

Health Materials and Strategies for the Prevention of Immigrants' Weight-Related Problems

Manuela Ferrari

University of Toronto, Toronto, Ontario, Canada

Stacey Tweed

Hospital for Sick Children, Toronto, Ontario, Canada

Joanna Anneke Rummens

University of Toronto, Toronto, Ontario, Canada

Harvey A. Skinner

York University, Toronto, Ontario, Canada

Gail McVey

Hospital for Sick Children, Toronto, Ontario, Canada

Existing health education materials dealing with healthy eating, active living, and body image were examined by immigrant parents of elementary school children to determine their relevance, cultural competence, and accessibility. A total of 13 immigrant mothers from Sri Lanka and China participated in a series of three focus groups. Study findings indicate that the present health education materials intended to help prevent weight-related problems could be improved to better meet the needs of new immigrant families. Immigrant mothers who participated in the study expressed their preferences for health education materials and prevention interventions undertaken in a culturally relevant/competent, knowledge-sharing, participatory manner. Acting on these suggestions could help practitioners and public health agencies develop more effective strategies that meet the requirements of ethno-cultural immigrant communities.

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Current literature regarding eating disorders and weight-related problems suggests that the eating behaviors and weight concerns of children are often shaped by their parents (Davison & Birch, 2001; Jaffe & Worobey, 2006). Parents seek information to help prevent weight-related problems in their children while also looking for ways to increase their self-esteem and healthy body image. At the same time, however, many parents worry that their children might become obese. As a result, parents might

often involuntarily engage in behaviors and communicate attitudes that can, in fact, promote body image dissatisfaction and unhealthy weight-control behaviors in their children (e.g., dieting, restrictive eating). Neumark-Sztainer (2005) has suggested that parents "can do more and say less" (p. 492). For example, parents should avoid making negative comments about their own body or someone else's. Indeed, parents should be aware that their behaviors and attitudes can influence their children and that they (the parents) can inadvertently send wrong and dangerous messages.

Some eating disorder prevention interventions have shifted from a classic, prevention-oriented approach (Levine & Smolak, 2006), which mostly focuses on individual health behavior change theories, to an explicit

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health promotion approach that aims at modifying environmental factors and empowering children and adolescents to have more control over their health (World Health Organization [WHO], 1986). This has led to the implementation of more ecological and comprehensive models of eating disorders and weight-related prevention interventions (Haines, Neumark-Sztainer, Perry, Hannan, & Levine, 2006; McVey, Tweed, & Blackmore, 2007). The use of ecological frameworks would logically involve consideration of parents' participation and support; however, the most optimal way or ways through which to engage them has yet to be expounded (Levine & Smolak, 2006).

To date, few school-based health interventions have been designed to involve parents in the prevention of weight-related problems in children with positive results (i.e., the interventions achieved the prevention goals and, at the same time, obtained good parental support and participation; Haines, et al., 2006; O'Dea & Abraham, 2000). Of primary concern is that the majority of prevention interventions do not engage parental support in any meaningful way (McVey et al., 2007; Smolak, Levine, & Schermer, 1998a, 1998b; Varnado-Sullivan et al., 2001). This is perhaps not as surprising as it might first seem, because public health practitioners, school staff, and researchers have repeatedly described facing major issues in recruiting parents and maintaining meaningful parental involvement in health-promotion activities (Griffith, 1998; Hahn, Simpson, & Kidd, 1996). Although the majority of parents are interested in learning more about child health-promotion practices, it is only the highly motivated parents or those with particular concerns regarding specific issues and/or diseases who actually participate in meetings and interventions.

Research studies conducted in school environments have identified several barriers to parental involvement, including socioeconomic status (SES), transportation, availability of child care, employment status, parents' level of education, single parent status, and a general lack of time (Griffith, 1998; Hahn et al., 1996). In addition, language-minority parents are even less likely to participate in school activities and prevention interventions because of linguistic barriers (Griffith, 1998). In a preliminary study conducted with minority, low-SES parents of preschool children, Goodell, Pierce, Bravo, and Ferris (2008) found a disconnection between parents and health care providers regarding the meaning of "overweight" and its potential health implications for children. The

authors suggested that to be more effective and meet the needs of low-SES families, health care providers should focus more on good health rather than weight during their interaction with parents. Nevertheless, in the eating disorder and weight-related problems literature, additional barriers and mechanisms that either discourage or encourage parents to become more engaged in their child's health activities are not yet clearly understood.

Given the increasing number of immigrants to North America from various parts of the world (Benton-Short, Price, & Friedman, 2005), the success of any prevention program geared at targeting weight-related problems would also depend on its ability to meet the diverse needs of ethno-communities, particularly recent newcomers. Different institutions such as schools, hospitals, and community centers must be aware of the unique needs and practices of diverse ethno-cultural communities to facilitate more culturally sensitive and appropriate interventions (Beiser, Armstrong, Ogilvie, Oxman-Martinex, & Rummens, 2005; Rummens, 2003). Therefore, there is a need to explore this field and develop culturally competent health education materials, programs, and knowledge sharing tools.

A useful preliminary question to consider is whether health care professionals and public health agencies are using appropriate strategies to involve parents in the prevention of eating disorders and weight-related problems. In attempting to answer this question, the present study provided a context for creating a dialogue with immigrant parents from two ethno-communities to generate new understandings regarding the relevance and cultural competence of existing health materials and strategies designed to prevent eating disorders and promote positive body image. We asked immigrant parents to review existing materials on healthy eating and active living, and to discuss the influence of existing media messages on healthy body image, to determine if the content of the materials was relevant and appropriate to their own experiences. Indeed, we wanted to know whether parents felt that the existing public health material enabled them to (a) be a positive role model for their children, (b) provide their children with a more supportive environment in which they could make healthy choices, and (c) help their children to develop self-confidence and self-esteem that focuses less on physical appearance. Parents were then asked to identify effective ways in which they currently access—and would prefer to access—health information

(e.g., online, library, schools) to help improve the health of their children and of their families.

Method

In this exploratory study we used an inductive qualitative approach to examine immigrant parents' responses to existing public health education materials and strategies. Focus groups were used as a means of generating rich data and valuable knowledge not captured through quantitative methods (Krueger, 1995). The key distinction between the focus group method and other forms of qualitative data collection is the social interplay that takes place between all participants (Duggleby, 2005), as each participant's comments are generated out of the narrative of others. According to Krueger (1995), focus groups enable enhanced collaboration between researchers and non-researchers, shape the role of the researcher, allow community members to take an active role within the research process, and unpack the complexity of minority cultural groups often excluded from the research process.

Participant Recruitment

After we received ethics approval from the research ethics boards at the Hospital for Sick Children and the University of Toronto, immigrant parents from two distinct ethno-communities (Tamil and Mainland Chinese) within the Greater Toronto Area (GTA) were invited to take part in this study. The sampling strategy was purposive rather than random (mixed purposeful sampling vs. randomized sampling), to receive the maximum range of information possible (Kuzal, 1999; Patton, 2002). Given the exploratory nature of this study, an attempt was made to maximize cultural contrasts by selecting two very different newcomer, ethno-cultural population groups, while at the same time choosing groups that are demographically well-represented within Canada's immigrant population.¹ Indeed, students from the Tamil (or South Asian) and Chinese communities are well represented in the GTA schools where prevention activities are currently being implemented.

We prepared a recruitment brochure to disseminate information regarding the proposed study to potential Tamil and Mainland Chinese community agencies. Two agencies, the Tamil Emergency Medical Services and the Toronto Chinese Community Services Association, expressed interest in being partners in the

study. Information was included in the agencies' e-newsletters, which were e-mailed to community members, and study brochures were also made available at both the partner and other community agencies (e.g., the Language Instruction for Newcomers to Canada (LINC) Program, South-Asian Family Support Services (SAFSS), and the South East Asian Services (SEAS) Centre). Two community coordinators from each community were identified by the community partner organizations and hired to be part of the research team. The coordinators were fully involved during the research design, participant recruitment, data generation, and preliminary data analysis phases, and their cultural knowledge was highly valuable to us.

To collaborate in the study, participants needed to be (a) recent immigrants or refugees who had been living with their families in Canada for at least 1 year but no more than 5 years; (b) members of the Tamil or Mainland Chinese communities in Toronto, Ontario, Canada; (c) parents (18 years of age or older) of elementary-school-aged children (ages 5 to 12 years); and (d) sufficiently fluent in conversational English to participate fully in the focus groups.

Six newcomer immigrant mothers participated in the Tamil focus group series and seven immigrant mothers participated in the Mainland Chinese focus group series. Using small focus groups, with six to eight participants, was particularly important to unpacking the complexity of immigrant families' lives and cultural changes before and after migration (Krueger, 1995).

The Tamil focus group was comprised of mothers of elementary- and high school children. Each mother had between one and three children, and most were homemakers, with the exception of one participant who had worked as a nurse before coming to Canada. At the time of the focus group, all mothers were students at an english-as-a-second-language (ESL) school. Most of the participants were already acquainted because they were in the same ESL class or frequented the same school. This is often considered problematic in qualitative research, as people who know each other might be less willing to share life experiences or tell sensitive stories. As a result, focus groups that take place with people who do not know each other and know that they might never see each other again often obtain the best results. However, in this case the Tamil participants indicated that it was important for them to know the other group members to feel free to speak. Community coordinators initially

faced several difficulties in recruiting the mothers because the participants were extremely shy and unfamiliar with research activities. The fact that other people they knew had agreed to participate helped them to overcome these concerns and contributed to the quality of the data. Additionally, reading from the field notes of one of the community coordinators:

The group was genuinely interested in the topic and was pleased to share their knowledge. I believe that the participants must have felt that they were in a safe place, as they were comfortable enough to share personal stories and make jokes. I also think that it helped that Manuela told them that she was a new immigrant herself. It made the women happier to know that she had gone through the same experiences as they had.

The fact that Manuela (the first author), the only research team member who attended all focus groups as an “outsider,” from an ethno-community group not included in the study, was also a new immigrant seemed to help participants to develop trust and express themselves freely.

The Mainland Chinese group was comprised of mothers who had between one and two children that collectively covered all three age ranges (infant, child, and adolescent); 3 had babies between 5 and 22 months of age. Before coming to Canada, 3 of these women had worked as high school teachers, one as a buyer, one as a banker, one as a researcher in a pharmaceutical company, and one as an airport employee. Only two—the buyer and the teacher—were able to obtain the same type of work in Canada. The other mothers were either underemployed or unemployed.

Data Collection

The first task for each community coordinator was to review the focus group questions developed by the researchers, prior to the focus group interview sessions, to maximize clarity of expression, as well as cultural appropriateness. No major changes were made from the original version; however, this step generated important discussions within the research team.

A series of three separate parent focus groups were held with each of the Tamil and Mainland Chinese mothers, respectively. The mothers met for 2 hours at each focus group session (for a total of 6 hours for each mother) to discuss the following three topics: eating habits, physical activity, and media pressures to conform to an ideal body image. Focus groups were

led by the community coordinators rather than the researchers to ensure an equal distribution of power between researchers and study participants, as well as to enable participants to share their life experiences in a nonjudgmental environment. The parents’ heritage language—Tamil or Mandarin, respectively—was used during the focus groups to ensure that the parents were able to fully express themselves.

The materials presented to the parents were *Canada’s Food Guide to Healthy Eating* (Minister of Health Canada, 2007), *Canada’s Physical Activity Guide to Healthy Active Living*² (Public Health Agency of Canada, 2002), and *The Student Body: Promoting Health at Any Size*³ (McVey, Gusella, Tweed, & Ferrari, 2009), a research-based online curriculum for teachers and public health practitioners, with a minor component for parents consisting of a 1-page handout on each topic.

Overall, there were three primary goals in presenting the public health materials. First, these materials were designed to make parents aware that they are healthy role models for their children through their engagement in regular physical activity, eating patterns, and food choices. The second goal was to impress upon parents the importance of providing children with a positive and supportive environment in which it is easier for them to make healthy choices. The third goal was to impress upon parents their role in helping children develop a strong sense of identity, as well as a sense of confidence in themselves. To allow parents to review the content of these materials, otherwise available only in English, we provided a translation of part of the materials.

The same questions were asked of the two ethno-cultural participant groups for all three sets of materials (healthy eating, active living, and media messages/body image) to determine their relevance, appropriateness, effectiveness, and cultural competency (see Appendix 1). We developed the questions with the intent of making them clear and easy to understand, capable of generating discussion, and comprehensive in their exploration of the materials.

All six focus group sessions were digitally recorded. The digital audio files were transcribed and translated into English by the community coordinators. The fact that each ethno-community had two community coordinators helped with the verification of the transcription and translation processes: One community coordinator transcribed and translated a focus group and the other reviewed the work done. Focus group transcripts were then prepared to facilitate thematic

analyses. All participant names were changed to pseudonyms to ensure confidentiality.

Trustworthiness was achieved within the study through (a) peer review and debriefing to ensure methodological effectiveness, and (b) member checks, used to verify the accuracy of the information provided by the participants and the first level of analysis. In qualitative research, data saturation is often the object of controversy, specifically how a researcher could obtain it or what meaning and understanding should be given to it (Morse, 1995). We moved from the traditional definition of data saturation—"collecting data until new information is obtained" only—to understanding data saturation as "adequacy" of the data (Morse, 1995).

Because the exploratory nature of this study was intended to collect a variety of rich and complete information, data saturation was obtained through specific methodological choices aimed at gathering a comprehensive picture of the experiences of immigrant families related to the object of enquiry. These methodological choices were (a) selecting a culturally cohesive sample, well-represented within Canada's immigrant population, for data generation; (b) working with two very different newcomer ethno-cultural groups so as to maximize and explore cultural contrasts; (c) letting community coordinators lead the focus groups (community coordinators mastered both language and cultural practices to access and understand the life of the immigrant mothers who attended the study); and (d) asking immigrant mothers to meet three times for a total of 6 hours (this allowed mothers to review the materials and transcriptions at home, discuss the information during the following session, and develop trust between participants, community coordinators, and researchers).

Data Analysis

Data analysis involved five steps: (a) data were organized and prepared for analysis; (b) all of the data were read to obtain a general sense of the information and to reflect on its original meaning; (c) a coding process was developed to organize the material into "chunks" (labeling a category with a term); (d) themes were delineated; and (e) interpretation or meaning of the data was extracted.

The first section below presents the data based on the relevance and cultural competence of the existing health education materials. The key analytic question here was whether or not the content provided in

the health education materials was considered practical and culturally appropriate with respect to the everyday lives of these immigrant families. The second section presents research findings regarding current access to existing health materials. The key questions here were whether these materials were sufficiently clear and easy to read and understand, and what were—or would be—the most effective ways for the parents to access such information.

Results

Relevance and Cultural Competency of Existing Health Education Materials

Parents as role models. Some study participants were clearly aware that, as parents, they are role models for their children and that their attitudes and behaviors influence their children's mental and physical development. Others became more aware of their role after reading the health materials:

Karuppamma: That is right. I feel that adults play a crucial role in the physical activity of children. If adults after dinner sit in front of the TV, kids would sit in front of the TV as well. If you go out for exercises, they would follow you.

Xiu Mei: I can relate on that point. Sometimes I feel lazy and would stay in bed and read rather than going out. Now after this [reading and discussing tips for parents], probably, when I am in bed again, I would think about going out.

Still, the mothers reported feeling insecure, as they had lost their parental role and family status after coming to Canada. After immigrating, most of the mothers had to go back to school to learn how to read and write in English. Like their children, they were students learning a new language. After coming to Canada, the majority of Chinese mothers had to find new jobs, often in an underemployed position that was less rewarding for them both economically and emotionally. It seems that there was a reversal in parent-child roles, where mothers were learning the new social and cultural roles through their children. Past cultural and well-being knowledge was also constantly being reconsidered and reevaluated because the mothers were not always sure what was correct or good practice in their new country. Both Chinese and Tamil mothers reported that they started to feel dissatisfied with their bodies:

Sudhanthira: We worried about [physical appearance] here. Back home, we looked the same generation after generation. When we see other people from different races, we are changing a little bit. Change a little, according to the situation, because people seem to be looking at us differently.

Kayalvizhi: Women won't go [to the gym], because we're shy. It's not in our culture . . . naturally we're shy; even for this study, many were shy to come. I think that's why our [Tamil] society is falling behind in many aspects.

Meiyang Mei: We have this feeling to lose weight. Back home, we eat rice like three times [a day]; we're trying to decrease it here.

Common practices, such as being active or playing with their children in public places, were described as more difficult for immigrant mothers after immigration than prior to immigration. Some of them felt shy about playing in outdoor places, such as parks, because of cultural and racial differences. Some mothers, after moving to Canada, started to become more concerned with their physical appearance. Immigrant mothers seemed to be more vulnerable to body dissatisfaction than they had been previously. Moreover, they described feeling powerless in their new society and, as a result, faced more difficulties when required to be a positive healthy role model for their children.

Providing children with a positive and supportive environment. Offering their children a better life—the chance to live in a country without war or a restrictive political regime, and to have a chance at a better education—was one of the major reasons these families chose to leave their native countries and move to Canada. All mothers acknowledged the importance and effectiveness of the health information provided to them in terms of providing their children with a better life. However, they reported several challenges in actually applying this health information.

Collectively, immigrant families have to go through many changes during the resettlement process. These changes include learning a new language, changes in work and employment status, diminished housing conditions, different dress, and changes to essential everyday life practices (including eating habits), to name but a few. For Chinese mothers, Canada represents a land where human rights are respected and protected. For Tamil mothers, this new country is a land without civil war. In the following representative quotes,

Tamil mothers talk about the loss of family members because of the ongoing civil war in Sri Lanka, and about their reasons for immigrating:

Sudhanthira: Back home, they [children] only heard bomb sounds and they prayed and asked, “Are we going to die?”

Ambigeswari: In the Jaffna hospital—that's where [we] took my brother at the same time they shot him—it was the time they shot the doctor, [name of the doctor].

Sudhanthira: Yes. Anytime shooting my country.

Karuppamma: My mom died from the Indian army bombshell.

Sudhanthira: When the army comes, we all run and hide. That's the time when the kids get scared. My husband was here [in Canada] and my son would say, “Mom, I may die without seeing Dad.”

Ambigeswari: Kids have made their lives safe here.

Sudhanthira: Really, why we came to Canada is for our safety, otherwise [in] our country, we're always happy. We don't have to work like here and struggle. There, it's a government job with good salary. Here, it's not like that—we have to work hard. Both of us have to work day and night. We wanted to save the lives of our kids and get a good future for them.

As one of the participants in the Mainland Chinese group mentioned, the first year in Canada was the start of a new life, from “scratch”:

Li Wang: To start with, I felt that my language was not good enough. The life environment has changed. I had to start from scratch again. In China, life was really comfortable. I had everything that I wanted. After coming here, all of a sudden, I have lost everything that I had. Also, I knew nobody here. I had to start from scratch for everything. My son said, “Mom, would we ever have a house as good as the one we had in China?” I said this was only for now. Over time, things would change.

Before coming to their new country, all of these immigrant families owned houses, usually with a garden. In Canada, the families were most often renting a one- or two-bedroom apartment. For this reason, they could not maintain their accustomed amount of house space, and other changes took place. For example, television was often more accessible to children:

Karuppamma: In most Tamil houses [in Canada], there's a television in front of the dining table. . . . They eat while watching TV. . . . Back home, there was a separate hall for eating. But here, the living room and kitchen is in the same area, so most of the time the kids watch TV and eat.

Sudhanthira: Yes, we're not supposed to do that [watching TV and eating at the same time]. First of all, we won't know how much we're eating.

Wang: If the children don't socialize, they would sit there watching TV. My son walks and jumps inside the house. But if you have a small house, the space, the room for him to exercise is limited. What I am saying is that it depends on the condition of your family.

The characteristics of the neighborhoods in which the families settled also played an important role in whether children were able to play outside and be active:

Wang: I think it depends. If you live in a neighborhood with adults only, they would not have playmates and they would have less exercise. That is my case. If you live in a neighborhood with children who like to play with you, that is different. Say for example, in my son's case, if the children across the street do not call on him, he would stay at home for the whole day. He would walk from my room to his room. I like exercise, but it is hard to do that.

One of the major challenges that parents faced was time. All participants highlighted that after coming to North America, they did not have enough time to maintain their usual healthy habits, practices, and social activities:

Agira: That's wrong, it's not in our ways of life to be like that [watching television during meals].

Ambigeswari: But back home, to make them eat, you show them the moon and the sun and try to make them eat by distracting them.

Tao: At least once a day, everyone in the family should get together—it's good for the kids, it's good for the couple. In some families [in North America], they see their father Monday and later see him Friday night. At my house, my kids stay up Friday night because they didn't get a chance to see him during the week.

Neither Tamil nor Mainland Chinese mothers felt they had sufficient time to play with, talk to, and look

after their children. The traditional custom of eating together was lost, because of the lack of time or different work schedules. They also had less time to interact with their extended family and friends:

Agira: Of course it is hard to do here. We have to finish our work and then take our kids out, but there we will take care of our work and the kids will go out, play, and come in when they are done. Here, we have to go after work or bring them in for chores; even if they say no, we drag them away saying that we can come only after work is done. Every day this is a problem.

Akkam: There is always happy [at home]. Here you can't even talk [to someone] when you want to. Even on the phone, they have no time. So instead, all you can do is watch a movie or get ready and go somewhere with the kids. That is the life. Sometimes, at a party or event, we will meet, but even that has a [takes] time. People are always saying that they need to go here, do that, finish it in this time, they say. That seems like a great difficulty.

Tao: There, no matter how much we work, beside us is family, so if we have a desire to talk or discuss, people have time in the evenings, but here it is not like that. Here, after work, to talk to your family about an issue, you have to see if they are free or if they even have time to talk.

Mothers were concerned about the fathers' frequent absence from the home because of long work schedules, and its impact on their family life:

Zhang: I think for my daughter, the quality [of free time] is better [here] than China. But for my husband and I, I feel in China was better than here. Because my husband [is] always busy. . . . He doesn't spend much time with me and my daughter.

Karuppamma: Back home, we had something like a little store or something, but we were [still] well off. . . . Here, he [husband] is dishwashing and cooking; there is a lot of labor to do here. So for that, back home he was a nice person, friendly, but here, because of that he is always angry, but he's a nice person. Even if the kids make noise, he gets angry quickly. This life has changed their mood. The kids don't know, they think, "Why is Dad getting angry all the time?" I know how he was before, and how much hard labor he is doing now.

Providing children with a positive and supportive environment in which it is easier for them to make healthy choices is an important element for healthy living, and was something the immigrant parents

recognized; however, it was difficult for them to put this knowledge into practice in their new everyday lives. The immigrant mothers described negative changes in their families' physical environment (e.g., housing conditions, neighborhood safety issues, access to a variety of fresh food choices) as well as their social environment (e.g., loss of contact with family members such as grandparents and friends). The positive atmosphere during meals was replaced by television watching and, moreover, the father seemed to have become more absent from daily family life.

Development of a sense of identity and self-confidence in children. Some parents were well aware of the importance of helping their children develop self-confidence and a belief in their abilities that is not dependent on physical appearance. In particular, within the Tamil culture, the idea of beauty is associated with the individual's personality and not with physical appearance. Two Tamil mothers described the ideal body shape for girls as follows:

Akkam: The bottom is wide, the top is wide, and the middle is thin, like a stem; moreover, back home, there is emphasis on big hips.

Kayalvizhi: You know what? Back home, we don't look at beauty alone, we look at how she gets along with others. That's beauty back home.

Parents were concerned about their children being excluded, or being identified as different in their new society. As a result, parents often pushed the children to engage in and adopt Western ways of life, including norms regarding physical appearance. In the process of trying to fit in, newcomer families were giving up part of their cultural identity and adopting a more Westernized way of life and image. As one mother, Karupamma, mentioned,

One day I told him that the pants he wears is like the way they wear it back home—"Why don't you dress more like other people here? Dress like your friends." . . . He says "Why, Mom, do you want me to dress like them, so does that mean you like them more? I don't like to dress like that." And that day I went to his school, and all the kids were saying how they liked what he was wearing and he said, "See, Mom, everyone likes what I'm wearing except you. My friend is wearing his shirt with no sleeves, I don't like that, I want to dress my own way." Since that day on, I let my kids dress the way they please.

All the mothers who attended the focus groups struggled to strike a balance between raising their

children based on traditional values, norms, and practices to help them find a sense of cultural identity, and learning and practicing Western customs so their children would fit in and be fully part of life in the new country. The preceding quotation is an excellent illustration of the importance of parents playing a supportive role in children's identity, self-esteem, and body image. There is a gap between what parents know is important for their children (for example, looking beyond the physical appearance to find beauty in a person), and what their actual practices, attitudes, and words impart to their children. For some immigrant parents, seeing their children fully express Western customs is often more important than seeing them maintain the traditional customs that might stigmatize them or target them as being different within the new society.

Accessibility of Health Education Materials

Study participants were pleased with the materials provided to them, and found them relevant in helping learn more about their new environment and health practices. Also, they felt that reading and discussing the information was useful in reflecting on their roles and attitudes:

Xiu Mei: After reading this, I understand that when it comes to our lives here, we spend less time with the kids. Even if they want to go out and play, we tell them that we'll go next time, and we put it off. I think we shouldn't do that and we should avoid that behavior.

Ambigeswari: We learned a lot of this information when we were young, but the food here is different, so it was useful. It says to use many of our vegetables and everything else is useful.

However, they were concerned that all materials available to the general public were only available in English. They found that the content was simple and easy to understand, but they pointed out that not all immigrant parents are comfortable reading English. This in and of itself can be a major barrier to parents accessing health information. It is therefore important to ensure this information is available in different languages so it is readily accessible to members of Canada's ethno-cultural communities, particularly to newcomer immigrant and refugee families:

Xiu Mei: If you have it in Chinese, more people would understand them. As for me, I studied this [meaning], I would be able to read it. To [friend], she would not be able to understand all.

Wang: Yesterday, I went to the Mandarin Center. Actually, I rarely go there. I saw people who have been here for 3 months, half a year, or a year. Their English is terrible. So I feel that if you want to use it for the Chinese community, you need it to be translated to Chinese.

Participants also indicated that the materials should be clear and short—one page in length. More detailed information longer than a page could then be compiled in a booklet format geared toward helping parents who want or need to know more about the topic. Parents appreciated the fact that the information was practical and easy to follow, in a step-by-step format:

Kayalvizhi: No, [it was] a little [long], but we were interested in it, so we wanted to read it. For just general information, for general people, this [the participant indicated the tips for parents from *The Student Body* (McVey et al., 2009)—a 1-page pamphlet] is okay. But [for] someone who wants more info . . . someone who's more interested this [the participant indicated *Canada's Physical Activity Guide to Healthy Active Living* and *Canada's Physical Activity Guide for Children* (Public Health Agency of Canada, 2002) booklet] is good.

Chu Hua: I said that the cover page, the first impression that it gave to people is active. As well, in terms of the content, it has graphics. As well . . . I have not read everything, but the first section on “build as you go,” I feel that it is good . . . it says how to “build up physical activity through at least 5 to 10 months.” It shows you what to do in the 1st month, what to do in the 2nd month, and the 3rd month. I think it is really good, step by step.

The women from the Tamil group especially enjoyed discussing these materials and topics. They indicated that they found the discussion very helpful because they were able to hear the other parents' points of view and critical thoughts on the content. They liked the fact that they were able to add new information and healthy tips to the material developed by the Minister of Health Canada through their discussions, and thereby contribute to research aimed at developing materials that were more appropriate and relevant to their life experiences. They also pointed to contributions to healthy eating made by immigrant ethno-cultural communities. Looking at the image of *Canada's Food Guide* (Minister of Health Canada, 2007) one mother added:

Now our stringhoppers [Sri Lankan breads], when you look at outside food, it is very cheap. When you

only buy fast food, it becomes expensive. There are Chinese people and others studying here and when they go to our restaurants to buy it is something that is cheap—base [price]—that they can buy. It is just enough, and digests easily. So you can add that, from our culture.

During the focus group sessions, participants were asked if they preferred any particular formats, such as booklets, flyers, videos, or online materials, or had any other ideas regarding the dissemination of health promotion materials that would help to ensure the accessibility of the study results, for them as well as for other immigrant parents. They identified workshops at community centers as being one of the best ways to reach parents and as an effective way to disseminate such information. These community associations and centers are an important resource for parents and especially for newcomers. They felt that health-promotion activities and workshops held in this environment could have high levels of parental response and participation:

Ambigeswari: For our society, discussion groups like these are useful. After going to one, then you could watch a video, and you will understand it better.

Sudhanthira: Yes, discussion groups are better.

Ambigeswari: When you are learning informative stuff, first you have to go to a discussion group to understand what it is saying, then you could watch [a] video, and understand it easily.

Sudhanthira: I don't think you should have limitations as to how old the kids are; you should invite everyone to the discussion group. It would be better if you do it as common to everyone. It would pass on to other generations, and everyone could learn about it.

Ambigeswari: We really don't watch things on this topic on TV [and video], but now, after we have knowledge, we're more aware of it.

Sudhanthira: We understand it better.

Kayalvizhi: When you understand something, you are more interested when watching it.

Parents in the Tamil study group pointed out that it was particularly easy for them to take part in the focus group interviews because they were held at their ESL school. Given that they were already in the building, all they had to do was change classrooms and assemble for the focus group sessions. For this same reason, it was also easy for them to take nutritional courses offered by public health nurses that were

held at their school, scheduled to follow their ESL classes. Equally important to participation was the fact that their ESL school provides child care, which is a critically important support for them, allowing them to take courses without worrying about their children. These kinds of support networks would play an equally important role in any intervention outreach initiative centered on the promotion of healthy eating, physical activity, and healthy body image.

It was particularly interesting to note that in this setting, lessons learned were also more readily transferable to nonparticipants. Focus group participants reported that at the end of the first focus group session they shared their learning experience with ESL classmates who were also parents. Subsequently, those classmates wanted to take part in the discussion. As one Tamil mother reported,

I tell them, this is how we talk, and they wanted to know if they could come stand and watch. I said, “No, it will not be right.” They wanted to sit beside us and hear what we had to say. I said, “Go home, this won’t work—I will tell you tomorrow.”

Finally, parents were also asked about the best ways to share the new information collected from other parents and from within the community at large. As mentioned, based on their current experience, they felt that small group discussions followed by distribution of supportive educational materials (e.g., online materials, booklets, videos) might be the most effective way to help immigrant parents. It is interesting to note the explicit reference to the inclusion of individuals from all age groups in the proposed discussion groups, a suggestion perhaps more in tune with the communities’ cultural norms and practices. At the same time, peer groups—such as the study focus group sessions themselves—were also identified as an effective mechanism for helping parents obtain new information and for reviewing and discussing it with others to generate critical thinking and find appropriate courses of action.

Discussion

This study was focused on the question of whether health care professionals and public health agencies are using the right strategies in involving ethnocultural parents in eating disorder and weight-related prevention interventions. Through the study we also explored ways in which newcomer immigrant

parents would prefer to access health education materials. The qualitative nature of this exploratory, community-based study enabled us to answer these questions beyond a simple “yes” or “no.” The use of a qualitative methodology provided a powerful means of suggesting new approaches, directions, and strategies that can be implemented to better support and involve new immigrant mothers in eating disorder prevention programs. In summary, immigrant mothers who participated in the study expressed their preferences for health education materials and prevention interventions undertaken in a culturally relevant, culturally competent, knowledge-sharing, participatory manner that is likely to be more effective in meeting the particular requirements of ethnocultural immigrant communities.

Immigrant mothers stated that the health information provided to them was only partially relevant to their experiences, especially given their unfamiliarity with their new environment. In particular, they had to face major and unique challenges in (a) being a positive role model for their children, (b) providing the children with a more supportive environment in which they could make healthy choices, and (c) helping their children develop self-confidence and self-esteem that focuses less on physical appearance.

The influence of urbanization, modernization, and acculturation processes as possible risk factors for body dissatisfaction and eating disorders is documented in the literature (Piran & Cormier, 2005). For example, the introduction of Western television in a rural community in Fiji has been correlated with increases in body dissatisfaction among Fijian girls (Becker, Fay, Gilman, & Striegel-Moore, 2007). As mentioned, after migration, immigrant mothers had to redefine themselves and their status within the family and larger society. Furthermore, they began to feel dissatisfied with their own body shape and, as a result, some of them started dieting or restricting their normal eating habits to control or change their body shape. These are specific and unique challenges faced by immigrant mothers after migration that have not yet been addressed within current prevention interventions. The content of the present health materials should be updated to include more relevant information pertaining to the lives of newcomer families. It should also include culturally competent information that meets the needs of immigrants from different ethnic communities.

Several areas warrant future exploration and integration into weight-related educational materials and

interventions. First, to become more culturally useful and relevant to newcomers' experiences, health education materials and strategies should consider the specific barriers that immigrant families encounter, including lack of social support, changes in physical environment (e.g., conditions within the home and neighborhood safety), time constraints, and parental stress. Second, there is a need for greater exploration of the impact of mothers' redefined social status and family roles, changes in mothers' body image identity, increases in mothers' body dissatisfaction, and discrimination vs. social integration for both parents and children.

The study results show that to have adequate access to health information, parents should be able to read those materials in the language they can best understand. Participants from both the Tamil and Mainland Chinese communities thus proposed a translation of those materials into their respective language so the content would be accessible and comprehensible. Short, easy-to-read pamphlets are essential to helping parents from various ethnic communities obtain health information. Additionally, support measures such as access to transportation, availability of free child care, and a convenient place and time for meeting can enhance parents' participation in health activities. Finally, although the mothers found reading the information to be useful, they felt that discussing the information with their peers would be a more effective means of learning and increasing their awareness. As such, alternative and/or different settings for meetings should be used. We recognize that these recommendations might also be relevant to the lives of nonimmigrant parents. However, the possible barriers that nonimmigrant parents encounter (e.g., lack of time) are interrelated with the specific ones that immigrant parents encounter (including lack of social support, unsatisfactory housing conditions and neighborhood safety, parental stress, changes in mothers' body image identity, and increases in mothers' body dissatisfaction).

The study findings also suggest that moving from a more institutionalized, traditional setting (e.g., school, health center) to a community setting (e.g., community agencies, ethno-cultural centers) might be one of the key strategies needed to involve and engage immigrant parents in prevention interventions. As mentioned, many of the existing healthy eating, active living, and positive body image health promotion initiatives are targeted at the school level. However, involving parents through school activities

is often difficult, if not impossible, in many cases (Griffith, 1998; Hahn et al., 1996). Ethno-cultural community centers were identified as the key place to hold events, workshops, and other activities that can help to support culturally distinct newcomer immigrant parents and their families in comparison to other settings (e.g., schools, hospitals, health centers). Ethno-community centers are places where there is an equal distribution of power and where ethno-cultural values, knowledge, and practices are acknowledged and taken into consideration. Immigrant mothers identified community centers as an ideal setting in which parents can share their knowledge and experiences, consult with each other, and implement health promotion interventions.

Moreover, the mothers identified discussion groups as being the most effective knowledge-sharing tool that would enable individuals to increase their knowledge and awareness of their health-related attitudes and behaviors. Mothers expressed their preference for participating in activities in which information is not presented through a lecture format (i.e., a top-down approach), but instead empowers them to share their knowledge, experiences, and concerns, and to learn from each other's practices. Discussion sessions, as well as peer group networks, are both characterized by a "bottom-up" type of intervention that is capable of readily empowering people to increase their knowledge base and help change their attitudes and behaviors. Results revealed that eating disorder prevention initiatives that target immigrant parents should change from a top-down, unidirectional method of knowledge transfer (e.g., flyers, brochures) to a bottom-up, multi-directional way of knowledge exchange (e.g., workshops based on dialogue and participation). Immigrant mothers would be more willing to participate in the activities if they felt that their knowledge and experiences would be taken into account and, consequently, the final outcomes of the prevention intervention would result in more culturally appropriate, equal knowledge sharing and implementation.

Some of the proposed recommendations are also supported by research implemented with nonimmigrant parents. Indeed, few successful eating-disorder and weight-related prevention programs have achieved a positive response from parents (Haines et al., 2006; O'Dea & Abraham, 2000), empowered parents to participate in interventions, created a nonjudgmental environment, or shown how parents' opinions and participation are important for program success. Some school programs addressing weight-related

problems have been developed in conjunction with parents' groups (Haines et al., 2006; O'Dea & Abraham, 2000; Smolak et al., 1998a, 1998b). From these studies, we know that activities led by students, such as student performances or live theater, receive a higher response than parents' nights or meetings that target parents only (Haines et al., 2006; McVey et al., 2007). Clearly, parents are proud to see their children perform, which likely motivates them to attend these types of events. At the same time, they are also more open, comfortable, and happy to see their kids performing than if they were attending a lecture by an "expert." It might be that giving students the space and power to disseminate healthy messages themselves might have a more positive response than if teachers or an expert do so.

Before entering into a discussion of the limitations and future directions of this study, it is important to reflect on the similarities and differences between the two ethno-cultural communities groups involved. As mentioned, an attempt was made to maximize cultural contrasts by selecting two very different immigrant ethno-cultural population groups, such as Chinese and Tamil cultures, to receive the maximum range of information possible. The themes presented in the data analysis and discussion sections largely describe similarities, while saying little about the differences between the two ethno-cultural groups. Each newcomer family had a unique story and experience. As such, differences were more present at the micro than macro level of analysis. In contrast, if we consider the overall immigrant experience, we find more similarities than differences. It is not surprising that immigrant mothers who participated in the study highlighted the same concerns and similar life experiences, given that we asked them to reflect on the transnational migration experience and acculturation process. Indeed, all of the families we spoke with were leaving behind their homeland life (which was based on specific sets of values, norms, and social structures) to learn and live in a new country and culture, with its own sets of values, norms, and social structures.

Some of the differences between the two groups, however, were linked with the time already spent in Canada. For example, Chinese mothers, who had immigrated earlier than the Tamil mothers, had established better social support systems, including securing employment and more economic stability, for some. In contrast, the Tamil mothers, who were more recent immigrants (having spent between 1 and 2 years in Canada), were still in the process of learning the language, developing a new social support system,

and were more economically unstable. Another difference stemmed from the relative sizes of the ethno-cultural communities in the territory; in this case, Chinese mothers could have access to more culture-specific food, shops, and activities organized by community centers than the Tamil mothers because the Chinese community is an older and more established ethno-community in the GTA. The differences between these two ethno-cultural groups should be further explored through more in-depth studies.

Limitations

The limitations of this work must be acknowledged. The exploratory, qualitative nature of this study does not allow the study results to be generalized beyond the participants. In a positivist quantitative paradigm this is considered to be a limitation. We also recognize that information was collected using small sampling and through a single method of data collection (i.e., focus groups). Qualitative research is highly contextualized and does not aim to achieve the criterion of generalizability. In contrast, study results are true in a specific place and time. Also, as mentioned, the fact that some of the participants already knew each other might have influenced participant responses. However, both the researchers and community coordinators believe that this was more helpful to the generation of participant data than harmful to it. Furthermore, all participants were fully aware that participant confidentiality during focus groups could be maintained only if each participant refrained from sharing the content of the discussion with others.

Conclusions

More ethno-community groups should be involved in future studies, to identify similarities and differences across different population groups. Immigrant parents who have been living in Canada for more than 5 years, as well as immigrant fathers, immigrant children, and mainstream parents, should be invited to share their opinions, experiences, and knowledge. Furthermore, based on the study results, similarities and differences between immigrant families and nonimmigrant families in accessing and using health education materials should be investigated. A wider variety of research methodologies might be implemented to explore in greater detail newly identified

areas or generated themes (such as change of the mother's status, role, and body image, and the father's role and his absence from the family life), and to establish generalizability of the study results (e.g., using in-depth interviews, surveys).

In conclusion, involving immigrant parents in eating disorder and weight-related problem prevention initiatives is a new area, which deserves additional exploration. It is our hope that in the future, parents from different ethno-cultural backgrounds will not be the missing participants in our prevention interventions, but rather, be directly involved in the development, implementation, and evaluation of those very interventions. This study is a first step in raising professionals' and public health agencies' awareness about the need to consider the cultural competence of current health strategies and materials, as well as generating possible new directions for further study.

Appendix 1 Focus Group Questions

What was your first impression of these materials in relation to:

the language?
the content?
the format?
the design?

Do you think these materials are relevant to you (and your family life)?

What is the one thing you like best about these materials?
What is the one thing you like the least?

Are there any parts of this material that seemed inappropriate?

Are there any parts of this material that seemed unclear?

Did you learn anything new from reading this material, from either the hard copy or online versions?

Which format (online or hard copy) did you like most or find most helpful?

Based on our past discussions, are there any changes you would suggest?

Notes

1. According to Statistics Canada (2004), the majority of newcomers (68%) were born in Asia. Another 15% are from Europe, 9% from Africa, and 6% from Central and South America and the Caribbean. The People's Republic of China is the leading country of birth, contributing 32,300 new immigrants to Canada. This was followed by India (25,800), the Philippines (11,300), and Pakistan (8,400). The 2006 Census (Statistics Canada, 2008)

shows that South Asians became Canada's largest visible minority group in 2006, surpassing Chinese for the first time. The populations of both were well more than 1 million.

2. *Canada's Food Guide to Healthy Eating* (Minister of Health Canada, 2007) and *Canada's Physical Activity Guide to Healthy Active Living* are government health education materials developed by the Public Health Agency of Canada (2002). These government-produced documents are distributed fairly widely across settings (schools, public health, physician offices), and their content is considered the status quo in terms of advice on healthy eating and physical activity. Printed materials are available at <http://www.hc-sc.gc.ca/fn-an/food-guide-aliment/index-eng.php> and <http://www.phac-aspc.gc.ca/pau-uap/fitness/downloads.html>

3. *The Student Body: Promoting Health at Any Size* (McVey et al., 2009), an online research tool for teachers, public health practitioners, and parents, aims to promote healthy body image and self-esteem in elementary school students by way of sensitizing teachers to more optimal teaching practices. The Web-based training has been evaluated using a randomized control trial with Canadian teachers and public health practitioners (McVey et al., 2009). It was found to be effective in increasing knowledge among teachers and self-efficacy to fight weight bias among public health practitioners. In addition to the hardcopy materials, further references to online educational information on the three topics discussed in the focus groups were given (see <http://research.aboutkidshealth.ca/thestudentbody/home.asp>). Printed materials are available at http://research.aboutkidshealth.ca/thestudentbody/resources/parent_handout_healthy_eating.pdf, http://research.aboutkidshealth.ca/thestudentbody/resources/parent_handout_active_living.pdf, and http://research.aboutkidshealth.ca/thestudentbody/resources/parent_handout_media.pdf

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Manuela Ferrari, MHS, is a doctoral student at the Dalla Lana School of Public Health, University of Toronto, and a graduate student, Community Health Systems Resource Group, Hospital for Sick Children, in Toronto, Ontario, Canada.

Stacey Tweed, MA, is a research analyst, Community Health Systems Resource Group, Hospital for Sick Children, and a doctoral student in clinical psychology, York University, Toronto, Ontario, Canada.

Joanna Anneke Rummens, PhD, is the director of CERIS—The Ontario Metropolis Centre for research on immigration and settlement; an assistant professor, psychiatry, on the Faculty of Medicine, University of Toronto; a health systems research scientist, Community Health Systems Resource Group; and a project investigator, Child Health Evaluative Sciences, at the Hospital for Sick Children, Toronto, Ontario, Canada.

Harvey A. Skinner, PhD, CPsych, FCAHS, is the dean of the Faculty of Health, York University, Toronto, Ontario, Canada.

Gail McVey, PhD, CPsych, is a health systems research scientist, Community Health Systems Resource Group, Hospital for Sick Children, and an assistant professor at the Dalla Lana School of Public Health, University of Toronto, Ontario, Canada.

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