; and the poor (Figure 4.3). The development of a modified model was justified by the assumption that at least some of the factors that make a population group vulnerable could also affect the use of health services by that population group as well as the outcomes of care (Gelberg et al., 2000).

The revised version includes, under each component of the original model, domains that are particularly relevant to the experience of vulnerable populations. These domains focus on social structure and enabling resources. Several of them clearly apply to recent immigrants. For example, among the predisposing factors the revised model includes 'country of birth', 'acculturation / immigration / literacy', and 'length of time in the community'. 'Ability to negotiate system' and 'information sources' are incorporated under enabling characteristics.

While brief, the overview of Andersen's model presented in this chapter is intended to highlight the essential features that make this model a useful theoretical framework for the study. The next section outlines a model from the field of information studies that describes information seeking behaviour. The two models, together, explain how access to and use of information resources are related to access to and use of health services.

Figure 4.3 – Behavioral Model For Vulnerable Populations



Adapted from Gelberg et al., 2000, p. 1278

B. Information Behaviour and Wilson’s Model

Almost at the same time as scholars in the health services research field were developing a better understanding of the factors influencing access to health services, the area of information studies concerned with information behaviour was growing dramatically, generating a vast literature on the information practices of individuals and groups. Both the notion of what constitutes ‘information behaviour’ and the theoretical infrastructure supporting scientific inquiry in this area were quickly evolving.

The definition of ‘information behaviour’ has progressively expanded to become: ‘how people need, seek, manage, give, and use information in different contexts.’ (Fisher et al., 2005, p. XIX). In addition, a large number of theories have been adopted, adapted or

developed de-novo to explain observed information practices. While most of these theories originate within the discipline of library and information science, a very significant proportion of them is rooted in the social sciences, the humanities, or computer science (Fisher et al., 2005). A multiplicity of approaches are represented within this theoretical body, among others: historical inquiry, constructivism, discourse analysis, critical theory, ethnography, socio-cognitive analysis, bibliometric analysis, and user-centred design approach (Bates, 2005). Such theoretical richness illustrates the strong academic interest in information behaviour. At the same time, the heterogeneity of speculative approaches may be also suggestive of an area of investigation in a state of fluid development, still far from finding its own distinctive and definitive traits.

While a comparative analysis of existing information behaviour theories, or even a thorough review of the scholarly production on information behaviour, are beyond the scope of this thesis, an understanding of some of the main conceptual developments produced in this area over the past few decades is essential to frame this study theoretically. Such ‘high-level’ review will also provide an introduction to the second model around which the theoretical infrastructure of this research project is organized.

A first development in the study of information practices has been a significant shift from an early focus on information sources and systems to users. Perhaps, the most powerful theoretical elaboration supporting such shift is the approach known as ‘Sense-making theory’ developed by Brenda Dervin and colleagues since the early 1970s. In Dervin’s words ‘Humans ... live in a world of gaps: a reality that changes across time and space and is at least in part “gappy” at a given time-space’ (Dervin, 1998), p.36. Sense making (and unmaking) is the process of ‘gap bridging’, a term that is not used, here, in its purposive, problem solving sense but instead identified as an essential mandate of the human condition (Dervin, 2005). People seek, process, create, and use information to make sense of their situation and information is meaningful only in the context of such process. Information, therefore, is rarely an end in itself but a means to an end. Users are those who

decide, in their own terms, what is informing and what is not. Sense-making becomes therefore integral to understanding how human beings derive meaning from information and is associated with the shift in research emphasis from information sources and systems to information users. The theory provides guidance for thinking about people, talking to them, asking questions of them, and designing systems to serve them as individuals seeking information in the context of a specific situation (Dervin, 1998).

A second evolutionary change worth considering here is the shift in research focus from the job-related information practices of professionals who act in the context of their own disciplines, mainly in institutional settings, to the information behaviour of lay people who make decisions in the context of their daily life activities. As Spink and Cole explain (Dervin, 1998; Spink et al., 2001b), what makes occupational- or school-related information behaviour different from the daily-life-activities-related one is that the former develops in a controlled environment with a definite end product in mind that has some sort of paradigmatic quality to it. The latter, conversely, is fluid, depending on the motivation, education and other characteristics of highly heterogeneous ordinary people seeking information for a multitude of different reasons. This results in highly unsystematic behaviour that often incorporates counterproductive practices determined by factors such as a need for coherence, feeling of uncertainty, or the irrational avoidance of information.

Savolainen defines 'Everyday-Life Information Seeking' (ELIS) as: 'the acquisition of various informational ... elements which people employ to orient themselves in daily life or to solve problems not directly connected with the performance of occupational tasks. Such problems may be associated with various areas of everyday life, for example, consumption and health care.' (Savolainen, 1995, p. 266). Information behaviour is determined by values, attitudes, and interests of individuals and by their assumptions concerning the availability of certain channels and sources and the easiness of their use. Savolainen bases his conceptualization of ELIS on Bourdieu's theory of 'habitus', defined

as a socially and culturally determined system of thinking, perception and evaluation internalized by the individual (Bourdieu, 1984). He describes the practical manifestation of habitus in terms of 'way of life'. Way of life, he says, refers to a certain 'order of things', where 'things' are the many activities taking place in the daily life world and 'order' refers to the choices individuals make in everyday life with respect to such activities. An individual's way of life represents an order of things he/she considers 'normal' or 'meaningful'. Whenever such order is disturbed, individuals act to restore it and gain experience that yields feedback on the effectiveness of their problem-solving activities, including the usefulness of different information sources and channels. Experience affects the information orientation of individuals and leads to certain information-seeking habits that are often unconscious.

A third focus of interest that has become increasingly central to the work of information behaviour researchers is the environment or context in which information transactions are embedded. Since the early 1980s, a number of scholars have described the impact of environmental and situational factors on users' information practices (Chatman, 1985; Chatman, 1987; Dervin, 1983; Dervin et al., 1986). The author who more than any others focused his attention on such factors, however, is probably Robert Taylor (Taylor, 1986; Taylor, 1991). He defines 'Information Use Environments' (IUE) as: 'the set of those elements that (a) affect the flow and use of information messages into, within, and out of any definable entity; and (b) determine the criteria by which the value of information messages will be judged' (Taylor, 1991, p. 218). It is important to notice that the description of a specific IUE may include not only dimensions such as geographic location or physical setting but also, perhaps more importantly, the socio-economic and cultural settings in which a group exists. Over time, the understanding of the fundamental role played by context in shaping the process of seeking, accessing, using and disposing of/preserving information has deepened to such extent that many information studies scholars now use the label 'behaviour' much more cautiously than in the past and often

prefer the term ‘information needs and uses’ to the term ‘information seeking behaviour’ (Dervin et al., 1986).

Taylor’s work focuses mainly on formal information sought in the context of recognized problems or concerns by groups of people who are active, experienced and critical users of information, such as engineers, legislators and practicing physicians. He affirms, however, that the structure offered by the IUE theory can be useful to the organization and interpretation of observations about other groups with different, less clearly predefined sets of problems and information needs, including, for example, the general public, the elderly, consumers, and the so-called ‘information-poor’.

Taylor suggests that, within the context of an IUE approach, attention should be given to those variables that truly contribute to the definition of the environment and behaviour of a specific user group. In many cases, he observes, traditionally collected demographic variables, focusing on the individual level, don’t play a major role. Conversely, non-demographic characteristics may be fundamental in describing a user group’s IUE. In his study, for example, he finds that variables such as media use, social networks, and attitudes toward new technology and innovation were among the most significant ones (Taylor, 1991).

While Taylor acknowledges that users show individual idiosyncrasies in their information practices, he suggests that the adoption of a group approach to the study of information behaviour has important advantages as real similarities can be found among individuals belonging to the same professional group, for example, and as several useful dimensions of the IUE approach have a collective meaning (Taylor, 1991). The interest in information users seen as groups has been shared by several authors and represents the fourth and final research focus included in this brief review. Overall, the body of research developed over the past few decades has clearly demonstrated that different groups have different

information practices, that is: familiarity with, access to, and uses of both formal and informal sources of information (Caidi et al., 2005, p. 304).

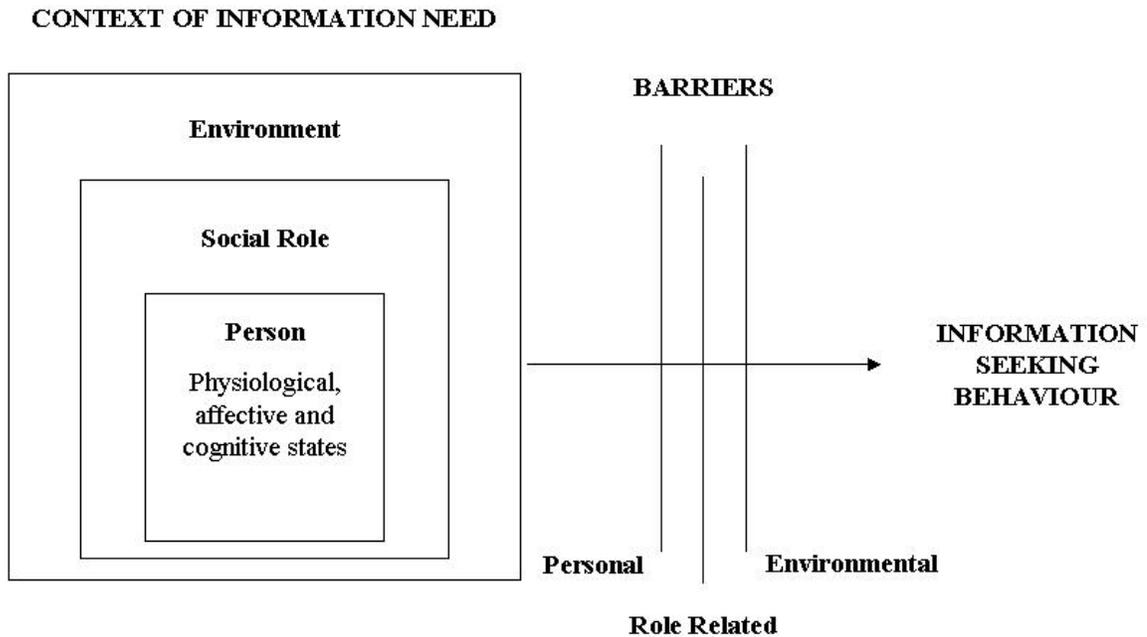
The literature is rich in studies on the information behaviour of different user groups. In addition to the already cited work focusing on professional groups, several researchers have explored the information practices of marginalized and disadvantaged population groups including, among others: inner city residents, the poor, people with limited formal education, the elderly, the inmate population, ethno-linguistic minorities, and immigrants (Agada, 1999; Caidi et al., 2005; Chatman, 1985; Chatman, 1987; Chatman, 1991a; Chatman, 1991b; Chatman et al., 1995; Chatman, 1996; Courtright, 2005; Fisher et al., 2004; Gollop, 1997; Kakai et al., 2003; Liu, 1995; Metoyer-Duran, 1991; Metoyer-Duran, 1993a; Metoyer-Duran, 1993b; Pettigrew, 1999; Pettigrew, 2000; Spink et al., 2001a). The vast majority of these studies are influenced by the four conceptual elements previously introduced. In other words, they adopt a *user-centred approach* to study the information practices of disadvantaged people, *as a group*, in the context of their *daily life activities* and taking into consideration the socioeconomic, cultural, geographic and physical dimensions of the *environment* in which they live.

Since the 1970s, various authors have tried to organize the observations and theories on information behaviour into a general model. One of the most prominent and accepted models has been the one first proposed by Wilson in 1981 (Figure 4.4) (Wilson, 1981).

In his paper, Wilson presents a flow chart describing the behaviour of an individual faced with the need to find information and a model of information-seeking behaviour that is particularly relevant to this study. The flow chart, linking concepts such as information need, information seeking, information exchange, and information use, was mainly aimed at helping scholars identify areas where additional research would be needed (Wilson et al., 1996). The model, an attempt to analyze more in depth the information-seeking component of the broader flow chart, includes: the circumstantial situation within which an

information need arises; the barriers that may influence either the stage of engaging into information seeking or the successful completion of a search; and the information-seeking behaviour itself (Wilson et al., 1996).

Figure 4.4 – Wilson’s 1981 Original Model Of Information-Seeking Behaviour

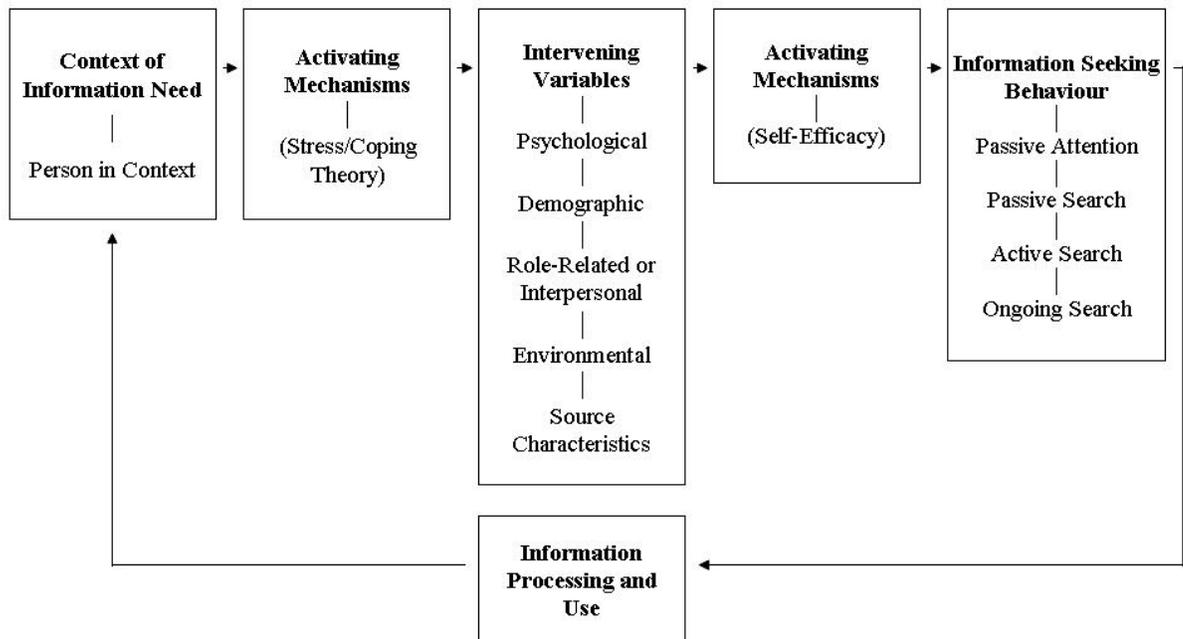


Adapted from Wilson and Walsh, 1996, Ch. 2, p. 3

Over time, Wilson and colleagues have revised and significantly expanded the original model. The most important development was proposed in 1996 after an extensive, interdisciplinary review of the literature on information-seeking behaviour (Figure 4.5) (Wilson et al., 1996). For their review, the authors explored a large number of studies in the fields of psychology, consumer behaviour, innovation research, health communication studies, organizational decision making, and information systems design.

Building on the basis of their review, in their 1996 paper Wilson and Walsh develop an in-depth analysis of the fundamental forces that lie at the root of the information-seeking behaviour construct, particularly the cognitive and affective dimensions of need and the motivations for information-seeking deriving from need. They observe how, especially with respect to health-related information needs, in addition to a cognitive dimension of need – the need to know, the desire to be informed, the need for order and meaning – people also experience an often strong affective dimension of need: obtaining information that will aid in dealing with the emotional aspects of a condition.

Figure 4.5 – The Expanded Version Of Wilson’s Model Of Information-Seeking Behaviour



Adapted from Wilson and Walsh, 1996, Ch. 7, p. 2

In addition, Wilson and Walsh explore theories, in various fields, able to shed a light on the mechanisms that, on the basis of need and motivation, activate the search behaviour and promote information processing and use. They find that a very general theory from psychology, the stress and coping theory (Folkman, 1984), seems to explain quite satisfactorily both the cognitive and affective dimensions of need. The theory identifies stress as a factor, originating from a subject-environment interaction, that is perceived as taxing or overwhelming, and threatening. Coping is the cognitive and behavioural response to stress. The theory appears to explain information-seeking as the emergence of a coping strategy.

Wilson and Walsh, however, make a distinction between the identification of information seeking as a potential coping strategy and the information-seeking behaviour itself. The subject's acknowledgement of the potential value of information seeking in countering stress does not automatically translate into action. Whether information-seeking behaviour is actually initiated or not depends on additional factors. The authors suggest various theories that may be useful to explain this step. One of those, the self-efficacy theory, seems to be particularly significant in the context of health-related information seeking. Self-efficacy is an individual's conviction that he or she can successfully execute a behaviour required to produce a certain outcome (Bandura, 1977). In the context of information-seeking behaviour, therefore, an individual may be aware of the potential usefulness of an information source but doubt his or her capacity to access the source and carry out the search properly (Wilson et al., 1996).

Wilson and Walsh also describe and categorize several barriers that hinder the information-seeking process, at various stages. Barriers can be broadly organized into four categories, depending whether they are related to individual characteristics, situational factors, environmental characteristics, and source-related aspects. While Wilson and Walsh position barriers at the very centre of their model, they make clear that this is simply a way to streamline the diagram. Barriers, in fact, may operate at different stages of the process

and the specific mechanism of their action may not even be possible to determine, in most cases. Barriers can be positioned at the very beginning of the process, preventing the initial emergence of a coping strategy. Alternatively, they can act between the identification of information-seeking as a suitable coping strategy and the information-seeking behaviour itself. Finally, they can hinder the process between the acquisition of information and its use.

Among individual barriers, Wilson and Walsh observe several impediments related to the physiological, demographic, socio-economic, cognitive, and emotional characteristics of the potential information user. Interpersonal barriers are to be expected whenever the information source is a person or whenever a person acts as a link between the potential user and the information source. Among the many potential environmental or situational barriers are, for example, time constraints, geographic distance, and differences in culture. Finally, source-related characteristics, too, can significantly influence the information-seeking process, particularly with respect to the actual or perceived accessibility of the source, its credibility, and the characteristics of communication channels between users and source.

With respect to the information-seeking behaviour itself, Wilson and Walsh observe that while 'active search', where an individual actively seeks out information, is usually considered the central 'mode' of searching, other modes do take place. 'Passive attention' can be identified when information is acquired without an intentional information-seeking process going on, such as when watching television programmes or listening to the radio. 'Passive search' is finding by coincidence information of relevance to the individual, while searching information on a different topic or while being involved in other behaviours. Finally, 'ongoing search' is the occasional continuing search carried out to update or expand an already established basic framework of ideas, beliefs, or values (Wilson et al., 1996, Ch. 5, p. 1).

C. Bringing Together Andersen's and Wilson's Models

As observed at the beginning of this chapter, Andersen's and Wilson's models can be considered as both analogous and complementing each other in illustrating how access to information on health and health-related services enables access to services.

With respect to their being analogous, the bidirectional arrows in figure 4.6 highlight factors in one model that may be considered as functionally analogous to factors in the other one.

- **Arrow #1** links 'Environment' in Andersen's model to 'Context of Information Need' in Wilson's. These components describe the environment in which needs arise and individuals act or do not act.
- **Arrow #2** links 'Need' in Andersen's model to 'Activating Mechanisms' in Wilson's. Needs are the factors that drive individuals to seek health care and are influenced by one's predisposing characteristics and enabling resources. Similarly, activating mechanisms are the cognitive and affective dimensions of the need for information. They result from the stress originating from a threatening subject-environment interaction and, as for Andersen's needs, they are influenced by multiple intervening factors and may or may not result in actual information seeking behaviour.
- **Arrow #3** links 'Predisposing Characteristics' and 'Enabling Resources' in Andersen's model to 'Intervening Variables' in Wilson's. These components include a heterogeneous group of factors – personal, interpersonal and environmental – that act either as barriers or facilitators, promoting or hindering individuals' behaviour.
- **Arrow #4** links the feedback loops in Andersen's model, which stresses the cyclical interactions between outcomes of care and population characteristics/health behaviour, to the feedback loop in Wilson's model, which highlights how the results of the information-seeking activity impact the information need context and the individual's experience.
- Finally, **Arrows #5** links 'Outcomes' in Andersen's model to both the 'Information Processing and Use' and the 'Person in Context' dimension of 'Context of Information

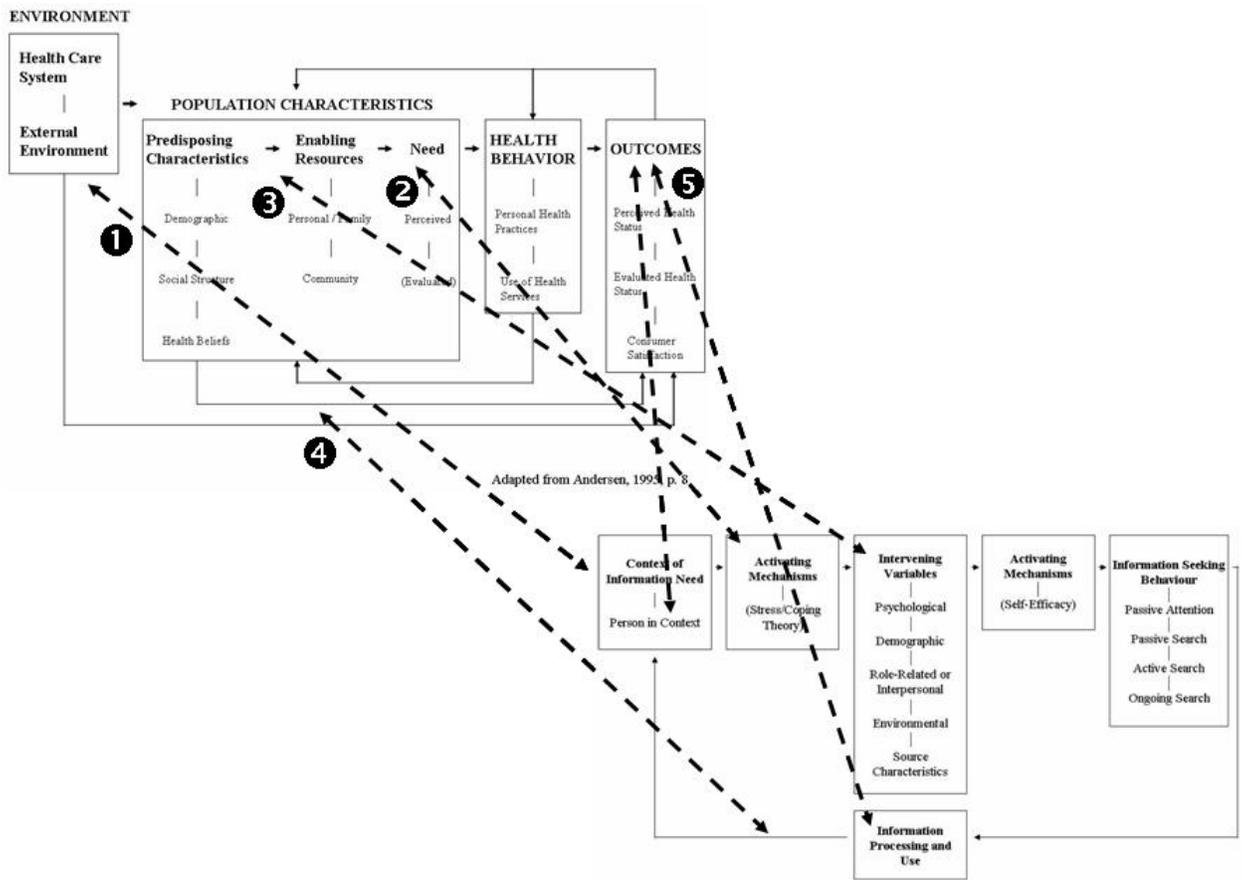
Need' components in Wilson's model. In both models, these components represent the change achieved by acting, the ultimate result, and the new individual who emerges at the end of a cyclical interaction.

The two models can also be considered as being complementary, as shown in figure 4.7.

Wilson's model theoretically explains and predicts how people access information sources.

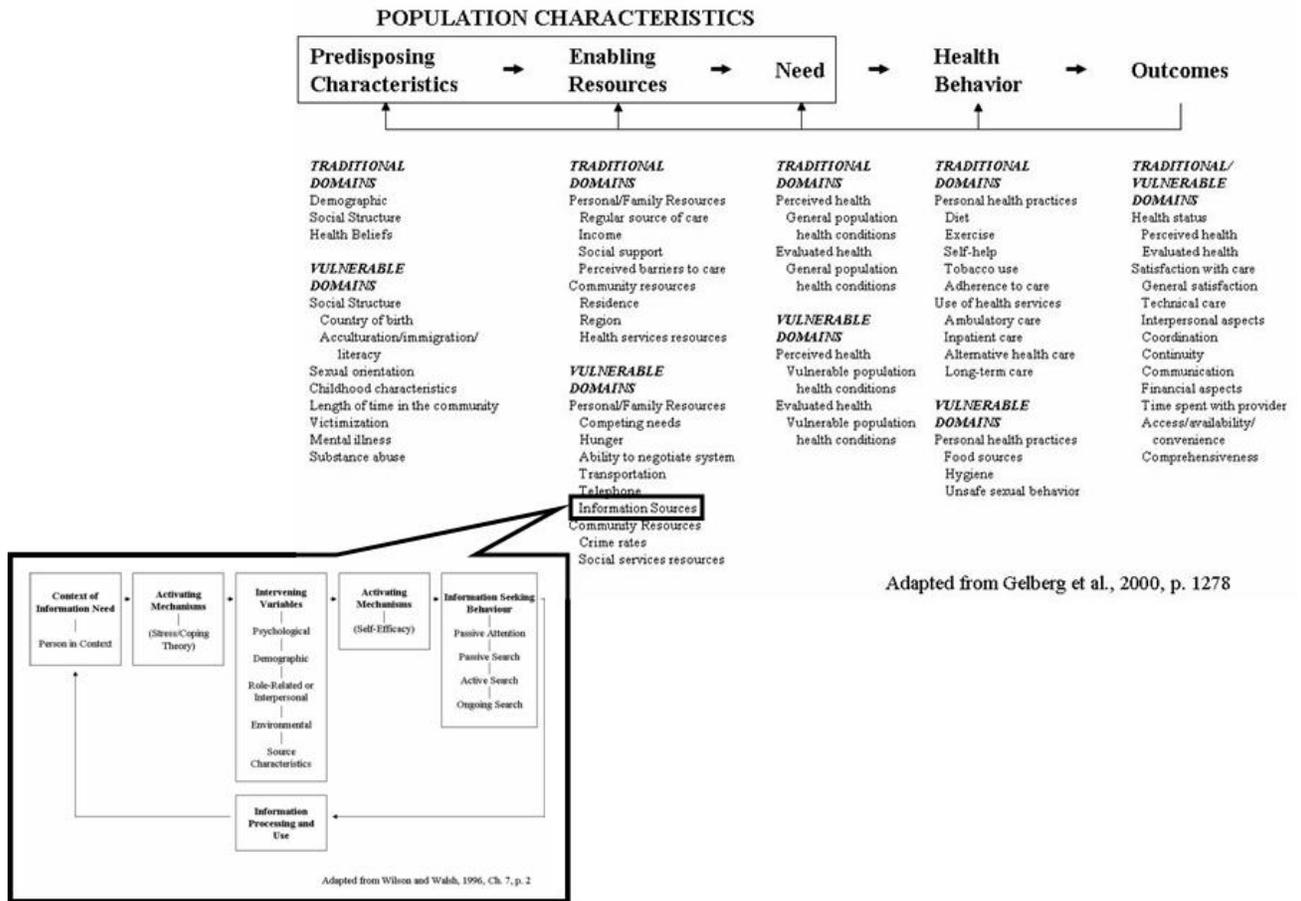
In the modified version of Andersen's model for vulnerable populations, information sources are, in turn, one of the enabling factors supporting access to health services.

Figure 4.6 – Analogies Between Andersen's and Wilson's Models



The analogous and complementary nature of the two models is of particular relevance for this study because their integration shows that: a) certain factors might represent barriers limiting access, at the very same time, to both health services and information services; and b) that barriers limiting access to information sources can be also considered as indirect barriers limiting access to health services.

Figure 4.7 – Andersen’s and Wilson’s Models: From Access To and Use Of Information To Access To and Use Of Health Services



In this chapter two models have been presented that help to understand the complex relationship between access to information resources and access to health services. Models cannot accurately represent the complexity of reality and of the subtle interplay of infinite factors that make it up. Andersen's and the Wilson's models are not exceptions and they do show some overall rigidity and a linearity that, in spite of the feedback loops they include, does not really allow for reverse currents or the bypassing of certain steps. They do serve, however, as starting points to systematically observe and analyze reality. They are also helpful for synthesizing existing literature, identifying gaps in knowledge, designing research initiatives, and ultimately developing policies more favourable to health (Woodward et al., 2001). This is the role the two models play here.

The next chapter will describe the methods applied in this study and introduce its two main components: the quantitative survey of 211 Toronto users; and the qualitative interviews conducted with some of them to gain a better understanding of the experience of newcomers struggling to negotiate and navigate a largely unknown health care system, and of the role access to information plays in this struggle.

D. References

Evans, T.; Whitehead, M.; Diderichsen, F.; Bhuiya, A.; Wirth, M. (Eds.) (2001) *Challenging Inequities in Health: From Ethics to Action*. New York: Oxford University Press.

Acosta-Ramirez, N.; Duran-Arenas, L.G.; Eslava-Rincon, J.I.; Campuzano-Rincon, J.C. (2005) 'Determinants of vaccination after the Colombian health system reform.' *Revista De Saude Publica*; 39; 3: 421-9.

Afilalo, J.; Marinovich, A.; Afilalo, M.; Colacone, A.; Leger, R.; Unger, B. et al. (2004) 'Nonurgent emergency department patient characteristics and barriers to primary care.' *Academic Emergency Medicine*; 11; 12: 1302-10.

Agada, J. (1999) 'Inner-city gatekeepers: An exploratory survey of their information use environment.' *Journal of the American Society for Information Science*; 50; 1: 74-85.

Andersen, R.M. (1968) *Behavioral Model of Families' Use of Health Services*. Chicago: University of Chicago.

Andersen, R.M. (1995) 'Revisiting the behavioral model and access to medical care: Does it matter?' *Journal of Health and Social Behavior*; 36; 1: 1-10.

Auslander, G.K.; Soskolne, V.; Ben Shahr, I. (2005) 'Utilization of health social work services by older immigrants and veterans in Israel.' *Health and Social Work*; 30; 3: 241-51.

Baker, R.S.; Bazargan, M.; Bazargan-Hejazi, S.; Calderon, J.L. (2005) 'Access to vision care in an urban low-income multiethnic population.' *Ophthalmic Epidemiology*; 12; 1: 1-12.

Bandura, A. (1977) 'Self-Efficacy: Towards a unifying theory of behavioural change.' *Psychological Review*; 84; 191-215.

Bass, D.M.; Looman, W.J.; Ehrlich, P. (1992) 'Predicting the volume of health and social services: Integrating cognitive impairment into the modified Andersen framework.' *The Gerontologist*; 32; 33-43.

Bass, D.M.; Noelker, L.S. (1987) 'The influence of family caregivers on elders' use of in-home services: An expanded conceptual framework.' *Journal of Health & Social Behavior*; 28; 184-96.

Bates, M.J. (2005) An Introduction to Metatheories, Theories, and Models. In: Fisher, K.E.; Erdelez, S.; McKechnie, L.E.F. (Eds.) *Theories of Information Behavior*. Pp. 1-24. Medford (NJ): Information Today.

Bazargan, M.; Bazargan-Hejazi, S.; Baker, R.S. (2005) 'Treatment of self-reported depression among Hispanics and African Americans.' *Journal of Health Care for the Poor & Underserved*; 16; 2: 328-44.

Borders, T.F.; Brannon-Goedeke, A.; Arif, A.; Xu, K.T. (2004) 'Parents' reports of children's medical care access: Are there Mexican-American versus non-Hispanic white disparities?' *Medical Care*; 42; 9: 884-92.

Bourdieu, P. (1984) *Distinction*. Cambridge (MA): Harvard University Press.

Braveman, P.; Gruskin, S. (2003) 'Defining equity in health.' *Journal of Epidemiology & Community Health*; 57; 4: 254-8.

Broyles, R.W.; Narine, L.; Brandt, E.N., Jr. (2000) 'Equity concerns with the use of hospital services by the medically vulnerable.' *Journal of Health Care for the Poor & Underserved*; 11; 3: 343-60.

Caidi, N.; Allard, D. (2005) 'Social inclusion of newcomers to Canada: An information problem?' *Library & Information Science Research*; 27; 3: 302-24.

Chatman, E.A. (1985) 'Information, mass-media use and the working poor.' *Library & Information Science Research*; 7; 2: 97-113.

Chatman, E.A. (1987) 'The information world of low-skilled workers.' *Library & Information Science Research*; 9; 4: 265-83.

Chatman, E.A. (1991a) 'Channels to a larger social world: Older women staying in contact with the great society.' *Library & Information Science Research*; 13; 3: 281-300.

Chatman, E.A. (1991b) 'Life in a small world: Applicability of gratification theory to information-seeking behavior.' *Journal of the American Society for Information Science*; 42; 6: 438-49.

Chatman, E.A. (1996) 'The impoverished life-world of outsiders.' *Journal of the American Society for Information Science*; 47; 3: 193-206.

Chatman, E.A.; Pendleton, V.E.M. (1995) 'Knowledge gaps, information-seeking and the poor.' *Reference Librarian*; 49/50; 135-45.

Coulton, C.; Frost, A.K. (1982) 'Use of social and health services by the elderly.' *Journal of Health and Social Behavior*; 23; 330-9.

Counte, M.A.; Glandon, G.L. (1991) 'A panel study of life stress, social support, and the health services utilization of older persons.' *Medical Care*; 29; 348-61.

Courtright, C. (2005) 'Health information-seeking among Latino newcomers: An exploratory study.' *Information Research - An International Electronic Journal*; 10; 2.

Davanzo, J.E. (1994) *The Relationship Between Autonomy and Medicare Utilization in an Elderly Sample*. A thesis submitted in conformity with the requirements for a degree of Doctor of Philosophy. Department of Health Services, University of California at Los Angeles.

Dervin, B. (1983) *An Overview of Sense-Making Research: Concepts, Methods, and Results to Date*.

Dervin, B. (1998) 'Sense-making theory and practice: An overview of user interests in knowledge seeking and use.' *Journal of Knowledge Management*; 2; 2: 36-46.

Dervin, B. (2005) What Methodology Does to Theory: Sense-Making Methodology As Exemplar. In: Fisher, K.E.; Erdelez, S.; McKechnie, L.E.F. (Eds.) *Theories of Information Behavior*. Pp. 25-30. Medford (NJ): Information Today.

Dervin, B.; Nilan, M. (1986) Information Needs and Uses. In: Williams, M. (Ed.) *Annual Review of Information Science and Technology*. Pp. 3-33. Medford (NJ): Learned Information.

Desai, M.M.; Rosenheck, R.A.; Kaspro, W.J. (2003) 'Determinants of receipt of ambulatory medical care in a national sample of mentally ill homeless veterans.' *Medical Care*; 41; 2: 275-87.

Doty, H.E.; Weech-Maldonado, R. (2003) 'Racial/ethnic disparities in adult preventive dental care use.' *Journal of Health Care for the Poor and Underserved*; 14; 4: 516-34.

Fisher, K.E.; Durrance, J.C.; Bouch Hinton, M. (2004) 'Information grounds and the use of needs-based services by immigrants in Queens, New York: A context-based, outcome evaluation approach.' *Journal of the American Society for Information Science and Technology*; 55; 754-66.

Fisher, K.E.; Erdelez, S.; McKechnie, L.E.F. (2005) Preface. In: Fisher, K.E.; Erdelez, S.; McKechnie, L.E.F. (Eds.) *Theories of Information Behavior*. P. XIX-XXII. Medford (NJ): Information Today.

Folkman, S. (1984) 'Personal control and stress and coping processes: A theoretical analysis.' *Journal of Personality and Social Psychology*; 46; 839-52.

Fosu, G.B. (1994) 'Childhood morbidity and health services utilization: Cross-national comparisons of user-related factors from DHS data.' *Social Science & Medicine*; 38; 9: 1209-20.

Freedman, V.A. (1993) 'Kin and nursing home length of stay: A backward recurrence time approach.' *Journal of Health and Social Behavior*; 34; 138-52.

Gelberg, L.; Andersen, R.M.; Leake, B.D. (2000) 'The behavioral model for vulnerable populations: Application to medical care use and outcomes for homeless people.' *Health Services Research*; 34; 6: 1273-302.

Gilbert, G.H.; Branch, L.G.; Longmate, J. (1993) 'Dental care use by U.S. veterans eligible for VA care.' *Social Science & Medicine*; 36; 361-70.

Gollop, C.J. (1997) 'Health information-seeking behavior and older African American women.' *Bulletin of the Medical Library Association*; 85; 2: 141-6.

- Goodwin, R.; Koenen, K.C.; Hellman, F.; Guardino, M.; Struening, E. (2002) 'Helpseeking and access to mental health treatment for obsessive-compulsive disorder.' *Acta Psychiatrica Scandinavica*; 106; 2: 143-9.
- Grace, S.L.; Evindar, A.; Kung, T.N.; Scholey, P.E.; Stewart, D.E. (2004) 'Automatic referral to cardiac rehabilitation.' *Medical Care*; 42; 7: 661-9.
- Guendelman, S. (1991) 'Health care users residing on the Mexican border: What factors determine choice of the U.S. or Mexican health system?' *Medical Care*; 29; 419-29.
- Gulzar, L. (1999) 'Access to health care.' *Image: Journal of Nursing Scholarship*; 31; 1: 13-8.
- Heslin, K.C.; Cunningham, W.E.; Marcus, M.; Coulter, I.; Freed, J.; Der-Martirosian, C. et al. (2001) 'A comparison of unmet needs for dental and medical care among persons with HIV infection receiving care in the United States.' *Journal of Public Health Dentistry*; 61; 1: 14-21.
- Honda, K. (2004) 'Factors underlying variation in receipt of physician advice on diet and exercise: Applications of the behavioral model of health care utilization.' *American Journal of Health Promotion*; 18; 5: 370-7.
- Jaynes, C.L. (2004) *Evaluating Health System Performance: Access to Interventional Cardiology for Acute Cardiac Events in the Rural Medicare Population*. A thesis submitted in conformity with the requirements for a degree of Doctor of Philosophy. Ohio State University.
- Kakai, H.; Maskarinec, G.; Shumay, D.M.; Tatsumura, Y.; Tasaki, K. (2003) 'Ethnic differences in choices of health information by cancer patients using complementary and alternative medicine: An exploratory study with correspondence analysis.' *Social Science & Medicine*; 56; 4: 851-62.
- Kane, D.J.; Zotti, M.E.; Rosenberg, D. (2005) 'Factors associated with health care access for Mississippi children with special health care needs.' *Maternal & Child Health Journal*; 9; 2 (Suppl.): S23-S31.
- Kelly, M.A.; Perloff, J.D.; Morris, N.M.; Liu, W. (1992) 'Primary care arrangements and access to care among African American women in three Chicago communities.' *Women and Health*; 18; 91-106.
- Kilbourne, A.M.; Andersen, R.M.; Asch, S.; Nakazono, T.; Crystal, S.; Stein, M. et al. (2002) 'Response to symptoms among a U.S. national probability sample of adults infected with human immunodeficiency virus.' *Medical Care Research & Review*; 59; 1: 36-58.

Kimerling, R.; Baumrind, N. (2005) 'Access to specialty mental health services among women in California.' *Psychiatric Services*; 56; 6: 729-34.

Lim, Y.W.; Andersen, R.; Leake, B.; Cunningham, W.; Gelberg, L. (2002) 'How accessible is medical care for homeless women?' *Medical Care*; 40; 6: 510-20.

Liu, M. (1995) 'Ethnicity and information seeking.' *Reference Librarian*; 49/50; 123-34.

McCusker, J.; Karp, I.; Cardin, S.; Durand, P.; Morin, J. (2003) 'Determinants of emergency department visits by older adults: A systematic review.' *Academic Emergency Medicine*; 10; 12: 1362-70.

Mechanic, D. (1979) 'Correlates of physician utilization: Why do multivariate studies of physician utilization find trivial psychosocial and organizational effects?' *Journal of Health and Social Behavior*; 20; 387-96.

Metoyer-Duran, C. (1991) 'Information-seeking behavior of gatekeepers in ethnolinguistic communities - Overview of a taxonomy.' *Library & Information Science Research*; 13; 4: 319-46.

Metoyer-Duran, C. (1993a) 'Information gatekeepers.' *Annual Review of Information Science and Technology*; 28; 111-50.

Metoyer-Duran, C. (1993b) 'The information and referral process in culturally diverse communities.' *RQ*; 32; 3: 359-71.

Miller, B.; McFall, S. (1991) 'The effect of caregiver's burden on change in frail older persons' use of formal helpers.' *Journal of Health and Social Behavior*; 32; 165-79.

Owusu, G.A.; Eve, S.B.; Cready, C.M.; Koelln, K.; Trevino, F.; Urrutia-Rojas, X. et al. (2005) 'Race and ethnic disparities in cervical cancer screening in a safety-net system.' *Maternal and Child Health Journal*; 9; 3: 285-95.

Patrick, D.L.; Stein, J.; Porta, M.; Porter, C.Q.; Ricketts, T.C. (1988) 'Poverty, health services, and health status in rural America.' *The Milbank Quarterly*; 66; 105-36.

Pescosolido, B. (1992) 'Beyond rational choice: The social dynamic of how people seek help.' *American Journal of Sociology*; 97; 1096-138.

Pettigrew, K.E. (1999) 'Waiting for chiropody: Contextual results from an ethnographic study of the information behaviour among attendees at community clinics.' *Information Processing & Management*; 35; 6: 801-17.

Pettigrew, K.E. (2000) 'Lay information provision in community settings: How community health nurses disseminate human services information to the elderly.' *Library Quarterly*; 70; 1: 47-85.

Richardson, L.D.; Hwang, U. (2001) 'America's health care safety net: Intact or unraveling?' *Academic Emergency Medicine*; 8; 11: 1056-63.

Rivnyak, M.; Wan, T.T.; Stegall, M.H.; Jacobs, M.; Li, S. (1989) 'Ambulatory care use among noninstitutionalized elderly: A causal model.' *Research in Aging*; 11; 292-311.

Savolainen, R. (1995) 'Everyday life information seeking: Approaching information seeking in the context of "way of life".' *Library & Information Science Research*; 17; 259-94.

Spink, A.; Cole, C. (2001a) 'Information and poverty: Information-seeking channels used by African American low-income households.' *Library & Information Science Research*; 23; 1: 45-65.

Spink, A.; Cole, C. (2001b) 'Introduction to the special issue: Everyday life information-seeking research.' *Library & Information Science Research*; 23; 4: 301-4.

Swanson, K.A.; Andersen, R.; Gelberg, L. (2003) 'Patient satisfaction for homeless women.' *Journal of Women's Health*; 12; 7: 675-86.

Taylor, R.S. (1986) *Value-Added Processes In Information Systems*. Norwood (NJ): Ablex Publishing.

Taylor, R.S. (1991) 'Information use environments.' *Progress in Communication Sciences*; 10; 217-55.

True, W.R.; Romeis, J.C.; Heath, A.C.; Flick, L.H.; Shaw, L.; Eisen, S.A. et al. (1994) *Genetic and Environmental Contributions to Health Care Need and Utilization: A Twin Analysis*.

Walker, M.L. (2005) *Stroke Care in Academic Health Centers: Does Third Party Payer Type Affect Equity of Physical Therapy Services and Discharge Disposition?* A thesis submitted in conformity with the requirements for a degree of Doctor of Philosophy. Virginia Commonwealth University.

Wallace, A.; Scott, J.; Klinnert, M.; Anderson, M.E. (2004) 'Impoverished children with asthma: A pilot study of urban healthcare access.' *Journal for Specialists in Pediatric Nursing*; 9; 2: 50-8.

Wilson, T.D. (1981) 'On user studies and information needs.' *Journal of Documentation*; 37; 3-15.

Wilson, T.D.; Walsh, C. (1996) *Information Behaviour: An Interdisciplinary Perspective*.

Wolinsky, F.D.; Johnson, R.J. (1991) 'The use of health services by older adults.' *Journal of Gerontology*; 46; S345-S357.

Woodward, D.M.; Drager, N.; Beaglehole, R.; Lipson, D. (2001) 'Globalization and health: A framework for analysis and action.' *Bulletin of the World Health Organization*; 79; 875-81.

World Health Organization (1978) *Primary Health Care: Report of the International Conference on Primary Health Care*. Alma-Ata, USSR, September 6-12, 1978. Geneva: World Health Organization.

Xu, K.T.; Smith, S.R.; Borders, T.F. (2003) 'Access to prescription drugs among noninstitutionalized elderly people in West Texas.' *American Journal of Health-System Pharmacy*; 60; 7: 675-82.

Chapter V – Methods

This chapter presents a detailed description of the study methods. As explained in Chapter II, this research initiative focused on 211 Toronto as an example of an information and referral service that could be considered ‘ideal’ for a number of reasons and that could potentially reach and support recent immigrants from a variety of linguistic backgrounds. Assessing how well 211 Toronto achieves its objectives and expanding our understanding of the challenges faced by recent immigrants who struggle to navigate and negotiate a largely unknown health care system will not only help to improve 211 Toronto but will also inform the development of policies and services that are essential to achieving equity in health in a highly multicultural society.

The chapter begins with an outline of the goal, objectives, and structure of the study, in section A. Section B describes the contribution of the thesis committee to the study. Section C summarizes the review process undertaken to obtain approval for the study protocol from the University of Toronto Research Ethics Board. The following sections – D to F – discuss, for each of the three study objectives, the procedures followed to achieve them. These procedures include: the rationale for the methods used; a description of the setting, location, and relevant dates; recruitment procedures, including eligibility criteria, sources, and methods of selection of participants; data sources and measurement; potential sources of bias and efforts to address them; study size and its justification; handling of variables; statistical methods; and issues of integration of results from different phases of the study.

A. Goal, Objectives, and Structure Of the Study

As discussed at the end of Chapter I, the goal of this study was to better understand the experience of recent immigrants struggling to navigate and negotiate a largely unfamiliar health care system and identify barriers limiting in a significant way their access to information services.

The study had three main objectives.

1. *To obtain a snapshot of 211 Toronto users who contact the service by phone, understanding how representative they are of Toronto's general population.*

A comparison between data collected surveying 211 Toronto callers and 2001 Census data could help identify population groups that are either under- or overrepresented among users and understand whether 211 Toronto is reaching those groups, such as recent immigrants, who might benefit the most from this service.

2. *To understand how 211 Toronto callers seeking health-related information use the information they obtain when contacting the service and their overall level of satisfaction.*

Certain individual characteristics of 211 Toronto callers might be associated with higher rates of success in solving problems and with higher levels of user satisfaction with the service. Correlation levels among a number of predicting variables and indicators of effectiveness and satisfaction can be measured and regression models tested.

3. *To gain a better appreciation of the experience of recent immigrants struggling to navigate and negotiate an unfamiliar health care system, focusing on their information needs, information seeking behaviour, knowledge of, attitude towards, and actual use of existing information sources, and barriers and facilitators experienced in the process of obtaining information.*

Building a better understanding of what recent immigrants had to endure and overcome before finding out about 211 Toronto and using it effectively would help focus on the most challenging aspects of their experiences. This is an essential first step towards the

development of support mechanisms to help them and those recent immigrants who are still unaware of this service.

To achieve these objectives, the study made use of both primary and secondary data. Primary data were collected through a phone survey and face-to-face unstructured qualitative interviews of 211 Toronto callers. Secondary data were extracted from the Census of Canada 2001 'Public Use Microdata File on Individuals', accessed through the University of Toronto Data Library Service (Statistics Canada, 2007).

The study employed research methods that belong to both the quantitative/post-positivist tradition (survey) and the qualitative/interpretative one (qualitative interviews). Mixed method research has been 'marketed' as a practice that breaches the boundary between these two traditions to achieve 'the best of both worlds' (Creswell, 1994; Patton, 1988; Wolcott, 2002). Several authors, however, have strongly criticized this view suggesting that an irresolvable contradiction exists between the ontological, epistemological, axiological, rhetorical and methodological assumptions of the two traditions and that a lack of acknowledgment of these contradictions may lead to incongruous results (Giddings et al., 2007).

Acknowledging Giddings and Grant's remark that often, in mixed methods research, there is a lack of clear understanding of what is mixed, whether methods or methodology, it is important to clarify that this study does not make any claim to methodological, and even less to paradigmatic integration. Instead, this research project remains clearly rooted in the quantitative/post-positivist research tradition. Methods have been selected considering their value for researching specific questions. In particular, qualitative interviews seemed the most appropriate way of achieving Objective #3. The aim here is not triangulation or cross-validation of data and analysis but, instead, achieving a broader research focus and a deeper understanding of social experiences and lived realities. In this sense, this research initiative could be classified as a 'two-phase design' in which the study phenomenon is

investigated at different and separate stages, a study design that, according to a framework proposed by various authors, represents the lowest level of integration between the two traditions (Creswell, 1994; DePoy et al., 1994).

Data collection was structured in three phases, each one of them directly related to one of the objectives.

Phase 1. Cross-sectional phone survey of 211 Toronto callers.

Phase 2. Follow-up phone survey of 211 Toronto callers seeking health-related information.

Phase 3. Qualitative, semi-structured, mainly face-to-face interviews with a small group of immigrant 211 Toronto callers from Spanish-speaking Latin American countries. The focus on Spanish-speaking immigrants was dictated by practical reasons, as the main investigator speaks Spanish fluently and was therefore able to conduct interviews in the participants' mother tongue.

B. Thesis Committee

The main investigator was guided and assisted by a thesis committee whose contributions were essential to the successful completion of the study. The thesis committee included four members with diverse expertise and a wide range of research interests including, among others: health services research; clinical and social epidemiology; quantitative and qualitative research methods; health geography; and information studies. The committee played a particularly important role in helping the main investigator bridge two quite different bodies of literature: one related to health services research and the other one to information studies. The advisory committee met on several occasions between May 2004 and May 2008. Between meetings, communication continued by email and feedback was offered by all members at various stages of development of the research project. Names and affiliations of advisory committee members are listed in Appendix 1.

C. Ethics Review Process

As the research project involved living human subjects, the study protocol and study instruments were submitted for review to the University of Toronto Health Sciences I Research Ethics Board. The final version of the approved protocol is included in Appendix 2. All approved data collection tools are presented in Appendix 4, including the: ‘Phase 1 Interview Guide – Counsellor’; ‘Phase 1 Interview Guide – Interviewer’ (English version); ‘Phase 1 Interview Guide – Interviewer’ (Spanish version); ‘Phase 2 Interview Guide’ (English version); ‘Phase 2 Interview Guide’ (Spanish version); and ‘Phase 3 Interview Guide’ (Spanish version).

Following the guidelines set by the Research Ethics Board, the protocol incorporated specific information on a number of aspects including, in particular:

- the study timeframe, organized around the three separate data collection phases;
- the recruitment process, explaining duties and responsibilities of 211 Toronto counsellors and of interviewers specifically hired for the study as well as the mechanisms of interaction between the two groups;
- the characteristics of study participants, listing the inclusion criteria applied and justifying the size of the study sample for each phase of the study;
- a brief analysis of the risks and benefits related to the study;
- an equally brief analysis of issues of privacy and confidentiality, explaining mechanisms for the protection of personal information and management of data in digital format;
- the study compensation policy, including reimbursement of those Phase 3 subjects who would participate in face-to-face interviews at the main investigator’s office;
- an essential description of data analysis and tools; and
- a brief overview of the strategy for the dissemination of final results.

With respect to the three data collection phases, the protocol included the following information.

Phase 1, cross-sectional phone survey:

- the objective and length of the interviews;
- the mechanism to obtain informed consent, and its monitoring;
- the type and amount of information collected by 211 Toronto counsellors about callers whose English was deemed insufficient to participate in the study.

Phase 2, follow-up interviews:

- the objective and length of the interviews;
- the mechanism to confirm participants' informed consent.

Phase 3, qualitative interviews:

- the objective and length of the interviews;
- the general themes treated during the interviews;
- the mechanism used to ensure informed consent and permission to audio record the interviews;
- information on the interviewers;
- information on the safety procedures to be followed in case of interviews carried out at the participant's home.

During data collection, a few minor modifications to the approved protocol were introduced for various reasons. None of these modifications reduced the level of protection of participants' privacy and confidentiality and in two cases they improved it.

Modifications to the approved protocol were as follows.

1. The approved protocol stated that, during Phase 1, all callers would have been interviewed in English with the exception of Spanish-speaking callers, who would have been asked by 211 Toronto counsellors for permission to be contacted by phone at a later time. Had permission been granted, they would have been called by the main

- investigator and interviewed in Spanish. It was decided, instead, not to make exceptions for Spanish-speaking callers and interview only those among them with a sufficient knowledge of the English language. This change was aimed at selecting a sample that would more closely represent the general population of 211 Toronto callers who speak English, without oversampling for Spanish-speaking users. Also, such modification significantly reduced the amount of personal information (i.e. names and phone numbers) that had to be recorded by counsellors and passed on to the main investigator, therefore potentially reducing threats to privacy and confidentiality.
2. The approved protocol stated that Phase 3 participants would have been identified among callers interviewed during Phase 2. While conducting follow-up interviews, however, it became clear that not enough callers matching the inclusion criteria for participating in the qualitative interviews would have been identified that way. Therefore, a Spanish-speaking 211 Toronto counsellor accepted to invite additional callers who asked health-related questions, independently, using the same invitation script included at the end of the 'Phase 2 Interview Guide' (Spanish version).
 3. The approved protocol stated that, in Phase 3 of the study, transcribed interviews would be entered into the 'Qualitative Solutions and Research – Non-numerical Unstructured Data Indexing Searching and Theorizing' (QSR NUD•IST) software for analysis. Instead, the 'NUD•IST Vivo' (NVivo) software was used, which is a more recent and powerful version of the old QSR NUD•IST produced by the same software company and able to support very fine-grained and intensive analyses (Gibbs, 2002).
 4. The approved protocol stated that an audio-tape recorder would be used during qualitative interviews. Instead, a digital recorder was used to eliminate the potential risk of misplacing tapes.

D. Objective 1: To Obtain a Snapshot Of 211 Toronto Users Who Contact the Service By Phone Understanding How Representative They Are Of Toronto's General Population

Objective 1 of the study was achieved conducting a cross-sectional survey on a sample of 211 Toronto users who contacted the service by phone, and who lived within the

boundaries of Toronto's Census Metropolitan Area (CMA), and comparing survey data with census data for the general population living in the same geographic area, to understand whether certain population groups were either under- or overrepresented among users of 211 Toronto. The term 'Census Metropolitan Area' is used by Statistics Canada to identify a geographic unit that includes a group of closely interconnected municipalities, due to people residing in one municipality and working in another, under the influence of a major urban centre, called urban core, having a population of at least 100,000 people at the time of the previous census (Statistics Canada - Census Operations Division, 2003). Toronto's CMA, shown in Figure 5.1, includes several municipalities clustered around the City of Toronto, the CMA urban core.

Survey methodology was the natural choice since it is the same approach used in the census and it represents an efficient data-gathering technique that offers the opportunity to collect a broad range of information on respondents (Shi, 1997).

The study was conducted over a period of six weeks between Monday July 25th and Friday September 2nd, 2005, for a total of 29 working days. The most important factor limiting the length of data collection activities was the availability of human resources, as explained later in the chapter. The same factor led to the decision of limiting data collection activities to weekdays, between 8am and 8pm.

All interviews were conducted on the phone at the time users contacted the service. 211 Toronto counsellors, after having thoroughly addressed callers' queries, would invite them to participate in the study. Callers who accepted the invitation were then transferred to an interviewer.

Figure 5.1 – Toronto’s Census Metropolitan Area



Source: University of Toronto, Data Library Service, Census of Canada, Reference Maps:
<http://www.chass.utoronto.ca.myaccess.library.utoronto.ca/datalib/cc06/refmap06.htm>

D.1 Recruitment Procedures

Four inclusion criteria were used to enrol participants:

1. speaking English fluently enough to understand the recruitment script and the questions included in the interview guide;
2. being 18 years old or older;
3. living within the boundaries of Toronto’s CMA; and
4. seeking information for oneself or a relative/friend, not for a client as part of one’s professional duties.

In spite of the obvious drawbacks created by limiting participation in the survey to English speakers only, particularly given the study's emphasis on recent immigrants, it was decided to conduct all interviews in English to simplify the survey's methodology. Fluency in English was assessed by 211 Toronto counsellors who, while offering their services, would probe callers' linguistic skills before deciding whether to invite them or not. Callers whose knowledge of the English language was deemed insufficient were excluded from the study. All other callers were invited and, if they agreed to participate, transferred from counsellors to interviewers. It was the interviewers' responsibility to test them for the remaining three inclusion criteria. The age limitation was introduced to eliminate the ethical complications of dealing with minors and to avoid the need to use proxy responses. The geographic limitation was needed to make the comparison of survey and census data possible. Finally, the fourth inclusion criterion was used to exclude those people who were not 211 Toronto's end users but employees of other human resources agencies that make use of 211 Toronto's unique database to help their own clients.

Initially, a fifth inclusion criterion, being a first-time caller, was adopted as it was thought it would be interesting to focus specifically on those users who were perhaps for the first time facing an 'information crisis'. This criterion, however, was dropped just two days into data collection for at least three reasons: 1) it was dramatically reducing the number of potential participants successfully enrolled; 2) its elimination makes the sample more representative of the general population of 211 Toronto callers who speak English and gives the opportunity to compare certain characteristics, such as the type of questions asked, between first-time users and repeat users; and 3) being a first-time caller does not guarantee that the caller is in fact facing an 'information crisis' for the first time. The 'being a first-time caller' criterion was not included in the final version of the study protocol, which is included in Appendix 3.

Eligible participants in the survey were randomly selected among 211 Toronto callers using systematic sampling. The sampling interval needed to recruit, over a period of six

weeks, enough participants, as defined according to criteria that will be presented later in the chapter, was calculated taking into consideration the following factors:

- the number of calls 211 Toronto had received in previous years, on average, during the same weeks, between 8am and 8pm;
- the percentage of callers who, historically, had been willing to participate in the quarterly monitoring surveys carried out by Findhelp, the agency responsible for the 211 Toronto service; and
- the percentage of those same callers with the characteristics defined by the survey inclusion criteria.

Each 211 Toronto counsellor was initially instructed to invite every 8th caller, for the duration of a work shift. At this stage, the only reason for excluding callers was if their knowledge of English was deemed by counsellors insufficient to understand the recruitment script included at the beginning of the interview guide and/or properly answer questions. In those cases, counsellors would only record, on their invitation form: the reason/s for calling; the language used in addressing the caller's query; and the age and sex of the caller. In all other cases, counsellors were instructed to invite all callers without exceptions. To facilitate this task, at the beginning of each shift counsellors would receive a check list that was used to record the total number of calls answered by each counsellors and to work as a reminder, helping them identify the callers they were to invite. The check list is included in Appendix 5, which also includes other tools used to manage and facilitate the data collection process. Soon, however, as explained in detail in Chapter VI, it became clear that an important percentage of 211 Toronto counsellors were not recording all calls they would answer and, as a result, were inviting a significantly smaller number of callers than initially planned. The situation did not significantly improve even if, on a daily basis, counsellors were encouraged to comply with the study protocol and study objectives and procedures were reviewed together. For this reason, trying to limit data loss and recruit a large enough number of callers in the limited time available, the sampling interval was reduced from every 8th to every 5th, then 3rd caller. Eventually, over the last few days of

data collection, interviewers were instructed to invite every single caller. Unfortunately, reducing the sampling interval did not achieve fully satisfactory results and, at the end of the process, the total number of completed interviews was still significantly smaller than the number initially planned, as reported in Chapter VI.

In the week immediately before data collection started, all 211 Toronto counsellors participated in compulsory training meetings that were officially called by Findhelp senior management. During those meetings counsellors learned about several aspects of the study, including: its goal and main objectives; the general methodology employed; the three data collection phases; sampling method; study sponsors; general guidelines and procedures; roles and responsibilities of the various stakeholders involved in the study design and implementation; counsellors' specific roles and responsibilities; operational definition of 'health-related question'; and expected results, and their planned uses, with particular emphasis on potential positive implications for the agency. They were also trained in the use of an 'invitation form' which can be found in Appendix 4. The form included a brief, standard invitation to participate in the survey and space to collect the following information: counsellor's name; date; time of the day; reason for call; language of consultation; and general annotations.

There are two major reasons why interviews were not directly conducted by 211 Toronto counsellors. First, counsellors are constantly on the phone answering users' queries and it was felt that the 10-15 additional minutes needed to complete each interview would have had a significant negative impact on the overall availability of the service. Second, as counsellors often learn very personal and sensitive information about callers in the process of answering their questions, it was thought that having a different person conducting the interviews, somebody who was not aware of the issues discussed during the call, would have increased callers' comfort levels. Also, the fact that callers were invited only after all their queries had been addressed made absolutely clear that their willingness to participate would not influence in any way the quality of service they received from 211 Toronto.

All interviews were conducted by a group of 12 selected and trained volunteers supported and supervised by a data collection coordinator. Most volunteers, all female but one, were identified through Skills for Change, a Toronto-based non-profit agency that provides learning and training opportunities to immigrants and refugees (www.skillsforchange.org). Interviewers were selected by the main investigator applying several criteria, including their: fluency in English; pleasant and open personality; sense of responsibility; personal interest in the research topic; and level of formal education. The data collection coordinator, who was offered a short-term contract by Findhelp, was a university graduate with previous experience in health research. She was selected following the same criteria used for the selection of interviewers.

The main investigator was directly responsible for training the coordinator and, with her help, all interviewers. Training activities were developed over a period of one week and included three two-hour sessions. During those sessions, interviewers, in addition to being introduced to all those aspects of the study already listed when describing 211 Toronto counsellors' training, learned how to use the interview guide. Each question included in the interview guide was discussed at length. Particular attention was given to: introductory and closing remarks; inclusion criteria; the way questions with long lists of pre-defined answers had to be asked; questions to be excluded depending on participants' answers to previous ones; transition from topic to topic; the criteria for using the 'New Canadian Module'; and the exit module.

In addition, the data collection coordinator received training related to her work supporting both counsellors and interviewers. Among others, her responsibilities included:

- ensuring that both counsellors and interviewers had all the materials they needed to work;
- overseeing and encouraging counsellors' participation in the study;
- collecting all study forms, after completion, and organizing them to facilitate data entry; and

- supporting interviewers' work and answering their questions whenever needed.

Finally, periodic refresher sessions with the coordinator and interviewers were also organized, during data collection, to monitor the process and discuss specific problems that arose from time to time.

The interview guide and data collection procedures were pre-tested for one week with the help of a group of interviewers and counsellors who volunteered their time. To ensure the appropriateness of the interview guide in terms of clarity, choice of words, order of questions and length, approximately 50 interviews were conducted during the pre-testing, half of which included the 'New Canadian' module. The tool resulted in easy application and was well suited to achieving the objectives of the survey. At the end of the pre-testing week, a meeting was held with all interviewers and the coordinator. Minor changes in wording were agreed upon as well as a change in the order of two questions.

It was at this stage that the decision to conduct interviews from 8am to 8pm only, and from Monday to Friday, was confirmed. The decision was based not only on the limited number of interviewers and the availability of just one coordinator but also on other practical reasons such as office off-hour accessibility and the personal safety of volunteers.

The main investigator was present at all times during the pre-testing phase and supervised all activities on a daily basis during data collection to: ensure data were properly recorded in the answer sheets; identify potential problems; provide ongoing feedback to the coordinator and interviewers; and facilitate the smooth development of the whole data collection process. In particular, the main investigator monitored a randomly selected subset of calls to ensure all interviewers would properly obtain informed consent from participants. As all interviews took place on the phone, no printed consent form was used. A recruitment script was included at the beginning of the interview guide and oral consent was sought in all cases.

The data collection process selected for this study had advantages and disadvantages. As previously mentioned, the separation of roles between counsellors and interviewers had both practical and ethical advantages. Making counsellors responsible for interviewing callers would have had a very significant impact in terms of overall availability of the service. Many counsellors would have also interpreted the request for a more significant involvement in the study as an unreasonable burden added to their daily duties. Finally, some callers might have felt uncomfortable if interviewed by the same person with whom they had just discussed sensitive and confidential issues. On the other hand, however, transferring calls from 211 Toronto counsellors to interviewers had some important disadvantages. In particular, the transfer process was not seamless due to technical limitations. Counsellors, in fact, had to dial a phone number to reach interviewers. If the line was busy because the first available interviewer was on the phone working with another caller, they had to try a second and then a third phone number to reach other available interviewers. On vary rare occasions, all interviewers working at a given time were busy and the counsellor had to apologize and let the caller go. Much more often, however, callers would get tired of waiting and hang up before the transfer was completed. In addition, only three lines were available for transfers and those lines were not dedicated ones but were also used by Findhelp for external calls. As further discussed in the next chapter, these problems, compounded by the relative lack of commitment to the study demonstrated by some of the counsellors, was the most important reason for data loss.

D.2 Data Sources and Measurement: Cross-Sectional Survey

The interview guide used for the cross-sectional survey, included in Appendix 4, is a much simplified version of the interview guide used by Statistics Canada in the 'Ethnic Diversity Survey' (EDS) (Statistics Canada, 2002). The EDS, collaboratively developed by Statistics Canada and the Department of Canadian Heritage (www.pch.gc.ca), is a survey conducted in 2002 with two primary objectives: to improve the understanding of how people's background affects their participation in the social, economic, and cultural life of Canada; and to better understand how Canadians of different ethnic backgrounds interpret and

report their ethnicity. The survey was designed with the 2001 census providing the frame for the sample. Topics covered included the following categories: respondent background; ethnic self-definition; knowledge of languages; family background; family interaction & social networks; civic participation; interaction with society; attitudes; trust and satisfaction; and socio-economic activities. In addition to informing policy and program development in the Department of Canadian Heritage, the information collected through the survey was also used to guide data collection in the area of ethnicity for the 2006 Census (Statistics Canada, 2002). The development of the EDS questionnaire content and design was the responsibility of an Advisory Committee that facilitated extensive discussions between specialists at Statistics Canada and at Canadian Heritage. Standard questions from Statistics Canada's surveys were included and a series of external qualitative tests based on one-on-one interviews and focus groups were conducted across Canada to validate the instrument. Results from a pilot test involving approximately 1,500 respondents were also included to develop and refine the survey instrument with the objective of evaluating questions and format of the questionnaire. EDS interviews were conducted between April and August 2002 on a sample of 57,242 persons who had answered the 2001 Census long questionnaire. Interviews, conducted on the phone by highly trained interviewers with the support of a powerful computer-assisted interviewing system and survey processing tool, had an average length of 35 to 40 minutes, with important variations due to respondents' specific situations. Interviews were conducted in the two official languages and in seven non-official ones.

The interview guide used for the cross-sectional survey was a shortened and much simplified adaptation of the EDS questionnaire English version. The most important objectives achieved through the adaptation process were to:

- retain only those questions that were directly related to the objectives of the study;
- reduce the length of the questionnaire to limit phone interviews to a maximum of 10 to 12 minutes;

- simplify the structure of some questions to adapt the instrument to the interviewing skills of volunteers who had received limited training; and
- include a few new questions related to the theme of access to information and knowledge of/experience with 211 Toronto services, not covered in the EDS.

The cross-sectional survey interview guide contained two sections: a General Module and a 'New Canadian' Module. All participants were invited to answer 28 questions included in the General Module. All respondents, with the exception of Canadian citizens by birth, were also invited to answer 11 questions included in the 'New Canadian' module.

Virtually all the questions were derived from the EDS questionnaire, including those in the categories: demographic descriptors; respondent background; knowledge of languages; family interaction & social networks; and socio-economic activities. In addition, the General Module included 10 original questions focusing on sources of health information, use of the internet, and knowledge/use of 211 Toronto services. Table 5.1 presents the complete list of variables included in the cross-sectional interview guide.

D.3 Data Sources and Measurement: Census Data

Every five years, Statistics Canada conducts a census that records information on every person living in Canada on Census Day, including those holding a temporary resident permit, study permit or work permit, and their dependents, as well as on Canadian citizens and landed immigrants who are temporarily outside the country (<http://www12.statcan.ca/english/census06/reference/info/overview>). When data analysis for this study was completed, the most recent available census data were those collected by self-enumeration on May 15, 2001. In that year, 80% of households received a short questionnaire containing seven basic questions, while 20% were given a long-form questionnaire with 59 questions (Statistics Canada - Census Operations Division, 2003).

Table 5.1 – List Of Variables Included In the Cross-Sectional Survey Interview Guide

#	Module	Topic	Variable	EDS (Y/N)
a	Inclusion criteria	-	18 years or older	N
b	Inclusion criteria	-	Living in Toronto's CMA	N
c	Inclusion criteria	-	Final information user	N
1	General	Demographic descriptors	Age	Y
2	General	Demographic descriptors	Sex	Y
3	General	-	Postal Code	N
4	General	Demographic descriptors	Marital Status	Y
5	General	Background	Legal Status in Canada	Y
6	General	Knowledge of languages	First Language Learned	Y
7	General	Knowledge of languages	Home Language	Y
8	General	Knowledge of languages	Language Used with Friends	Y
9	General	Knowledge of languages	Language Used at Work	Y
10	General	Family & social interactions	Relatives Co-Living (#)	Y
11	General	Family & social interactions	Relatives in Canada	Y
12	General	Family & social interactions	Interactions with Rel.	Y
13	General	Family & social interactions	Groups/Org. Membership	Y
14	General	Info. sources / 211 TO	Health Info. Sources	N
15	General	Info. sources / 211 TO	Access to Family Doctor	N
16	General	Info. sources / 211 TO	211 TO Referral	N
17	General	Info. sources / 211 TO	Use of the Internet	N
18	General	Info. sources / 211 TO	Access to Internet	N
19	General	Info. sources / 211 TO	Internet and Health Info.	N
20	General	Info. sources / 211 TO	Knowledge of 211 TO Web Site	N
21	General	Info. sources / 211 TO	Use of 211 TO Web Site	N
22	General	Info. sources / 211 TO	211 TO Phone/Web Preference	N
23	General	Info. sources / 211 TO	Reason for Preference	N
24	General	Socio-economic activities	Formal Education	Y
25	General	Socio-economic activities	Employment Status	Y
26	General	Socio-economic activities	Source of Income	Y
27	General	Socio-economic activities	Personal Income	Y
28	General	Socio-economic activities	Household Income	Y
1	'New Canadian'	Background	Country of Birth	Y
2	'New Canadian'	Background	Year of Arrival in Canada	Y
3	'New Canadian'	Background	Country of Residency Bef. Can.	Y
4	'New Canadian'	Background	Immigration Category	Y
5	'New Canadian'	Family & social interactions	Relatives in Can. (Time of Imm.)	Y
6	'New Canadian'	Family & social interactions	Relatives in TO (Time of Imm.)	Y
7	'New Canadian'	Family & social interactions	Friends in Can. (Time of Imm.)	Y

#	Module	Topic	Variable	EDS (Y/N)
8	'New Canadian'	Family & social interactions	Friends in TO (Time of Imm.)	Y
9	'New Canadian'	Family & social interactions	Friends from Same Country	Y
10	'New Canadian'	Socio-economic activities	Formal Education pre Can.	Y
11	'New Canadian'	Socio-economic activities	Employment pre Canada	N

The secondary data used in the study to compare the survey population of 211 Toronto callers with the general population living within the boundaries of Toronto's CMA were extracted from the Census of Canada 2001 'Public Use Microdata File on Individuals' (Statistics Canada 2007) that was accessed through the University of Toronto Data Library Service (<http://www.chass.utoronto.ca/datalib/>). Microdata were extracted using the version 3.1 of the Survey Documentation and Analysis tool (SDA). This is a set of programs for the documentation and web-based analysis of survey data developed and maintained by the Computer-assisted Survey Methods Program at the University of California, Berkeley (<http://sda.berkeley.edu>).

The 'Public Use Microdata File on Individuals' contains data from a sample of anonymous respondents representing 2.7% of the total population enumerated in the census and provides information on the demographic, social and economic characteristics of the Canadian population (Statistics Canada 2007). Microdata files are unique among census products in that they give access to non-aggregated data that can be manipulated and grouped in different ways offering the opportunity to create tabulations and analyze relationships between demographic, social, and economic variables, therefore constituting a powerful research tool. The 'Public Use Microdata File on Individuals' includes data on Canadian citizens, landed immigrants and non-permanent residents of Canada who hold an employment, a student, or a Minister's authorization, or who are refugee claimants. On the other hand, however, it excludes residents of institutions, such as jails or religious institutions, and foreign residents who are visiting Canada temporarily. Due to the nature of microdata files, certain information might lead to the identification of individual respondents. To preserve confidentiality, Statistics Canada applies a number of strict

measures such as grouping certain data into broader categories and not making available data for small geographic areas. Each record included in the microdata file represents, on average, many other units that are not part of the sample. To represent all of the missing units and obtain population estimates, a weighting factor corresponding to the number of units represented by each record is included in the file.

The 2001 'Public Use Microdata File on Individuals' includes 125,643 census respondents living in the Toronto's CMA. To compare survey and census data in a meaningful way, only census respondents who were 18 years old or older were included in the comparison. In addition, after discussing the issue with Findhelp management and 211 Toronto counsellors, it was decided it would be safe to assume that the survey did not include any institutional residents. Table 5.3 lists and briefly describes all Microdata variables used in the survey-census comparison.

D.4 Potential Sources Of Bias

Several factors present potential sources of bias in the study and limit the representativeness of the selected sample.

1. First, and most significantly, study participants were included or not depending on their knowledge of the English language. As already explained, this inclusion criterion was introduced to make the survey manageable within the limits created by the available time, human, technical, and financial resources. A multi-lingual survey would have been in fact significantly more complex to conduct and, in any case, would have not completely eliminated the problem of excluding some groups, given the extremely large number of languages spoken in Toronto. In the context of the reported study, not a lot could have been done to limit the impact of this inclusion criterion, beyond taking it into account when analyzing survey results. This limitation is not dissimilar in nature from focusing on users of 211 Toronto to understand the challenges faced by recent immigrants who struggle to access information, instead of directing one's attention to those who do not even succeed in reaching this service. As

**Table 5.2 – List Of Public Use Microdata File Variables
Used In the Survey-Census Comparison**

#	Variable	Description
1	Age	Age at previous birthday derived from date of birth. The variable shows the single years of age from 0 to 84 years of age. Persons 85 and older are grouped into one category only.
2	Sex	Sex of the respondent.
3	Historical Comparability Indicator of Marital Status	This variable includes common-law partners under the 'Married' category. It was selected for comparison as its categorization system perfectly matches the one used in the survey.
4	Citizenship	Refers to the legal citizenship status of the respondent. It includes Canadian citizen by birth and by naturalization.
5	Immigrant Status Indicator	Classifies the population according to whether they are non-immigrants, landed immigrants, or non-permanent residents.
6	Mother Tongue	Refers to the first language learned at home in childhood and still understood by the individual at the time of the census.
7	Home Language Most Often Spoken	Refers to the language spoken most often at home by the individual at the time of the census.
8	Language Used Most Often at Work	Refers to the language used most often at work by the individual at the time of the census.
9	Highest Level Of Schooling	Refers to the highest grade or year of elementary or secondary (high) school attended, or to the highest year of college education completed, whether in Canada or before migrating.
10	Total Household Income Groups	The sum of the total incomes of all members of that household.
11	Total Income	Refers to the total money income received by the individual during calendar year 2000.

such, it will be further discussed in Chapter VIII. Knowledge of English as an inclusion criterion creates another problem, however. The linguistic assessment was conducted, usually in a very short amount of time, by a fairly large number of 211 Toronto counsellors and represents their own subjective judgment. No tools to measure English knowledge objectively could have been introduced to help counsellors with this task, given the study recruitment mechanisms. Different counsellors might have judged linguistic skills differently. Variation might have been particularly significant between counsellors whose first language was English and those having a different mother tongue. The resulting sample might have been therefore biased, particularly because different counsellors invited significantly different numbers of callers. 211

Toronto counsellors, however, are highly trained and very experienced professionals who have learned how to quickly assess callers' communication difficulties. Their skills were expected to minimize variation in judgement. In fact, as reported in the next chapter, a comparative analysis of callers invited by different counsellors was conducted and no significant systematic differences were uncovered.

2. 211 Toronto counsellors were instructed to invite all callers identified by the sample interval who spoke English well enough to understand the informed consent script and the interview questions. No other exceptions were admitted. However, it is very likely that other callers were also intentionally excluded by counsellors. For example, an invitation to participate in a survey would not have been deemed appropriate where a caller contacted the service in the context of a major personal emergency or with questions of a particularly sensitive nature. The only way to minimize this problem was to encourage counsellors continuously to invite callers in all cases but the most extreme ones. On the one hand, missing those callers was particularly serious given the interest of the present study in users who are most in need. On the other hand, however, it is reasonable to believe that only a very small percentage of missed callers belonged to this category.
3. At the opposite end of the spectrum, it is equally likely that some of the callers who contacted the service requesting a very basic piece of information, such as a phone number or an address, would have been more inclined to reject the invitation, not wanting to spend ten minutes or more on the phone and, perhaps, valuing less the service just received. Both in this as in the previous case, it was hoped that notes recorded by the counsellors on the invitation forms would give an idea of the dimensions of these phenomena.
4. Another potential source of bias for this study was the time of data collection. As previously explained, interviews were conducted between 8am and 8pm from Monday to Friday, and between the end of July and early September. Conceivably, results might have been different had the study been conducted at a different time. However, from the analysis of historical 211 Toronto data and from interviews held with

counsellors and Findhelp management, it can be concluded that at least the time of day and week did not have a significant effect on the sample characteristics. In fact, a much smaller number of calls are received at night and on weekends and the questions asked at those times are not significantly different from those asked during the day on weekdays. The only difference seems to be a small percentage of callers who contact the service, particularly late at night, more as a way of reaching a 'friendly voice' than because they really have a question to ask. Less clear is the impact of conducting the study during the summer. For certain groups of users, such as the elderly for example, the need for support might increase during the summer when younger family members tend to leave the city on vacations. Conversely, questions related to needs created, for example, by winter weather conditions would not be common during the summer. The only way to understand seasonal differences would be to repeat the study at a different time of the year.

5. From time to time 211 Toronto launches advertising campaigns targeting specific ethno-linguistic groups. A targeted campaign might have resulted in a skewed distribution of certain characteristics in the sample, depending on the nature of the campaign itself. The main investigator received assurance from Findhelp management that no campaign had been launched in the months immediately preceding the survey.
6. Finally, the changes in sampling interval introduced during data collection, described in a previous section of this chapter, resulted in a sample in which callers who contacted the service at a later stage were overrepresented. However, there are no obvious reasons to suspect that this sample be less representative than the one that would have been obtained had the sampling interval not been modified. There are also no reasons to suspect periodicity or cyclical patterns among callers that, given the intervals employed, would have resulted in a biased sample.

D.5 Sample Size

The sample size for Phase 1 of the study was calculated as a function of the number of participants needed for Phase 2, who were a sub-set of Phase 1 participants. The aim was

to recruit approximately 80 participants in Phase 2, for reasons that will be explained later in this chapter. To maximize the chances of recruiting enough participants during Phase 2, the sample size for Phase 1 was calculated on the basis of factors such as 211 Toronto historical utilization rates and other average statistics derived from Findhelp's quarterly monitoring surveys. These statistics included: percentage of callers accepting to participate in brief phone interviews; percentage of callers accepting to be called back for a follow-up interview; percentage of callers matching the four inclusion criteria applied in this study; and percentage of callers asking health-related questions. Using such information, it was calculated that approximately 1,300 callers had to be interviewed in Phase 1 to make sure that a sub-set of 80 participants could be recruited for Phase 2. Historical data suggested that, to be able to identify 1,300 callers willing to participate, approximately 3,400 callers had to be invited. This number represents 10% of the total number of calls received by 211 Toronto in one month. Taking into consideration that the survey would miss calls received at night or on weekends, it was decided to invite every 8th caller over a period of time of six weeks. Considering that there were no anticipated risks to participants this fairly large sample size was deemed acceptable.

D.6 Data Handling and Statistical Analysis

The main investigator created and was responsible for maintaining a Microsoft Office Excel database used to store survey data. Every morning, the coordinator transcribed data from the previous day's answer sheets into the electronic database. At a later time, the main investigator would review the work done by the coordinator to assure the quality of information recorded. Coding was not needed as codes were already included in both the interview guide and answer sheet.

At the end of the data collection process, the main investigator edited the Excel database to ensure data were consistently formatted, no duplicate records were included, records containing no information or a very limited number of variables were discarded, and all obvious mistakes were eliminated. The quality of data transcription was also checked for

the second time. This round included two separate activities. The first one was a full revision of a randomly selected sample of records, representing 10% of the total. The second one was a review of the whole database, following a 48-item checklist that focused on: a) variables that, for various reasons, might have been more prone to transcription errors, and; b) pairs of variables that were related to each other so that the value given to the first one would result in a specific value/range of values for the second one. The results of this final check were very encouraging. From the overall revision of the 10% sample it resulted that errors had been made in less than 1% of questions (0.7%). All identified errors were trivial in nature and did not suggest any specific pattern. The checklist-based review showed an even lower frequency of errors. The final step in the process of editing the database was the re-coding of several variables to facilitate their analysis and comparisons with census data. Table 5.2 lists all re-coded variables.

Data analysis was developed using the SAS/STAT software (SAS Institute, 2003).

Univariate and bivariate analysis, including measures of central tendency, distribution and shape, was conducted to explore data and for descriptive purposes. Descriptive analysis included: essential demographic variables; variables related to the history and time of migration, in the case of 'New Canadians'; information-related variables, including an analysis of the questions asked by 211 Toronto callers; and socio-economic variables.

With respect to the analysis of questions asked by callers, questions were analyzed and organized according to three different categorization systems.

1. First, they were classified into two groups, 'health-related questions' and 'non-health-related questions'. 'Health-related questions' were those that focused on:
 - specific diseases/conditions;
 - health providers/services (including institutional, community, and home services);
 - therapies and drugs;

**Table 5.3 – List Of Survey Variables Re-Coded For Analytical Purposes
and To Make Survey/Census Comparisons Possible**

#	Variable	Comments
1	Age	Re-coded into a categorical variable for census comparison ¹
2	Sex	Re-coded for census comparison (Male from '1' to '2'; Female from '2' to '1')
3	Marital status	Re-coded for census comparison (changes in categories)
4	Mother tongue	Re-coded for census comparison (as official/nonofficial)
5	Language spoken at home	Re-coded for census comparison (as official/nonofficial)
6	Language spoken at work	Re-coded for census comparison (as official/nonofficial)
7	Sources of health information	Specific answers given in 'Others' classified in a small number of broad categories
8	Sources of referral to 211 Toronto	Specific answers given in 'Others' classified in a small number of broad categories
9	Location for Internet access	Specific answers given in 'Others' classified in a small number of broad categories
10	Reasons for preferring phone/Internet 211 services	Specific answers given in 'Others' classified in a small number of broad categories
11	Legal status in Canada	Re-coded for census comparison (changes in categories)
12	Occupation	Specific answers given in 'Others' classified in broad categories
13	Personal income	Re-coded into a categorical variable for census comparison*
14	Family income	Re-coded for census comparison (changes in categories)
15	Level of formal education	Highest level of formal education achieved before moving to Canada and highest level of formal education achieved in Canada combined into one variable for census comparison

¹ Explained below.

- administrative aspects of health care (e.g.: where to obtain a Ontario Health Insurance Plan card, how to apply for the Ontario Drug Benefit Program for cancer patients, etc.);
- the health needs of specific population/patient groups (the elderly, newborns, people with physical or mental disabilities, etc.).

Participants in this phase of the study who asked health-related questions were eligible to participate in Phase 2 of the study, the follow-up interview.

2. Second, all questions were analyzed for content, in a more granular way, and grouped into 16 thematic categories. The ‘health-related questions’ included five of these categories while the remaining 11 categories fell under ‘non-health-related questions’.
3. Finally, they were classified into two groups depending on whether they represented simple, factual questions, as defined by Taylor (Taylor, 1991), or complex ones. 211 Toronto counsellors are highly-experienced professionals trained to analyze complex problems, break them down into their constituent components, and identify the information needed to address each component. It is therefore fair to say that if 211 Toronto was used only by people who simply need, for example, a phone number, and address, or the exact name of a specific agency the services would be underutilized. Questions of this type were categorized as being factual. Conversely, questions related to complex problems that made full use of 211 Toronto’s potential were defined as complex.

Questions were also analyzed based on callers’: age; sex; marital status; mother tongue; access to a family physician; legal status in Canada; history and time of immigration; immigration category; and level of formal education. In particular, as the study focuses on the challenges faced by recent immigrants, respondents were grouped, for analytical purposes, into three categories depending on whether they were Canadian born or moved to this country later in life, and on the time of migration. The three categories were: Canadian by birth; long-time immigrants, those who had moved to Canada five or more years before the date of the interview; and recent immigrants who, at the time of their participation in the study, had spent less than five years in Canada. Visitors (7, or 1.1%) are included in the last group as their experience, given the objective of this study, can be assimilated in many ways to the one of recent immigrants.

As stated at the beginning of this chapter, one of the objectives of the study was to understand how representative 211 Toronto callers are of Toronto’s general population. A

comparison between data collected surveying 211 Toronto callers and 2001 Census data for Toronto's CMA can in fact help to identify population groups that are either under- or overrepresented among users of this service and to understand whether 211 Toronto is reaching those groups, such as recent immigrants, who might benefit the most from this service. Ten variables were comparable between survey and census, either directly or, as previously explained, after re-coding. They were: age; sex; marital status; highest level of formal education achieved; legal status in Canada; personal income; family income; mother tongue; language most commonly spoken at home; and language most commonly spoken at work. These ten variables were compared between the general survey and census populations as well as between the 'New Canadian' survey and census populations. It was assumed that the population living within the boundaries of Toronto's CMA had not changed significantly enough, between 2001 and 2005, to make such comparisons meaningless.

All the variables used for survey/census comparisons, with the exception of 'age' and 'personal income', were categorical and their distributions were therefore compared using the chi-square statistic. 'Age' and 'personal income' were continuous variables and could have been compared using either the t-test or a nonparametric test, depending on the characteristics of the sample distribution. In reality, however, the t-test could not be applied because neither of these variables were normally distributed in the survey. In addition, lack of access to census data at the individual level made the use of a nonparametric test also impossible. Because of these limitations, the variables 'age' and 'personal income' were re-coded as categorical variables and compared using the chi-squared statistic.

Finally, the results from this phase of the study were compared, for validation purposes, to the information Findhelp routinely collects on 211 Toronto. Every three months, in fact, a short questionnaire is administered to a small random sample of callers to explore their characteristics and monitor 211 Toronto's impact. Several statistics from the survey were

compared to those in reports produced by the agency for the quarters immediately before and after the quarter during which the study was conducted and for the same quarter in the years before and after the year the survey was completed.

E. Objective 2: To Understand How 211 Toronto Callers Seeking Health-Related Information Use the Information They Obtain When Contacting the Service and Their Overall Level Of Satisfaction.

This objective was achieved conducting follow-up interviews with 211 Toronto callers who had already taken part in the cross-sectional survey. In particular, the study intended to explore a possible association between certain individual characteristics of 211 Toronto callers and both higher/lower rates of success in solving problems and higher/lower levels of user satisfaction with the service. Follow-up interviews were conducted in July and August 2006, approximately ten months after the completion of the first study phase.

The choice of conducting Phase 2 of the study several months after Phase 1, and not just a few days or weeks later, was made to get a better understanding of the long-term advantages of using 211 Toronto, particularly with respect to complex problems that would require a series of steps and some time to be resolved. This choice, however, wasn't free of problems. The most important challenge during this phase was to actually contact potential participants. In several cases, in fact, the phone numbers left by survey participants at the end of the first interview were incorrect. More often, during the time between the first interview and the follow-up, people had moved and no information on their whereabouts was available or phone lines had been disconnected. In other cases, potential participants could not be reached in person, even if the phone number was correct and still valid. To ensure everybody whose phone number had been confirmed had the same chances to be included in this phase of the study, it was decided that a maximum of five attempts would be made, in all cases, before giving up.

E.1 Recruitment Procedures

At the end of the Phase 1 phone interviews, respondents were asked for consent to be contacted again, a few months later and only if needed, for a short follow-up interview. After reviewing the data collected during Phase 1, participants who had given permission and who had asked a health-related question were included in the invitation list for Phase 2.

Follow-up interviews were conducted by the main investigator with the help of a trained research assistant. The assistant was an undergraduate student who had already worked with the main investigator and who was hired on a short-term contract. The training she received was very similar to the one given to 211 Toronto counsellors and to the interviewers during the first phase of the study. In addition, she also learned how to use the Phase 2 interview guide (see Appendix 4).

E.2 Data Sources and Measurement

The interview guide was developed by the main investigator under the supervision of the advisory committee. It included an initial recruitment script which reminded participants about the study objectives and main characteristics and was intended to confirm their consent to participate.

The interview was designed to be as fast and simple to conduct as possible. It contained 11 questions and did not last more than five minutes, including the initial and exit scripts. Questions focused on the role played by 211 Toronto in finding a solution to/answering the callers' problems/questions, their overall satisfaction with the service, their intention to use it again, and other sources of information they had used to solve their problems/answer their questions.

The main investigator and the research assistant together conducted the first 10 interviews to pilot test the guide and make sure there would be no inconsistencies in the way it was

used. At the end of the piloting period, only a few very minor changes were made as the tool was extremely easy to administer.

E.3 Potential Sources Of Bias

The only obvious bias that can be recognized in this phase of the study is related to the ability of respondents to recall specific information regarding their previous call to 211 Toronto, after several months and after having perhaps repeatedly contacted the service, in the meantime, for other reasons. To minimize the effects of this bias, after respondents answered the first question in the interview guide, which asked what the main reason for contacting the service had been at the time of their first interview, their answers were compared to those included in the already existing database from Phase 1. If the two were different, the recorded version was suggested and respondents were given enough time to reconstruct in their minds the actual circumstances of that call before continuing with the interview. Similarly, in case a respondent did not remember at all the reason for her/his previous call, the answer was read to her/him before continuing.

E.4 Sample Size

As previously mentioned, the planned sample size for Phase 2 of the project was 80. Interviewing this number of callers made it possible to assess the explanatory value of up to three individual caller characteristics in regression models including as dependent variables measures of user satisfaction with the service and of service effectiveness. This in accordance with the 'rule of thumb' suggesting that N should be equal to $50 + 8 * M$, where M = number of independent variables included in the model (Green, 1991). The decision to include in the regression models only the three individual caller characteristics that would show the highest levels of correlation with the dependent variables was made to keep the number of callers included in Phase 1 manageable within the limits imposed by time and human resources constraints.

E.5 Data Handling and Statistical Analysis

As soon as interviews were completed, the main investigator transcribed data from the answer sheets to the Excel database already used for Phase 1. Records were rigorously cross-checked for quality assurance by the investigator and the research assistant. All records were reviewed twice and very few, minor errors identified and eliminated.

As in the case of data from the first phase of the study, univariate analysis was conducted, with the help of SAS/STAT, to explore the results of follow-up interviews and for descriptive purposes. In addition, relations between individual caller characteristics and dependent variables of user satisfaction and service effectiveness were investigated. The three dependent variables used were: problem solved/not solved; perceived level of usefulness of 211 Toronto; and level of overall satisfaction with the service. The independent variables investigated were: age; sex; mother tongue; language most commonly spoken at home; level of formal education achieved before moving to Canada; level of formal education achieved after moving to Canada; overall level of formal education achieved; personal income; family income; legal status in Canada; and history and time of migration. As all dependent variables were categorical, Fisher's exact test was used to investigate their relations with categorical independent variables and Spearman correlation to investigate their relations with the two variable: age and personal income. Logistic regression techniques were going to be applied to models including the dependent variable 'problem solved/not solved' and multiple regression techniques to those including the other two dependent variables.

F. Objective 3: To Gain a Better Appreciation Of the Experience Of Recent Immigrants Struggling To Navigate and Negotiate an Unfamiliar Health Care System, Focusing On Their Information Needs, Information Seeking Behaviour, Knowledge Of, Attitude Towards, and Actual Use Of Existing Information Sources, and Barriers and Facilitators Experienced In the Process Of Obtaining Information.

To achieve the third and last objective of the study, a small number of qualitative interviews were conducted with 211 Toronto callers who were native Spanish-speakers from Latin-American countries. During interviews, several aspects of participants' experiences were explored to provide descriptions of information use and effect in the words of users, as suggested by Taylor (Taylor, 1991). Specifically, the aim was to: better understand and map the 'information pathways' they followed; their perception of the type of information needed to navigate and negotiate the Canadian health care system; strategies and techniques used to obtain needed information; information sources that were trusted and those that were not; information and communication technologies used in the process; places visited; information materials accessed; interaction with others seeking similar information and with 'system gatekeepers'; and barriers encountered when trying to access information. Focusing on processes and how things happen adds depth and substance to the understanding of newcomers' experiences that can be gained through this study.

Even if, as explained at the beginning of this chapter, this study remains clearly rooted in the post-positivist/quantitative tradition of research, qualitative interviews were deemed to be an appropriate method to achieve Objective #3 as their exploratory nature gives interviewers the freedom to raise topics, formulate questions, and move in new directions, not only focusing on the facts related to the subject matter but also, and perhaps more importantly, framing them in the context of the interviewees' lives, delving into the meaning given by participants to such experiences, in other words (Warren, 2002). Qualitative interviews may provide rich descriptions of individuals' own accounts of their perspectives, actions, knowledge, thoughts and feelings, focussing on meaning, interpretations, attitudes, and motivations.

Without including, at this point, a lengthy analysis of the debate as to whether the quality of qualitative research could and should be assessed according to the same criteria used to measure the quality of quantitative research, essentially reliability and validity (Mays et al., 2006), this chapter and Chapter VII, which presents the results of the analysis of the qualitative interviews, aim at providing sufficient information to help the reader form her/his own judgement on the credibility of this study. While qualitative researchers do not aim at generalizing research findings to a wider population, good quality qualitative research aims at generating understanding that can be applied in other settings, a concept known as transferability. To facilitate transferability it is considered important to provide an exhaustive description of the research setting, characteristics of the study participants, data collection and analysis procedures, as well as a rich and comprehensive presentation of the research findings (Graneheim et al., 2004). The remaining of this chapter, and Chapter VII, will describe all these aspects in detail.

At the beginning of each interaction, participants were assured that the interview was not about ‘answering correctly’ a certain number of questions but was instead an opportunity for them to tell their ‘stories’ as if they had been talking to an old friend, back ‘home’, who did not know anything about life in Canada. These interviews can be read, therefore, as personal narratives. Narratives seemed to be an appropriate way of exploring and analyzing the identity of individuals who were facing life-changing conditions, the way they represented and contextualized their experiences, and the role played by information in their effort to ‘make sense’ of such conditions (Gibbs, 2002; Riessman, 2002). Narratives also represent a unifying structural element that contributes to the integrity and internal soundness of the inquiry.

The decision to focus on Spanish-speaking immigrants gave the main investigator, who is fluent in Spanish, the opportunity to interview participants in their own language. This, in turn, made it possible for participants to describe their experience in a direct way, using their own words, an essential precondition to access meaning. Describing processes and

experiences in newcomers' terms, listening to their voices, using images and metaphors of their choice, adds power and intensity to the account resulting in a more vital and meaningful research work. In addition, Spanish represented an opportunity to break free from the constraints created by the exclusive use of the English language that characterized the first two phases of the study. The challenges posed by working across languages will be discussed later in the chapter.

Participants were invited by a Spanish-speaking 211 Toronto counsellor who used the invitation script included at the end of the 'Phase 2 Interview Guide' (Spanish version). The counsellor was instructed to invite only callers who had asked health-related questions and who had been living for less than five years in Canada. Given the emphasis of the study on the challenges faced by immigrants who are learning how to navigate and negotiate a largely unknown health care system, it seemed appropriate to interview people who had experienced such challenge in the recent past.

Callers who accepted the initial invitation and gave their first names and phone numbers were promptly contacted by the main investigator who explained the nature and objectives of the study and provided additional details on the interview, including its format, the type of questions that would be included, and its length. In total, the main investigator attempted to contact 37 callers, 28 of whom were women. In most cases, he was unable to reach them for a variety of reasons including: an incorrect phone number had been given (or recorded); nobody answered the phone even after several attempts were made at different times of the day and evening; nobody returned the call after repeated messages had been left; or it was impossible to reach the individual who had given his/her availability and the person/s who answered the phone sounded displeased or quite directly asked the researcher not to call again. Eventually, the main investigator was able to speak on the phone with 14 potential participants. Ten of them, nine women and one man, confirmed their interest and set an appointment for the interview. Four, conversely, said they had changed their minds. Of the four, three were women who seemed surprised to

realize the main investigator was a man (his name, in fact, is usually recognized as a female name both in English and Spanish) and explained, quite openly, that meeting a male stranger for an interview would have created problems with their partners. The last person was a male who apologized and said he was too busy at work to find the time for the interview.

Participants could choose between a face-to-face or a phone interview, depending on their availability and preferences. Face-to-face interviews could take place either at the investigator's office, in a public place, or at the interviewees' homes. In addition, the investigator explained that informants would not receive any compensation for participating but that a small reimbursement was available (CDN \$25) to offset transportation, child care, and other expenses they would incur to participate in face-to-face interviews at the investigator's office.

All participants who set an appointment for the interview showed up at the agreed upon time. The only exception was a young woman who lived quite far from the investigator's office and had problems with public transportation on the day of the interview. Her appointment was rescheduled for the following week and, in that occasion, she arrived on time.

Interviews were conducted between August 2006 and March 2007. Eight of them took place at the main investigator's office while two were conducted on the phone. Both participants who chose to be interviewed on the phone had physical limitations, as one of them had recently undergone a surgery and the other one was legally blind. In one case, a participant was invited who had been living in Canada for longer than five years. As the mistake was discovered only at the time the interview started, it was decided to complete it anyway.

Given the very time consuming recruitment process and the limited resources available to conduct the study, only ten interviews were completed. As a result, it was impossible to attain the level of variation in informants' socio-demographic characteristics and experiences – including, among others, time spent in Canada, living alone or with family, immigration category and legal status in Canada, and level of formal education – that would have permitted an exploration of common themes across different groups. In particular, all participants but one were women. This could be explained by the combined effect of several factors: first, as evident in historical Findhelp data and confirmed by this study, most 211 Toronto callers are women; second, women could be more interested in discussing topics such as access to information on health and social services as they might feel identifying those services as being mainly their responsibility; finally, among recent immigrants, men could be working outside the home more often than women and have less time available to take part in interviews.

All interviews were conducted by the main investigator with the support of a research associate who had been previously trained in all aspects of the study methodology. The research associate was a native Spanish speaker who worked as a community mental health consultation clinician at a local hospital and who had more than twenty years of experience supporting members of the Latin American community in Toronto. He was interested in contributing to the research initiative for reasons very similar to those, already described in Chapter II, that have been driving the main investigator. Together, the two researches had good observational, interviewing, interpretive, and writing skills.

Interviews lasted between 60 and 75 minutes and were conducted using an open-ended, minimally structured interview guide that was developed on the basis of the research literature and feedback from advisory committee members. At the beginning of each interview, a recruitment script was read to the participant, which included a description of the study nature and purpose and two requests: one for permission to start the interview and the second one for permission to audio record it.

The main investigator and the research associate conducted all interviews together, alternating their roles as interviewer and observer. While the former would lead the interaction with the participant, the latter would: listen, annotate reactions, feelings, insights, interpretations and reflections; and ask, at the end of each interview, additional questions or clarifications about perceived ambiguities in previous responses. The observer played an important role as he helped, from the beginning of the process, to keep notes that would be later used to contrast initial assumptions and expectations with the body of data collected.

No separate pilot testing of the interview guide was conducted. However, data collection and analysis run parallel and the tool was gradually modified and expanded on the basis of the results and experience accumulated during the initial interviews. Eventually, it included: an initial face sheet covering several individual demographic variables as well as descriptors of the participant's immediate social environment; a main section focusing on aspects of the respondent's experience immediately before and after relocating to Canada; and a final section on health-related information. The revised interview guide is included in Appendix 4. Wording and order of questions continued to change, from interview to interview, depending on the flow of each interaction and on previous experience.

Interviews were audio recorded and all efforts were made to ensure the highest possible sound quality. Specifically, a professional digital recorder equipped with an external microphone was used; all interviews, both in person and on the phone, were conducted in a very quiet meeting room; batteries were regularly checked and frequently replaced; and participants were encouraged to speak loudly enough and at the right distance from the microphone.

A Spanish-mother-tongue health professional was hired to transcribe the interviews and the transcription work started as soon as possible after each interview had been completed. Following good standard practice (Poland, 2002), at the beginning of the process the main

investigator met with the transcriber to briefly present the nature and purpose of the study and discuss the level of detail that was required in transcriptions. The investigator was also available on an ongoing basis to answer specific questions and help solve problems with particularly challenging sections of the recordings. Also, after each transcription had been completed and before, as required by the Research Ethics Board, the original recording file was deleted, the main investigator would review the quality of each interview transcript comparing it to the audio recording to identify and eliminate errors. The review process revealed a very satisfactory quality of transcriptions and very few errors were identified, most of which were minor semantic ones.

The main investigator and the research associate independently analyzed and coded the transcripts for emerging themes, novel ideas, patterns and exceptions. Then, over several meetings, they worked to compare and supplement each other's analyses, confirming shared results, working to understand and resolve, or integrate, differences, ensuring the soundness of reported description, and striving to achieve a satisfactory depth of analytical rigor, on the whole. While all informants were invited to contribute to the analytical effort with feedback and suggestions, as a form of member check that would have improved the quality of the study, none of them accepted the invitation even after it was clearly explained that no special skills were needed.

Doing research across languages and cultures presents unique challenges. As different cultures interpret reality in different ways and languages reflect such differences, translation is the act of re-interpreting meaning related to a specific language and culture to convey it in the researchers' own language (Larkin et al., 2007). As assumptions about meanings correspondence across languages affect analysis and research results, translations are not trivial undertakings aiming at identifying word equivalence, but become instead exercises in cultural brokerage that are integral part of the analytical effort (Temple et al., 2004). In this study, however, while the challenge of working across cultures remained unchanged, the language barrier, at least, was lowered as interviews were conducted,

recorded, transcribed, and analyzed in Spanish, a language common to both participants and researchers. The two interviewers and the transcriber spoke Spanish, two of them as their mother tongue and the third one at an almost equivalent level. The remaining challenge, presenting the results of the analysis in English, was negotiated through a process of iterative reviews by members of the advisory committee, to ensure clarity and language consistency.

The two researchers were well aware of the methodological challenges generated by both interviewees' and interviewers' individual characteristics. On the interviewees' side, respondents were particularly 'problematic' as they were distinctly situated individuals along the ethnic, cultural, class, and gender dimensions, being at the same time: members of a 'nonmainstream' group; in all but one case women; in some cases from low socio-economic conditions; and speaking a language other than English. On the interviewers' side, the two researchers were: male; university-educated professionals; members of an advantaged socio-economic group; and long-term, reasonably well-integrated immigrants. There is no doubt that these contrasts shaped the flow of the interviews and had to be carefully considered, both in relation to the interview process and the interpretation of interview material, to avoid the emergence of crude and simplistic portrayals of complex and nuanced experiences (Dunbar et al., 2002). Several factors were probably at play, acting concurrently and in opposite directions, to constantly shift participants' perceptions of interviewers as 'insiders/outsideers'.

Among the factors that probably brought participants and interviewers closer, an important one was certainly language. Indeed, the 211 Toronto counsellor who helped with the invitations reported that, in many cases, the most important reason identified by callers for accepting was their understanding that interviews would be conducted in Spanish. All informants, with no exceptions, seemed very happy and almost eager to participate and share their stories. Being able to do so in their own language clearly made a difference.

A second significant factor was that both researchers were themselves immigrants, one of them being from the same geographic area and 'visible minority' group as the respondents. With respect to the main investigator, even if in all probability his 'whiteness' acted as a distancing feature, at least initially, its effect must have been toned down by two factors. First, participants knew that the main investigator had spent several years living and working in a number of Latin American countries and had some understanding of their realities. Second, interviewees likely realized his English was not the English spoken by the 'average Canadian' and this fact probably mitigated their perception of the researcher as 'other'.

An additional element that might have increased participants' acceptance of the interviewers was the perception of an existing link between them and 211 Toronto, a service that, in their words, had made a difference in their lives and had their interests at heart. This feeling was likely reinforced by researchers' attitudes, as they showed a strong interest in participants' experiences while maintaining an 'active interviewing' approach (Holstein et al., 1995), empathizing with respondents and, whenever possible, answering their questions about services or other aspects of life in Canada. At the same time, conducting the interviews in a setting other than the 211 Toronto offices may have reduced the risk of respondents trying to answer questions 'politely' resulting in a biased depiction of their experience with the service.

Other factors, however, worked to distance researchers from participants, reinforcing their role as 'outsiders'. In particular, the fact that both interviewers were male almost certainly represented a significant barrier, considering that: nine out of ten participants were women; they were from societies where male chauvinism is widespread; and the decision to move to Canada was, for some of them, directly related to problems with domestic violence. Although these women chose to participate, discussing certain aspects of their experience with men who were presumably perceived as being in a position of power must have been difficult. As previously pointed out, a few women who had initially accepted the invitation

to participate changed their mind when they realized the main investigator was male. It is possible that other women rejected the invitation for the same reason.

Another distancing feature between participants and researchers was that the latter were not 'typical immigrants'. Considering the hurdles most participants had experienced in Canada, it must have been inevitable for them to see researchers as very successful, privileged individuals.

In addition, and in spite of what said above, the ethnic background of the main investigator must have acted as a distancing factor. In the main investigator's experience, no matter how long a North American, or a European, lives in Latin America and how deep his/her integration in the local society is, s/he will always remain distinctively visible. This condition is epitomized by the word 'Gringo', the not necessarily derogatory term used in most Central and South American Spanish-speaking countries to indicate foreigners from different cultures, and particularly English speakers. 'Gringo' is a term used to indicate an archetypally different, unintelligible culture and language.

Finally, two factors that may have influenced the quality of communication were the intimidating and value-laden hospital environment where interviews were conducted and the fact that there was no time to develop and nurture any kind of relationship with participants in an informal, non research-related setting. The choice of conducting the interviews at the main investigator's office was dictated by practical considerations and limited time and financial resources. Undoubtedly, meeting participants in their own environment to get a more direct understanding of the daily struggles they face would have resulted in a qualitatively different experience.

G. References

- Creswell, J.W. (1994) *Research Design: Qualitative and Quantitative Approaches*. Thousand Oaks (CA): Sage.
- DePoy, E.; Gitlin, L.N. (1994) *Introduction to Research: Multiple Strategies for Health and Human Services*. St. Luis (MO): C.V. Mosby.
- Dunbar, C.Jr.; Rodriguez, D.; Parker, L. (2002) Race, Subjectivity, and the Interview Process. In: Gubrium, J.F.; Holstein, J.A. (Eds.) *Handbook of Interview Research: Context & Method*. Pp. 279-298. Thousand Oaks (CA): Sage.
- Gibbs, G.R. (2002) *Qualitative Data Analysis: Explorations With NVivo*. Maidenhead (UK): Open University Press.
- Giddings, L.S.; Grant, B.M. (2007) 'A Trojan horse for positivism?: A critique of mixed methods research.' *Advances in Nursing Science*; 30; 1: 52-60.
- Graneheim, U.H.; Lundman, B. (2004) 'Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness.' *Nurse Education Today*; 24; 105-12.
- Green, S.B. (1991) 'How many subjects does it take to do a regression analysis?' *Multivariate Behavioral Research*; 26; 499-510.
- Holstein, J.A.; Gubrium, J.F. (1995) *The Active Interview*. New York: Henry Holt.
- Larkin, P.J.; Dierckx de Casterle, B.; Schotsmans, P. (2007) 'Multilingual translation issues in qualitative research: Reflections on a metaphorical process.' *Qualitative Health Research*; 17; 4: 468-76.
- Mays, N.; Pope, C. (2006) Quality in Qualitative Health Research. In: Mays, N.; Pope, C. (Eds.) *Qualitative Research in Health Care*. 3rd ed. Pp. 82-101. Oxford (UK): Blackwell - BMJ Books.
- Patton, M.Q. (1988) Paradigms and Pragmatism. In: Fetterman, D.M. (Ed.) *Qualitative Approaches to Evaluation in Education: The Silent Scientific Revolution*. Pp. 116-137. New York: Praeger.
- Poland, B.D. (2002) Transcription Quality. In: Gubrium, J.F.; Holstein, J.A. (Eds.) *Handbook of Interview Research: Context & Method*. Pp. 629-649. Thousand Oaks (CA): Sage.

Riessman, C.K. (2002) Analysis of Personal Narratives. In: Gubrium, J.F.; Holstein, J.A. (Eds.) *Handbook of Interview Research: Context & Method*. Pp. 695-710. Thousand Oaks (CA): Sage.

SAS Institute (2003) *SAS/STAT Software, Version 9.1 of the SAS System for Windows*. Cary (NC): SAS Institute Inc.

Shi, L. (1997) *Health Services Research Methods*. Albany (NY): Delmar Publishers Inc.

Statistics Canada (2002) *Ethnic Diversity Survey Questionnaire*. Ottawa (ON): Statistics Canada - Housing, Family and Social Statistics Division.

Statistics Canada (2007). Census of Canada, 2001: Public Use Microdata File - Individuals File. Revision 2. Ottawa (ON): Statistics Canada. Data Liberation Initiative, 2006/04/26. (STC 95M0016XCB). <http://myaccess.library.utoronto.ca/login?url=http://r1.chass.utoronto.ca/myaccess.library.utoronto.ca/sdaweb/html/canpumf.htm> [On-line].

Statistics Canada (2003) *2001 Census Handbook*. Ottawa: Statistics Canada.

Taylor, R.S. (1991) 'Information use environments.' *Progress in Communication Sciences*; 10; 217-55.

Temple, B.; Young, A. (2004) 'Qualitative research and translation dilemmas.' *Qualitative Research*; 4; 161-78.

Warren, C.A.B. (2002) Qualitative Interviewing. In: Gubrium, J.F.; Holstein, J.A. (Eds.) *Handbook of Interview Research: Context & Method*. Pp. 83-101. Thousand Oaks (CA): Sage.

Wolcott, H.F. (2002) 'Writing up qualitative research... better.' *Qualitative Health Research*; 12; 91-103.

Chapter VI – Results I: Survey

This chapter presents the most significant results of the study survey component.

Andersen’s and Wilson’s models, which have been described and extensively discussed in Chapter IV, are used here as a framework of reference to organize and interpret the study results. As shown in Table 6.1, most of the variables discussed in this chapter fall into three of Andersen’s broad categories: ‘predisposing characteristics’; ‘enabling resources’; and ‘outcomes’. For each of these categories, the table suggests the corresponding categories in Wilson’s model.

Table 6.1 – Overview Of Quantitative Results

#	Factors	Andersen’s Categories	Wilson’s Corresponding Categories	Results
1	Age	Predisposing	Intervening	Survey respondents were significantly ¹ younger than the general population of Toronto.
2	Sex	Predisposing	Intervening	Respondents, with the exception of recent immigrants, were predominantly female.
3	Being an immigrant	Predisposing	Contextual / intervening	One half of respondents (49%) were ‘New Canadians’.
4	Having lived in the community for a short time	Predisposing	Contextual / intervening	Recent immigrants were significantly more numerous among respondents than in the general population of Toronto.
5	Personal/family resources	Enabling	Intervening	Respondents were poorer than the general population of Toronto.
6	Personal/family resources	Enabling	Intervening	Respondents were better educated than the general population of Toronto.
7	Personal/family resources	Enabling	Intervening	Survey respondents were less likely to be in a formal relationship, being either single, separated, divorced, or widowed, than the general population of Toronto.

¹ In this table, as throughout the chapter, differences are regarded as significant when they are statistically significant at the .05 level.

#	Factors	Andersen's Categories	Wilson's Corresponding Categories	Results
8	Ability to negotiate system	Enabling	Intervening	Only 31% of respondents asked complex questions while 54% asked factual questions (see Chapter V – Methods for definitions of these terms).
9	Perceived 'information status'	Outcome	Contextual / Activating (I) / Information processing and use	85% of participants in the follow-up interviews felt they had answered their original question.
10	Satisfaction with service: - technical component - interpersonal aspects - time spent with provider - access / availability / convenience	Outcome	Information processing and use	60% of survey respondents were repeated users. Among participants in the follow-up interviews: 1) 40% said 211 Toronto was the only source of information they had used to answer their original question; 2) 78% consider 211 Toronto either a helpful, very helpful, or the single most helpful source of information they had used; 3) 67% were either satisfied or highly satisfied with the service; and 4) 77% used the service again in the time between the first survey and the follow-up call or intended to use it again in the future.

While several individual results deserve separate consideration and will be discussed later in the chapter, taken as a whole these results suggest that 211 Toronto achieves mixed results in terms of successfully reaching those groups who might benefit the most from the service.

On the one hand, 211 Toronto seems to be successful at lowering some of the barriers traditionally experienced by vulnerable population groups, including being an immigrant, having lived in the community for a short time, and having limited economic resources. Also, users are generally quite satisfied with the service received and believe 211 Toronto was instrumental or even essential in finding solutions to their problems.

On the other hand, however, the service seems to be less successful in reaching older and less educated users, whether immigrants or not. In addition, a majority of users did not make appropriate use of 211 Toronto and asked factual questions, as defined in the previous chapter, that could have been easily answered making use of other, less sophisticated services.

This chapter is structured into several sections. Section A summarizes the data collection process and reports response and completion rates. Section B presents the descriptive analysis of the survey data, including: history and time of migration; essential demographic variables; additional immigration-related variables; information-related variables, with an analysis of questions asked by 211 Toronto callers; and socio-economic variables. The results of the comparison between survey data and 2001 Census data for Toronto's Census Metropolitan Area (CMA), aimed at identifying population groups who were either under- or overrepresented among 211 Toronto callers, are summarized in Section C. Section D presents the analysis of data collected during the follow-up phase of the survey, which focused on issues of effectiveness and satisfaction. A validation of survey results is included in section E. Finally, conclusions are presented in section F, including a summary of the most important results.

A. Data Collection Process Overview – Response and Completion Rates

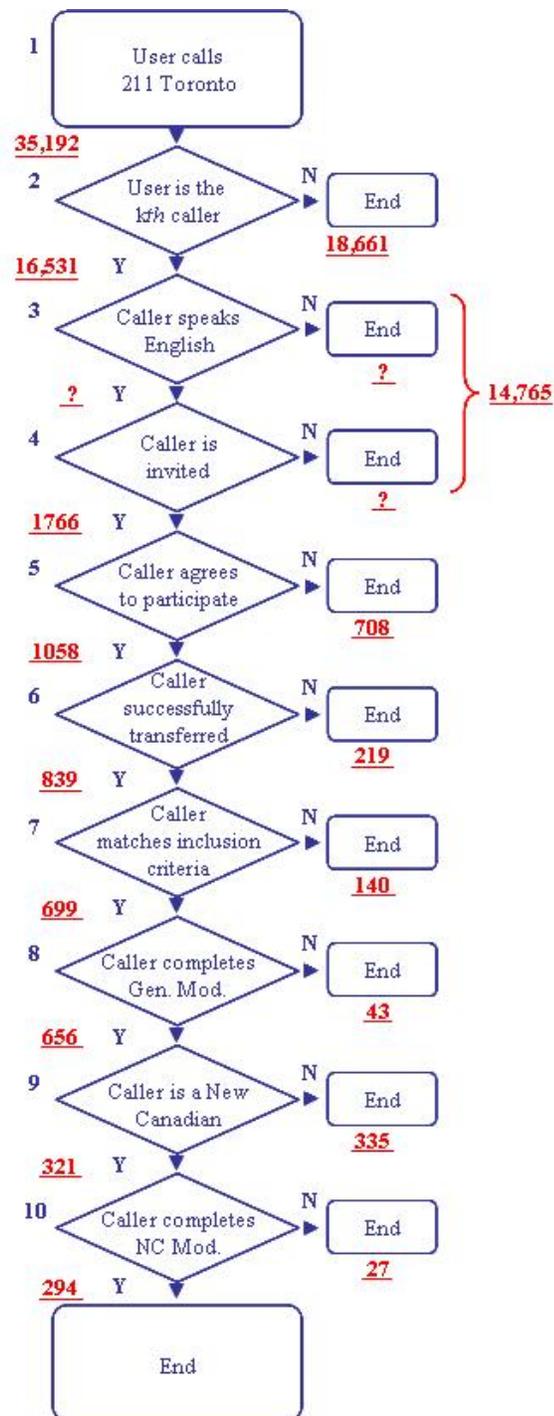
Figure 6.1 presents a flowchart that breaks down the data collection process described in the previous chapter into discrete steps. For each step the number of 211 Toronto callers involved is shown underlined.

Several figures presented in the flowchart are worth careful consideration.

1. As a result of the systematic sample used in this phase of the study, 16,531 of the 35,192 calls received by 211 Toronto within the survey timeframe were eligible for inclusion (Step 2). As explained in Chapter V, according to the study protocol the only reason for excluding callers at this stage of the process was if their knowledge of

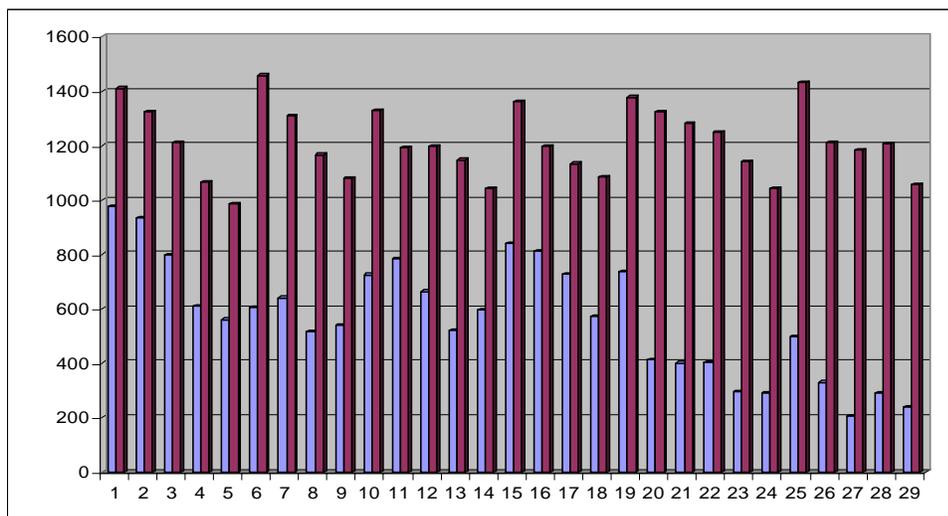
English was deemed to be insufficient to understand and answer the questions included in the interview guide. In all other cases, 211 Toronto counsellors were instructed to invite callers, without exceptions. However, a review of the information recorded in the study dataset and the historical data collected by 211 Toronto reveals that the difference between the 16,531 potential participants as calculated on the basis of the sampling interval and the 1,766 callers who were actually invited cannot be explained simply by language limitations. Nor can such difference be explained by the addition of callers who were excluded because they were in an emergency situation that would have made an invitation highly inappropriate. The fact that language limitations were not the main reason for excluding such a large number of callers becomes evident when reviewing the data collection materials. Counsellors explicitly indicated lack of English as a reason to exclude callers in only 36 cases. This number is too far from the total number of excluded callers to suggest any significant role for language limitations even if it represented an underestimation, considering the number of incomplete forms. Also, there is a very large variability in the number of calls recorded and invitation forms properly filled out among the 26 counsellors who contributed to the study. Of them, five contributed more than 100 invitations to the study, with one contributing more than 200, while some counsellors contributed very few invitations, two of them less than ten. The fact that some counsellors were on vacation during part of the data collection process while others were working only part time does not fully explain these variations. In addition, as shown in Figure 6.2, over the course of the data collection period there was a general tendency to record, and therefore invite, increasingly less callers. The darker bars in the figure show the total number of calls received by 211 Toronto over the 29 days of the study while the lighter bars show the number of calls recorded by counsellors in their daily check lists.

Figure 6.1 – Data Collection Steps



While the darker bars show a fairly stable flux of calls with a clear weekly pattern (highest number of calls on Monday and lowest on Friday, the second week having four days only as Monday August the 2nd was a holiday), the lighter bars clearly show a diminishing trend in the number of calls recorded by counsellors. All these elements suggest that the most important reason for non-invitation was the lack of commitment to the study of some counsellors, a problem that became more and more evident over time. As already mentioned in the previous chapter, lower-than-expected numbers of invitations became quite suspicious early in the data collection process. Counsellors were therefore encouraged to comply with the study protocol virtually on a daily basis while the sample interval was reduced on three separate occasions in an attempt to increase the number of completed interviews. Neither tactic achieved fully satisfactory results.

Figure 6.2 – Comparison Of Total Number Of Calls Received By 211 Toronto and Number Of Callers Invited To Participate In the First Phase Of the Survey



Darker bars = Total number of calls received by 211 Toronto

Lighter bars = Number of calls recorded by counsellors in their daily check lists

Historical data collected by 211 Toronto confirm the hypothesis that language was not the main obstacle to be overcome to achieve a larger number of completed interviews. Quarterly reports consistently show that approximately 40% of all calls received by 211 Toronto are made by users whose first language is not English (FindHelp Information Services, 2005). This means that, in the worst case scenario, if that entire 40% of callers did not speak English well enough to be able to answer the interview questions, still approximately 9,900 callers should have been invited. This number would actually be even higher because the 40% historical figure represents callers whose first language is other than English, not those with a poor knowledge of this language. Even assuming the worst case scenario, the number of callers who were invited still represents less than 20% of all callers who should have been invited.

It is important to mention that the invitation patterns of counsellors with different language skills were analyzed and compared to make sure they did not bias the collected data. No evidence of this was found. The results of the analysis, however, are not detailed here as they would make individual counsellors easily identifiable. To conclude, missed invitations represent the most important cause of data loss in this study. However, there is no evidence suggesting that they undermined the validity and precision of data.

2. Another problem that had a negative impact on the number of completed interviews was the need to transfer calls from counsellors to interviewers. Only three phone lines were available for the study and at some times all of them were busy. In other, less numerous cases, all interviewers available at a certain time were busy with previous callers. In both cases, several 211 Toronto users who had initially accepted to participate did not have the time to wait for an available line or interviewer and hung up. As the flowchart shows (Step 6), 219 of the 1058 callers who had accepted the invitation (20.7%) were lost due to these problems.

3. A fairly high percentage of all callers invited (1058 of 1766, or 59.9%, Steps 4 and 5) accepted to participate in the study. Also, of all callers successfully transferred to an interviewer (839, Step 6) 699 or 83.3% matched all inclusion criteria and of this last group 656 or 93.8% completed the 'General Module' of the interview guide. This last percentage represents, by definition (Kviz, 1977), the overall response rate for the study. With a deeper, ongoing involvement of 211 Toronto counsellors, and eliminating the technical problems related to the phone lines, it would have been possible to complete ten times the number of interviews. In that hypothetical scenario, however, the availability of interviewers would have probably become a limiting factor. The problems described at points 1 and 2 had a very significant impact on the overall completion rate of the study, defined as the number of callers who completed the 'General Module' of the interview guide (Step 8) divided by the total number of potential study participants according to the study sample interval (Step 2) $\times 100 = 656 / 16,531 \times 100 = 4.0\%$ (Kviz, 1977).
4. A similar analysis can be conducted for participants who were 'New Canadians'. In this case, taking into consideration the additional inclusion criterion defining this subgroup, the response rate can be calculated as 91.6% and the completion rate as 1.8%.
5. With respect to the inclusion criteria for which information is available (Step 7), of the 140 callers who were excluded 46 were 'lost' during the first three days of the study, before 'first-time caller' was eliminated as one of the criteria, as explained in Chapter V. The inclusion criterion that led to the elimination of the largest number of callers was 'seeking information for oneself, a relative or a friend, not for a client as part of one's professional responsibilities'. 115 callers (13.7%) were in fact excluded as they contacted the service on behalf of other agencies. The two remaining criteria, age and living within the boundaries of the Toronto CMA, resulted in the exclusion of a much smaller number of callers, 10 and 16 respectively.

B. Descriptive Analysis Of Survey Data

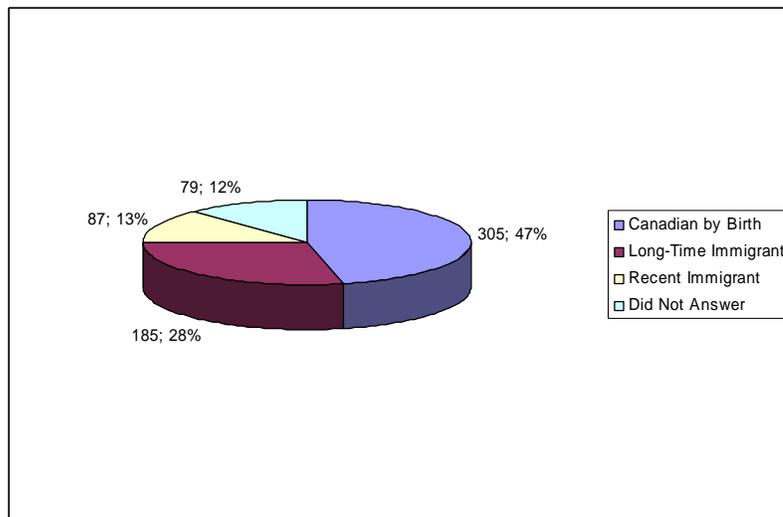
B.1 History and Time Of Migration

321 survey respondents (48.9%) had moved to Canada after birth while only 305 (46.5%) were Canadian born. 30 respondents (4.6%) did not give any information on their **status in Canada** (throughout the next two sections of this chapter, names of variables are highlighted to guide the reader). Later in the chapter these percentages will be compared to the 2001 Census data and further discussed. Figure 6.3 shows the study sample by **history and time of migration**. Data on time of migration was not available for 79 respondents (12.0%).

B.2 Essential Demographic Variables

With respect to **sex** of callers, of 656 respondents, 473 (72.1%) were female, 178 (27.1%) male, and 5 (0.76%) gave other responses or did not respond at all. It is not surprising to realize that almost three quarters of 211 Toronto callers were female. This result confirms what is already known about gender roles within families and the fact that women are usually responsible for seeking assistance for both themselves and other members of the family by contacting health, social and other human services. The role of women as family ‘information brokers’ is also confirmed by a statistically significant difference between the percentage of male and female callers who were seeking information for relatives or friends. Only 11% of male callers sought information for others compared to almost 20% of women ($p = .0186$). This result is also consistent with 211 Toronto historical data (FindHelp Information Services, 2005). What is surprising, however, is that this sex distribution does not apply to recent immigrants. Among them, as shown in Tables 6.2, there was a virtually perfect 50-50 split between male and female callers.

Several explanations could be suggested for the different sex distribution among callers who are recent immigrants. Of them, the following seem to be quite probable on the basis of what we know about this population group.

Figure 6.3 – Respondents By History and Time Of Migration**Table 6.2 – Sex By History and Time Of Migration**

	Male N (Row %)	Female N (Row %)	TOTAL
Canadian by Birth	77 (25.6)	224 (74.4)	301
Long-Time Immigrant	35 (19.0)	149 (81.0)	184
Recent Immigrant	44 (50.6)	43 (49.4)	87
TOTAL	156 (27.3)	416 (72.7)	572 (100.0)

Chi-Square = 30.75 (p = .0001)

First, in some other cultures women might have a less active role in communicating with the external world and the responsibility for solving practical everyday problems might stay with men. Second, it is reasonable to think that, even in those cultures where women do play the role of 'knowledge brokers', the multiple challenges created by the resettlement experience might profoundly influence traditional roles and require a more active participation of both men and women to face them. Finally, according to the 2001 Census, the level of education among female recent immigrants 18 years of age and older living in the Toronto CMA, measured as the highest level of schooling achieved, was significantly lower than the level of education of male recent immigrants ($p = .0001$). Years of schooling and fluency in English can be expected to be related among immigrants who are not English native speakers. Because of their language skills, male recent immigrants would take responsibility for contacting services by phone more often than in other user groups. Of course, the three factors here considered could all simultaneously contribute to the observed sex split. In addition, the result might not reflect at all the actual role played by men and women in seeking information. In some cultures women could be less willing than men to interact and share personal information with strangers, even on the phone, and therefore would have been less likely to agree to be interviewed for the survey. This would have resulted in a biased sample for this specific group of respondents.

The mean **age** of respondents ($N = 629$) was 39.4 years with a standard deviation of 13.4. There is no statistically significant difference between the mean age of Canadian-born (40.3 years) and long-time immigrants callers (41.2 years). Recent immigrant callers, however, were on average five years younger than callers belonging to the previous two categories (35.1 years). This result perfectly reflects the 2001 Census data showing that recent immigrants living in Toronto, as a whole, were on average five years younger than the general population, once individuals less than 18 years old were excluded to make the census population comparable to the study population.

With respect to the **marital status** of respondents: 298 were single/never married (45.3%); 222 were married or living common law (33.8%); 49 (7.5%) were divorced; 46 (7.0%) lived separated; and 22 (3.3%) were widowed. Information on the marital status of 19 participants (2.9%) is missing. With some minor differences, these percentages are consistent across all sub-groups defined by history and time of migration. Again, a tentative interpretation of this result will be given later in the chapter when comparing it to the marital status distribution in Toronto's general population.

B.3 Additional Immigration-Related Variables

The study sample fully captures the highly multicultural nature of Toronto's population. In addition to English (58.1%), 51 languages were listed as respondents' **mother tongues** including, among the most common: Spanish (6.5%), French (3.3%), Chinese (2.9%), Italian (2.3%), Farsi (1.8%), Somali (1.8%), Tamil (1.8%), Urdu (1.8%), and Arabic (1.7%). Only 73.5% of respondents indicated English as the **language most commonly spoken at home**, 80.8% as the language most commonly spoken **with friends**, and 91.3% as the language normally spoken **at work/school**. It is interesting to observe that even a noteworthy minority of Canadian citizens by birth, more than one respondent in six, answered that their mother tongue was not English. 4.6% indicated French as the first language they learned in their childhood while 17 non-official languages were included among the responses. English was the mother tongue of 43.8% of long-time immigrants and 17.2% of recent immigrants. Also, 62.7% of long-time immigrants said they usually speak English at home in comparison to 36.8% of recent immigrants.

The 321 respondents (48.9%) who were born outside of Canada indicated 74 different countries as their **place of birth**. Table 6.3 compares the ten most common countries of birth for all respondents born outside of Canada, for long-time immigrants, and for recent immigrants. Differences reflect shifting patterns of migration toward this country.

Table 6.3 – Country Of Birth

Long-Term Immigrants (%)	Recent Immigrants (%)	All Immigrants (%)
Jamaica (15.1)	India (12.6)	Jamaica (9.3)
United Kingdom (5.4)	China (11.5)	India (5.9)
Somalia (4.3)	Nigeria (6.9)	China (4.7)
Sri Lanka (4.3)	Philippines (6.9)	United Kingdom (3.7)
Trinidad & Tobago (4.3)	Pakistan (5.7)	Pakistan (3.4)
Guyana (3.8)	Bangladesh (4.6)	Sri Lanka (3.4)
Bangladesh (3.2)	Colombia (4.6)	Bangladesh (3.1)
India (3.2)	Mexico (4.6)	Guyana (3.1)
Pakistan (3.2)	Iran (3.4)	Philippines (3.1)
Iran (2.7)	Sri Lanka (3.4)	Trinidad & Tobago (3.1)

Of the 321 foreign-born participants, 120 (48.2%) belonged to the family class **immigration category**, 69 (27.7%) to the independent class, 44 (17.7%) were refugee claimants, and 9 (3.6%) belonged to the business class. No information is available for 59 participants. The immigration category distribution is significantly different for long-term immigrants and for recent ones ($p = .001$) with refugees, business class immigrants and independent applicants being much more numerous among recent immigrants and family class applicants more numerous among long-term immigrants. This result reflects the immigration trends already discussed in Chapter II.

B.4 Information-Related Variables

The interview guide included several questions on access to health information. The most common single **source of health information** for survey participants was the family doctor (309 respondents or 47.1%). Knowing this, it is important to observe that 10.7% of respondents (70) said they did not have a family doctor. Access to a family doctor was significantly different ($p = .0001$) among Canadian-born participants (31; 10.2%), long-time immigrants (7; 3.8%) and recent immigrants (20; 23.0%). Among other answers to

this question: 60 participants (9.1%) considered the Internet as their main source of health information; 29 (4.4%) asked their relatives; 18 (2.7%) their friends; 13 respondents (2.0%) would look for information in the media; and 5 (0.8%) would ask colleagues at work or school. 194 (29.6%) participants indicated other sources of health information including: 211 Toronto itself (46; 7.0%); community health services (43; 6.5%); and other phone services such as Telehealth Ontario (42; 6.4%) (http://www.health.gov.on.ca/english/public/program/telehealth/telehealth_mn.html). No information was available for 28 participants (4.3%).

With respect to how participants had learned about this service, 209 respondents (31.9%) said they had **found out about 211 Toronto** through word of mouth, from relatives and friends. 196 participants (29.9%) learned about it through other community agencies, government services, health providers or through school. Additional means included: advertisements (78; 11.9%); the phone book, yellow pages, or other directories (69; 10.5%); the media (24; 3.7%); and the Internet (9; 1.4%).

525 participants (80.0%) had used the **Internet** before while 114 (17.4%) had not. Of those who had used the Internet, 59.4% said they had searched for health-related information and 39.4% had not. Only 195 respondents (37.1%) were aware that 211 Toronto can be reached through the Internet and, of those aware, 53.1% had used the **211 Toronto web site** in the past. 61.5% of this last group preferred to use the phone-based service, 28.8% said their preference would depend on the circumstances and/or the type of information they needed, and only 8.6% gave their preference to the Internet-based version of the service. Among the reasons for preference mentioned by participants, 57 (54.8%) said that the phone service is easier to use and more effective while only 6 (5.8%) thought the same of the Internet-based service. With respect to all Internet-related questions, no statistically significant differences were found across history and time of migration sub-groups.

As already explained in Chapter V, the invitation forms used by 211 Toronto counsellors included a descriptive field for **questions asked by callers**. Only the main question asked during each phone call was recorded. A total of 1,766 invitation forms were completed during the study. 116 invitation forms (6.6%), however, do not contain information on questions, in most cases because the phone call ended, for a number of different reasons, before a question was actually asked. 489 callers (27.7%) asked health-related questions and 1,135 (64.3%) other types of questions. In 142 cases (8.0%) either no information was available or the information recorded was insufficient to categorize the question. 552 callers (31.3%) asked complex questions while 955 (54.1%) asked factual ones, such as questions about phone numbers or addresses. In 143 cases (8.1%) the nature of the questions was unclear.

Questions were organized into thematic categories as presented in Table 6.4. These categories were not pre-defined but were built through content analysis of questions. It is interesting to observe that this process produced categories that are virtually identical to those historically used by 211 Toronto to monitor their phone service. Also, percentages for each category are generally very consistent with historical data. Only the broad 'Health-Related Questions' category is larger than the 'Health' category found in 211 Toronto quarterly reports. In this case, the difference is probably due to the very inclusive definition of 'health-related' used in the study. No significant differences were found when comparing thematic categories between the sub-group of 656 callers who completed the first phase of the survey and the broader group of 1,766 callers for whom an invitation form is available.

Table 6.4 – Thematic Categories

Categories	Examples	N	%
<i>Health Related</i>		489	27.7
Administrative/Bureaucratic Aspects	‘Where is the nearest OHIP office?’; Immigrant with no OHIP calling for health services for 3 yr old daughter	54	3.1
Disease/Condition-Related Questions	‘Can I have the number for AA?’; ‘What sort of resources or contact information do you have for people who have asthma?’	39	2.2
Needs of Special Groups	Looking for number for Street Health; Looking for resources for two cousins who are deaf and blind	114	6.5
Providers & Services	Requested number for Telehealth Ontario; Existing counselling services regarding sexuality	274	15.5
Other Health-Related Questions	Requested numbers for the Canadian Council on Rehabilitation and work; ‘My husband needs help with transportation he has lots of medical appointments’	8	0.5
<i>Non-Health-Related Questions</i>		1,135	64.3
Basic Needs (Food + Housing)	Address of a food bank; Information on how to find food stamps and affordable housing	172	9.7
Consumer/Commercial	Location of a Goodwill retail store; Needed help to resolve an issue with Enbridge	46	2.6
Children’s services	Looking for the Office of the Child and Family Service Advocacy; Looking for programs that helps pay the cost of private school tuition	73	4.1
Education, Recreation, and Similar	Looking for number for Peel District School District; Looking for some form of computer training	130	7.4
Employment Services	‘What is the telephone number for Employment Insurance?’; ‘I want to work in Canada as a nurse: what do I have to do?’	94	5.3
Government Agencies/Offices	MPP Rosario Marchese’s phone number; Immigration matters concerning a cousin	332	18.8
Language Instruction	‘Can I have the LINC phone number to take the English test?’; ‘What does someone who wants to take ESL classes do? Do they need to be assessed?’	30	1.7

Categories	Examples	N	%
Legal services	Number for Aboriginal Legal Services; Wanted to speak to a lawyer to ask some questions	85	4.8
Other Non-Governmental & Community-Based Services	Asked for a church number; 'Does 211 accept volunteers?'	132	7.5
Transportation Services	TTC phone number; 'I want to know how to go to Finch and McCowan'	23	1.3
Other Non-Health-Related Questions	'What time is it?'; Call regarding bugs in an apartment and how to get rid of them	18	1.0
<i>Not Categorized</i>		142	8.0

It is interesting to observe that complex questions were significantly more common among health-related questions than among non-health-related ones ($p = .0001$). In the former group, 45.1% of questions were complex and 54.9% were not. In the latter one only 33.3% of questions were complex while two thirds were not. Another interesting result is that health-related questions become more and more common with age.

A significant difference ($p = .01$) exists when comparing health- and non-health-related questions across three age groups: 18-39 (28.3% health-related and 71.7% non-health-related); 40-64 (31.5% health-related and 68.5% non-health-related); and 65 and older (55.2% health-related and 44.8% non-health-related). No other statistically significant differences were found when thematic categories were compared by sex, marital status, mother tongue, access to a family physician, legal status in Canada, history and time of migration, immigration category, and level of formal education.

B.5 Socio-Economic Variables

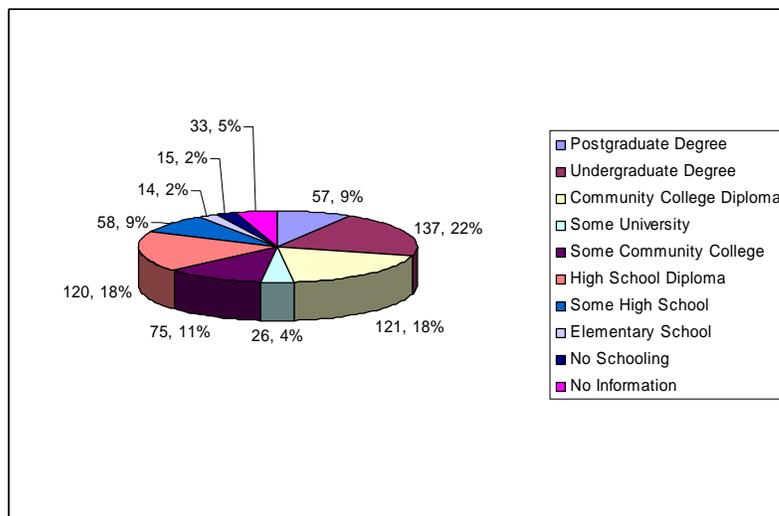
As shown in Figure 6.4, survey participants represented a highly educated group, with 81.7% of respondents holding at least a high school degree. Table 6.5 shows the **overall level of formal education** achieved, by history and time of migration, including schooling

before and after resettlement. The table shows a significant gradient across the three groups, with callers who were recent immigrants showing the highest achievements and Canadian-born callers the lowest. More than 60% of new Canadian respondents had obtained a high school degree before resettling in Toronto and the vast majority of them had achieved some level of post-secondary education. Almost one third of them did not pursue any further education in Canada.

While approximately half of the respondents, 319 or 48.6%, had been working for most of the 12 months before the survey, either employed or self-employed, almost one in five (17.7%) had been looking for paid work during the same period (Figure 6.5).

Respondent who had been looking for paid work were most numerous among recent immigrants (20; 23.0%) compared to 19.9% among Canadians by birth (58) and 15.7% among long-time immigrants (29). These differences are statistically significant ($p = .002$). The survey also included a question about pre-resettlement employment and data shows a highly significant change in unemployment for immigrants, from 3.2% pre-resettlement to 16.6% post-resettlement. It should be noticed, however, that this steep increase could be due at least in part to a different definition of 'employment/self-employment' in countries other than Canada, often characterized by very large informal economy sectors.

Employment and self-employment were the most common **source of income** (43%) followed by governmental sources (33%) (Figure 6.6).

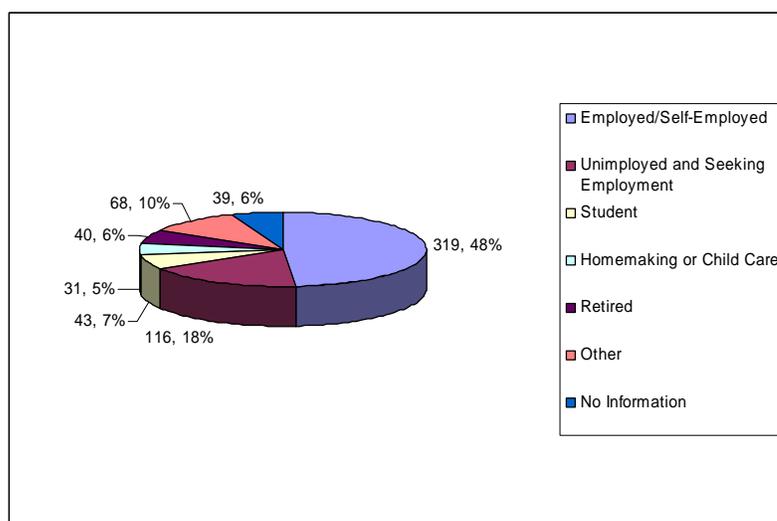
Figure 6.4 – Highest Level Of Formal Education Achieved**Table 6.5 – Overall Level Of Formal Education By History and Time Of Migration**

	Less Than High School N (Row %)	High School Diploma N (Row %)	Post- Secondary Education N (Row %)	TOTAL
Canadian by Birth	57 (19.0)	60 (20.0)	183 (61.0)	300
Long- Time Immigrant	15 (8.1)	39 (21.2)	130 (70.6)	184
Recent Immigrant	1 (1.1)	9 (10.3)	77 (88.5)	87
TOTAL	73 (12.8)	108 (18.9)	390 (68.3)	571 (100)

Chi-Square = 33.13 (p = .0001)

Respondents' mean **personal income**, from all sources and calculated before taxes, for the 12 months before the survey, was Can\$ 27,340. It is important to notice, however, that no information is available on 307 participants, representing 46.8% of survey participants. An income gradient exists across the three groups defined in terms of history and time of migration, with Canadian by birth having a mean personal income of Can\$ 29,599, long-established immigrants of Can\$ 27,832 and recent immigrants of Can\$ 19,036. However, the differences between these three groups, analyzed using the Kruskal-Wallis test, are not significant ($p = .52$). Recent immigrants also show the highest percentage of 'no income' consistent with higher levels of unemployment in this group.

Figure 6.5 – Employment Status In the Previous 12 Months



The distribution of the approximate total household income of respondents, before taxes, for the 12 months before the survey is shown in Figure 6.7. Again, no information is available for 308 subjects, representing 46.9% of all survey participants. As shown in Table 6.6, recent immigrants are the sub-set of callers with the largest proportion of

Figure 6.6 – Main Source Of Income

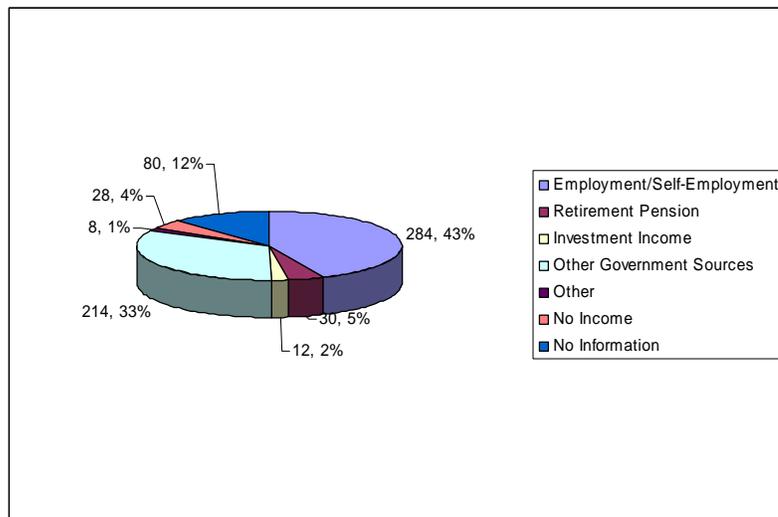
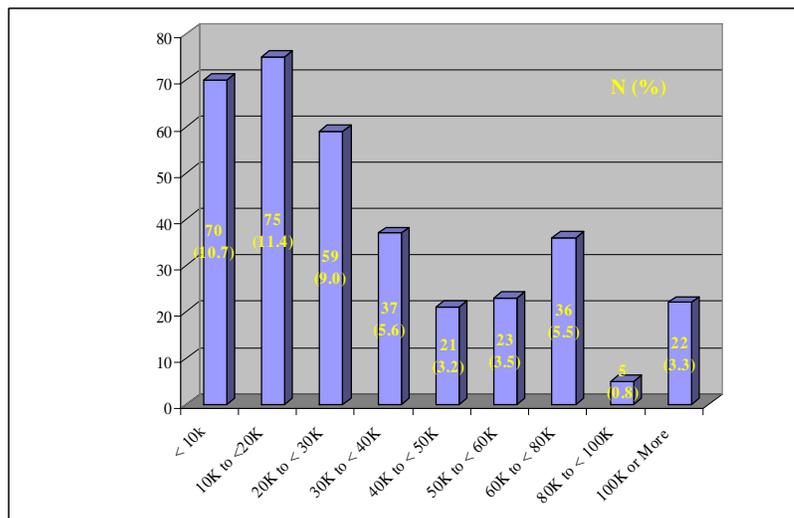


Figure 6.7 – Total Household Income Distribution



respondents in the lowest household income group (87.5%) and the smallest (2.1%) in the highest income group. Differences across the three groups are of borderline statistical significance.

Table 6.6 – Household Income By History and Time Of Migration

	< 40k N (Row %)	40K to <80K N (Row %)	80K and More N (Row %)	TOTAL
Canadian by Birth	113 (68.1)	38 (22.9)	15 (9.0)	166
Long- Time Immigrant	73 (64.6)	31 (27.4)	9 (8.0)	113
Recent Immigrant	42 (87.5)	5 (10.4)	1 (2.1)	48
TOTAL	228 (69.7)	74 (22.6)	25 (7.6)	327 (100)

Chi-Square = 9.36 (p = .0526)

C. Comparison Between Survey and Census Data

As already explained in Chapter V, to measure the degree of success achieved by 211 Toronto in reaching and supporting those population groups that could benefit the most from the service, and newcomers in particular, several variables were compared between survey and census data to understand whether certain population groups were either over- or underrepresented among 211 Toronto callers. The survey population was compared to the general population 18 years old or older living within the boundaries of Toronto's CMA at the time of the 2001 Census. In addition, the survey and census recent immigrant sub-groups were also compared. The results of such comparisons are summarized in Table 6.7. As discussed in the following paragraphs, the image of 211 Toronto that can be drawn from these comparisons is not clear-cut.

The comparisons of the variable 'legal status in Canada' and of the language-related variables suggest that 211 Toronto effectively reaches 'new Canadians'. Landed immigrants and non residents were significantly more numerous in the survey population than in the general Toronto population. In the survey, more than 20% of callers were either landed immigrants or non-residents, compared to 14.1% in the general population. Conversely, citizens by birth and citizens by naturalization, considered together, were significantly less numerous among callers (78.1%) than in Toronto's general population (85.9%). In addition, among recent immigrants, landed immigrants were significantly more numerous than immigrants who, having already become citizens by naturalization, had presumably spent a longer time in Canada. Considering that the study excluded callers whose knowledge of English was deemed to be insufficient to properly understand and answer the interview questions, these results represent a conservative estimate of the true differences between the two populations. The language-related results show the effect that such exclusions had on the sample composition. Survey participants, in fact, spoke an official language (English, in the virtual totality of cases) as their mother tongue, the most common language at home, and the most common language at work, significantly more often than members of the general population. The only exception is represented by recent immigrants with respect to English as their mother tongue. In this sub-group, in spite of the language-based exclusions, there was no significant difference between survey participants and the general population of recent immigrants. This result, too, supports the conclusion that 211 Toronto does successfully reach newcomers.

With one exception (the comparison of personal income between surveyed recent immigrants and recent immigrants in the general population, which is non-significant) all comparisons of income show that 211 Toronto callers are on average significantly poorer than Toronto's general population. In the literature, poverty is considered as an important factor negatively impacting the health status of a population, the process of post-

Table 6.7 – Comparison Between Survey and Census Data: Results Summary

Variable	Population	Result
Legal status in Canada	General	Landed immigrants and non residents were significantly more numerous in the study population ($p = .0001$)
Legal status in Canada	Recent immigrants	Landed immigrants were significantly more numerous, and citizens by naturalization significantly less numerous, in the study population ($p = .0002$)
Sex	General	Female individuals were significantly more numerous in the study population ($p = .0001$)
Sex	Recent immigrants	There was no significant difference in sex distribution between the two populations ($p = .73$)
Age	General	The study population was significantly younger ($p = .0001$)
Age	Recent immigrants	The study population was significantly younger ($p = .015$)
Marital status	General	Single, separate, and divorced individuals were significantly more numerous, and married individuals significantly less numerous, in the study population ($p = .0001$)
Marital status	Recent immigrants	Single individuals were significantly more numerous, and married and separated/divorced individuals significantly less numerous, in the study population ($p = .016$)
Formal education	General	The level of formal education of the study population was significantly higher ($p = .0001$)
Formal education	Recent immigrants	The level of formal education of the study population was significantly higher ($p = .0001$)
Personal income	General	The study population had significantly lower personal income ($p = .0001$)
Personal income	Recent immigrants	There was no significant difference in personal income between the two populations ($p = .99$)
Household income	General	The study population had significantly lower household income ($p = .0001$)
Household income	Recent immigrants	The study population had significantly lower household income ($p = .0001$)
Mother tongue	General	The proportion of individuals whose mother tongue was a non-official language was significantly lower in the study population ($p = .0001$)
Mother tongue	Recent immigrants	There was no significant difference in the proportion of individuals whose mother tongue was a non-official language between the two populations ($p = .37$)
Language most commonly spoken at home	General	The proportion of individuals who commonly spoke a non-official language at home was significantly lower in the study population ($p = .006$)
Language most commonly spoken at home	Recent immigrants	The proportion of individuals who commonly spoke a non-official language at home was significantly lower in the study population ($p = .001$)
Language most commonly spoken at work	General	The proportion of individuals who commonly spoke a non-official language at work was significantly lower in the study population ($p = .025$)
Language most commonly spoken at work	Recent immigrants	The proportion of individuals who commonly spoke a non-official language at work was significantly lower in the study population ($p = .039$)

resettlement adaptation, and the struggle to access information sources. This result suggests that 211 Toronto does reach economically disadvantaged groups for whom being able to access information might be particularly important.

On the other hand, some of the results originating from the survey-census comparisons suggest that a few barriers do exist limiting the potential impact 211 Toronto could achieve. In particular, the survey population was significantly younger than the general Toronto population 18 years of **age** or older. Also, the recent immigrant sub-group of the survey population was significantly younger than recent immigrants living within the boundaries of Toronto's CMA. These results, which are in line with historical data collected by 211 Toronto, might be indicative of a service limitation. As suggested at the beginning of the chapter, a lack of information on the characteristics of the service could be discouraging certain groups who are usually less familiar with new technologies. Not knowing that all calls are answered by a counsellor, the elderly might be afraid of having to deal with a complicated automated answering system. Among recent immigrants, the problem might be compounded by language problems, in that older immigrants might be, on average, less fluent in English.

Similarly, the higher **level of formal education** found in the survey population, both in general and among recent immigrants, could be an indicator of the presence of some barriers to the use of 211 Toronto. As in the case of the elderly, people with lower formal education not only could find it more difficult to learn about the service and truly appreciate its potential, but could also be afraid of having to deal with a complicated computerized answering system. In addition, as previously suggested, among recent immigrants lower formal education is presumably associated with lower fluency in English. This would result in lower use of the service, for fear of not being able to communicate. On the other hand, however, if the lower-formal-education-level/lower-English-fluency association is true, the survey methodology would have led to the exclusion of many recent immigrants with a low level of formal education, therefore

overestimating the level of formal education of this sub-group. As it is not possible to know how important the net effect of the language-related exclusions was, these results should be interpreted with caution.

Finally, there are at least two set of comparisons whose results cannot be easily interpreted in terms of 211 Toronto success in reaching those population sub-groups who might make the most of the service. The **sex** distribution of survey participants has already been discussed. Survey/census comparisons confirm the different sex distribution in the general population and in the population of recent immigrants. In the former case the survey population is overwhelmingly female and very significantly different from Toronto's general population. In the latter case, however, the male/female split perfectly reproduces the one in the general population of recent immigrants.

A second result of difficult interpretation relates to the survey/census comparison of **marital status**. The study population, when compared to Toronto's general population, showed a much larger proportion of individuals who were either single, separate, or divorced (61.7% in the study population compared to 33.3 in the general population) than married (34.8% compared to 61.4%). Of course, being single, separate, or divorced does not necessarily mean having a weak social support network. In addition, no correlation was found in the study between this and other variables that might suggest social isolation, such as not having other relatives in Canada or not being involved in the activities of any groups or organization. Participants who were single, separate or divorced, however, as one would expect, were more often living alone. These results seem to suggest that those people who have less opportunities to discuss a problem with somebody close might find in 211 Toronto an important ally. This, in turn, would suggest that 211 Toronto is successful in catering to the needs of people with a relatively weak immediate social circle. Further research is definitely needed to either confirm or deny this interpretation.

D. Follow-Up Interviews: 211 Toronto Effectiveness and Users' Satisfaction With the Service

Of the 656 callers who completed Phase 1 of the survey, 153 (23.3%), who had asked health-related questions, gave their consent to be contacted again to complete the follow-up interview. Of them, 73 (47.7%) were interviewed again. Between the first and second interviews most callers were lost because they had had their phone line disconnected or had moved in the meanwhile. Only 6 (3.9%) actually refused to participate in the follow-up interview mentioning reasons such as lack of time or interest.

To understand whether participants in the follow-up phase were consistently different from study participants taken as a whole, several variables were compared between the two groups. None of the variables measured, however, showed any statistically significant difference between the two groups, including: age; sex; marital status; mother tongue; language most commonly spoken at home; language most commonly spoken at work; legal status in Canada; history and time of immigration; highest level of formal education achieved; occupation; personal income; family income; being a 211 Toronto first-time caller or returning caller; having used the Internet; using the Internet to find health-related information; knowledge of the 211 Toronto web site; use of the 211 Toronto web site; and expressed preference between accessing 211 Toronto by phone or on the Internet.

All follow-up interviews started by reminding respondents of the reason why they had called 211 Toronto at the time of their first interview. Participants were then asked whether 211 Toronto had helped them answering their original question. Four participants (5.5%) responded that contacting 211 Toronto had been a complete waste of time; eight (11.0%) said it had been of little help; nine (12.3%) said it had been helpful; 27 participants (37.0%) answered that 211 Toronto had been very helpful; and 20 (27.4%) said it had been the single most helpful source of information for them. Moreover, 62 respondents (84.9%) felt that they had answered their original question while only six (8.2%) said they had not.

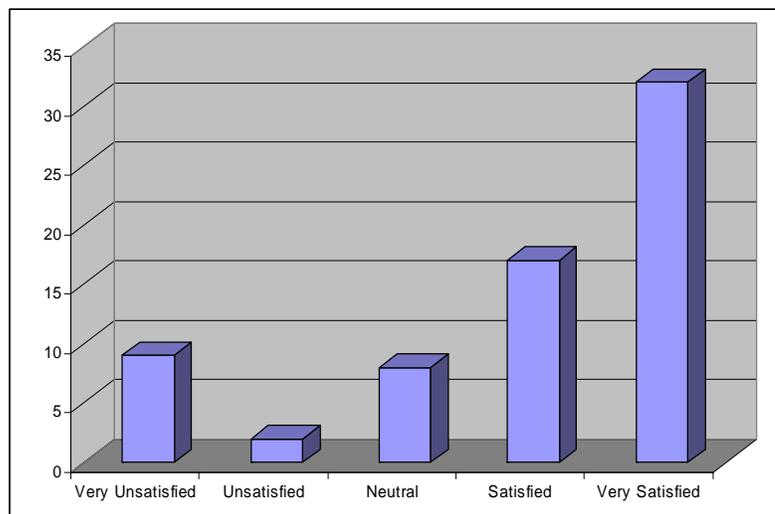
No statistically significant differences were found across the three groups of Canadian-born, long-time immigrants, and recent immigrants with respect to these two variables.

The main obstacles encountered while trying to answer the original question were identified by participants who had not found a solution as a failure on the part of 211 Toronto to provide needed information and by participants who had found a solution as, among others: having to make too many phone calls before finally finding the answer through 211 Toronto; not knowing whom to call or which service to contact; having problems reaching the right people even after the appropriate number had been found; bad information quality; and not knowing exactly what they were looking for.

Responses to the question ‘all considered, how satisfied are you with the service 211 Toronto offers on the phone’ were distributed as follows (Figure 6.8): nine participants (12.3%) said they were very unsatisfied; two (2.7%) said that they were unsatisfied; eight (11.0%) answered that they were neutral; 17 (23.3%) that they were satisfied; and 32 (43.8%) said they were very satisfied.

A comparative analysis of this variable by history and time of migration shows statistically significant differences with highest levels of satisfaction among new Canadians, as shown in Table 6.8. In the table, the original five possible answers were collapsed into two broader categories to reduce the number of cells with small expected counts. The new category ‘Low satisfaction’ includes the original answers ‘very unsatisfied’, ‘unsatisfied’, and ‘neutral’ while ‘High satisfaction’ includes the answers ‘satisfied’ and ‘very satisfied’.

The largest group of respondents (29 or 39.7%) said that 211 Toronto had been the only source of information they had needed to find a solution to their original problem. 14 participants (19.2%) said they had used the Internet, too, without specifying which web sites they had been accessing. Ten respondents (13.7%) had obtained useful information from other community agencies, government services, health providers and school sources.

Figure 6.8 – Level Of Overall Satisfaction With 211 Toronto

**Table 6.8 – Levels Of Overall Satisfaction With 211 Toronto Phone Services
By History and Time Of Migration**

	Low Satisfaction N (Row %)	High Satisfaction N (Row %)	TOTAL
Canadian by Birth	13 (41.9)	18 (58.1)	31
Long-Time Immigrant	2 (10.5)	17 (89.5)	19
Recent Immigrant	2 (16.7)	10 (83.3)	12
TOTAL	17 (27.4)	45 (72.6)	62 (100)

Chi-Square = 6.7 (p = .035)

Eight participants (11.0%) consulted the phonebook, the yellow pages, the Blue Book – a directory of human services available in Toronto published by the same agency that coordinates 211 Toronto, or other directories. Four participants (5.5%) said they had been helped to find information by relatives or friends and that they had found answers through word of mouth. Finally, three participants (4.1%) answered saying they had been using multiple sources of information to solve their original problem.

The majority of respondents (38 or 52.0%) said they used again 211 Toronto between the time of the first interview and the follow-up contact. Virtually all of them felt the service can help in many different ways and gives high quality information on a very broad variety of topics. Among the 32 respondents (43.8%) who had not used 211 Toronto again after the original call, 18 (56.2%) explained that the only reason why they hadn't used it again was lack of need and that they were sure they would use the service again in the future.

When asked whether they had any suggestions for improving 211 Toronto, 16 participants (21.9%) said more effective and widespread advertising of the service is essential. 12 respondents (16.4%) said the service is excellent as it is and they had no advice to give. Finally, 12 participants (16.4%) said 211 Toronto database could be expanded not only in scope but also geographically, including services that are outside of the Greater Toronto Area.

One of the original objectives of the study was to investigate relations between individual characteristics of 211 Toronto callers and indicators of user satisfaction and service effectiveness. To achieve this objective, correlation levels between several potentially predictive variables and the three dependent variables “problem solved/not solved”, “perceived level of usefulness of 211 Toronto” and “level of overall satisfaction with the service” were tested. As shown in Table 6.9, two of the three dependent variables had, each, one independent measure that was significantly correlated. The overall level of formal education achieved was weakly related to problem solved/not solved (Phi

coefficient = .31) while status in Canada was strongly correlated to level of overall satisfaction with the service (Phi coefficient = .55). Given this result, it was decided not to conduct any regression analysis.

Table 6.9 – Correlation Between Individual Characteristics Of 211 Toronto Callers and Indicators Of User Satisfaction and Service Effectiveness

Fisher's Exact Test	Problem Solved/ Not Solved Phi Coeff. (p value)	Usefulness of 211 Toronto Phi Coeff. (p value)	Overall Satisfaction with 211 Toronto Phi Coeff. (p value)
Sex	.19 (.14)	.34 (.38)	.30 (.21)
Mother Tongue	.24 (.08)	.17 (.76)	.33 (.14)
Language at Home	.15 (.59)	.15 (.99)	.30 (.22)
Education Pre Canada	.19 (.46)	.24 (.59)	.18 (.87)
Education Canada	.24 (.10)	.32 (.24)	.32 (.20)
Overall Education	.31 (.03)	.34 (.10)	.36 (.06)
Family Income	.29 (1.00)	.93 (.17)	.73 (.94)
Status in Canada	.26 (.15)	.42 (.21)	.55 (.01)
History & Time Migr.	.25 (.27)	.32 (.73)	.50 (.07)
Spearman Correlation	Coeff. (p value)	Coeff. (p value)	Coeff. (p value)
Age	-0.12 (.34)	-0.08 (.50)	.04 (.76)
Personal Income	.10 (.55)	-0.14 (.40)	.08 (.64)

E. Validation Of Survey Results

The results presented in this chapter were discussed and validated during a meeting with Findhelp senior management. They were also compared to the historical information the organization routinely collect on 211 Toronto.

Virtually all results of interest confirmed information already available to Findhelp.

- The significantly higher proportion of female callers observed in the study confirms historical data that consistently show a percentage of female callers close to 70%. The 50-50 male-female split among recent immigrants, however, represented a completely new piece of information.
- The age distribution of callers also coincides, showing a relative underrepresentation of people 65 and older in both quarterly reports and the survey.
- The percentages of people speaking an official language as their mother tongue are approximately 60% both in the survey and historically.
- Finally, Findhelp senior managers were extremely interested in the results of the analysis of questions asked by callers and in particular in the complex vs. factual classification. Never in the past had a similar analysis been formally conducted but the study results confirmed a generalized impression that had already been brought to their attention by many frustrated information counsellors who felt underutilized having to respond to a large number of factual questions.

Discrepancies between the study and the information already available to Findhelp were few and related to variables of minor interest. For example, while the study shows that 43% of respondents were employed or self-employed during the previous 12 months and only 4% had no income at all, 211 Toronto historical data suggest that only 25-35% of users have a full-time employment while 20-23% have no income at all. Also, the survey suggests word of mouth, among relatives and friends, as the main source of referral to the service (32%) while other community agencies, government services and similar contributed 30% of referrals only. However, according to Findhelp data other agencies are responsible for almost half of all referrals while the phone book is the second most important source of referrals, helping 18-20% of all users.

During the same meeting, the lack of commitment to the study of some counsellors was also discussed. Findhelp senior managers were not surprised and acknowledged the need to change the organizational culture to increase counsellors' awareness of 211 Toronto potential as a source of primary information and to ensure future opportunities to participate in other research initiatives.

F. Conclusions

The most significant results of the survey component of this study can be summarized as follows.

- 211 Toronto appears to be lowering some of the barriers traditionally experienced by vulnerable groups in their struggle to access both information services and health services. In particular, factors such as being an immigrant, having lived in the community for a short time, and being poor do not apparently limit access to this service.
- 211 Toronto appears to be very effective at reaching immigrants in general and recent immigrants in particular. 211 Toronto callers closely match the linguistic heterogeneity and variety of geographic origins of immigrants living in Toronto, the shifting patterns of the immigration phenomenon, and the challenges so often faced by newcomers.
- Survey results suggest high levels of service effectiveness and user satisfaction. Of all survey respondents, 60% were repeated users. The percentage of 211 Toronto callers who felt that their questions had been answered and/or their problems solved was very high. One third of respondents saw 211 Toronto as the most helpful source of information they used and the majority of respondents reported that it was the only source of information they needed. Satisfaction was higher among immigrants than among Canadian-born users. This result might be interpreted as: a reflection of different initial expectations; a tendency of immigrants to respond in a particularly polite way to the question; a consequence of 211 Toronto being particularly valuable for newcomers; or the end result of a combination of these factors. The fact that long-time immigrants are the most satisfied group supports the latter interpretation and

seems to indicate that increasing levels of satisfaction among newcomers might be the result of repeated positive experiences with the service.

- 211 Toronto shows some significant limitations, too. In particular, the service seems to be less successful in reaching the elderly and the less educated. In addition, a significant percentage of users did not use it appropriately, as suggested by the high percentage of factual questions asked by callers. These limitations could be explained, at least in part, by suggesting that some fundamental features of 211 Toronto are either not known or misunderstood by a significant portion of current and potential users. In particular, it is possible that many potential callers, influenced by their experience with other phone-based services, might be afraid of contacting 211 Toronto thinking they would have to negotiate a complicated automated answering systems and deal with English-speaking operators. The elderly, who often tend to be less comfortable using new technologies, and those with a lower degree of formal education might be particularly hampered by these fears. The large percentage of factual questions asked by callers could also be explained by a lack of understanding of the service features. In fact, many users might think that 211 Toronto offers only basic information such as names of other services/agencies and addresses. Some users might even confuse the number '211' with the '411' phone directory service number. These problems should be taken into consideration in the development of effective and broadly reaching advertising and educational campaigns. The high percentage of factual questions could also be explained in at least two additional ways, however. First, it is possible that 211 Toronto counsellors simplified queries when recording information on the invitation forms. Second, callers might have asked simple questions at the beginning of their interaction with counsellors but the information exchange might have become more complex later on during the phone conversation. In other words, the initial, factual questions might have represented in some cases entry points to the 'real' questions. The communication styles and cultural traits of individual callers might have influenced the way the phone call was structured.

- Other results, while interesting, are more difficult to interpret. For example, the 50-50 sex distribution among recent immigrants could reflect either some characteristics of that user group, as previously discussed in this chapter, some limitations of the service, which might not be reaching female recent immigrants as effectively as it reaches males, or biased results due to low female participation in the study. Similarly, the marital status distribution in the survey population, previously discussed, could be interpreted as an indicator of 211 Toronto's success at reaching people with a relatively weak social network. This conclusion, however, needs to be verified through further research.
- The data on questions asked by callers are also quite interesting. The thematic categories that were built to describe such questions show how comprehensive and wide-ranging the role played by 211 Toronto is. The information offered by this service covers virtually every aspect of life in Canada. Health-related questions, almost one third of the total, show the complex and multifaceted nature of the concept of health in the experience of users. Complex questions were significantly more numerous among health-related questions than among other types of questions. The majority crossed the artificial boundary between the 'health field' and other fields translating into practice the dimensions of supportive care introduced in Chapter II. While the elderly use 211 Toronto significantly less than other age groups, they ask significantly more health-related questions when they do call. This is another result that should be taken into consideration when advertising the service to avoid missing an important opportunity with this population sub-group. Finally, the survey confirms that family doctors are still considered by the general public as the most important source of health information. At the same time, however, it also shows that respondents in general, and recent immigrants in particular, had problems finding a family doctor. This tension further emphasizes the importance of 211 Toronto as an essential source of information for newcomers.
- The questions about the use of the Internet show the increasingly important role played by this medium. Most respondents used the Internet and the majority of them had

sought health-related information through it. Yet, when it comes to exploring solutions for complex, personal problems the response is unequivocal: most people prefer the direct interaction with a human being.

- Finally, the analysis developed early in the chapter on the data collection process highlighted some problems encountered when dealing with 211 Toronto information counsellors. Most counsellors perceived the study as additional work not included in their job description. 211 Toronto's organizational culture does not currently emphasize the importance of research to monitor the service and maximize its impact. Given the wealth of critical information that could be collected and analyzed on an ongoing basis while offering the service, it is essential that 211 Toronto fully realize this potential and engage its counsellors in this objective.

G. References

FindHelp Information Services (2005) *211 Toronto Quarterly Reports. 3rd Quarter for 2004, 2005, and 2006. Reports for the 2nd and 4th Quarters, 2005.*

Kviz, F.J. (1977) 'Toward a standard definition of response rate.' *Public Opinion Quarterly*; 41; 265-7.

Chapter VII – Results II: Qualitative Interviews

As explained in Chapter V, a small number of qualitative interviews were conducted to gain a better appreciation of the experience of recent immigrants struggling to navigate and negotiate an unfamiliar health care system. Interviewees were 211 Toronto callers who had contacted the service with a health-related question. They were all native Spanish speakers from Latin America and all of them, with one exception, had spent less than five years in Canada. Interviews focused on their experience in this country and explored the most significant hurdles they had faced since their arrival and the role information had played in the process.

This chapter includes five sections. Section A introduces the ten participants and offers brief overviews of their experiences in Canada. Section B presents some general results derived from the analysis of the qualitative interviews. In this section, as in the following ones, important analytical ‘nodes’ are highlighted to guide the reader. Section C presents results that are directly linked to the experience of respondents with health and health-related services. Section D focuses on participants’ identification and use of information sources. A tentative map of the information pathways followed by respondents in their effort to navigate and negotiate health and health-related services in Toronto is included here. Finally, Section E revisits and summarizes the most significant results of this phase of the study.

A. Participants

Of the ten 211 Toronto callers interviewed, nine were female. Respondents’ ages ranged between 28 and 56 with the majority of them being in their 30s. Six of them were either separated, divorced, widowed, or had never been married. The plan was to interview only recent immigrants, defined as people who had been living in Canada for less than five years. However, the researchers realized that one of the candidates they met at the main investigator’s office was instead a long-established immigrant. As she had travelled from

quite far away to participate, they decided to include her anyway. Most respondents had spent less than three years in Canada. Six participants were from Mexico, three from Colombia and one from Ecuador. All of them, with one exception, had entered Canada as refugee claimants. In three cases their claims were still under review. All participants were living in Canada with family members, in most cases with their children. All respondents had a secondary level of formal education and two of them had attended post-secondary academic institutions. At the time of the interview, none of them were working and only one had worked before in Canada. Eight interviews were conducted face to face, at the main investigator's office, and two on the phone. The two researchers rotated as lead interviewers.

To help the reader follow the analysis presented in this chapter, in this section each participant is briefly introduced and her/his experience in Canada summarized. To protect participants' privacy pseudonyms have been used throughout the chapter and minor aspects of their life histories have been modified.

Ana

Ana was a Colombian woman, in her early 50s, who had moved to Canada with her family. They had had to leave Colombia and a very comfortable lifestyle after her husband had received serious threats. They entered Canada in the first half of 2002 as refugee claimants and spent the first couple of months living in a shelter. Some people they had met at the shelter, and a daughter who had already been living in Canada for some time, became their main sources of support and information. The most challenging obstacle Ana had faced was language. Another significant problem had been the dramatic change in social status they had experienced. What Ana appreciated the most about her new life in Canada was the opportunity to live in peace, away from the daily episodes of violence she had experienced back home. Ana's interactions with health providers had been difficult, for various reasons. Over time, Ana and her family had developed a small circle of Latin American friends who supported each other in various ways, often sharing information.

Only very recently, watching a TV program, Ana had understood what type of help 211 Toronto offers. After trying the service, she was very satisfied with it.

Beatriz

Beatriz was born in Colombia and, after six years spent in the United States, she moved to Canada with her daughter's family because their refugee claims south of the border had been rejected. She was in her mid 50s and, in Canada, she had experienced serious health problems and undergone two surgeries. The most difficult barrier she still had to face was language. She found communication with her family doctor particularly difficult and believed he had underestimated her health problems and waited too long before referring her to a specialist. Most of the information she had received on how services work in Canada had come from neighbours and other newcomers. All considered, she was extremely grateful for the opportunity that Canada had offered her and her family.

Carla

Carla was a woman in her late 20s who had come to Canada, from Mexico, in 2004. She was married and lived in Toronto with her husband and two children. She had a university degree and found it extremely frustrating not to be able to apply her professional skills here, particularly because she had been told that Canada needs people with her background. Carla and her husband intended to apply as independent immigrants but, because of inaccurate information, they realized too late that the application process could not be initiated from Canada. When they realized it, somebody advised them that applying as refugees was the only remaining option. In spite of the difficulties, Carla appreciated the peacefulness of life in Canada and the many services available here. Their sources of information on Canada, both before and after relocating, had been few and of dubious quality. For many reasons, Carla's experience with the Canadian health system had been quite difficult. Carla believed that the communication problems she had experienced, particularly with health providers, were due not only to language but also to other, deeper

cultural barriers. In fact, those problems remained even after she had found providers who spoke Spanish.

Diana

Diana was an Ecuadorian woman in her late 40s who had moved to Toronto almost twenty years earlier to get married. At that time her husband, also from Ecuador, had been already in Canada for several years. Diana, who had never previously thought of leaving her family and home country, had spent the first few years of her life in Canada under her husband's protective wing, without worrying too much about having to learn English and understand how things worked here. The situation had changed dramatically, however, after her husband had got seriously ill and eventually passed away. Diana was left alone with two small children and virtually no social support, not even from her family in Ecuador as she had decided to keep the news of her husband's illness and death to herself to protect her mother. Diana had struggled for years to ensure her children's survival and her own. Her experiences with health providers, in general, had been extremely difficult. Over time, the most important source of information for her had been friends, most of whom were Latin American, too.

Emilia

Emilia was a 31 year old woman from Mexico who had moved to Canada in early 2004. She had successfully claimed refugee status. At arrival, she had gone through a dramatic experience as she had been arrested and detained, with her husband and their children, before being sent to a shelter. While living at the shelter Emilia had started to realize that the conditions of women in Canada were very different from what she had been experiencing in her home country. That realization had fuelled pre-existing tensions between her and her husband. Eventually, her husband had physically attacked her. He had been arrested and charged and she had filed for divorce. In addition to the usual hurdles faced by most newcomers, which had been amplified by her lack of English and the confusing, often contradictory information she had received from a variety of sources,

Emilia had fought a long struggle to ensure proper care for one of her children who suffered from a serious developmental disorder.

Flor

Flor had come to Canada in 2006, from Mexico, with her two children. To avoid a possible traumatic experience, she had entered Canada as a tourist and had later applied as a refugee claimant, after having found asylum in a shelter. She had left her home country to escape a situation of violence created by the mental illness of a close relative. In Toronto, Flor, who didn't speak any English, had faced numerous challenges. In particular, she had dealt with the learning disability of one of her children. Most of her experiences with health providers had been negative. On one occasion, her family doctor had misdiagnosed and inappropriately treated a problem Flor and her children had been suffering from. Flor was a very determined woman. However, while she had been very successful at identifying a large number of information sources and services useful to address her needs, she felt she was still fighting with a very fragmented system that was not designed to support newcomers' integration efforts.

Gladis

Gladis had come to Canada from Mexico, with her three children, in late 2005. She was in her early 40s and divorced. She had decided to leave her country to avoid her former husband's physical and psychological abuses. At the airport, on the day of her arrival, she had been confronted by a very aggressive interpreter who was working with the immigration officer, and had been detained. She had spent several weeks at a shelter. One of her children, unable to adapt to the new lifestyle, had gone back to Mexico after suffering from severe depression and being hospitalized on multiple occasions. For a long time, Gladis had not sought health care as she was afraid that using health services could have negatively affected her refugee claim.

Hugo

Hugo was an engineer in his late 50s who had moved to Canada from Colombia in 2004 after receiving serious threats. Before relocating to Toronto, his family had spent almost two years in Miami. In spite of his decades-long experience working for multinational corporations, Hugo had been unable to find a job in Canada. Yet, he was very thankful for the way this country had welcomed him and his family. Language had represented the most difficult barrier Hugo had faced. Hugo's understanding of the Canadian health care system was still very limited and his experience with health service had not been without problems.

Indira

Indira was a 35 year old woman from Mexico who had moved to Canada at the end of 2004. She was divorced and had three children. She had arrived to Canada, alone, after a long history of family violence. Over the months following her arrival, Indira had fought hard to convince her former husband to let their children move to Canada with her. As a consequence, she had fallen in a state of profound depression. Her memory was clouded and the experiences she had gone through during her first months in Canada felt like a confused nightmare. For several months, she had been unable to find any kind of support. Only after her children had finally joined her in Canada had she been able to see a psychiatrist. Finding a family doctor to address one of her children's problem had been a long and painful process that on three occasions had led Indira to a hospital emergency room.

Jimena

Jimena was a married woman from Mexico who had arrived to Canada at the end of 2002. Her husband, once a wealthy entrepreneur, had been forced to leave and had lost everything as a result of a serious dispute with powerful and corrupted local politicians. Being legally blind, Jimena's experience as an immigrant had been particularly difficult. Her life in Toronto had been a dramatic tale of disempowerment resulting from the

combined effects of language, information, and physical barriers. She had felt profoundly isolated unable as she was to see, speak and understand. It had been thanks to a very helpful landlady that Jimena and her family had started the slow process of re-building their lives in Canada.

B. General Results

As noted above, nine out of ten participants were refugee claimants. Four respondents explained that their **decision to emigrate** had been the result of sudden crises that had put themselves and their families in danger. They had fled from widespread corruption, endemic criminality or internal armed conflicts.

In three other cases, domestic violence and the widespread male chauvinism saturating society in their countries of origin were mentioned by respondents as immediate reasons for seeking refuge in Canada. Gladis and Indira had fled the physical and psychological abuses inflicted upon them by their former husbands. Indira explained that the police and authorities in general had not helped her as, in her words: '[Women] don't have a strong voice over there.' Flor had been physically attacked, on several occasions, by a close male relative who suffered from severe mental health problems and was likely angry for having to depend economically on her. She had also experienced discrimination in the workplace. She said: 'I was a secretary and, in my 30s, I was already old. Employers said they preferred a young, attractive secretary, even if she had no experience, to an older woman.'

Only two participants, Emilia and Flor, said that economic reasons had played a role in their decision to move to Canada. In Emilia's case, it had been her husband who had decided to move here, seeking better conditions. She had had to follow him even if she was very scared at the idea of moving to an unknown country. Flor was hoping that Toronto would offer her better employment chances. At the time of the interview, however, she was still looking for a job.

With respect to the **reasons for choosing Canada** as their destination, half of the participants said that they had moved here because they knew somebody, either a relative or a friend, who was already living in the country. The other half had simply heard ‘good things about the place.’

Carla had learned about Canada through advertisements in local newspapers and had been told by some individuals, who said they were working for the Canadian Embassy, that this is ‘a country of opportunities, a place where people with professional skills are needed and welcomed and where getting residency is not too difficult.’

Flor said that, many years before migrating, her sister had heard positive things about this country from a Canadian man who had retired in Mexico. He used to say that Canada is an ideal place where to raise children.

Gladis said that a friend had told her about a program, which was offered here, supporting women victims of domestic violence. The same friend had also told her that in Canada children, the elderly and animals are highly respected.

Hugo had thought of visiting Canada for many years before finding refuge here. For him, as for Beatriz, Canada represented a new opportunity after a negative experience in the United States.

Jimena said that her husband had checked on the Internet and had realized that in Canada it was easier to be accepted as a refugee than in the United States ‘where one has to hide from justice and everything turns into a legal problem.’

Most participants admitted **they knew ‘very little! No, nothing!’ about life in Canada, before migrating**. Carla said that her husband had been a few days in Canada, before they moved, as a member of a sport delegation and that, therefore, ‘he already knew this

country, didn't he?' She added that, before their arrival, they had thought things were different here, on the basis of the information they had got from people who were advertising Canada as a land of opportunities for professionals who know the language. She said these individuals pressure people into relocating to Canada emphasizing the many job opportunities existing here and the easiness of obtaining permanent residency. Initially, she had thought that those individuals were working for the Canadian Embassy. Later on, however, she realized they were probably just looking for a business opportunity. She said: 'In the Latin American community you know everything about everybody. You often hear "No, he is not here now. He is working in Mexico promoting [Canada] to bring people over."' Carla concluded: 'so one ends up imagining something different, right? Those people are not very sincere. Relocating to Canada is not as simple as they say. They don't tell you the whole story.' Carla and her husband had come to Canada hoping to apply as independent immigrants, not knowing the process could not be started from here. When they realized their mistake they were not sure whether to go back and apply from Mexico or to apply as refugees. A friend told them to try the refugee avenue. 'Now we know that applying as refugees wasn't the right thing to do. But it is too late!'

Emilia said that, in spite of having two brothers already living in Canada, she was shocked by the contradictions between the image of the country she had before migrating and the reality she encountered here. 'My brothers, the eldest in particular, had told me wonders about Canada. When I arrived, the dreamland I was expecting turned into a nightmare! They had been my only source of information, I didn't know anything else about Canada.'

Flor said that, in spite of having a sister who had already been living here for a year or two, she knew very little about the place. '[My sister] didn't know very much – she said – Actually, we learned more about available services after I moved here. What I learned through my sister wasn't even half of what I know now!'

Gladis said that, after a friend told her about the support available in Canada for women who are victims of domestic violence, she started to seek information about the country on the Internet. She accessed information offered by the Government of Canada. She was also offered information by private individuals but she could not use their help because she couldn't pay for their services. 'In Internet I saw Vancouver, Toronto. I thought it was really nice. I learned about the climate, the population, history. Also, my friend told me about the country. What she told me was very different from what I found when I arrived. I had a completely different perspective and when I was here I had to learn to survive in an environment very different from the one she had described. She told me that Canada was a very safe place, that there was no violence. But it is different. As all large cities [even Toronto] has its dangerous areas.'

Hugo said he collected some information on Canada from acquaintances who were already living here. He also used the web site of Citizenship and Immigration Canada. His knowledge of the country, however, was very limited. He felt he still had a lot to learn.

Indira didn't know anything about the country, its institutions, and government services. She said: 'What you hear and what you experience when you come over are two different things. I heard positive things and experienced negative ones, right? People tell you certain things and avoid telling you others.'

Finally, Jimena said that her husband had used the Internet to assess how good their chances of being accepted as refugees were. Beyond that, he had come to Canada without knowing anything or anybody.

Whether it was for the lack of comprehensive and accurate information on Canada or simply the natural consequence of migrating, all participants, with the exception of the two who had moved to Toronto from the US, experienced their landing in Canada as shocking, disorienting, and disempowering. Virtually all of them perceived a profound, all-

encompassing estrangement between their lives before and after relocating. This was expressed, in Spanish, by the obsessive use of the word '**diferente**': different. In this context, the word has a particularly strong nuance and emphasizes the incommensurable natures of life before and after, of two realities that do not and cannot overlap in any way. Everything fell into the 'different' category.

Ana said: 'we came from another thing, totally different'; '[here] everything is completely different from what we had there'; '[my husband says] that here he cannot apply his professional skills (he was a mining engineer) because everything is different, the ground is different.' Beatriz said: 'our culture is different, the way we treat each other'.

Diana added that '[back home] the weather is completely different' and implicitly suggested a parallel between the coldness of the climate and the remoteness of people in Canada. Emilia's children perceived the move to Canada as a 'total change, that is, for my children it was a sudden change of place, of language, of home, of everything.'

Flor believed that the differences she perceived in the way the concept of health is interpreted here and in her country of origin are unquestionable and final: 'I believe those differences are not going to become less important over time because we are different, we come from a different culture.'

Gladis' eldest daughter went back to Mexico because 'she did not like Canada, she did not like the language, she did not like her new friends, she did not like school. She did not like anything.' With respect to his knowledge of the English language, Hugo said that 'when I was in Colombia I thought I could speak English ... but when we arrived, we realized how different it is!'

The feeling of **disempowerment** was equally widespread and related to many aspects of the new experience: the isolation created by the language barrier; the need to constantly

rely on others to overcome even the simplest daily challenges; the loss of one's social support network; and the frustration deriving from not being able to apply one's professional skills and expertise. All aspects that, in the literature, are distinctly recognized as stressors related to the resettlement experience (Ahmad et al., 2004b; Fowler, 1998).

Ana said: 'the lack of communication was appalling. ... We always had to ask for help with interpreting and translating ... we always needed somebody and, sometimes, nobody was available ...'; and 'It was like starting everything from scratch'. She added that her husband, a very successful professional at home, apparently got used to the new situation, took everything in a positive way, and said he was very happy studying English. But, she said, 'for him, too, it must have been very hard. He leaves home early in the morning to go to English classes, very responsibly, as if he was going to work.'

Beatriz, who was experiencing serious health problems and had undergone two surgeries, said: 'I spent two years jailed in an apartment looking at buildings. Also, ... the lack of a car... many things, right?'; and 'it is not easy to be immobilized wearing a plaster cast and watching television in English!'

Carla, who back home had completed a university degree in accountancy but could not find a job in Canada, said: 'I have no doubts there are opportunities for Latin American people here, but it is not easy... [here] our knowledge is a bit undervalued. I studied for five years to complete my degree, then a one year practice... so, how many years does it take to be ready?' Talking about her husband, an architect, she continued: 'You know what is frustrating? That one knows how much people make cleaning floors, for example, or working in a factory, and [a professional with a university degree] just because his documentation is not the same, that is, he has the knowledge but did not study here, he makes the same money. His work is more responsibility but he is paid as little as them. Isn't it frustrating?' She concluded: 'How many times I did cry thinking of my country!'

And the worst is that, being refugees, we cannot go back home to visit! We live here tied up as prisoners. It is horrible!’

During her first few years in Canada, Diana felt she was completely dependent on her husband because she did not speak English. ‘I am an extroverted person who always says what she thinks’ she said ‘but I had to tell my husband and he had to translate. It is not the same as expressing one’s feeling directly!’ After her husband death, she found herself having to depend on acquaintances to access the services she needed, acquaintances who were often too busy to help. ‘Eventually I had to face things on my own, even if that meant communicating with signs, because I needed [those services]. Moreover, it wasn’t nice to hear all the time people telling me they did not have time to help!’

Indira, describing the frustrating experience of looking for help for her daughter, who was suffering from increasingly severe headaches, said: ‘Sometimes I feel so helpless because I would like to scream and insult them in English and I cannot! Sometimes I would like to be rude and scream at them... because she is my daughter and I cannot see her being so sick while nobody understand what she has... What can I do more than...’

However, the most shocking example of disempowerment was Jimena’s experience. Jimena was legally blind and the most difficult problem she had to face when she came to Canada was, in her words ‘the realization that in this country I wasn’t just blind, I was also deaf and mute. I would walk in the street without being able to understand what people said, and without being able to speak, because it wasn’t me speaking, it was like birds speaking... It was devastating and I drowned in depression. That wasn’t life for me.’ Jimena’s daily life was a continuous struggle. On one occasion, for example, her younger daughter developed high fever. As Jimena could not read the thermometer, and her husband was not at home, she had to rely on her elder son, six at that time, to assess the little child’s temperature and give her the right dose of medicine. Equally dramatic was the experience of taking her son to school. Between their home and the school was a large and

extremely busy street. Once again, Jimena had to rely on her son to make sure they would cross safely, with a green light, avoid other obstacles, and safely reach the school. For the first week or so, she also had to sit in the school lobby and wait until the end of classes because she could not go back home on her own.

To confirm a common result in the literature on immigration (Ahmad et al., 2004a; Ahmad et al., 2004c; Ahmad et al., 2004b; Asanin et al., 2008; Deri, 2005; Lai et al., 2007; O'Mahony et al., 2007), one of the most important factors contributing to the feeling of disempowerment was clearly the **language barrier**. Not being able to speak English was probably the most difficult obstacle experienced by participants and negatively influenced many aspects of their daily lives. As Ana, Beatriz, Carla, and Diana said, having to depend all the time on people who could translate for them was very difficult, particularly when those people made it clear that it was difficult for them to find the time to help. As Beatriz commented, '[If I spoke English] I wouldn't have to rely on other people and disturb them, asking to be taken here and there. People are busy. They have to work, to study, they have their own lives and without English one becomes a burden.'

The lack of English didn't just represent a barrier when dealing with others but, more in general, contributed to the respondents' sense of isolation and disempowerment in many other ways, as they found it impossible to read, watch television, get groceries. It is interesting to notice that the language problem came as a surprise for several respondents. In fact, they had studied English before moving to Canada and thought they actually knew the language much better than they actually did. Hugo, for example, said: 'When I was living in Colombia I thought I could speak English. My children, who didn't know any English at all, thought I could speak. When we arrived we realized how different and how difficult it was ... when somebody speaks quickly, when one is watching the news, or has to answer a phone call.'

Some respondents, such as Beatriz, were surprised when they realized how little is done in Canada to support people speaking other languages. She said: 'Without English it is very difficult to communicate with others, in all situations: at a bank; going to see a doctor; trying to find your way around. I do understand that English is the language of Canada but it would be really good, given the large number of people who come here from other places, if more information was available in Spanish, for example, more magazines, pamphlets.'

Carla had been studying English since her arrival but improvement was painfully slow. Soon, her children had learned enough English to be able to help. Carla, however, was very critical of those people who would choose to stick to the Hispanic community, did not learn English, and would rely on their children as interpreters. She said: 'I will never use my children as interpreters. Yes, from time to time I do ask them to help a bit with a word or phrase but I always make the effort to communicate. I believe it is important for the image they have of me!' This is a good example of the common, sometimes surreptitious changes in family roles brought about by the resettlement experience (Fowler, 1998).

Emilia added: '[Language is a constant barrier.] For example, doing groceries, everything is in English and one doesn't know anything, doesn't even know what things are for. I didn't even know how to buy laundry detergent. ... For a long time we ate only soup because we didn't know anything else, we didn't understand anything.'

After relocating to Canada, respondents experienced significant **changes** in their lives: **socio-economic; of social status; and of social role**. In some cases, particularly for those participants who had enjoyed a privileged existence prior to migrating, such changes were predominantly negative and compounded the feelings of uncertainty, frustration, and disempowerment expressed by so many of them. Changes that, one more time, are acknowledged in the literature as common stressors associated to migration (Ahmad et al., 2004b). Ana said: 'We started looking for an apartment but everything was so different

from what we had back home. ... My husband used to work in a private company and had a prestigious position; we owned a house; we both had our own car; my husband was very well known in our community... respected by all our friends... how could that magic dream disappear like that!... We found a one-bedroom apartment but I was used to a big house in a high-scale, gated community. We were well known there. People respected and admired us, particularly my husband. Since our arrival we have been living in an uncomfortable, small apartment.'

Similarly, Hugo said: '[When we arrived] we had to go to the food banks. At the beginning that was really shocking because we were not used to that. [Back home] our socio-economic status was very good. I was a top manager in a transnational corporation. My children were used to a comfortable lifestyle. Getting here and having to line up to get something to eat at a food bank ... It was very hard!'

Jimena added: 'Our social status in Mexico was very good. My husband owned his own manufacturing company, a good job. My son was going to go to a good private school. Our life had strong roots there. We owned some land and were going to build a house there, a big house. My husband drove an SUV. In short, we had everything we needed to be happy!' After moving, however: 'We didn't have any money. [When Christmas came] we could not buy presents for our children. My husband had to cross the whole city, changing three buses, to get to a place where, we had been told, toys were given for free to families with no financial resources.'

For others, those who did not belong to an advantaged minority, the changes resulting from migrating were of a different nature, sometimes negative and sometimes positive. As mentioned above, due to her problems with the English language, Carla struggled to maintain her role as a model and a guide for her children, who were learning much faster than her.

On the positive side, however, the move to Canada helped Emilia understand how negative the relationship with her husband had been. She said: '[My husband] didn't like Canada at all, not at all! But I started to like it almost immediately. I realized that women, in Canada, have rights. I liked it. He didn't. I started to understand I was worth something and at the same time he realized something was changing. He realized I was changing and that made him feel inferior. That created serious problems between the two of us. ... In Mexico [a woman] is like a dog, like a cat. I know it sounds terrible but over there a woman is like an object. But here a woman is valued for what she is: a person!'

Also positive was the change experienced by Flor: '[Back home], when I finished high school, my mother told me "the money your father is sending us is not enough, you have to work!". I started to work. But what I really wanted to do was to go to school. [Now, I can go back to school because] I feel at peace here, I feel safe. And I feel my children are safe too.'

One of the open questions included in the interview guide was about participants' **experience at arrival and the immediate problems** they had to face. All but one interviewee were refugees and, for some of them, the first contact with Canada was traumatic. Clearly, before arriving, they had no idea what to expect.

Beatriz arrived with her daughter's family and they were sent to a shelter: 'It was traumatic because we were expecting nothing like that. The place smelled all the time of cigarette smoke. Everything, our clothes, our suitcases, everything smelled of cigarette. When we left, the children went on coughing for more than two months. The children, my daughter, and myself went through a very difficult time.'

Emilia said: 'It was a traumatic experience because when we arrived we applied as refugees at the airport and they told us we had committed a crime and jailed us. They put

us in a cell with the children and treated us very badly. Later on they sent us to a refugee shelter, a hotel in Scarborough.’

Gladis’ experience was even more dramatic. ‘It was shocking. When I arrived I was not going to apply as a refugee. A friend told me not to do so because at the airport people are treated very badly. My friend gave me her phone number but the name of another person who was already a Canadian resident. But the interpreter realized that. She told me that the number and the name did not correspond, she started asking questions and telling me I was a liar. She said I could end up in jail, that I wasn’t welcomed in Canada and that I was going to be deported. She was screaming at me. She was very cruel. I was in shock for months. All the time I felt they were coming for me, I thought the immigration officers were coming to get me and take me away ...’ While telling her story Gladis started to cry. ‘Eventually I told her (the interpreter) that I was coming to ask for refuge. On our way to the detention centre they were going to handcuff me. One officer was going to handcuff me but the other one pointed towards the children with a sign of his head, and so they did not handcuff me. My youngest daughter was sleeping and did not realize what was happening but the other two did. We spent the night at the detention centre. In the morning they took us back to the airport without telling us anything. I didn’t know what was going on and I thought they were going to deport us. They took my fingerprints and photographed me. Only later, in the early afternoon, they told me I could go and gave me the brown paper.’

Not all experiences were dramatic, however. Hugo, for example, arrived to Canada with his family, from the US, by land, and claimed refugee status at the point of entry. ‘When I told the immigration officers we were applying for refugee status their reaction was very good. They said “Welcome to Canada” and that felt really good, we felt safe.’

As reported above, virtually all participants mentioned language as one of the most significant challenges they had faced after arrival. Not being able to speak and understand English made it much more difficult for them to deal with the multiple and intertwined

problems they had to face all at the same time: looking for a place where to live; finding sufficient, affordable food for the whole family; looking for a job; finding a school for the children; following a myriad of different bureaucratic processes, including understanding the legal procedure to become permanent residents; learning how to move around Toronto and how to understand and use cardinal directions, which are not commonly employed in Latin America; and learning how to use public transportation. All of this while at the same time having to manage the emotional stress resulting from leaving one's family and social circle, overcome the feeling of isolation and disempowerment, and get used to the new climate.

Some of the participants' accounts were particularly significant. Emilia, for example, described how stressful the experience of moving to Canada and living in a family shelter had been for her eldest son, who suffered from autism: 'his crises became more and more frequent and we could not control his tantrums.' The increasingly stressful situation added to the pre-existing problems between her and her husband. One day he attacked and hit her. He was arrested, jailed and eventually found guilty. That episode led to their separation and divorce.

Gladis said: 'I had to learn about Toronto, what living here really means. I had to learn to use the subway because I had so many bureaucratic procedures to complete... I found a lawyer. He was a bad one. I found another one. I learned so much...'

Hugo added: 'Learning how to move around Toronto was really difficult. We would get lost all the time. I had to buy a compass and a map to help. But even with them, and in spite of being an amateur flying navigator and having a good sense of orientation, at the beginning I would get lost anyway.' Jimena, talking about her husband's experience, said: 'Somebody offered to help him get a credit card. He gave this man 200 dollars a month for one year. At the end we did not get the credit card and we lost the money. For several

months he paid 400 dollars a month to sleep on an armchair. Before we reached him in Toronto he had never slept in a bed!’

Among their immediate problems, respondents also mentioned several examples of challenges related to the use of health services, such as getting an Ontario Health Insurance Plan (OHIP) card or finding a family doctor. These experiences will be described in the following section of this chapter.

While struggling to overcome the many problems encountered after their arrival, most participants, including the one who had been living in Canada for almost two decades, could rely on very limited **social support networks**. Most of them had either a relative or two living in Canada or had met other Latin American newcomers at the shelter, school, or church. None of them, however, felt they had received a lot of support from their networks. Ana said: ‘We had a daughter who had been living here for approximately six months before we arrived. From time to time she would get frustrated and tell us “you can’t do anything on your own!?” We always felt mortified and afraid of becoming a burden. But she helped us anyway.’

Diana said: ‘Here in Canada I realized how distant friends can be. It is not like back home where friends are there for you in good and bad times. Here they tell you “No, I don’t have time, I am busy, I have to work”. They don’t listen very much nor they show a lot of interest in one’s problems.’ Her situation was particularly dramatic because, after her husband’s unexpected death, she had remained alone with two small children and she could not speak English. At that time, she received little support from acquaintances here in Canada and no support at all from friends and family in Ecuador because ‘For years, I didn’t tell anybody back home that my husband had died because I didn’t want my mother to worry for me.’

Emilia commented: 'I see that people from other countries do help each other here. But this is not true in the Hispanic community. I don't know why we are not closer to each other and more supportive...'

In some cases, however, certain individuals had been extremely important sources of help for some respondents. Jimena, for example, found a lot of support in her former landlady, a woman from Uruguay who had been living in Canada for decades.

Some of the comments made by participants clearly show that cultural reductionism is not the right solution to the challenge of facilitating interactions in a highly multicultural society. Even among people from the same country, in fact, cultural differences may be dramatic. Carla, for example, felt very uncomfortable in dealing with a Mexican woman she had met immediately after entering Canada because 'In my country people who have a bit more education are different. Their aspirations are different, the way they speak, their habits, behaviours, everything is different. So, even if she was our first source of information here, we saw many things we really didn't like and decided to distance ourselves from her.'

Indira, who had suffered for several months from severe depression, explained that she could not really discuss her problem with her best friend because: 'To her, depression is a normal state. Women like her are used to depression. Actually, they don't even know that depression exists as they see that condition as a normal part of life. They are used to husbands who dominate and hit them and to sons who get drunk, or take drugs, and come and go as they wish. She would have said "You don't have anything! This is not a problem!" She is a very good friend and I truly respect and admire her, but I knew she could not understand because of her social level and education.'

In spite of the challenges they had to overcome during the resettlement period, most participants were very **happy to live in Canada** and very appreciative of the opportunities

this country had offered them. Most of them really enjoyed their peaceful existence here and stressed the contrast between their lives before and after moving.

Ana said: 'We encountered peace. Not the danger of our country where one day there is no electricity because a bomb destroyed the line, another day something else... Here one doesn't have to be afraid of getting mugged, raped, robbed all the time. ... Canada is a country where people come first, they are respected, human rights are respected! There are so many good things in Canada... the only problem is winter!'

Beatriz added: 'The very first thing I would tell somebody who doesn't know Canada is how this country welcomed us, how it opened its doors for us, in all aspects! Nobody had ever paid the rent for me, before, nobody had ever given me food, with the exception of my parents and my husband. Also, here one can study and improve and has the chance to contribute to this wonderful country! I am so happy to be here!'

Carla said: 'If we are not accepted as refugees we will go back home and apply as immigrants. We'll start the whole process again. ... While there are many things we were expecting to find in Canada and we didn't, there are also many other things we were not expecting at all and we did find. The help the government gives people... I don't know... the food banks... things you would never find in my country.'

Hugo said: 'Everything is so different! Like night and day! ... One falls in love with the country and wants to be able to give back as much as possible. ... Here I see a future for my children, more attention to education, to the family.'

Indira said: 'In Canada, I learned not to get surprised about anything. When my common sense suggests that a certain service should not exist, there it is! Like 211 for example! ... If I had to leave this country I would still feel very grateful and I would never forget Canada because here I have been treated as a woman is never treated in my country, as a

person with rights. It has been very hard for my children, from time to time, but eventually everything has been very good.’ Finally, Jimena said: ‘In Canada I learned that if one has a problem there is always a solution, there are always people ready to help!’

From time to time, however, it felt like interviewees were going overboard not to be perceived as being ungrateful. Generalizations have limited value, yet it is true that in many Latin American cultures people tend to interpret criticisms as lack of good manners. This attitude may have influenced some of their comments. In addition, it was clear that even if at the beginning of each interview it had been clearly explained that the two researchers had no direct links with 211 Toronto, nevertheless most respondents were still associating them to a service they considered particularly helpful. This, too, may have contributed to their effort to sound positive and appreciative.

There are several examples of this kind of ‘**politeness**’. Beatriz said: ‘In spite of the many problems I have been treated very well. Nothing is perfect, right? I cannot complain. ... Difficulties are a thing of the past. One becomes a better person going through that kind of experiences.’ Carla said: ‘Even if Canada isn’t the way I had imagined it, it’s not bad. ... If you compare what a resident earns with what a refugee does, you feel it is unfair. But if you compare what a refugee makes here to what a Mexican earning minimum wages makes back home, then you realize how good it is!’ She also said: ‘The fact that I don’t like certain things doesn’t mean they are not good! It’s just that here things are different.’ Indira, after commenting on some of the hurdles usually faced by newcomers, concluded: ‘But at the end of the day who am I to offer my opinion? The government knows better!’

Among the **negative aspects of life in Canada**, the one that was particularly emphasized by respondents was the systematic undervaluing of the professional training and experience they had before moving here, a problem sometimes defined as ‘deskilling’ (Newbold, 2005). Carla said: ‘When one arrives, she comes with expectations and hopes. But then she realizes that things are not easy. It is like starting everything from scratch

because the work experience one has in her country of origin helps very little. At the end of the day people always ask for the ‘Canadian experience’. But to gain Canadian experience one has to work, right? Some people told us “you have to get your degree again, here! You have to go back to study again!” We were not expecting this because there is so much advertising about the need for professionals in Canada.’ Indira said: ‘Watching a TV program, I learned how many physicians we have in Canada who have studied abroad and who are now working as taxi drivers. ... Now I understand why it is so difficult to find a family doctor here!’

Interviewees were asked whether they had ever experienced **racism** in Canada. Most of them answered negatively. Ana said: ‘No, never, never, never! Everybody have been very respectful, considerate, and friendly.’ Those who did answer positively, described only minor incidents that might be ascribed more to the frustration deriving from difficult communication than to actual racism. Beatriz said: ‘Here, in the apartment building where we live, sometimes we have experienced a bit of tension with the superintendent. She gets annoyed because we don’t speak English very well. The same happened with a person working at one of the offices where my daughter went looking for assistance. My daughter said “I understand English but, please, speak slowly” and that woman reacted impatiently.’ Emilia, talking about her doctor, said that the receptionist was a racist. ‘With others she was joking and was very friendly. With me she has always been a racist. The doctor knows that but he doesn’t give a lot of importance to the issue.’ Carla, however, said: ‘When people know you are a refugee they look at you in a different way. The same is true when looking for a job. You feel you are marginalized. Being a refugee is not the same as being a landed immigrant.’

Interestingly enough, some of the participants made comments that might be interpreted as examples of veiled racism. For example, one participant, commenting on how difficult it was to find a family doctor in Canada, said that in her area doctors were ‘unfortunately all Chinese’. Another participant, talking about a very negative experience she had had at a

motel shelter, emphasized the fact that the place was managed by ‘some East Indians’. A different interpretation key could be applied to these examples, however. Most participants came from places that are not even remotely as multicultural as Toronto. Citing the ethnic origin of people they interacted with could simply indicate their reaction to the novelty of such environment. Similarly, the comment on doctors being all Chinese could suggest frustration for not being able to find somebody with whom communication would be possible. Several authors confirm the importance for immigrants of spatial proximity to culturally appropriate care (Asanin et al., 2008; Deri, 2005; Wang, 2007).

C. Experience With Health and Health-Related Services

In their countries of origin, participants had had different experiences with the **health care system**. Some of them had private health insurance and, with one exception, had been quite happy with the attention received. Most of them had opted for private care because they believed public and social insurance services delivered care of inferior quality. Others, who had been formal sector employees or members of families linked to the army or the police, had been covered by a variety of social insurance schemes. Some of these plans covered drug expenses, too. Levels of satisfaction varied but, generally speaking, were fairly high. A couple of participants had had to pay out of their own pockets for health care. At least one of them, however, had clearly benefited from some ‘flexibility’ within the system: ‘In Mexico you can find a solution to a lot of problems through friendship. When I could not pay a private doctor I would go to the social insurance hospital. Even if I had no right to use it, as I wasn’t employed, I could use it because I had friends there. And that hospital is a bit better than the public hospital, which is horrible. So, thanks to the help of some friends, I could see a doctor and I would even get drugs for free.’ Virtually all respondents seemed to share the belief that public health services are synonymous with bad quality and private health services with good quality. There is not doubt that this belief, compounded by some negative experiences they had had in Canada with long waiting times, inadequate continuity of care, and the unfriendly attitude of some providers,

contributed to the sceptical and partially mistrustful attitude towards the system displayed by most respondents.

With one exception, in their home countries respondents were used to seeing specialists without the need to go through a family doctor for referral. They all were clearly upset by the system in place in Canada as they felt it limited their freedom not only to see the type of doctor they felt would be the most appropriate to deal with their problems but also the individual specialist of their choice. Hugo, for example, said; '[In Colombia] we almost always used specialists. If we had a general question we would ask my wife's brothers, who are doctors. They would say: "Look, you have such and such problem. Go to this specialist who is a friend of mine!"' At least three factors contributed to amplifying this feeling: first, the fact that it had been extremely difficult, for many of them, to find a family doctor who would accept new patients; second, what they perceived as a resistance, on the family doctor's part, to refer them; and, finally, what they thought were shockingly long waiting times between the visit with the family doctor and the appointments with the specialists. Also, when a specialist could be seen without going through the family doctor, such as in the case of a dentist or an ophthalmologist, they found the cost prohibitive. Again, Hugo said: 'In Colombia, going to a specialist wouldn't be very expensive. Here, however [it is]. For example, my son needs to complete an orthodontic treatment but it is too expensive for us and we have to wait before he can continue the treatment. My niece, who lives in Spain, is a dentist. I spoke with her and she said that if we weren't going to continue the treatment we had to take the brackets off because otherwise they would create problems over time. As I am a mechanical engineer I had to do it. I got my pliers and removed the brackets one by one, very carefully. My niece explained to me how to do that and my son is now feeling better because the brackets, without maintenance, were damaging his teeth.'

Most interviewees had their **first experience with the Canadian health care system** soon after relocating. Some of them were directed to a doctor by an immigration officer, for a

health assessment, as soon as they claimed refugee status. Others felt the need to see a doctor because of some specific health concerns. For two participants, however, seeking help hadn't been an easy decision to make. Gladis said: 'It took me a long time before deciding to use the health services here. I was afraid. I thought that people from immigration would think I was taking advantage of the Canadian system and deport me. Because of that [fear], I didn't even look for a family doctor. But when my daughter had a severe nervous breakdown I had to call 911. She spent almost six weeks in the psychiatric unit of a local hospital.' Indira said: '[When I got depressed] I didn't want to go and see a doctor because I was afraid he would give me some drugs and I would get addicted. So, I took it "the Mexican way", as we say, bravely! I suffered from depression for many months before looking for help. It was only when my daughter arrived that I started to look for a doctor because she, too, was sick.'

One half of the participants described their first encounter with the Canadian health care system in negative terms. Ana said: '[The doctor] was very unfriendly, very unsympathetic. She gave us a form to become our family doctor. But no... we would never accept!' Carla said: 'My youngest child got sick and [a friend] recommended her paediatrician. That was the first time we used the health services. It didn't seem very good to me. It's different, it's very different from Mexico. I didn't like [the doctor's] attitude. Also, he had a bad reaction when I asked him additional questions about my son's health. He said that "No, we have to leave this problem to the next appointment. This time we can only take care of one problem!'. Because of that, the service didn't seem very good to me, the doctor wasn't very friendly.' Diana's experience had been particularly traumatic: 'My first experience with a doctor, here in Canada, was very, very bad. I was very young and the doctor ... well, he was flirting with me. He made me sit and he was sitting very close to me. I noticed he was... well... So, he tried to put his arms around me and tried to kiss me. I didn't tell my husband but I said "I don't want to come back here to see this doctor because it always takes a very long time to get an appointment!" It was an excuse to never go back there!' Flor added: 'We went to a nearby doctor who used to attend people from

the shelter. The doctor didn't care at all about us. It was clear that the only thing he really wanted was for us to leave. I felt really bad. I thought "Well, what is the problem? Are we carrying some disease? Do we have leprosy? Why is he so rude?" We had to go back to see that doctor once more and it was the same. I never again wanted to see him!' Finally, Indira said: 'I found [a doctor] nearby but when we went to see him I didn't like his attitude. I know my English is not perfect but with a little effort I can communicate. He didn't want to explain anything to me about my daughter's condition. He got irritated when I asked more questions. He was in a rush and was already standing by the door. He didn't send me away with words but he did with his attitude. ... I went back to see him, once again for my daughter's problem, but this time I changed my attitude. I wasn't rude but I was very firm and I told him I would not leave unless he first explained to me exactly what the problem was! He sighed and said "OK" and explained everything to me and this time I didn't leave like the first time.' It is worth noting that, in the literature, newcomers often describe the approach of family physicians as rushed, impersonal, incomprehensive, and lacking depth (Asanin et al., 2008).

A few participants had positive experiences to report. Emilia, whose son suffers from autism, said: 'We told the public health nurse [who worked at the shelter] that my son was suffering from continuous crises and tantrums due to the radical changes he was going through. She took us to a paediatrician. When we were in Mexico, every single doctor who saw my son would say the same. I would tell them: "My son is autistic!" but they would say: "No, your son is not autistic. He suffers from attention deficit!", or "he is hyperactive!", or even "he has speech problems!" In Mexico, physicians know nothing about autism! Leaving Mexico was a lucky coincidence because as soon as the doctor saw my son he said: "This child is autistic!" And I thought: "Thank God!" He visited my son very carefully, observed his behaviour, his reactions. He treated him well and dedicated enough time to visiting him.'

Jimena said: ‘Finding [our family doctor] was a real twist of fate. Our lawyer sent us for the psychological assessment before our refugee hearing. At that time I was feeling really bad for the stress of being in a new country where I felt so disempowered and handicapped, more than in Mexico. So, when I met the psychologist I let everything off and told her everything I was going through. She looked really worried and she asked me if I was seeing a doctor. When I said no, she told me that in that same building there was a doctor who spoke Spanish and that we could go at that very time to talk to him. Then, she went with us to the doctor’s office and talked to his assistant and told her we needed an appointment immediately. So, that doctor saw us, was very nice to us, and became our family doctor!’

Participants had several other stories to share about **further experiences with the Canadian health care system**, some of them quite dramatic. Most of those experiences had been frustrating due to a number of factors including, among others: the difficulty of finding a family physician; long waiting times at hospital emergency departments or before getting appointments with specialists; the challenge of learning and understanding health care practices in Canada; and, perhaps more important than any other aspects, communication problems with providers and the attitude of many of them. Other authors have described similar experiences (Lai et al., 2007).

Initially, most respondents did not know anything about the role of a family doctor within the Canadian health care system as no comparable role existed in their countries of origins. At the time of the interviews, while they all had had the opportunity to learn that family doctors are the system gatekeepers, they still did not have a clear idea about this role. They did not know, for example, that family doctors are themselves specialists. Carla, for example, said: ‘I guess a family doctor is like a resident in Mexico, a doctor who can treat the most common problems, who can help with basic things.’ Gladis added: ‘When I was told that I needed to find a family doctor I thought it was like the general doctor in Mexico. But now I know that the family doctor here is actually very important. He is the one who

makes decisions and refers.’ For some respondents, finding a family doctor had been particularly difficult due to their condition as refugees. Indira said: ‘I found a family doctor after two months of calling every single doctor in town. Many don’t want to work with people on welfare, who have the brown paper. They complain because, they say, the government pays them after a long, long time. Now I know that finding a family doctor is not just a problem for us, for the refugees, but a more general problem. Many of the doctors I had called told me to call back in three, four months. It was really difficult ... While looking for a family doctor my daughter had to go three times to a hospital emergency department. I was very angry with the system here!’

Another significant problem, for several respondents, was the time it would take to see a specialist, even when there was a clear need for it. Beatriz, for example, said: ‘I arrived to Canada, in November 2004, with very serious knee and foot problems. When I was finally able to find a family doctor, he sent me for some clinical tests and other things and then he referred me to a rheumatologist. My problems were so serious that the rheumatologist was unable to manage them and, eventually, he referred me to another specialist, an orthopaedic surgeon. But I didn’t get to see the surgeon until April 2006, one and a half years after my arrival! It took so long to get an appointment with the specialist. I don’t know why. If it was because the first doctor did not give enough importance to my knee problem or what. But it was very serious. I could not extend my leg and my foot started to bend. I couldn’t walk at all, not even for one block. For one and a half years, I spent most of my time on a wheelchair or sitting at home, looking at buildings out of the window. When I finally saw the orthopaedic surgeon, she immediately said: “This is serious. You need surgery immediately!” I had a knee replacement surgery a week after I saw her. Later on, in October 2006, she intervened on my foot. She was very surprised to find me in those conditions. She said I am too young for that kind of problems.’

Several other participants commented on the long waiting times between the request for an appointment with the specialist and the actual visit. Carla said: ‘I had a problem and

needed to see a gynaecologist. I went to see my family doctor and, through him, I got an appointment with the specialist three months later. I find really difficult to understand something like that: I have a problem today and I get an appointment three months from now!? ... I just cannot believe it!

Diana, whose husband had passed away several years earlier, said: 'When my husband was already ill, his family doctor told him "You have to get an appointment with this specialist immediately!" But when he called they told him it would take two months. I told him: "You cannot wait for two months! You speak English and can insist!" Eventually, he got an appointment in one month. And my insisting was for nothing. Imagine, one month! In that time you can save the life of a man or let him die! This is not acceptable!'

Hugo added: 'After telling my doctor three, four, five times that I had a problem with my finger and I was in pain he finally sent me to a plastic surgeon, as it looks like the problem is carpal tunnel syndrome. I booked an appointment in early January. I got it for mid April!'

The problem of waiting times at hospital emergency departments was also raised by a few interviewees. Hugo said: 'My son had an accident playing basketball, at school. We got a call and took him to emergency in the morning. We waited so long that, as we had, coincidentally, an appointment with our family doctor in the afternoon, we ended up taking him from the hospital to the family doctor who eventually treated him.'

Indira said: 'As soon as [my daughter] got to Canada she started to suffer from food allergies, flues, terrible headaches. [As we could not find a family doctor] she ended up in hospital three times. The first time we went to emergency we had to wait for eight hours. They left us there, my daughter and I, without any food. They said it was because she had been vomiting.'

All participants, in different ways, had had to learn about health care practices in Canada. It wasn't always easy. Often, once they had understood how things worked, they would still find it very difficult to understand the logic of those practices. In other cases, their feeling was that the system was simply not working properly.

For example, Carla said: 'Something I do not understand [about the Canadian health care system] is that in Mexico when a doctor requests some clinical tests I go to a lab. Then, when the results are ready, I get them from the lab and take them to my doctor. He reviews the results with me and explains what the meaning of each test is. Here, it's not like that! I hadn't seen anything like this earlier! Results are sent directly back to the doctor. My gynaecologist told me: "If they don't contact you again it means everything is fine!" I cannot believe it!?'

Indira said: 'I couldn't sleep and my doctor gave me a prescription for some pills. I went to the drugstore but the pharmacist told me that those pills were not covered by the welfare and she couldn't give them to me. She said she would call the doctor and ask for a different medication. But she could not get in touch with the doctor and after a few days I got tired of having to go back again and again and wait. Eventually I said "It doesn't matter! Let's forget it!" I didn't want to talk to anybody else.'

Hugo added: 'My wife was suffering from a really bad shoulder pain. As our family doctor could not see her before eight days, we went to a walk-in clinic. She got an x-ray and they said they would call to book an appointment. They never called!'

However, the most significant aspects of participants' interactions with the Canadian health care system that emerged during the interviews were the myriad of communication problems they experienced when interacting with providers and their perception of providers' attitude towards them. In many cases, language was an obvious factor. Beyond language, however, several other cultural factors and idiosyncratic practices and beliefs on

both parts complicated the patient-provider relationship. The ten interviews include a large number of examples of these problems. The most significant are reported below.

Ana said: ‘To see a doctor here and one in Colombia is very different. Here, you have to ask questions all the time, you almost have to push the doctor to explore alternative hypotheses. In Colombia a doctor examines, asks questions, and makes a diagnosis. It is more, I don’t know how to explain this, more proactive in reaching a diagnosis. Here the doctor waits for patients to tell him things. Here, it is more like “Oh, I forgot to test for this or that.” I like more the Colombian system. I feel safer there. I trust more the doctor. Also, an appointment lasts longer in Colombia and there is more time for everything. Here everything is done in a rush.’

Carla said: ‘[After having discussed my first problem] I would tell the doctor: “You know what? I also feel pain here or there.” And he would answer “For that, book another appointment!” I am not the only one who has experienced this kind of treatment. I know many, many people who told me the same!’

Diana said: ‘The most important difference I see between home and here is that in Ecuador the physician takes 20-30 minutes to visit you and asks a lot of questions. Here, however, doctors give you two-three minutes. You tell them “It hurts here” and they answer “That’s normal, don’t worry!” Here, just because the visit is paid for, the only thing doctors say is “Next patient, please! Next patient!” It feels like they are more interested in the financial aspects than in the human ones.’

Flor described her experience the following way: ‘Until now, none of the doctors I saw would take note of the information I was sharing with them. Like, I would say “In Mexico I was given this and that. This drug for this problem and that other drug for that other problem.” I am not telling them to give me the same drugs just because I was using them in Mexico. But they just don’t listen and are not interested in what one has to say.’ She

continued: 'I changed [several family doctors]. Now I go to a community health centre. The doctor I usually see doesn't speak Spanish and doesn't seem to really care that much. I saw her three or four times with my children but, honestly, I don't trust her. Every time I go I have to repeat my whole medical history because, even if it she has a written copy of it, she doesn't take the time to read it! Also, she is very, very young and, I am sorry I have to say this, but I feel she doesn't have a lot of experience.' Then, she concludes: 'My feeling about doctors in Canada is that they are colder, they don't show interest, are very distant. In my country a doctor shows interest. He can even scold you, sometimes! They share the patient's worries, their own way of course, but they do! Here, they don't! They don't! Here one is treated as an object. I feel like I am an object.'

Indira said: 'I told [my doctor] that I wasn't feeling well, that I was feeling very anxious and depressed. I asked him if I could get some kind of help. He laughed and said that the welfare doesn't pay for psychologists and that going to a psychiatrist would be useless because he would prescribe drugs and I didn't want to take any drugs. He had already made all the decisions on my behalf. Now, I don't even want to walk one block with him!' Lack or inadequate response by health care providers to immigrants' depression-related needs is reported in the literature (Beiser, 2005).

Beatriz clearly interpreted a doctor prescribing drugs as a sign of being truly interested in the patient's problem. 'I guess that in Colombia we get spoiled. There, when you go to the doctor for a cold or a flue he gives you antibiotics. Here they don't care, they don't prescribe anything. One has to be in really bad shape for the doctor to care. I spoke to many people and it looks like all family doctors are the same.' Carla, in spite of coming from a different country, clearly agreed with her: 'If I go to the doctor, in Mexico, and tell him that I have a throat ache, he checks my throat and prescribes a medicine. Usually, he prescribes antibiotics. Here, the doctor says: "Drink a lot of water, drink lots of liquids!"'

Carla stressed the cultural barriers, beyond language, that make communication difficult: 'At this point, the only doctor I have here who is not Latin American is my gynaecologist. I can truly communicate only with doctors who speak my own language. It's not just the language, right? It is culture. I say this because my gynaecologist does speak some Spanish but, yet, our culture is different. I have learned, growing up in Mexico, how the encounter with a doctor should go. I go to see my paediatrician and he says "Hi! How are you?", he shakes my hand and says "Please, come in!", and this and that. But when I go to see a Canadian doctor the distance is enormous... I don't know. This is why I say our culture is different. It is about the way we treat each other, the warmth in a relationship. It is not the same here.'

Gladis suggested that often doctors don't make a real effort to communicate: 'Last Monday I saw my gynaecologist. She doesn't speak Spanish. I was trying to communicate using my very limited English but the only thing she was able to say was "I don't understand! I don't understand!" I saw she was very stressed, very nervous, as if she didn't want to attend me. I felt like she didn't really want to understand, like she wasn't even making an attempt to understand. When I left I went to a lab that is in the same building to get some blood tests done. The nurse there did speak Spanish. I told her what had happened and she said she would go back with me and help me interpreting. She was really nice! We went back to the gynaecologist clinic and guess what? First, I realized that the doctor's assistant does speak Spanish but hadn't said anything! And then, when the lab nurse spoke to the doctor, the doctor said: "It's OK, I had understood her already!"

In some cases it is really difficult, if not impossible, to understand which factors resulted in a failed patient-provider interaction, whether the problem was a communication one or something more. For example, Carla described a negative experience she had had with a dentist: 'I went to see a dentist because my son had a cavity. He was Canadian and because of that we didn't understand each other very well. He told me he was going to pull the tooth out. I was trying to understand if it was possible to fill the cavity instead of pulling

the tooth out. He said no. In these situations, I always ask people I know back in Mexico for advice: my gynaecologist, my paediatrician, or dentist. I asked for the opinion of three different dentists back in Mexico and all of them told me not to let him pull the tooth out. I felt really confused and powerless. If I could, I would go back to Mexico and have my children treated there but I cannot leave Canada as I am a refugee claimant. So, the dentist here didn't want to treat my son and I don't know whether it was because the treatment was too expensive or what. So, I had to look for another doctor and, luckily, I found a dentist who was from Mexico. He treated my son and my son did not lose his tooth!

Another example of failed interaction whose causes could not be really understood through the interviewing process was Diana's shocking experience at the time of her husband's death: 'All the time, doctors would tell me that my husband was going to get better and go home soon, that there was nothing to worry about, that he was young and strong. This is one thing I don't like [in Canada]: that they don't tell you the truth. I don't like the ideology of hiding the truth from relatives. I would have preferred to know the truth. I would have been prepared. My husband and I could have talked clearly. I could have asked him what to do after he was gone [with the children, with my life]. Later on, however, when he was already agonizing, they said: "How did you think he would get better if chemotherapy is just experimental?" I hated those words so much! Why didn't they say they were not sure? That things could have gone either way? Instead, they didn't say anything until the very end, when he was already dying.'

In other cases, however, participants described situations in which, apparently, providers did make mistakes that compromised their relationship with the patient. For example, Flor said: 'On one occasion, we had a skin problem. First it started with my sister's family and then we got the same problem. I went to see my doctor several times over a period of three months. She gave us a cortisone acetate cream. But the cream wouldn't do anything and it was even damaging our skin. I would tell her "This cream is useless! It is not working!" but she wouldn't even listen to me and instead she would look in her books and say "Let

me see what is covered by welfare.” Eventually, months later, my sister was referred to a dermatologist by her doctor and as soon as the dermatologist saw her he said “This is scabies!” and gave her instructions on how to eliminate the problem and how to avoid passing it to others. My sister told me everything and we were able to quickly solve the problem. Meanwhile, my doctor was still looking into her books I cannot believe we got scabies! In Mexico I had never seen that problem, not even among really poor people. I was angry. How is it possible that in Canada something like this happens and, in addition, they give me the wrong treatment and I have to suffer for months!?’

Indira said: ‘[That doctor] even misdiagnosed my two sons. He said they both had liver problems. I almost had a heart attack! I asked him if he was a hundred per cent sure. I demanded to have more tests done. Eventually, all tests came back negative. My sons were fine! As it had been so difficult to find that doctor, even if [previously] he hadn’t been able to understand what my daughter’s problem was, I had decided to stay with him anyway. But after the mistaken diagnoses of my sons I left!’

Not all experiences reported by participants were negative, of course. Ana, for example, said: ‘I had a very good experience with the Immigrant Women’s Health Centre (a community-based non-profit agency serving immigrant women, refugee women and women of colour, in Toronto – <http://www.immigranthealth.info>). The female doctors who attend me at the Centre are very thorough, they are not constantly checking the time, and they ask questions. The first time I went there a woman welcomed me in Spanish, interviewed me, and then acted as an interpreter during the visit. It’s a well organized place where people work in a well coordinated way and one does not have to wait to see the doctor. Everybody are very friendly. Doctors are very respectful and warm. They wait outside while one gets ready. I don’t know if I can continue going there, however, because I think it is a place for newcomers.’

Another positive experience was the attention Beatriz received for her osteoarticular problems, in particular from the orthopaedic surgeon who treated her: 'I am still surprised when I think how much she got interested in my case and how well she treated me! Because of her concern and respect I felt immediately much better, less depressed. She really went out of her way to help me! Also, through the hospital where I had surgery, I got a wheelchair, a walker, and a bathtub seat. When one has serious health problems, doesn't speak the language, doesn't have resources [it is really difficult]. But now that I am done with the two surgeries I can only thank God for the medical care I received here. In Colombia I could not have had surgery. I would have had to find the money because many health plans, I understand, don't cover this type of interventions. The family doctor we found is also good! He is relaxed and takes the time to answer questions!'

Emilia, talking about her new family doctor, said: 'I like him very much because when I told him that my son was "special needs" (English used in the interview) he looked at him differently, like... with love. And he treats him very well and makes jokes with him and asks me a lot of question about how well my son is taken care of, whether he is going to school, and so on. Also, he makes enough time to attend us and explain things.'

Jimena, talking about her experience giving birth to her daughter, said: 'It was at the hospital that doctors realized I couldn't see well. They sent a social worker, and a nurse, to help us at home. The doctors didn't let me go home until after I spoke to the social worker and with a psychologist. When I had my daughter everybody at the hospital treated us really well. Luckily, the gynaecologist could speak Spanish and that was really important.' With respect to her physical disability, she also said: 'Later on, I could go to an institute for the blind. There, I could learn to read using my finger, something that had been my dream for years. In Mexico, since I started to lose my sight, I wanted to go to a school for the blind but it wasn't possible, for many reasons. Canada gave me the opportunity to learn to read, to use a walking cane, and to have confidence in myself. Before coming here I was

somehow hiding my problem. Today I feel perfectly comfortable when I say that I am a disabled person.'

A very interesting result was that, in spite of the many problems and negative experiences participants had in Canada, many of them said that they still preferred the Canadian health care system to the systems in their countries of origin, in particular when it came to availability of resources and advanced technology. Ana, for example, said: 'Even if I prefer the interaction with the doctor I used to have in Colombia, in general I trust more things here. There are more resources available here and health is taken more seriously. In Canada there is more investigation going on, more funding for research, and I heard that hospitals are better, even if I have never used one.' Similarly, Carla said: 'Of course technology is much more advanced [here] than in our country, but the health care system as a whole....' Finally, Indira said: 'Paradoxically, in spite of my negative experiences [in Canada], I believe that people give more importance to health here than in Mexico. Here people are more careful and there is a lot of available health information everywhere, just everywhere and about everything. Even if one is not looking for information, information is there!'

D. Information Sources and Information Pathways

The final part of each interview focused on the informational aspects of respondents' experience in Canada. This section summarizes the most significant results related to the experience of participants with the identification of information sources on health and health-related services, and their use. In addition, the section includes the results of an attempt to map the information pathways followed by respondents while learning to navigate and negotiate the Canadian health care system. The objective is to highlight similarities and differences in their experiences and gaps that could be potentially reduced or eliminated by well-directed interventions.

Most respondents reported that the main **sources of information on health and health-related services in their countries of origin** had been their doctors and other health providers, a response in line with other authors' observations (Cotten et al., 2004). A few mentioned the radio and TV as additional or alternative sources. Indira commented on how difficult it was to obtain any kind of health-related information in Mexico. Lack of financial resources, she said, was always the excuse. Beatriz, who had started to suffer from rheumatoid arthritis while living in the US, explained how important it had been, at that time, to be receiving information on her condition in Spanish: 'The hospital where I was treated would periodically send me information. First I got information in English but later on they were able to send it in Spanish. The American Arthritis Society would send me educational material in Spanish covering numerous topics, from the clinical aspects of arthritis to its treatment, lifestyle, nutrition, sleeping, ... all in my language! It literally changed my life and I am still making use of that information!'

With respect to the **sources of information on health and health-related services in Canada**, perhaps the most frequent comment made by respondents was that they hadn't identified a single, outstandingly important source but, instead, they had 'learned about the various services available a bit at a time and from many different sources', in Ana's words. Even when they emphasized that either an individual or an institution had been particularly helpful and had significantly impacted their lives in Canada, finding comprehensive and meaningful information had been nonetheless difficult.

Flor said: 'Even if I got some information from the shelter, what I learned about the health care system I learned it mainly out of necessity and by direct experience, trial and error. Nobody came and told me how it works. For example, when I was accepted as a refugee I got my health card but I didn't know how to use it. I went to a dental clinic and gave the card to the receptionist. She said she didn't need it. She said I would get attention for free even without the health card (Flor was on welfare). "Even if I am not working?" I asked, and she said yes.'

Gladis added: 'While I was living at the shelter I learned a lot about life in Toronto, on my own. I learned how to use the subway, even if I got lost many, many times. I learned about all the bureaucratic stuff I had to do. I would go everywhere alone and I would learn like that, by doing. I even found a lawyer that way!' She continued: 'The only thing about the health care system they told me at the shelter was that I had to find a family doctor. Nothing more than that. They didn't tell me why I had to find a family doctor or how to find one.'

Indira explained that even if, as already reported, she believed that '[In Canada] there is information everywhere!' it was still difficult to access it in a relevant and timely fashion. In her own words: 'If the government wanted to help newcomers it should [collect, organize and make available such information focusing] on all the processes new immigrants have to follow, step by step, in a very detailed way. The more information we have the more we can defend ourselves from people who are taking advantage of us or who treat us badly. Perhaps a manual of the immigrant, of the refugee claimant is a silly idea but'

Finally, Jimena said: '[Our landlady] helped my husband fill forms so that he no longer had to pay somebody for that. She also helped him understand that he had been paid inadequately for his job.' She continued: '[That was really important because] nobody in Canada tells you what you have to do, where you have to go! It is difficult to meet somebody who doesn't have his own agenda and who is truly willing to help for free. At the beginning my husband and I paid a very stiff price for our ignorance!'

When looking for information, virtually all respondents had been helped by people they had met by accident: other newcomers; people who had already gone through the same problems they were experiencing; neighbours; and people met at various offices or at points of entrance to Ontario. More rarely, they would get some help by relatives who had been in Canada longer than them. In Carla's case, her family had been lucky enough to

meet at a bus stop, soon after their arrival, a woman who worked for 211 Toronto. The woman was from a Latin American country, too, and gave them information on a multitude of aspects of life in Canada, in Spanish. Often, 'information chains' for mutual support would spontaneously develop among newcomers attending English courses, volunteering, or going to the same church. Informal social networks have been acknowledged in several studies as essential sources of information for immigrants (Ahmad et al., 2004a; Courtright, 2005; Deri, 2005; Dyck, 1995; Leduc et al., 2004).

Other significant sources of information had been community centres and shelters. However, even in the case of shelters, that should represent obvious settings for supporting newcomers and refugees in particular, help had been often limited. In some cases, such as in Beatriz's experience, the shelter was just a motel and offered no support to guests. In other cases, as explained by Ana and Emilia, none of the personnel would speak Spanish. Even when information was given it was often very basic and fragmented, as reported by more than one respondent. Not all experiences with shelters and community centres had been negative, of course. Emilia, for example, was very happy with the support received at the Barbara Schlifer Commemorative Clinic (www.schliferclinic.com), a Toronto-based counselling, legal, interpretation, information and referral service for women who are survivors of violence. Flor, who had been living for some time at a World Vision shelter, said: 'At the shelter everybody were so nice to us and so supportive. They helped me with all aspects of resettlement, even when I had to look for an apartment. At the shelter there was one person who would take specific care of each aspect of the process. They would also help with interpretation. They also gave me a list of resources in the area where I went to live, later on, including doctors, dental clinics, legal clinics, hospitals, community centres, parks, libraries, ... everything!' At the shelter, she had also met a Spanish-speaking volunteer who would go there from time to time bringing information on resources available for newcomers who spoke Spanish only.

Having to rely on such a disjointed set of information sources had several negative consequences. First, as Carla very clearly explained: ‘When you get information from all sides, distinguishing good and bad information is difficult. There are people who know a lot and can really help. But there are other people who don’t really know anything but still like to give advice. For example, we were told that the only way for us to stay in Canada was to apply as refugees. I think that was bad advice.’ Emilia confirmed: ‘Newcomers at the shelter would also help each other, whenever possible. ... Unfortunately, many people who have just arrived and don’t know anything still want to give you advice and sometimes the information you get is really bad quality.’ And Gladis: ‘For a long time I did not use the health services because somebody had told me that people from immigration were going to think that I was taking advantage of the Canadian system and I was afraid. People talk a lot but information is rarely true.’ Secondly, in some cases participants had met people who had openly taken advantage of their desperate need for information and guidance. For example, Emilia said: ‘I met a woman from Latin America, here in Toronto, who works with newcomers helping them with all the bureaucracy and other needs. She helps them but her goal is just to make money and she is not a very honest person.’ More dramatic had been the experience of Jimenas’ husband: ‘At the beginning, my husband had contacted a man he had met on the Internet to get some help. But that man took advantage of my husband. He asked him for \$2,500 to fill a work permit form, something that now we know can be done for free at any community centres!’ A third consequence of having to depend on multiple, often inconsistent information sources was that most respondents would not find out at all about many available and useful resources, or discover them very late. Informal social networks are important sources of information but the quality of such information is often uneven and they do not help get a clear picture of local health care (Courtright, 2005). Diana said: ‘There are things that are really very, very useful out there. But if we don’t know they are out there we don’t use them.’ Finally, respondents made clear that even at the time of the interview there were still many grey areas in their understanding of the Canadian health care system. Ana said: ‘I wonder if there is a difference between services offered to permanent residents and those available to

citizens. Flor said: ‘I don’t know what is going to happen when I start to work. Am I still going to keep my health card?’ Hugo added: ‘We found a family doctor but we didn’t know what his role was, exactly. Even now we don’t really know. We don’t know when we can go directly to a specialist and when we cannot. Can we keep our family doctor when we move to a different area of the city? Having a family doctor, can we go and see a different one? Would we have to pay the second one? What kind of right to health care do we have as refugees, as residents and when we become citizens? Do we have the right to dental care, the general doctor, specialists, drugs? What do we have to do to get drugs with government support? Do we have to subscribe to a drug plan? Where do we have to go? There is a lot we still don’t know!’

It is interesting to observe that while respondents had been regular users of the informal, patchy network of information sources described above, most of them had also been an active part of it. In fact, they had helped with information and referrals friends from back home, who had arrived to Canada after them, and other newcomers they would meet at school, at the shelter, or at the local church.

With respect to other sources of information, such as printed materials, the radio, the TV, and the Internet, virtually all respondents said that they had played a secondary role in the early stages of the resettlement process. For most of them, the main reason not to use other resources had been language, as very little was available in Spanish. Later on, once their English had improved, some of them had started to use those sources.

When describing the sources of information they had used in Canada, more than half of respondents spontaneously mentioned **211 Toronto** as one of the most important ones. Hugo, for example, said that he and his family had used the service on many occasions and for a variety of reasons. 211 Toronto had helped them find their family doctor, for example. Indira explained that the service had become her main source of information after she had discovered it. She said: ‘Sometimes I ask them to help me in ways they are not

even supposed to help, and they help me anyway!’ Jimena said: ‘Had my husband known about 211 Toronto at the very beginning he would have saved [a lot of] money and would have [found immediately an answer to his questions.] We need comprehensive information, in our own language, as soon as we arrive!’

The majority of respondents did not learn about 211 Toronto immediately after arriving to Canada. With the exception of Carla, the interviewee who had met the 211 Toronto counsellor at a bus station, other participants had heard about the service from different people, from the radio or TV, or picking up leaflets at a clinic or community centre. Hugo was the only interviewee who had learned about the service on his very first day in Canada. The person who had processed his refugee claim form at the point of entry, a woman from Latin America, had told him about the service and offered additional advice on the resettlement process. For all participants, finding out about 211 Toronto had also been difficult because they had never before experienced anything similar and therefore could not even conceptualize the existence of a service like that. Indira, however, emphasized with irony the profound differences between her experience in Mexico and in Canada saying: ‘It will take a thousand years before something similar is developed in Mexico! If nobody had told me about this service, I would have imagined that it existed because we are in Canada and this country always surprises me. Many of the things I would believe do not exist here, following common sense, do in fact exist!’

Even after learning about 211 Toronto, and sometimes even after using it several times, most participants did not know very much about the service, how it works and the type of information it could offer. They knew that some counsellors would be able to help them in Spanish. Some of them even knew that the service is available 24 hours a day. But none of them knew that they could reach a counsellor without having to go through an automated answering system. Also, only Hugo and Jimena seemed to be aware of the fact that, in Hugo’s words: ‘No matter what the problem is, one can always find some kind of support

through 211 Toronto!’ Most other respondents believed instead that the service would provide addresses and phone numbers or information on ‘schools and doctors.’

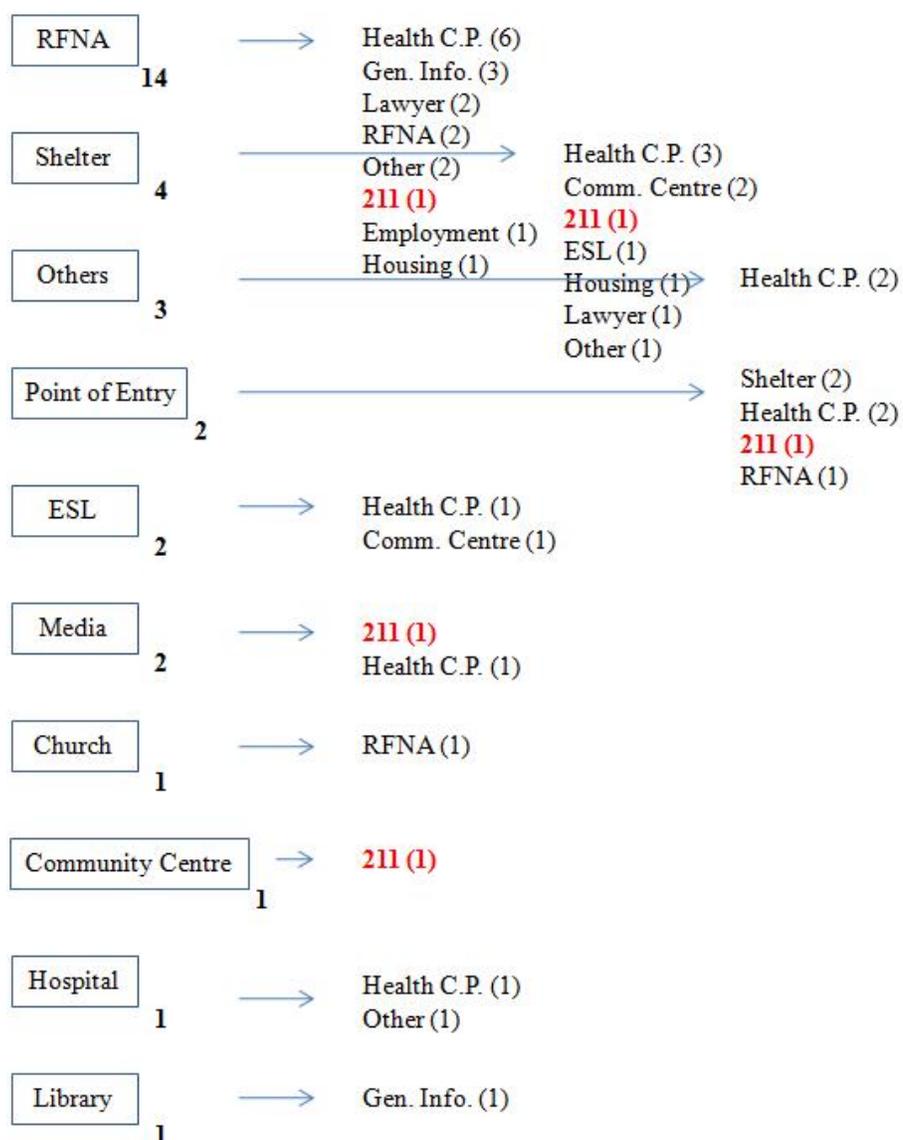
All respondents, however, had had very positive experiences with 211 Toronto. For example, Ana said: ‘When I called I got the information I was looking for. I also liked the fact that I could speak directly to somebody. It was a positive experience. Speaking directly to a person in Spanish made me feel closer to him. I did trust him more because of that.’ Carla added: ‘When I call 211 Toronto I don’t know the person on the other side of the phone, right, but I trust that person anyway because I know he is going to help me. Usually they are very friendly and very helpful. They also speak Spanish. Perhaps, the most important reason why I continue using the service is counsellors’ friendliness and respectfulness. Their attitude makes me trust them more. Also, the information they give me is always correct and useful. 211 Toronto is the most important source of information I have. That’s why I always recommend this service to my friends. I really wouldn’t have any suggestion for improving the service.’ Diana was equally enthusiastic: ‘I absolutely love that service, I love it! My first thought when I am at home or walking on the street and I face a problem is: I can call 211! They give good quality information. [Counsellors] are extremely friendly and professional, both those who speak English and those who speak Spanish. They explain everything in detail and make you feel comfortable. That’s why I trust the service!’ Flor explained how 211 Toronto counsellors go out of their way to help callers: ‘I called them and asked whether they could help me to communicate with the receptionist of a health centre to get instructions on how to get there. The man said: “We don’t usually do this but I would be very happy to help you, this time!”’ These comments are just examples of how all respondents felt about the service. Two additional factors confirmed respondents’ high levels of satisfaction: first, the only suggestion for improving the service was to advertise it more; and, second, the only criticisms were that sometimes all lines are busy and that on one occasion the information they had provided to one respondent hadn’t been accurate. One of the reasons for trusting 211 Toronto counsellor might have been that they were perceived by respondents more as members of their own

informal social support network than as professionals paid to help them. The fact that 211 Toronto counsellors spoke Spanish, were always very friendly and respectful, and were willing to ‘break the rules’ to help callers may have shaped such perception.

The qualitative component of the study had several original objectives one of which was to collect information useful to draw a tentative map of the information pathways followed by respondents while learning to navigate and negotiate the Canadian health care system. The pathways would show sources of information – both individuals and organizations/institutions – and how such sources were linked to each other in a network of direct and indirect referrals. The hope was to draw a common map that would somehow integrate and summarize the experiences of all respondents to highlight common patterns as well as individual variations. Such map could be used to identify problematic areas, areas where information barriers were clearly evident for example, to be improved or eliminated through ad hoc interventions. It could also be used to identify ideal ‘entry points’ where newcomers could be efficiently and effectively reached by information efforts specifically designed to reach out to them.

As previously explained, however, the analysis of the qualitative interviews showed such a fragmented and complex network of sources and referrals patterns to make virtually impossible the task of identifying commonalities and summarize the various experiences into one map only. As an alternative, Figure 7.1 is presented to show the nature and complexity of the first two steps in newcomers’ information pathways.

Figure 7.1 – Information Pathways: First and Second Steps



RFNA = Relatives/Friends/Neighbours/Acquaintances

Point of Entry = Point of Entry to Canada/Ontario – Immigration Offices

ESL = English as a Second Language schools

Health C.P. = Health Care Provider

Gen. Info. = General Information (on various aspects of the resettlement process)

Comm. Centre = Community Centre

Blue arrows show both direct referrals (e.g.: the referral from a family doctor to a specialist) as well as indirect ones (information provided by source of information that leads the newcomer to a new source of information)

Numbers show occurrences

A few interesting aspects of the diagram can be highlighted:

- respondents used a large variety of ‘entry points’;
- the informal network of individual contacts (relatives, friends, neighbours, acquaintances) is by far the most important element in the early phases of the pathway;
- there is a significant difference between the variety of information and referrals offered by each ‘entry point’; again, individual contacts play the most important role;
- none of the respondents used 211 Toronto as an ‘entry point’; and
- 211 Toronto is used as a second step of the information pathway in only approximately 10% of cases.

E. Conclusions

This section highlights some of the most significant results obtained from the analysis of the qualitative interviews.

- The most notable characteristic that unifies all respondents, with one exception, is their being either refugee claimants or recognized refugees. It is not clear why other groups of newcomers using 211 Toronto were not represented among participants. A possible explanation is that refugees who had gone through a particularly challenging adaptation process, and had made the most of the support offered by 211 Toronto, were more willing to share their experiences than other groups who perhaps had utilized the service to a lesser extent. Even if the experience of refugees is possibly more ‘extreme’ than that of other categories of immigrants and their needs might be more numerous and diverse, the type of information they need is presumably fairly similar to what all newcomers need.
- When participants came to Canada they knew very little, if anything at all, about their destination country. It is surprising to realize how some highly educated and socially/economically successful respondents chose a country apparently only because they had heard ‘good things about the place.’ This result can be explained, at least in part, by considering that: 1) in several cases, the decision to move had been made in the context of an emergency; and 2) ‘selecting a new country’ is not a mundane type of

activity for most people and no formal or informal training is available to carry it out efficiently. Formal education and other professional and social skills might be relatively worthless in this case.

- Not only did most participants not know anything about Canada, but they arrived with expectations that in most cases clashed with the reality they encountered. In some cases they did not find what they were hoping for while in other cases they did find resources and services they had never thought of. These resources included services that were conceptually so remote from what they had experienced in their countries of origin to become virtually 'invisible'. That was probably one of the reasons why most participants had discovered 211 Toronto only late in the resettlement process.
- It was clear that the reality of resettlement, including aspects such as the emotional shock of relocation, linguistic and cultural barriers of all types, and the need to solve multiple, complex, and intertwined tasks, all at the same time in an unknown environment, had amplified respondents' needs for reliable, consistent, and comprehensive information. They needed information and guidance on an extremely broad spectrum of subjects. Some of the problems they were facing, such as learning how to use the subway or the cardinal reference system for finding one's way across the city, might sound trivial to a person accustomed to live in a large North American city but, as confirmed in the literature (Asanin et al., 2008), are extremely serious for immigrants who don't speak the language and don't know the local geography and public transit system. At the other end of the spectrum, they needed information of fundamental importance, whose quality would have a profound impact on their lives. A good example was the information Carla and her family had used to select the best course of action to obtain residency in Canada.
- Given the importance information played in early resettlement, the fact that respondents had been unable to identify and use a single source of reliable and comprehensive information represented a particularly serious problem. Instead, they had had to learn a bit at a time: from direct experience, trial and error; from others who had been dealing with the same problems, often building 'information chains' for mutual support; and

from several, unrelated, often inconsistent sources of information. Even shelters had failed to help them, in most cases. Gladis' example was a good illustration of the problem: at the shelter, she had been told that she had to find a family doctor but nobody had explained to her why and how to find one.

- Both Indira and Jimena had clearly identified what they perceived as the central problem: there is a lot of information available but not in the right format. Indira suggested that the government should collect, organize and make available information closely geared to each step of to the various processes recent immigrants have to follow. To her, the development of a 'manual of the immigrant' was not such a silly idea after all. Jimena went straight to the point: newcomers need reliable, comprehensive information, in their own language, as soon as they land.
- The last points suggest at least two possible directions for improvement that will be further explored in the final chapter. First, a service like 211 Toronto would be ideally suited to develop a kit of information dissemination tools that could be used to aggressively reach out to recent immigrants and support them with the kind of solutions described by Indira and Jimena. The idea of 211 Toronto playing a central and active role in supporting newcomers is particularly attractive given the high levels of satisfaction with the service, and trust, expressed by all respondents. In addition, information and communication technologies could be used to support a virtual community of newcomers, built on the Wikipedia's model, aimed at maximizing the efficiency and impact of the casual 'information chains' described by recent immigrants.
- With respect to health-related issues, navigating and negotiating the Canadian health care system had been extremely challenging for most respondents. Beyond the numerous and diverse problems experienced by participants, their responses emphasize a radically different attitude towards different facets of the system. On the one hand they disliked the 'typical' patient-provider relationship, the lack of continuity of care, and other aspects of the Canadian health care system that are acknowledged as problems by most Canadians but that must have had an even stronger impact on them, given their

vulnerability. On the other hand they seem to value the amount of resources, technology and research supporting the system, as well as the technical skills of Canadian health care providers. This contrast is not particularly surprising, however, as language and cultural differences impact certain experiential aspects more than others.

F. References

- Ahmad, F.; Shik, A.; Vanza, R.; Cheung, A.; George, U.; Stewart, D.E. (2004a) 'Popular health promotion strategies among Chinese and East Indian immigrant women.' *Women & Health*; 40; 1: 21-40.
- Ahmad, F.; Shik, A.; Vanza, R.; Cheung, A.M.; George, U.; Stewart, D.E. (2004b) 'Voices of South Asian women: Immigration and mental health.' *Women & Health*; 40; 4: 113-30.
- Ahmad, F.; Stewart, D.E. (2004c) 'Predictors of clinical breast examination among South Asian immigrant women.' *Journal of Immigrant Health*; 6; 3: 119-26.
- Asanin, J.; Wilson, K. (2008) "'I spent nine years looking for a doctor": Exploring access to health care among immigrants in Mississauga, Ontario, Canada.' *Social Science & Medicine*; 66; 6: 1271-83.
- Beiser, M. (2005) 'The health of immigrants and refugees in Canada.' *Canadian Journal of Public Health*; 96; 2 (Suppl.): S30-S44.
- Cotten, S.R.; Gupta, S.S. (2004) 'Characteristics of online and offline health information seekers and factors that discriminate between them.' *Social Science & Medicine*; 59; 9: 1795-806.
- Courtright, C. (2005) 'Health information-seeking among Latino newcomers: An exploratory study.' *Information Research*; 10; 2: Paper 224 [Available at <http://InformationR.net/ir/10-2/paper224.html>].
- Deri, C. (2005) 'Social networks and health service utilization.' *Journal of Health Economics*; 24; 6: 1076-107.
- Dyck, I. (1995) 'Putting chronic illness 'in place': Women immigrants' accounts of their health care.' *Geoforum*; 26; 3: 247-60.
- Fowler, N. (1998) 'Providing primary health care to immigrants and refugees: The North Hamilton experience.' *Canadian Medical Association Journal*; 159; 4: 388-91.

Lai, D.W.; Chau, S.B. (2007) 'Effects of service barriers on health status of older Chinese immigrants in Canada.' *Social Work*; 52; 3: 261-9.

Leduc, N.; Proulx, M. (2004) 'Patterns of health services utilization by recent immigrants.' *Journal of Immigrant Health*; 6; 1: 15-27.

Newbold, K.B. (2005) 'Self-rated health within the Canadian immigrant population: Risk and the healthy immigrant effect.' *Social Science & Medicine*; 60 ; 1359-70.

O'Mahony, J.M.; Donnelly, T.T. (2007) 'The influence of culture on immigrant women's mental health care experiences from the perspectives of health care providers.' *Issues in Mental Health Nursing*; 28; 5: 453-71.

Wang, L. (2007) 'Immigration, ethnicity, and accessibility to culturally diverse family physicians.' *Health Place*; 13; 3: 656-71.

Chapter VIII – Discussion and Implications

This study contributes new information on the experience of recent immigrants struggling to navigate and negotiate an unfamiliar health care system and on the role information and referral services like 211 Toronto can play in supporting them. The study was developed within the theoretical framework represented by two pre-existing, independently developed models that, considered together, help to understand the complex relationship between access to information sources and access to health services. The two models are: a modified version of Andersen's 'Behavioral Model of Health Services Use' (Andersen, 1995) developed by Gelberg et al. to closely fit the experience of vulnerable population groups (Gelberg et al., 2000); and Wilson's 'Information-Seeking Behavior' model (Wilson et al., 1996). The simultaneous analysis of the two models shows analogies and complementarities that highlight the importance of information as an enabling resource affecting the use of health services and suggests that some factors could, at the very same time, limit access to both health services and information services.

As previously explained, the study's main objectives were to:

1. obtain a snapshot of 211 Toronto users who contact the service by phone, understanding how representative they are of Toronto's general population;
2. understand how 211 Toronto callers seeking health-related information use the information they obtain when contacting the service and their overall level of satisfaction; and
3. gain a better appreciation of the experience of recent immigrants struggling to navigate and negotiate an unfamiliar health care system, focusing on their information needs, information seeking behaviour, knowledge of, attitude towards, and actual use of existing information sources, and barriers and facilitators experienced in the process of obtaining information.

Quantitative methods, phone surveys, were adopted to achieve objectives 1 and 2 and qualitative interviews to achieve objective 3. This chapter, after bringing together the most significant results from the quantitative and qualitative components of the study, draws some general conclusions and examines their practical implications for policy and service delivery.

The chapter includes five sections. Major findings are summarized and discussed in Section A. Section B examines the most important limitations of the study. Section C explores the implications of the study results at the policy and service levels. Section D briefly summarizes a general strategy for the dissemination of the study results. Finally, Section E offers suggestions for further research.

A. Major Findings

Objective 1 was pursued by conducting a phone survey with callers of 211 Toronto. The following were the most significant findings of this phase of the study.

1. 211 Toronto callers closely match the linguistic heterogeneity and variety of ethnic origins of immigrants living in Toronto, the shifting geographic patterns of the immigration phenomenon, and the differences in immigration category distribution between long-term and recent immigrants that can be observed in the general Toronto population.
2. Of all respondents, 73% were female. This result confirms what is already known about gender roles within families and the fact that women, as caregivers and ‘lay health care providers’, are traditionally responsible for seeking information on health and other human services (Wilson et al., 1996). It is also consistent with data periodically collected by 211 Toronto (FindHelp Information Services, 2005). What is surprising, however, is that the survey does not show a similar difference among recent immigrants. In this sub-group a virtually perfect 50-50 split was observed between male and female callers. Several factors, individually or interacting among them, can be suggested as possible explanations: in some cultures women might play a less

significant role in communicating with the external world; the multiple challenges created by the resettlement experience might profoundly influence traditional roles, requiring a more active participation of men; and female recent immigrants might be, on average, less fluent in English than males. With respect to this last hypothesis, for people whose first language is not English, formal education and knowledge of the English language are probably related and, according to 2001 Census data, female recent immigrants were on average significantly less formally educated than male recent immigrants. Alternatively, the first explanation suggested above could also produce a biased result as in some cultures women might be less willing than men to interact with strangers and participate in surveys.

3. One third of all questions asked by callers were health-related. Complex questions were significantly more common among health-related questions (45.1%) than among non-health-related ones (33.3%). Health-related questions became increasingly common with age.
4. The content analysis of questions asked by participants reveals the complexity of their information needs and the fundamental role 211 Toronto could play in exhaustively addressing such needs.
5. Among survey respondents, 60% were repeated users of 211 Toronto. The high percentage of repeated users may be interpreted as an indication of high satisfaction with the service.
6. Domains identified in Gelberg's model as intervening variables that are particularly relevant to the experience of vulnerable population groups (Gelberg et al., 2000), such as being an immigrant, having lived in the community for a short time, and having limited economic resources, do not appear to be significant barriers to accessing 211 Toronto. In fact, almost one half of all respondents (49%) were 'New Canadians' compared to 46% who were Canadian born. Also, landed immigrants and non-residents were significantly more numerous in the survey than in the general Toronto population. Conversely, citizens by birth and citizens by naturalization, grouped together, were significantly less numerous among callers than in the general population. In addition,

focusing the comparison on recent immigrants only, landed immigrants were significantly more numerous and citizens by naturalization less numerous in the study population. These results underestimate the actual differences existing between the survey population and the general Toronto population as the study excluded callers whose knowledge of English was deemed insufficient to participate and most of the excluded callers were presumably 'New Canadians.' Finally, when comparing survey participants with the general Toronto population in terms of both personal and household incomes, the former were on average significantly poorer than the latter.

7. Conversely, other domains, which in Gelberg's model are classified as both traditional and vulnerable predisposing characteristics (Gelberg et al., 2000) and in Wilson's model as intervening variables (Wilson et al., 1996), seem to play a more important role in limiting access to 211 Toronto. In particular, the service seems to be less successful in reaching older and less educated users, whether immigrants or not. The survey population was significantly younger than the general adult Toronto population. The same was true for the recent immigrant sub-group. Also, respondents had, in general, a significantly higher level of formal education than the general Toronto population. A significant difference in the same direction was observed among recent immigrants. In the last case, however, results should be interpreted with caution because, as already mentioned, low levels of formal education are presumably associated with lower fluency in English for people with different mother tongues. This association would have resulted in the exclusion from the survey of less educated recent immigrants and the magnitude of such exclusion is unknown.
8. A majority of users (54%) asked simple questions, previously defined as 'factual', therefore somehow 'underutilizing' 211 Toronto. Only 31% of participants asked complex questions, that is, questions that made full use of the problem solving skills 211 Toronto counsellors offer.
9. Almost one third of all respondents (32%) learned about 211 Toronto through word of mouth, from relatives and friends.

Objective 2 was pursued by conducting a follow-up phone survey with 211 Toronto callers who had contacted the service asking health-related questions. The most significant results for this phase of the study were the following.

10. The vast majority of participants in the follow-up interviews (84.9%) felt they had found an answer to their original question and believed 211 Toronto had been instrumental or even essential in achieving such results.
11. A significant percentage of respondents (39.7%) said that 211 Toronto had been the only source of information they had needed to answer their original question.
12. Of all respondents, 67.1% were either satisfied or highly satisfied with the service. Statistically significant differences in levels of satisfaction were found when analyzing this variable by history and time of migration. The highest percentage of highly satisfied respondents (89.5%) was found among long-time immigrants and the lowest (58.1%) among Canadians by birth. This result could be explained as either a reflection of different initial expectations, proof that 211 Toronto is particularly valuable for newcomers, or both.
13. The most common suggestion on how to improve 211 Toronto offered by respondents was, by far (21.9%), to advertise the service more widely and effectively.

Objective 3 was achieved by conducting a small number of qualitative interviews with 211 Toronto callers who had contacted the service asking health-related questions and who were all, with one exception, recent immigrants from Spanish-speaking Latin American countries. The main results of the qualitative component of the study can be summarized as follows.

14. Several respondents had left their home countries completely unprepared, knowing very little or nothing about life in Canada. Their decisions to leave had often been the result of sudden crises. In general, they had received incomplete or misleading information about the immigration process and life in Canada, both before migrating and after their arrival. It is surprising to realize that even highly educated and

socially/economically successful respondents had decided to move to Canada for the only reason that they had heard ‘good things’ about this country.

15. The reality of resettlement, linguistic and cultural barriers, and the need to solve multiple, complex, and intertwined tasks all at the same time in an unknown environment had amplified respondents’ need for reliable, consistent, and comprehensive information. They required information and guidance on an extremely broad spectrum of subjects.
16. Negative experiences with the Canadian health care system had been very common among participants. Typical problems included: the difficulty of finding a family physician; rushed consultations; providers’ unfriendly, unsympathetic, dismissive attitudes; long waiting times at hospital emergency departments and before getting appointments with specialists; challenges in learning and understanding health care practices in Canada; and, more important than any other barrier, communication problems with providers.
17. None of the participants had identified a single, outstandingly important source of information on health and health-related services in Canada. Instead, they had learned about available services a bit at a time, from a variety of different sources, out of necessity and by direct experience, trial and error. In their experience, a vast quantity of information is potentially available in Canada but such information is not readily available and it is very difficult to access in an efficient and timely fashion.
18. In the opinion of participants, having to rely on such a disjointed set of information sources had several negative consequences: it was confusing and made it difficult for them to distinguish between good and bad quality information; it made them vulnerable to people who would take advantage of their desperate need for information and guidance; and made it difficult for them to find out about available services and useful resources.
19. With respect to 211 Toronto, participants said they had found the service extremely useful. However, the majority of respondents did not learn about 211 Toronto immediately after arrival. Finding out about 211 Toronto had also been difficult

- because they had never before experienced anything similar and therefore could not even conceptualize the existence of a service like that. Even after learning about 211 Toronto, and sometimes even after using it several times, most participants did not know very much about the service, how it works and the type of information it offers.
20. Respondents said that 211 Toronto counsellors' friendly and respectful attitude, the fact that they speak their language, and the precision and usefulness of the information they give were the most important reasons for them to trust the service.
 21. The attempt to draw a map of the information pathways followed by respondents in their effort to navigate and negotiate the Canadian health care system was largely unsuccessful. The intent was to integrate and summarize the experiences of all respondents to highlight common patterns and individual variations. However, the analysis of the qualitative interviews showed such a fragmented and complex network of information sources and referral patterns to make virtually impossible the task of identifying commonalities. It was possible, however, to summarize in visual form the first two steps of the pathways. The resulting image confirms that respondents used a variety of 'entry points', relied mainly on an informal network of individual contacts and disjointed sources of information, and did not take advantage of 211 Toronto until later in the process.

211 Toronto represents a useful case study to learn about the immigration experience in this city and the information needs of newcomers. Callers, in fact, reflect quite closely the ethno-linguistic make up of the general population of immigrants living in Toronto and show comparable trends, over time, in terms of geographical origins and distribution across different immigration categories. In addition, the survey population seems to be representative of the larger population of users who have historically contacted 211 Toronto by phone, as shown by comparing survey results and historical data routinely collected by Findhelp.

The results of this study emphasize the information challenges faced by recent immigrants. The thematic categories developed through the content analysis of callers' questions show how wide-ranging newcomers' needs for information are. The information offered by 211 Toronto covers virtually every aspect of life in Canada. Health-related questions, almost one third of the total, reflect the complex and multifaceted nature of the concept of health in the experience of users. Complex questions were significantly more numerous among health-related questions than non-health-related ones. The majority of such questions reflect the dimensions of supportive care introduced in Chapter II. Also, the elderly, who on average face more common and more serious health problems, asked significantly more health-related questions than callers belonging to younger age groups. Even if qualitative interviews reflect the particular experience of refugees, some aspects of this experience are presumably shared by a larger proportion of newcomers. Many of them probably come to Canada knowing very little about this country and with unrealistic expectations. Once here, they have to tackle several, intertwined problems, all at the same time, while facing language and other cultural barriers and struggling not to get lost, both literally and metaphorically. The challenge can be overwhelming and the results not necessarily positive. Negative experiences with many aspects of life in Canada are common, particularly with respect to the health care system, as shown in the accounts of many interviewed participants.

Instead of receiving the kind of coordinated and comprehensive support they would need, recent immigrants face a vast amount of disorganized, often confusing, and sometimes poor quality information that reaches them through a dispersed constellation of disjointed sources. Mainly learning by trial and error, they often fall prey to people who take advantage of their desperate need for guidance. As illustrated by the qualitative interviews, newcomers identify, usually by accident, a variety of information 'entry points' and follow a myriad of different referral pathways. Even family doctors, who are acknowledged by the majority of survey participants as the most important source of health-related information, are often not accessible to newcomers.

The study suggests that while 211 Toronto represents an efficient and effective way to gain access to information on a broad variety of topics, including health and health-related services, and solve even complex problems with the support of highly trained counsellors who act as knowledge brokers, the service does not achieve its full potential. On the one hand, in fact, 211 Toronto seems to reach quite effectively newcomers, users find it very helpful, trust it, and show high levels of satisfaction with the service. On the other hand, however, both the survey and the qualitative interviews suggest that callers do not learn about it until late in the process of resettlement. The main problem seems to be a lack of knowledge of the service, which is often 'discovered' by accident through word of mouth, and a limited understanding of the richness of information 211 Toronto can offer and of the complexity of problems it may help solve. As explained by several interviewees, even after using 211 Toronto for a while not very much is known about it. To confirm this, again and again respondents repeated that the service should be advertised more widely and effectively. In other words, 211 Toronto's limitations in reaching the elderly and the less educated might be due not to some intrinsic characteristics of the service but to an ineffective advertising and educational strategy.

The study also confirmed some of the findings produced by *Levelling the Playing Field*, the study described in Chapter II (Hohenadel et al., 2007). In particular, language was confirmed as the most fundamental barrier experienced by participants when accessing health services. Yet, it wasn't the only barrier and, as several respondents clearly explained, other cultural barriers were present and poor communication practices on both their side and providers' were also to blame. Finally, both studies show how difficult it is for patients to verbalize barriers and problems they are facing. As explained in Chapter II, a reason for this could be that problems and barriers are not even conceptualized as such by immigrants. Many of them, in fact, come from realities where health and social services are less developed than in Canada and might consider as normal what is perceived here as a problem or barrier. Also, in the case of both 211 Toronto and other services that had been studied during *Levelling the Playing Field*, participants had problems identifying them

because, not having ever used analogous services before, they could not even conceptualize them or envision their existence.

B. Study Limitations

The study shows several limitations. Some of them are general while others are specifically related to each one of the three distinct data collection phases. The most important limitations are briefly summarized in the following paragraphs.

The study goal was to better understand the experience of recent immigrants struggling to navigate and negotiate a largely unfamiliar health care system and identify barriers limiting in a significant way their access to information services. For this reason, focusing on 211 Toronto users, instead of directing one's attention to newcomers in general, including those who do not even succeed in reaching this service, represents an obvious limitation. On the other hand, making use of 211 Toronto as a case study had at least two advantages: first, it was a fairly efficient way of identifying and reaching, in a relatively short time, a very large number of newcomers who were seeking information; and, second, it offered the opportunity to explore strengths and weaknesses of a service model that might be considered as an ideal response to the needs of recent immigrants.

The initial cross-sectional phone survey included only English speakers. This limitation is particularly significant, given the study's emphasis on recent immigrants. Yet, a multi-lingual survey would have been considerably more complex and expensive to conduct, and unfeasible considering the time and financial resources available for the completion of this research project. In addition, broadening participation to a few other languages would have not completely eliminated the problem of excluding certain groups of newcomers, given the very large number of languages spoken in Toronto. The follow-up survey, too, suffered from the same limitation as its participants were a sub-set of those included in the cross-sectional survey.

211 Toronto counsellors were instructed to invite every single caller identified by the sample interval who spoke English well enough to understand the informed consent script and the interview questions. This enrolment mechanism was less than ideal as the language assessment was conducted, in a very short time, by a fairly large number of 211 Toronto counsellors who had to make a decision based on their own subjective judgement. It is not difficult to imagine how individual counsellors might have judged linguistic proficiency differently, particularly as some of them were native English speaker while others were not. Even if a comparative analysis of callers invited by different counsellor did not uncover any significant systematic differences, the lack of objective means to assess language proficiency remains a potential limitation.

Beyond English proficiency, no other exceptions were admitted in the invitation of callers identified by the sample interval. However, 211 Toronto counsellors very likely excluded other callers such as, for example, those contacting the service in the context of a major, immediate emergency or with questions of a particularly sensitive nature. Even if the number of callers excluded for this type of reasons presumably represented a very small percentage of all potential respondents, missing them was nevertheless a significant limitation of the study as they were users with particularly serious problems who could benefit the most from the service.

Similarly, the study may have missed a proportionally larger number of users requesting very basic, factual type of information, such as phone numbers or addresses. Presumably, in fact, these callers were more inclined to reject the invitation to participate in the survey as they were probably less willing to spend ten or more minutes of their time on the phone after having asked a question that required a very short answer.

With respect to the time of data collection, the most significant source of bias may have been conducting the study during the summer. Seasonal factors could have influenced both the type of users contacting the service and the type of questions asked by them. For

example, elderly people who feel more socially isolated at a time when their families leave the city to go on vacation could use the service more often during the summer than at other times of the year.

A final, important limitation of the first phase of the study was the amount of data lost due to the lack of commitment of some 211 Toronto counsellors. As explained in detail in Chapter VI, of all callers who should have been asked to participate in the cross-sectional survey, according to the sampling interval, only about 10% were actually invited. Such significant difference can only be explained acknowledging that not all counsellors felt the same level of responsibility with respect to the study. This, in turn, created a negative feedback loop as the effort needed to enrol participants increased for all counsellors and, over time, more and more counsellors invited less and less callers.

Two main limitations can be observed with respect to the follow-up survey. First, the time between the first interview and the follow-up call, approximately ten months, was clearly too long. In fact, almost half of all participants who had given their consent to be contacted again were lost as, in the meanwhile, their phone lines had been disconnected or they had moved and no information on their whereabouts was available. Second, the risk for recall bias was high as it was probably difficult for participants to remember the questions they had asked at the time of their first call, particularly for those who, in the meantime, had repeatedly contacted the service for other reasons.

With respect to the qualitative interviews, due to the limited time and resources available to conduct the study and the very time consuming recruitment process, only ten interviews were completed. Because of that, it was not possible to attain the level of variation in informants' socio-demographic characteristics and experiences needed to explore common themes across different groups. In particular, all participants but one were women and all of them, with one exception, were either recognized refugees or refugee claimants.

The significant differences existing between the two interviewers and the ten respondents, in terms of individual characteristics, represent another limitation of the qualitative component of the study. Interviewers were: male; university educated; members of an advantaged socio-economic group; and long term, well integrated immigrants.

Respondents were: women, in all but one case; newcomers belonging to a particularly disempowered group; members of a 'nonmainstream' group; part of a culturally distinct 'visible minority'; in several cases from low socio-economic conditions; and speaking a language other than English. Undoubtedly, these contrasts shaped the communication flow and had to be taken into consideration both during the interviews and when analyzing transcripts to avoid crude and simplistic interpretations.

In addition, for practical reasons and to minimize the investment of time and financial resources, most interviews were conducted in person at the main investigator's office, which is located within a hospital. Certainly, such an intimidating and value-laden environment, compounded by the fact that there was no time to develop and nurture any kind of relationship with participants in an informal, non-research-related setting, limited the extent and influenced the quality of communication between interviewers and informants.

Several measures were taken to minimize the effects of the potential limitations described above on the validity and generalizability of the findings. For example, 211 Toronto counsellors participated in compulsory training meetings, officially called by Findhelp senior management, during which the goal and objectives of the study, the general methodology, guidelines and procedures, and roles and responsibilities of the various stakeholders were presented and discussed. Also, counsellors were encouraged, on a daily basis, to carefully follow all procedures that had been agreed upon and, specifically, to invite all callers whose English was good enough.

In Phase II of the study, to minimize the effects of the recall bias, after respondents answered the first question in the follow-up interview guide, which asked what the main reason for contacting 211 Toronto at the time of their first interview had been, their answers were compared to those already included in the Phase I database. If the two were different, the earlier version was read out to respondents and they were given enough time to reconstruct in their minds the actual circumstances of that call, before continuing with the interview.

In the case of qualitative interviews, several measures were applied to minimize the impact of the significant differences existing between interviewers and interviewees on the quality of the communication flow. First, it was decided to interview only Spanish-speaking immigrants to give the main investigator, who is fluent in Spanish, the opportunity to conduct the interviews in that language. Participants could therefore describe their experiences in a direct way, using their own words. This, in turn, had a clear effect on their desire to contribute to the study. All participants, in fact, seemed very happy and even eager to share their stories. Also, the main investigator was supported by a research associate who was a native Spanish speaker from South America and who had more than twenty years of experience supporting members of the Latin American community in Toronto. In addition, particular emphasis was given to all those factors that would have brought participants and interviewers closer to each other. Among others: interviewers shared with participants some of their own experiences as recent immigrants in Canada; the main investigator made sure participants knew that he had spent several years living and working in a number of Latin American countries and had some understanding of their realities; and it was also clear that the main investigator's first language was not English. There was another factor that probably brought together interviewees and researchers: most participants felt that both interviewers were somehow linked to 211 Toronto, a service that, in their words, had made a difference in their lives and had their interests at heart.

Finally, in addition to all the measures that were adopted to minimize the effects of specific study limitations, all known limitations were carefully taken into consideration when interpreting the results of the three study phases.

C. Study Implications

The following implications at the policy and service levels can be inferred on the basis of the key findings of the study.

1. The information needs of recent immigrants are complex and multifaceted. They require information and guidance on a very broad spectrum of subjects. To help them avoid negative experiences and encourage the appropriate use of existing services, they should receive timely, appropriate, and reliable information on existing health and health-related services as soon as possible after they relocate to Canada. A sort of ‘Surviving Your First Year in Canada’ manual, in their own language, would help them identify existing services and useful resources. Such ‘manual’ should be available at all points of entry and at other locations commonly frequented by newcomers. While publications and online resources to support recent immigrants do exist, for example the guide ‘A Newcomer’s Introduction To Canada’ published by Citizenship and Immigration Canada and available both online and in PDF format (<http://www.cic.gc.ca/EnGLIsh/resources/publications/guide/index.asp>), they are often not widely known, are usually available on the web, a medium many newcomers still find difficult to use, are published in few languages only, and are infrequently updated. The ‘manual’ should be available in multiple formats and on multiple platforms, from a paper copy to a multimedia application working on information kiosks, to a phone-based tool, to a collection of web-based resources. Also, the ‘manual’ should include not just information on subjects of interest for newcomers, but also annotated links to a variety of other pre-existing information resources and advice on how to use them.
2. Appropriate information should also be made available to potential immigrants, in their countries of origin, well before they make the final decision to move to Canada, to

ensure they get a realistic idea of the opportunities and challenges they are going to experience once here.

3. Fundamental strategies to make the health care sector able to address the needs of an increasingly multicultural society include, at a minimum: the expansion of educational programs for health providers; a radical increase in the offer of translation and interpretation services; and simplified procedures to licence foreign trained health professionals, viewing their diverse backgrounds as an asset to the system as a whole, instead of as a problem.
4. The effort to support newcomers should become a collective one: community organizations serving immigrants, libraries, and appropriate government services should be all involved in the dissemination of the manual and in using other elements of the information dissemination toolkit to maximize the chances of reaching all new immigrants.
5. Information and communication technologies could also play a role in supporting recent immigrants. For example, they could be used to create and maintain a virtual community of newcomers built on the Wikipedia's model, sharing 'survival tips' and solutions to common problems, that would take to the next level the casual 'information chains' described by some of the study participants.
6. Also, highly sophisticated but easy to use information kiosks making intensive use of multimedia to create a natural interface could be developed as entry points that would help 'triage' newcomers, directing users with basic, factual questions to databases of FAQs while referring those with more complex queries to information counsellors. This approach would ensure a correct level of utilization of services like 211 Toronto while increasing their efficiency and overall reach.

Study implications specifically related to 211 Toronto deserve separate treatment. As already discussed, the information offered by 211 Toronto covers virtually every aspects of life in Canada, including health and health-related services. Also, the study suggests that this service represents for newcomers a potentially very efficient and effective way to gain

access to information and solve even complex problems. 211 Toronto seems to reach well recent immigrants. Users: find the service very helpful; appreciate counsellors' friendly and respectful attitude, and the fact that they can speak their language; trust 211 Toronto; and show high levels of satisfaction with it. However, the study also suggests that callers do not learn about 211 Toronto until late in the process of resettlement and often 'discover' it by accident or through word of mouth. They also have a limited understanding of the richness of information 211 Toronto can offer, even after using it for a while, and, because of that, they don't take full advantage of the service. Lack of understanding of the nature of this service might also represent a particularly significant barrier for certain categories of users such as the elderly and the less educated. To reduce these limitations 211 Toronto should aggressively reach out to newcomers and make sure they find out about it as early as possible after moving to Canada and make the most of the service. The aim should be for 211 Toronto to become *the* information 'entry point' for newcomers. Specific recommendations include the following.

7. A service like 211 Toronto would be ideally suited to develop a kit of information dissemination tools, including the above-mentioned 'Surviving Your First Year in Canada' manual, that could be used to reach out to recent immigrants through a variety of channels.
8. A broader and more informative advertising strategy should be developed to ensure both potential and current users truly understand the type of services offered by 211 Toronto.
9. 211 Toronto should play a central role in the effort to develop the type of information kiosks described above (point 6). 'Triaging' newcomers would in fact help the service concentrate its limited resources on helping those users who face complex problems while at the same time supporting everybody else quickly and easily answer simpler, factual questions.
10. 211 Toronto should promote and support initiatives aimed at training community – based 'information coaches' who could help newcomers identify and access

appropriate information sources, therefore expanding the service coverage beyond what counsellors can currently achieve.

11. Finally, a radical process of change in the institutional culture of 211 Toronto should be promoted to avoid the type of problems experienced with counsellors during data collection. Most counsellors perceived the study as extra work not included in their job description and as a favour to the main investigator. This resulted in a significant loss of data. 211 Toronto senior management does not fully appreciate the importance of information that could be systematically collected from users and analyzed on an ongoing basis while offering the service. Such information could be used as a 'by product' that could be sold to secondary users such as policy makers, researchers, and the media, therefore contributing to the sustainability of the service. It is essential for 211 Toronto's senior management to realize this opportunity fully and to engage counsellors effectively.

D. Dissemination Of Study Results

The preliminary results of the quantitative component of this study were presented to Findhelp senior management with the double intention of sharing as early as possible some of the most interesting findings and validating the study results.

Preliminary results were also presented at various venues. In particular, a presentation on the role of information and referral services as partners in research initiatives was given at the Canadian Community Information and Referral Conference held in 2006 in Niagara Falls. Also, findings from the study were included in a paper focusing on globalization, migration and marginalization presented in Ottawa at the Fourteenth Canadian Conference on International Health. Finally, a poster was accepted for presentation at the 2007 annual conference of the American Public Health Association.

In the fall of 2008, a presentation of the final quantitative and qualitative results of the study will be given to 211 Toronto management and counsellors. The same presentation

will also be made available, by webcast, to the 1,000 community information and referral providers that operate under the umbrella of the Alliance of Information & Referral Systems (www.airs.org). Also, an invitation has been received to present the complete findings of the study to the Canadian Community Information and Referral Conference 2008, that will be held in Kingston at the end of September.

In the future, the final results will be also submitted to other academic conferences, both in the health and in the information studies fields. All dissemination activities will aim at facilitating communication and cooperation between these two fields. The quantitative component of the study, the qualitative one, and an expanded, systematized version of the review of the literature on information sources for newcomers will be submitted for publication in peer-reviewed journals, as separate papers.

Finally, over the past several months the Centre for Global eHealth Innovation, in collaboration with several other organizations working with newcomers, has been engaging Citizenship and Immigration Canada to develop a collaborative effort that would enable the creation of tools able to support newcomers effectively. The effort, largely based on the findings of this study, is starting to produce its first results and negotiations are currently under way to flesh out a program that would be aimed at developing, testing, and deploying some of the tools previously described in this chapter.

E. Directions For Future Research

The findings summarized and discussed in this chapter should be considered as a starting point to develop a broader research agenda focusing on the challenges faced by recent immigrants struggling to navigate and negotiate the Canadian health care system and to move beyond the intrinsic limitations of this study. The following are examples of possible directions for future research.

1. First, it would be important to further develop the examination of Gelberg's and Wilson's models initiated in this study (Gelberg et al., 2000; Wilson et al., 1996). The

integration of the two models has been used here to help understand the complex relationship between access to information sources and access to health services. The resulting model shows how barriers limiting access to information sources can be considered as indirect barriers limiting access to health services. In addition, the analogies existing between the structures of the two models suggest that certain factors might represent, at the very same time, barriers limiting access to both health services and information services. In the case of vulnerable population groups, such as recent immigrants, Gelberg's assumption that some of the factors that make a population group vulnerable can also affect the use of health services and the outcomes of care can be expanded to say that they can also limit the use of information and referral services. To build on this study, it would be important to focus on individual factors in order to assess their relative importance within the context of the integrated model.

2. A second direction for future research would be to focus the attention beyond 211 Toronto, to include newcomers who do not reach this service. In particular, working in collaboration with Citizenship and Immigration Canada and with community agencies supporting newcomers, it would be interesting to gain a better and more direct understanding of the experience of newcomers during the very first weeks in Canada.
3. Building on the previous point, it could also be possible to develop an intervention study comparing the experience of a group of newcomers who have been immediately directed to 211 Toronto, or to a similar service, with the experience of a comparable group of recent immigrants who have not received any specific support after relocating to Canada.
4. Also, it would be important to develop a comparative analysis of experiences across language groups. Of particular interest would be contrasting numerically large and small ethno-linguistic groups to explore the role played by social networks in facilitating the identification of appropriate services and their access and use.
5. Finally, using an ethnographic approach, it would be very interesting to develop an in-depth analysis of questions asked by 211 Toronto callers to gain a better understanding

of how they perceive and understand their own problems and needs, and how they ask for help.

F. References

Andersen, R.M. (1995) 'Revisiting the behavioral model and access to medical care: Does it matter?' *Journal of Health and Social Behavior*; 36; 1: 1-10.

FindHelp Information Services (2005) *211 Toronto Quarterly Reports. 3rd Quarter for 2004, 2005, and 2006. Reports for the 2nd and 4th Quarters, 2005.*

Gelberg, L.; Andersen, R.M.; Leake, B.D. (2000) 'The behavioral model for vulnerable populations: Application to medical care use and outcomes for homeless people.' *Health Services Research*; 34; 6: 1273-302.

Hohenadel, J.; Kaegi, E.; Laidlaw, J.; Kovacik, G.; Cortinois, A.A.; Kang, R. et al. (2007) 'Leveling the playing field: The Personal Coach Program as an innovative approach to assess and address the supportive care needs of underserved cancer patients.' *Journal of Supportive Oncology*; 5; 4: 185-93.

Wilson, T.D.; Walsh, C. (1996) *Information Behaviour: An Interdisciplinary Perspective.*

Appendix 1 – Advisory Committee Members

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Appendix 2 – Review Of the Literature: Search Strategy

The following terms were used, with minor modifications, to search the literature on immigration and health across the included databases (see Chapter III).

- Emigration and immigration
- Immigrant or immigrants
- Transients and migrants
- African continental ancestry group/ or Indians, Central American/ or Indians, South American/ etc. (keywords indicating ancestry by geographic area)
- Ethnic groups/ or African Americans/ or arabs/ etc. (keywords indicating ethnicity)
- Residential mobility
- Ethnic: minorit:
- Racial: minorit:
- Geographic locations
- Immigra:
- Refugees
- Refugee:
- Migrant:
- Migration:
- Displaced
- Foreign
- Foreigner
- Asylum seeker:
- Foreign-born
- Defector:
- Multicultur:
- Divers:
- Cultur:
- Acculturation
- Ethno:
- Marginali:
- Foreignborn:
- Cross-cultural comparison
- Cultural characteristics
- Cultural diversity
- Ethnology
- Intercultural:
- Multi-ethnic:
- Multiethnic:

- New comer:
- Newcomer:
- Canada
- British Columbia/ or Alberta/ etc. (Keywords indicating Canadian Provinces and Territories)
- Limit – English language

Appendix 3 – Study Protocol

ETHICS REVIEW PROTOCOL FORM

For information concerning submission deadlines and meeting dates refer to the UT Ethics Website: http://www.research.utoronto.ca/ethics_home.html

1. Background, Purpose, Objectives

‘Supporting Recent Immigrants in Their Effort to Access Information On Health and Health-Related Services: The Case of 211 Toronto’ is a research project aimed at improving our understanding of how services using information and communication technologies (ICTs) can support recent immigrants in their effort to navigate and negotiate an unfamiliar health care system. The study will focus on 211 Toronto Community Connection Service (211 Toronto), an information and referral service accessible by phone, on the internet, or by email.

An in-depth understanding of how recent immigrants can be supported in navigating and negotiating health and health-related services is particularly important in Canada. Every year, a large number of newcomers make this country their home. According to the 2001 National Census, in that year almost 20% of all Canadian permanent residents, or 5.4 million people, were foreign born. Toronto is the most popular resettlement area in Canada. Two thirds of all newcomers move to Ontario and, of these, 80% choose Toronto as their final destination. Foreign-born residents constitute 44% of Toronto’s total population and represent almost 200 ethnic groups. Immigration will most likely continue and increase over the next decades and its effects on Canadian society will become even more evident.

A significant proportion of recent immigrants face daunting cultural, linguistic, and socio-economic barriers resulting in unequal access to and use of health services and producing a complex geography of inequities. While access to health services is the ultimate result of the combined action of several related factors, in the case of recent immigrants the availability of relevant and timely information seems to be an essential precondition for their successful navigation and negotiation of an unfamiliar health care system. An increasing number of information and referral services have been created to support potentially marginalized groups, including recent immigrants. Experience, however, has shown that reaching out and meeting the needs of those who might benefit the most from these services is a major challenge. Most commonly, information and referral services are used mainly by members of the mainstream culture belonging to middle and upper socio-economic groups. Conversely, potentially marginalized groups are those who use these services the least. It is important to understand how to modify and improve these services to reach these groups more effectively.

211 Toronto has been chosen as it could be considered an 'ideal' one-stop information and referral service. It is free of charge and available 24 hours a day, seven days a week. Users reach highly trained and experienced counsellors without having to go through an automated answering system. As a group, counsellors speak approximately ten languages and can communicate with users, through interpreters, in almost any language spoken in Toronto. Finally, 211 Toronto offers information on an extremely broad range of services and government agencies operating in the city.

The proposed study will aim to achieve the following three main objectives.

1. To obtain a portrait of 211 Toronto users living in Toronto and assess how representative they are of the general local population.
2. To understand how 211 Toronto users who seek information on health and health-related services use the information obtained, as well as their level of satisfaction with 211 Toronto.
3. Focusing on 211 Toronto users who are recent immigrants, to explore: their information needs; information seeking behaviour; knowledge of, attitudes towards, and actual use of existing information sources; and barriers and facilitators experienced when accessing information.

2. Research Methodology

The study will be structured into three parts.

- I) A cross-sectional survey of 211 Toronto users who contact the service by phone.
- II) A follow-up exploration of how 211 Toronto callers use the information they have obtained.
- III) A 'mapping exercise' aimed at identifying the 'information pathways' followed by 211 Toronto callers, who are recent immigrants, to reach the service.

Part I

The study will focus on 211 Toronto users who access the service by phone. A telephone survey will be conducted by a small group of trained interviewers specifically hired for this study. A sample of callers who give their consent to participate in the study and match the eligibility criteria will be interviewed. The interview guide included as Appendix I will be pilot tested and problems discussed with all interviewers. A revised version of the interview guide will be prepared and submitted to the Research Ethics Board as an amendment to this protocol. Once the final version of the interview guide is approved data collection will start.

The interview will take up to approximately 10 minutes to be completed. Interviews will take place at the end of the phone call, only after counsellors have addressed callers' queries. As all interviews take place on the phone, no printed consent form is used. A recruitment script is included at the beginning of the interview guide and oral consent is sought. A randomly selected sub-set of calls will be monitored by the principal investigator to ensure informed consent is properly obtained by interviewers. All callers will be interviewed in English with the exception of Spanish-speaking callers, who will be asked by 211 counsellors for permission to be contacted by phone at a later time. If permission is granted, they will be called by the principal investigator and

interviewed in Spanish. 211 Toronto counsellors will probe callers' knowledge of English before initiating the interview process. Callers whose English is deemed insufficient to properly understand the recruitment script and/or the interview guide will not be invited to participate in the study. In these cases, counsellors will only record: the reason/s for the call; the language used to address the caller's query; and the age and sex of the caller. This information will be used in the context of this study exclusively to highlight some of its potential limitations.

At the end of the phone interview, respondents will be asked for permission to be contacted again by phone, if needed. After reviewing the data collected during the first part of the study, participants who have asked a health-related question will be contacted by the principal investigator and invited to participate in Part II of the study.

Part II

Callers interviewed in English who gave their permission to be contacted again and who had originally asked health-related questions will be reached by the principal investigator or a research assistant. The objective of this second interview is to measure their level of satisfaction with the service and its effectiveness in terms of referral to appropriate health and health-related services. The follow-up interview will last up to five minutes for those participants who have already completed the English version of the Phase I Interview Guide and up to 15 minutes for those Spanish-speaking participants who still have to complete the Phase I Interview Guide.

Participants will be asked:

- whether they recall the information they received from 211 Toronto;
- whether they have been making use of such information;
- whether such information helped them identify health and health-related services that they consider appropriate to their needs;
- whether they believe 211 Toronto helped them solve the problem that had originally pushed them to contact the service;
- to rate their overall level of satisfaction with 211 Toronto;
- ways to improve the service; and
- other sources of information/support they used to solve their problem.

If respondents who originally gave their consent to be contacted again for the follow-up interview have changed their minds, they will have the option not to participate. The interview guide for follow-up calls, including the initial recruitment script aimed at reconfirming respondents' consent to participate, is attached to be reviewed by the Research Ethics Board.

Spanish-speaking callers who granted permission to be contacted again will be contacted by phone by the principal investigator and interviewed in Spanish. At the end of the interview, if they 1) had originally asked a health related question and 2) are recent immigrants from a Spanish-speaking Latin American country, they will be invited to participate in a one-hour, in-depth interview aimed at exploring the 'information pathways' they have followed to reach 211 Toronto (Part III of the study). The Spanish version of the interview guides for Part I and II of the study, including the initial recruitment scripts are attached to be reviewed by the Research Ethics Board.

The choice of focusing on Spanish-speaking recent immigrants is dictated by practical reasons, as the principal investigator will be able to conduct follow-up interviews and in-depth face-to-face interviews (Part III) in their mother tongue.

Part III

Part III of the study will be aimed at exploring and mapping the 'information pathways' followed by 211 Toronto users, who are recent immigrants from Spanish-speaking Latin American countries and ask health-related questions, to reach the service. Through in-depth interviews, several aspects of their experience will be explored including: their perception of the type of information needed to navigate and negotiate the Canadian health care system; strategies and techniques used to obtain needed information; information sources trusted and those not trusted; use of ICTs during the process; places visited; information materials accessed; interactions with others seeking similar information and with 'system gatekeepers'; and barriers experienced when accessing information.

Interviews will last approximately one hour and will be jointly carried out by the principal investigator and a research associate either face to face or on the phone, depending on participants' availability and preferences. The research associate will be a Spanish mother tongue individual trained by the principal investigator in the methodology of the study, including its ethical implications. Face-to-face interviews will be carried out preferably at the principal investigator's office or in a suitable public venue. If the interview takes place at the participant's home, the principal investigator and the research associate will strictly adhere to the safety precautions listed in the Toronto Police publication 'Crime Prevention for Professional Home Visitors'. In particular, they will: carefully plan each visit; implement all appropriate safety measures during the visit; and notify the principal investigator's office immediately after a home interview has been completed. In-depth interviews will focus on the period of time between the experience of migration to the first contact with 211 Toronto and from such contact to the time of the interview. The interview guide, minimally structured and open-ended, is attached to be reviewed by the Research Ethics Board. It includes a recruitment script and request for permission to audio tape the interview. Data collection and content analysis will be developed in parallel so that initial results will be used to improve the interview guide over time.

Timeframe

Part I of the study will start at the beginning of July 2005, or as soon as approval from the Research Ethics Board has been obtained. Parts II of the study will be conducted in July, 2006, or as soon as approval from the Research Ethics Board has been obtained. Part III of the study will be conducted between August and September 2006. It is expected that the data collection phase of the study will be completed before the end of September, 2006.

Data analysis

Results from the three parts of the study will be managed and analysed by the principal investigator. Results from the initial and follow-up phone interviews will be entered into a database and analyzed using SAS statistical software to generate

descriptive statistics and to compare and contrast the population of 211 Toronto phone service users with the general population of Toronto's Metropolitan Census Area. Data from Part I and II of the study will be used to test an explanatory model including several individual characteristics of 211 Toronto phone users as potential predictors of information use and satisfaction.

All interviews from Part III of the study will be audio-tape recorded, transcribed, and entered into Qualitative Solutions and Research – Non-numerical Unstructured Data Indexing Searching and Theorizing (QSR NUD*IST) software by the principal investigator. Written or audio-taped field notes and written analytic and self-reflective memos will be added to the data corpus to document and enrich the analytic process and improve evidentiary adequacy. Transcripts will be independently analyzed and coded for emerging themes, patterns, and novel ideas by the principal investigator and by the research associate. The two will then collaborate and integrate their findings. Hypothesis and propositions will be tested through data queries. QSR NUD*IST will support this process. All material produced on the basis of the in-depth interviews will be shared with participants and, as much as possible, participants will be involved in the data analysis process.

Dissemination of Results

Results will be shared as broadly as possible with organizations and individuals interested in the research issue and particularly with those working to support newcomers in Canada. To this end, results will be disseminated through peer-reviewed journals, internet-based communications, personal contacts, presentations and workshops.

Implications of the Study

This study has real potential to significantly contribute to a better understanding of:

- the barriers and facilitators experienced by recent immigrants in their effort to navigate and negotiate an unfamiliar health care system;
- the role of information in supporting their effort;
- the role of information and referral services in reaching out and connecting with an extremely diverse population of newcomers; and,
- the role such services could play in supporting other potentially underserved population groups.

3. Participants

Study participants will include a sample of 211 Toronto users contacting this service on the phone. Inclusion criteria for Part I of the study are:

- being 18 years old or older;
- living within the boundaries of Toronto's Metropolitan Census Area;
- and
- seeking information for oneself or a family member/friend (not for a client as part of one's professional duties).

Part II of the study will include a sub-set of participants to Part I who ask health-related questions. Part III of the study will include a sub-set of participants to Part I who: 1) ask a health-related question; and 2) are recent immigrants (less than five year since their arrival to Canada) from a Spanish-speaking Latin American country.

The number of participants needed for Part II of the study is the critical factor for sample size calculation. The recruitment of 80 participants in Part II of the study will make it possible to test a regression analysis model including up to 3 covariates. This will permit assessing the explanatory value of the most important variables measured in the study and related to users' individual characteristics.

Taking the 80 participants needed for Part II of the study as a starting point it is possible, working backwards, to calculate the sample size for Part I. 211 Toronto receives approximately 34,500 calls per month. From previous surveys of callers it is known that: approximately 47% of callers match all four inclusion criteria for Part I of this study; about 20% of callers ask health-related questions; approximately 80% of callers accept to participate in brief phone interviews; and approximately 45% accept to be called back for a follow-up interview. Using this information it appears that approximately one in ten callers, or 3,400 callers, should be invited to participate in Part I of the study to make sure that a sub-set of 80 participants can be recruited for Part II. This number could be reached in about one month of work. Considering that there are no anticipated risks to participants and that, given the large number of callers, such number can be reached in a relatively short period of time, this sample size could be considered acceptable.

Finally, ten to twenty subjects will be recruited to participate in Part III of the study, or as many as needed to reach theoretical saturation. To maximize variation, 211 Toronto callers showing a diverse array of individual characteristics will be recruited in Part III of the study.

4. Recruitment

Participants will be recruited among individuals who contact 211 Toronto by phone, after all their queries have been addressed. Counsellors will invite each caller to participate in Part I of the study. After having obtained a preliminary consent by the caller, counsellors will transfer the call to one of the interviewers specifically hired for the study. The interviewer will then complete the recruitment script and obtain informed consent before starting the actual interview. All 211 counsellors and interviewers specifically hired for the study will be informed about the objectives of the study, trained to use the interview guide, and supervised by the principal investigator.

5. Risks and benefits

There are no known or anticipated risks to participants. The identity of participants will be protected as specified in the following section of this protocol. A better understanding of 211 Toronto users' experiences, expectations and preferences, as well as their information and health needs, will contribute to improving the

effectiveness of this and similar services and benefit future users, including participants in the study who might be using 211 Toronto again.

6. Privacy and confidentiality

Personal information, such as names and phone numbers, needed for follow-up phone calls, in-depth interviews, and interviews in Spanish will be recorded by the interviewer in a separate name list with identification numbers assigned to each subject. The name list will be shared only with the principal investigator. The principal investigator will enter all information into a computer-hosted database and immediately destroy the paper version. The database, and a backup copy, as well as all the additional material in digital format related to the study, will be password protected and kept in two separate, stand-alone computers. After the follow-up phone calls have been completed, in Part II of the study, all identifying information will be immediately destroyed. The same will be done with Spanish-speaking callers' personal information. All tapes will be destroyed after Part III audio taped interviews have been transcribed and validated and, in any case, no later than February 28th 2007. Once feedback on the analysis of qualitative data collected in Part III of the study has been obtained from participants, all identifying information will be immediately destroyed. No identifying information will be released in the dissemination phase of the project.

7. Compensation

No compensation will be offered to participants. Participants who take part in face-to-face, in-depth interviews at the research office will be offered a fixed reimbursement of CDN\$25 to offset the expenses they may incur to participate in the study, such as transportation or child care. This amount seems reasonable and commensurate to the type of expenses they might face and, in the principal investigator's experience, is consistent with reimbursements offered to participants in similar studies.

8. Conflicts of interest

There are no known conflicts of interest.

9. Informed Consent Process

As discussed above, it will not be possible to obtain written informed consent for Parts I and II of the study. Interviewers will make sure callers know enough English to be able to properly understand the recruitment script and will obtain oral consent on the phone. The principal investigator will randomly monitor a number of calls to ensure the recruitment script is appropriately employed. In Part III of the study, participants will be asked to give oral consent and permission to record the interview. Participants' consent will be audio taped at the beginning of each interview. A copy of the recruitment/consent script, including telephone contact information for the investigators and the University of Toronto ethics review office, will be handed out to

all participants.

10. Scholarly review

N/A

11. Additional ethics reviews

N/A.

12. Contracts

N/A.

13. Clinical Trials

N/A.

Appendix 4 – Data Collection Tools

PHASE 1 – INTERVIEW GUIDE – COUNSELLOR

Principal Investigator: Andrea A. Cortinois – Phone: 416-340-4800 x 8706
Academic Supervisor: Dr. Alejandro (Alex) R. Jadad – Phone: 416-340-4800 x 6903
University of Toronto Ethics Review Office – Phone: 416-978-3165

ID#: <ID>

Counsellor's Name: _____ Date: ____ / ____ / ____ Time: ____ : ____
am / pm

dd mm yy

Reason/s for call (in caller's own words):

Language of consultation:

- * **Do you have any other question today?**
- * **Before we end our phone call, I would like to discuss with you one more thing.**
- * **We are working with the University of Toronto to study and improve 211 Toronto. Can we ask you some questions, in English, about yourself and how you found out about 211 Toronto? It will take a maximum of 10 minutes.**
- * (If the caller agrees, add:) **Thank you very much: an interviewer will now talk to you.**
- * (If the caller does not agree, add:) **Thank you very much anyway. Have a good day/evening**

Annotations:

GENERAL MODULE

(Please, NOTICE: All questions refer to the caller, even if he/she is seeking information for a relative/friend)

- G_01 How old are you?
 <01> _____
 <97> (Refuse)
- G_02 Are you male or female?
 <01> M
 <02> F
- G_03 We would like to know where 211 Toronto callers live. May I know the first three digits of your postal code?
 <01> _____
 <97> (Refuse)
 <98> (Don't know)
- G_04 What is your marital status?
 <01> Married or living common law
 <02> Widowed
 <03> Separated
 <04> Divorced
 <05> Single, never married
 <06> Other (Specify): _____
 <97> (Refuse)
- G_05 What was the language that you first learned at home as a child and that you can still speak?
 <01> : _____
 <97> (Refused)
 <98> (Don't know)
- G_06 What language do you speak most often at home?
 <01> : _____
 <97> (Refused)
 <98> (Don't know)
 <99> (Not applicable)

- G_07 What language do you speak most often with your friends?
 <01> : _____
 <97> (Refused)
 <98> (Don't know)
 <99> (Not applicable)
- G_08 What language do you speak most often at work/school?
 <01> : _____
 <97> (Refused)
 <98> (Don't know)
 <99> (Not applicable)
- G_09 How many relatives live with you? (By relatives, I mean persons who are related to you by blood, marriage, or adoption)
 <01> : _____
 <97> (Refused)
- G_10 Do you have any other relatives living elsewhere in Canada?
 <01> Yes
 <02> No > go to G_12
 <97> (Refused) > go to G_12
 <98> (Don't know) > go to G_12
- G_11 In the past 12 months, how often have you been in touch with them, either seeing them, talking on the phone, writing or e-mailing them? Was it
 <01> At least once a week
 <02> At least once a month
 <03> At least three times a year
 <04> Once or twice a year
 <05> Not at all
 <97> (Refused)
 <98> (Don't know)
- G_12 Have you been involved in any groups or organizations in the past 12 months? For example, a sports team, a hobby club, a political organization, a community organization, an ethnic organization, etc.?
 <01> Yes
 <02> No
 <97> (Refused)
 <98> (Don't know)

- G_13 Where do you normally go for health information?
- <01> Relatives
 - <02> Friends
 - <03> Colleagues at work/school
 - <04> Your family doctor
 - <05> The media (newspapers, magazines, etc.)
 - <06> The Internet
 - <07> Other (Specify): _____
 - <97> (Refused)
 - <98> (Don't know)
- G_14 Do you have a family doctor?
- <01> Yes
 - <02> No
 - <97> (Refused)
 - <98> (Don't know)
- G_15 How did you find out about 211 Toronto?
- <01> : _____
 - <97> (Refused)
 - <98> (Don't know)
- G_16 Have you ever used the Internet?
- <01> Yes
 - <02> No > go to G_23
 - <97> (Refused) > go to G_23
 - <98> (Don't know) > go to G_23
- G_17 Where do you normally access the Internet?
- <01> At home
 - <02> At work
 - <03> At school
 - <04> At an Internet café, library or
other public access point
 - <05> Other (Specify): _____
 - <97> (Refuse)
 - <98> (Don't know)
- G_18 Have you ever used the Internet to find health-related information?
- <01> Yes
 - <02> No
 - <97> (Refused)
 - <98> (Don't know)

- G_19 Do you know that 211 Toronto can be reached on the Internet, too?
 <01> Yes
 <02> No > go to G_23
 <97> (Refused) > go to G_23
 <98> (Don't know) > go to G_23
- G_20 Have you ever used the 211 Toronto web site?
 <01> Yes
 <02> No > go to G_23
 <97> (Refused) > go to G_23
 <98> (Don't know) > go to G_23
- G_21 Do you prefer to use 211 Toronto on the phone or on the Internet?
 <01> 211 on the phone
 <02> 211 on the Internet
 <03> It depends on the circumstances /
 on the type of information I need
 <97> (Refused) > go to G_23
 <98> (Don't know) > go to G_23
- G_22 Why?
 <01> : _____
 <97> (Refused)
 <98> (Don't know)
- G_23 What is the highest level of formal education you attained in Canada?
 <01> Postgraduate degree (Ph.D., Master's degree, degree
 in Medicine, Dentistry, Veterinarian Medicine or
 Optometry)
 <02> Undergraduate university degree, teacher's college
 or nursing school
 <03> Diploma or certificate from community college, trade,
 technical or vocational school or business college
 <04> Some university
 <05> Some community college, trade, technical or
 vocational school, or business college
 <06> High school diploma
 <07> Some high school
 <08> Elementary school
 <09> No schooling
 <10> Other (Specify): _____
 <97> (Refused)
 <98> (Don't know)

- G_24 What is your status in Canada?
- <01> Canadian citizen by birth?
 - <02> Canadian citizen after immigrating?
 - <03> Landed Immigrant?
 - <04> Refugee?
 - <05> Visiting Canada but not living here?
 - <07> Other (Specify): _____
 - <97> (Refuse)
 - <98> (Don't know)
- G_25 In the past 12 months, what was your employment status?
- <01> Working at a job or business
 - <02> Looking for paid work
 - <03> Going to school
 - <04> Household work and/or unpaid childcare
 - <05> Retired
 - <06> Other (Specify): _____
 - <97> (Refused)
- G_26 What was your main source of personal income in the past 12 months? (By income, I mean the money that you received from a job or business, from the government or from some other source)
- <01> Employment or self-employment
 - <02> Retirement pensions
 - <03> Investment income (rental income, dividends and interest, deposits and savings, stocks, mutual funds, etc.)
 - <04> Other federal or provincial government sources
 - <05> Other (Specify): _____
 - <06> No income
 - <97> (Refused)
 - <98> (Don't know)
- G_27 What is your approximate total personal income, before taxes, from all sources in the past 12 months?
- <01> Can\$ _____
 - <02> No income
 - <97> (Refused)
 - <98> (Don't know)

- G_28 What is your approximate total household income (including your personal income and income received by any other member of your household)?
- <01> Less than \$10,000
- <02> \$10,000 to less than \$20,000
- <03> \$20,000 to less than \$30,000
- <04> \$30,000 to less than \$40,000
- <05> \$40,000 to less than \$50,000
- <06> \$50,000 to less than \$60,000
- <07> \$60,000 to less than \$80,000
- <08> \$80,000 to less than \$100,000
- <09> \$100,000 or more?
- <97> (Refused)
- <98> (Don't know)

(END OF GENERAL MODULE)

NEW CANADIAN MODULE

(The following questions are asked to all respondents with the exception of Canadian Citizens by birth – Question G_24, p. 5, code <01>)

- N_01 In which country were you born?
- <01> : _____
- <97> (Refused)
- N_02 In what year and month did you first come to Canada to live?
- <01> Year: _____ Month: _____
- <97> (Refused)
- <98> (Don't know)
- N_03 Besides your country of birth, have you lived in any other country for at least 3 years, immediately before coming to Canada to live?
- <01> Yes (Specify): _____
- <02> No
- <97> (Refused)
- <98> (Don't know)

- N_04 What is your immigration category?
- <01> Family class
- <02> Independent class
- <03> Business class
- <04> Refugee
- <05> Other (Specify): _____
- <97> (Refused)
- <98> (Don't know)
- N_05 When you arrived in Canada, did you have relatives already living here? (By relatives, I mean persons who are related to you by blood, marriage, or adoption)
- <01> Yes
- <02> No > go to N_07
- <97> (Refused) > go to N_07
- <98> (Don't know) > go to N_07
- N_06 (Does this relative / do most of these relatives) in Canada live in Toronto or close by?
- <01> Yes
- <02> No
- <97> (Refused)
- <98> (Don't know)
- N_07 When you arrived, did you have friends who were not relatives already living here in Canada?
- <01> Yes
- <02> No > go to N_09
- <97> (Refused) > go to N_09
- <98> (Don't know) > go to N_09
- N_08 (Does this friend / do most of these friends) live in Toronto or close by?
- <01> Yes
- <02> No
- <97> (Refused)
- <98> (Don't know)

- N_09 How many of your friends, here in Canada, were also born in your birth country?
- <01> All of them
- <02> Most of them
- <03> About half of them
- <04> A few of them
- <05> None of them
- <06> Don't have any friends in Canada
- <97> (Refused)
- <98> (Don't know)
- N_10 What is the highest level of formal education you attained before coming to Canada?
- <01> Postgraduate degree (Ph.D., Master's degree, degree in Medicine, Dentistry, Veterinarian Medicine or Optometry)
- <02> Undergraduate university degree, teacher's college or nursing school
- <03> Diploma or certificate from community college, trade, technical or vocational school or business college
- <04> Some university
- <05> Some community college, trade, technical or vocational school, or business college
- <06> High school diploma
- <07> Some high school
- <08> Elementary school
- <09> No schooling
- <10> Other (Specify): _____
- <97> (Refused)
- <98> (Don't know)
- N_11 What was your employment status during the last 3 years before you moved to Canada?
- <01> Working at a job or business
- <02> Looking for paid work
- <03> Going to school
- <04> Household work and/or unpaid childcare
- <05> Retired
- <06> Other (Specify): _____
- <97> (Refused)

(END OF NEW CANADIAN MODULE)

EXIT MODULE

- * **The interview is over. Thank you for answering our questions!**
- * **As I said earlier, this interview is part of a study to improve the quality of services offered by 211 Toronto. Would you be willing to participate in a follow-up phone interview in approximately a month? It would take about five minutes. If you agree the researcher, Mr. Andrea Cortinois, will call you, only if additional data is needed.**
- * **If you are interested, I would like your first name and your phone number so that the researcher can contact you, if needed. Your name and phone number will be kept strictly confidential. I will give them only to the researcher.**

(Record the respondent's information on your 'Personal Information Form')

- * **Thank you so much again for your time and help! The information you shared with us will be very useful in improving our services! Unless you have any questions I would let you go back to your activities. Have a nice day/evening!**

(END OF INTERVIEW)

PHASE 1 – INTERVIEW GUIDE – SPANISH VERSION

Principal Investigator: Andrea A. Cortinois – Phone: 416-340-4800 x 8706
 Academic Supervisor: Dr. Alejandro (Alex) R. Jadad – Phone: 416-340-4800 x 6903
 University of Toronto Ethics Review Office – Phone: 416-978-3165

- * **Buenos/as (días/tardes/noches), mi nombre es Andrea Cortinois. Soy un investigador en la Universidad de Toronto. Podría hablar con (el Señor/la Señora) (name of potential respondent), por favor?**
- * **El día (date of first interview) Usted llamó a 211 Toronto. En esa ocasión Usted dijo que estaba dispuesto a contestar algunas preguntas como parte de un estudio sobre 211 Toronto.**
- * **Antes que Usted decida si quiere participar me gustaría contarle un poco más acerca de esta entrevista.**
- * **La entrevista va a tomar un máximo de quince minutos y es estrictamente confidencial. Sus respuestas serán utilizadas exclusivamente para este estudio. Le garantizamos que su información se mantendrá en forma privada y confidencial.**
- * **Usted no tiene que contestar todas las preguntas. Si prefiere no contestar una pregunta, por favor dígame y pasaremos a la siguiente.**
- * **Sus respuestas nos ayudarán a entender como ofrecer un mejor servicio a los usuarios futuros de 211 Toronto, incluyendo a Usted mismo, en caso que vuelva a llamar.**
- * **Finalmente, si Usted tiene alguna pregunta sobre el estudio, yo podría responderle o Usted puede comunicarse con el Dr. Alejandro Jadad, supervisor académico del estudio, o con la Oficina de Asuntos Éticos de la Universidad de Toronto. Si Usted lo desea, puedo proporcionarle los números telefónicos. También, si lo desea, puedo enviarle una copia impresa de esta información.**
- * **Antes de decidir si quiere participar, ¿tiene Usted alguna pregunta?**
- * **¿Tengo su consentimiento para iniciar la entrevista?**

INCLUSION CRITERIA

- | | | | |
|-------|--|-----------------------------|-----------------------------|
| IC_01 | ¿Es Usted mayor de edad? | Sí <input type="checkbox"/> | No <input type="checkbox"/> |
| IC_02 | ¿Vive Usted en Toronto? | Sí <input type="checkbox"/> | No <input type="checkbox"/> |
| IC_03 | Usted está buscando información: | | |
| | a) ¿para Usted mismo? | | <input type="checkbox"/> |
| | b) ¿para un familiar o un amigo? | | <input type="checkbox"/> |
| | c) ¿para un cliente como parte de sus actividades profesionales? | | <input type="checkbox"/> |

(If the caller answers negatively either question IC_01 or IC_02, or selects option c) for question IC_03, please say)

Mis disculpas. Como Usted (es menor de edad/no vive en Toronto/está buscando información para un cliente como parte de sus actividades profesionales y no para Usted mismo o para un familiar o amigo/a) no podemos continuar con esta entrevista. Le agradezco mucho por su tiempo y por su cooperación. ¡Que tenga un buen día!
(Otherwise, continue with the questionnaire)

GENERAL MODULE

(Please, NOTICE: All questions refer to the caller, even if he/she is seeking information for a relative/friend)

- G_01 ¿Cuántos años tiene Usted?
 <01> _____
 <97> (Se niega a contestar)
- G_02 ¿Es Usted hombre o mujer?
 <01> Hombre
 <02> Mujer
- G_03 Nos interesa saber dónde viven los usuarios de 211 Toronto. ¿Podría Usted decirme los primeros tres dígitos de su código postal?
 <01> _____
 <97> (Se niega a contestar)
 <98> (No sabe)
- G_04 ¿Cuál es su estado civil?
 <01> Casado/a o en unión libre
 <02> Viudo/a
 <03> Separado/a
 <04> Divorciado/a
 <05> Soltero, sin nunca haberse casado antes
 <06> Otra (especifique): _____
 <97> (Se niega a contestar)
- G_05 ¿Cuál es el primer idioma que Usted aprendió de niño/a, en su casa, y que todavía puede hablar?
 <01> : _____
 <97> (Se niega a contestar)
 <98> (No sabe)

- G_06 Usualmente ¿Qué idioma habla Usted en su casa?
 <01> : _____
 <97> (Se niega a contestar)
 <98> (No sabe)
 <99> (No se aplica)
- G_07 Usualmente ¿Qué idioma habla Usted con sus amigos?
 <01> : _____
 <97> (Se niega a contestar)
 <98> (No sabe)
 <99> (No se aplica)
- G_08 Usualmente ¿Qué idioma habla Usted en su trabajo o donde estudia?
 <01> : _____
 <97> (Se niega a contestar)
 <98> (No sabe)
 <99> (No se aplica)
- G_09 ¿Cuántos familiares viven con Usted? (me explico: familiar es quien está relacionado con Usted: directamente, como sus abuelos, padres, tíos, hermanos, primos, hijos, sobrinos o nietos; por casarse, como su esposo/a y los familiares de el/ella; o por adopción)
 <01> : _____
 <97> (Se niega a contestar)
- G_10 ¿Tiene Usted a otros familiares en Canadá que no viven con Usted?
 <01> Sí
 <02> No > go to G_12
 <97> (Se niega a contestar) > go to G_12
 <98> (No sabe) > go to G_12
- G_11 En los últimos 12 meses, ¿qué tanto se ha puesto en contacto con ellos, bien sea personalmente, con una visita, o telefónicamente, o por medio de una carta o correo electrónico?
 <01> Al menos una vez a la semana
 <02> Al menos una vez al mes
 <03> Al menos tres veces al año
 <04> Una o dos veces al año
 <05> Nunca
 <97> (Se niega a contestar)
 <98> (No sabe)

- G_12 ¿Ha participado Usted en las actividades de algún grupo o asociación en los últimos 12 meses? Por ejemplo un club deportivo, un club que organiza actividades para el tiempo libre, una organización política, una organización de la comunidad, una organización étnica, etc.?
- <01> Sí
- <02> No
- <97> (Se niega a contestar)
- <98> (No sabe)
- G_13 Usualmente, ¿dónde busca usted información relacionada con su salud?
- <01> Familiares
- <02> Amigos
- <03> Colegas de trabajo o estudio
- <04> Su médico de familia
- <05> En los medios de comunicación (diarios, periódicos, etc.)
- <06> En el Internet
- <07> Otra (especifique): _____
- <97> (Se niega a contestar)
- <98> (No sabe)
- G_14 ¿Tiene Usted a un médico de familia?
- <01> Sí
- <02> No
- <97> (Se niega a contestar)
- <98> (No sabe)
- G_15 ¿Cómo se enteró de 211 Toronto?
- <01> : _____
- <97> (Se niega a contestar)
- <98> (No sabe)
- G_16 Alguna vez, ¿ha utilizado Usted el Internet?
- <01> Sí
- <02> No > go to G_23
- <97> (Se niega a contestar) > go to G_23
- <98> (No sabe) > go to G_23

- G_17 Normalmente ¿Dónde accede Usted a Internet?
- <01> En su casa
- <02> En su trabajo
- <03> En su escuela/universidad
- <04> En un café Internet/una biblioteca u
otro lugar público
- <05> Otra (Especifique): _____
- <97> (Se niega a contestar)
- <98> (No sabe)
- G_18 Alguna vez ¿ha utilizado Usted el Internet para buscar información sobre salud?
- <01> Sí
- <02> No
- <97> (Se niega a contestar)
- <98> (No sabe)
- G_19 ¿Sabía Usted que puede tener acceso a los servicios de 211 Toronto también por Internet?
- <01> Sí
- <02> No > go to G_23
- <97> (Se niega a contestar) > go to G_23
- <98> (No sabe) > go to G_23
- G_20 Alguna vez ¿ha utilizado Usted los servicio de 211 Toronto por Internet?
- <01> Sí
- <02> No > go to G_23
- <97> (Se niega a contestar) > go to G_23
- <98> (No sabe) > go to G_23
- G_21 ¿Prefiere Usted utilizar los servicios de 211 Toronto por teléfono o por Internet?
- <01> Por teléfono
- <02> Por Internet
- <03> Depende de las circunstancias / del
tipo de información que necesite
- <97> (Se niega a contestar) > go to G_23
- <98> (No sabe) > go to G_23
- G_22 ¿Por Qué?
- <01> : _____
- <97> (Se niega a contestar)
- <98> (No sabe)

G_23 ¿Cuál es el nivel de educación formal más elevado alcanzado por Usted en Canadá?

- <01> Postgrado ('Ph.D.', 'Master's degree', degree in Medicine, Dentistry, Veterinarian Medicine o Optometry)
- <02> Licenciatura, 'teacher's college' o 'nursing school'
- <03> Diploma o certificado de un 'community college', de un 'trade, technical or vocational school' o de un 'business college'
- <04> Estudios universitarios no concluidos
- <05> Estudios en un 'community college, trade, technical or vocational school', o en un 'business college' no concluidos
- <06> Diploma de 'High school'
- <07> Estudios de 'high school' no concluidos
- <08> Estudios primarios 'Elementary school'
- <09> Ninguna educación formal en Canadá
- <10> Otra (Especifique): _____
- <97> (Se niega a contestar)
- <98> (No sabe)

G_24 ¿Cuál es su estado actual en Canadá?

- <01> Ciudadano canadiense por nacimiento
- <02> Ciudadano canadiense luego de inmigrar
- <03> 'Landed Immigrant'
- <04> Refugiado oficialmente reconocido
- <05> Está de visitas en Canadá pero no vive aquí
- <07> Otra (Especifique): _____
- <97> (Se niega a contestar)
- <98> (No sabe)

G_25 En los últimos 12 meses ¿Cuál fue su ocupación?

- <01> Trabajando en un negocio
- <02> Buscando trabajo remunerado
- <03> Estudiando en el sistema de educación formal
- <04> Trabajando en la casa/cuidando a niños sin remuneración
- <05> Jubilado
- <06> Otra (Especifique): _____
- <97> (Se niega a contestar)

G_26 En los últimos 12 meses ¿Cuál ha sido su fuente principal de ingresos? (Por 'ingresos' se entiende dinero que Usted recibió como remuneración por su trabajo en un negocio, o del gobierno o de otra fuente)

- <01> Empleo o trabajo independiente
- <02> Pensión de jubilado
- <03> Ingreso de inversiones (alquileres, intereses o dividendos accionarios, intereses bancarios, etc.)
- <04> Otras fuentes del gobierno provincial o federal
- <05> Otra (Especifique): _____
- <06> No tuvo ingresos
- <97> (Se niega a contestar)
- <98> (No sabe)

G_27 En los últimos 12 meses ¿Cuál fue su ingreso personal total, antes de los impuestos?

- <01> Can \$ _____
- <02> No tuvo ingresos
- <97> (Se niega a contestar)
- <98> (No sabe)

G_28 En los últimos 12 meses ¿Cuál fue su ingreso familiar total, aproximadamente? (incluyendo su ingreso personal y el ingreso de otros miembros de su familia)

- <01> Menos de \$10,000
- <02> Entre \$10,000 y \$20,000
- <03> Entre \$20,000 y \$30,000
- <04> Entre \$30,000 y \$40,000
- <05> Entre \$40,000 y \$50,000
- <06> Entre \$50,000 y \$60,000
- <07> Entre \$60,000 y \$80,000
- <08> Entre \$80,000 y \$100,000
- <09> \$100,000 o más?
- <97> (Se niega a contestar)
- <98> (No sabe)

(END OF GENERAL MODULE)

NEW CANADIAN MODULE

(The following questions are asked to all respondents with the exception of Canadian Citizens by birth – Question G_24, p. 5, code <01>)

- N_01 ¿En qué País nació Usted?
 <01> : _____
 <97> (Se niega a contestar)
- N_02 ¿En qué año y mes llegó Usted a Canadá para quedarse a vivir aquí?
 <01> Año: _____ Mes: _____
 <97> (Se niega a contestar)
 <98> (No sabe)
- N_03 Inmediatamente antes de llegar a vivir en Canadá, ¿vivió Usted en otro País que no fuera su País de nacimiento, por un tiempo de tres años o más?
 <01> Sí (Especifique): _____
 <02> No
 <97> (Se niega a contestar)
 <98> (No sabe)
- N_04 ¿A cuál categoría de inmigrantes pertenece Usted?
 <01> 'Family class'
 <02> 'Independent class'
 <03> 'Business class'
 <04> Refugiado
 <05> Otra (Especifique): _____
 <97> (Se niega a contestar)
 <98> (No sabe)
- N_05 Al llegar a Canadá ¿tenía Usted familiares que ya vivían aquí? (familiar es quien está relacionado con Usted: directamente, como sus abuelos, padres, tíos, hermanos, primos, hijos, sobrinos o nietos; por casarse, como su esposo/a y los familiares de el/ella; o por adopción)
 <01> Sí
 <02> No > go to N_07
 <97> (Se niega a contestar) > go to N_07
 <98> (No sabe) > go to N_07

- N_06 ¿Sus familiares residentes en Canadá (o la mayoría de ellos) vivían cerca o en la ciudad de Toronto?
 <01> Sí
 <02> No
 <97> (Se niega en contestar)
 <98> (No sabe)
- N_07 Al llegar a Canadá ¿Tenía Usted amigos, que no fueran familiares, que ya vivían aquí?
 <01> Sí
 <02> No > go to N_09
 <97> (Se niega a contestar) > go to N_09
 <98> (No sabe) > go to N_09
- N_08 ¿Sus amigos residentes en Canadá (o la mayoría de ellos) vivían cerca o en la ciudad de Toronto?
 <01> Sí
 <02> No
 <97> (Se niega a contestar)
 <98> (No sabe)
- N_09 Entre sus amigos que viven en Canadá ¿Cuántos nacieron en el mismo País donde nació Usted?
 <01> Todos
 <02> La mayoría
 <03> Más o menos la mitad
 <04> Algunos de ellos
 <05> Ninguno
 <06> No tengo amigos en Canadá
 <97> (Se niega a contestar)
 <98> (No sabe)

- N_10 ¿Cuál es el nivel de educación formal más elevado alcanzado por Usted antes de llegar a Canadá?
- <01> Postgrado (doctorado o maestría)
 - <02> Licenciatura
 - <03> Diploma o certificado de una institución post-secundaria
 - <04> Estudios universitarios no concluidos
 - <05> Estudios hacia diploma o certificado de una institución post-secundaria no concluidos
 - <06> Diploma de bachillerato
 - <07> Estudios de colegio no concluidos
 - <08> Estudios primarios
 - <09> Ninguna educación formal antes de llegar a Canadá
 - <10> Otra (Especifique): _____
 - <97> (Se niega a contestar)
 - <98> (No sabe)
- N_11 ¿Cuál era su ocupación durante los tres años inmediatamente antes de venir a Canadá?
- <01> Trabajando en un negocio
 - <02> Buscando trabajo remunerado
 - <03> Estudiando en el sistema de educación formal
 - <04> Trabajando en la casa/cuidando a niños sin remuneración
 - <05> Jubilado
 - <06> Otra (Especifique): _____
 - <97> (Se niega a contestar)

(END OF NEW CANADIAN MODULE)

(Continue to the follow-up interview – Phase 2 Interview Guide)

PHASE 2 – INTERVIEW GUIDE

Principal Investigator: Andrea A. Cortinois – Phone: 416-340-4800 x 8706
 Academic Supervisor: Dr. Alejandro (Alex) R. Jadad – Phone: 416-340-4800 x 6903
 University of Toronto Ethics Review Office – Phone: 416-978-3165

Recruitment Script

- * **Good (morning/afternoon/evening), my name is (name of the interviewer). I am a (researcher/research assistant) at the University of Toronto. May I speak to (Ms/Mr) (name of potential respondent), please?**
- * **On (date of first interview) you called 211 Toronto. At that time you answered some questions we had for you, as part of a study on 211 Toronto, and said you were willing to participate in a follow-up phone interview.**
- * **Before you decide if you want to continue, let me remind you about the study.**
- * **This call will take five minutes or less and is strictly confidential. (I will not share your information with anybody/I will share your information only with the researcher who is conducting this study). Your answers will only be used in this study. Your privacy is protected at all times.**
- * **You don't have to answer any of the questions if you don't want to. Please, just let me know and we will move to the following question or terminate the interview if you prefer.**
- * **Your answers will help us better understand how to help 211 Toronto users including yourself, if you use the service again in the future.**
- * **Finally, if you have any questions or concerns about this study, you can let me know, now, (or you can call Mr. Andrea Cortinois, the researcher who is conducting this study). You can also call (my/his) supervisor, Dr. Alex Jadad, or the Ethics Review Office at the University of Toronto. I can give you their phone numbers immediately, if you like. You can also ask for a paper copy of this information.**
- * **Before you decide if you want to participate or not, do you have any questions?**
- * **Do I have your consent to start the interview?**

Interview Guide

PH-II_01 Do you remember what question you asked or what problem you were trying to solve when you called 211 Toronto on (date of first interview)?

- <01> _____
- <97> (Refused) > go to PH-II_09
- <98> (Don't remember/not sure)

PH-II_02 The respondent's answer <01> matches the recorded question:

- <01> Yes
 <02> No

(If the respondent does not remember the reason/s for her/his call, or if his/her response differs from the question as recorded at the time of the first interview, read the recorded question to the respondent)

PH-II_03 How helpful was 211 Toronto in answering your original question/assisting you with your original problem?

- <01> It was a complete waste of time
 <02> It was of little help
 <03> It was helpful
 <04> It was very helpful
 <05> It was the single most helpful source of information for me
 <97> (Refuse)
 <98> (Don't know/not sure)

PH-II_04 At this time, do you think you have found an answer to your original question/have solved your original problem?

- <01> Yes > go to PH-II_06
 <02> No
 <97> (Refuse) > go to PH-II_07
 <98> (Don't know/not sure) > go to PH-II_07

PH-II_05 If NOT, why? In your view, what have been the main obstacles to answering your question/solving your problems?

- <01> _____ > go to PH-II_07
 <97> (Refuse) > go to PH-II_07
 <98> (Don't know/not sure) > go to PH-II_07

PH-II_06 If YES, in your view what have been the main obstacles you had to overcome in order to answer your question/solve your problem?

- <01> _____
 <97> (Refuse)
 <98> (Don't know/not sure)

PH-II_07 All considered, how satisfied are you with the service 211 Toronto offers on the phone?

- <01> Very unsatisfied
 <02> Unsatisfied
 <03> Neutral
 <04> Satisfied
 <05> Very satisfied
 <97> (Refuse)
 <98> (Don't know/not sure)

PH-II_08 In addition to 211 Toronto, what other sources of information did you use to answer your original question/solve your original problem (individuals/organizations/ Internet)?

- <01> _____
 <97> (Refuse)
 <98> (Don't remember/not sure)

PH-II_09 Have you used 211 Toronto again after (date of first interview)?

- <01> Yes
 <02> No
 <97> (Refuse) > go to PH-II_11
 <98> (Don't remember/not sure) > go to PH-II_11

PH-II_10 If YES/NOT, why?

- <01> _____
 <97> (Refuse)
 <98> (Don't remember/not sure)

PH-II_11 Do you have any suggestion to improve the service 211 Toronto offers on the phone?

- <01> _____
 <97> (Refuse)
 <98> (Don't know/not sure)

Exit Script

*** The interview is over. Thank you so much again for your time and help! The information you shared with us will be very useful in improving 211 Toronto services! Unless you have any questions I would let you go back to your activities. Have a nice (day/afternoon/evening)!**

PHASE 2 – INTERVIEW GUIDE – SPANISH VERSION

Principal Investigator: Andrea A. Cortinois – Phone: 416-340-4800 x 8706
 Academic Supervisor: Dr. Alejandro (Alex) R. Jadad – Phone: 416-340-4800 x 6903
 University of Toronto Ethics Review Office – Phone: 416-978-3165

(Continue from Phase I – Interview Guide – Spanish Version)

Interview Guide

Hablemos ahora de la llamada que Usted hizo a 211 Toronto el día (date of first interview)

PH-II_01 ¿Usted se acuerda de la pregunta que tenía o del problema que estaba intentando resolver cuando llamó a 211 Toronto el día (date of first interview)?

- <01> _____
 <97> (Se niega a contestar) > go to PH-II_09
 <98> (No se acuerda/No está seguro)

PH-II_02 The respondent's answer <01> matches the recorded question:

- <01> Yes
 <02> No

(If the respondent does not remember the reason/s for her/his call, or if his/her response differs from the question as recorded at the time of the first interview, read the recorded question to the respondent)

PH-II_03 ¿Que tan útil fue 211 Toronto en ayudarla a encontrar una respuesta a su pregunta inicial/una solución a su problema inicial?

- <01> Fue una pérdida completa de tiempo
 <02> No fue muy útil
 <03> Fue útil
 <04> Fue muy útil
 <05> Fue en absoluto la más valiosa fuente de información para mi
 <97> (Se niega a contestar)
 <98> (No sabe)

PH-II_04 A esta altura, ¿cree Usted haber encontrado una respuesta a su pregunta inicial/haber resuelto su problema inicial?

- <01> Sí > go to PH-II_06
 <02> No
 <97> (Se niega a contestar) > go to PH-II_07
 <98> (No sabe) > go to PH-II_07

PH-II_05 Si NO, ¿por qué? En su opinión, ¿cuáles han sido los obstáculos más importantes para encontrar una respuesta a su pregunta inicial/para resolver su problema inicial?

- <01> _____ > go to PH-II_07
 <97> (Se niega a contestar) > go to PH-II_07
 <98> (No sabe) > go to PH-II_07

PH-II_06 Si SÍ, ¿cuáles han sido los obstáculos más importantes que tuvo que superar para encontrar una respuesta a su pregunta inicial/para resolver su problema inicial?

- <01> _____
 <97> (Se niega a contestar)
 <98> (No sabe)

PH-II_07 En resumen, ¿cuál es su nivel de satisfacción con relación a los servicios que 211 Toronto ofrece por teléfono?

- <01> Para nada satisfecho/a
 <02> No muy satisfecho/a
 <03> Neutral
 <04> Satisfecho/a
 <05> Muy satisfecho/a
 <97> (Se niega a contestar)
 <98> (No sabe)

PH-II_08 Además de 211 Toronto, ¿cuáles otras fuentes de información utilizó Usted para encontrar respuesta a su pregunta inicial/para resolver su problema inicial? (individuos/organizaciones/Internet)?

- <01> _____
 <97> (Se niega a contestar)
 <98> (No sabe)

PH-II_09 Después del día (date of first interview), ¿ha utilizado Usted 211 Toronto otras veces?

- <01> Sí
 <02> No
 <97> (Se niega a contestar) > go to PH-II_11
 <98> (No sabe) > go to PH-II_11

PH-II_10 Si SÍ/NO, ¿por qué?

- <01> _____
 <97> (Se niega a contestar)
 <98> (No sabe)

PH-II_11 ¿Tiene Usted alguna sugerencia para mejorar los servicios que 211 Toronto ofrece por teléfono?

- <01> _____
 <97> (Se niega a contestar)
 <98> (No sabe)

A – EXIT MODULE FOR RESPONDENTS WHO:

1) ASKED HEALTH-RELATED QUESTIONS;

3) AND ARE RECENT IMMIGRANTS (5 YEARS OR LESS).

(See question N_02, p. 7 of Phase I Interview Guide – came to Canada in July 2000 or later)

- * **¡Hemos llegado al final de la entrevista! ¡Muchas gracias por contestar nuestras preguntas!**
- * **Como dije antes, esta entrevista es parte de un estudio que se lleva a cabo para mejorar la calidad de los servicios ofrecidos por 211 Toronto. ¿Estaría Usted interesado en participar en una entrevista para analizar más a fondo su experiencia, en unas cuantos días? La entrevista tomaría aproximadamente una hora y Usted recibiría \$25 canadienses para cubrir sus gastos. Como siempre, toda la información que Usted nos proporcionaría sería completamente confidencial. Si Usted está de acuerdo, volvería a llamarla muy pronto para definir el día, la hora y el lugar para dicha entrevista.**

-
- * **Una vez más, ¡Muchas gracias por su tiempo y ayuda! ¡La información que Usted compartió con nosotros va a ser muy útil para mejorar los servicios de 211 Toronto! A menos que Usted tenga preguntas, voy a dejarla volver a sus actividades. ¡Que tenga muy buenos/buenas (días/tardes/noches)!**

B – EXIT MODULE FOR ALL OTHER RESPONDENTS

- * **¡Hemos llegado al final de la entrevista! Una vez más, ¡Muchas gracias por su tiempo y ayuda! ¡La información que Usted compartió con nosotros va a ser muy útil para mejorar los servicios de 211 Toronto! A menos que Usted tenga preguntas, voy a dejarla volver a sus actividades. ¡Que tenga muy buenos/buenas (días/tardes/noches)!**

PHASE 3 – INTERVIEW GUIDE

Principal Investigator: Andrea A. Cortinois – Phone: 416-340-4800 x 8706
 Academic Supervisor: Dr. Alejandro (Alex) R. Jadad – Phone: 416-340-4800 x 6903
 University of Toronto Ethics Review Office – Phone: 416-978-3165

- * **Antes que Usted decida si quiere participar me gustaría contarle un poco más acerca de esta entrevista.**
- * **La entrevista va a tomar una hora aproximadamente y es estrictamente confidencial. Sus respuestas serán utilizadas exclusivamente para este estudio. Le garantizamos que su información se mantendrá en forma privada y confidencial.**
- * **Quisiéramos grabar la entrevista para asegurarnos que no nos vamos a olvidar nada de sus palabras. Solamente los dos investigadores presentes aquí en este momento tendrán acceso a las grabaciones. Las grabaciones se guardarán en un cajón cerrado con llave en la oficina del investigador principal y se destruirán una vez se hayan transcrito.**
- * **Usted no tiene que contestar todas las preguntas. Si prefiere no contestar una pregunta, por favor díganos y pasaremos a la siguiente. También, en cualquier momento Usted desee interrumpir la entrevista, por favor díganos y terminaremos de inmediato.**
- * **Sus respuestas nos ayudarán a entender como ofrecer un mejor servicio a los usuarios futuros de 211 Toronto, incluyendo a Usted mismo, en caso que vuelva a llamar.**
- * **Si Usted lo desea, con mucho gusto podemos compartir con Usted el análisis de esta entrevista para escuchar sus comentarios.**
- * **Finalmente, si Usted tiene alguna pregunta sobre el estudio, yo podría responderle o Usted puede comunicarse con el Dr. Alejandro Jadad, supervisor académico del estudio, o con la Oficina de Asuntos Éticos de la Universidad de Toronto. Si Usted lo desea, puedo proporcionarle los números telefónicos. También, si lo desea, puedo dejarle una copia impresa de esta información.**
- * **Antes de decidir si quiere participar, ¿tiene Usted alguna pregunta?**
- * **¿Tenemos su consentimiento para iniciar la entrevista? Por favor conteste “sí” o “no”.**
- * **¿Tenemos su consentimiento para grabar la entrevista? Por favor conteste “sí” o “no”.**

1. Información Personal

- En qué País nació?
- En que año y mes llegó a Canadá?
- Inmediatamente antes de llegar a Canadá vivió en otro País que no fuera su País de nacimiento?
- Edad
- Estado civil

- Con quién vive aquí? Miembros de su familia que viven con Usted, su edad, género y nivel de educación formal
- Tiene Usted a otros familiares, u otras personas que Usted considera como familia, en Canadá? En dónde viven?
- Tiene contactos habituales con familiares y amigos en su País de origen?
- Estado de migración en Canadá (ciudadano, landed immigrant, refugiado oficialmente reconocido, refugiado a la espera de reconocimiento, de visita, otro)
- A cuál categoría de inmigrantes pertenece? (family class, independent class, business class, refugiado, otro)
- Educación formal (antes de llegar a Canadá y en Canadá)
- Ocupación (antes de llegar a Canadá y en Canadá)
- Hace cuánto trabaja en eso?
- Cómo encontró a su trabajo actual?
- Qué le parece de su trabajo actual?
- Cuál es el perfil demográfico de sus colegas de trabajo (edad, género, país de origen)?

2. Preguntas de Carácter General (Historias/Experiencias)

Tenemos ahora algunas preguntas de carácter general que nos gustaría conteste como si estuviera contando su historia y sus experiencias a un amigo/a a quien no ve desde hace tiempo, quien vive en su País de origen, y quien no sabe nada de Canadá.

2.1 Cuéntenos sobre su llegada a Canadá.

- ¿Por qué tomó la decisión de mudarse aquí?
- ¿Qué tanto sabía sobre la vida en Canadá antes de llegar?
- ¿Qué tanto sabía sobre las instituciones en este país?
- ¿Cuáles fueron los primeros problemas que tuvo que solucionar?
- ¿Qué más se acuerda sobre las primeras semanas que pasó aquí?
- ¿Cuál era su nivel de conocimiento del idioma inglés cuando llegó a Canadá?

2.2 ¿Se acuerda cuándo fue la primera vez que necesitó utilizar servicios de salud en Canadá? ¡Cuéntenos!

- ¿Qué sabía, en ese momento, sobre los servicios de salud de Canadá?
- ¿Por dónde empezó Usted a buscar información?
- ¿Quién la ayudó?
- ¿Cuál fue su primer contacto con el sistema de salud de Canadá? (médico de familia; “walk-in clinic”; departamento de emergencias de un hospital)
- ¿Sabía qué es un “médico de familia”? ¿Sabía cuánto importante es su papel aquí?

2.3 Aquí en Canadá, después de ese primer contacto, quisiéramos saber cómo aprendió, poco a poco, lo que sabe ahora sobre el sistema de salud. ¿Podría contarnos los pasos que siguió en el proceso de aprendizaje? ¿Podría dibujar mentalmente un mapa del recorrido que siguió desde el momento cuando por primera vez dijo a si mismo/a “tengo un problema de salud” y ahora?

- ¿Quién más la ayudó, después de ese primer contacto?
- ¿A dónde fue para encontrar ayuda e información?
- ¿Qué leyó?
- ¿Encontró respuestas mirando la tele?
- ¿Encontró respuestas escuchando la radio?
- ¿Leyendo periódicos y diarios?
- ¿Llamando por teléfono a algún servicio de información y apoyo?
- ¿En el Internet?
- ¿Cuáles fuentes fueron las más útiles? ¿Por qué?
- ¿Cuáles fuentes de información le parecieron más confiables? ¿Por qué?
- ¿Hay algunas personas, organizaciones o medios de información que fueron especialmente útiles para encontrar una respuesta a sus preguntas en la comunidad hispana?
- ¿Y afuera de dicha comunidad?
- En su búsqueda de información sobre servicios de salud, ¿tuvo Usted la oportunidad de ayudar a otras personas quien también estaban enfrentando problemas similares y buscando la misma información?
- ¿Recibió ayuda de dichas personas?
- ¿Encontró a algún profesional de salud – enfermeras, médicos, farmacéutico, etc. – quien fue especialmente importante en ayudarla a encontrar lo que Usted buscaba?
- ¿Cuáles fueron las barreras más importantes que Usted encontró en su búsqueda de información?

2.4 ¿Qué sabe Usted de 211 Toronto?

- ¿Cómo encontró este servicio?
- ¿Con qué frecuencia lo utiliza?
- ¿Qué tan útil es 211 Toronto, por lo general, para encontrar respuestas a sus preguntas? (una pérdida completa de tiempo; no muy útil; útil; muy útil; en absoluto la fuente más valiosa de información)
- ¿Por lo general, cuál es su nivel de satisfacción con los servicios que 211 Toronto ofrece por teléfono? (para nada satisfecho/a; no muy satisfecho/a; neutral; satisfecho/a; muy satisfecho/a)
- ¿Es un tipo de servicio que ya conocía antes de llegar a Toronto?
- ¿La información que recibió de 211 Toronto le pareció confiable? ¿Por qué?
- ¿Sabe quién apoya en términos de finanzas a 211 Toronto?
- ¿Tiene alguna sugerencia para mejorar los servicios ofrecidos por 211 Toronto?

3. Salud: Antes y Después

- ¿Qué hacía en su país de origen cuando tenía un problema de salud?
- En su país de origen, ¿Dónde encontraba información sobre problemas de salud y como prevenirlos ó solucionarlos?
- ¿Qué diferencias encontró en la manera de entender la palabra “salud” en su país de origen y aquí en Canadá?
- ¿Qué tipo de información Usted cree que sea necesaria para solucionar problemas de salud? ¿Cómo definiría Usted “información relacionada con la salud”? ¿Cómo demarcaría Usted una línea de confine entre información que sí está relacionada con la salud e información que no está relacionada con la salud? ¿Podría Usted dar ejemplos de distintos “tipos” de información relacionada con la salud?

*** ¡Hemos llegado al final de la entrevista! Una vez más, ¡Muchas gracias por su tiempo y ayuda! ¡La información que Usted compartió con nosotros va a ser muy útil para mejorar los servicios de 211 Toronto! A menos que Usted tenga preguntas, voy a dejarlo volver a sus actividades. ¡Que tenga muy buenos/buenas (días/tardes/noches)!**

Appendix 5 – Other Tools Used For Data Collection

Data Collection Supervisor: List of Daily Responsibilities

1. Every morning at 8am:
 - make sure volunteers can access the office, are sitting at their desks and have all the material they need to start working;
 - double check the daily counsellor management sheet and distribute the envelopes with the study material to all counsellors who start at 8am or earlier.
2. Collect all the envelopes left by counsellors in the drop off box and double check their content, making sure all the material, both completed forms and unused ones, have been returned.
3. Put back the unused material in the appropriate boxes in the study office to be re-distributed. Put the completed forms in the collection boxes, to be entered into the database (separate boxes for: counsellor's form; counsellor's daily check list; answer sheet; and personal info sheet for follow-up calls).
4. During the day, make sure to hand out the envelope with the study material every time a new counsellor starts his/her shift.
5. Make sure every is fine with the volunteers. In particular make sure they:
 - have all the forms they need;
 - get an answer to any questions they might have;
 - have a chance to go to the toilet or for a short break whenever they need it (and replace them temporarily);
 - give the supervisor all the completed forms for the day.
6. Let the investigator know every time more material for the study is needed.
7. Before leaving, prepare the counsellors' envelopes for the following day (1 daily call check list and 30 invitation forms).

Data Collection Supervisor: Form For the Daily Management of Counsellors' Participation

211 Toronto / eHealth Innovation Study 2005
Daily Counsellors' Management Form

Date: ____ / ____ / ____

Prepared by: _____

#	Counsellor's Name	Time Start / 8am	Time Finish / 8pm	# Recr. Gvn.	# Recr. Rtn.	Call Check Gvn.	Call Check Rtn.
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							

Counsellors: Checklist – Page 1

211 Toronto / eHealth Innovation Study 2005

**SEE INSTRUCTIONS
ON BACK** →

Counsellor's Name: _____

Date: ____ / ____ / ____

**Interviewers' Phone Numbers: 416-338-0727
416-392-4560
416-392-0067**

Telephone Call #:

1	26	51	76	101	126	151	176
2	27	52	77	102	127	152	177
3	28	53	78	103	128	153	178
4	29	54	79	104	129	154	179
5	30	55	80	105	130	155	180
6	31	56	81	106	131	156	181
7	32	57	82	107	132	157	182
8	33	58	83	108	133	158	183
9	34	59	84	109	134	159	184
10	35	60	85	110	135	160	185
11	36	61	86	111	136	161	186
12	37	62	87	112	137	162	187
13	38	63	88	113	138	163	188
14	39	64	89	114	139	164	189
15	40	65	90	115	140	165	190
16	41	66	91	116	141	166	191
17	42	67	92	117	142	167	192
18	43	68	93	118	143	168	193
19	44	69	94	119	144	169	194
20	45	70	95	120	145	170	195
21	46	71	96	121	146	171	196
22	47	72	97	122	147	172	197
23	48	73	98	123	148	173	198
24	49	74	99	124	149	174	199
25	50	75	100	125	150	175	200

Health-related questions are:

- Questions related to a disease/condition (physical conditions, mental health conditions, addiction problems, etc.)
- Questions related to a therapy (Western medicine, alternative medicine, psychotherapy, etc.)
- Questions related to a health service/provider (hospital-based, community-based, or home-based service)
- Questions related to administrative/bureaucratic aspects of health care (OHIP cards, drug benefits, etc.)
- Questions related to the health and supportive care needs of special groups (the elderly, newborns, disabled people, etc.)

Counsellors: Checklist – Page 2

211 Toronto / eHealth Innovation Study 2005

REMEMBER!

- The study focuses exclusively on 211 Toronto calls.
- Please, invite every 5th caller, no matter what his/her characteristics are or the reasons for calling.
- The only exception is if a caller's English is not good enough to understand the recruitment script and interview questions.
- If you transfer a call to another counsellor who speaks the caller's language, do not count that call as one you received. The counsellor who actually answers the caller's questions will be responsible for inviting him/her.

Interviewers: Addendum To Interview Guide

PHASE I

INSTRUCTIONS – ADDENDUM TO INTERVIEW GUIDE

QUESTION IC_02

List of municipalities included in the Toronto Census Metropolitan Area:

Ajax	Georgina	Oakville
Aurora	Halton Hills	Orangeville
Bradford West	King	Pickering
Gwillimbury	Markham	Richmond Hill
Brampton	Milton	Scarborough
Caledon	Mississauga	Toronto
East Gwillimbury	Mono	Uxbridge
East York	New Tecumseth	Vaughan
Etobicoke	Newmarket	Whitchurch-Stouffville
Georgina Island 33	North York	York

QUESTION G_19

If a respondent asks the address of the 211 Toronto website, it is: **www.211Toronto.ca**

QUESTION N_01

List of Spanish-speaking Latin American countries:

Argentina	Dominican Republic	Nicaragua
Bolivia	Ecuador	Panama
Chile	El Salvador	Paraguay
Colombia	Guatemala	Peru
Costa Rica	Honduras	Uruguay
Cuba	Mexico	Venezuela

Interviewers: Form For the Collection of Personal Information

211 TORONTO / eHEALTH INNOVATION STUDY 2005
PERSONAL INFORMATION FORM

Date: ____ / ____ / ____

Interviewer's Name: _____

	ID#	FOLLOW-UP INT.	IN-DEPTH INT.	FIRST NAME	PHONE #	H / W / M	TIME OF DAY
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							