Uncharted Paths: The Use of Traditional, Complementary and Alternative Medicine (TCAM) among Sub-Saharan Africans living in the Greater Toronto Area (GTA)

by

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Abstract

The appeal of traditional, complementary, and alternative medicine (TACM) is growing among persons living in developed countries. Personal beliefs and traditional values about health and healthcare are deemed significant motivations for the use of TCAM. While existing studies have focused on diverse population groups, including persons of European and Asian descent, TCAM use and behaviour among persons of sub-Saharan African (SSA) descent living in Canada and other developed countries remains unknown. Existing studies on TCAM and healthcare-seeking behaviour of racial or ethnic minorities suggests possible alienation due to sociocultural health beliefs and practices. These studies fail to investigate the role of context in the identity construction and sociocultural belonging and how this ultimately affects the choice of healing practices. Anthias’ (2002, 2008, 2012a) asserts that immigrants and their descendants have complex relationships with different locales – country of residence (or naturalised countries) and country of origin. This complex relationship entails social, cultural, symbolic and material ties between homelands and destinations. This research seeks to examine TCAM use among persons of SSA origin living in the GTA and to understand how ethnocultural identity informs the use of TCAM remedies using Anthias’ translocational positionality as a theoretical framework.

The study uses a sequential mixed-method approach to garner data on sociodemographic characteristics, transnational relationships, health status and health care-seeking behaviours of persons of SSA origin living in the Greater Toronto Area. Lifetime prevalence of TCAM use among respondents of SSA descent is ~57.14% and 12-month prevalence of TCAM use is ~23.81%. About 48.72% of the respondents indicated the TCAM used are of their ethnocultural
origin. A sizeable proportion of respondents had unmet TCAM need (~20.88%) and engaged in transnational healthcare-seeking behaviour or medical return (~39.56%).

The findings of the interview show the meaning associated with ethnocultural identity and the broader contextual factors that influence the utilisation of ethnocultural identity in health promotion or healthcare-seeking. The findings of the interviews challenge the alienation assumption and show the ability of participants to transcend and transition between ethnocultural identities in different contexts.
Dedication

For my parents (Sarah Acquaye, Mr. Samuel Baidoo and Mr. Roland Amegbor) for their innumerable support in all endeavours of my life, including my academic journey. I also dedicate this thesis to the loving memory of my maternal grandfather (Opanyin Kobina Kwei) for being my inspiration in life and the faith he had in me.
Acknowledgements

I wish to express my sincere gratitude to the respondents and interviewees of this research for their time and interest in participating in this study. This thesis would not be possible without your willingness to share your experiences and motivations with me. I would also like to thank the leaders and members of the various community-based groups and organisations I contacted during my research: the Nigerian Canadian Association, Igbo union, Yoruba union, Sierra Leonean Canadian Federation, Ghanaian-Canadian Association of Ontario, Seneca Village Community Centre, Scarborough Centre for Healthy Communities, Senior Adult Services.

My profound appreciation to my supervisor and mentor, Professor Mark Warren Rosenberg, for his continuous support of my Ph.D. study and related research. His guidance helped me in all the time of research and writing of this thesis. I could not have imagined having a better advisor and mentor for my Ph.D. study. I would also like to thank the rest of my thesis committee members: Professor Audrey Kobayashi, Professor Heather Castleden and Professor Beverly Mulling (the committee Chair) for their support and encouragement. Their doors were always open to me whenever I ran into difficulties and needed guidance. My sincere thanks also go to Professor Joyce Davidson for her for the role she played in my coming to Queen’s University; her interest and support together with that of my supervisor (Prof. Mark W. Rosenberg) made me apply to the Queen’s PhD program. Although I never had the opportunity to meet and interact with you, I want you to know I will forever remain grateful. I would also use this opportunity to thank Professor (Emeritus) Jan Hesselberg (University of Oslo) and Prof. Alex B. Asiedu (University of Ghana) for the role and support they gave in my academic journey. My journey as a doctoral student was memorable due to the help of the staff in the Department of Geography and
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<table>
<thead>
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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>CAM</td>
<td>Complementary and Alternative Medicine</td>
</tr>
<tr>
<td>GCAO</td>
<td>Ghanaian Canadian Association of Ontario</td>
</tr>
<tr>
<td>GTA</td>
<td>Greater Toronto Area</td>
</tr>
<tr>
<td>NCA</td>
<td>Nigerian Canadian Association</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
</tr>
<tr>
<td>RDS</td>
<td>Respondent-Driven Sampling</td>
</tr>
<tr>
<td>SSA</td>
<td>Sub-Saharan Africa/Sub-Saharan African</td>
</tr>
<tr>
<td>TCAM</td>
<td>Traditional, Complementary, and Alternative Medicine</td>
</tr>
<tr>
<td>TM</td>
<td>Traditional Medicine</td>
</tr>
<tr>
<td>U.K.</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>USA</td>
<td>United States of America</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
<tr>
<td>WW2</td>
<td>Second World War/World War Two</td>
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Chapter 1

Introduction

1.1 Background

The global health care arena in the past three decades has been transformed by the growth in the use of traditional, complementary and alternative medicine (TCAM) in both developed and developing countries. The increase in public interest in the use of TCAM is particularly high in Western societies where conventional biomedicine has dominated the health care landscape (Bishop & Lewith, 2010; Bishop, Yardley, & Lewith, 2010; Bodeker & Kronenberg, 2002; Boon, 2002). TCAM has become a critical component of health care systems of many developed countries, including Canada, Australia, the United Kingdom, and the United States (Andrews & Boon, 2005; Eardley et al., 2012; Hunt et al., 2010; McLaughlin, Lui, & Adams, 2012).

Whereas there are many definitions and conceptions of TCAM, the term is often used in reference to medical and health practices that have different traditions, practices, and bodies of knowledge from conventional biomedicine (Adams et al., 2011; Bodeker, Kronenberg, & Burford, 2007; Reid, Steel, Wardle, Trubody, & Adams, 2016). Thus, TCAM encapsulates both indigenous health traditions of the world (for example, Ayurveda and traditional Chinese Medicine), as well as, contemporary alternative forms of health care such as chiropractic, aromatherapy, and naturopathy. A distinct feature of these alternative forms of health care is their psychosocial paradigm of health and wellbeing (Anyinam, 1990; Bignante, 2015; Bodeker et al., 2007; Cassidy, 2006). A fundamental concept and a commonality that exists in the different forms of TCAM is the interconnectedness of the body, the mind, and the environment,
which ultimately determines one’s state of health (Andrews, Evans, & McAlister, 2013; Bodeker et al., 2007; Spencer, 1999; Synovitz & Larson, 2013). TCAM treatments are thus designed to restore a systemic balance to the patient and not only tackle the physical manifestation of ill health (Andrews, Evans, & McAlister, 2013; Bodeker et al., 2007; Cassidy, 2006).

Studies in Canada show that more than half of the country’s population use TCAM remedies in their lifetime (Esmail, 2017; Meyer, 2012) while a 12-month prevalence of TCAM is between 12% to 20% (Andrews & Boon, 2005; Williams, Kitchen, & Eby, 2011). Some studies assert the growth in the use of TCAM in Canada and other western industrialized countries is as a result of an increase in a diverse ethnocultural population, especially in urban areas (Coulter & Willis, 2007; Li, Verhoef, Best, Otley, & Hilsden, 2005; D Su, Li, & Pagán, 2008). There are structural barriers associated with seeking biomedical care and differences in sociocultural health beliefs and practices drive persons of racial or ethnic minority background to seek TCAM (Bodeker et al., 2007; Cassidy, 2006; de Medeiros et al., 2016; Synovitz & Larson, 2013). Others argue the rise is the result of increased migration of people from the global south, who transmit established healing practices from their “homeland” (or countries of origin) to their new homes (host or destination countries) (Coulter & Willis, 2004). Another group of researchers argue increased information and knowledge on alternative forms of healing, as well as exposure to different beliefs (and practices) about health and healthcare, has led to the emergence of ‘smart consumers’ – well-informed people or patients who possess the knowledge to seek care or treatment options that improves their health and wellbeing (Bauer & Rayner, 2012; Wiles & Rosenberg, 2001). Whatever the reason may be, we cannot ignore the relationship between international migration and the growth of TCAM in developed countries. Consequently, developed countries with high
proportions of immigrant populations, such as Canada, the United States, the United Kingdom, Germany, and Australia, have the highest proportion of TCAM users in the developed world (Bowe, Adams, Lui, & Sibbritt, 2015; Coulter & Willis, 2004, 2007; Esmail, 2017; Hall, Griffiths, & McKenna, 2014; Kemppainen, Kemppainen, Reippainen, Salmenniemi, & Vuolanto, 2017; Neiberg et al., 2011).

1.2 Problem rationale

There are few studies on the ethnocultural diversity of the Canadian population and its influence on the use of TCAM. The studies that do exist tend to focus on Canadians of East Asian origin such as Chinese immigrants or Canadians of Korean or Chinese origin (Lai & Chappell, 2007; Ma, 1999; Quan et al., 2008; Roth & Kobayashi, 2008). To the best of my knowledge, there is currently no study on the use of TCAM by persons of sub-Saharan African (SSA) origin and how their ethnocultural background influences the use of TCAM. Research shows that a significantly high proportion of the population in SSA relies on traditional medicine for their acute and chronic health care needs (McFarlane, 2015; Thorsen & Pouliot, 2015; World Health Organisation, 2013). There are few studies on their health care seeking behaviour with regards to TCAM in developed countries, such as Canada. While sociocultural beliefs (and practices) and structural racism have been recognized barriers to access to biomedical health care among racialised or ethnic minorities (Chalmers & Omer-Hashi, 2002; Culley, 2006; Gee & Ford, 2011; Grady & McLafferty, 2007; Madden, 2015), there is little knowledge or understanding on how these factors drive or inform TCAM use or care-seeking behaviour among persons of SSA origin living in Canada.
Recent migration figures show a continuous increase in the number of immigrants from Africa and those Canadian-born of SSA origin. Between 2006 and 2011, an estimated 145,700 immigrants arrived in Canada from Africa, representing 12.5 per cent of newcomers within that period (an increase from 10.3% in 2000 – 2005, 7.3% in 1990, and 1.9% before the 1970s) (Statistics Canada, 2013a). Given the prevalence of TCAM use in SSA, there is a need to understand the effect of structural barriers and ethnocultural identity on the use of TCAM by persons of SSA origin, as well as, general TCAM use among this group of Canadian residents. The differences in health and healthcare policies between their countries of origin and Canada means the factors that promote the use of TCAM in SSA may not be present in Canada. For instance, legal residents of Canada have access to universal biomedical healthcare which is absent in most SSA countries while TCAM remedies are readily available in SSA. Thus, this knowledge is crucial to further our understanding of whether there is a continuity in the use of indigenous African remedies by this group of people. Currently, such knowledge in the Canadian context is non-exist; and there is little knowledge in other developed world contexts as well.

Knowledge from existing studies shows that the motivations and enabling factors for the use of TCAM are multifaceted. In terms of motivations, the literature shows that adverse health conditions, biomedical care related-factors, such as lack of empathy or sensitivity, and structural barriers to biomedical care (such as insurance coverage) are major motivating factors for the use of TCAM remedies among the population in developed countries (Arthur et al., 2012; Canizares, Hogg-Johnson, Gignac, Glazier, & Badley, 2017; Edge, Newbold, & McKeary, 2014; McKeary & Newbold, 2010; Sewitch, Yaffe, Maisonuneuve, Prchal, & Ciampi, 2011). Studies in Canada show that persons with chronic health conditions, such as cancer, HIV and inflammatory
bowel disorder, have higher prevalence of TCAM use compared to the general population (Furler, Einarson, Walmsley, Millson, & Bendayan, 2003; Sewitch et al., 2011; Weizman et al., 2012). Some researchers opine that the drive to use TCAM among these patients is mainly due to the inability of biomedicine to treat these conditions (Weizman et al., 2012). Findings from other studies also show that structural barriers associated with biomedical care drive persons of immigration origin especially racialised individuals to seek an alternative form of healing (González-Vázquez, Pelcastre-Villafuerte, & Taboada, 2016; Krause, 2008). It is difficult to relate these findings to persons of SSA origin given the little or non-existent research on their TCAM health(care) seeking behaviour in developed countries.

Similarly, elusive to our understanding is the effect of socioeconomic factors on access and use of TCAM remedies given most studies focus on persons of European and Asian descents. The literature identifies health insurance coverage, gainful employment and high-income status as major enablers of access and use of TCAM remedies, especially professional-based care such as chiropractic and homeopathy (Andrews, 2003; Canizares et al., 2017; Esmail, 2017; Lafferty et al., 2006; Wolsko, Eisenberg, Davis, Ettner, & Phillips, 2003). Persons of immigrant origin, especially persons of SSA descent, face significant economic challenges upon their immigration to Canada and other developed countries. They often work in low skill jobs that pay low wages and do not provide employment-related benefits such as health insurance coverage (Lu, Kaushal, Denier, & Wang, 2017; Prus, Tfaily, & Lin, 2010a; Subedi & Rosenberg, 2016). Additionally, findings from existing studies on the population in SSA shows that affordability and accessibility are major determinants of the use of TCAM (Ae-Ngibise et al., 2010; World Health Organisation, 2013). In SSA context, traditional or indigenous medicine is easily accessible as
they are sourced from the natural environment and also affordable compared to biomedical pharmaceuticals (Pouliot, 2011; Pouliot & Treue, 2013); albeit other studies have questioned the latter claim in view of the increasing commercialization of traditional medicine in the region (Amegbor, 2017a; Thorsen & Pouliot, 2015). In contrast, TCAM is highly commercialised in western industrialised countries and often not supported by existing universal health coverage (Wiles & Rosenberg, 2001). This knowledge raises the question of potential unmet TCAM need among persons from SSA origin living in Canada given their relatively poor socioeconomic status and use of remedies from the immediate environment in their countries of origin.

1.3 Research Aims and Objectives

The broad aim of my research is to examine TCAM use among persons of SSA origin living in the Greater Toronto Area (GTA). Given existing studies suggest a sense of alienation among racialised persons or person of ethnic minority background in their access and use of biomedical care, the research also seeks to understand how ethnocultural identity informs the use of TCAM remedies. These two broader aims are the gaps in TCAM research both in Canada and in other developed countries. Specific objectives to fulfil the two goals are:

1. To examine the effect of health, care-related factors and socioeconomic status on TCAM use among persons of SSA origin living in the GTA.

2. To examine the effect of health, care-related factors and socioeconomic status on unmet TCAM use among persons of SSA origin living in the GTA.

3. To examine the effect of health, care-related factors and socioeconomic status on transnational healthcare or medical return use among persons of SSA origin living in the GTA.
4. To understand how or to what extent ethnocultural identity, ageing and context influence healthcare-seeking behaviour of different groups of persons living in the GTA.

To achieve these research objectives, a set of specific research questions were formulated for each objective. The research questions inform the analysis and discussion in the subsequent chapters of this doctoral thesis. The first and second research objectives are guided by research questions (a to f):

a) Is health status associated with the use of TCAM among persons of SSA origin living in the GTA?

b) Is the difference in the use of TCAM among persons with chronic health status and those without chronic health status statistically significant?

c) What is the nature of the relationship between biomedical care-related characteristics – as perceived by persons of SSA origin living in the GTA – and the current use of TCAM?

d) Are there statistically significant differences in perceived biomedical care-related characteristics and the use of TCAM?

e) Are socioeconomic characteristics associated with the use of TCAM use among persons of SSA origin living in the GTA?

f) Are there differences in the use of TCAM by socioeconomic status statistically significant among persons of SSA origin living in the GTA?

The third and fourth research objectives are guided by research questions g to j:

g) Are health status, biomedical care-related characteristics, and socioeconomic status of persons from SSA origin living in the GTA significantly associated with unmet TCAM need?
h) Are the differences in unmet TCAM need by health status, biomedical care-related characteristics, and socioeconomic status statistically significant?

i) Are health status, biomedical care-related characteristics, and socioeconomic status of persons from SSA origin living in the GTA significantly associated with medical return (transnational health care seeking)?

j) Are differences in medical return among persons of SSA origin living the GTA by health status, biomedical care-related characteristics, and socioeconomic status statistically significant?

The final research objective is guided by research questions k to m:

k) How do persons living in the GTA describe themselves in an everyday context?

l) In what context or situation do people employ their socio-cultural knowledge and resources in their health(care) seeking behaviour?

m) In Canada’s hetero-cultural society, does the type of TCAM use conform to ethnocultural and age identities?

1.4 Thesis outline

The rest of the thesis consists of seven chapters. The second chapter (Chapter 2) focuses on the review of existing literature on TCAM. It delves into the popularity of TCAM in Canada, and the global context then discusses the motivations for the global appeal of TCAM. The chapter also discusses the political economy of TCAM in the Canadian context, especially given the country’s universal health care coverage for biomedical or physician-based services. The chapter also explores the link between race, ethnicity, ageing and the use of TCAM. The final segment of
the chapter delves into the theoretical framework that informs this thesis and discusses the relationship between identity and health.

Chapter 3 focuses on the methodological approach of the research. It discusses the research design, the sampling technique and techniques of primary data collection. In this chapter, I also critique the methods and techniques adopted for the research. The chapter also discusses issues of research ethics, power and the researcher’s positionality, as well as, the limitations of the research methods. Chapter 4 describes the sociodemographic characteristics of the study sample. It also highlights their health status, insurance coverage, perceptions and experiences with biomedical care. Further, the chapter examines the association between respondents’ sociodemographic characteristics and their health outcome.

Chapters 5 and 6 focus on persons of SSA descent in order to address the first four objectives of the thesis. The two chapters focus on persons of SSA origin living in the GTA. Chapter 5 looks at the effect of health status, biomedical care-related factors and socioeconomic characteristics on the use of TCAM in the past 12 months before the research survey. It uses multivariate logistic regression analysis to examine this association then compares the findings to existing studies on other populations. Chapter 6 deals with objectives three and four. Similar to the previous chapter, it uses descriptive and inferential statistics to understand the unmet TCAM needs and transnational healthcare (medical return) among persons of SSA origin living in the GTA. It seeks to examine the effects of health status, biomedical care-related characteristics, transnational ties, and socioeconomic status on unmet TCAM need on one hand and medical return on the other.
Chapter 7 focuses on the last research objective. The findings and the discussion in the chapter are based on in-depth semi-structured qualitative interviews with 22 participants living in the GTA. It uses the findings from the qualitative data to understand how persons from different ethnocultural or sociocultural background construct their identities and how context shape or influences such identity construction. It also explores how sociocultural knowledge and identity are employed in the context of health and healthcare. The final chapter (Chapter 8) sums up the discussion of the findings in view of the research objectives and research questions presented in this chapter. It also offers a discussion on the contribution of the thesis to existing studies and knowledge on TCAM, as well as, to the broader literature on health and medical geography. The final part of the chapter includes suggestions or recommendations for future research in TCAM and ethnocultural identity or knowledge.
Chapter 2

Literature Review

2.1 Introduction
This chapter of the thesis delves into knowledge and research on traditional, complementary and alternative medicine (TCAM) from both Canadian and global context. The chapter review existing literature on the popularity of TCAM in developed countries, discuss the political economy of TCAM in a universal healthcare coverage environment. The chapter also discusses the relationship between ethnic or racial identity and the use of TCAM from a sociocultural perspective, and highlights the challenges associated with access and use of TCAM among ethnic minority groups in Canada and other developed countries such as the United States (US), Australia, United Kingdom (UK) and other European countries. Subsequently, the chapter discusses existing literature on ageing and the use of TCAM, focusing on themes such as a holistic approach to ageing, multimorbidity and issues of access and use of TCAM among Canadian seniors and those in other developed countries. Lastly, the chapter introduces and discusses the philosophical positions and theories that provide a guiding framework for unpacking the ethnicity and age as contextual factors that influence the use of TCAM. The section discusses critical theories of race and ethnicity in the context of healthcare-seeking behaviour and the use of TCAM in developed countries, including Canada.

2.2 Defining: Traditional, complementary and alternative medicine (TCAM)
The healthcare system or services in many contemporary societies can at best be described as pluralistic. This phenomenon describes the co-existence of different traditions, practices and modalities of complementary or competing medical systems (Amegbor, 2017b; Kiene et al.,
In Canada and other developed countries, the healthcare landscape is characterised by the existence of conventional biomedicine (or allopathic) and other alternative forms of healthcare. The term conventional biomedicine (henceforth referred to as biomedicine) as used in this chapter and other parts of the thesis refers to medical care provided by physicians and other allied health professional, such as registered nurses, physical therapists and psychologists, as well as other forms of healthcare practices widely taught in medical schools and used in hospitals (Bishop et al., 2010; Eisenberg et al., 1998; Metcalfe, Williams, McChesney, Patten, & Jetté, 2010). On the other hand, TCAM refers to a broad array of healthcare modalities that compromise indigenous knowledge of health and healthcare practices and other forms of therapies that are not based on beliefs and cultures of indigenous societies and not part of the biomedical healthcare system (Bignante, 2015; Bodeker, Kronenberg, & Burford, 2007; Cassidy, 2006; Wilson & Richmond, 2009). TCAM is generally distinguished into two categories: traditional medicine (TM) and complementary and alternative medicine (CAM) (Bodeker, Kronenberg, & Burford, 2007a; Micozzi, 2006). TM is defined as “the sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness” (World Health Organisation, 2013). CAM, on the other hand, is “a broad set of health care practices that are not part of that country’s tradition or conventional medicine and are not fully integrated into the dominant health-care system.” (World Health Organisation, 2013). In some medical contexts, certain aspects of indigenous healing practices have been adopted and incorporated into the formal health system or developed as a parallel field complementing or as an alternative to biomedicine (Bodeker et al., 2007). These forms of complementary or
alternative healthcare therapies usually drop the traditional or cultural belief(s) that informs these indigenous healthcare practices in their sociocultural settings.

There are diverse TCAM therapies based on different cultural beliefs and bodies of knowledge. However, researchers agree that there are certain commonalities among these different therapeutic practices that distinguish them from biomedicine. A common feature of TCAM therapies is their psychosocial paradigm of health and wellbeing (Anyinam, 1990; Bignante, 2015; Bodeker et al., 2007; Cassidy, 2006). TCAM therapies espouse a holistic approach to health and healthcare – that is, these healthcare therapies acknowledge the physical, mental, emotional, energetic and spiritual dimensions of the individual (Mackenzie & Rakel, 2006). They hold the fundamental concept that the body, the mind and one’s sociocultural (including the physical) environment are connected and they ultimately determine one’s state of health (Bodeker et al., 2007; Spencer, 1999; Synovitz & Larson, 2013). Illness or sickness is seen as a disruption of the delicate balance between the various dimension of the individual (Andrews, 2003; Anyinam, 1990; Cassidy, 2006; Mizrachi, Shuval, & Gross, 2005). TCAM healing practices, thus, focus on restoring this balance between the body, the mind and the sociocultural environment (Andrews, Evans, & McAlister, 2013; Bodeker et al., 2007; Cassidy, 2006). The healing process often involves examining patients’ current health condition in the context of their social and medical history to determine the diagnosis and therapies to restore the balance between the different dimensions of the individual.

On the other hand, biomedicine is conceptually base on Newtonian physics and pre-evolutionary biology where the human body is viewed as a ‘machine’ whose individual component can be
studied and understood to tackle sickness or illness (Micozzi, 2006; Shuval, Mizrachi, & Smetannikov, 2002). This approach to health and healthcare is based on a materialist and reductionist point of view of health (Beresford, 2010; C. Duncan, Jones, & Moon, 1996; Micozzi, 2006). The materialist and reductionist approach to health and healthcare posit that external physical or natural mechanisms are mainly responsible for illness (Cassidy, 2006; Kleinman, Eisenberg, & Good, 1978; McKee, 1988). The biomedical healthcare model is based on the assumption that diseases are caused by alterations in the body biochemistry or structures (Tataryn, 2002). It, thus, embrace a linear cause-effect relationship that limits disease-causation or ill-health to physical mechanisms and principles (Hoffmann, 2003; Tataryn, 2002). To tackle ill health, practitioners emphasise removing the ‘foreign bodies’ that invade the human body and cause sickness (Cassidy, 2006). The patient is viewed as passive; hence, biomedicine tends to be disease-centred and practitioner-centred rather than patient-centred (Cassidy, 2006). The term patient-centred care can be defined as “care that informs and involves patients in medical decision making and self-management, coordinates and integrates medical care, provides physical comfort and emotional support, understands the patients' concept of illness and their cultural beliefs, and understands and applies principles of disease prevention and behavioural change appropriate to diverse populations” (Maizes, Rakel, & Niemiec, 2009, pp. 277–278).

2.3 TCAM: Canadian & global dimensions

There is a growing global appeal for TCAM among patients and the general population. A plethora of literature and studies have captured the growth in public interest TCAM, as well as, the interest of key national and international stakeholders (Andrews & Boon, 2005; Bishop & Lewith, 2010; Bishop et al., 2010; Boon, 2002; Boon, Olatunde, & Zick, 2007; Eisenberg et al.,
The growing interest in TCAM is mainly because of patterns of TCAM care utilisation among the population in both developed and developing countries. Evidence in existing studies suggests that half of the population in developed countries use TCAM, while the proportion for the population in developing countries is even greater (Bodeker et al., 2007). In some studies, the reported proportions of the population in developed countries using TCAM are, however, considerably lower (Andrews & Boon, 2005; Harris, Cooper, Relton, & Thomas, 2012; Williams, Kitchen, & Eby, 2011). Most scholars attribute the variation in the estimates of people using TCAM in the developed countries, to the operational definition of the term as employed in these studies (Foltz et al., 2005; Harris & Rees, 2000; Ni, Simile, & Hardy, 2002). When TCAM therapies are examined as an aggregate of all forms of healthcare therapies outside the formal healthcare system, the reported prevalence rate tends to be generally high; however, when TCAM, as examined by individual therapies studies, report lower prevalence rates. In studies, where TCAM definition is limited to herbal supplements, vitamins and minerals, the reported prevalence of utilization is often high – averagely between 26% to 50% (Black, Lam, Nguyen, Ihenacho, & Figueiredo, 2016; Cheung, Wyman, & Halcon, 2007; Lai & Chappell, 2007; Lunny & Fraser, 2010; Neiberg et al., 2011). The reported prevalence for professional based TCAM care is generally lower – 10% to 20% – for TCAM practices such as chiropractic and acupuncture. The health issue or disease also influence the estimated and reported proportions of the general population using TCAM in developed and developing countries under consideration in the studies (Arthur et al., 2012; Garrow & Egede, 2006; Willison & Andrews, 2004).
Nevertheless, there is a consensus that the use of TCAM remedies in developed countries has increased rapidly in the last three decades. In Europe, studies in the UK, Germany, the Netherlands, Italy and the Czech Republic indicate that between 10 to 70% of the general population used TCAM remedies each year. In a report of a recent study using the European Social Survey (Round 7) about 25.9% of the total population in Europe used TCAM remedies over a 12 month period (Kemppainen et al., 2017). The study also reported variation in 12-month prevalence rates among countries in Europe with the lowest rate in Hungary (9.5%) and the highest rate in Germany (39.5%). In the UK, a systematic review of studies on TCAM observed that one-year prevalence of TCAM use among the population was 41.1% and a lifetime prevalence was 51.8% (Posadzki, Watson, Alotaibi, & Ernst, 2013). However, the authors cautiously note that the prevalence rates for methodologically sound surveys were lower – 26.3% and 44% respectively – than the general reported prevalence, affirming the prevalence rates reported by Hunt et al., (2010). A study in the Czech Republic shows that about 76.0% of the population reported using a one or more TCAM therapies in a one month period, with the majority of respondents using vitamins/minerals (54.6%) and herbal medicine (47.8%) (Pokladnikova & Selke-Krulichova, 2016).

Similarly, studies in Australia and the US report that a significant proportion of the population use TCAM or have used a TCAM modality in their lifetime (Leach, 2013). The reported prevalence rate of the use of TCAM often varies depending on the section of the population under consideration, the type of TCAM being examined and the study design (Foltz et al., 2005; Sullivan, Gilbar, & Curtain, 2015). In Australia, the reports of existing studies show that the use of TCAM practitioners is generally low, between 8.8% and 26.5% (MacLennan, Myers, &
Taylor, 2006; MacLennan, Wilson, & Taylor, 2002; Yen, Jowsey, & McRae, 2013); while 52.2% to 74% of the population used self-prescribed TCAM (Bowe et al., 2015; MacLennan et al., 2006). A 2005 nation-wide survey reported a 68.9% prevalence rate for the use of TCAM among Australians and 44.1% prevalence rate for consulting a TCAM practitioner (Xue, Zhang, Lin, Da Costa, & Story, 2007). In the US, reports estimate that the prevalence for the use of TCAM remedies in a 12-month period was 32.3% in 2002 and 33.2% in 2012 (Clarke, Black, Stussman, Barnes, & Nahin, 2015). Evidence in existing studies shows that when prayer is considered as a TCAM modality, the estimated prevalence of TCAM is considerably higher (62%) among adults in the US (Barnes, Powell-Griner, McFann, & Nahin, 2004; Neiberg et al., 2011).

The appeal of TCAM is also considerably high in Canada. In some studies, it is estimated that about 70% of the country population regularly use TCAM for their healthcare needs (G. C. Bodeker et al., 2007; Esmail, 2017). Others report a lower prevalence rate for the use of TCAM in Canada (Andrews & Boon, 2005; Boon, Brown, Gavin, Kennard, & Stewart, 1999; McFarland, Bigelow, Zani, Newsom, & Kaplan, 2002). A critical review of the literature shows that the prevalence rate for TCAM tends to be considerably higher in studies where researcher focus on chronic conditions, such as cancer, HIV/AIDS and chronic pain (Boon et al., 2000; Foltz et al., 2005; Furler, Einarson, Walmsley, Millson, & Bendayan, 2003). However, studies that explore population-wide prevalence report much lower prevalence rate – 12 to 20% (Andrews & Boon, 2005; Williams et al., 2011). Studies using the Canadian Community Health Survey (CCHS) and the National Population Health Survey (NPHS) show that about 12.4%
(2001 to 2005) and 17.0% (1998-9) of Canadian population reported using TCAM (Harris, Cooper, Relton, & Thomas, 2012; Metcalfe, Williams, McChesney, Patten, & Jetté, 2010)

2.4 Motivations for using TCAM
Complex sociocultural and health factors mainly influence global and domestic appeal for TCAM. Individual-level, contextual and sociocultural factors inform the choice of TCAM modalities for healthcare needs. However, the decision to use TCAM and the type of TCAM to use are often the interplay of these three factors. Some persons may use TCAM due to its philosophical underpinning in their personal beliefs about health and healthcare while others use TCAM because it relates to their values or spiritual beliefs regarding the nature of their illness (Astin, 1998; Synovitz & Larson, 2013). Kaptchuk and Eisenberg (1998) identify four tenets of TCAM that appeal to its users in both developed and developing countries: nature, vitalism, “science” and spirituality.

The use of natural remedies instead of chemical or synthetic ones is a major motivation for TCAM use in developed countries (Synovitz & Larson, 2013). Studies that focus on vitalism (Andrews et al., 2013; Coulter & Willis, 2007; Synovitz & Larson, 2013). Coulter and Willis (2007) define vitalism as “the acceptance that all living organisms are sustained by a vital force that is different from and greater than physical and chemical forces”. TCAM modalities refer to this concept by different names; in homeopathy it is referred to as a “spiritual vital force” (Kaptchuk, 2006), “Qi” or “Ki” in oriental medicine (Ning, 2013); “prana” in Ayurvedic medicine (Ning, 2013); “innate intelligence” in chiropractic (Barry, 2006); and “vis medicatrix naturae” in naturopathy (Coulter & Willis, 2007; Kaptchuk, 2006). TCAM practitioners argue
this force promotes harmony and homeostasis that can cure illness via balancing the force to restore harmony between the patient and cosmic energy (Coulter & Willis, 2007; Kaptchuk, 2006; McKee, 1988; Synovitz & Larson, 2013). Central to the concept of vitalism is the notion that the human body can heal itself when given a chance (Ning, 2013). The concept of vitalism elicits different beliefs, practices and behaviours to health and healthcare, as well as, redefines the role of the healthcare provider as a facilitator of the self-healing process (Coulter & Willis, 2007). In contrast to biomedicine, where the patient is a passive actor in the healing process, Kaptchuk (2006) argues the concept of vitalism fosters active engagement of the patient in the healing process. In this vein, researchers argue that vitalism makes TCAM a distinct paradigm from biomedicine (Coulter & Willis, 2007). Researchers also argue that the incorporation of spirituality in the healing process of TCAM has also been a major factor in its global and domestic appeal (Andrews et al., 2013; Hsiao et al., 2008; Thomson, Jones, Browne, & Leslie, 2014b, 2014a). They argue spiritual or religious experiences and worldview have a significant influence on people’s view of health and illness.

2.5 Political economy of TCAM - a private market-based healthcare
Healthcare plays a crucial role as a social policy by which society promotes, enhances, and protects the wellbeing of its members (McGregor, 2001). Decisions on support for health or healthcare in Canada and the rest of the world are influenced by a mosaic of political, economic and sociocultural factors. In developed countries, healthcare has been a major controversial policy area in the last decades due to a perceived rise in healthcare expenditure in relation to their ageing populations (Blank & Burau, 2014). There has been considerable debate in the past decade on the appropriate role for the state or government to play in the healthcare sector
especially with regards to financial efficiency and social equity in the face of increasing health inequalities among the population (Raphael, 2015; Saltman & Ferroussier-Davis, 2000). In Canada, healthcare financing and services for essential services, such as TCAM, dental care and optometry, have changed in the provinces in the last decades (Amegbor & Rosenberg, 2018; Leake & Birch, 2008; Locker, Maggirias, & Quiñonez, 2011; Steinbrook, 2006). The Canada Health Act (CHA) insures physician and hospital-based services; albeit, there are considerable differences across the provinces in terms public-funding or coverage for non-physician and non-hospital care services (Amegbor & Rosenberg, 2018; Wiles & Rosenberg, 2001). Knowledge from existing studies shows that in times of fiscal austerities public funding and support for some public health care programs, including TCAM modalities, decline or are removed due to insufficient funding (Bevan & Brown, 2014; McClean & Moore, 2013; Vallerand, Fouladkhsh, & Templin, 2003). Canadians pay for TCAM care mainly through private insurance, employee-benefits or direct out-of-pocket expenditure (Boon et al., 1999; Furler et al., 2003; Statistics Canada, 2003).

At best, TCAM healthcare in Canada and many other developed countries can be described as a private market-based healthcare system, best understood from economic and political perspectives. Economically, the healthcare and pharmaceutical sectors in developed countries have been a major field of production and profit (Loeppky, 2014). These sectors account for a significant amount of revenue generation in Canada and other developed countries. In Canada, one report estimates that about $8.8 billion were spent on TCAM remedies between the latter half of 2015 and the first half of 2016; representing a significant increase from $8.0 billion in 2005/06 and $6.3 billion in 1996/7 (Esmail, 2017). Reports in the US estimate that the population spends about $34 billion out-of-pocket on visits to TCAM practitioners and remedies.
These figures, together with billions of dollars spent on other sectors of the health industry, provide substantial revenue for national and local governments in terms of taxations. Thus, it is economically wise for most governments, including those of countries with universal healthcare coverage (like Canada, the UK, and Germany) to shift the burden of financing TCAM to the individual. Although some argue for the inclusion of certain types of TCAM modalities in provincial federal healthcare programs (Lakshmi et al., 2015; World Health Organisation, 2013), the apathy of some provincial governments to this idea can be understood from this economic perspective as well as the potential cost associated with publicly financing TCAM in the country.

Politically, public support and regulation of TCAM in Canada have a chequered history. Before the 2004 New Canadian Natural Health Products (NHP) regulations, some TCAM modalities (most herbal medicine) were classified as food which meant although they could not make health claims they were not required to undergo rigorous testing before their approval (Moss, Boon, Ballantyne, & Kachan, 2007). TCAM drugs, such as vitamins and minerals, on the other hand, had to go through rigorous evaluation similar to manufacturing standards of pharmaceutical drugs; even though the former is less risky than the latter (Moss et al., 2007). The old policy framework on TCAM in Canada, similar to the US 1994 Dietary Supplement Health and Education Act (Goldstein, 2002), contributed significantly to the growth of TCAM, as practitioners (mostly herbal medicine) were not required to prove the efficacy of their remedies. Similarly, there were no regulatory bodies that oversaw the activities of TCAM practitioners as self-employed businesspeople with significant autonomy over their work practices (Andrews, Peter, & Hammond, 2003; Clarke, Doel, & Segrott, 2004). The new regulatory policy classifies
TCAM remedies involving herbs, vitamins, minerals and homoeopathy as drugs under the Food and Drugs Act, albeit they have different level regulations from biomedical pharmaceutical drugs (Moss et al., 2007).

While the regulation of TCAM practitioners differs across provinces (Boon, 2002), evidence suggests attempts by some provinces to regulate certain modalities of TCAM such as naturopathy, acupuncture. Some modalities, especially chiropractic, are directly regulated by provincial bodies while others are indirectly regulated through giving accreditation to colleges (such as The College of Traditional Chinese Medicine and Acupuncture Practitioners, the Canadian College for Naturopathic Medicine and Alternative Medicine College of Canada) for the training and licensing of practitioners. Usually, regulated TCAM modalities, such as chiropractic, enjoy some form of state or public support through full or limited coverage under provincial universal healthcare programs (Wiles & Rosenberg, 2001). This form of public support contributes significantly to their popularity or use among residents in a province or territory. For instance, studies indicate that TCAM use in western Canadian provinces, such as Alberta, Manitoba and British Columbia, is considerably higher than other provinces due to provincial coverage for some remedies (Eisenberg et al., 1993; Esmail, 2017; Millar, 1997; Wiles & Rosenberg, 2001). Invariably, we cannot discard the role or influence of political policies on availability, accessibility and utilisation of TCAM in Canada and other developed countries.

Political and economic factors also influence the geography of TCAM practices - location and concentration of services, as well as, diversity of modalities in a geographic space in both
developed and developing countries. The biomedical healthcare systems in Canada, and other developed and developing countries have enjoyed political backing and maintain significant influence in healthcare delivery. However, the growth of TCAM practices, especially in developed countries and urban communities in developing countries, is mainly driven by consumer behaviour and market forces (Adams, Lui, & McLaughlin, 2009; Rayner & Bauer, 2017; Sirois & Purc-Stephenson, 2008; Wiles & Rosenberg, 2001). In developed countries, including Canada, some researchers purport the growing demand for TCAM (despite its associated cost) is as much about consumerism as it is about seeking healthcare (Coulter & Willis, 2004, 2007; Rayner & Bauer, 2017). Coulter and Willis (2007) assert that consumerism associated with TCAM is also fuelled by the availability of useful information on health and healthcare options via the internet and other mass consumer ICT platforms. TCAM ‘consumers’ in developed countries have access to requisite health information necessary to decide the best option of care to use in addressing healthcare – hence, the ‘smart consumer’ analogy (Wiles & Rosenberg, 2001).

In response to consumer demand, TCAM practitioners often locate their ‘business’ and practice in metropolitan areas with large populations and the necessary capital to patronise their trade (Meyer, 2012; Vallerand et al., 2003; Williams, 2000). Large urban agglomeration, such as the GTA area in Ontario, does not only offer a financial attraction to TCAM practitioners but also a multiculturally diverse population with different perspectives on their health and healthcare needs. Whereas the use and practice of TCAM are not confined to urban areas only, evidence from the existing literature shows that TCAM practitioners and the diversity of modalities are more urban-centred (Meyer, 2010, 2012). Meyer (2010) observed that while the number and
diversity of biomedical services in small towns in Ontario (e.g. Kingston) were near the provincial average, the supply of TCAM practitioners and services were considerably lower. He further notes that most peripheral regions in the province (especially, areas in the north) are very distant from TCAM services but relatively proximate to some form of biomedical care services (Meyer, 2012). Wiles and Rosenberg (2001) also note that the consumption of TCAM is generally higher in large urban areas than smaller urban regions and rural areas; albeit other studies observed the opposite (Adams, Sibbritt, & Lui, 2011; Hollenberg, Lytle, Walji, & Cooley, 2013; Reid et al., 2016).

In developing countries, such as SSA countries, research shows that the use of TCAM remedies in self-care management is more prevalent in rural areas while seeking licensed TCAM healers is dominant among urban dwellers. The commodification of TCAM remedies (often referred to as Traditional Medicine in SSA context), was mainly as a result of the decline government investment in biomedical healthcare, particularly during the period of structural adjustment programs (Hsu, 2009; Janes, 1999). Also, there have been efforts to assimilate indigenous medical practices into the neoliberal health care market system via licensing and professionalization of TCAM healers in SSA countries, such as Ghana (Flint, 2001; Kamat, 2008; Kigen, Ronoh, Kipkore, & Rotich, 2013; Lakshmi et al., 2015; McFarlane, 2015). The withdrawal of government support for biomedical care through the introduction of user fees as well as other economic and health policies created a potential vast healthcare market for TCAM healers in this part of the world (Janes, 1999). This scenario is particularly true for urban dwellers due to their inability to self-medicate with TCAM remedies as a result of limited knowledge of traditional healing or unavailability of such remedies occurring naturally in the
urban environment as is the case in rural areas (Bodeker, 1995). This phenomenon created a professional class of indigenous medical practitioners under a neoliberal environment, who offered their goods and services through the free market to individuals in urban areas (Ayo, 2012). Thus, in the view of Flint (2001) licensing of TCAM healers coupled with urbanisation and medical commodification (both TCAM and biomedicine) led to a market-driven competition between TCAM healers and biomedical professionals. Urbanisation in SSA countries driven by neoliberal economic and political policies has contributed to the demand for TCAM among urban dweller in SSA and other parts of the developing world (Bodeker, 1995; Van Andel, Myren, & Van Onselen, 2012).

On the other hand, the use of TCAM in rural areas and its popularity among rural dwellers are mainly the results of biomedical resource scarcity, financial barriers and socio-cultural acceptability of traditional healing systems compared to biomedical care (Pouliot, 2011; Van Andel et al., 2012). For most rural dwellers in SSA, access to biomedical care remain elusive, as the majority cannot afford the cost associated with it (Ae-Ngibise et al., 2010; Arthur, 2012; Kusi, Enemark, Hansen, & Asante, 2015). Rural communities in SSA are endemic poverty areas and have a disproportionately higher prevalence of morbidity and mortality cases (Adjei & Buor, 2012; Beiersmann et al., 2007; Tabi, Powell, & Hodnicki, 2006). TCAM remains an important healthcare remedy for most people in rural SSA (Mugisha, Kouyate, Gbangou, & Sauerborn, 2002; Pouliot, 2011; Van Andel et al., 2012; Van Andel, Van Onselen, Myren, Towns, & Quiroz, 2015). Aside from financial barriers to biomedical services, long physical distance to biomedical facilities due to unavailability of services contribute significantly to the use of TCAM (Buor, 2002; Pouliot, 2011; Sato, 2012a). The distribution of biomedical care facilities
and resources tend to be strongly urban bias with a higher number of biomedical professionals concentrated in urban areas (Van Andel et al., 2012). Thus, traditional remedies and community healers provide affordable and accessible forms of healthcare for rural dwellers (Pouliot, 2011; Tabi et al., 2006; Van Andel et al., 2012). Sociocultural beliefs and practices also play crucial roles in the use of TM among rural dwellers in SSA and other developing countries (Amegbor, 2017b; Coulter & Willis, 2007; Hampshire & Owusu, 2013). TCAM is deeply embedded in the sociocultural practices of the community; hence, there is a strong cultural attachment to TCAM among community members (Pouliot, 2011). The cultural attachment, among other factors, plays a significant role in the use and acceptance of TCAM, especially among rural dwellers in SSA.

2.6 Ethnicity & TCAM
TCAM remains an integral healthcare resource for many ethnic minority groups in developed countries (Cassidy, 2006; Kong & Hsieh, 2012; Lai & Chappell, 2007; Neumann & Bodeker, 2007). In recent years, major urban areas in developed countries have become multi-racial or multi-ethnic societies (Goonewardena & Kipfer, 2005; Qadeer, 1997). The growth in diverse ethnic population in Canada and other developed countries is mainly the result of both voluntary and involuntary migration from the global south. Voluntary migration of immigrants takes the form of economic or labour migrants moving to developed countries for employment opportunities. Involuntary migrants are often people displaced by war, natural disasters and famine. Ethnicity and cultural origin have a significant influence on the use of TCAM, as healthcare-seeking behaviour is often driven by sociocultural beliefs (de Medeiros et al., 2016). Among ethnic minorities in developed countries, social, cultural and political values about health
and healthcare are major motivating factors for the use of TCAM (Bodeker et al., 2007). Their socio-cultural worldview of health contradicts the biomedical reality of health and healthcare (Bodeker et al., 2007; Cassidy, 2006). Research shows that ethnic and racial minorities face significant challenges in their access and use of biomedical care, even in a public-funded healthcare system, such as the Canadian healthcare system (Chadwick & Collins, 2015; Edge & Newbold, 2013; Wang & Kwak, 2015; Woodgate et al., 2017). Studies in Canada and other parts of the developed world shows that ethnic/racial minorities and persons of immigrant origin (especially those from the global south) have lower levels of healthcare accessibility and utilization compared to the native-born population and other immigrant groups (Chadwick & Collins, 2015; Fenta, Hyman, & Noh, 2006, 2007; Siddiqi, Zuberi, & Nguyen, 2009; Wang & Kwak, 2015; Woodgate et al., 2017). Choi (2009) posits that interaction of social, cultural and individual socioeconomic characteristics influences immigrants’ access and use of healthcare services. The lack of cultural empathy among biomedical professionals (Bulman & McCourt, 2002; Chalmers & Omer-Hashi, 2002), structural racism (Gee & Ford, 2011; Murrell, Smith, Gill, & Oxley, 1996; Viruell-Fuentes, Miranda, & Abdulrahim, 2012), lack of family doctors and language barriers – for recent migrants (Green, Bradby, Chan, Lee, & Eldridge, 2002; Hall et al., 2014) also have considerable effect on the ability of ethnic and racial minorities to access and use biomedical care services. These barriers to biomedical care influence the use of TCAM remedies among immigrant populations, especially persons of visible minority (González-Vázquez et al., 2016; Grineski, 2011b; Thomas, 2010)
2.6.1 Challenges to access to healthcare among ethnic minority groups

2.6.1.1 Lack of cultural empathy or cultural sensitivity

The lack of cultural understanding about patients, especially persons of an ethnic/racial minority background, has been cited as a major barrier between biomedical healthcare providers and their patients (Edge et al., 2014; McKeary & Newbold, 2010; Woodgate et al., 2017). As previously noted, biomedical healthcare with its scientific basis excludes sociocultural beliefs and practices from its diagnosis and treatment process (Bodeker et al., 2007; Cassidy, 2006). Most biomedical professionals handling ethnically diverse populations in developed countries do not have an adequate understanding of the cultural issues or beliefs that influence the health, health beliefs and health practices of their patients (Woodgate et al., 2017). Biomedical healthcare professionals also do not receive adequate training on cultural sensitivity, hence they lack cultural empathy when treating or diagnosing racialised patients (Asanin & Wilson, 2008; Higginbottom et al., 2013; McKeary & Newbold, 2010). For instance, studies among Somali women in the UK and Canada show that most healthcare providers were insensitive to the potential effect of some cultural practices (for example, female genital mutilation (FGM)) in the caregiving process (Bulman & McCourt, 2002; Chalmers & Omer-Hashi, 2002). Most women in the studies complained of inadequate management of pain associated with FGM in their maternity care experiences. Similarly, Woodgate et al. (2017) observed that some aspects of the caregiving process, such as a female patient undressing in front of a male doctor, can be culturally inappropriate and create uneasiness among patients of racialised or minority ethnic background. The issue of the lack of cultural sensitivity as a barrier to biomedical care is not only peculiar to persons SSA origin but also among other ethnic/racialized groups in Canada, such as the Indigenous population (Castleden, Crooks, Hanlon, & Schuurman, 2010) and immigrants of Asian origin (Lai &
Chappell, 2007; Lai & Chau, 2007; Wang & Kwak, 2015). Additionally, the lack of cultural sensitivity and cultural appreciation can create cultural distance between the biomedical caregiver and their patients (that is, where patients and biomedical professionals hold different views about the diagnosis and the treatment or healing process). To minimize the effect of cultural apathy among biomedical professional on access and use of healthcare, researchers and stakeholders advocate for sensitivity training, multicultural or ethnically diverse biomedical professionals, as well as the practice of culturally safe care (Castleden et al., 2010; Denison, Varcoe, & Browne, 2014; Higginbottom et al., 2013; McKeary & Newbold, 2010).

2.6.1.2 Language barriers

Inability to speak the host country’s official language(s) has been identified as a major barrier to access and use of formal healthcare services (mostly biomedical care) (Pottie, Ng, Spitzer, Mohammed, & Glazier, 2008; Rechel, Mladovsky, Ingleby, Mackenbach, & McKee, 2013). Evidence shows that persons with limited language proficiency (that is, in the official language) have poor health outcomes (Lebrun, 2012; Pottie et al., 2008). The inability to communicate in an official language(s) impede doctor-patient relationships, create miscommunications or misunderstanding of diagnosis as well as affect adherence to treatment (Kim et al., 2011; McWhirter, Todd, & Hoffman-Goetz, 2011; Pavlish, Noor, & Brandt, 2010). The effect of language as a barrier to access and utilisation of biomedical care is noted to be more evident among new immigrants (especially from a non-official language speaking country), older immigrants and refugees (Newbold, Cho, & McKeary, 2013). For instance, Lai & Chau (2007) observed that the inability of biomedical professionals to speak Chinese was cited by older Chinese immigrants in Canada as a major barrier to access to healthcare services. Lum, Swartz, and Kwan (2016) made a similar observation among the immigrant population living in the Niagara region of Ontario.
Similar observations have been reported among refugees and non-native language speaking immigrants in major migrations destinations countries in the developed world, such as Australia (Clark, Gilbert, Rao, & Kerr, 2014) and the US (Jang, 2016; Kim et al., 2011). The presence of language barriers in the access and use of biomedical care services results in patients depending on close social relations as informal translators or seeking biomedical professionals of similar cultural or social origin (Lum et al., 2016; Newbold et al., 2013). The biomedical healthcare systems in Canada and other developed countries are not adequately equipped with language interpretations services to handle the demands of new migrants or refugee with limited language proficiency (Edge et al., 2014; Higginbottom et al., 2013; Lebrun, 2012; McKeary & Newbold, 2010). Some institutions with such services have closed down the service or face the threat of closing down due to limited funds or budgetary constraints (McKeary & Newbold, 2010; Newbold et al., 2013). In view of this challenges, ethnic and racial minorities groups may seek TCAM services from healers of similar sociocultural background due to the “ease of communicating with such healers” (Wang & Kwak, 2015) or travel to their countries of origin for treatment. To address the impact of language as a barrier to access to biomedical care, some researchers advocate for a collaborative network with established or settled immigrants communities (Woodgate et al., 2017). This collaboration will considerably reduce the cost associated with providing language interpretation services while improving access and use for new immigrants and refugees.

2.6.1.3 Structural racism/discrimination

Ethnic and racial disparities in access to healthcare (biomedical or professional care) are well-documented in existing literature (Johnson et al., 2004; McKeary & Newbold, 2010; Tang & Browne, 2008). Factors that contribute to such disparities are multifaceted; however, discrimination based on ethnic or racial background has been acknowledged a major barrier to
access and use of biomedical or professional care (Castleden et al., 2010; Chadwick & Collins, 2015; Siddiqi, Shahidi, Ramraj, & Williams, 2017; Stepanikova & Oates, 2017; Wang & Kwak, 2015). While such discrimination, especially in the Canadian context, is not an overt denial of healthcare service, discrimination is often embedded in institutional policies and practices that may inhibit the ability of racialised patients to seek needed care. Structural discrimination in access and use of biomedical care services often manifest in the form of language and cultural barriers, and the worst case through open displays of bias due to one’s visible minority status. In the case of the former, McKeary and Newbold (2010) note that denial of services to non-native language(s) (English and French) speakers by family physicians due to language constitute institutional and systemic discrimination in the biomedical healthcare system. Some researchers also refer to racial stereotype behaviour by some biomedical professionals as evidence of systemic racism in the delivery of healthcare service (Johnson et al., 2004; Tang & Browne, 2008). Castleden et al. (2010) observed that among Canada’s Indigenous peoples, experiences of prejudice and discrimination in the biomedical healthcare system have led to many suppressing or not acknowledging their Indigenous identity “in order to avoid substandard care”. The problem of structural racism or discrimination in biomedical care is not peculiar to Canada, as researchers have acknowledged the existence of the problem in other developed countries, including countries in Europe (Rechel et al., 2013), and the US (Gee & Ford, 2011; Viruell-Fuentes et al., 2012). Immigrants and persons of ethnocultural minority background may utilize TCAM services to avoid the discriminatory practices associated with seeking biomedical care (Duncan, 2015; Fong, 2008; Wang & Kwak, 2015)

2.6.1.4 Socioeconomic factors
Although most developed countries (except for the US) offer universal biomedical healthcare coverage for its citizens and residents, socioeconomic factors remain significant barriers to access and use of biomedical care services. Studies in Canada and other developed countries offer mixed evidence on immigrant or foreign-born residents’ access to primary and preventive healthcare vis-à-vis native-born population (Lebrun & Dubay, 2010; Prus, Tfaily, & Lin, 2010; Siddiqi et al., 2009; Williams, Mohammed, Leavell, & Collins, 2010). The findings of some studies suggests that foreign-born populations have poorer health (Lasser, Himmelstein, & Woolhandler, 2006; Lebrun & Dubay, 2010; Newbold & Danforth, 2003; Prus et al., 2010b), while others report foreign-born population to have better health compared to the native-born population (Cunningham, Ruben, & Narayan, 2008; Lu, Denier, Wang, & Kaushal, 2017; Singh & Hiatt, 2006). The differences in findings may be the result of the definition of the foreign-born population in these studies. Studies that include a substantial proportion of recent-immigrants, asylum seeker and refugees in their foreign-born population are more likely to observe a significant difference in access to healthcare among this population compared to native-born population (Hamilton, 2015; Newbold et al., 2013). Existing evidence demonstrates that recent-immigrants, refugees and asylum seekers have limited access to healthcare due to both sociocultural and socioeconomic factors (Edge & Newbold, 2013; McKeary & Newbold, 2010; Woodgate et al., 2017). However, documented immigrants or established immigrants population may not have similar socioeconomic challenges in their access and use of healthcare services (Newbold, 2009). In market-oriented healthcare systems, such as that of the US, evidence shows that residents of foreign origin as more likely to be uninsured or have limited healthcare insurance coverage compared to native-born population (Lu, Kaushal, et al., 2017; Prus et al., 2010b). Documented
immigrants and naturalised citizens in countries with universal healthcare coverage, such as Canada and the U.K, are more likely to be covered under a nation-wide insurance scheme. Additionally, some provinces have a waiting period for new residents (mainly immigrants and refugees) to become eligible for the provincial healthcare program (McKeary & Newbold, 2010; Newbold et al., 2013). Some scholars suggest that the effect of socioeconomic factors on access and use of healthcare services by foreign-born or immigrant population is mainly the result of their social and economic marginalisation in developed countries (Edge & Newbold, 2013). It is widely acknowledged that there are differences in economic opportunities available for a native-born population compared to foreign-born and racialised groups in developed countries (Edge & Newbold, 2013). Such economic discriminations limit immigrants or foreign-born population’s ability to access and use healthcare services, contributing to their poor health. In the context of such socioeconomic barriers, the literature suggests that immigrants, especially persons of visible minority status, depend on TCAM in the host countries or their countries of origin to meet their healthcare needs.

2.6.2 TCAM use among ethnic minority groups

There are ethnic/racial differences in the use of TCAM among the general population in developed countries. Studies show that sociocultural and health beliefs have a significant influence on a population’s healthcare-seeking behaviour (Cardinal et al., 2009; Read et al., 2014; Shim, 2010; Synovitz & Larson, 2013). The ethnocultural appeal of TCAM is often presented as a major motivating factor for its use among ethnic/racial minority groups in developed countries (Bodeker et al., 2007; Cassidy, 2006; World Health Organisation, 2013). However, the general view in the literature indicates that there is a high prevalence of TCAM use
among non-Hispanic whites relative to other racialised groups (Bishop & Lewith, 2010; Kelly et al., 2006; Rhee, Evans, McAlpine, & Johnson, 2017). Kelly et al. (2006) observed that the overall prevalence of herbal or natural supplement was highest in non-Hispanic whites (19%) relative to Hispanic (12%) and Blacks (9.5%). Others observed that the growth in TCAM therapies, particularly chiropractic, massage and acupuncture, is more noticeable among non-Hispanic whites than other racial or minority groups (Grzywacz et al., 2005; Dejun Su & Li, 2011). Consistently, findings from existing studies (especially from the US) shows that TCAM use among black population is lower than other racial groups (Barnes et al., 2004; Bishop & Lewith, 2010; Hammond, 2005; Rhee et al., 2017). Among patients with chronic pain, the findings indicate that black patients are 50% less likely to use TCAM services compared to white patients (Ndao-Brumblay & Green, 2010). In terms of mental health, the probability of black patients with moderate mental distress utilising TCAM is relatively lower (30.2%) compared to non-Hispanic Asians (37.8%) and Hispanics (35.9%) (Rhee et al., 2017). However, a critical scan of the literature shows that the findings on the effect of ethnicity/race on TCAM use is complex and often dependent on the context of the study, the definition of TCAM (as employed in the study) and the TCAM modalities under consideration.

The context of the study has a significant influence on the effects of race or ethnic background on the use of TCAM. In the majority of the studies that report a higher prevalence of TCAM use among non-Hispanic whites, TCAM definition or therapies defined as TCAM is often restricted to licensed or regulated practices such as chiropractic, massage therapy and acupuncture. The limited conception of TCAM modalities is particularly true for national demographic and health surveys such as the National Health Interview Survey (NHIS, US) or the Canadian Community
Health Survey (CCHS). The findings of studies using such national surveys suggest a lower prevalence of TCAM use among ethnic minority groups, particularly among blacks (Neiberg et al., 2011; Rhee et al., 2017; Dejun Su & Li, 2011). Neiberg et al. (2011) assert that the restriction in the definition of TCAM in such surveys can ultimately reduce the number of TCAM remedies use reported by ethnic minorities groups. They criticise these surveys as defining TCAM types based on remedies used by the majority ethnic or racial group – non-Hispanic white population. A review of TCAM use by ethnicity shows that the evidence is inconclusive on whether there are ethnic or racial differences (Bishop & Lewith, 2010). Contrary to popular conviction, the findings of some studies in developed countries show that Blacks or persons of African descent have a higher prevalence than whites (Cappuccio, Duneclift, Atkinson, & Cook, 2001; Cherniack et al., 2008). Additionally, studies that broaden the concept of TCAM and usually explore ethnicity and use of specific therapies observe that the patterns of therapies use vary among ethnic or racial groups (Hsiao et al., 2006a; Mackenzie, Taylor, Bloom, Hufford, & Johnson, 2003; Villa-Caballero et al., 2010).

Evidence from the literature suggests that the use of non-professional based TCAM is generally high among blacks. For instance, Mackenzie et al. (2003) observed that blacks (or African Americans) were more likely to use home-based TCAM remedies while whites were more likely to use professional or regulated practices such as chiropractic. In the UK, some studies suggest that persons of African descent were more likely to use over-the-counter TCAM remedies (Cappuccio et al., 2001). When prayer is considered as a TCAM modality, blacks are likely more than other racial groups to utilise this form of remedy to address their healthcare needs (Bell et al., 2005; Hsiao et al., 2006a). This observed difference may be the result of ethnocultural beliefs
and practices as well as socioeconomic differences. Regulated and licensed TCAM therapies, such as massage and chiropractic, are usually private market-based healthcare services hence the ability to use these remedies depends on enabling factors like income, or personal or employment-based health insurance coverage (Andrews, 2003; Canizares et al., 2017; Esmail, 2017; Furler et al., 2003). Persons of ethnic or racial minority background may not have the financial capability or insurance coverage to utilise such services given their economic marginalisation – as previously reported. Studies shows that ethnic minority groups in market-based healthcare systems are often more likely to be uninsured or lack adequate health insurance coverage that can enable them use healthcare services (TCAM) (Bell et al., 2005; Cappuccio et al., 2001; Hsiao et al., 2006a, 2008; Rhee et al., 2017). In Canada and the U.S, findings of existing studies show that persons of African descent score lower in socioeconomic measures compared to whites (Kail & Taylor, 2014; Owusu, 2003). Thus, the significant use of non-professional based TCAM modalities, such as prayers, may be the only alternative to addressing their healthcare needs rather than as a complementary to professional care. Inevitably, the role of socioeconomic factors in access and use of TCAM care is similar to that observed in access and use of biomedical care services.

2.7 Ageing & TCAM

Population ageing in developed countries is coupled with the growth of chronic health conditions (Griffith, Raina, Wu, Zhu, & Stathokostas, 2010; Martin & Schoeni, 2014; Prince et al., 2015). With the projected growth of the older population in these countries, some researchers opine that TCAM use will experience exponential growth (Mackenzie & Rakel, 2006). The proportion of older persons using TCAM in Canada and other developed countries varies
significantly across studies (Bauer & Rayner, 2012; Groden, Woodward, Chatters, & Taylor, 2017). The prevalence of people aged 65 years and above using TCAM in North America (US and Canada) ranges between 41% and 87% (Bauer & Rayner, 2012), while the figure is between 28% and 42% for older persons in the UK (Andrews, 2002; Thomas, Nicholl, & Coleman, 2001). Again, the differences in reported prevalence in TCAM use among the older population is due to the conceptual definition of TCAM in the various studies, as well as, the context of the study – whether among the general older population or older persons with certain chronic health conditions. The reported prevalence among the general older adult population tend to be lower (Kelner & Wellman, 1997; Ni et al., 2002; Reid et al., 2016) while the use of TCAM among persons with chronic health conditions is generally high (Arthur et al., 2012; Sewitch, Yaffe, Maisonneuve, Prchal, & Ciampi, 2011; Sullivan et al., 2015; Weizman et al., 2012).

Mackenzie and Rakel (2006) suggest the “baby boomer” generation will drive the growth in the use of TCAM among older persons in developed countries. This assertion is supported by reports from recent studies in Canadian and other parts of the world. For instance, Canizares et al., (2017) in their study observed a cohort effect in the use of TCAM remedies among Canadian adults. Their findings show that recent cohorts (generation X and baby boomers) were more likely to use TCAM practices and chiropractic compared to than their predecessors. Ho et al. (2014) also observed that baby boomers were more likely to use TCAM albeit their predecessors (termed “silent generation”) were twice as likely to have more chronic diseases and more painful conditions. Bauer and Rayner (2012) argue that as the baby boomer generation ages their demand for TCAM will rise, given the ability of TCAM therapies to reduce frailty, increase
independence, enhance successful ageing, and supplement expensive biomedical care. These findings affirm evidence in early literature (Kessler et al., 2001) and support the observations in recent studies (Chao et al., 2015; Groden et al., 2017).

The generational variation in the use of TCAM modalities among older persons and older persons compared to younger persons can be understood from both life course and geographical perspectives. A life course approach offers an explanation on the effect of social, economic and political policies acting across the entire life course of a generational influence current health status and healthcare-seeking behaviour. It is evident that the social and economic situations in developed countries before and after the second world war (WW2) were completely different. Evidence suggests that baby boomers have more purchasing power compared to all other generational groups (Jang & Ham, 2009). This distinct purchasing or spending ability stems from the social and political environment in the post WW2 era. The baby boomer generation was born in the period of “plenty” relative to the economic depression that characterised the era of their predecessors; the reconstruction of economies after the war gave great impetus to the growth of manufacturing industries (Jang & Ham, 2009). Easterlin, Schaeffer, and Macunovich (1990, 1993) observed although average real earning declined among the baby boomers, their average real income per adult equivalent has improved significantly. Generous social welfare schemes across the developed world after the war, including universal healthcare, may have freed extra capital for healthcare spending outside the formal healthcare system. Additionally, employment-related working benefits, such as health and dental plans, for the generation and later generations might also explain their higher consumption or use of TCAM remedies compared to persons in the older generation who lacked such benefits (Groden et al., 2017; Jang & Ham, 2009).
The increasing availability of TCAM remedies in developed countries overtime also accounts for the popularity and the growth in the use of TCAM therapies among baby boomers and later generations. The relaxation of immigration laws in many developed countries after the second world war resulted in the mass migration of immigrants from Asian countries such as India and China (Boyd & Vickers, 2000; Lovelock, 2000). Before the second world war, most developed countries, including Canada, had a strict immigration quota for non-white populations. In the last decades of the 19th century, the majority of immigrants to Canada were from Southern and Eastern European countries such as Italy, Ukraine, Hungary and Russia (Boyd & Vickers, 2000). Boyd and Vickers (2000) assert that Canadian government policies on immigration during the late 1800s and early 1900s were aimed at “prevention immigration on the basis of … and non-European origin”. However, new regulations in the post-world war two period, especially in 1967 (introduction of the points-based system), made it easier for non-Europeans or non-whites to immigrate to Canada. The post-world war two period marked the growth in ethnic and racial diversity in Canada and other western European countries, including Pacific countries such as Australia and New Zealand (Coulter & Willis, 2004; Lovelock, 2000). The migration of East and Southern Asians into Canada and other developed countries resulted in the introduction of traditional Asian healing practices by the new immigrants. This view is supported by Coulter and Willis (2004) who opine that migration and transmission of traditional healing practices from “other lands” (mostly the global south) have been contributory factors for the growth of TCAM in developed countries.
Consequently, the period of new immigration reforms in developed countries coincided with the era of the baby boomers and generation x. Thus, the availability of TCAM remedies in the formative years of the baby boomers and later generations may have contributed to its popularity (in use) among these generations compared to their predecessors (Groden et al., 2017). Persons born during and after the second world war had alternative or complementary healing practices to use aside from biomedical care, invariably giving them a greater level of independence in their healthcare-seeking behaviours.

### 2.7.1 Age-related chronic conditions and the use of TCAM

As the number of older persons in developed countries grows and life expectancy continues to increase, experts argue the number of people with frail health conditions will likewise increase (Moore, Rosenberg, & Fitzgibbon, 1999; Prince et al., 2015). Although chronic health conditions are not peculiar to older persons, existing knowledge and evidence show that chronic conditions are more prevalent among the older population (Moore et al., 1999; Prince et al., 2015; Van Oostrom et al., 2016; Willison & Andrews, 2004). A recent report by Statistics Canada (2017a) shows that more 50% of persons aged 65 years and above reported being diagnosed with arthritis and hypertension. Among this group of Canadians, the highest prevalence was among those age 75 years and above (Statistics Canada, 2017a). Similarly, over 60% of Canadians aged 65 years and older have multiple chronic health conditions (Sibley, Voth, Munce, Straus, & Jaglal, 2014). Reports from other developed countries offer similar evidence on the high prevalence of chronic degenerative conditions among older persons. In England, the prevalence of hypertension among older persons ranges from 30% to 75% among persons aged 60 years and above, with a prevalence of 60% and above among persons aged 75 years and over (Melzer et
al., 2015). Other studies estimate that over 40% of persons aged 65 years and older in the UK have one or more chronic condition (Dhalwani et al., 2016; Parker, Moran, Roberts, Calvert, & McCahon, 2014). While it is argued that the natural process of ageing increases one’s susceptibility to chronic health conditions, the rise of these conditions can also be attributable to other non-age-related factors such as health care and society related developments (Van Oostrom et al., 2016).

In view of the growing number of older persons and chronic health conditions in developed countries, some researchers postulate that the future demand for TCAM will increase significantly (Garrow & Egede, 2006; Willison & Andrews, 2004). The prevalence of TCAM use among persons with one or more chronic health conditions is generally higher than that of the general population (Arthur et al., 2012). Among cancer patients, it is estimated that between 40% to 91% of cancer patients use some form of TCAM in addressing their healthcare needs (Boon et al., 2000; Hyodo et al., 2005; Mao, Farrar, Xie, Bowman, & Armstrong, 2007; Molassiotis et al., 2006; Tough, Johnston, Verhoef, Arthur, & Bryant, 2002; Yates et al., 2005). Among Canadian cancer patients, Tough et al. (2002) estimated about 49% use TCAM with psychological and spiritual modalities constituting the most frequently used therapies (65%). Likewise, a study among breast cancer survivors in the province of Ontario shows that about 67% of patients used some form of TCAM in attempts to boost their immune systems (Boon et al., 2000). In the US, the results of some studies indicate that the vast majority of 9 in 10 cancer patients use some form of TCAM, when prayer, meditation and exercise are considered as TCAM modalities (Yates et al., 2005). Studies on other types of chronic health conditions report a similar proportion of TCAM use among patients. Among inflammatory bowel disease (IBD),
56% reported using TCAM due to the ineffectiveness of conventional (or biomedical medicine) (Weizman et al., 2012). In Minnesota, Cheung, Wyman and Halcon (2007) found out that about 44% and 24% of persons aged 65 years and older were using TCAM to treat arthritis and chronic pain, respectively. In most cases, older persons with chronic health problems use TCAM as part of their self-management care (Arcury et al., 2006).

2.7.2 A holistic approach to healthy ageing

Older persons tend to suffer from chronic health and functional disabilities compared to the younger population (Mackenzie & Rakel, 2006; Ormel et al., 1997; Prince et al., 2015). The experience of chronic health and functional limitations among older persons increases their susceptibility to depressive conditions or other symptoms of poor mental health (Garrido & Kane, 2009; Huang, Dong, Lu, Yue, & Liu, 2010; Roberts, Kaplan, Shema, & Strawbridge, 1997; Smits et al., 2008; van den Hoek et al., 2016). While allopathic (biomedical) healthcare provides effective treatment for the acute symptoms associated with chronic conditions, professionals in this field often are unable to diagnose and treat mental health problems that emanate from these conditions (Mackenzie & Rakel, 2006; Menear et al., 2015). By its philosophical underpinning, biomedicine lacks a holistic approach to physical and mental health; that is, diagnosis and treatment procedures usually ignore the biopsychosocial dimensions of the patient (Mackenzie & Rakel, 2006). Evidence from existing studies shows that when older patients (or patients in general) suffer physical comorbidity only, their chronic depressive conditions are less likely to be diagnosed by their primary care providers (in a biomedical setting) (Menear et al., 2015; Menear, Duhoux, Roberge, & Fournier, 2014; Nuyen et al., 2005). Depression and other psychosocial conditions are effectively diagnosed only when patients have
known psychiatric comorbidity in addition to their comorbid physical conditions (Menear et al., 2015; Schwarzbach et al., 2014).

TCAM remedies with their patient-centred and holistic approaches offer older persons the psychosocial aspects of the healing process that is missing in biomedical care (Hsiao et al., 2008; Kaptchuk & Eisenberg, 1998; Maizes et al., 2009; Nissen, Weidenhammer, Schunder-Tatzber, & Johannessen, 2013). TCAM modalities consider the patient’s physical, social, emotional and spiritual dimensions and offer a healing therapy that seeks to restore the balance between these dimensions (Amegbor, 2014; Barnes & Bloom, 2008; Bodeker et al., 2007). By emphasising other non-physical aspects of the patient’s life, TCAM healer can restore the psychological wellbeing of older persons with chronic health and improve their overall wellbeing beyond the treatment of symptoms. Some TCAM remedies improve mental health and psychosocial wellbeing of chronically ill older persons through fostering a sense of community, support and belonging (Hsiao et al., 2008; Lawsin et al., 2007; Tobon, 2010). TCAM therapies delivered in a group format tend to foster social bonds and social network of group members (Hsiao et al., 2008; Wren, Wright, Carson, & Keefe, 2011; Yagli & Ulger, 2015). Social bonds gained through these therapeutic practices minimise depressive symptoms among members and foster psychosocial wellbeing of group members (Bystritsky et al., 2012). For instance, yoga is known to reduce social isolation while improving a patient’s/user’s flexibility, anxiety and pain (Mackenzie & Rakel, 2006; Tobon, 2010; Wang, 2010). Goldman & Cornwell (2015) further stress that TCAM offers older persons a sense of autonomy and independence – traits which signifies markers of successful ageing – through active involvement in the healing process.
2.8 Theoretical Framework- Translocational Positionality

2.8.1 Association between identity and health – a theoretical overview

As social beings, the sociocultural settings we live in influence our behaviour and lifestyle. Contrary to the prior assumption of the self as a distinct psychological entity, proponents of identity theory postulate that the self is a social construct or a reflexive process of social interactions (Callero, 2003; Stets & Burke, 2000). According to these proponents, the self can be construed as a collection of identities that portray the roles an individual occupies in the social structure (Callero, 2003; Stets & Burke, 2000). Identity(ies) are seen as a product of the self, defined through the process of internalizing the meanings of social constructs and expectations associated with one’s position in the social network and the role expectations linked with this position (Callero, 2003; Giddens, 2001; Hogg, Terry, & White, 1995; Terry, Hogg, & White, 1999). That is, identities are formed through the reflexive process of an individual categorising, classifying or naming one’s self in particular ways relative to other forms of classifications (Callero, 2003; Giddens, 2001; Hogg et al., 1995; Terry et al., 1999). In simple terms, Giddens (2001, p. 29) defines identity as “the understandings people hold about who they are and what is meaningful to them”. The meanings and expectations associated with one’s position in a social network or social group are inculcated through the process of socialisation – the process new members or children are educated about their society’s culture (Giddens, 2001). These roles or positions associated with meaning and expectations ultimately shape or guide individual behaviour (Callero, 2003; Giddens, 2001; Haslam, Jetten, Postmes, & Haslam, 2009). Nevertheless, Giddens, (2001) cautions that the process of socialisation or social interactions of the individual is not passive in the social interactions that create their identities but constantly engage with these processes or interactions.
The active role of the individual in the processes of categorisation or identification gives rise to two distinct yet closely related forms of identity: social identity and self-identity. Social identity refers to personal identification in terms of group memberships or group identification assigned by others based on similar characteristics or attributes among individuals (Callero, 2003; Giddens, 2001; Haslam et al., 2009). On the other hand, self-identity refers to a self of uniqueness in one’s relationship with others (Giddens, 2001). These two forms of identification have a significant influence on health, health behaviours, and access to healthcare. In the case of social identity, conformity to group behaviours, a sense of belonging and purpose may have a positive influence on an individual’s physical and psychosocial wellbeing. Evidence from some studies shows that social changes that compromise group identity or social identity usually leads to adverse health outcomes among membership of the group (Dion, Cantinotti, Ross, & Collin-Vézina, 2015; Elias et al., 2012; Richmond & Ross, 2009; Ross, Dion, Cantinotti, Collin-Vézina, & Paquette, 2015; Kathi Wilson, Rosenberg, & Abonyi, 2011). For instance, studies in Canada show that efforts to westernize the Indigenous population through dispossession or displacement and cultural indoctrination (via the residential school system) resulted in adverse physical and psychosocial health outcomes among this group of Canadians (Dion et al., 2015; Elias et al., 2012; Richmond & Ross, 2009; Ross et al., 2015). Studies also show that strong social ties, through social support and sense of belonging, among the country’s Indigenous population can lead to positive health outcomes (Browne-Yung, Ziersch, Baum, & Gallaher, 2013; Richmond & Ross, 2008; Richmond, Ross, & Egeland, 2007; Waterworth, Rosenberg, Braham, Pescud, & Dimmock, 2014). Research also acknowledges that social pressures and obligations associated with group belonging/identity can also lead to adverse health outcomes among members.
(Richmond & Ross, 2008; Waterworth et al., 2014). Additionally, such social labels may be employed by others as mechanisms for discrimination, marginalization and stereotyping (Browne-yung, Ziersch, Baum, & Gallaher, 2013; Castleden et al., 2010; Iwasaki, Bartlett, & O’Neil, 2005; Nelson & Wilson, 2018; Senese & Wilson, 2013; Van Herk, Smith, & Tedford Gold, 2012). Regarding self-identity, individual agency and choice are primal in health and healthcare behaviour. On the one hand, individuals have the abilities and capacities to embrace or regret the meanings and expectations associated with their identities while on the other the choices they make can enhance their health or contribute to their experience of adverse health. That is, human agency plays a crucial role in the appraisal of illness and responses to ill health in conformity or contrast to the broader sociocultural values or beliefs on health.

2.8.2 Translocational Positionality Framework

As presented earlier, existing studies on ethnic or racial minorities and TCAM suggest that alienation due to the biomedical model of health and its practices are major motivations for the former's use of complementary or alternative therapies. These studies purport that TCAM users, especially persons of ethnic/racial minority origin in developed countries, are detached from the biomedical care system due to contradictions between their worldview and the biomedical approach to care. This assertion construes the social identities of TCAM users as fixed and static. However, knowledge from existing sociological and geographic studies shows that identities are fluid (Anthias, 2008; Waters, 2009). The notion of static identity limits the ability of the individual to transcend different social positions or embody different forms of identities without necessarily relegating others.
The proposed research adopts translocational positionality as a theoretical framework to examine the versatility of multi-cultural individuals, especially in an ethnoculturally diverse setting, and their care-seeking behaviour in the use of TCAM. Translocational positionality, as a theoretical concept, is conceived as a “placement within a set of relations and practices that implicate identification and performativity or action” (Anthias, 2002, p. 501). Through its emphasis on social position (the outcome of social actions, practices, and meanings) and social positioning (the process of practices, actions, and purpose within a social context), the theory offers an immediate concept between objectivism and subjectivism. It does so by admonishing researchers to focus on the social space where social structures and individual agency meet to construct the identity of the social actors we study or their sense of belonging (Anthias, 2002, 2008, 2011). In this regard, (Anthias, 2002) conceives positionality as harmonising social structures (as social position/social effect) and agency (as social positioning or meaning and practices).

As a theoretical lens, translocational positionality stresses that the positions and outcomes observed within any given social context are as a result of intersections between a number of different social structures and processes, including transnational ones (Anthias, 2012a). Additionally, it emphasises the complex interplay of a range of locations (social spaces) and the dislocation of these spaces in relation to broader social-demographic characteristics such as gender, ethnicity, national belonging, class and racialization (Anthias, 2002, 2012a, 2012b). Anthias (2001) asserts that identity markers such as culture, origin, and language, may function as resources used by the individual or a group contextually or situationally. Thus, adopting a translocational positionality line of thought and reasoning, the proposed research seeks to
understand the context and the situation in which persons of SSA origin, use available social resources (social structures both in Canada and in their country of origin), and their behaviour, motivations, and rationale in their choice of TCAM therapies for their health care needs. The theoretical framework will be used to understand the process of constructing social identity and a sense of belonging, in the choice and use of alternative medical knowledge or remedies. It will thus enhance our understanding of how motivations, factors and social mechanisms that lead an individual to embrace their ethnocultural identity in seeking treatment in one context and dropping such identity in another. Translocational positionality helps situate the complex interplay of the structures that govern an individual’s behaviour and his/her agency within different national and socio-cultural contexts (Anthias, 2012a).

Studies on ethnocultural, racial and socio-demographic diversity in developed countries and the use of health care services often adopt a transnational framework (Fong, 2008; Horton & Cole, 2011; Krause, 2008; Şekercan, Lamkaddem, Snijder, Peters, & Essink-Bot, 2015; Stan, 2015; Wang & Kwak, 2015). Transnationalism, as a theoretical framework addresses and acknowledges people’s multiple trans-social locations and allegiance, hitherto ignored in a nation-based approach (Anthias, 2016). Nonetheless, a transnational approach fails to acknowledge the versatility of social belonging and the contextual construction of ethnocultural identity (Anthias, 2008, 2011, 2012a). That is, transnationalism sheds little light on the contradictions and complexities of placing social actors within different social locales other than national borders (Anthias, 2016). Translocational positionality stresses that depending on the meaning and context, social boundaries (identity and sense of belonging) are fluid and changeable (Anthias, 2012b). Therefore, construction of social identity and group belonging is
not fixed but can change from time to time based on the context or situation of analysis, which can often reveal contradictory, complex and dialogical positionalities (Anthias, 2001, 2008, 2009, 2016). It recognises that the individual’s ethnocultural position in society often changes when placed in different categories or social locales (context and situation). Thus, translocational positionality, as a theoretical framework places emphasis on “the importance of context, the situated nature of claims and attributions” in often complex and shifting locales (Anthias, 2002). It is incumbent upon us as researchers to seek and examine the social and cultural processes and contexts that inform the use or selection of a particular medical therapy.

An increasing number of studies and literature on TCAM, make reference to non-disclosure of TCAM use by patients to biomedical health professionals (Boon et al., 2000; Chao, Wade, & Kronenberg, 2008; Nissen et al., 2013; Okoro, Zhao, Li, & Balluz, 2011), as well as, the limited or non-existing regulations for certain TCAM practices (Bodeker et al., 2007). For instance, a study in Australia shows that more than two-thirds (77%) of patients do not disclose their use of certain TCAM remedies to their physicians (Robinson & McGrail, 2004). Such gaps in the knowledge of a patient’s use of TCAM by their physicians can sometimes lead to catastrophic consequences for the patient and their dependents. The use of translocational positionality becomes ideal for exploring health care choices by Canada’s heterogeneous society, considering the multiple social locales of most Canadians, as well as, social boundaries and divisions in Canadian society. Thus, as a theoretical lens, translocational positionality is not only useful in studying the health care seeking behaviour Canada’s diverse ethnocultural groups but also that of other subcultural groups whose lifestyle and health behaviours often deviates from that of the mainstream groups. A translocational positionality framework will foster the study’s aim of
navigating the shifting sense of identity and belonging among Canada’s ethnocultural groups in their use of socio-cultural relations and resources in different political, economic and social contexts to address their health care needs.
Chapter 3

Research Design and Methods

3.1 Introduction

The discussion in the previous chapter highlights existing research studies on traditional, complementary and alternative medicine. The discussion also points to the gaps in the existing literature on TCAM, with regards to the influence of ethnocultural background and ageing in the choice of remedy. This chapter focuses on the methodological approaches adopted in the research design and the collection of primary data from the field or study site. The chapter discusses the rationale for the choice of methods and their appropriateness for the achieving the proposed aims and objectives of this thesis and addressing or answering the research questions introduced in the first chapter (Chapter 1). It also discusses the research ethics, power and my positionality as a researcher in the entire research process.

In line with the proposed study’s objectives, a case study methodological approach was employed as a research design. Existing literature offers multiple definitions of a case study. A case study methodological approach can be understood as “an intensive study of a single unit for the purpose of understanding a larger class of (similar) units” (Gerring, 2004, p. 342). Others define it as the study and contextual analysis of a case (event, instances, conditions) or a limited number of cases and explanations of the case(s) (Baxter, 2010; Dooley, 2002). In many contexts, a case study evokes an in-depth understanding of the phenomenon, the contextual mechanisms that influence as well as help explain the phenomenon of interest. Case study research has a constructivist paradigm; nonetheless, it accommodates the notion of objectivity (Baxter & Jack, 2008). Kyburz-Graber (2004) notes that a case study research design has a comprehensive research design which
includes both qualitative and quantitative methods informed by a theoretical background. Thus, a case study research design espouses pluralism with a keen focus on the dynamic relationship between the subject and object of the study. This research approach is often misconceived as not transferable or generalisable, hence lacking scientific rigour (Flyvbjerg, 2016; Kyburz-Graber, 2004; Ruddin, 2006). Baxter (2010) and others (Flyvbjerg, 2016; Kyburz-Graber, 2004; Ruddin, 2006) debunk this assertion, explaining that through careful selection of cases and creation of a useful theory that is neither too abstract nor too case-specific, one can achieve analytical or theoretical generalisation. Kyburz-Graber (2004) further distinguishes between statistical logic which seeks generalisation through a large number of responses to a distinct number of categories and replication logic that seeks a close association between the research findings and the supporting theory. The choice of a case study as a methodological approach enables this study to cover the contextual conditions or mechanism that inform ethnocultural and senescent use of TCAM.

The proposed research adopts a multi-method research approach in the data gathering and analysis process. As stated in the introductory chapter, this study seeks to examine TCAM healthcare utilisation behaviour through a critical understanding of how social structures and individual agency (expressed through ethnocultural ties and ageing) interact in social space to inform the use and choice of TCAM. These research objectives demand the use of both quantitative and qualitative research techniques. The former approach enables the observation of patterns and determinants of TCAM health-seeking behaviour among the study sample (sub-Saharan Africans living in the GTA). Whereas, a qualitative research approach offers an in-depth understanding of the role of ethnicity in the use of TCAM. Researchers advocate for the combined use of
quantitative and qualitative methods in health and social science studies (Creswell, Klassen, Clark, & Smith, 2011; Mcevoy & Richards, 2006). The methods and processes of inquiry that we use as social scientists are often deeply rooted in our philosophical understanding of social reality (Fries, 2009). The philosophical, theoretical intent and the objectives of social science inquiry informs the choice of methods and analysis to ensure rigour in the research process (Wilson & McCormack, 2005). The study’s theoretical framework – translocational positionality – and the objectives inform the choice of the multi-methods research approach. A multi-method research approach offers leeway in investigating the broader behavioural patterns of treatment-seeking behaviour, as well as, solicits in-depth understanding of how social structures and individual agency influence the choice of TCAM among Canada’s heterogeneous social groups. Additionally, this methodological approach offers comprehensive investigative and analytic techniques of unravelling the complex paradox of ageing, multi-morbidity and the use of TCAM (Clarke, 2009; Johnson, Onwuegbuzie, & Turner, 2007; Ozawa & Pongpirul, 2014; Riazi, 2016).

The adoption of a multi-method research approach is nevertheless not without its challenges and critique. In the case of the latter, some researchers and scholars argue that quantitative and qualitative methods of inquiry are based on mutually exclusive assumptions (ontological and epistemological positions); hence there is no common ground between the two approaches (Guba & Lincoln, 1994). However, this view of quantitative and qualitative methods of inquiry is often based on a fallacious conception of social reality as a discrete and aggregate phenomenon, hence the distinctiveness and uniqueness of the aspects we study as researchers. An alternative view to this fallacy is the view of social reality as a continuum with both patterned and observable, and unique and often unobservable aspects (Collins, Onwuegbuzie, & Jiao, 2007; Graff, 2014; Burke
Johnson, Onwuegbuzie, & Turner, 2007). The *Weltanschauung* of this alternative position is that both methods are tools of looking at an extreme end of this continuous reality. Thus, to have a comprehensive appreciation of social reality, there is the need to combine these methods for a detailed analysis of the phenomenon of interest (Johnson & Onwuegbuzie, 2004; Meetoo & Temple, 2003).

A multi-method approach also offers a transformative-emancipation perspective in the study of TCAM within the Canadian context (Mertens, 2010; Shannon-Baker, 2016). As noted in the literature review chapter, studies on TCAM use among sub-Saharan Africans living in Canada and other developed countries is limited. The views, perspectives, experiences and motivations for using TCAM among this group of people in the western context is missing in the literature. A multi-method research approach affords this study the ability to observe patterns of TCAM use among this group of Canadians as well as convey their experiences and motivations for using TCAM in the context of their ethnocultural identity and their location. That is, multi-method research offers an all-inclusive approach to explore the dialectics of the macro and micro aspects of social reality. It offers a common platform for assessing individual psychology, human agency, culture, social structures and social policies (Gilbert, 2006); and how they shape or influence TCAM usage in Canada, as well as, contribute to the identified paradox of ageing, multi-morbidity and the use of TCAM. The purpose of combining these two methods is not to seek validation of the findings of one method or the other, but rather to recognize that they complement each other in the search for a holistic view of social reality (Creswell et al., 2011; Johnson & Onwuegbuzie, 2004; Meetoo & Temple, 2003).
The act of combining quantitative and qualitative research methods in social science studies has its challenges. One such challenge is making sense of the dissonant data obtained using methods of different philosophical views of social reality (Johnstone, 2004; Perlesz & Lindsay, 2003). This challenge becomes crucial, especially when trying to link highly contextualised interpretative findings gained using qualitative methods with generalised empirical results of a quantitative method (Bryman, 2004). Consequently, this challenge results in the difficulty of successfully integrating the two datasets in a multi-method research strategy (Woolley, 2009). Nevertheless, we can address this problem by acknowledging that, the purpose of combining the two methods is to examine different facets of the social phenomenon – ethnocultural diversity, ageing and the use of TCAM – under consideration (Clarke, 2009; Sale, Lohfeld, & Brazil, 2002). A multi-method research approach, therefore, offers multiple constructions and interpretations of TCAM usage in Canada and the paradox embedded in it with regards to ageing; as well as, provides a tool for delving into the complexities of the country’s ethnocultural diversity and the use of TCAM. Thus the murkiness in combining and successfully integrating both methods, as well as the potential contradictory findings they may reveal, will enhance debate, theory and research on Canada’s multicultural society and the plurality of TCAM (Bowleg, 2012).

### 3.2 Study site

The proposed study site for this research is the Greater Toronto Area (GTA). The reason for choosing Toronto as the study area is its multicultural ethnic landscape, which epitomises Canada’s ethnocultural diversity. Multiculturalism has been the pinnacle of the Canadian identity, as well as the nation’s pride (Burnet, 1975; Esses & Gardner, 1996; Wood & Gilbert, 2005). The country is described as a country of diversity (Esses & Gardner, 1996); and equally, the geography
of Canada is a geography of diversity. The driving force behind Canada’s multicultural society is immigration; first of white settlers from Europe and later Asians, Hispanics, Arabs and Africans (Keil & Ali, 2006). Multiculturalism in Canada is more evident in urban than rural areas, albeit the phenomenon is often about the entire country. The demographic composition of Canadian cities, such as Toronto, Montreal, Vancouver, and Ottawa, epitomises multiculturalism in the country (Goonewardena & Kipfer, 2005). Major Canadian cities are the preferred destinations for many immigrants entering the country due to the socioeconomic opportunities cities offer to new immigrants.

Figure 3.1 Map of the Study Area - The Greater Toronto Area
The municipality of Toronto is Canada’s largest multicultural city and also the economic engine of the country. The diverse ethnocultural makeup of the city leads many to describe it as the most multicultural city in the world (Keil & Ali, 2006). Whereas this assertion is contestable, it does emphasise the city’s rich ethnic and cultural diversity. It is estimated that between 2001 and 2006, a quarter of Canada’s 1.1 million international immigrants moved to Toronto (City of Toronto, n.d.). The metropolis is home to 30 per cent of all recent immigrants and 20 per cent of all immigrants; while, over 30 per cent of the residents in the proposed study site speak a language other than English or French (City of Toronto, n.d.). A recent survey by Statistics Canada indicates that 51 per cent of residents in Toronto were born outside Canada (Statistics Canada, 2013a). The 2011 National Household Survey (NHS) estimates that about 221,590 people living in the city identify as being of African origin (Statistics Canada, 2013b). A total of 182,785 out of the city’s residents of African origin are of SSA origin (Statistics Canada, 2013b). GTA is an ideal study site for the study, given my focus on ethnocultural diversity and the use of TCAM. The proposed study area offers a large and an adequate sample size of persons of SSA origin, as well as, other socio-demographic groups for the study’s comparative outlook.

3.3 Study population
As noted previously, the GTA is the site chosen for this study; hence, persons aged 18 years and older living the GTA were the target population, excluding institutionalised persons. The target population, for this study, was categorised into three main groups: residents of sub-Saharan African origin (mainly from West African countries such as Nigeria, Ghana and Sierra Leone), older persons (persons aged 65 years and above) and other residents (persons of non-sub-Saharan African descent). Residents of sub-Saharan African origin and older persons were considered
accessible populations, given these group of persons were the main focus of the study.

Accessible population refers to a group of participants that are available and eligible for participation in the research (Onwuegbuzie & Leech, 2010). Participants in this study are mainly residents of Nigerian, Ghanaian and Sierra Leonean origin living in the GTA. However, a smaller sample of other residents from non-sub-Saharan African origin was included in this study for comparative purpose.

3.4 Sampling techniques

Although residents of sub-Saharan African origin and older persons living in the GTA are characterised as an accessible population in the previous section, there was no population list or sample frame available to me at the beginning of this study. In the absence of such a list, a non-probability sampling method was employed in identifying and selecting potential participants for the study. Non-Probability sampling is a deviation from probability sampling principles, in that the sampling process relies on the subjective judgement of the researcher in selecting cases or units (of the population) to include in the study (Tansey, 2007). This approach to selecting subjects of a research study is criticised as lacking generalisability, and its usefulness in scientific inquiry is often questioned (Abrams, 2010; Burke Johnson et al., 2007; Teddlie & Yu, 2007). However, some researchers argue that prior knowledge of the subject (topic or persons of interest) or a philosophical assumption, which guides both probability and non-probability sampling designs, implies particular cases from the entire population. As Uprichard (2013) notes, such prior knowledge is a prerequisite of probability sampling as such sampling can only be done when the sampling frame is known. The selection of cases or subjects in probability sampling is not arbitrary, so is the case for non-probability sampling. By this, I do not imply the two types of
sampling are the same but only debunk the lack of generalisability argument often used by some scholars to ‘delegitimise’ the use of non-probability sampling in a scientific and academic study. A non-probability sample can offer an empirical generalisability for the groups or settings of interest and analytic generalisability in terms of conceptual power of the phenomenon of interest; that is, offering assertions relevant for the study population and for further inquiry (Collins et al., 2007; Higginbottom, 2004).

A Respondent Driven Sample (RDS) technique was employed to select respondents for the quantitative research. RDS is a non-probability sampling technique employed for studies involving hard-to-reach populations or hidden populations (Benoit, Jansson, Millar, & Phillips, 2005; Heckathorn, 1997). A study population is termed hidden or hard-to-reach when there is no sampling frame or list of the targeted population being studied, and there is an existence of a substantial privacy concern (Gile & Handcock, 2010; Heckathorn, 2002; Salganik & Heckathorn, 2004). This sampling or respondent selection technique is thus ideal, given there is no population list of persons of SSA origin living in the GTA and the study area’s older population is unavailable to me, hence categorising them as hidden or hard-to-reach. Using racialised identity in a population survey to target the former group runs the risk of adding other black ethnocultural communities, such as African-Canadians or African-Caribbean Canadians, to the targeted population due to their similar African origin yet different socio-cultural orientation (Owusu, 2003). Furthermore, racial profiling in the selection of persons of SSA origin risks excluding other racialised groups living in Canada who are of SSA origin. Countries in SSA have considerable White, Arab and Asian populations that have strong ethnic/cultural ties to these countries.
RDS is a traditional sampling method for gathering representative data from a sub-cultural group or a socially networked group (Johnston, Whitehead, Simic-Lawson, & Kendall, 2010). The approach is based on the notion that respondents of a particular socio-cultural group are better able to locate and recruit members than researchers (Semaan, 2010). This sampling technique starts with an initial set of subjects referred to as seeds, who then recruit the first wave of respondents, and the first wave recruits the second wave of respondents until the final sample size is achieved (Abramovitz et al., 2009). RDS is similar to other non-probability sampling techniques, such as snowball sampling, in that it involves chain referral sampling; however, it features allow it to overcome shortfalls inherent in non-probability sampling (Magnani, Sabin, Saidel, & Heckathorn, 2005). Snowball sampling is limited by choice of seed and short recruitment chain, while time-location sampling is limited by capturing the population that frequently use the selected location (Kendall et al., 2008; Magnani, Sabin, Saidel, & Heckathorn, 2005; Muhib et al., 2001). Other limitations of non-probability sampling techniques include bias due to the non-random selection of seeds, volunteerism, and masking (Heckathorn, 1997; Heckathorn, 2002; Salganik & Heckathorn, 2004; Semaan, 2010). RDS overcomes these shortcomings through lengthy referral chains, recruitment quotas and the use of data on network size to adjust for oversampling biases in the recruitment process (Johnston, Sabin, Hien, & Huong, 2006; Kendall et al., 2008). Nevertheless, RDS is susceptible to other biases such as differential recruitment effectiveness, differential recruitment pattern, and heterogeneity in degree (Abramovitz et al., 2009).

The RDS techniques used in this study can at best be termed as a ‘quasi-respondent driven sampling’. Unlike RDS where the initial and subsequent sample seeds directly recruit members of their social network, I directly recruited participants with the seeds acting as gatekeepers to social
groups as well as directing me to where persons in their social networks can be reached or found. The approach was adopted to minimise the cost associated with traditional RDS sampling techniques. The sampling process started with clustering the study population into three groups as noted earlier: persons of SSA origin, older persons and others.

3.4.1 Recruitment of participants from the SSA group

Recruitment of participants from the SSA group started with contacting potential gatekeepers who were leaders or executives in three Anglophone West Africa national associations namely – the Ghanaian Canadian Association of Ontario (GCAO), the Nigerian Canadian Association (NCA) and the Joint Help Support Association of Sierra Leone. The gatekeepers in these national association served as the initial sample seed for this study. They were knowledgeable about the various sub-national or ethnic groups of persons of West African origin living in the GTA. Their connections with members of their associations meant they were able to help locate leaders of other sub-groups and other potential participants. The leaders of sub-national and ethnic groups, as well as those of Western African Christian organisations, formed the seed for the second wave of the recruitment process. The seeds for the second wave helped recruit members of their associations or organisations by informing me of meeting or events being held by the group. During these events, I made presentations about the purpose of the research to the group members. Members who expressed interest in participating in the study were given a self-addressed envelope with paid postage containing the research materials – a survey questionnaire, a letter of information and a consent form (for those interested in taking part in the interview phase of the research). In larger sub-national or ethnic groups, such as the Akan, Igbo and Yoruba ethnic groups, leaders of smaller community groups who participated in the second wave of sampling became
gatekeepers for recruiting participants in these smaller groups. Similar to the recruitment approach used in selecting the seeds for the second wave, participants for the third wave were recruited during community events or gathering such as annual picnics, festival celebrations, and after church services. In some cases, leaders of these smaller sub-national or sub-ethnic groups added me to their social media platforms, mainly WhatsApp; where I introduced myself, and posted information about my research study with members of the group.

3.4.2 Recruitment of older persons

Similar to the recruitment process used for selecting potential participants from the SSA group, the recruitment process for older persons living in the GTA started with reaching out to community seniors’ associations or organisations. Executive directors or community program officers in these organisations were contacted to seek consent and permission to recruit potential participants. Where consent and permission for recruitment were given, copies of the research poster were pasted on the premises of the organisations. Flyers with information on the research study were also given to the organisations to be distributed to members and patrons of the community organisation or facilities during meetings and events. Copies of the research instruments were sent to seniors interested in participating in the study. These individuals became the initial seed for the older persons’ recruitment process. Participants from the first stage of recruitment were also given a research booklet containing information on the study description and letter of information to distribute among older persons in their social networks. Older persons interested in the study made contact via an email address or a telephone number included in the research booklet. This group of participants formed the second seed or second wave of the recruitment process for older persons.
3.4.3 Recruitment of other participants
The initial seed for recruitment of participants in the other group was done through community organisations and during community events. First, consent and permission for recruitment were sought from organisation executives or event organisers. Initial contact with leaders of organisations or event organisers included explaining the purpose of the research study and sending copies of the research materials (study description, letter of information and research poster) to these gatekeepers. Members or participants were approached during the events and interested persons were given the research instrument as well as flyers of the research to share with interested persons in their social network.

3.5 Quantitative data collection techniques
The study employed a cross-sectional study design in gathering quantitative data. Whereas causal relations cannot be inferred from this type of study, it provides a convenient means of estimating the prevalence of behaviour, as well as, ascertaining the association between study variables. A cross-sectional design proposed in this study is a cheap, quick and easy way of collecting survey data within a limited timeframe (Sedgwick, 2014). The study first used quantitative research survey techniques as a way of examining the broader patterns of TTCAM usage among persons of SSA origin and Canadian residents of other ethnocultural origins, as well as, highlight existing patterns of TCAM among the older population in Canadian society. A survey questionnaire was employed to solicit information on TCAM care-seeking behaviour of persons of SSA origin and Canadian residents of other ethnocultural origins. This data collection technique helped identify the regularities and contradictions in the use of TCAM among Canada’s diverse ethnocultural groups. Additionally, the technique shed light on relationships between structural variables and
indicators of an agency, and how such relationships contribute to the observed pattern and the paradox of the use of TCAM observed in older persons living in Canada.

The survey questionnaire was available in paper-based and online formats. As previously noted, hard copies of the survey questionnaires were distributed during community or association events to members of Anglophone West African groups interested in participating in the study. For participants recruited through from seniors’ groups, copies of the questionnaire were mailed to a contact address provided in their correspondence. Copies of the survey questionnaire were also distributed to interested persons in the other group who were contacted at specific events or locations. An online survey design using ‘Google Forms’ was also made available on social media platforms of Anglophone West African groups for interested members to access the survey questionnaire. Also, the link to the online survey was sent or provided to participants from the seniors’ group and other groups who expressed a preference for this mode of participation. A total of 348 respondents participated in the survey questionnaire, comprised of 247 respondents for the paper-based questionnaire and 101 respondents for the online survey. For the paper-based survey, 850 questionnaires were distributed, giving a response rate of 29.06%. Recruitment of participants and data collection for this study was carried out between July, 2017 and August, 2018.

The study blended both close-ended and open-ended types of questions in the survey questionnaires. The use of the latter type of questioning allows the informants or participants to provide more details to some closed-ended questions that may need further elaborations. The questionnaire was organised into seven modules. The first module delved into the individual’s characteristics such as age, sex, education and income. The second module covered the
respondent’s sociodemographic background such as ethnic or racial identity, country of birth and immigration status. The third examined the care-seeking behaviour for TCAM focusing on the type of remedies sought by respondents, previous history of usage, TCAM care financing and unmet TCAM need. The fourth part of the survey questionnaire delved into health status and insurance coverage, while the fifth part inquired about respondent’s transnational, sociocultural and communal ties. The penultimate section of the questionnaire focused on chronic and multimorbid conditions and the last section covered issues of access and use of allopathic care in the GTA.

3.6 Qualitative data collection techniques
A criterion sampling technique was employed in selecting informants for this phase of the study. Criterion sampling is defined as the selection of cases or persons that meet some predetermined importance or interest (Bradshaw & Stratford, 2010; Suri, 2011). This sampling technique enables researchers to focus solely on the phenomena or cases of interest resulting in a comprehensive understanding of the topic under consideration (Suri, 2011). Given the focus of this thesis, the use of TCAM was used as a criterion for the selection of participants for the second phase of the study. The aim was to seek detailed information, experiences, and knowledge of how ethnocultural ties and age influence the use of TCAM among seniors and persons of SSA origin. The information garnered through this research method provides in-depth knowledge on the context or situation in which Canadians and residents of Canada employ their transcultural knowledge and biocultural resources in meeting or addressing their health care needs through the use of TCAM remedies. This follows the logic of using a multilevel sequential mixed method design to produce a more comprehensive picture of TCAM use in Canada, devoid of the biases and gaps intrinsic in the use
of a mono-method design (Denscombe, 2008; Feilzer, 2009). Thus, the findings of the qualitative research complement the quantitative findings.

3.6.1 Interviewing technique and recruiting informants

Interviewing can be conceptualised as a verbal interchange in which a person attempts to elicit information from another (Dunn, 2010). This method of inquiry enables researchers to present authentic insight into people’s experiences and the meaning they attach to everyday experiences in social reality (Cloke et al., 2012; Silverman, 1993). The act of interviewing is a popular method used in soliciting or gathering information about people’s experience of a phenomenon and the meanings embedded in this experience. This form of interaction and data collection occurs in our everyday conversation with others. However, the act of interviewing in academic research entails “diplomacy in contacting informants and negotiating ‘research deals’” (Dunn, 2010).

An in-depth interview technique is used to gather informants’ diverse meanings, opinions, and experiences in their TCAM seeking behaviour in the context of their ethnocultural background and senescence. Whereas this technique can be time-consuming, it offers a deep and detailed appreciation of the complex behaviours and motivations that inform the use of TCAM in Canada’s pluralistic health care environment (Cloke et al., 2012; Dunn, 2010; Silverman, 1993). Additionally, the use of in-depth interviews eliminates the potential uneasiness of informants sharing their experiences as well as minimises the issue of imposition of meanings and unseen power relations in a group discussion (Wilkinson, 1998).
A semi-structured interviewing approach was used for the interviewing process. This form of interview questioning provides flexibility in the interviewing process while focusing on the core themes of the study (Dunn, 2010). It also allows for the uncovering of new insights on the phenomena of interest, not thought of initially before the research. As Dunn (2010) notes, the role of the researcher in the interviewing approach is that of an interventionist, as the researcher mainly directs the informant's discussion on the core themes of the research. A semi-structured interview technique allows informants to interpret and provide meanings of their experiences and events. Thus, the use of a semi-structured interview approach was used to help explore and understand how social capital (in the form of individual and communal bonds, and ethnocultural resources) influence the use of TCAM. It also facilitated uncovering of the effect of ageing or age on access and use of TCAM by seniors.

Participants for the interviews were recruited from the quantitative survey. Participants in the quantitative research survey who met the inclusion criterion (persons who use TCAM) were asked to indicate their willingness to participate in an in-depth interview voluntarily. Eligible interested persons included their contact information in a detached form included in the research materials provided to participants who used the paper-based questionnaires. Although, both the survey and the contact information form were sent in the same envelope, they were separated on delivery to ensure complete anonymity of the survey. Participants who used the online survey provided contact information in the form of a telephone number or an email address. Twenty-eight (28) respondents in the quantitative sample expressed interest in being interviewed. Participants who expressed interest in the interview process were sent a letter of information explaining the purpose of the research study, storage of their information and contact information.
of community counselling services in the GTA. The contact information (email address) of four participants who expressed interest in being interviewed were invalid while two participants withdrew due to lack of availability. There were no other discernible patterns among those who expressed an interest in being interviewed but were then excluded. Thus, 22 persons were interviewed for this study comprising 9 persons from the SSA group, 4 persons of African-Caribbean origin, 8 persons of European descent and 1 person of Asian descent. Participants completed a consent form indicating their approval to be interviewed as well as their understanding that their participation was voluntary. Copies of the Letter of Information and Consent form are in Appendices D and E, respectively.

3.6.2 Interviewing process

Participants who consented to participate in the qualitative phase were contacted via the contact information they provided. In their correspondence, participants were also asked to indicate their preferred dates and time for the interview, as well as, the preferred mode of interviewing with the following options available: face-to-face, telephone, and video call. Most informants opted for telephone interviews; however, three persons opted for written responses to the interview questions. To accommodate such persons, the semi-structured interview guide was structured and standardised to capture topics and areas of interest in the research. A copy of the structured interview questions is in Appendix B.

To protect informants’ privacy during the telephone interviewing process, private rooms in the Department of Geography and Planning at Queen’s University were booked, and interviews were conducted in these rooms with only the researcher present at the time of the interviews. Before
the interviews, informants were made aware the conservation was being recorded and asked to confirm their consent to the recording once again. All informants consented to be recorded. Additionally, informants were asked if they had any questions or concerns about the study before the start of the interview. Informants generally raised questions about having access to the findings of the study in the future, as well as, questions about their anonymity. Informants were informed they could access written reports or manuscripts about the study from the Geographies of Ageing Projects Laboratory (GAPLab) website (the web address included in the LOI) or contact me via my contact information on the LOI for copies of such reports or manuscripts. Copies of previously authored publications were made available to informants upon request. With regards to their anonymity, informants were informed their identity would be anonymised in transcribed documents, written reports, publications and the original recorded interviews would be saved on secured encrypted memory devices. All questions and concerns were addressed to the satisfaction of the informants before the start of the interview. The average duration for the interview was 20 minutes; the shortest interview was 9 minutes 13 seconds, and the lengthiest was 1 hour 16 minutes and 14 seconds.

The interviews started with a brief self-introduction and the purpose of the research study. The introduction was to help build rapport with the informants. Rapport building is an important element in qualitative inquiry, as it enables the researchers to establish a sense of mutual trust with the informant (Elmir, Schmied, Jackson, & Wilkes, 2011; Karnieli-Miller, 2009). The process of building rapport often entails reciprocity through the exchange of information between the researcher and the informant (Booth & Booth, 1994; Peters, Jackson, & Rudge, 2008). Self-disclosure is one approach to building rapport (Dickson-Swift, James, Kippen, &
Liamputtong, 2007), as it helps informants to know the researcher, as well as help, initiate the interview. Some researcher argues attempts to foster rapport with informants particular vulnerable population may be a coercive approach to garner information the latter may not willingly provide hence leading to future regrets for disclosing such information (Dickson-Swift et al., 2007; Peckover, 2002). To minimise this potential effect or the effect of influencing the informant’s narratives on the research topics, information about myself limited to my status as a graduate student of the Department of Geography and Planning, Queen’s University and about GAPLab.

A pyramid structure approach was adopted for the interviewing process. Pyramid interviewing structure implies starting the interviews with easy or general questions and ending with topic-specific questions. This approach allows the researcher and informant to become accustomed to the interview as well as help maintain the rapport built at the beginning of the interview. The interview started with general questions about informant’s sociocultural background, communal ties and their perceptions of health. This section explored identity construction of informants with questions concerning how the informant identifies themselves, their ascribed sociocultural worldviews, where they perceive as their home and what being healthy means to them. The next section of the interview delved into health status, health seeking and health promotion behaviours. The final section of the interview focused on the use of TCAM. The interviewing process ended with thanking informants for their participation and inquiring if they had any questions, concerns or suggestions. I also used this opportunity to inform informants they can share my contact information and information about the research with family, friends or neighbours who might be interested in participating in the study.
3.7 Ethics, power and researcher’s positionality

The research process in the humanities and social sciences is a social construct which involves interactions between the researcher and the participant within a social context. Societal norms often influence the construction of knowledge through the research process, individual expectations (of both the researcher and the participant) and structures of power (Karnieli-Miller, 2009; Kobayashi, 2009; Whitson, 2017). Social structures and the process of knowledge construction through the research process can have both intended and unintended consequences at every stage of the research and knowledge dissemination process. Dowling (2010) asserts that social research has a potential influence on society and its people through altering people’s behaviour by participating in the research, as well as, through sharing and communicating the findings of the research. Social research calls for considerable reflections on the influence of social structures and the relationship between the researcher and the researched, on knowledge production and its potential effect on society.

Ethical consideration is an essential aspect of all research, both academic and non-academic. Research ethics can be construed as the responsibilities and obligations of the researcher to the researched through the researcher’s conduct in garnering knowledge, interpreting participations experiences, meaning and behaviour, and the used of the knowledge gained through the research (Dowling, 2009, 2010). The interest of participants must always be at the forefront of the research process to ensure their privacy is protected, informed consent sought, and potential harm mitigated. In view of these principles, researchers acknowledge that ethical considerations in research rest on informed consent, privacy, harm to the researcher and the researched,
exploitation of the research subject, and sensitivity to the geopolitical and sociocultural context or differences. These considerations are important because social research involves the creation of a relationship between the researcher and the researched, and discussion of the researched’s personal life. The latter often involves detailed description and discussions about the individual’s life experiences and their personal meanings to the social phenomenon of interest to the researcher.

To address these ethical considerations in my research, ethical approval for the study protocol was sought from Queen’s University’s General Research Ethics Board (GREB). Concerns raised by GREB reviewers were addressed at the institutional level before the commencement of the research. I also obtained consent from the various organisations contacted during the research before contacting their members or posting the research on their communication platforms, including social media platforms. For most Anglophone West African organisations in the GTA, the consent or approval for the research was given verbally (through telephone calls). However, community organisations, such as seniors’ associations in the GTA, provided written consent via email. Participants in both the quantitative survey and the qualitative interviews were provided with a LOI that explained the purpose of the research, their anonymity and storage of their data. Participants were also made aware that their participation in the research was voluntary.

Similarly, the process of withdrawing from the research and requesting recorded information to be destroyed was also made known to participants in the qualitative interview before and after the interview. As noted earlier, permissions were obtained from informants before the recording of the interviews. To ensure their privacy, informants were not asked their names during the interview process. In the transcribed data, informants were identified by pseudo names assigned
for the purpose of analysis and interpretation of the data. The quantitative survey was completely anonymous with no self-identifying information.

Power relations between the researcher and the researched are embedded in social research. Relations of power in research are more evident in qualitative methods of inquiry as they involve interpersonal relationships between the researcher and the researched in the creation of knowledge. To advance methodological rigour in the research process, experts in the field of qualitative studies note the need to be self-reflexive in the research and knowledge construction process (Dowling, 2010; England, 1994; Kobayashi, 2003, 2009). This reflexivity can be achieved through self-conscious examination of the researcher’s position in the knowledge construction process and the dynamism of the researcher’s social location through space and time the during the research process (Kobayashi, 2009; Mullings, 1999). Whereas the process of self-reflexivity has the tendency to be self-indulgent as observed by Kobayashi (2003, 2009), the process helps situate the constructed knowledge in the context of societal norms, individual expectations (of both the researcher and the participant) and structures of power (of both the researcher and the researched). That is, the knowledge or information garnered through the research process is shaped by the researcher’s and the ‘researched’s’ positionalities – their affects, social meanings and the power they possess (Kobayashi, 2009). This view of the research processes and knowledge construction contradicts Guelke’s (1974) view of the researcher as ‘tabula rasa’ who observes and records the knowledge and experiences of the informants.

In this study, I recognise my positionality as a graduate student, and an Anglophone West African is much more than being an insider or outsider to the various community groups and
organisations contacted during the research. My identity and the agency I embody, through my affects, social location and knowledge, were active in the construction of identities and meanings. The awareness of the research informants of this positionality may have overtly or subtly informed the words or phrase they used in describing their identity and ethnocultural belonging. Knowledge construction, in the form of how informants identify themselves was not only influenced by my positionality but also by the current geopolitics of North America. Some informants in describing their identity as ‘Canadian’ were quick to highlight what distinguishes a Canadian from his/her southern neighbour with regards to the current USA government policy on racialised immigrants. I delve into much more detail on the influence of my positionality and geopolitics on identity construction among the research informants later in chapter 5. As noted in previous chapters, this study examines the effect of ethnocultural ties (including ethnocultural identity) on the use of TCAM. In summary, I recognise the influence of my identity and geosocial context on the meanings and interpretations of the identity and the social world created by informants in this study. The issue of intersubjectivity is not peculiar to this study but embedded in all qualitative methods of inquiry (Dowling, 2009, 2010).

3.8 Research limitations and challenges

The research methods adopted and the data collection process for this study had some challenges. In this section, I mainly focus on the methodological limitations of the study. Methodological limitation concerns the shortcomings of the study design, the sampling approach, measures used in collecting the data and the issue of self-reported data. The first methodological limitation of this study concerns the nature of the study design. Like most social
science research, this study adopted a cross-sectional survey approach in the collection of primary data. Cross-sectional studies are “snapshot” observation of phenomena among a population at a point in time or a short time duration. This methodological approach is ideal for collecting data and information on individual characteristics and prevalence of an outcome of interest among a given population (Levin, 2006). By their nature, cross-sectional studies are simple, easy, fast, and an inexpensive method of collecting primary data within a limited time period. Yet, these advantages render cross-sectional study design a less favourable method of examining causal relationships between events and outcomes. Cross-sectional studies by their nature lack a time dimension, albeit recruitment of participants, may occur over a period of time – as was the case for this study (Sedgwick, 2014; Sedgwick, 2015). The inability of cross-sectional studies including this current study, to demonstrate temporal relationship inhibit their ability to infer causation between events and outcomes or variables of interest (Barros & Hirakata, 2003; Reichenheim & Coutinho, 2011).

The second limitation pertains to selection or sampling bias, which also relates to the study design (cross-sectional design). The purpose of sampling in quantitative research is to select representative subjects from a study population. However, the task of achieving a true representative sample is a difficult one, particularly in cases, where a full list, or sample frame of all eligible subjects is unavailable – as acknowledged previously in the chapter. Although a suitable sampling technique was adopted to overcome this challenge, studies suggest that non-respondents in surveys with high non-response rate (60% to 80%) are systemically different from respondents thus creating the issue of self-selection bias (Martikainen, Laaksonen, Piha, &
Lallukka, 2007; Yu & Tse, 2012). Evidence from existing studies suggest that persons of lower socioeconomic background are less likely to respond to a survey, particular when there is no incentive for participation – as was the case in this study (Freudenstein, Arthur, Matthews, & Jagger, 2001; Goldberg et al., 2001; Lorant, Demarest, Miermans, & Van Oyen, 2007). The occurrence of selection bias in this study could be as a result of the sampling technique. Knowledge from studies in social capital suggests that people tend to bond and associate themselves with individuals with whom they share similar traits or characteristics (ethnicity and social class) – homophily (McPherson, Smith-Lovin, & Cook, 2001; Poortinga, 2012; Song, 2011).

Thus, the seeds from wave 1 and wave 2 of the RDS procedure might likely have recruited persons of similar characteristics for the study. Also, recruitment of respondents for the survey was mostly done at social gatherings, social events, and social media platforms hence people who do not engage in such gatherings or social media are likely to be excluded from the selection process. Systemic differences, especially demographic difference between non-respondents and respondents, can limit the precision of survey estimates (Rupp, Triemstra, Jacobi, Dinant, & van den Bos, 2002). Third, the small sample size for the study means the results for this study cannot be generalised for the study’s target populations. The final methodological limitation pertains to information bias; that is, self-reported surveys are prone to bias emanating from selective memory, telescoping (that is assigning events or experiences to time periods that are different from the time of their occurrence), exaggeration (respondents may overestimate or underreport certain events or experiences) and attribution (the potential for
respondents to assign positive outcome or events to their own agency and negative outcome to external forces or mechanism).

3.9 Summary
The discussion in this chapter focused on the methods and techniques for data collection. The chapter starts with an epistemological discussion on the study design and the rationale for adopting a case-study and a multi-method approach for this research. The chapter proceeded with a discussion of the study site and the study population. It also delved into the sampling technique and the sampling process for selecting participants for this research. The quantitative and qualitative data collection methods were also discussed in this chapter as well as issues about ethics, power, and the researcher’s positionality. Methodological limitations of this study were also considered in the chapter.
Chapter 4

Characteristics of Study Sample – Descriptive and bivariate analysis.

4.1 Introduction

The discussion of the previous chapter focused on the methods and techniques of selecting participants for the study, as well as, the data collection processes. The chapter also discussed issues pertaining to ethics, power relations and my positionality in the research process. The discussion in this chapter focuses on the descriptive characteristics of the study sample (respondents). The first part of the chapter reports on the sociodemographic characteristics of the research participants, including their age, sex, educational level, country of birth, and immigration status. The second part delves into health characteristics of the respondents while the third section entails a descriptive summary of respondents’ perceptions of biomedical care-related factors, such as quality of care and accessibility to care. The fourth part of the discussion focuses on TCAM care, specifically history of TCAM usage, current TCAM usage, history of TCAM use prior to immigrating to Canada (for respondents of SSA origin), and unmet TCAM need. The data and information from the study sample are presented in two components: the entire study sample (including persons of non-sub-Saharan African origin) and persons of sub-Saharan African origin only. The final component of this chapter is a discussion of the association between sociodemographic characteristics and health outcomes; specifically, general health status, chronic health status, and mental health status.

Recent estimates from Statistics Canada suggest there are about 58,830 persons of central and western African origin living in the Toronto Census Metropolitan Area (CMA) (Statistics Canada, n.d.-a). From this figure, it is estimated that 20,465 are of Ghanaian origin, 19,330 of
Nigerian origin and 815 of Sierra Leonean origin (Statistics Canada, n.d.-a). Based on the figures above, the sample of persons of 273 represents 0.46% of the total number of persons of central and western African origin living in the Toronto Census Metropolitan Area. From the sub-Saharan African sample, 259 respondents were from the three West African anglophone countries – Ghana, Nigeria, and Sierra Leone – that was defined as the primary sample pool for this study (see Chapter 3). This figure represents 0.64% of persons of Ghanaian, Nigerian and Sierra Leonean origin living in the Toronto CMA.

4.2 Sociodemographic characteristics

Table 4.1 shows the summary of the sociodemographic characteristics of the study sample. The average age of participants was 42.45 years, with an age range of 18 years to 85 years (the median age was 39 years). The majority of the survey respondents were females (54.89%), married (58.05%) and persons with post-secondary degree (68.10%). With regards to income, ~33.62% of the sample earned annual personal income between $40,000 and $59,999, and ~57.18% of the surveyed participants lived in households with an annual income of $80,000 or more. This suggests that the majority of the respondents were living in higher income households. Additionally, the vast majority of the respondents were Canadian citizens or had Canadian citizenship (77.89%). Most of the survey respondents were of sub-Saharan African origin (78.45%) followed by persons of other African descent (8.62%) and non-Hispanic, Whites (7.76%). In line with the target population for this study, the majority of the surveyed sampled were Anglophone West Africans living in the GTA. The majority of respondents were persons born in Ghana (35.63%) followed by persons of Nigerian origin (29.60%) and Canadian born
respondents (12.64%). For persons of immigrant origin, the mean length of stay in Canada was 17 years with the lowest and highest duration being 1 and 81 years, respectively.

Table 4.1 Summary of Descriptive Characteristics of Survey Respondents

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Age</td>
<td>42.45 (18 - 85)†</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>157 (45.11%)</td>
</tr>
<tr>
<td>Female</td>
<td>191 (54.89%)</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>202 (58.05%)</td>
</tr>
<tr>
<td>Living-common law</td>
<td>19 (5.46%)</td>
</tr>
<tr>
<td>Widowed</td>
<td>6 (1.72%)</td>
</tr>
<tr>
<td>Separated</td>
<td>7 (2.01%)</td>
</tr>
<tr>
<td>Divorced</td>
<td>17 (4.89%)</td>
</tr>
<tr>
<td>Single/never married</td>
<td>97 (27.87%)</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>&lt; High school</td>
<td>1 (0.29%)</td>
</tr>
<tr>
<td>High school</td>
<td>18 (5.17%)</td>
</tr>
<tr>
<td>Some post-secondary</td>
<td>92 (26.44%)</td>
</tr>
<tr>
<td>Post-secondary degree</td>
<td>237 (68.10%)</td>
</tr>
<tr>
<td>Personal Income</td>
<td></td>
</tr>
<tr>
<td>&lt; $20,000</td>
<td>49 (14.08%)</td>
</tr>
<tr>
<td>$20,000 - $39,999</td>
<td>86 (24.71%)</td>
</tr>
<tr>
<td>$40,000 - $59,999</td>
<td>117 (33.62%)</td>
</tr>
<tr>
<td>$60,000 - $79,999</td>
<td>33 (9.48%)</td>
</tr>
<tr>
<td>$80,000 or more</td>
<td>63 (18.10%)</td>
</tr>
<tr>
<td>Household Income</td>
<td></td>
</tr>
<tr>
<td>&lt; $20,000</td>
<td>20 (5.75%)</td>
</tr>
<tr>
<td>$20,000 - $39,999</td>
<td>30 (8.62%)</td>
</tr>
<tr>
<td>$40,000 - $59,999</td>
<td>50 (14.37%)</td>
</tr>
<tr>
<td>$60,000 - $79,999</td>
<td>49 (14.08%)</td>
</tr>
<tr>
<td>$80,000 or more</td>
<td>199 (57.18%)</td>
</tr>
<tr>
<td>Immigration Status</td>
<td></td>
</tr>
<tr>
<td>Citizen</td>
<td>271 (77.89%)</td>
</tr>
<tr>
<td>Permanent resident</td>
<td>52 (14.94%)</td>
</tr>
<tr>
<td>Temporary resident</td>
<td>4 (1.15%)</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Student visa</td>
<td>20 (5.75%)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (0.29%)</td>
</tr>
</tbody>
</table>

**Racial Background**

- **Hispanic** | 4 (1.15%) |
- **Non-Hispanic, white** | 27 (7.76%) |
- **East Asian** | 1 (0.29%) |
- **South Asian** | 5 (1.44%) |
- **Arab** | 1 (0.29%) |
- **Black or African (sub-Saharan Africa)** | 273 (78.45%) |
- **Black or African (other)** | 30 (8.62%) |
- **Mixed race** | 7 (2.01%) |

**Length of Stay**

- 17 (1 - 81) *a*

**Country of Birth**

- **Cameroon** | 5 (1.44%) |
- **Canada** | 44 (12.64%) |
- **China** | 1 (0.29%) |
- **Congo** | 2 (0.57%) |
- **Egypt** | 1 (0.29%) |
- **Ghana** | 124 (35.63%) |
- **Guatemala** | 1 (0.29%) |
- **Guyana** | 1 (0.29%) |
- **Jamaica** | 3 (0.86%) |
- **Kenya** | 9 (2.59%) |
- **Libya** | 1 (0.29%) |
- **Nigeria** | 103 (29.60%) |
- **Northern Ireland** | 1 (0.29%) |
- **Pakistan** | 2 (0.57%) |
- **Peru** | 1 (0.29%) |
- **Romania** | 1 (0.29%) |
- **Scotland** | 1 (0.29%) |
- **Sierra Leone** | 33 (9.48%) |
- **South Africa** | 3 (0.86%) |
- **Tanzania** | 2 (0.57%) |
- **Trinidad** | 3 (0.86%) |
- **United States** | 4 (1.15%) |
- **Zambia** | 1 (0.29%) |

*a = mean, range in parenthesis*
4.3 TCAM care characteristics of respondents

The survey questionnaire elicited information about respondents’ TCAM use and care-seeking behaviour (Table 4.2). The finding shows that the lifetime prevalence of TCAM use among the study sample was ~55.75%. Among participants that had used TCAM in their lifetime, 76.29% indicated they used a TCAM modality of their ethnocultural origin compared to 23.71% who did not. Respondents used a vast array of TCAM remedies, including professional care and self-care. For professional care, respondents used services, such as chiropractic, acupuncture and homoeopathy. Self-care remedies included steam baths, essential oil smudging, honey, lime, TCP, herbal tea and ginger. Among respondents who have used TCAM in their lifetime, the majority (48.45%) indicated they use or used TCAM occasionally (Figure 4.1). The current prevalence of TCAM use among the survey respondents was 29.02% - that is, the proportion of respondents that used TCAM 12 months before the survey. The majority of the respondents that used TCAM 12 months prior to the survey stated the paid out-of-pocket (41.84%) and private health insurance plan (28.57%). Regarding the source of TCAM used in the past 12 months before the survey, 39.60% of respondents who used TCAM mentioned licensed practitioners as the source, while 33.66% stated they engaged in self-medication.
Table 4.2 Summary of TCAM use and behaviour among respondents

<table>
<thead>
<tr>
<th>Category</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TCAM - Lifetime prevalence</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>194 (55.75%)</td>
</tr>
<tr>
<td>No</td>
<td>154 (44.25%)</td>
</tr>
<tr>
<td>TCAM - Ethnocultural origin</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>148 (76.29%)</td>
</tr>
<tr>
<td>No</td>
<td>46 (23.71%)</td>
</tr>
<tr>
<td>TCAM - 12 months prevalence</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>101 (29.02%)</td>
</tr>
<tr>
<td>No</td>
<td>247 (70.98%)</td>
</tr>
<tr>
<td>Source of TCAM - 12 months prevalence</td>
<td></td>
</tr>
<tr>
<td>Licensed practitioner</td>
<td>40 (39.60%)</td>
</tr>
<tr>
<td>Professional healer other</td>
<td>9 (8.91%)</td>
</tr>
<tr>
<td>Self-medicated</td>
<td>34 (33.66%)</td>
</tr>
<tr>
<td>Family member/social relation</td>
<td>10 (9.90%)</td>
</tr>
<tr>
<td>Combined</td>
<td>8 (7.92%)</td>
</tr>
<tr>
<td>Medical Return</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>117 (33.62%)</td>
</tr>
<tr>
<td>No</td>
<td>231 (66.38%)</td>
</tr>
<tr>
<td>Unmet TCAM need</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>73 (20.98%)</td>
</tr>
<tr>
<td>No</td>
<td>275 (79.02%)</td>
</tr>
</tbody>
</table>
The findings of the survey also show that 33.62% of the study sample engaged in transnational healthcare-seeking or medical return. In this study, medical return was defined as returning to Canada with TCAM remedies or travelling outside Canada to use TCAM (Q25). The vast majority of the respondents that engaged in medical return were of immigrant origin, and the
TCAM remedies were sourced from their countries of origin. Approximately 33.17% of respondents of immigrant origin indicated that had engaged in medical return compared to 9.09% of Canadian born respondents who travelled outside for TCAM or came back to Canada with TCAM. Respondents rarely engaged in medical return or transnational healthcare-seeking; in the survey, 82.05% of respondents that engaged in medical return indicated they rarely do this. The finding also shows that 20.98% of the study sample had unmet TCAM needs – that is, they did not get the TCAM care they needed in the 12 months period prior to the survey. The majority of persons of sub-Saharan African origin noted unavailability of TCAM remedies as the reason for unmet need while persons of other racial groupings cited cost as the motivating factor for unmet TCAM needs. Figure 4.3 shows the proportional distribution of reasons for unmet TCAM by racial groups. Likewise, foreign-born respondents mentioned non-availability of TCAM as a major factor for unmet TCAM needs (Figure 4.4). Both race ($\chi^2=26.997, V=0.459, p<0.001$) and immigration ($\chi^2=13.994, V=0.468, p<0.001$) history were strongly associated with the reason for unmet TCAM needs.

![Figure 4.3 Reasons for unmet TCAM among racial groups](image-url)
4.4 Insurance coverage and health status characteristics

Table 4.3 shows the summary characteristics of respondents’ health and health insurance status. A vast majority (91.95%) of the study sample was covered by the provincial health insurance scheme (OHIP). The majority of the respondents also indicated that they had additional health insurance coverage (73.28%) through employment. Figure 4.5 shows the percentage distribution of additional health insurance coverage by type. A substantial proportion of respondents had a family doctor or physicians (88.22%); albeit only 14.98% stated their family physician was of similar sociocultural background. In terms of health status, ~93.39% of respondents stated their health was good or excellent (Excellent=48.85%, Very good=28.45% and Good=16.09%) compared to ~6.61% of respondents who classified their health status as fair or poor. The proportion of respondents who deemed their mental health status as excellent, very good or good
(~96.26%) was slightly higher than the proportion for general health status. Only 3.74% of respondents surveyed rated their mental health status as fair or poor.

Table 4.3 Insurance coverage and health characteristics of respondents

<table>
<thead>
<tr>
<th></th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance - Provincial health plan</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>320 (91.95%)</td>
</tr>
<tr>
<td>No</td>
<td>28 (8.05%)</td>
</tr>
<tr>
<td>Insurance - Additional health plan</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>255 (73.28%)</td>
</tr>
<tr>
<td>No</td>
<td>93 (26.75%)</td>
</tr>
<tr>
<td>Family physician</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>307 (88.22%)</td>
</tr>
<tr>
<td>No</td>
<td>41 (11.78%)</td>
</tr>
<tr>
<td>Physician - Similar sociocultural background</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>46 (14.98%)</td>
</tr>
<tr>
<td>No</td>
<td>261 (85.02%)</td>
</tr>
<tr>
<td>Health status</td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td>170 (48.85%)</td>
</tr>
<tr>
<td>Very good</td>
<td>99 (28.45%)</td>
</tr>
<tr>
<td>Good</td>
<td>56 (16.09%)</td>
</tr>
<tr>
<td>Fair</td>
<td>20 (6.61%)</td>
</tr>
<tr>
<td>Poor</td>
<td>3 (0.86%)</td>
</tr>
<tr>
<td>Mental health status</td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td>211 (60.63%)</td>
</tr>
<tr>
<td>Very good</td>
<td>86 (24.71%)</td>
</tr>
<tr>
<td>Good</td>
<td>38 (10.92%)</td>
</tr>
<tr>
<td>Fair</td>
<td>10 (2.87%)</td>
</tr>
<tr>
<td>Poor</td>
<td>3 (0.86%)</td>
</tr>
<tr>
<td>Functional limitations</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>37 (10.63%)</td>
</tr>
<tr>
<td>No</td>
<td>311 (89.37%)</td>
</tr>
<tr>
<td>Chronic conditions</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>78 (22.41%)</td>
</tr>
<tr>
<td>No</td>
<td>270 (77.59%)</td>
</tr>
<tr>
<td>Average Number of chronic conditions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.28 (0 - 9)</td>
</tr>
</tbody>
</table>
The prevalence of functional limitation (disability) in activities of daily living was 10.63%. In terms of chronic health conditions, ~21.26% of respondents indicated they had a chronic illness. The mean number of chronic illness was 2.28, and the range for the number of chronic illness was 0 to 9 illnesses. The major chronic health conditions reported by respondents were hypertension and musculoskeletal pains. Figure 4.6 shows the word frequency map (word cloud) for chronic health conditions reported by respondents.

![Chart showing the proportional distribution of additional insurance coverage.](image)
4.5 Respondents’ perceptions of biomedical care

In the survey, respondents were also asked about their perceptions and experience with seeking biomedical care. Table 4.4 shows the summary result of these perceptions and experiences. Overall, the majority of the surveyed respondents were of the view that the biomedical care they received in the GTA was excellent (46.55%) and very good (32.18%); while 3.74% and 1.44% rated the quality as fair and poor, respectively. Most respondents also opined that available biomedical care services were highly adequate (46.26%) and adequate (34.77%) for their healthcare needs. However, 6.61% of respondents thought the services were inadequate or highly inadequate for their healthcare needs. With regards to empathy and sensitivity to sociocultural needs, the responses were fairly split between “yes” (42.24%) and “don’t know” (46.55%); only 11.21% of respondents surveyed indicated their biomedical care providers did not show empathy or were not sensitive to their sociocultural needs. Most respondents also felt comfortable in the biomedical care environment (90.52%) compared to ~9.48% of respondents who felt somewhat
comfortable or uncomfortable. Only some respondents (13.51%) offered submissions highlighting their experiences of difficulty in access to biomedical care and incidents of marginalisation, discrimination, stereotyping or being disrespected in their access or use of biomedical care in the GTA.

“During labour, the doctor shouted at me about the contractions I was feeling. He was frustrated with the information I provided about where I felt my contractions (the incident occurred in Brampton). At the emergency, the nurse questioned my story about being chased by coyotes and injuring my knee (the incident occurred in Mississauga)” (F, 34, University, Ghanaian-born)

“When I was a young adult, I had gone to see a specialist about my epilepsy. The doctor asked me a question; I said: “excuse me?” He said, “does epilepsy make you deaf” in a very rude tone of voice.” (F, 59, High school diploma, Canadian-born)

Similarly, fewer respondents (10.34%) reported facing difficulties or challenges in their access to biomedical care in the GTA. The majority of respondents surveyed mentioned waiting time for specialised services and emergency care as the major challenges or difficulty they faced in accessing biomedical care in the GTA. Respondents had to wait for a long time for required specialist services such as hip-replacement and reproductive health issues. Others also mentioned the numbers of hours they spent at emergency care units as a major challenge with biomedical care in the GTA: Below are some submissions offered by the respondents:
“The main challenge is the wait time to get specialist services, e.g. hip-replacement surgery. I was on the wait list for almost six months before I got mine.” (M, 75, University degree, Canadian-born)

“The waiting time in E.R stays. Not enough staff to answer questions. A couple of times there have been no doctors in the area (midnight) either off on a break or shift change. Fortunately, I don't need the E.R for myself that often” (F, 82, University degree, Canadian-born)

Table 4.4 Respondents' perceptions and experiences with biomedical care

<table>
<thead>
<tr>
<th></th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality of Biomedical Care</strong></td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td>162 (46.55%)</td>
</tr>
<tr>
<td>Very good</td>
<td>112 (32.18%)</td>
</tr>
<tr>
<td>Good</td>
<td>56 (16.09%)</td>
</tr>
<tr>
<td>Fair</td>
<td>13 (3.74%)</td>
</tr>
<tr>
<td>Poor</td>
<td>5 (1.44%)</td>
</tr>
<tr>
<td><strong>Adequacy of Biomedical Care</strong></td>
<td></td>
</tr>
<tr>
<td>Highly adequate</td>
<td>161 (46.26%)</td>
</tr>
<tr>
<td>Adequate</td>
<td>121 (34.77%)</td>
</tr>
<tr>
<td>Somewhat adequate</td>
<td>43 (12.36%)</td>
</tr>
<tr>
<td>Inadequate</td>
<td>17 (4.89%)</td>
</tr>
<tr>
<td>Highly inadequate</td>
<td>6 (1.72%)</td>
</tr>
<tr>
<td><strong>Sensitive and Empathy – Sociocultural</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>147 (42.24%)</td>
</tr>
<tr>
<td>No</td>
<td>39 (11.12%)</td>
</tr>
<tr>
<td>Don't know</td>
<td>162 (46.55%)</td>
</tr>
<tr>
<td><strong>Comfort - Biomedical Environment</strong></td>
<td></td>
</tr>
<tr>
<td>Very comfortable</td>
<td>209 (60.06%)</td>
</tr>
<tr>
<td>Comfortable</td>
<td>106 (30.46%)</td>
</tr>
<tr>
<td>Somewhat comfortable</td>
<td>23 (6.61%)</td>
</tr>
<tr>
<td>Uncomfortable</td>
<td>10 (2.87%)</td>
</tr>
</tbody>
</table>
Marginalisation/Stereotyping/Discrimination

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>47 (13.51%)</td>
</tr>
<tr>
<td>No</td>
<td>301 (86.49%)</td>
</tr>
</tbody>
</table>

Difficulties - Access to Biomedical Care

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
<td>36 (10.34%)</td>
</tr>
<tr>
<td>No</td>
<td>312 (89.66%)</td>
</tr>
</tbody>
</table>

4.6 Sociodemographic status and health outcomes: cross-tabulation analysis

Table 4.5 shows the cross-tabulation analysis for general health status by respondents’ sociodemographic characteristics. In this analysis, respondents that indicated their general health status was “excellent”, “very good” and “good” were categorised into a single group labelled “good+” while the rest were grouped under “fair/poor” status. The results indicate that age is strongly significantly associated with reported general health status ($\chi^2=77.482$, $V=0.472$, $p<0.001$). The finding shows an inverse association between age and health status; that is, the proportion of respondents with good, very good or excellent health status decline with age. For instances, in this study, all respondents in the age category of 18 to 24 years reported excellent health status compared to ~63.83% of respondents aged 60 years and above. The result also shows that marital status was moderately associated with reported general health status ($\chi^2=20.601$, $V=0.243$, $p<0.001$). Single and never-married respondents reported good, very good, or excellent health status ($?$); 92.76% of married or common-law respondents stated their health status as good, very good or excellent while 76.67% of divorced or separated or widowed respondents reported similar health status. Respondents’ educational status and annual personal income were also moderately associated with general health status.
Table 4.5 Cross-tabulation analysis of health status by sociodemographic characteristics

<table>
<thead>
<tr>
<th></th>
<th>Good+</th>
<th>Fair/poor</th>
<th>$\chi^2$ (Cramer's V)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 to 24 years</td>
<td>100.00</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>25 to 34 years</td>
<td>97.65</td>
<td>2.35</td>
<td></td>
</tr>
<tr>
<td>35 to 44 years</td>
<td>98.91</td>
<td>1.09</td>
<td>77.482 (0.472)****</td>
</tr>
<tr>
<td>45 to 59 years</td>
<td>96.81</td>
<td>3.19</td>
<td></td>
</tr>
<tr>
<td>60 years and above</td>
<td>63.83</td>
<td>36.17</td>
<td></td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>93.63</td>
<td>6.37</td>
<td>0.027 (0.009)</td>
</tr>
<tr>
<td>Female</td>
<td>93.19</td>
<td>6.81</td>
<td></td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married/common-law</td>
<td>92.76</td>
<td>7.24</td>
<td></td>
</tr>
<tr>
<td>Widowed/separated/divorced</td>
<td>76.67</td>
<td>23.33</td>
<td>20.601 (0.243)****</td>
</tr>
<tr>
<td>Single/never married</td>
<td>100.00</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; High school</td>
<td>0.00</td>
<td>100.00</td>
<td></td>
</tr>
<tr>
<td>High school</td>
<td>94.44</td>
<td>5.56</td>
<td>16.582 (0.218)**</td>
</tr>
<tr>
<td>Some post-secondary</td>
<td>90.22</td>
<td>9.78</td>
<td></td>
</tr>
<tr>
<td>Post-secondary degree</td>
<td>94.94</td>
<td>5.06</td>
<td></td>
</tr>
<tr>
<td><strong>Personal income</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;$20,000</td>
<td>100.00</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>$20,000-$39,999</td>
<td>87.21</td>
<td>12.79</td>
<td></td>
</tr>
<tr>
<td>$40,000-$59,999</td>
<td>96.58</td>
<td>3.42</td>
<td>12.352 (0.188)*</td>
</tr>
<tr>
<td>$60,000-$79,999</td>
<td>87.88</td>
<td>12.12</td>
<td></td>
</tr>
<tr>
<td>$80,000 or more</td>
<td>93.65</td>
<td>6.35</td>
<td></td>
</tr>
<tr>
<td><strong>Household income</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;$20,000</td>
<td>90.00</td>
<td>10.00</td>
<td></td>
</tr>
<tr>
<td>$20,000-$39,999</td>
<td>96.67</td>
<td>3.33</td>
<td></td>
</tr>
<tr>
<td>$40,000-$59,999</td>
<td>88.00</td>
<td>12.00</td>
<td>4.249 (0.111)</td>
</tr>
<tr>
<td>$60,000-$79,999</td>
<td>91.84</td>
<td>8.16</td>
<td></td>
</tr>
<tr>
<td>$80,000 or more</td>
<td>94.97</td>
<td>5.03</td>
<td></td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black - SSA</td>
<td>93.41</td>
<td>6.59</td>
<td></td>
</tr>
<tr>
<td>Black - Other</td>
<td>100.00</td>
<td>0.00</td>
<td>3.601 (0.102)</td>
</tr>
<tr>
<td>Non-Black</td>
<td>88.89</td>
<td>11.11</td>
<td></td>
</tr>
</tbody>
</table>

*** p<0.001; ** p<0.01; * p<0.05; + p<0.1
Similar to general health status, the responses for mental health status were re-categorised into a binary response. Again, respondents who reported “excellent”, “very good” and “good” were categorised into a single group labelled “good+” while the rest were grouped under “fair/poor” status. The results indicated that marital status and annual household income were moderately associated with reported mental health status. For marital status, the proportion of widowed, separated or divorced respondents who reported good, very good or excellent was relatively lower (83.33%) than the proportion for the other response categories. The lowest proportion of respondents who reported good, very good or excellent mental health status for household income was persons living in households with an annual income of less than $20,000.

Table 4.6 Cross-tabulation analysis of mental health status by sociodemographic characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Good+</th>
<th>Fair/Poor</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 to 24 years</td>
<td>93.33</td>
<td>6.67</td>
<td></td>
</tr>
<tr>
<td>25 to 34 years</td>
<td>96.47</td>
<td>3.53</td>
<td></td>
</tr>
<tr>
<td>35 to 44 years</td>
<td>94.57</td>
<td>5.43</td>
<td>2.479 (0.84)</td>
</tr>
<tr>
<td>45 to 59 years</td>
<td>97.87</td>
<td>2.13</td>
<td></td>
</tr>
<tr>
<td>60 years and above</td>
<td>97.87</td>
<td>2.13</td>
<td></td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>98.09</td>
<td>1.91</td>
<td>2.649 (0.087)</td>
</tr>
<tr>
<td>Female</td>
<td>94.76</td>
<td>5.24</td>
<td></td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married/Common-law</td>
<td>98.19</td>
<td>1.81</td>
<td></td>
</tr>
<tr>
<td>Widowed/separated/divorced</td>
<td>83.33</td>
<td>16.67</td>
<td>16.269 (0.216)**</td>
</tr>
<tr>
<td>Single/never married</td>
<td>95.88</td>
<td>4.12</td>
<td></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>&lt; High school</td>
<td>100.00</td>
<td>0.00</td>
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</tr>
<tr>
<td>High school</td>
<td>88.89</td>
<td>11.11</td>
<td></td>
</tr>
<tr>
<td>Some post-secondary</td>
<td>95.65</td>
<td>4.35</td>
<td>3.261 (0.097)</td>
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<tr>
<td>Post-secondary degree</td>
<td>97.05</td>
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<tr>
<td><strong>Personal income</strong></td>
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</table>
Table 4.7 shows the cross-tabulation results for chronic health status by respondents’ sociodemographic characteristics. The result indicates that age and marital status are strongly associated with chronic health status. Age had a direct association with chronic health status, such that the proportion of respondents with chronic health conditions increased with increasing age. About 63.83% of respondents aged 60 years and above indicated they had a chronic condition. The result shows that the proportion of respondents with chronic conditions was relatively high among widowed/separated/divorced persons (43.33%). Respondents’ race, education and annual household income were weakly associated with chronic health status.

Overall, persons of non-African descent had a higher proportion of chronic conditions – 42.22%, compared to 19.41% for persons of SSA descent and 20.00 for persons of other African descent.

The proportion of respondents with chronic health conditions decreased with increase in educational level. The proportion of respondents with chronic health conditions was relatively higher (45.00%) for persons living in households with an annual income of less than $20,000.
Table 4.7 Cross-tabulation analysis of chronic health status by sociodemographic characteristics

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Age</td>
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</tr>
<tr>
<td>18 to 24 years</td>
<td>0.00</td>
<td>100.00</td>
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<tr>
<td>25 to 34 years</td>
<td>7.06</td>
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<td>35 to 44 years</td>
<td>11.96</td>
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</tr>
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<td>45 to 59 years</td>
<td>32.98</td>
<td>67.02</td>
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<td>60 years and above</td>
<td>63.83</td>
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<tr>
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<td></td>
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<tr>
<td>Male</td>
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<td>76.43</td>
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<tr>
<td>Female</td>
<td>21.47</td>
<td>78.53</td>
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<td>Marital Status</td>
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<td></td>
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<td>25.00</td>
<td>75.00</td>
</tr>
<tr>
<td>Widowed/separated/divorced</td>
<td>43.33</td>
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<td>90.72</td>
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<td>0.00</td>
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<tr>
<td>High school</td>
<td>16.67</td>
<td>83.33</td>
</tr>
<tr>
<td>Some post-secondary</td>
<td>30.43</td>
<td>69.57</td>
</tr>
<tr>
<td>Post-secondary degree</td>
<td>19.41</td>
<td>80.59</td>
</tr>
<tr>
<td>Personal income</td>
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<td></td>
</tr>
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<td>87.76</td>
</tr>
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<td>$20,000-$39,999</td>
<td>23.26</td>
<td>76.74</td>
</tr>
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<td>19.66</td>
<td>80.34</td>
</tr>
<tr>
<td>$60,000-$79,999</td>
<td>33.33</td>
<td>66.67</td>
</tr>
<tr>
<td>$80,000 or more</td>
<td>28.57</td>
<td>71.43</td>
</tr>
<tr>
<td>Household income</td>
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<tr>
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<td>45.00</td>
<td>55.00</td>
</tr>
<tr>
<td>$20,000-$39,999</td>
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<td>86.67</td>
</tr>
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<tr>
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<td>12.24</td>
<td>87.76</td>
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<td>$80,000 or more</td>
<td>24.12</td>
<td>75.88</td>
</tr>
<tr>
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</tr>
<tr>
<td>Black - SSA</td>
<td>19.41</td>
<td>80.59</td>
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<td>Black - Other</td>
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<td>80.00</td>
</tr>
<tr>
<td>Non-Black</td>
<td>42.22</td>
<td>57.78</td>
</tr>
</tbody>
</table>

*** p<0.001; ** p<0.01; * p<0.05; + p<0.1
4.7 Discussion of findings

The descriptive and bivariate analysis offers some insightful findings; however, the findings are not generalizable for the entire GTA population. Persons from sub-Saharan African countries constitute a large proportion of this study’s sample; hence, the result may be skewed towards this group of residents. Notwithstanding, the demographic characteristics of the sample bear some similarities with the demographic characteristics of the Canadian population. The findings show that on the average, the study sample is middle-aged persons, females and highly educated persons. The mean (42.45 years) and median ages (39 years) of respondents in this study are comparable to estimates from Statistics Canada; recent estimates indicate that median age of Canadians is 40.8 years and the average age is 40 years (Statistics Canada, n.d.-b, 2012). The distribution of respondents by household income shows that the median household income is $80,000 and above, which is comparable to estimates from Statistics Canada - $70,336 (Statistics Canada, 2017c).

With regards to TCAM prevalence, the findings of this study report estimates similar to that reported in other studies in the Canadian context. In their study of TCAM use among Chinese and Canadians of European descent, Quan et al. (2008) reported a lifetime prevalence of between 59% and 60%. However, their estimate and the estimate from this study are generally low compared to reported lifetime prevalence among the general population in Canada. Studies on the general Canadian population show that between 70% to 79% of Canadians use TCAM remedies in their lifetime (Esmail, 2017; Meyer, 2012). The current TCAM prevalence among the study sample is relatively higher than reported estimates in previous studies, albeit lower when compared to the results of other studies. In this study, 23.71% of respondents indicated they had used a TCAM modality in the past 12 months before the survey. In their study,
Andrews and Boon (2005) reported that studies in Canada show a 15% prevalence of TCAM use within a twelve-month period. On the other hand, other studies suggest that a little over half of the Canadian population use at least one TCAM modality in a twelve-month period (Esmail, 2017). A plausible explanation for the difference could be the definition of TCAM in these studies. The literature shows that when TCAM is narrowly defined (mainly as chiropractic and homoeopathy), the prevalence of use is generally low compared to when the definition captures other self-medicating practices such as the use of vitamins and minerals, herbs (Bowe et al., 2015; Yen et al., 2013).

The findings of the study also show that in general respondents had positive views on the quality of biomedical care in the GTA, as well as, its adequacy to treat or meet their healthcare needs. The findings of this study also indicate that biomedical caregivers are generally sensitive or empathetic towards their patients, contrary to suggestions that biomedical caregiver or professional may be insensitive to the sociocultural background of the diverse community they serve as reported in existing studies. There is the possibility by its nature the biomedical professionals in the GTA are exposed to persons of diverse culture; hence, their ability to empathise and be sensitive to sociocultural needs of their patients. Another plausible reason could be the diverse nature of the biomedical professionals in the GTA. These positives, notwithstanding there is the need to tackle issues of discrimination, marginalisation and disrespectfulness towards patients. The findings show that these experiences are not only peculiar to ethnic minorities or persons of immigration background.
Similar to the findings of existing studies, the bivariate analysis shows the effect of sociodemographic and economic factors on health outcomes. From the findings, we observe that socioeconomic status is significantly associated with health status (general and mental) and chronic health status. The findings of this study show that younger respondents, highly educated persons and persons with high income or living in high incomes households have better health and lower prevalence of chronic health conditions. The findings show age is associated with general health and chronic conditions but not mental health status. This finding suggests that the higher prevalence of fair or poor health and chronic conditions among older adults could be the effect of senescence. Knowledge from existing studies shows that older adults tend to be more susceptible to chronic health issues; hence, they are more likely to report poor health (Prince et al., 2015; Sibley et al., 2014; Van Oostrom et al., 2016). Insights from existing studies also show education promotes positive health behaviour and improved health outcomes among a population while higher income may enable individuals to access and use health care services when needed including preventive healthcare services (Black, Hsu, & Taylor, 2015; Buckles, Hagemann, Malamud, Morrill, & Wozniak, 2016; Cutler & Lleras-Muney, 2010; White, St. John, Cheverie, Iraniparast, & Tyas, 2015).
Chapter 5

Traditional, Complementary and Alternative Medicine Use Among Persons of Sub-Saharan African Origin Living in the GTA – A Quantitative Analysis

5.1 Introduction

It is acknowledged that the majority of people in sub-Saharan Africa use traditional healers, indigenous healing practices and remedies to meet their healthcare needs (Pouliot, 2011; Tabi et al., 2006). Traditional medicine and its healing practitioners are conceptualized as encompassing “the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness” (World Health Organisation, 2013, p. 15). The WHO estimates that between 60 to 80% of people living in the sub-region rely on traditional medicines (World Health Organisation, 2013). Traditional medicine is embedded in the socio-cultural worldview of traditional African societies (Amegbor, 2017a, 2017b; Hampshire & Owusu, 2013; Twumasi, 1975, 1979). They usually consist of healing practices, knowledge and beliefs used to treat, diagnose and prevent illness as well as maintain well-being (Tabi et al., 2006). The indigenous healing systems co-exist with modern biomedical care in many contemporary sub-Saharan African societies – a phenomenon described as medical pluralism (Amegbor, 2017b; Pouliot, 2011; Sato, 2012a; Towns, Mengue Eyi, & Van Andel, 2014). Nevertheless, evidence from existing studies shows that access to biomedical care remains elusive for many people in SSA, especially among the poor and rural dwellers (Aikins & Marks, 2007; Ansah et al., 2009; Perkins et al., 2009; Soors, Dkhimi, & Criel, 2013).
The popularity of traditional medicine among the population in SSA is generally attributed to its accessibility, affordability, availability and cultural acceptability (Ae-Ngibise et al., 2010; Anyinam, 1987; Muela et al., 2000; World Health Organisation, 2013). The assumption has been that traditional healers, remedies and healing resources are found in the immediate environment, non-commercialized and are based on generational use and approval, contrary to biomedical healthcare (Anyinam, 1987; Bierlich, 1999; Sato, 2012b; van der Geest, 1992). Thus, aside sociocultural beliefs and practices, researchers point to socioeconomic and spatial factors as major barriers to modern healthcare, and motivators for the use of traditional medicine in SSA (Arthur, 2012; Kusi et al., 2015; Parmar, De Allegri, Savadogo, & Sauerborn, 2014; Perkins et al., 2009). For instance, Ae-Ngibise et al. (2010) in their study on the use of traditional healers for mental health problems observed that scarcity of biomedical care resources, the high cost of treatment and uneven distribution of western psychiatric care resources were major driving factors for the use of traditional healers. In a study among women in urban Mali, Bove et al. (2012) note that inability to afford biomedical care as a major determinant for the use of traditional medicine.

The demand and use of TCAM in SSA is driven by socioeconomic factors (and cultural beliefs); nonetheless, evidence from the literature suggests that public policy has a mediating effect on the influence of socioeconomic factors on access and use of biomedical care services (Agyepong & Adjei, 2008; Ali, Cookson, & Dusheiko, 2017). The introduction of user fees for public health services (in the 1980s) placed financial constraints on many people in the sub-region in the face of the economic crisis that confronted most countries (Blanchet, Fink, & Osei-Akoto, 2012; Defo, 2014; Tenkorang, 2016). Per the demands of the IMF and World Bank structural
adjustment program (SAP), countries in the sub-region were required to scale back on public expenditure on health, education and employment. Many countries, including Ghana, Burkina Faso, Uganda, and Nigeria, introduced user-fee for public health care services as part of cost-recovery programs meant to minimize government expenditure on health (Akazili, Garshong, Aikins, Gyapong, & McIntyre, 2012; Basaza, Criel, & Van Der Stuyft, 2010; McKinnon, Harper, & Kaufman, 2015; Mills et al., 2012; Ridde, 2015). The findings of some studies suggest the use of biomedical services dropped and the use of TCAM increase exponentially with the introduction of user fees (De Allegri, Sarker, Hofmann, Sanon, & Böhler, 2007; Muela, Mushi, & Ribera, 2000b). On the contrary, the Canada health care system provides residents free universal access to primary health care services (Harrington, Wilson, Rosenberg, & Bell, 2013; Kathleen Wilson & Rosenberg, 2002), eliminating the financial barriers associated with the use of biomedical care in SSA. Tabi et al. (2006) further posit that changes in an individual’s socioeconomic status and their removal (migration) means them from traditional values, including their health and healthcare norms and values. This proposition as well as the contextual difference in healthcare policies (SSA and Canada) offer an opportunity to examine TCAM use and care seeking behaviour of persons of SSA living in the GTA.

While it is generally acknowledged that most people from sub-Saharan Africa use traditional resources and healers for their healthcare needs, there is little or no knowledge on whether there is a continuity in the use of TM or TCAM when they migrate to developed countries, such as Canada. In view of this gap in knowledge and research, this chapter of the thesis examines the use of TCAM among persons of sub-Saharan Africa origin living in the GTA; focusing on their current TCAM use. Thus, the chapter focuses on the first research objectives of this thesis:
examine TCAM use and care seeking behaviour of persons of sub-Saharan Africa origin living in the GTA. Based on the findings and knowledge from existing studies, the following research questions guided the empirical inquiry:

a) Is health status associated with the use of TCAM among persons of sub-Saharan Africa origin living in the GTA?

b) Is the difference in the use of TCAM among persons with chronic health status and those without chronic health status statistically significant?

c) What is the nature of the relationship between biomedical care-related characteristics – as perceived by persons of sub-Saharan Africa origin living in the GTA – and the current use of TCAM?

d) Are there statistically significant differences in perceived biomedical care-related characteristics and the use of TCAM?

e) Are socioeconomic characteristics associated with the use of TCAM use among persons of sub-Saharan Africa origin living in the GTA?

f) Are there differences in the use of TCAM by socioeconomic status statistically significant among persons of sub-Saharan Africa origin living in the GTA?

5.2 Data & methods

The primary data came from a cross-sectional survey of persons of sub-Saharan Africa origin living in the GTA. Both paper-based survey and online survey were used in soliciting responses from the target population. Respondents were sampled using RDS sampling techniques. A detailed discussion of the sampling and data collection techniques can be found in Chapter 3.

The analysis is based on data from 273 respondents made up of 205 respondents from the paper-
based survey and 68 respondents from the online survey. The survey solicited information on previous use of TCAM, and the use of TCAM in the past 12 months. Basic demographic and socioeconomic status information as well as chronic health information were also garnered through the survey.

5.2.1 Measures

The main outcome measure was the use of TCAM in the past 12 months (Q22) before the survey. Respondents were asked if they had used any form of TCAM, with examples given as traditional African medicine, traditional Chinese medicine, Ayurvedic medicine, chiropractic, in the past 12 months. The question had two valid responses and was coded as: “Yes =1” and “No=2”.

The selection of independent variables used in the analysis was guided by the conceptual framework espoused in this chapter. Three broad categories of predictors were selected from the survey questions to examine their association and relationship with current TCAM use among persons of sub-Saharan Africa origin. The first set of predictors focus on chronic health conditions. Chronic morbidity or multimorbidity is deemed as a major determinant for the use of TCAM (Arthur et al., 2012; Boon et al., 2000; Sewitch et al., 2011). Existing studies on TCAM in Canada and other parts of developed world, have frequently explored the effect of chronic health status on the use of TCAM among the general population or a specific category of the population (Hsiao et al., 2008; Sirois, 2008; Sullivan et al., 2015; Weizman et al., 2012). Respondents were asked if they had any chronic health conditions (Q41), and the question had binary responses: “Yes” and “No”.
The second set of predictors focused on care-related factors. As noted in Chapter 2, the barriers and challenges associated with biomedical care services have often been cited as major motivating factors for the use of TCAM especially among ethnic/racial minority and socioeconomically vulnerable groups (Bulman & McCourt, 2002; Chadwick & Collins, 2015; Hall et al., 2014). Existing studies indicate that factors associated with biomedical care, such as lack of sociocultural empathy or sensitivity (Woodgate et al., 2017) and discrimination (Castleden et al., 2010; McKeary & Newbold, 2010), inhibit the ability of racialised persons to access and use biomedical care. In view of this, questions on perceived quality of biomedical care (Q51), perceived adequacy of biomedical care for respondent’s health and healthcare needs (Q52), empathy from biomedical care providers (Q53), comfort in the biomedical care environment (Q54), discrimination/marginalization (Q55), challenges/difficulties with accessing biomedical (Q56) were examined as predictors of current TCAM use. Empathy, discrimination/marginalisation and challenges/difficulties were dichotomous-response variables with the following valid responses: “Yes” and “No”. The others were ordinal response variables. Respondents were asked to rate the quality of biomedical care using the following criteria: “Excellent”, “Very good”, “Good”, “Fair” and “Poor”. Respondents were also asked to rate the adequacy of biomedical care considering their healthcare needs using the following scale: “Highly Adequate”, “Adequate”, “Somewhat adequate”, “Inadequate”, and “Highly inadequate”. Regarding comfort of the biomedical care environment, respondents were asked their perceived comfort taking to account their sociocultural or religious background using the following criteria: “Very comfortable”, “Comfortable”, “Somewhat comfortable”, and “Uncomfortable”. The effect of socioeconomic (or sociodemographic) status on access and use of health care services, including TCAM, is well-documented in existing literature (Andrews, 2003; Andrews
Studies show that factors such as age, sex, education, income, and immigration status influence one’s ability to afford, access and use TCAM in developed countries (Hanssen et al., 2005; Sullivan et al., 2015; Thomson et al., 2014b). Informed by this, respondents’ age, sex, marital status, educational status, household income and immigration status, as well as country of origin, were examined to determine their association with current TCAM use among persons of sub-Saharan Africa origin.

5.2.2 Analysis

First, a descriptive analysis was performed to examine the distribution of the variables as well as ascertain the characteristics of the study sample. The descriptive analysis reports both the frequency and percentage distribution for the outcome variables and predictors used in this section of the thesis. Second, a bivariate cross-tabulation computation was performed to explore the association between the outcome variable and the predictors. Pearson’s chi-square test was used to determine the association between the study outcomes and the independent variables; while Cramer’s V test was performed to determine the strength of the association. The latter is expressed as:

$$\phi_c = \sqrt{\frac{\chi^2}{N(k-1)}}$$

(1)

Where $\phi_c$ denotes Cramer’s V; $\chi^2$ represents the Pearson chi-square, N is the sample size involved in the test and k is the lesser number of categories of the variables. Values less than 0.20 show a weak association, values ≥0.20 and <0.30 demonstrate a moderate association, and values ≥0.30 show a strong association.
Lastly, a multivariate logistic regression analysis was performed to examine the relationship between the predictors and the outcome variable. The descriptive analysis showed that the outcome measure was asymmetrically distributed; hence, a complementary logistic regression model was performed to assess its relationship with the predictors. This analytic technique was adopted because the outcome variable fails the symmetric distribution assumption of binomial logistic regression. Complementary logistic regression relaxes the symmetrical distribution assumption, thus appropriate for rare events or events with a very small or a very large incidence of occurrence (Amegbor, Rosenberg, & Kuuiire, 2018; Hedeker, 2008). It also ensures that the analysis of the event does not produce biased parameter estimates (Amegbor, Kuuire, Robertson, & Kuffuor, 2018; Hedeker, 2008). Four regression models were built. The first model (Model 1) examines the relationship between chronic health status and current TCAM use only. The second model (Model 2) examines the relationship between care-related factors and current TCAM use only. The third model (Model 3) examines the relationship between socioeconomic status and current TCAM use only; while the final model (Model 4) is a full model of all the predictors in the three previous models. In Model 4, previous use of TCAM in the country of origin and health insurance coverage (Extended Health Care plan) were included as control variables.

In the bivariate and multivariate analysis, the responses of some predictor variables were re-categorised into few responses to eliminate the problem of responses with no cases or very few cases. For instance, education was re-categorised into a dichotomous variable with the following responses: Non-university certificate or degree (all cases with less than bachelor’s degree or certificate) and university certificate or degree (all cases with bachelor’s degree and above). Other variables recoded or re-categorised include adequacy (biomedical care), marital status, immigration status, and country of origin. The goodness of fit for the models was assessed by
Wald’s chi-square, Cragg and Uhler’s pseudo R-square, the Akaike Information Criterion (AIC) and the Bayesian Information Criterion (BIC). Multicollinearity in the multivariate models was checked by computing the tolerance and the variance inflation factor (VIF) for the predictor variables. Some variables used in the bivariate cross-tabulation (personal income and number of chronic conditions) were dropped from the multivariate logistic analysis due to the issue of multicollinearity. For easy interpretation of the findings, the exponentiated beta coefficients or the odds ratio are reported for the multivariate logistic regression analysis. All statistical analyses were performed using STATA (version 14.2) software package by StataCorp (College Station, TX).

5.3 Results

5.3.1 Univariate results

Table 5.1 presents a descriptive summary of the study variables used in this chapter. The results indicate that 57.14% of respondent had ever use TCAM, and 48.72% of respondents indicated using TCAM from their country of origin. The proportion of respondent currently using TCAM (including TM) is relatively low – 23.81% – compared to previous or past usage. In terms of chronic health condition, most respondents indicated they had none (81.86%) while 6.96% and 11.36% of respondent surveyed reported have one and two or more chronic health conditions respectively. Most respondents rated the quality of biomedical care as excellent (52.01%) with a very low proportion of respondents (2.20%) describing the quality of care as fair.
Similarly, about half of the respondents (50.55%) surveyed indicated the biomedical care they receive is highly adequate for their health care needs. The proportion of respondents who rated biomedical care as highly inadequate was very low – 1.10%. Respondents generally indicated biomedical care professionals were empathic towards them (41.39) or indicated that they did not know if biomedical healthcare professional were empathic to their sociocultural views (48.72%). A higher proportion of respondents indicated they felt very comfortable in the biomedical care environment (65.57%), have not experienced any form of discrimination or stereotyping (93.04%), and had no challenges accessing biomedical care in the GTA (92.67%).

In terms of socioeconomic characteristics, respondents were fairly evenly distributed within three age groups – 25 to 34 years (24.18%), 35 to 44 years (28.21%), and 45 to 59 years (28.94%). A relatively higher proportion of respondents surveyed were females (53.48%), married or common-law (69.23%), and had a university certificate or degree (82.05%). Additionally, most respondents had annual personal incomes between $20,000 and $59,999, and household incomes of $80,000 or more. The majority of respondents also indicated being Canadian citizens (74.36%). Regarding country of origin, most respondents indicated Ghana (45.42%) or Nigeria (37.73%) as their country of origin.
Table 5.1 Descriptive summary of study variables (n=273)

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous TCAM use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>117</td>
<td>42.86</td>
</tr>
<tr>
<td>Yes</td>
<td>156</td>
<td>57.14</td>
</tr>
<tr>
<td>Previous TCAM use - Country of origin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>140</td>
<td>51.28</td>
</tr>
<tr>
<td>Yes</td>
<td>133</td>
<td>48.72</td>
</tr>
<tr>
<td>Current TCAM use - past 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>208</td>
<td>76.19</td>
</tr>
<tr>
<td>Yes</td>
<td>65</td>
<td>23.81</td>
</tr>
</tbody>
</table>

| Chronic health                                |           |      |
| Chronic health status                         |           |      |
| No (ref)                                      | 223       | 81.68|
| Yes                                           | 50        | 18.32|
| Number of chronic conditions                  |           |      |
| None                                          | 223       | 81.68|
| One                                           | 19        | 6.96 |
| Two or more                                   | 31        | 11.36|

| Biomedical care factors                       |           |      |
| Quality - Biomedical care                     |           |      |
| Excellent                                     | 142       | 52.01|
| Very good                                     | 84        | 30.77|
| Good                                          | 41        | 15.02|
| Fair                                          | 6         | 2.20 |
| Poor                                          | 0         | 0    |
| Adequacy - Biomedical care                    |           |      |
| Highly adequate (ref)                         | 138       | 50.55|
| Adequate                                      | 86        | 31.50|
| Somewhat adequate                             | 34        | 12.45|
| Inadequate                                    | 12        | 4.40 |
| Highly inadequate                             | 3         | 1.10 |
| Empathy - Biomedical care                     |           |      |
| No (ref)                                      | 27        | 9.89 |
| Yes                                           | 113       | 41.39|
| Don't know                                    | 133       | 48.72|
| Comfort - Biomedical care setting             |           |      |
| Very comfortable                              | 179       | 65.57|
| Comfortable                                   | 77        | 28.21|
**Somewhat comfortable**
- 14 (5.13)

**Uncomfortable**
- 3 (1.10)

**Discrimination/Stereotyping - Biomedical**
*No (ref)*
- 249 (93.04)

*Yes*
- 19 (6.96)

**Challenges - Biomedical**
*No (ref)*
- 253 (92.67)

*Yes*
- 20 (7.33)

### Socioeconomic factors

**Age**
- **18 to 24 years**
  - 21 (7.69)
- **25 to 34 years**
  - 66 (24.18)
- **35 to 44 years**
  - 77 (28.21)
- **45 to 59 years**
  - 79 (28.94)
- **60 years and above**
  - 30 (10.99)

**Sex**
- **Male**
  - 127 (46.52)
- **Female**
  - 146 (53.48)

**Marital Status**
- **Married/Common-law**
  - 189 (69.23)
- **Widowed/Sep/Divorced**
  - 21 (7.69)
- **Single/never married**
  - 63 (23.08)

**Education**
- **Non-university certificate or degree**
  - 49 (17.95)
- **University certificate or degree**
  - 224 (82.05)

**Personal income**
- <$20,000
  - 32 (11.72)
- $20,000-$39,999
  - 73 (26.74)
- $40,000-$59,999
  - 94 (34.43)
- $60,000-$79,999
  - 22 (8.06)
- $80,000 or more
  - 52 (19.05)

**Household income**
- <$20,000
  - 8 (2.93)
- $20,000-$39,999
  - 23 (8.42)
- $40,000-$59,999
  - 33 (12.09)
- $60,000-$79,999
  - 41 (15.02)
- $80,000 or more
  - 168 (61.54)

**Immigration Status**
- **Citizen**
  - 203 (74.36)
- **Permanent resident**
  - 48 (17.58)
- **Other**
  - 22 (8.06)
Country of Origin

<table>
<thead>
<tr>
<th>Country</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ghana</td>
<td>124</td>
<td>45.42</td>
</tr>
<tr>
<td>Nigeria</td>
<td>103</td>
<td>37.73</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>32</td>
<td>11.72</td>
</tr>
<tr>
<td>Other - SSA</td>
<td>14</td>
<td>5.13</td>
</tr>
</tbody>
</table>

5.3.2 Bivariate results

Table 5.2 shows the cross-tabulation results for current TCAM use by chronic health, care-related and socioeconomic factors. The chronic health status and the number of conditions were significantly associated with current use of TCAM, and the Cramer’s V test shows the association as strong ($V=−0.36$). A higher proportion of persons with chronic health conditions (56.00%) and those with two or more chronic health conditions (58.06%) indicated using TCAM remedies in the past 12 months prior to the survey. In terms of biomedical care-related factors, adequacy was strongly associated with current use of TCAM ($V=0.38, p<0.001$). Quality of biomedical care was moderately associated with current use of TCAM ($V=0.28, p<0.001$) while comfort with care settings ($V=0.17, p<0.05$) and discrimination/stereotyping ($V=0.15, p<0.01$) were weakly associated with current use of TCAM. Empathy and challenges with biomedical care were not significantly associated with current use of TCAM. Previous use of TCAM and previous use of TCAM (in country of origin) were significantly associated with current TCAM use. The result of the Cramer’s V test shows that while previous TCAM use was strongly associated with current TCAM use ($V=−0.40$), the effect for previous TCAM use was moderate ($V=−0.25$). Regarding socioeconomic factors, the results indicate age was strongly associated with current TCAM use ($V=0.30, p<0.001$), while marital status ($V=0.21, p<0.01$) and personal income ($V=0.20, p<0.05$) were moderately associated with current TCAM use.
Table 5.2 Cross-tabulation analysis of TCAM use in the past 12 months (n=273)

<table>
<thead>
<tr>
<th>Health status</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>Chi2 (Cramer’s V)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic health status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>28 (56.00)</td>
<td>22 (44.00)</td>
<td>34.965 (0.358)***</td>
</tr>
<tr>
<td>No</td>
<td>37 (16.59)</td>
<td>186 (83.41)</td>
<td></td>
</tr>
<tr>
<td>Number of conditions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>37 (16.59)</td>
<td>186 (83.41)</td>
<td></td>
</tr>
<tr>
<td>One</td>
<td>10 (52.63)</td>
<td>9 (47.37)</td>
<td>35.157 (0.359)***</td>
</tr>
<tr>
<td>Two or more</td>
<td>18 (58.06)</td>
<td>13 (41.94)</td>
<td></td>
</tr>
</tbody>
</table>

| Biomedical care factors        |         |        |                   |
| Quality of Biomedical care     |         |        |                   |
| Excellent                      | 19 (13.38) | 123 (86.62) |                   |
| Very good                      | 25 (29.76) | 59 (70.24)  | 21.548 (0.281)***  |
| Good                            | 18 (43.98) | 23 (56.10)  |                   |
| Fair                            | 3 (50.00)  | 3 (50.00)   |                   |
| Poor                            |          |          |                   |
| Adequacy - Biomedical Care     |         |        |                   |
| Highly adequate                | 18 (13.04) | 120 (86.96) |                   |
| Adequate                       | 21 (24.42) | 65 (75.58)  |                   |
| Somewhat adequate              | 21 (61.76) | 13 (38.24)  | 38.882 (0.377)***  |
| Inadequate                     | 3 (25.00)  | 9 (75.00)   |                   |
| Highly inadequate              | 2 (66.67)  | 1 (33.33)   |                   |
| Empathy                        |          |          |                   |
| Yes                            | 25 (22.12) | 88 (77.88)  |                   |
| No                             | 9 (33.33)  | 18 (66.67)  | 1.545 (0.075)      |
| Don’t know                     | 31 (23.31) | 102 (76.19) |                   |
| Comfort with Biomedical care environment |       |        |                   |
| Very comfortable               | 33 (18.44) | 146 (81.56) |                   |
| Comfortable                    | 26 (33.77) | 51 (66.23)  | 8.301 (0.174)*     |
| Somewhat comfortable           | 5 (35.71)  | 9 (64.29)   |                   |
| Uncomfortable                  | 1 (33.33)  | 2 (66.67)   |                   |
| Discrimination/Marginalisation/Stereotyping |       |        |                   |
| Yes                            | 10 (41.67) | 14 (58.33)  | 4.625 (0.130)*     |
| No                             | 55 (22.09) | 194 (77.91) |                   |
| Challenges or difficulties - Biomedical care |       |        |                   |
| Yes                            | 6 (30.00)  | 14 (70.00)  | 0.456 (0.041)      |
| No                             | 59 (23.32) | 194 (76.68) |                   |
## Socioeconomic factors

### Age
- **18 to 24 years**: 1 (4.76) 20 (95.24)
- **25 to 34 years**: 11 (16.67) 55 (83.33)
- **35 to 44 years**: 11 (14.29) 66 (85.71)
- **45 to 59 years**: 33 (41.77) 46 (58.23)
- **60 years and above**: 9 (30.00) 21 (70.00)

### Sex
- **Male**: 32 (25.20) 95 (74.80)
- **Female**: 33 (22.60) 113 (77.40)

### Marital Status
- **Married/Common-law**: 48 (25.40) 141 (74.60)
- **Widowed/Sep/Divorced**: 10 (47.62) 11 (52.38)
- **Single/never married**: 7 (11.11) 56 (88.89)

### Education
- **Non-university certificate or degree**: 15 (30.61) 34 (69.39)
- **University certificate or degree**: 50 (22.32) 174 (77.68)

### Personal income
- **< $20,000**: 3 (9.38) 29 (90.63)
- **$20,000-$39,999**: 16 (21.92) 57 (78.08)
- **$40,000-$59,999**: 19 (20.21) 75 (79.79)
- **$60,000-$79,999**: 8 (36.36) 14 (63.64)
- **$80,000 or more**: 19 (36.54) 33 (63.46)

### Household income
- **< $20,000**: 1 (12.50) 7 (87.50)
- **$20,000-$39,999**: 4 (17.39) 19 (82.61)
- **$40,000-$59,999**: 11 (33.33) 22 (66.67)
- **$60,000-$79,999**: 8 (19.51) 33 (80.49)
- **$80,000 or more**: 41 (24.40) 127 (75.60)

### Immigration Status
- **Citizen**: 54 (26.60) 149 (73.40)
- **Permanent resident**: 7 (14.58) 41 (85.42)
- **Other**: 4 (18.18) 18 (81.82)

## Other variables

### Previous TCAM use
- **Yes**: 60 (38.46) 96 (61.54) 43.0769 (0.397)***
- **No**: 5 (4.27) 112 (95.73)

### Previous TCAM use - Country of origin
- **Yes**: 46 (34.59) 87 (64.41) 16.605 (0.247)***
- **No**: 19 (13.57) 121 (86.43)
5.3.3 Multivariate results

Table 5.3 presents the result of the complementary logistic regression models. In Model 1, the result shows that respondents with chronic health conditions were 4.525 times (p<0.001) more likely to be currently using TCAM. For care-related factors (Model 2), the results demonstrate that adequacy and previous TCAM use were significantly associated with current use of TCAM. Respondents who rated biomedical care as somewhat adequate or inadequate for their health care needs were 4.854 times (p<0.01) more likely to have used TCAM in the past 12 months. The result for Model 3 shows that age and marital status were significantly associated with current use of TCAM. Respondents aged 35 to 44 years were less likely (OR=0.425, p<0.1) to use TCAM, compared to those aged 60 years and above. Compared to married or common-law, respondents who were widowed or separated or divorced were 2.337 times (p<0.05) more likely to have used TCAM in the past 12 months before the survey.

In the final model (Model 4), chronic health status, previous TCAM use, age, marital status and country of origin were significantly associated with current use of TCAM. Similar to the results for Model 1, respondents with chronic health conditions were more likely to have used TCAM in the past 12 months. In Model 4, respondents with chronic health conditions were 2.619 times (p<0.05) more likely to have used TCAM in the past 12 months. None of the measures of biomedical care-related characteristics was statistically significant. Regarding age, respondents
in the age group 45 to 59 years were 2.397 times (p<0.05) more likely to have used TCAM in the past 12 months, compared to those aged 60 years and above. Respondents who were widowed or separated or divorced were more likely (OR=2.455, p<0.1) to use TCAM, compared to those married or in a common-law relationship. Previous use of TCAM in country of origin as a control variable was significantly associated with current TCAM use; persons who used TCAM in their country of origin prior to migrating to Canada were 1.810 times (p<0.1) more likely to use TCAM. The results of the Cragg & Uhler's pseudo R square from the four models show that a relatively higher proportion of variability in the used of TCAM in the past 12 months is explained by all study predictors in Model 4 (~34%). Chronic health status only, biomedical care-related factors only and socioeconomic factors only accounted for ~16%, ~19%, and ~18% respectively of variability in TCAM used in the past 12 months.
<table>
<thead>
<tr>
<th>Health status</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic health status</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No (ref)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>4.525 (1.155)***</td>
<td></td>
<td>2.619 (1.288)*</td>
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</tr>
<tr>
<td>Biomedical care factors</td>
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<td></td>
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<tr>
<td>Quality of Biomedical care</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
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<td></td>
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</tr>
<tr>
<td>Very good</td>
<td>1.625 (0.765)</td>
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<td>1.752 (0.821)</td>
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<tr>
<td>Good</td>
<td>1.628 (0.905)</td>
<td></td>
<td>1.977 (1.140)</td>
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<tr>
<td>Fair</td>
<td>2.485 (2.140)</td>
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<td>3.602 (3.130)</td>
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<tr>
<td>Adequacy - Biomedical Care</td>
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<tr>
<td>Highly adequate</td>
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<tr>
<td>Adequate</td>
<td>1.440 (0.690)</td>
<td></td>
<td>1.092 (0.541)</td>
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<tr>
<td>Somewhat adequate</td>
<td>4.854 (2.732)**</td>
<td></td>
<td>1.703 (1.215)</td>
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<td>Inadequate/highly inadequate</td>
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<tr>
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<td></td>
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</tr>
<tr>
<td>Yes</td>
<td>1.393 (0.651)</td>
<td></td>
<td>1.303 (0.669)</td>
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<td>1.449 (0.749)</td>
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<td>Comfort with Biomedical care environment</td>
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<tr>
<td>Very comfortable</td>
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<tr>
<td>Comfortable</td>
<td>1.144 (0.396)</td>
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<td>1.421 (0.533)</td>
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<tr>
<td>Somewhat comfortable</td>
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<td>1.390 (1.043)</td>
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<td>0.842 (0.801)</td>
<td></td>
<td>0.868 (0.797)</td>
<td></td>
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<tr>
<td>Discrimination/Marginalisation/Stereotyping</td>
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<td></td>
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</tr>
<tr>
<td>No</td>
<td></td>
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### Challenges or difficulties - Biomedical care

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<tr>
<td></td>
<td>1.210 (0.608)</td>
<td>0.974 (0.673)</td>
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### Socioeconomic factors

**Age**

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<tr>
<td>60 years and above (ref)</td>
<td>1.543 (0.603)</td>
<td>2.397 (0.891)*</td>
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<td>45 to 59 years</td>
<td>0.425 (0.194)+</td>
<td>1.329 (0.713)</td>
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<tr>
<td>35 to 44 years</td>
<td>0.664 (0.345)</td>
<td>1.868 (1.063)</td>
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<tr>
<td>25 to 34 years</td>
<td>0.187 (0.223)</td>
<td>0.961 (1.192)</td>
</tr>
<tr>
<td>18 to 24 years</td>
<td>0.187 (0.223)</td>
<td>0.961 (1.192)</td>
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**Sex**

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<tbody>
<tr>
<td>Male (ref)</td>
<td>0.825 (0.230)</td>
<td>1.071 (0.329)</td>
</tr>
<tr>
<td>Female</td>
<td>0.825 (0.230)</td>
<td>1.071 (0.329)</td>
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**Marital Status**

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<th>Yes</th>
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</thead>
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<tr>
<td>Married/Common-law (ref)</td>
<td>2.866 (0.127)*</td>
<td>2.455 (1.171)+</td>
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<tr>
<td>Widow/Sep/Divorced</td>
<td>0.800 (0.480)</td>
<td>0.889 (0.507)</td>
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</table>

**Education**

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<th>No</th>
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<td>University certificate or degree (ref)</td>
<td>1.130 (0.384)</td>
<td>1.278 (0.485)</td>
</tr>
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<td>Non-university certificate or degree</td>
<td>1.130 (0.384)</td>
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**Household income**

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<th>No</th>
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<tbody>
<tr>
<td>$80,000 or more (ref)</td>
<td>0.657 (0.299)</td>
<td>0.954 (0.476)</td>
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<tr>
<td>$60,000-$79,999</td>
<td>0.657 (0.299)</td>
<td>0.954 (0.476)</td>
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<tr>
<td>$40,000-$59,999</td>
<td>1.189 (0.439)</td>
<td>1.507 (0.627)</td>
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<td>$20,000-$39,999</td>
<td>0.373 (0.408)</td>
<td>0.751 (0.772)</td>
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<tr>
<td>&lt;$20,000</td>
<td>0.346 (0.344)</td>
<td>0.187 (0.284)</td>
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**Immigration Status**

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</thead>
<tbody>
<tr>
<td>Citizen (ref)</td>
<td>0.558 (0.289)</td>
<td>0.742 (0.378)</td>
</tr>
<tr>
<td>Permanent resident</td>
<td>0.558 (0.289)</td>
<td>0.742 (0.378)</td>
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Other

Control Variable
Health Insurance
No (ref)
Yes 1.359 (0.622)

Previous TCAM use - Country of origin
No (ref)
Yes 1.810 (0.642)+

Model Information
Log pseudolikelihood
Wald's Chi2
Cragg & Uhler's R2 0.160 0.187 0.184 0.336
AIC 1.007 1.111 1.121 1.181
BIC -1245.551 -1155.859 -1149.532 -1042.903

Robust standard error in parenthesis; ***p<0.001, **p<0.01, *p<0.05, +p<0.1
5.4 Discussion

The focus of this chapter was to examine the effect of chronic health status, care-related factors and socioeconomic status on the use of TCAM among persons of SSA descent in the past 12 months. The finding of the descriptive analysis shows that the current prevalence of TCAM (in the past 12 months) is relatively low – 23.81% – among the respondents of the survey compared to lifetime prevalence of TCAM (57.14%). Compared to estimates of the use of TCAM in Canada in other, the proportion of respondents using TCAM in this study falls somewhere between the lower and higher estimates found in other studies. The difference in the proportion of Canadians using TCAM is mainly due to differences in conceptualising TCAM in the various studies and the focus population. Generally, reported estimates among Canadians with chronic health conditions are high – 49% to 85% (Bodeker et al., 2007; Esmail, 2017; Sewitch et al., 2011; Tough et al., 2002); while studies focusing on the general population often report relatively lower prevalence – 12% to 20% (Andrews & Boon, 2005; Harris et al., 2012; Metcalfe et al., 2010; Williams et al., 2011). Also, the observed proportion of persons who have used TCAM in the past or use TCAM currently (past 12 months) is lower than the reported prevalence of TCAM use in respondents’ countries of origins. As noted earlier, studies show that between 60% to 80% of people in SSA use TCAM remedies for their healthcare needs (World Health Organisation, 2013). The observed prevalence of TCAM use among persons of SSA origin living in the GTA may be the result of the Canadian healthcare policy environment, issues of affordability and accessibility to TCAM in the Canadian context as well as the potential waning of traditional norms and values about health and healthcare among the respondents. The reported prevalence of TCAM use among persons of SSA origin living in the GTA is also lower than reported estimates for the general population in Canada. The Canadian healthcare
system provides free access to a physician and hospital-based services for all residents through provincial healthcare programs such as the Ontario Health Insurance Plan (OHIP). This healthcare policy eliminates the cost associated with seeking biomedical care, which has been acknowledged by many researchers and policy-makers as a major deterrent to access and use of biomedical care services in SSA (Arthur, 2012; Kusi et al., 2015; Parmar et al., 2014). Thus, we can postulate that the difference in biomedical care provision policies in Canada and SSA is a plausible factor for the lower prevalence of TCAM use among sub-Saharan Africans living in the GTA. This assertion is buttressed by recent studies in the SSA region, especially Ghana, which show that a considerable proportion of people use biomedical care services for their healthcare needs due to the existence of social or community health insurance schemes (Akazili et al., 2012; Blanchet et al., 2012; Fenny et al., 2016; Parmar et al., 2014). While these health insurance plans do not provide universal coverage for all residents in SSA countries, research shows that health insurance plans improve and increase access and use of biomedical healthcare services among subscribers (Fenny et al., 2016; Fenny, Asante, Enemark, & Hansen, 2015; Onwujekwe et al., 2009; Robyn, Fink, Sié, & Sauerborn, 2012).

It can also be argued that while TCAM remedies used in SSA are mainly sourced from the natural environment and are less commercialised, while TCAM in Canada is heavily commercialised. In SSA, particularly in rural areas, people use medicinal plants and herbs to address healthcare, such as malaria, fever and diarrhoea (Pouliot, 2011; Pouliot & Treue, 2013; Towns & Van Andel, 2016; Van Andel et al., 2015). These remedies are usually sourced from the immediate environment; hence, there is no associated cost. Some studies suggest that there are no charges or costs associated with seeking traditional healers for severe or complex health
conditions (Pouliot, 2011). Services are often based on familial and communal ties, which provide the basis for organised activities, including healthcare (van der Geest, 1992). Culturally, some communities believe money or paying for healing destroys the potency of the remedy (Bierlich, 1999). Although, the situation or pictures TCAM described in these studies are more reflective of rural communities, the TCAM tends to be more commercialized in urban areas where healers serve the urban population with their skills and knowledge for a fee (Ndhlala, Stafford, Finnie, & Van Staden, 2011; Quiroz et al., 2014; Van Andel et al., 2012). Studies suggest the use of TCAM is generally low among the population in the urban context (Amegbor, 2017a; Barimah, 2013; Pouliot, 2011; Romay-Barja et al., 2015; Sato, 2012a).

The care financing for TCAM in Canada is similar to the urban context of SSA. Most provincial health care plans do not provide coverage for TCAM services (Esmail, 2017; Furler et al., 2003; Wiles & Rosenberg, 2001). For instance, Ontario’s OHIP does not provide additional coverage for TCAM modalities, including chiropractic care. Residents must pay for the cost of TCAM services through out-of-pocket, private health insurance plans or employee-related benefits (Andrews, 2003; Canizares et al., 2017; Esmail, 2017; Furler et al., 2003). Paying for TCAM may constitute a significant challenge as respondents may not hold employment that provides coverage for such healthcare options or have the means to pay for the cost associated with using such services.

Thirdly, the lower prevalence of TCAM use among persons of SSA origin living in the GTA may be the result of their waning of traditional norms and values about health and healthcare. The theory of modernisation postulates social and economic development bring pervasive
changes to a society’s culture (Tabi et al., 2006). Studies show that as people acquire higher education, traditional norms and values play a less significant role in their social behaviour and lifestyle (Sato, 2012a; Tabi et al., 2006). For instance, studies in the sub-region demonstrate that educated persons are more likely to use biomedicine for their healthcare needs, while less educated persons rely on TCAM (Chinsembu, 2016; Odinka et al., 2014; Sato, 2012a). In the case of persons of SSA origin living in the GTA, one may argue that their integration into the culture of Canada coupled with their occupied socioeconomic status weans them from traditional prior traditional norms and values about health and healthcare. This is not to suggest that persons of SSA living in developed countries completely abandon their sociocultural values upon immigration. However, it can be hypothesised that their education and interaction with the cultures of developed countries (including biomedicine) may change their perceptions of the causes of diseases and chronic health hence their changed healthcare-seeking behaviour.

5.4.1 Chronic health status as a determinant of TCAM use

Similar to existing studies, the findings of the bivariate analysis and regression models show that chronic health status is a significant predictor of current TCAM use among persons of SSA living in the GTA. Studies show that persons with chronic health conditions such as cancer, hypertension, arthritis and diabetes are more likely to use TCAM compared to the general population (Garrow & Egede, 2006; Jones, Maloney, Boneva, Jones, & Reeves, 2007; Sirois, 2008; Weizman et al., 2012). In Canada, studies show that about 77% of people with HIV (Ontario) and 91% of cancer patients (Montreal, Quebec) indicated using TCAM for their healthcare needs (Furler et al., 2003; Sewitch et al., 2011). Foltz et al. (2005) also observed about 39% of Canadians with chronic back pain use TCAM. Studies in the United States and other
developed countries also buttress the association between chronic health and the use TCAM (Bazargan et al., 2008; Corner et al., 2009; Ojukwu, Mbizo, Leyva, Olaku, & Zia, 2015). Patients with chronic health conditions may often combine biomedical therapy with TCAM. Sweet et al., (2016) in their study, observed that a significant proportion of patient receiving chemotherapy (43.7%) and radiation (32.3%) used one or more TCAM remedies. Some scholar suggests the high prevalence of TCAM use among patients with chronic health conditions may be the results of their dissatisfaction with biomedical care (Weizman et al., 2012). Patients may view available biomedical care options as ineffective, have an adverse effect which increases their pain or see their care providers as impersonal (Foltz et al., 2005; Hsiao et al., 2008; Maizes et al., 2009; Nissen et al., 2013). These reasons, among others, may account for the increased likelihood of TCAM use among respondents with chronic health conditions. The chronic illness or conditions reported by the respondents of this study are similar to those studies and show have a high association with the use of TCAM. Respondents with chronic health conditions reported having cardiovascular and musculoskeletal conditions such as hypertension, arthritis, lower back pains and other cardiovascular. However, the results reveal that while chronic health status is strongly associated with TCAM, care-related factors and socioeconomic status have a mediating effect on this observed relationship (Table 5.3). The odds ratio and model robustness for chronic health status wane in the final regression model (Model 4) compared to the first model (Model 1).

5.4.2 Care-related factors as a determinant of TCAM use

Existing studies cite lack of cultural sensitivity, empathy and stereotyping as a major barrier to biomedical care services, especially among visible minorities or racialised individuals (Chalmers & Omer-Hashi, 2002; Edge et al., 2014; McKeary & Newbold, 2010; Woodgate et al., 2017).
These studies suggest that biomedical professionals usually do not possess adequate knowledge and understanding of the sociocultural beliefs of ethnic or racial minorities, including SSA immigrants (Woodgate et al., 2017). These factors, as well as other challenges associated with biomedical care, are considered push factors encouraging people to seek TCAM care. Findings of this study show that only a small proportion of respondents surveyed reported lack of sociocultural empathy (9.89%), feeling somewhat comfortable or uncomfortable (6.23%), experiencing discrimination (6.96%) or having difficulties accessing and using biomedical care services (7.33%).

Furthermore, the bivariate and multivariate results suggest perceived adequacy of biomedical care to one’s healthcare needs, and history of previous TCAM may be the driving factors for current TCAM use among persons of SSA origin living in the GTA. Perceived causes of ill health and the ability of a particular form of treatment to address the underlying causes might also influence healthcare-seeking behaviour of an individual (Ae-Ngibise et al., 2010; Amegbor, 2014; McDonald & Slavin, 2010). Perceived adequacy of treatment is often informed by the type of disease (or poor health) and individual or sociocultural beliefs about health (Coulter & Willis, 2007).

Psychological factors such as cognition, beliefs and values are crucial to treatment-seeking behaviour (Lorenc, Ilan-Clarke, Robinson, & Blair, 2009). TCAM users express a strong belief in the effectiveness of the remedies they use due to the natural origin and strong cultural attachment of these remedies (Adams, Sibbritt, Broom, et al., 2011; Grzywacz et al., 2005; Kemppainen et al., 2017). Studies among South Asians living in the UK also show that patients
beliefs about illness influence their perception of safety and efficacy of available treatment options (Ismail, Wright, Rhodes, & Small, 2005; Ismail, Wright, Rhodes, Small, & Jacoby, 2005; Rhodes, Small, Ismail, & Wright, 2008). Among cancer patients, Arthur et al. (2012) observed that the belief in a holistic approach to healing was a major motivating factor for seeking TCAM. The findings of the effect of perceived adequacy on TCAM care seeking among persons of SSA origin supports the findings of the existing literature. Patients with strong beliefs and trust in biomedical care rely on this healing option for their healthcare needs irrespective of the complexity of their health condition (Arthur et al., 2012; Buhling, Daniels, Studnitz, Eulenburg, & Mueck, 2014; Kraft, 2009). On the other hand, patients with less trust and belief in the efficacy of biomedical care may resort to TCAM (Flaherty et al., 2001; Solomon & Adams, 2015; Sullivan et al., 2015). Patients with severe health conditions are more likely to view TCAM as part of their healthcare needs due to their natural origin as well as focus on the psychosocial wellbeing of patients (Read et al., 2014; Robinson, Chesters, & Cooper, 2009; Williams et al., 2011). Similarly, experience from previous use of TCAM and the ability of the selected remedy to address one’s health concerns may inform the decision to use or not use TCAM for their current or future health care needs. Previous studies suggest the lack of knowledge or adequate information may inhibit a person’s desire or ability to seek TCAM care (Jain & Astin, 2001; D Su et al., 2008).

5.4.3 Socioeconomic status as a determinant of TCAM use

The findings of this study suggest current TCAM use is strongly associated with age and marital status of persons of SSA origin living in the GTA. The result of the bivariate analysis (Table 5.2) shows that age has a strong association with the use of TCAM in the past 12 months before
the study survey. The use of TCAM was generally high among persons within the age range of 45 to 59 years (41.77%) followed by persons aged 60 years and above (30.00%); while lower for persons below 45 years of age. From the multivariate analysis, the result indicates the difference between persons aged 45 to 59 years and those aged 60 years and above (reference group) were statistically significant such that persons in the former age category were more likely to have used TCAM in the past 12 months compared to the reference group. The age of 45 years is generally considered the start of middle-age or mid-life, where individuals become susceptible to age-related chronic health conditions. Thus, the high prevalence of TCAM use may be the result of existing chronic health conditions or persons aged 45 years and above may adopt TCAM as a health promotion measure against the chances of developing chronic health conditions (Canizares et al., 2017; Harris et al., 2012).

In terms of the multivariate finding on age, we postulate that persons aged 45 years to 59 years are within the working-age category hence are more likely to be covered by work-related health insurance benefits. This enables them to the have greater access to TCAM compared to those aged 60 years and above who are nearing retirement or retired hence may not have access to such work-related benefits. The finding is similar to that in the existing literature that suggests that middle-aged persons are more likely to use TCAM remedies compared to older persons (Bishop & Lewith, 2010; Reid et al., 2016; Thomson et al., 2014b). In developed countries, the findings of existing studies suggest that the use of TCAM is more prevalent among middle-aged adults compared to other age groups (Bishop & Lewith, 2010; Neiberg et al., 2011; Thomson et al., 2014b).
With regards to marital status, the finding shows that widowed/separated/divorced persons were more likely to have used TCAM in the past 12 months compared to those married or common-law. Here, we postulate that widowed or separated or divorced marital status often comes with associated psychosocial challenges hence the higher likelihood of using TCAM among persons in this category. The strains of marital dissolution can have negative health consequences for married couples (Williams & Umberson, 2004). Similarly, studies show that marital satisfaction and support reduces negative psychosocial health consequences (Leopold & Kalmijn, 2016; Lim & Raymo, 2016; Rollock & Lui, 2016; Simon, 2002). For instance, Holt-Lunstad et al. (2008) observed that married individuals tend to have greater life satisfaction, and high marital quality significantly lowered blood pressure, stress and depression. The grief of losing one’s life as well as the lost one’s social ties or social support can have negative psychological consequences on a person’s health (Kawachi & Berkman, 2001; Ott, 2003; Strohschein, McDonough, Monette, & Shao, 2005). As previously noted, TCAM healers pay attention to the psychosocial dimensions of their patients’ life thus may offer support and guidance needed to overcome the negative health consequences associated with marital divorce, separation or losing a partner. TCAM modalities that offer group-based activities, such as yoga, also provides the social and emotional support needed to overcome grief from marital dissolution or the loss of a partner.

5.4.4 Study limitations

In addition to the limitations discussed in Chapter 3, specific to the analysis carried out in this chapter there are limitations to the measures used to assess socioeconomic status, health status and biomedical care-related factors. First, the lack of a sample frame for the study population (persons of SSA origin living in the GTA) and the small sample size imply the findings in this
chapter may not be representative of the entire study population. As noted in Chapter 3, there is the possibility of selection bias in the sampling process, and the distribution of the study sample by socioeconomic status (as seen in Chapter 4) shows this. The proportion of persons with lower levels of education and persons of low-income status in the study sample may be considerably lower than the proportion in the actual population (personal and household). The estimates reported in this chapter may not be accurate for the actual population. For instance, the large standard errors (robust) observed in the multivariate analysis may be an indication of low statistical precision for population parameter estimates. Second, the data for this chapter was obtained through a cross-sectional survey. This implies that we cannot assume causality between the set of predictors used in the chapter and the outcome variable of interest (the use of TCAM in the past 12 months before the survey). Third, the variables used measures of health status, biomedical care-related features, and socioeconomic status are not comprehensive. For instance, the measure of health status used in the chapter only focused on chronic health status. The type of chronic health conditions and their severity were not measured or used in the analysis in this chapter. Fourth, health status, perceptions about biomedical care, and socioeconomic status of respondents in this study were self-reported; hence, there is a tendency for respondents to overestimate or underreport their health and socioeconomic status.
5.5 Summary

This chapter of the thesis focused on the use of TCAM among persons of SSA origin living in the GTA. The discussion explored the effects of health status, perceptions about biomedical care in the GTA, and socioeconomic status on TCAM use in the past 12 months prior to the survey. Answering research questions a) and b), the findings revealed that health status is strongly associated with TCAM use and they further show that persons with chronic health status are more likely to use TCAM. Regarding research questions c) and d), the findings suggested that measures of biomedical care-related factors have differential associations with TCAM use. Respondents’ perception of the adequacy of biomedical care for their healthcare needs were strongly associated with TCAM use, while perception of the quality of care received had a moderate association with TCAM use. The multivariate model indicated the differences in TCAM use among respondents by their perception of biomedical care-related factors was not statistically significant. The finding also demonstrated that respondents’ age and marital status have a strong and a moderate, respectively, association with TCAM use in the past 12 months. The differences in the use of TCAM by socioeconomic status was statistically significant for age and marital status.
Chapter 6
Examining Unmet Traditional, Complementary and Alternative Medicine Need and Medical Return Among Persons of SSA Origin Living in the Greater Toronto Area (GTA)

6.1 Introduction
The previous chapter examined health and socioeconomic determinants of current TCAM use among persons of SSA origin living in the GTA. This chapter will delve into the phenomena of unmet TCAM needs and medical return (or transnational healthcare) among persons of SSA origin living in the GTA. The chapter focuses on the second and third research objectives of the thesis – explore unmet TCAM needs and medical return (transnational healthcare) among persons of SSA origin living in the GTA. Specifically, the chapter seeks to answer the following specific research questions: a) Are health status, biomedical care-related characteristics, and socioeconomic status of persons from SSA origin living in the GTA significantly associated with unmet TCAM need? b) Are the differences in unmet TCAM need by health status, biomedical care-related characteristics, and socioeconomic status statistically significant? c) Are health status, biomedical care-related characteristics, and socioeconomic status of persons from SSA origin living in the GTA significantly associated with medical return (transnational health care seeking)? d) Are differences in medical return among persons of SSA origin living the GTA by health status, biomedical care-related characteristics, and socioeconomic status statistically significant?
The TCAM ‘healthcare-scape’ in developed countries is mainly dominated by well-established healthcare therapies (such as chiropractic and homoeopathy) and oriental medicine (such as traditional Chinese medicine and Ayurvedic medicine). In some countries, aspects of oriental medicine are stripped of their traditional beliefs and values, modernised and incorporated into the formal healthcare system (Coulter & Willis, 2004; Green et al., 2002; Samano et al., 2005). The modernisation process entails formal training in medical and allied health science schools, as well as licensing or certification of practitioners (Mak, Mak, Shen, & Faux, 2009; World Health Organisation, 2013). Consequently, these ‘reformed traditional healing practices’ may be covered by existing state health plans or private health insurances plans (Barrett, 2003; Boon, 2002; Meeker & Haldeman, 2002). Existing studies on TCAM access and use in developed countries usually focus on these well-established TCAM (e.g., chiropractic and homeopathy) and oriental healthcare therapies such as acupuncture, Chinese herbal medicine and Ayurvedic medicine (Ijaz, Boon, Welsh, & Meads, 2015; Kelner, Wellman, Welsh, & Boon, 2006; Kong & Hsieh, 2012; Lai & Chappell, 2007; Rossi, Baccetti, Firenzuoli, & Belvedere, 2008; Thomson et al., 2014b; Watt et al., 2012).

The presence of traditional African healing remedies in developed countries is very limited, and their practices are not entrenched in the healthcare sector. Despite the limited presence of traditional African therapies in developed countries, a considerable number of SSA migrants live in developed such as Canada, the United Kingdom, the United States and other western European countries. In 2004, there were an estimated 7.2 million African migrants living in OECD countries, representing 13% of the immigrant population from non-OECD countries (Bossard, 2005). Currently, an estimated 11 million African immigrants are living in OECD
countries (Arslan et al., 2014). Figures from Statistics Canada indicate about 637,485 Canadian residents are of African origin comprising 8.5% of the country’s total immigrant population (Statistics Canada, 2017b). As previously noted, knowledge from existing studies and stakeholder reports show that the vast majority of people in SSA depend on traditional healing remedies for their healthcare needs (O’Brien et al., 2012; Pouliot, 2011; Pouliot & Treue, 2013; Towns & Van Andel, 2016; World Health Organisation, 2013; Zizka et al., 2015). Indigenous medical resources are employed to address basic or acute health conditions such as fever, malaria, typhoid and pains (Komlaga et al., 2015; Pouliot, 2011; Towns et al., 2014; Van Andel et al., 2012). Traditional medical remedies are also sought for chronic or complex health problems such as hypertension and diabetes (Aikins, 2005; Bignante, 2015; de Wet, Ramulondi, & Ngcobo, 2016; Kigen et al., 2013; Salihu Shinkafi, Bello, Wara Hassan, & Ali, 2015; Stanifer et al., 2015).

Although traditional African medicine plays a vital role in the healthcare-seeking behaviour of persons from SSA and its presence in Canada is limited, there are currently no studies on unmet TCAM needs. Similarly, knowledge and research on transnational healthcare behaviour among sub-Saharan Africans living in Canada are limited. Studies in Europe and North America report transnational healthcare-seeking behaviour among other immigrants groups, such as the Chinese, South Koreans, Romanians and Mexicans (Fong, 2008; Lee, Kearns, & Friesen, 2010; Şekercan et al., 2015; Stan, 2015). For instance, South Korean immigrants living in Toronto are reported to travel back to their country of origin to seek essential healthcare due to sociocultural, geographic and other economic barriers they face in Canada (Wang & Kwak, 2015). Most respondents in the study cited long wait times as major motivations for seeking care back home. Among Mexican
immigrants living in the United States, challenges associated with access to health care (such as cost) and other features of the country’s medical system such as constant referrals and tests, lack of person-centred care and limited English language, encouraged cross-border healthcare-seeking in Mexico (Horton & Cole, 2011; Wallace, Mendez-luck, Castañeda, Wallace, & Mendez-luck, 2009). Experiences of discrimination, stereotyping or marginalisation have been identified as another motivation for seeking cross-border or transnational healthcare by persons of immigrant origin (Bergmark, Barr, & Garcia, 2010; Kemppainen, Kemppainen, Skogberg, Kuusio, & Koponen, 2018; Wang & Kwak, 2015).

There are significant sociocultural differences among immigrant groups and the healthcare system or policies in their countries of origin. Immigrants from Asian countries, such as South Korea and Taiwan, may be eligible for the universal health insurance coverage in their countries of origin (Lee et al., 2010; Sun, 2014; Wang & Kwak, 2015). Taiwanese immigrants are entitled to the country’s universal public healthcare services; this has been a motivating factor for transnational healthcare-seeking among Taiwanese immigrants living in the United States (Sun, 2014). Similarly, Stan (2015) asserts that the benefits of free and universal access to healthcare coupled with difficulties associated with receiving care in Ireland have been a major influence in transnational healthcare-seeking behaviour among Romanian immigrants living in Ireland. Contrarily, universal and free access to healthcare remains elusive to most people in SSA (Aryeetey et al., 2013; Fenny et al., 2016; Jehu-Appiah et al., 2011; Mills et al., 2012; Powell-Jackson & Ansah, 2015). While countries, like Ghana and Burkina Faso, have attempted to provide free and affordable healthcare coverage for their citizens and residents through national or community-based health insurance schemes, the dream of a universal coverage remains
distant (Akazili et al., 2014; Lagomarsino, Garabrant, Adyas, Muga, & Otoo, 2012; Mills et al., 2012). In Ghana, estimates from existing studies and reports suggest that about 60% of the country’s population are uninsured (Alhassan, Nketiah-Amponsah, & Arhinful, 2016). Given these differences, the findings of existing studies on transnational healthcare among other immigrant groups may not apply to SSA immigrants, especially in the context of TCAM and Canada’s universal healthcare coverage for legal residents.

Studies identify cultural incompetence of biomedical healthcare practitioners as another one of the major barriers to quality healthcare among ethnic minorities in developed countries (Castleden et al., 2010; Kemppainen et al., 2017; Şekercan et al., 2015; Wang & Kwak, 2015; Woodgate et al., 2017). The discourse on barriers to healthcare and transnational healthcare behaviour among immigrants have mainly focused on the utilization of biomedical care in their countries (Bergmark et al., 2010; Jesus & Xiao, 2013; Landeck & Garza, 2002; Sun, 2014; Wallace et al., 2009; Wang & Kwak, 2015). Currently, there is limited knowledge of transnational healthcare-seeking behaviour in the context of ethnic medicine or sociocultural healing practices. Sociocultural beliefs and practices, as well as, traditional norms play significant roles in the health and healthcare-seeking behaviour of people from traditional societies in the global south, including SSA (Ae-Ngibise et al., 2010; Amegbor, 2014; Amoah, Sandjo, Bazzo, Leite, & Biavatti, 2014; Quiroz et al., 2014). Given the limited presence of traditional African healing practices and remedies in western countries, it becomes imperative to explore and analyse unmet TCAM needs and the phenomenon of travelling back to their country of origin to use TM/TCAM.
6.2 Methods

The primary data for this chapter is from the cross-sectional survey of persons of SSA origin living in the GTA collected by the author in 2018 (see Chapter 3). The total sample size of persons interviewed in the survey is 273 respondents – from both the paper-based survey (205) and the online survey (68). Aside from sociodemographic characteristics, TCAM use and health status information, the survey also solicited information on unmet TCAM need and respondents’ transnational healthcare behaviour.

6.2.1 Measures

There were two outcome measures of interest for analysis in this chapter – unmet TCAM need and medical return. The first outcome measure (unmet TCAM need) was derived from the survey question “During the past 12 months, was there ever a time when you felt that you needed a traditional (e.g. traditional African medicine, traditional Chinese medicine and Ayurvedic), a complementary or an alternative medicine (e.g. chiropractic, massage therapy, acupuncture, homoeopathy)? but you could get it or did not receive it?” (Q28). While the question did not constrain unmet TCAM need to traditional African healing remedies, the majority of respondents (~88%) stated unavailability of the remedies they needed in Canada as the reason for their unmet TCAM need (see Chapter 4). The response was binary and coded as: “1=Yes” and “0=No”. For the second outcome measure, respondents were asked if they had to return to their country of origin for traditional medical care or to obtain traditional medicine or return to Canada with traditional healing remedies from their country of origin (Q25). Likewise, this outcome had binary responses and was coded as: “1=Yes” and “0=No”.
Based on the knowledge from existing studies and the research questions for this chapter, four sets of predictor variables were assessed for their relationship with unmet TCAM and medical return. The first predictor focused on health status. Health status was measured by the presence or absence of chronic health condition(s) (Q41). In the survey, respondents were asked if they had any chronic health conditions, and the responses were coded as: “1=Yes” and “0=No”. The second set of predictors dealt with characteristics of biomedical care. The measures for this include perceived quality of care (Q51), adequacy of biomedical care (Q52), empathy or sociocultural sensitivity of biomedical care professionals (Q53), perceived comfort with biomedical care environment (Q54), incident of discrimination or marginalisation or stereotyping associated with seeking biomedical care (Q55), and difficulties or challenges associated with seeking biomedical care (Q56). The measures for quality, adequacy and comfort were ordinal response variables while empathy, discrimination/marginalisation/stereotyping and difficulties with biomedical care were dichotomous variables. Respondents were asked to rank their perception on the quality of biomedical care, the adequacy of biomedical care for their health needs and how comfortable they felt in biomedical care environment (including hospitals, clinics and family physician care settings).

The third set of predictors focused on transnational ties. Two measures were used to assess transnational ties: a recent visit to country of origin and active transnational ties with social relations in country of origin. The first measure was derived from a question (Q35) on whether respondents have visited their country of origin in the past 12 months before the survey. The question had two valid responses: Yes and No. The second measure was derived from two survey questions: “Do you send money or material gifts to family and friends in your country of
origin?” (Q36) and “Do you (or your partner) have a property in your country of origin?” (Q37). Respondents who answered in the affirmative to one or more of these questions were grouped into a single category and coded as: “1=Active transnational ties”; while those who answered ‘No’ to both questions were grouped and coded as: “0=Non-active transnational ties”. Studies on transnationalism and migration indicate property ownership and remittance are important means of affirming interpersonal relations between migrants and social relations in their countries of origin (Carling, 2008; Mazzucato, 2008).

Sociodemographic characteristics shape health behaviours, illness and health perceptions, as well as, influence immigrants’ transnational mobility (Bell et al., 2005; Bochaton, 2014; Lokdam, Kristiansen, Handlos, & Norredam, 2016). Previous studies suggest that socioeconomic factors are significantly associated with transnational healthcare behaviour among immigrants living in developed countries (Şekercan et al., 2015). Economic capability to afford the cost of travel or engage in a medical visit to one’s country of origin plays a crucial role in the decision to engage in transnational healthcare or medical return (Bochaton, 2014). Socioeconomic status is associated with the ability to access medical care, especially in the context where the needed medical services are not covered by existing state or employee health insurance plans (Chao, Wade, Kronenberg, Kalmuss, & Cushman, 2006; Wiles & Rosenberg, 2001). Thus, sociodemographic factors were included in the list of predictors to assess their effect on unmet TCAM and medical return. Age, sex, marital status, education, household income and immigration status were used as sociodemographic predictors of unmet TCAM need and medical return. Health insurance status in the form of Extended Health Care (EHC) plan and previous
history of TCAM use in country of origin were included as measures. These two variables were employed as control variables in the analysis.

6.2.2 Analysis

Bivariate statistical analysis was performed to assess the association between the selected predictor variables and the outcome measures using the Pearson chi-square test. Similar to the statistical procedure for Chapter 5, Cramer’s V test was performed to determine the strength of the association. Multivariate stepwise logistic regression models were developed to examine the association of health status (chronic health status), characteristics of biomedical care (quality, adequacy, empathy, comfort, discrimination and difficulties), and socioeconomic status (age, sex, marital status, education, household income and immigration status) with unmet TCAM need and medical return. Again, unmet TCAM need and medical return were unevenly distributed hence failed the symmetrical assumption of binomial logistic regression.

For this reason, a complementary logistic regression function was adopted to ensure that the analysis of the outcomes did not produce biased parameter estimates (Amegbor, Kuuire, et al., 2018; Hedeker, 2008). Wald’s chi-square assessed the goodness of fit for the models, Cragg and Uhler’s pseudo R-square, the Akaike Information Criterion (AIC) and the Bayesian Information Criterion (BIC) are also reported. Multicollinearity in the multivariate models was checked through computing the tolerance and the variance inflation factor (VIF) for the predictor variables. Results of the tolerance and VIF show none of the predictor variables was redundant; that is, multicollinearity is not biasing the logistic regression estimates. The highest VIF value was for chronic health status (3.63), and the mean VIF for all predictor variables was 2.11. For
easy interpretation of the findings, the exponentiated beta coefficients or the odds ratios are reported for the multivariate logistic regression analysis. All statistical analyses were performed using STATA (version 14.2) software package by StataCorp (College Station, TX).

6.3 Results

6.3.1 Univariate & Bivariate results

The results of the descriptive statistics show that ~20.88% of respondents surveyed expressed having unmet TCAM need and ~39.56% indicated they have engaged in medical return (transnational healthcare-seeking in their countries of origin). Table 6.1 shows the result of the cross-tabulation analysis of unmet TCAM needs among persons of SSA origin living in the GTA. The results show that chronic health status is significantly associated with unmet TCAM needs. The proportion of respondents who have chronic health conditions with unmet TCAM need was relatively higher (66.00%) than those without chronic health status but had unmet TCAM need (10.76%). The result of the Cramer’s V test shows that chronic health status had a strong association with unmet TCAM need (V=0.536, p<0.001).

Regarding biomedical care characteristics, the results show that all measures were significantly associated with unmet TCAM need. Perceived quality of biomedical care (V=0.378, p<0.01) and perceived adequacy of care (V=0.549, p<0.01) were strongly associated with unmet TCAM, while empathy and perceived comfort with biomedical care environment were moderately associated with unmet TCAM need. The proportions of respondents with unmet TCAM need were generally higher among those that expressed more negative views on the quality of
biomedical care and adequacy of biomedical for their healthcare needs. Approximately 51.85% of respondents who indicated their biomedical care providers did not demonstrate (show) empathy or sensitivity to their sociocultural/religious worldviews indicated they had unmet TCAM need. Discrimination ($V=0.159, p<0.01$) and difficulties ($V=0.167, p<0.01$) associated with accessing biomedical care had weak associations with unmet TCAM need.

<table>
<thead>
<tr>
<th>Health status</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>Chi2 (Cramer's V)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic health status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>33 (66.00)</td>
<td>17 (34.00)</td>
<td>75.436 (-0.536)***</td>
</tr>
<tr>
<td>No</td>
<td>24 (10.76)</td>
<td>199 (89.24)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Biomedical care factors</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>Chi2 (Cramer's V)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Biomedical care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td>10 (7.04)</td>
<td>132 (92.96)</td>
<td></td>
</tr>
<tr>
<td>Very good</td>
<td>27 (32.14)</td>
<td>57 (67.86)</td>
<td>39.064 (0.378)***</td>
</tr>
<tr>
<td>Good</td>
<td>19 (46.34)</td>
<td>22 (53.66)</td>
<td></td>
</tr>
<tr>
<td>Fair</td>
<td>1 (16.67)</td>
<td>5 (83.33)</td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Adequacy - Biomedical Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highly adequate</td>
<td>6 (4.35)</td>
<td>132 (95.65)</td>
<td></td>
</tr>
<tr>
<td>Adequate</td>
<td>21 (24.42)</td>
<td>65 (75.58)</td>
<td></td>
</tr>
<tr>
<td>Somewhat adequate</td>
<td>20 (58.82)</td>
<td>14 (41.18)</td>
<td>82.239 (0.549)***</td>
</tr>
<tr>
<td>Inadequate</td>
<td>10 (83.33)</td>
<td>2 (16.67)</td>
<td></td>
</tr>
<tr>
<td>Highly inadequate</td>
<td>-</td>
<td>3 (100.00)</td>
<td></td>
</tr>
<tr>
<td>Empathy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>22 (19.47)</td>
<td>91 (80.53)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>14 (51.85)</td>
<td>13 (48.15)</td>
<td>17.901 (0.256)***</td>
</tr>
<tr>
<td>Don't know</td>
<td>21 (15.79)</td>
<td>112 (84.21)</td>
<td></td>
</tr>
<tr>
<td>Comfort with Biomedical care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very comfortable</td>
<td>27 (15.08)</td>
<td>152 (84.92)</td>
<td></td>
</tr>
<tr>
<td>Comfortable</td>
<td>22 (28.57)</td>
<td>55 (71.43)</td>
<td>13.866 (0.225)***</td>
</tr>
<tr>
<td>Somewhat comfortable</td>
<td>7 (50.00)</td>
<td>7 (50.00)</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------</td>
<td>-----------</td>
<td></td>
</tr>
<tr>
<td>Uncomfortable</td>
<td>1 (33.33)</td>
<td>2 (66.67)</td>
<td></td>
</tr>
<tr>
<td>Discrimination/Marginalisation/Stereotyping</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>10 (41.67)</td>
<td>14 (58.33)</td>
<td>6.883 (-0.159)**</td>
</tr>
<tr>
<td>No</td>
<td>47 (18.88)</td>
<td>202 (81.12)</td>
<td></td>
</tr>
<tr>
<td>Challenges or difficulties - Biomedical care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>9 (45.00)</td>
<td>11 (55.00)</td>
<td>7.601 (-0.167)**</td>
</tr>
<tr>
<td>No</td>
<td>48 (18.97)</td>
<td>205 (81.03)</td>
<td></td>
</tr>
</tbody>
</table>

**Socioeconomic factors**

**Age**
- 18 to 24 years: 2 (9.52) | 19 (90.48)
- 25 to 34 years: 10 (15.15) | 56 (84.85)
- 35 to 44 years: 6 (7.79) | 71 (92.21) 33.303 (0.350)**
- 45 to 59 years: 23 (29.11) | 56 (70.89)
- 60 years and above: 16 (53.33) | 14 (46.67)

**Sex**
- Male: 30 (23.62) | 97 (76.38) 1.082 (-0.063)
- Female: 27 (18.49) | 119 (81.51)

**Marital Status**
- Married/Common-law: 44 (23.28) | 145 (76.72)
- Widowed/Sep/Divorced: 6 (28.57) | 15 (71.43) 5.051 (0.136)+
- Single/never married: 7 (11.11) | 56 (88.89)

**Education**
- Non-university certificate or degree: 16 (32.65) | 33 (67.35) 5.011 (-0.136)*
- University certificate or degree: 41 (18.30) | 183 (81.70)

**Personal income**
- <$20,000: 4 (12.50) | 28 (87.50)
- $20,000-$39,999: 18 (24.66) | 55 (75.34)
- $40,000-$59,999: 14 (14.89) | 80 (85.11) 6.572 (0.155)
- $60,000-$79,999: 6 (27.27) | 16 (72.73)
- $80,000 or more: 15 (28.85) | 37 (71.15)

**Household income**
- <$20,000: 4 (50.00) | 4 (50.00)
- $20,000-$39,999: 4 (17.39) | 19 (82.61)
- $40,000-$59,999: 5 (15.15) | 28 (84.85) 5.424 (0.141)
- $60,000-$79,999: 7 (17.07) | 34 (82.93)
- $80,000 or more: 37 (22.02) | 131 (77.98)

**Immigration Status**
- Citizen: 48 (23.65) | 155 (76.35)
- Permanent resident: 3 (6.25) | 45 (93.75) 7.703 (0.168)*
- Other: 6 (27.27) | 16 (72.73)
Control variables

Previous TCAM use - Country of origin

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>47 (35.34)</td>
<td>10 (7.14)</td>
<td>32.823 (0.347)***</td>
</tr>
<tr>
<td>No</td>
<td>86 (64.66)</td>
<td>130 (92.86)</td>
<td></td>
</tr>
</tbody>
</table>

Health insurance status

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>40 (18.52)</td>
<td>176 (81.48)</td>
<td>3.490 (-0.113)+</td>
</tr>
<tr>
<td>No</td>
<td>17 (29.82)</td>
<td>40 (70.18)</td>
<td></td>
</tr>
</tbody>
</table>

***p<0.001, **p<0.01, *p<0.05, +p<0.1

For sociodemographic factors, the results indicate that age, marital status, education and immigration status were significantly associated with unmet TCAM needs. While age had a strong association with unmet TCAM need (V=0.350, p<0.001), marital status, education, and immigration status had a weak association with unmet TCAM need. The proportion of respondents with unmet TCAM need increases with an increase in an age category, such that 53.33% of respondents aged 60 years and above had unmet TCAM need compared to 9.52% among those aged 18 to 24 years. The proportion of respondents widowed/divorced/separated with unmet TCAM need (28.57%) was relatively higher than that for their other marital status categories. Likewise, the proportion of respondents with a non-university certificate or degree with unmet TCAM need (32.65%) was relatively higher than those with a university degree or certificate (18.30%). Previous history of TCAM use (in country of origin) and health insurance status (EHC) were significantly associated with unmet TCAM need. Previous history of TCAM was strongly associated with unmet TCAM (V=0.347, p<0.001) while health insurance had a weak association with unmet TCAM (V=0.113, p<0.1).

Table 6.2 shows the results for the cross-tabulation analysis of medical return. The results demonstrate that chronic health status was strongly associated with medical return (V=0.527, p<0.001). Only three of the six measures used to assess biomedical care-related factors were
significantly associated with medical return. Perceived quality of biomedical care and perceived adequacy of biomedical care were strongly associated with medical return; while empathy had a weak association with medical return ($V=0.160$, $p<0.05$). For transnational ties, the results show that maintaining transnational relations through remittances and property ownership was strongly associated with medical return ($V=0.392$, $p<0.001$). Approximately 51.26% of respondents that indicated they maintained transnational ties engaged in medical return compared to only 8.11% who do not maintain transnational contacts. All sociodemographic indicators were significantly associated with medical return. Only age and marital status had strong associations with medical return; while personal income, household income and immigration status were moderately associated with medical return. The proportion of respondents that had engaged in medical return increased with increase in age; ~93.33% of respondents age 60 years and above indicated they had engaged in medical return. Sex and education had a weak association with medical return.

Table 6.2 Cross-tabulation analysis of Medical Return (n=273)

<table>
<thead>
<tr>
<th></th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>Chi2 (Cramer's V)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic health status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>47 (94.00)</td>
<td>3 (6.00)</td>
<td>75.871 (-0.527)***</td>
</tr>
<tr>
<td>No</td>
<td>61 (27.35)</td>
<td>162 (72.65)</td>
<td></td>
</tr>
<tr>
<td><strong>Biomedical care factors</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of Biomedical care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td>36 (25.35)</td>
<td>106 (74.65)</td>
<td></td>
</tr>
<tr>
<td>Very good</td>
<td>42 (50.00)</td>
<td>42 (50.00)</td>
<td>33.795 (0.352)***</td>
</tr>
<tr>
<td>Good</td>
<td>29 (70.73)</td>
<td>12 (29.27)</td>
<td></td>
</tr>
<tr>
<td>Fair</td>
<td>1 (16.67)</td>
<td>5 (83.33)</td>
<td></td>
</tr>
<tr>
<td>Adequacy - Biomedical Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highly adequate</td>
<td>30 (21.74)</td>
<td>108 (78.26)</td>
<td></td>
</tr>
<tr>
<td>Adequate</td>
<td>37 (43.02)</td>
<td>49 (56.98)</td>
<td></td>
</tr>
<tr>
<td>------------------------------</td>
<td>------------</td>
<td>------------</td>
<td></td>
</tr>
<tr>
<td>Somewhat adequate</td>
<td>28 (82.35)</td>
<td>6 (17.65)</td>
<td>63.183 (0.481)***</td>
</tr>
<tr>
<td>Inadequate</td>
<td>12 (100.00)</td>
<td>0 (0.00)</td>
<td></td>
</tr>
<tr>
<td>Highly inadequate</td>
<td>1 (33.33)</td>
<td>2 (66.67)</td>
<td></td>
</tr>
<tr>
<td>Empathy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>43 (38.05)</td>
<td>70 (61.95)</td>
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<td>17 (62.96)</td>
<td>10 (37.04)</td>
<td>6.962 (0.160)*</td>
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<tr>
<td>Don't know</td>
<td>48 (36.09)</td>
<td>85 (63.91)</td>
<td></td>
</tr>
<tr>
<td>Comfort with Biomedical care environment</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Very comfortable</td>
<td>64 (35.75)</td>
<td>115 (64.25)</td>
<td></td>
</tr>
<tr>
<td>Comfortable</td>
<td>36 (46.75)</td>
<td>41 (53.25)</td>
<td>3.438 (0.112)</td>
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<tr>
<td>Somewhat comfortable</td>
<td>7 (50.00)</td>
<td>7 (50.00)</td>
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<tr>
<td>Uncomfortable</td>
<td>1 (33.33)</td>
<td>2 (66.67)</td>
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<tr>
<td>Yes</td>
<td>13 (54.17)</td>
<td>11 (45.83)</td>
<td>2.348 (-0.093)</td>
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<tr>
<td>No</td>
<td>95 (38.15)</td>
<td>154 (61.85)</td>
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</tr>
<tr>
<td>Challenges or difficulties - Biomedical care</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>6 (30.00)</td>
<td>14 (70.00)</td>
<td>0.825 (0.055)</td>
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<tr>
<td>No</td>
<td>102 (40.32)</td>
<td>151 (59.68)</td>
<td></td>
</tr>
</tbody>
</table>

**Transnational Ties**

Recent Visit - Country of Origin |            |            |
| Yes                          | 39 (45.88) | 46 (54.12) | 2.063 (0.087)    |
| No                           | 69 (36.70) | 119 (63.30) |

Transnational ties - Country of Origin |            |            |
| Yes                          | 102 (51.26)| 97 (48.74) | 42.002 (0.392)*** |
| No                           | 6 (8.11)   | 68 (91.89) |

**Socioeconomic factors**

Age |
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>18 to 24 years</td>
<td>0 (0.00)</td>
<td>21 (100.00)</td>
</tr>
<tr>
<td>25 to 34 years</td>
<td>12 (18.18)</td>
<td>54 (81.82)</td>
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<tr>
<td>35 to 44 years</td>
<td>14 (18.18)</td>
<td>63 (81.82)</td>
</tr>
<tr>
<td>45 to 59 years</td>
<td>54 (68.35)</td>
<td>25 (31.65)</td>
</tr>
<tr>
<td>60 years and above</td>
<td>28 (93.33)</td>
<td>2 (6.67)</td>
</tr>
</tbody>
</table>

Sex |
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Male</td>
<td>58 (45.67)</td>
</tr>
<tr>
<td>Female</td>
<td>50 (34.25)</td>
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Marital Status |
<table>
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<tr>
<td>Married/Common-law</td>
<td>94 (49.74)</td>
<td>95 (50.26)</td>
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<tr>
<td>Widowed/Sep/Divorced</td>
<td>10 (47.62)</td>
<td>11 (52.38)</td>
</tr>
<tr>
<td>Single/never married</td>
<td>4 (6.35)</td>
<td>59 (93.65)</td>
</tr>
</tbody>
</table>
Table 6.3 shows the results of the multivariate complementary logistic regression test for unmet TCAM need. The association between chronic health status and unmet TCAM need was assessed in Model 1. The result shows that chronic health status is significantly associated with unmet TCAM need. Respondents who indicated that they had a chronic condition(s) were more likely to have unmet TCAM need (OR=9.474, p<0.001). In Model 2, elements of biomedical care were used as predictors of unmet TCAM need. Perceived quality of care, adequacy, empathy and difficulties with access to biomedical care were significantly associated with unmet TCAM need.
Respondents who had a negative view of the quality of biomedical care in the GTA were 2.356 times (p<0.1) more likely to have unmet TCAM need. Respondents who had more negative perceptions of the adequacy of biomedical care were more likely to have unmet TCAM need. Respondents who indicated that they had difficulties accessing biomedical care in the GTA were more likely to have unmet TCAM need (OR=4.869, p<0.001).
### Table 6.3 Determinants of Unmet TCAM need among persons of SSA origin in GTA (n=273)

<table>
<thead>
<tr>
<th>Health status</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic health status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No (ref)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Yes</td>
<td>9.474 (2.600)***</td>
<td>4.588 (2.368)**</td>
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### Biomedical care factor

<table>
<thead>
<tr>
<th>Quality of Biomedical care</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very good</td>
<td>2.356 (1.068)+</td>
<td>2.323 (1.152)+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>1.697 (0.880)</td>
<td>1.960 (1.174)</td>
<td></td>
<td></td>
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<tr>
<td>Fair</td>
<td>0.539 (0.563)</td>
<td>0.279 (0.371)</td>
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</table>

<table>
<thead>
<tr>
<th>Adequacy - Biomedical Care</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highly adequate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequate</td>
<td>4.516 (2.239)**</td>
<td>3.176 (1.839)*</td>
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<tr>
<td>Somewhat adequate</td>
<td>15.695 (8.168)**</td>
<td>4.771 (3.261)*</td>
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<td></td>
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<tr>
<td>Inadequate/highly inadequate</td>
<td>26.726 (16.097)**</td>
<td>7.172 (6.118)*</td>
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<table>
<thead>
<tr>
<th>Empathy</th>
<th>Model 1</th>
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<th>Model 4</th>
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<td>No</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>0.782 (0.323)</td>
<td>0.704 (0.339)</td>
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<td></td>
</tr>
<tr>
<td>Don’t know</td>
<td>0.347 (0.152)**</td>
<td>0.321 (0.163)*</td>
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<table>
<thead>
<tr>
<th>Comfort with Biomedical care environment</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very comfortable</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comfortable</td>
<td>0.644 (0.250)</td>
<td>1.128 (0.460)</td>
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</tr>
<tr>
<td>Somewhat comfortable</td>
<td>0.884 (0.438)</td>
<td>1.038 (0.615)</td>
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</tr>
<tr>
<td>Uncomfortable</td>
<td>0.280 (0.376)</td>
<td>1.136 (2.015)</td>
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<table>
<thead>
<tr>
<th>Discrimination/Marginalisation/Stereotyping</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
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</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

148
Yes 1.295 (0.573) 2.175 (1.216)

Challenges or difficulties - Biomedical care
No
Yes 4.869 (2.405)** 5.467 (3.632)**

**Socioeconomic factors**

**Age**

- 60 years and above (ref)
- 45 to 59 years
  - 0.438 (0.150)*
  - 1.009 (0.444)
- 35 to 44 years
  - 0.137 (0.070)***
  - 1.072 (0.884)
- 25 to 34 years
  - 0.241 (0.159)*
  - 1.070 (0.856)
- 18 to 24 years
  - 0.121 (0.125)*
  - 0.369 (0.529)

**Sex**

- Male (ref)
  - Female
    - 0.725 (0.217)
    - 0.702 (0.236)

**Marital Status**

- Married/Common-law (ref)
  - Widowed/Sep/Divorced
    - 1.854 (0.904)
    - 2.688 (1.793)
  - Single/never married
    - 0.701 (0.540)
    - 2.186 (2.126)

**Education**

- University certificate or degree (ref)
  - Non-university certificate or degree
    - 1.847 (0.609)+
    - 5.156 (2.030)***

**Household income**

- $80,000 or more (ref)
- $60,000-$79,999
  - 0.595 (0.250)
  - 0.637 (0.389)
- $40,000-$59,999
  - 0.526 (0.265)
  - 0.226 (0.181)+
- $20,000-$39,999
  - 0.322 (0.208)+
  - 0.376 (0.342)
- <$20,000
  - 1.257 (0.859)
  - 1.484 (1.172)

**Immigration Status**

- Citizen (ref)
  - Permanent resident
    - 0.505 (0.343)
    - 0.609 (0.635)
### Other

<table>
<thead>
<tr>
<th></th>
<th>5.270 (3.862)*</th>
<th>9.611 (8.632)*</th>
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### Control variables

#### Health Insurance

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<table>
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<tr>
<td>No (ref)</td>
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<tr>
<td>Yes</td>
<td>0.898 (0.367)</td>
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#### Previous TCAM use - Country of origin

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<tr>
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<td>Yes</td>
<td>2.825 (1.429)*</td>
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### Model Information

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<tr>
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<th>-139.872</th>
<th>-93.529</th>
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<tr>
<td>Log pseudolikehood</td>
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<td></td>
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<tr>
<td>Wald's Chi2</td>
<td>67.11***</td>
<td>75.36***</td>
<td>48.10***</td>
<td>79.92***</td>
</tr>
<tr>
<td>Cragg &amp; Uhler's R2</td>
<td>0.323</td>
<td>0.449</td>
<td>0.243</td>
<td>0.610</td>
</tr>
<tr>
<td>AIC</td>
<td>0.815</td>
<td>0.832</td>
<td>1.009</td>
<td>0.866</td>
</tr>
<tr>
<td>BIC</td>
<td>-1298.137</td>
<td>-1232.138</td>
<td>-1189.071</td>
<td>-1129.046</td>
</tr>
</tbody>
</table>

Robust standard error in parenthesis; ***p<0.001, **p<0.01, *p<0.05, +p<0.1
With regards to sociodemographic factors (Model 3), the results indicate that age, education, household income and immigration status were significantly associated with unmet TCAM need. Respondents below the age 60 were less likely to have unmet TCAM need. Non-university certificate or degree holders were more likely to have unmet TCAM need (OR=1.847, p<0.1); however, respondents living in households with an annual income of $20,000 to $39,999 were less likely (OR=0.322, p<0.1) to have unmet TCAM need. Immigration status wise, persons in the other category were 5.270 times (p<0.05) more likely to have unmet TCAM need. Model 4 included all predictors from the previous models. The results show that after controlling for biomedical care characteristics and sociodemographic factors, chronic health status was still significantly associated with unmet TCAM. The exponentiated beta coefficient estimate (odds ratio) for persons with chronic health condition(s) reduced by ~4.886; that is, persons with chronic health condition(s) were 4.588 times (p<0.01) more likely to have unmet TCAM need. For biomedical care-related factors, the results show that adequacy, empathy, and difficulties with access (to biomedical care) were significant predictors of unmet TCAM need after controlling for chronic health status and sociodemographic factors.

Respondents with lower levels of perceived adequacy and those who had difficulties accessing biomedical care were more likely to have unmet TCAM need. Respondents who reported the quality of biomedical care in the GTA was very good were 2.323 times (p<0.1) more likely to have unmet TCAM need, compared to those who rated the quality of care as excellent. Respondents who selected “don’t know” for empathy were 0.321 times (p<0.05) less likely to have unmet TCAM need. The statistical significance of quality (biomedical) waned after introducing chronic health status and sociodemographic factors as additional covariates.
Likewise, the statistical significance of age and household income – as sociodemographic factors – waned after introducing chronic health status and biomedical care-related factors. The relationship between education and immigration status became more robust. Persons with a non-university certificate (or degree) were 5.156 times (p<0.001) more likely to have unmet TCAM need. Respondents in the “other” category of immigration status were more likely to have unmet TCAM need (OR=9.611, p<0.05). Respondents who lived in a household with an annual income of $40,000 to $59,999 were less likely to have unmet TCAM need, compared to those living in households with an annual income of $80,000 or more (OR=0.226, p<0.1). Previous history of TCAM use (in country of origin) was significantly associated with unmet TCAM need; respondents who used TCAM in their country of origin before immigrating to Canada were 2.825 times (p<0.05) more likely to have unmet TCAM need. The model diagnostics show that Model 1, Model 2, Model 3, and Model 4 explained ~32%, ~45%, ~24%, and ~61% of the variance in unmet TCAM need, respectively. The AIC estimates show that Model 3 (sociodemographic factors only) was the least statistically preferable model, compared to the other models.

6.3.3 Multivariate results – Medical return

Table 6.4 shows the results of the multivariate complementary logistic regression analysis for medical return. Model 1 examined the association between chronic health status and medical return only. The results indicate that chronic health status is significantly associated with medical return; persons with chronic health issues were more likely (OR=8.804, p<0.001) to engage in medical return. Model 2 assessed the association between biomedical care-related factors and medical return. Perceived quality of biomedical care and perceived adequacy of biomedical care
were significant predictors of medical return. Respondents who rated biomedical care services in the GTA were fair in terms of quality were less likely (OR=0.087, p<0.1) to engage in medical return. In terms of adequacy of biomedical care to respondent’s health care needs, persons who expressed lower levels of adequacy, compared to those who thought biomedical care was highly adequate, were more likely to engage in medical return. Transnational factors were assessed in Model 3, given the knowledge in existing literature. The findings show that respondents who maintained transnational ties through remittances and property ownership (in country of origin) were more likely to engage in medical return (OR=8.672, p<0.001), compared to those who did not. The associations between sociodemographic factors and medical return were examined in Model 4. Age, marital status, education, and household income were significantly associated with medical return. Respondents below the age of 60 years were less likely to engage in medical return. Persons with non-university certificates or degrees were more likely to engage in medical return (OR=1.582, p<0.1). Persons who live in households with an annual income of $20,000 to $39,999 were less likely (OR=0.215, p<0.01) to engage in medical return.

The final model (Model 5) included all predictors from the previous models. Chronic health status was still a significant predictor of medical return; respondents who had chronic condition(s) were 2.480 times (p<0.05) more likely to engage in medical return after introducing biomedical care-related, transnational, and sociodemographic factors as additional covariates. For biomedical care-related factors, perceived quality, adequacy, and comfort with the care environment were significantly associated with medical return. Respondents who thought the biomedical care in the GTA was fair were less likely to engage in medical return (OR=0.087, p<0.01). On the contrary, persons who expressed biomedical care was somewhat adequate
(OR=7.356, p<0.05) and inadequate/highly inadequate (OR=4.658, p<0.1) were more likely to engage in medical return. Respondents who felt uncomfortable in biomedical care settings were also more likely to engage in medical return (OR=21.607, p<0.01). Again, respondents who maintained transnational ties were more likely to engage in medical return (OR=3.481, p<0.1).

Regarding sociodemographic factors, age, education, and household income were significantly associated with medical return. Similar to the results in Model 4, persons under the age of 60 years were less likely to engage in medical return. Respondents with a non-university certificate or degree, compared to those with a university degree, were more likely to engage in medical return (OR=1.634, p<0.05). For household income, the results showed a mixed pattern.

Respondents living in households with an annual income of $40,000-$59,999 were more likely (OR=2.316, p<0.1) to engage in medical return, while those who lived in a household with less than $20,000-$39,999 were less likely (OR=0.314, p<0.1) to engage in medical return (note result only significant for $20,000-$39,999 income category). Respondents with previous history of TCAM use in their country of origin were 2.565 times (p<0.01) more likely to engage in medical return. The model diagnostics (AIC estimates) indicate that Model 2 (biomedical care-related factors) and Model 3 (transnational factors) were the least statistically preferred models, while Model 1 (chronic health status) was the most statistically preferred model. The pseudo R-squared values indicate that ~35%, ~34%, ~22%, ~50%, and ~67% of the variance in medical return were explained by Model 1, Model 2, Model 3, Model 4, and Model 5, respectively.
### Table 6.4 Determinants of Medical Return among persons of SSA origin in GTA (n=273)

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
<th>Model 5</th>
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<tr>
<td><strong>Health status</strong></td>
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<tr>
<td>Chronic health status</td>
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<tr>
<td><em>No (ref)</em></td>
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<td></td>
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<tr>
<td><em>Yes</em></td>
<td>8.804 (2.089)**</td>
<td>2.480 (1.012)*</td>
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<tr>
<td><strong>Biomedical care factors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of Biomedical care</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Excellent</em></td>
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</tr>
<tr>
<td><em>Very good</em></td>
<td>1.177 (0.345)</td>
<td>1.003 (0.424)</td>
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<td><em>Good</em></td>
<td>0.917 (0.368)</td>
<td>0.680 (0.507)</td>
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<tr>
<td><em>Fair</em></td>
<td>0.087 (0.116)+</td>
<td>0.087 (0.085)**</td>
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<tr>
<td>Adequacy - Biomedical Care</td>
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<tr>
<td><em>Highly adequate</em></td>
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<tr>
<td><em>Adequate</em></td>
<td>2.469 (0.756)**</td>
<td>1.643 (0.711)</td>
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<tr>
<td><em>Somewhat adequate</em></td>
<td>11.037 (4.339)**</td>
<td>7.356 (6.963)*</td>
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<tr>
<td><em>Inadequate/highly inadequate</em></td>
<td>23.112(12.426)**</td>
<td>4.658 (3.770)+</td>
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<tr>
<td>Empathy</td>
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<tr>
<td><em>No</em></td>
<td></td>
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<tr>
<td><em>Yes</em></td>
<td>0.921 (0.338)</td>
<td>1.526 (0.774)</td>
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<tr>
<td><em>Don’t know</em></td>
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<td>1.586 (0.835)</td>
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<tr>
<td>Comfort with Biomedical care environment</td>
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<tr>
<td><em>Comfortable</em></td>
<td>0.603 (0.171)</td>
<td>0.623 (0.245)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td><em>Somewhat comfortable</em></td>
<td>0.525 (0.247)</td>
<td>0.759 (0.576)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Uncomfortable</em></td>
<td>1.063 (1.189)</td>
<td>21.607 (27.081)**</td>
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</tr>
<tr>
<td>Discrimination/Marginalisation/Stereotyping</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>No</em></td>
<td></td>
<td></td>
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</table>
Challenges or difficulties - Biomedical care
| Yes | 1.432 (0.608) | 1.477 (0.800) |
| No  | 0.526 (0.252) | 0.215 (0.204) |

Transnational Ties
Recent Visit - Country of Origin
| No (ref) | | |
| Yes | 0.931 (0.193) | 1.320 (0.401) |

Maintain ties - Country of Origin
| No (ref) | | |
| Yes | 8.672 (3.706)** | 3.481 (2.274)+ |

Socioeconomic factors
Age
60 years and above (ref)
| 45 to 59 years | 0.466 (0.142)** | 0.428 (0.209)+ |
| 35 to 44 years | 0.092 (0.036)*** | 0.137 (0.081)*** |
| 25 to 34 years | 0.164 (0.078)*** | 0.358 (0.256) |
| 18 to 24 years | d | d |
Sex
| Male (ref) | | |
| Female | 0.695 (0.162) | 0.930 (0.300) |
Marital Status
| Married/Common-law (ref) | | |
| Widowed/Sep/Divorced | 1.006 (0.370) | 1.397 (0.844) |
| Single/never married | 0.358 (0.223)+ | 0.392 (0.250) |
Education
| University certificate or degree(ref) | | |
| Non-university certificate or degree | 1.582 (0.440)+ | 1.634 (0.656)* |
Household income

156
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<tr>
<th>Income Category</th>
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<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
<th>Model 5</th>
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<td>$80,000 or more (ref)</td>
<td>0.850 (0.288)</td>
<td>0.846 (0.361)</td>
<td>1.383 (0.497)</td>
<td>2.316 (1.119)+</td>
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<tr>
<td>$60,000-$79,999</td>
<td>0.215 (0.186)+</td>
<td>0.314 (0.211)+</td>
<td>1.515 (0.759)</td>
<td>1.010 (0.984)</td>
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<tr>
<td>$40,000-$59,999</td>
<td>1.383 (0.497)</td>
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<tr>
<td>$20,000-$39,999</td>
<td>0.215 (0.186)+</td>
<td>0.314 (0.211)+</td>
<td>1.515 (0.759)</td>
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<tr>
<td>&lt;$20,000</td>
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<td>1.010 (0.984)</td>
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Immigration Status

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<th>Status</th>
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<th>Model 3</th>
<th>Model 4</th>
<th>Model 5</th>
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<tr>
<td>Citizen (ref)</td>
<td>0.628 (0.257)</td>
<td>0.476 (0.217)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Permanent resident</td>
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</tr>
<tr>
<td>Other</td>
<td>0.989 (0.891)</td>
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Control variable

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<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
<th>Model 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>No (ref)</td>
<td>2.565 (0.851)**</td>
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<td></td>
<td></td>
<td></td>
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Model Information

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<th>Model 3</th>
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<td>Log pseudolikelihood</td>
<td>-142.194</td>
<td>-143.176</td>
<td>-158.637</td>
<td>-1154.427</td>
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</tr>
<tr>
<td>Wald's Chi2</td>
<td>84.00***</td>
<td>120.63***</td>
<td>25.81***</td>
<td>94.27***</td>
<td>109.41***</td>
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<tr>
<td>Cragg &amp; Uhler's R2</td>
<td>0.351</td>
<td>0.344</td>
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<td>-1132.844</td>
<td>-1186.064</td>
<td>-1048.443</td>
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</table>

Robust standard error in parenthesis; ***p<0.001, **p<0.01, *p<0.05, +p<0.1
6.4 Discussion

This chapter of the thesis sought to examine unmet TCAM needs and the phenomenon of medical return (or transnational healthcare-seeking) among persons of SSA origin living in the GTA. A significant proportion of SSA surveyed reported having unmet TCAM need (~21%) and engaging in medical return (~40%). When asked to explain the reason for their unmet TCAM need, most respondents indicated that unavailability of needed TCAM remedies was the major factor for their unmet needs. Responses such as “not available in Toronto” or “not available in Canada” were common reasons provided by respondents. Knowledge from existing studies on traditional medicine and health-seeking behaviour in SSA show that the majority of traditional medicine users rely on medical plants and remedies sourced from the immediate natural environment (Dahlberg & Trygger, 2009; Pouliot, 2011; Pouliot & Treue, 2013). This knowledge, as well as the limited presence of traditional African healers in the GTA and Canada at large, may account for respondents unmet TCAM needs. TCAM modalities available in the Canadian context are alien to persons of SSA, as the majority of these modalities are based on oriental (South and East Asian) sociocultural beliefs. Similarly, other practices, such as chiropractic and homeopathy, are based on values and attitudes linked to the early development of biomedicine and a rejection of it (Bishop, Yardley, & Lewith, 2007; O’Callaghan & Jordan, 2003; Templeman, Robinson, & McKenna, 2015; Verheij, De Bakker, & Groenewegen, 1999) which may not be in conformity with traditional healing beliefs, norms, values and practices of SSAs living in the GTA. In the absence of TCAM remedies native to their country (cultural) of origin, most respondents engage in cross-border healthcare-seeking in order to meet their TCAM needs. These cross-border
(medical return) healthcare-seeking behaviour may include travelling to a country of origin to receive TCAM treatment and returning to the GTA or Canada with remedies from a country of origin.

6.4.1 Determinants of unmet TCAM need

Studies on unmet healthcare needs have largely focused on the biomedical healthcare context. Studies focusing on unmet needs and TCAM have generally concentrated on how unmet physical and emotional needs drive patients’ use of TCAM (Habermann et al., 2009; Mao et al., 2008) or how unmet need by biomedical care drive patients’ motivation to seek TCAM care (Evans et al., 2007; Piérard, 2012; Dejun Su & Li, 2011; Williams et al., 2011). These studies suggest that the lack of physical and emotional support by biomedical care providers drive patients to seek alternative forms of care (Boon et al., 2000; Kremser et al., 2008). Some studies also assert socioeconomic barriers associated with biomedical care – which consequently contribute to unmet biomedical care need – push patients to TCAM providers in order to address their unmet biomedical care need (Dejun Su & Li, 2011). Currently, there is limited knowledge of unmet TCAM health care needs. The findings of the bivariate analysis suggest that chronic health status, perceived quality of biomedical care, perceived adequacy of biomedical care, and age are strongly associated with unmet TCAM needs. With regards to the multivariate results, the findings show that chronic health status and some measures of biomedical care and sociodemographic characteristics significantly predict unmet TCAM needs among respondents.
Chronic health is seen as a major determinant of TCAM use. Studies show that the prevalence of TCAM use among persons with chronic health is relatively higher than the general population (Arthur et al., 2012; Boon et al., 2000; Fries, 2014; Mao et al., 2007; Okoro, Zhao, Li, & Balluz, 2012). For diabetic patients, the research suggests between 57% to 73% of patients use TCAM to address their healthcare needs (Spinks, Johnston, & Hollingsworth, 2014). A study among cancer patients in Montreal found that about 86% of patients surveyed used at least one TCAM modality in the past one month before the study, while 91% had used a TCAM modality in the past 12 months before the study (Sewitch et al., 2011). Studies in the United States and Australia similarly report a higher prevalence of TCAM usage among chronically ill patients (Ojukwu et al., 2015; Sullivan et al., 2015; Sweet et al., 2016).

Interestingly, the results of this study indicate that respondents with chronic health conditions are more likely (OR=5.809, p<0.001 – Model 3, Table 6.3) to have unmet TCAM need, compared those without chronic conditions. The relationship between chronic health conditions and unmet TCAM needs among respondents could be the effect of reverse causation. That is, the chronic health conditions of respondents may render them economically inactive, contributing their inability to access the TCAM remedies they need. This situation is plausible, given the current provincial healthcare plans do not provide adequate coverage for TCAM treaties. In Ontario, the provincial healthcare plan (OHIP) does not provide coverage for TCAM remedies, including chiropractic services. Coverage for some TCAM remedies is done through third-party coverage (the Extended Health Care plan) which are usually provided by some employers and through direct out-
of-pocket expenditure (Boon et al., 1999; Furler et al., 2003; Statistics Canada, 2003). The disabling effect of chronic health conditions may limit respondents’ access to jobs and their subsequent access to employment-related health benefits. Thus, their inability to pay for the cost associated with accessing TCAM in Canada or outside Canada may account for their unmet TCAM needs. Also, studies suggest Canadians of immigrant origin are less economically endowed, compared to their non-immigrant counterparts (Agyekum, 2016; Dean & Wilson, 2009; Goldring, Berinstein, & Bernhard, 2009; Grant & Nadin, 2007). The former usually work in low-wage and precarious jobs that may not provide employment-related health benefits to its workers. This may also be a plausible explanation for the unmet need among respondents with chronic conditions who needed TCAM treatment. In a context where there is no or limited public support of healthcare, studies show that persons with chronic health conditions usually have limited access and use of services – due to their socioeconomic vulnerabilities and other structural barriers – contributing to their unmet healthcare needs.

Regarding biomedical care characteristics, the findings show that respondents who expressed lower levels of adequacy and those who had difficulties/challenges accessing biomedical care were more likely to have unmet TCAM needs. Currently, there is no study on this topic; it is difficult to compare these findings with information or knowledge in existing literature. I hypothesise that the association between these biomedical care features and unmet TCAM could be the additive effect of other socioeconomic factors. A plausible explanation is that the TCAM remedies needed by these respondents do not exist in the GTA or Canadian context; hence, their unmet
treatment needs. To such respondents, there are no “alternative” forms of care for their need, albeit they have challenges accessing biomedical care or view biomedical care as inadequate for their healthcare need. The decision on the appropriate treatment to use or seek is often informed by existing knowledge of health and healthcare. Respondents of immigrant origin may know remedies in their country of origin for their health needs, and the unavailability of these healing resources in their current place of residence may constitute an unmet healthcare need for them. As noted previously, respondents expressed this view when asked the reason for their unmet TCAM need. While alternative forms may exist, these treatments may be too expensive for the respondents or respondents may not have adequate information or knowledge on these forms of treatments. Evidence from existing studies shows that inadequate knowledge or information about TCAM and lack of support from biomedical providers constitute significant barriers to access and use of TCAM (Cheung et al., 2007; Jain & Astin, 2001; Wardle, Lui, & Adams, 2012). Similarly, studies suggest that the direct financing of TCAM place an undue financial burden on users and limiting the ability of persons of lower socioeconomic status to access and use TCAM (Maskarinec, Shumay, Kakai, & Gotay, 2000; E. O’Reilly, Sevigny, Sabarre, & Phillips, 2014; Roth & Kobayashi, 2008; Suzuki, Eusebius, & Makled, 2016).

While age was strongly associated with unmet TCAM needs (V=0.350, p<0.001), the multivariate results shows that chronic health status and characteristics of biomedical care have a mediating effect on this association. In the multivariate model assessing sociodemographic factors only (Model 3), the findings indicate that respondents aged 59
years and below are less likely to have unmet TCAM need. However, the statistical significance of this association vanished after introducing chronic health status and biomedical care-related factors as additional covariates. Findings from existing studies indicate that the use of TCAM declines with age (Adams et al., 2009; Grzywacz et al., 2005). A plausible explanation is that persons age 60 years and above may have considerable financial challenges in meeting their TCAM needs. People in this age category include older persons who have retired from employment hence may not be covered by employment-related healthcare benefit plans (Bauer & Rayner, 2012). Respondents aged 60 years and above may be contending with income decline and chronic ailments due to senescence. The socioeconomic cost of managing chronic conditions coupled with reduced income can result in their inability to access and use TCAM when needed. Studies in Canada and other developed countries shows that access and use of TCAM are associated with younger age and higher income earners (Foltz et al., 2005; Ness, Cirillo, Weir, Nisly, & Wallace, 2005; Reid et al., 2016). The current financing of TCAM services – through private insurance and direct out-of-pocket – especially in the province of Ontario, means people with limited income and those without extended healthcare plans are more likely to face considerable constraints in their access and use of TCAM services inside or outside of Canada. The findings also indicate that persons with non-university certificate or degree are more likely (OR=5.574, p<0.001) to have unmet TCAM need. Given the relationship between educational status and socioeconomic wellbeing, I offer the argument above as a plausible explanation for the observed association. That is, respondents with a non-university degree may seldom hold employment that provides them with health-related benefits or may not have the
financial capabilities to afford the direct cost associated with accessing and use TCAM services. Respondents in the “other” immigration category may be in a similar situation, as most of these respondents are international students with study visas.

6.4.2 Determinants of medical return

Studies on immigrants’ health indicate barriers such as discrimination, lack of cultural understanding or sensitivity and other socioeconomic factors may limit the ability of immigrants to access and use quality healthcare in their host countries (Chalmers & Omer-Hashi, 2002; Kemppainen et al., 2018; Şekercan et al., 2015; Wallace et al., 2009; Woodgate et al., 2017). The absence of culturally accepted remedies embedded in the sociocultural norms and values of immigrants can also contribute to their inability to access and use healthcare (Edge et al., 2014; Lebrun & Dubay, 2010; Lum et al., 2016). The latter is true for persons of SSA origin whose traditional healing beliefs and practices are not well established in the healthcare landscape of most developed countries as traditional Asian healing practices. In this section, the discussion focusses on chronic health status, biomedical care features and sociodemographic factors as determinants of medical return or transnational healthcare consumption in country of origin. From the bivariate and multivariate analyses, the findings show that chronic health status, perceived quality of biomedical care, perceived adequacy of biomedical care, maintaining transnational ties, age, and household income consistently have a significant association with medical return among respondents.
The findings show that respondents with chronic health conditions are more likely to engage in medical return – that is, returning to country of origin to use or get TCAM remedies. This finding is consistent with existing studies. Studies among immigrants in Europe and North America show that persons with chronic health status are more likely to engage in transnational healthcare-seeking or returning to their country of origin for treatment (Bastida, Brown, & Pagán, 2008; Lokdam et al., 2016; Şekercan et al., 2015; Wallace et al., 2009). In the United States, Wallace et al. (2009) observed that Mexican immigrants with chronic health conditions were more likely to travel back to Mexico for care. Similarly, a study of ethnic minorities in the Netherlands – including Ghanaian immigrants – found that chronic health status is associated with engaging in medical return (Şekercan et al., 2015). Researchers argue that the motivation for transnational healthcare-seeking behaviour among immigrants, particularly persons from the global south, could be interpersonal quality care by biomedical care providers or the medical care cultures in countries of origin that shape immigrants’ perceptions on how care should be provided and what is expected of biomedical care providers (Şekercan et al., 2015; Wallace et al., 2009).

Others argue that the decision by immigrants with chronic health to engage in medical return is shaped their perceived quality of biomedical care and its ability to treat their health problems or healthcare needs. These studies indicate that persons with chronic illness may view biomedical care in the host country as highly inadequate as healthcare providers only provide temporary relief from pain and symptoms (Lokdam et al., 2016). Thus, immigrants with chronic health status may seek alternative treatment or
professional opinions in their countries of origin. The findings and explanation are similar to reported motivations for the use of TCAM among persons with chronic illness in SSA. Evidence from studies in SSA countries suggests that the most of patients with chronic illness seek TCAM to address their health problems (Aikins, Awuah, Pera, Mendez, & Ogedegbe, 2015; Kigen et al., 2013; Nxumalo, Alaba, Harris, Chersich, & Goudge, 2011; Pouliot, 2011; Thorsen & Pouliot, 2015). For instance, Sato (2012) found that the use of TCAM for acute and chronic illnesses increased by two and three fold when second recourses are taken into account. The heavy reliance on traditional healers for chronic illnesses or recurring illnesses is due to traditional beliefs in spiritual causes of diseases and ill health; and traditional medical practitioners are seen as experts in dealing with spiritually derived ill health (Aikins, 2005; Amegbor, 2014; O’Brien et al., 2012).

The findings of this study show a similar association between respondents’ perceived adequacy of biomedical care to address their healthcare needs. Respondents who expressed lower levels of opinion on the adequacy of biomedical care were more likely to engage in medical return. The findings also show that respondents who felt uncomfortable with the biomedical care environment were more likely to engage in medical return. These respondents may travel outside the GTA and Canada to use TCAM in their country of origin in order to meet their health and healthcare needs. Contrary to the findings of existing studies, the results indicate that respondents who expressed a lower opinion on the quality of biomedical care were less likely to engage in medical return. The quality of biomedical care received in the host country has been identified as
a major determinant of medical return (Grineski, 2011b; Horton, 2013; Messias, 2002; Ruggeri et al., 2018). In the United States, Latin American immigrants who expressed poor views about the quality of biomedical care were more likely to engage in transnational healthcare-seeking – that is, seeking care in their countries of origin (Horton, 2013; Horton & Cole, 2011; Messias, 2002). The findings could be that, while respondents may rate the quality of care in Canada lower, it does not necessarily mean the services in their countries of origin are better or more efficient (Bergmark et al., 2010; Lokdam et al., 2016). This case may be particularly true for biomedical care in most SSA countries where quality of healthcare has been of grave concern to major stakeholders (Goudge, Gilson, Russell, Gumede, & Mills, 2009; Kruk et al., 2016; Lloyd-Sherlock, Beard, Minicuci, Ebrahim, & Chatterji, 2014; Sousa et al., 2014; Webster et al., 2014).

Transnational networks play crucial roles in transnational healthcare-seeking practices. Transnational ties are vital social capital among immigrants, and it shapes the health and healthcare-seeking behaviour of immigrants (Kessing, Norredam, Kvernrod, Mygind, & Kristiansen, 2013; Messias, 2002; Thomas, 2010; Wang & Kwak, 2015). Studies suggest that active participation in transnational networks enable immigrants to directly or indirectly access and acquire healing remedies back in their countries of origin (Villa-Torres et al., 2017). Direct access to healing methods back in a country of origin is through regular visits or visits. Indirect access is usually done through friends or relatives who may send or return from a “home” country with healing materials, or remotely (via phone conversations and email) provide knowledge or information on alternative healing
methods (Bochaton, 2014; Kessing et al., 2013; Villa-Torres et al., 2017). For instance, a study by Sanon et al. (2016) observed that Haitian immigrants who maintained transnational contacts usually receive healing advice from relatives and friends back “home”, including the need to use “cultural-based herbal medicines. Consistent with knowledge from existing studies, the findings show that SSAs who maintained ties (through remittances and property ownership) were more likely (Model 3 – OR=8.672, p<0.001; Model 5 – OR=3.389, p<0.05) to engage in medical return. The sense of reciprocity embedded in transnational networks implies immigrants with poor health can count on the support and help of friends and relatives in moments of poor health (Thomas, 2010). Respondents who maintained transnational ties are thus likely to go home to access and acquire TCAM remedies for their care needs or may receive these remedies from their friends and relatives in times of ill health.

Regarding sociodemographic factors, the findings show that age, education, and income were significantly associated with medical return for both bivariate and multivariate analysis. Although sex and marital status were strongly associated with medical return in the cross-tabulation analysis, the multivariate analysis shows that they did not have a statistically significant association with medical return among the study respondents. The findings for age and education is consistent with knowledge from existing literature. Studies suggest that increasing age is associated with transnational healthcare practices (Şekercan et al., 2015; Wallace et al., 2009). Older immigrants are more likely to seek care in their countries of origin (Sun, 2014; Wallace et al., 2009). Similar to these findings, the results of this study show that older respondents (respondents aged 60 years
and above from SSA) were more likely to seek healthcare in their countries of origin, compared to their younger counterparts. Existing studies offer cultural incompetence and fragmentation of care in the biomedical setting, especially in developed countries, as major factors for transnational healthcare-seeking behaviour among older immigrants (Boyd et al., 2007; Golden, Tewary, Dang, & Roos, 2010; Guruge, Thomson, & Seifi, 2015; Lee et al., 2010). In the case of the latter, navigating the healthcare system with multiple contacts with different providers and incomplete information transfer can be of great challenge to older persons, especially when care involves seeking alternative healers outside the formal healthcare system (Baillie et al., 2014; Boling, 2009; Jeffs et al., 2017; Sykes, Baillie, Thomas, Scotter, & Martin, 2017). Here, I offer a second plausible explanation that older persons are more likely to engage in medical return due to their limited financial resources and healthcare coverage for TCAM services. As previously stated, the current provincial healthcare plan does not provide coverage for TCAM services; hence, patients have to pay through third-party insurers or out-of-pocket. Going back to country of origin for TCAM remedies may be a cheaper and culturally acceptable option to older persons who are more susceptible to chronic health issues.

Studies also show that persons with lower levels of education are more likely to engage in transnational health practice (medical return) (Bastida et al., 2008; Şekercan et al., 2015). Less educated immigrants in developed countries, including Canada, seldom hold employment that provides additional coverage for non-publicly funded care services (Dean & Wilson, 2009; Malambwe, 2012; Subedi & Rosenberg, 2016). Thus, such
people may not be able to afford the cost of seeking TCAM care in Canada. Immigrants especially racialised persons, face considerably socioeconomic challenges in Canada, as they are often underemployed (Dean & Wilson, 2009; Guerrero & Rothstein, 2012; Slack & Jensen, 2007). Studies in North America show that immigrants from sub-Saharan Africa and Asia often work in jobs they are overqualified and earn relatively lower than other racial and immigrant groups (Corra & Kimuna, 2009; Grant & Nadin, 2007; Subedi & Rosenberg, 2016). The findings of this study show that respondents with a non-university degree are more likely to engage in medical return. Based on the knowledge from the existing literature, I argue transnational health practices, especially in relation to TCAM, may be more affordable to such persons compared to seeking TCAM care in the GTA or Canada. The findings also corroborate studies on TCAM use in SSA. These studies show that less educated persons are more likely to seek TCAM where persons with higher education show preference for biomedical care (Pouliot, 2011; Sato, 2012a; Thorsen & Pouliot, 2015; Van Andel et al., 2012). Thus, the observed association could be an indication of continued healthcare-seeking behaviour among respondents with a non-university degree.

6.4.3 Study limitations

The limitations of the analysis and findings in this chapter are similar that noted in the previous chapter (Chapter 5). Again, we cannot draw causal inference from the association between the study’s predictor variables and outcomes due to the cross-sectional nature of the data. The small sample size means the observed association between health status, biomedical care-related factors, socioeconomic status and unmet
TCAM or medical return may not be representative of the study population. Regarding the outcome measures, medical return was measured as a lifetime event hence current socioeconomic and chronic health status may not be significantly associated with current behaviour (medical return). As with quantitative methods of inquiry, the findings do not provide an in-depth understanding of how the predictor variables influence unmet TCAM need and medical return among the study’s respondents.

6.5 Summary
The discussion in this chapter focused on the phenomena of unmet TCAM need and medical return or transnational healthcare-seeking among persons of SSA origin living in the GTA. The purpose of the analysis was to determine whether the measures of health status, biomedical care-related characteristics and socioeconomic status are significantly associated with unmet TCAM need and medical return. Also, the multivariate analysis sought to determine whether differences among respondents – regarding their health status, perceptions of biomedical care, and socioeconomic status – in unmet TCAM need and medical return were statistically significant. The findings suggest that health status, perception of the quality of biomedical care and perceived adequacy of biomedical care are strongly associated with unmet TCAM need among persons of SSA origin living in the GTA. Empathy or sensitivity of biomedical professionals to sociocultural views and respondents’ perceived comfort in biomedical care environments were moderately associated with unmet TCAM need while discrimination and challenges associated with receiving biomedical care had weak associations with unmet TCAM need. Similar to the findings for unmet TCAM need, health status, perception of the quality of biomedical
care, and perceived adequacy of biomedical care were strongly associated with medical return. Empathy or sensitivity of biomedical professionals to sociocultural views was also moderately associated with medical return. Elements used as measures of socioeconomic status had different levels of association with unmet TCAM need and medical return. Consistently, respondents’ age was strongly associated with both unmet TCAM need and medical return.
Chapter 7

Identity, health and healthcare-seeking behaviour – A translocational positionality perspective

7.1 Introduction

In Chapters 5 and 6 of this thesis, I examined the effect of health status, biomedical care-related characteristics, and socioeconomic status on the use of TCAM, unmet TCAM needs, and medical return among persons of SSA. The results show that some measures of these broader contextual factors have significant associations with the three outcomes (the use of TCAM, unmet TCAM needs, and medical return). In the chapters, I discussed how these findings relate to existing studies and how the findings contribute to the existing knowledge of TCAM in Canada. The current chapter focuses on narratives on identity, health and healthcare-seeking behaviour that emerged from qualitative interviews. Here, I adopt a translocational positionality framework – proposed by Anthias (2008, 2002) – as a framework for understanding the contextual and temporal dimensions of social identity. Translocational positionality as an analytical approach enables us to examine how broader contextual mechanisms or social structures shape individual agency. It also allows for a critical examination of the processes involved in identity construction, hence accounting for the active role of human agency in a social context (Rogers & Ahmed, 2017). As a theoretical lens, translocational positionality helps us understand how spatial and temporal context mould an individual’s position (identity) and positioning (agency or their capabilities and abilities to make changes or alter one’s self) within the interplay of different social locations (Anthias, 2008, 2009, 2012a). The
goal here is to understand how the context of health and healthcare shape the construction of social identities and cultural heritage of Canadians living in the GTA; and ultimately, evoke their ethnocultural identity and resources to address their health and healthcare needs.

Knowledge from existing studies and the literature on TCAM indicate that cultural traditions and beliefs are key determinants of TCAM among the population, particularly among visible minorities and other racialized persons (Bishop & Lewith, 2010; Chao, Wade, Kronenberg, Kalmuss, & Cushman, 2006; Hsiao et al., 2006, 2008; Kirmayer et al., 2003; Roth & Kobayashi, 2008; Wiles & Rosenberg, 2001). Nevertheless, the literature also indicates that TCAM remedies are often used as complementary or alternative care to biomedical care (Chao et al., 2008). This knowledge shows that sociocultural beliefs and practices of healthcare seekers do not necessarily imply a rejection of biomedical care; it demonstrates the fluidity of social identity and its multi-layered aspects. Similarly, it also indicates the role or influence of health and the healthcare context on decisions to embrace these cultural beliefs and practices in meeting health(care) needs. Using Anthias’ translocational positionality (discussed in Chapter 2) as a theoretical framework, I explore how residents of GTA construct and construe their identity in the health(care) and non-health(care) related context. Translocational positionality theory posits that social identity is not given but constructed within a social context; thus social identities can change or shift with context; similarly it can also contradict previous forms of identification (Anthias, 2008, 2012a). Applying this concept to health(care) behaviour, Anthias’ translocational positionality theory enable us to
understand how context influences the construction of social identities (or social locations including ethnicity, race, gender, class and sexuality) created through the interplay of social structures (health or healthcare systems) and individual agency (capacity or capabilities to do act independently or make decisions).

7.2 Methods
The data for this chapter was drawn from qualitative interviews with 22 participants. A detailed discussion of the methods and processes used in the collection of the qualitative data can be found in the third chapter (Chapter 3). This section provides a brief overview of the methods and the process, as well as, the approach or technique adopted in analysing the data. The data was collected through fieldwork conducted between July, 2017 and September, 2018. The majority of participants (22) were interviewed via telephone.

As noted earlier (in Chapter 3), a semi-structured interview approach was adopted for the interviewing participants. This approach provides participants with the flexibility of discussing their personal experience and narratives about health, identity and belonging, as well as, enabled me (as the researcher) to interrogate these themes or topics during the interviews. Narratives about place, identity, belonging and health(care) were selected for this chapter of the thesis as they help to understand and navigate the complexity and versatility of ethnocultural identity, transnational identity and embodied health beliefs (and practices) of interviewees. Using an explorative in-depth interview technique, participants were engaged in discussion or conversations about their social identity, sense
of place and belonging, and their experiences about health and healthcare within the Canadian context, with focus on the GTA.

In this study the recruitment of interviewees did not end with data saturation. Some researchers argue that there is a need to attain saturation to ensure data quality (Morse, 2015), but others caution against the use of saturation as a gold standard for qualitative research (Guest, Bunce, & Johnson, 2006; Malterud, Siersma, & Guassora, 2016; O’Reilly & Parker, 2013). The latter argue that the diverse nature of qualitative research means there is no single standard for measuring research quality and view such attempts as problematic (O’Reilly & Parker, 2013; Saunders et al., 2018). The quality of qualitative research should be assessed through the transparency of the research process and grounded in the epistemology of the guiding framework or theory (O’Reilly & Parker, 2013). O’Reilly and Parker (2013) also argue that the focus on the quality of research should be on appropriateness and adequacy. They assert that the sampling approach ought to be pragmatic and flexible to allow the research questions to be answered sufficiently with an adequate sample. The data and information from interview participants provide novel insight into how spatiotemporal context shapes experiences and meanings associated with identity and health; thus provide answers to the research questions guiding this study.
7.2.1 Analysis

7.2.1.1 Transcribing and coding

Participants were interviewed in English. Recorded interviews were anonymised and transcribed verbatim using NCH Express Scribe Transcription software. Following Dunn's (2010) advice, the transcribed interviews included descriptions of gestures and tones of participants during the interview were noted. He argues this help maintain the ethnographic “sense” of the interview, such as a sense of hesitancy or embarrassment during the interview. The use of a thorough ‘orthographic transcripts (verbatim account of verbal and non-verbal utterances) helped preserve meanings and maintain the original nature of the interviews (Braun & Clarke, 2006; Dunn, 2010; Ziebland & McPherson, 2006). The rapport between participants and me during the interviews meant some participants disclosed personal names, or identities of family members, close friends or family healthcare professionals during the interview. These names were anonymised with pseudonyms during the transcription process. Participants were identified in the transcribed interviews by unique codes which represent the order of interviewing; for example, the first participant to be interviewed was identified as “Informant 1”. The transcribed interviews were imported into QSR NVivo software for coding and analysis. Participants’ basic sociodemographic information (age, education, gender/sex, ethnic or racial identity, and occupation) were matched with the transcripts.

The next stage of the qualitative data analysis process entailed coding the transcribed interviews. Coding is defined as “… a process of identifying and organizing themes in qualitative data …” (Cope, 2010, p. 281). The process results in data reduction and re-
organisation of the data in a manner that encourages a more systematic and thorough analysis of the data; thus, effectively linking the data to an analytical idea or generating theories from these empirical data (Cope, 2010; Jackson, 2001). The initial stage of the coding process involved the use of descriptive codes that reflected the broad themes of the semi-structured interview themes. Next “in vivo” codes were generated after thoroughly reading the interview transcripts. In vivo codes refers to descriptive codes are common themes or topics generated directly from the interview (Cope, 2010). These codes were then re-organised into analytic codes that reflect salient themes that emerged from the interview with participants. These analytic codes were useful in understanding contextual influences on identity construction or the fluidity of participants’ ethnic or cultural identity.

7.2.1.2 Thematic analysis

The transcribed and coded data were analysed using a thematic approach. Braun and Clarke, (2006) define thematic analysis as “a method for identifying, analysing and reporting patterns (themes) within data.” Compared to other forms or methods of qualitative data analysis, thematic analysis offer researchers a flexible and compatible approach to analysing individuals’ subjective experiences of social phenomena, including health (Braun & Clarke, 2006; Percy, Kostere, & Kostere, 2015). While thematic analysis is independent of theory and epistemology, it can also be applied to a variety of theoretical and epistemology methods of inquiry (Braun & Clarke, 2006). In this study, it can be applied to the proposed theoretical framework (translocational positionality) to explore how context influence identity construction and sense of belonging in relation to health and healthcare. The themes from the data were driven by the study’s proposed
theory helping me link the knowledge from the data with concepts from the theory. The flexibility of thematic analysis and semi-structured interview approach meant narratives about social and cultural identities emerged during the interviews as opposed to using a narrative interview approach to unearth the influence of context on participants’ identity construction.

7.3 Results & Discussion

Table 7.1 shows the basic sociodemographic information of the research participants. Participants for the qualitative interviews were mainly persons of immigrant origin living in the GTA; however, a small sample of non-immigrant (mainly White) Canadians was included for comparative purpose. The majority of participants of immigrant origin were Anglophone West Africans living in the GTA. The research participants were between the ages of 23 to 83 years. The majority of the participants were female (63.64%), with the remaining 36.36 per cent self-identifying as males. Participants were highly educated – with college and university degrees, and currently employed. Unemployed participants were mainly seniors aged 65 years and above. With regards to participants of immigrant origin the minimum number of years of living in the GTA was 12 years while the maximum was 32 years since immigrating to Canada.
Table 7.1 Sociodemographic characteristics of interviewees

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>Sex</th>
<th>Education</th>
<th>Employment</th>
<th>Group</th>
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<tr>
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</table>

Three themes on identity and belonging emerged from the interviews that frame the discussion in this chapter. The first theme entailed everyday construction of an identity or how participants described their identity and belonging in an everyday context. The second theme is focused on re-affirming identity and sense of belonging through health(care). The third theme that emerged was on health knowledge keepers in the transnational relationship in Canada and country of origin; while the fourth theme centred on the dialectics of health (care) in Canada and country of origin. The last theme focused on shifting transnational identities with insights from data and field.
7.3.1 Everyday construction of identity and belonging

Participants were asked to describe themselves at the beginning of the interview and these identities were interrogated – that is, they were asked what their identities meant to them. This initial question was to help understand how participants identify themselves in an everyday context. Their answers reveal three major forms of identities. The first form of identity pertains to national identity, both with Canada and their country of origin. This form of identity construction was notable among participants of SSA and southern/eastern European descents living in the GTA. These participants described themselves as being Nigerian-Canadians, Ghanaian-Canadians and Armenian-Canadian. These descriptions revealed the significance of their migratory history on their identity construction.

The labels of identity among participants of SSA and Eastern/Southern European origin espouse the concept of a fluid identity that the ability of persons of immigrant origin (especially visible minorities) to move between two or more cultures makes their identities transcend fixed or static views of identity (Anthias, 2008, 2012a; Boccagni, Lafleur, & Levitt, 2015). That is, the identities of such persons are not fixed on one location, culture, ethnicity or citizenship. It denotes multiple views or perspectives that are inherent in immigrants due to their interaction with different cultures, places and social locales; which enables them to express views and experiences of different places simultaneously, albeit not confined to double consciousness (Anthias, 2011; Plaza, 2006). The form of identification (e.g., Ghanaian-Canadian) references the social position of SSA immigrants in Canada and the processes that give rise to their experiences in both
Canada and their country of origin – social positioning. It also connotes their connections with both Canada and their countries of origin. When participants were asked what it meant to be “Nigerian-Canadian” or “Ghanaian-Canadian”, they referred to their attachment to both their countries of origin and Canada through family, friends, community and citizenship. Similarly, participants of southern and eastern European descent point to the immigration of their parents as a rationale for the label, albeit one participant did not have direct ties with his parent’s country of origin.

“Well! I will describe myself as being Ghanaian-Canadian … I said that because I came from Ghana. I was born in Ghana, grew up there, did my first degree in development planning in Ghana before I moved to Canada. I still have my family members in Ghana; my mother is in Ghana, my father passed away about five years ago. I have two sisters and an elder brother in Ghana … I also have a family here in Canada, two sons … and I am a Canadian citizen” (Participant_12, SSA descent, F, 50)

“In terms of my identity, I would say I am a Nigerian-Canadian. I am Nigerian because that is my home country and my ancestral land. I was born there, I have my family there. My wife and I came to Canada in 1991, that is more than twenty years ago. Almost 26 or 27 years ago, if I’m right. We came with my daughter and my son … My younger daughter was born here in Windsor, that is where we first settle when we moved to Canada” (Participant_22, SSA descent, M, 62)
“I would say I’m half Italian and I’m half Slovak, but I was born in Canada. My parents and grandparents immigrated to Canada. So, my father was born in Italy and my mother was born here but her parent had just arrived before her birth, so she got Canadian citizenship … For my maternal side, my grandmother and grandfather, they were born in what is now referred to as Slovakia” (Participant_1, European descent, M, 34)

The similarity in the construction of an identity based on “homeland” (country of origin) and host country (or current country of residence) among participants of anglophone West-African origin and those of southern and eastern European origin, reflect the similarity in the processes that created these identities. Like early southern and eastern European immigrants, the recent migration of persons of SSA origin to Canada was shaped by the economic and social crisis in their countries of origins. In their immigration pattern the two groups (SSA and Eastern or Southern European immigrants) often concentrate in a place maintaining some norms, culture and values of their “homeland” (countries of origin) while embracing some norms, culture and values of their host country. Thus, creating integrated and plural identities which co-exist without trade-off and based on context.

The second form of identification was by race and national identity. Canadians of African descent – mainly of Caribbean origin and second-generation immigrants (including those with both parents from SSA origin) defined their identity as “Black-Canadian” or
“African-Canadian”. This label similar to the previous form of identification conveys the notion of an identity that embodies both racial and “Canadian” values. However, this label differs significantly from the previous label in that the former draws on national identity while the latter draws on a Pan- African or Black identity and a ‘Canadian’ identity.

“I would describe my identity as African-Canadian … that means my bloodline connects to the continent (referring to African). Because we as negro people don’t realise that we are not peculiar in one country … we are indigenous to the continent. We need to start calling ourselves Negros, Africans … You may be born in Africa and I may be born in the Caribbean, but we are connected by bloodline” (Participant_3, African-Caribbean descent, F, 42)

“I just identify myself just as an African-Canadian … Well! I was born in Guyana in South America but consider myself as an African. My ancestors were brought to Guyana from African through the slave trade. Africa is my ancestral home that is why I call myself an African … I came here in 1987 when I was 5 years old. I am now a Canadian citizen. (Participant_4, African-Caribbean descent, F, 45)

For participants of African-Caribbean descent and second generation West African anglophone participants, their Pan-African identity may be shaped by their experiences of discrimination, marginalising and racial stereotyping. Researchers’ suggest that such
experiences and challenges discourage the formation of distinct national identities among this group of Canadians compared to others of similar racial or cultural origin whose identity is shaped foremost by the context of immigration which enables them to form distinct social spaces for national identities (Plaza 2006, Kasinitz et al. 2002). Thus, for African-Caribbeans and second generation anglophone West Africans a Pan-African identity becomes a unifying factor for combating the socio-economic discrimination they face and identity that creates a sense of togetherness or belonging. This view is evident in some participants’ narratives where they talk about the racial connection among persons of African descent irrespective of their place of birth. Similarly, the Pan-African identity is also imbued with narratives of slavery and origin. Participants talk about their dislocation or displacement from their “ancestral homeland” and their sociocultural connection to this homeland irrespective of their physical absence. Associated with this phenomenon of dislocation through slavery and colonialism is the experience of socioeconomic discrimination, racial stereotyping and marginalisation faced by persons of African descent in developed countries (Gee & Ford, 2011; Rechel et al., 2013; Viruell-Fuentes et al., 2012). Thus, the process of discrimination and marginalisation embedded in historical and current events shape the social position(s) (i.e., the Pan-African identity) of this group of participants.

The third form of identity construction was mostly observed among participants of European descent. These participants described themselves by their Canadian nationality only. That is, participants of European descent mainly described themselves as Canadian when they were asked to describe their identity. The label of being Canadian was mainly
informed by participants citizenship status (by birth). For some participants the meaning of being Canadian transcends citizenship and place of birth; the Canadian identity is imbued with certain moral values and cultural heritage. These values included being accommodating, tolerant and supportive of others who are in need. For instance, one participant of European descent remarked:

“Canadian, white … what does it mean being a Canadian? Well, first of all you have to live in Canada ok! I guess you don’t have to live in Canada but being a Canadian is I think being a kinder, gentler society than our large society neighbour to the south; being proud of our heritage which is English and French, both and being a more socialistic nation …. So being a Canadian to me is being more tolerant and accepting to other people … being inclusive” (Participant_9, European-descent, F, 77)

This narrative on the Canadian identity is not devoid of context, given this participant was interviewed at the time the current US administration barred persons of certain sociocultural status and refugees from certain countries from entering the country. As seen in her remarks above, the participant contrasts these values to the current political discourse in the United States. The reference of English and French as part of the Canadian heritage point to her social positioning and ethnocultural heritage which is intertwined with the country’s colonial history. The heritage is imbued by both historical processes, and current political legislative and administrative context that defines the Canadian identity. For instance, English and French are the country’s official languages
and individuals who want to attain a “Canadian” status are required to demonstrate proficiency in one of these languages.

7.3.2 (Re)Affirming sense of belonging and identity through health and medicine

In this theme, I explore the cultural attachment associated with the use of TCAM as a healthcare and health promotion resources. Two patterns were observed in participants’ discourses on affinity with identity and sense of belonging through the use of TCAM. The first entails participants who viewed the use of TCAM modalities associated with their ethnocultural background as a means of reasserting their cultural identity and sense of belonging. Participants in the studies noted that using TCAM becomes a means of engaging with their heritage and identity. Thus, TCAM remedies are not only employed in the presence of an illness or sickness but are used as health promotion resources that deepen one’s connection with their heritage and nature. This view was particularly strong among participants of African descent (including persons of SSA and African-Caribbean descent) and participants with adverse (or chronic) health conditions.

Participants of African-descent expressed a strong connection to the cultures of their country of origin through medicinal plants, cloves and food. Participants talked about how the main food options available in Canada contribute to their adverse health conditions, such as hypertension and diabetes. They affirmed these food options are not indigenous to them and their homelands hence their health problems; and they emphasised the need to embrace food options that are “native to the homeland” or they
considered “nkrasefou aduane – rural or village food1”. To other the use of TCAM remedies means reconnecting with “African philosophy” and identity which encourages the use of natural remedies to address health problems. The quotes below are examples of participants’ views:

“Yeah, so if I were to be in Ghana now there will be a lot of things that I would’ve used … Some things that we take them for granted, we don’t even regard them, and we feel that it’s nkrasefou aduane or the poor man’s food … they are very healthy to the body. So, even the high blood pressure, boiling, I don’t know how they call it but “pr3k3s3” … boiling pr3k3s3 and drinking the water like a tea alone can let me go off my medication so why wouldn’t I? So if I were to be in Ghana, I would’ve used some these things “ (Participant 12, SSA decent, F, 50)

“… well I think that now a lot of the food that particularly come from either the Caribbean or the motherland (Africa) … all of them are starting to be seen as more things we should eat because I think that other people are seeing the benefits from them and all the other plants … people didn’t know about but we are now seeing it; seeing more of the benefits of going back to original foods and eating things we may have pushed away because we are in the Northern American society … and think some of us are trying to go back to

1 This term nkrasefou is often a derogatory word used in reference to what is normally consider “uncivilized” or non-modern lifestyle.
the foods we were originally eating. “ (Participant_4, African-Caribbean descent, F, 45)

“No! Not necessarily. Not when you have the knowledge I have. I will be honest with you; my health is not great but at the same time I know what to take for anything because I’m Jamaican born; I was born in the Caribbean. We don’t go to the doctor and you know this, for someone from Africa. If you don’t have the bush knowledge, then you go to the bushman or woman. There’s no need for anyone on earth to go to the doctor, even for childbirth ok? … Hospitals are for triage treatment … That means you get a wound when blood is gushing out of your body like a fountain then you go to the hospital ok … but if you don’t have a triage type injury, then you treat yourself because the original African philosophy and teaching is heal thyself”

(Participant_3, African-Caribbean descent, F, 42)

Studies on Ghanaian and other West African immigrants show that cultural attachment and sense of belonging is often affirmed through food or nutritional behaviour. Food is acknowledged as an important marker of group identity and central component of culture passed on to members through the process of socialisation (Brown, Edwards, & Hartwell, 2010; Cervellon & Dubé, 2005; Verbeke & López, 2005). While others posit that strong attachment to ethnic food among immigrants may be due to food neophobia (the rejection of unknown food or nutritional items) (D’Antuono & Bignami, 2012; Verbeke & López, 2005), research suggests that nutritional changes among immigrants lead to poor health
outcomes (Brown & Paszkiewicz, 2017; McDonald & Kennedy, 2005; Subedi & Rosenberg, 2016). In Canada and other developed countries, evidence from existing studies indicate that immigrants (particularly racialized and visible minorities) have disproportionately high incidences of cardiovascular chronic health conditions, such as obesity, hypertension and diabetes (Creatore et al., 2010; Newbold, 2009; Newbold & Danforth, 2003; Wang & Hu, 2013). Among other factors, these negative health outcomes are often attributed to poor eating or nutritional habits which is often the result of lower income and work demands (Brown & Paszkiewicz, 2017; McDonald & Kennedy, 2005; Subedi & Rosenberg, 2016). In this context, participants of African descent (both persons of SSA origin and persons of African-Caribbean origin) may view traditional foods (food from the homeland) and ethnocultural healing remedies as means to regain the positive health status they had before their immigration to Canada. While in the SSA context these food options may be regarded food for the poor, the Canadian context helps participants appreciate the health benefits of these food, as well as, foster their connections with their countries of origin. The use of traditional foods and medicine as health-promoting remedies also fosters social bonds/networks among participants and their social relations (both in Canada and their countries of origin). The sense of belonging and cultural attachment associated with the use of traditional resources may also improve the psychosocial wellbeing of participants with adverse health conditions.

Participants also mentioned the use of existing social networks to access remedies or native food, and the creation of social networks that help promote attachments to native heritage. Participants of SSA descent relied on some existing networks in Canada and
country of origin to obtain indigenous TCAM remedies or medical food items for their health care needs. Participants of African-Caribbean descent mentioned the creation or existence of social media groups (on platforms such as Google Meetup and Facebook) that are aimed at promoting healthy food options, health and wellness, as well as, a sense of community among persons of African (and African-Caribbean descent) living in the GTA. These platforms also served as avenues for promoting “black heritage” African-descent living in the GTA through community events with resource persons, such as artists, musicians and entrepreneurs.

“… they are all black, like black vegans. So there’s a group for black vegans, there’s a black social group … because it’s nice we all have the same sort of cultural background … we can understand it from the sense of the food we like may not be good for us and find an alternative food; so we can enjoy the food we like … So there’s a couple of social groups, travel groups. They are all black groups” (Participant_4, African-Caribbean descent, F, 45)

The second pattern has to do with participants who identified with other cultural beliefs and practices outside their own. This view was mainly expressed by seniors and participants with chronic health conditions. Some participants expressed affinity with the health beliefs and healthcare practices of the TCAM modalities they employ for their health and healthcare needs. These modalities were not associated with participants’ ethnocultural background; however, they opined that the healing approach of the modalities they use aligned with their views on health and healthcare. For others, the
modalities were the closest thing to their ethnocultural healing practices in Canada. Among the latter, the TCAM modalities they employed were a substitute for their ethnocultural healing practices and remedies that are not available in the Canadian context. Similar to the support network and social bonds witnessed among participants of African descent, some participants also noted that the social connections with healers and other TCAM users improved their sense of belonging. For these participants the TCAM remedies they sought did not only serve as a therapy for their healthcare needs but also enabled them to build social bonds through active participation in a ‘medico-social’\textsuperscript{2} group contributing to their psychosocial wellbeing. Some participant mentioned their prior social isolation due to their medical condition. The statements below are examples of affinity with the sociocultural beliefs and practices espoused by the TCAM remedies used by some participants; and how it enhanced their sense of belonging through social bonds:

“As a patient … with my family doctor, with my cardiologist and I’m not getting anywhere. But when I go to the naturopath clinic that is run by students, there has been an empathy at least in my case; okay Mark (pseudonym) you’ve lost your mother. They gave me homoeopathic remedy to deal with grief … in the end I feel that I was much more supported by naturopathic clinic. My mother would tell me her grandmother; they knew, when someone was sick they knew how to go into the forest and which mushroom, which tree would help, which plant or which herb … and so I

\textsuperscript{2} A coined term used as reference to social groups or organization created for the purpose of promoting health, healing or treatment.
would say from a cultural point of view it has informed my mother’s
treatment and it has informed my treatment as well that you know, this is
what was done in Europe and naturopathy is the closest to that. And so it’s
one of those things where I think from the Slovak part yes! That informs it.
The Italian part, no!“ (Participant_1, European descent, M, 34)

“I was involved in an accident somebody hit from behind on December 2nd, so
it aggravated the pre-existing pain that I have on my body … When I visit
home, I use local physiotherapy by the traditional doctor … In fact when I
was younger in Nigeria, I used a lot of traditional medicines, you know like
‘Ogwuiaba’ and ‘Dogwonyaro’. I still used them anytime I visit but not as
frequently as I did because you can easily get them here in Toronto, I should
say even Canada … As I was saying the accident aggravated my pain and a
friend recommended acupuncture … yeah even acupuncture I use it. I used it
anytime winter comes to manage my pains. Even though it is not the same as
the local physiotherapy I use in Nigeria, they are all the same … they are both
traditional just that one is African method and the other is Chinese … and
they both work fine for my pains.” (Participant_22, SSA descent, M, 62)

Immigration has transformed the GTA into a cosmopolitan metropolis. In this space,
residents interact with people of diverse sociocultural and ethnic backgrounds. Through
such interaction some residents embrace aspects of cultures and a social life that are alien
to their own. For instance, Williams (2000) argues that the growth of TCAM use among
the population in developed countries is potentially due to growth in public knowledge and awareness of alternative health practices. He argues that this knowledge is driven by sociocultural factors including changing cultural attitudes and beliefs, as well as, willingness to adopt new health care practices. Residents in The GTA may embrace different healing beliefs and practices through their interaction with others or exposure to TCAM practitioners in the metropolis. Thus, the GTA provides a sociocultural context where markers of identity, including health beliefs and practices, are embraced or adopted by residents to meet their health and healthcare needs. Through these alternative healing practices, patients form bonds with other health seekers, reducing their risk of isolation – as a result of their chronic health status. Social bonds formed through this health-seeking behaviour have the potential to reduce susceptibility to depression and other common mental health disorders; through their participation in group activities and group support, patients improve their psychosocial wellbeing and their overall health (Bystritsky et al., 2012; Hsiao et al., 2008; Wren et al., 2011; Yagli & Ulger, 2015).

7.3.3 Cross-border health resource and knowledge sharing among immigrants

Cross-border health(care) knowledge and resources sharing featured prominently in the discourse of participants of immigrant origin, particularly persons of SSA and African-Caribbean descent. The findings of existing studies suggests that potentials barriers such as discrimination, culturally incompetent care and lack of health insurance coverage, drive the decision of immigrants to seek biomedical care in their country of origin (Kemppainen et al., 2018; Lokdam et al., 2016; Şekercan et al., 2015; Wallace et al., 2009). While these findings are valid in the context of the studies, the motivations may be
different for other contexts. For instance, for the majority of studies in the United States cost of care and lack of insurance coverage have often been cited as a major motivation for immigrants seeking care in their countries of origin (Choi, 2013; Grineski, 2011a; Sanon et al., 2016; Wallace et al., 2009). In countries with universal healthcare systems, such as Canada, Norway and New Zealand, the motivation for seeking care in countries of origin has largely been lack of cultural competency among professionals in the biomedical care sector (Kemppainen et al., 2018; Koehn, Neysmith, Kobayashi, & Khamisa, 2012; Lee, Kearns, & Friesen, 2010; Tiilikainen & Koehn, 2011). Also, the target population of the majority of the studies are people from neighbouring states or countries; thus, engaging in cross-border healthcare-seeking may be an affordable option compared to received care in the host country.

In this study, unavailability of traditional or ethnocultural medical resources in the GTA and Canada was the main motivations for participants engaging in cross-border or transnational healthcare-seeking. Participants talked about seeking healthcare advice on traditional remedies from family members and social relations in their countries of origin. The need to seek medical (healthcare) advice from relatives back “home” is often necessitated by the lack of improvement in an existing chronic health condition after seeking biomedical care. For older adult participants, the need is also motivated by prior knowledge of a “native” treatment for their health condition due to their engagement with traditional medicine in their countries of origin. Participants travel back to country of origin to utilise traditional remedies on the recommendation of family members (in Canada and country of origin) or in some cases transnational relations send these
remedies (often herbs or herbal products) to participants via the post or a known person returning to Canada. Some of these medicinal products can be obtained from African shops (shops that sell African food produce); these are native food items with medicinal properties, such as ‘soro wisa’ – Guinea pepper (*Piper guineense*), ‘efom wisa’ – *alligator pepper* (*Aframomum melegueta*), ‘hwentia’ - Grains of Selim (*Xylopia aethiopica*).

“For the basic ones like *wisa, hwentia, prekese*³ and *akakaduro* (ginger) I get them mostly from the Ghanaian shops here … There are some drugs we don’t have here so when I visit Ghana, or someone is going back home I ask them to get me some. At times, I call my younger sister to send them to me through the post office … and she sends them by EMS. But they are usually the bottled ones” (Participant_14, SSA descent, F, 56)

“… so, I haven’t been to Jamaica in such a long time. So, what I usually do is, if I have a friend who’s going back, I would ask them to get me some herbs from my family … Because they love me, so they will just give me whatever I ask for or I will tell them what I need, or I literally write down or tell them to remember a list of herbs that I want brought back up here. Two years ago, my friend Abena (pseudonym) went to Jamaica and I said; ok you going to stay for 2 weeks, good! I want some soursop ok? And I thought she was going to give me like a handful, she brought me a big bag full of soursop leaves” (Participant_3, African-Caribbean descent, F, 42)

³ *Tetrapleura tetraptera*
These findings corroborate the findings of existing studies on the relevance of transnational and social ties in cross-border healthcare-seeking behaviour of immigrants (Grineski, 2011a; Krause, 2008). Immigrants rely on the knowledge and advice of transnational relations for remedies to their adverse health conditions in what Krause (2008) terms “transnational therapy networks”. Krause (2008) observed a similar flow of traditional medicine from Ghana to Ghanaian immigrants living in Europe for self-care purposes. Interestingly, in her studies she noted biomedical drugs as part of remedies sent from Ghana to Europe. These biomedical pharmaceuticals are mostly requested by undocumented Ghanaian immigrants who do not have general practitioners or family doctors hence cannot get prescribed drugs when sick. In this study participants only mentioned traditional or ethnocultural medicine as remedies they seek or bring from their countries of origin. It is possible participants of this study did not need these biomedical drugs because they were all documented immigrants and legal residents of Canada; thus, have access to a family doctor or a general practitioner.

Immigrants’ evaluation of their health status and healthcare options is usually informed by knowledge about health beliefs and practices garnered in both countries of origin and host countries. Prior health knowledge and healthcare-seeking behaviour are crucial for transnational healthcare practice. Usually such prior behaviour and knowledge are merged with new knowledge about adverse health conditions. This blended knowledge creates a new form of transnational healthcare practice where some participants use their

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4 Transnational therapy network refers to health(care) related formal and informal activities that span national borders.
GPs (and advanced healthcare resources) for diagnosing health problems and relying on traditional (or ethnocultural) medicines from their place of origin for treatment. For instance, Participant_3 a Canadian of African-Caribbean descent (with immigrant origin) talks about her inability to diagnose her health problems hence her reliance on biomedical care for such knowledge. Once the diagnosis is confirmed, she uses this knowledge to seek ethnocultural therapies or remedies for the diagnosed health condition.

“Well, there was a time last year when I was having chest pains and I didn’t know what it was, and I couldn’t figure things out, so I just went to the hospital. Like there are certain times where you can’t really joke around when it comes to like chest pains on the left side … however, I know that I have high blood pressure and I know what teas to drink to lower my blood pressure … when I discovered that I have high blood pressure, I said that’s ok, I came home, I got the diagnosis, which the hospital doctors are really good for ok? So, you can go there to get the diagnosis, but once you get your diagnosis you want, you run to the house and rip-up their prescription (she laughs)”

(Participant_3, African-Caribbean descent, F, 42)

In worse scenarios they may travel back to their countries of origin for a cure if the treatment given by their Canadian healthcare providers fail to address their health problems. Transnational ties with social relations in countries of origin and persons of similar national or ethnocultural origin are crucial for participants access to traditional healing remedies from the countries of origin. Among participants of African descent, the
function of community social ties in cross-border healthcare operates in two ways: first, the community serves as resource persons for traditional medicine from countries of origin and second, it serves as a means through which family members in countries of origin send traditional medicine to relations living in Canada.

“… My father recommended I go back to Nigeria for treatment for my asthma. I was on asthma medication and we both felt my condition was getting worse. He mentioned my grandma used to treat conditions like me when he was in Nigeria … So I went to visit my grandmother and she gave me some herbs. I was in Nigeria for two months and I saw considerable improvement in my condition. In fact when I got back to Canada, I could go without my asthma medication. Recently, I noticed the condition is getting back to worse, so I called my grandma to send me some of the herbs she gave me. I think I didn’t get it right the first thing because after taking the herbs I didn’t feel like I felt when she gives me that medication … So I called her gave to find out if it the same herbs as I wasn’t noticing any improvement … it was then she showed me how to prepare it … I bring some of the herbs when I visit or when my dad or mum is visiting, I ask them to bring them” (Participant_18, SSA descent, M, 29)

Participants of SSA origin also reciprocate with health/medical resources and knowledge sharing through providing support for biomedical care in their countries of origin. Two forms of this support were noted in the interviews with participants and through field observation: individual support and group support. The first form of support usually
entails participants contributing money towards the treatment of their close social relations in their country of origin. The funds are usually used for biomedical care for an urgent health emergency or some pre-existing chronic health condition. However, some participants also disclosed that they contributed funds towards traditional medical care for their family members in their countries of origin. The second form of support involved broader group support. The SSA immigrant community in the GTA and Canada at large also provide valuable support for biomedical care in their communities and countries of origin. Some leaders of SSA national and ethnic groups who participated in this study mentioned their contribution towards improving basic biomedical care in their communities and countries of origin through the provision of biomedical care resources, such as ambulances, community health centres, and wheelchairs. They noted the challenges that people in their communities of origin face their access to basic health care.

7.3.4 Best of both worlds: Participants’ experiences and opinions on health(care)

Another theme that emerged from participants’ experiences with biomedical care and TCAM was the benefits of both health care therapies to their healthcare needs. For instance, participants of SSA origin talked about the easy accessibility of traditional healing remedies in their countries of origin. They acknowledged the difficulty associated with accessing these remedies in Canada and also noted that while some of the traditional remedies are obtained in Canada there were no guarantees of their availability in times of need. In their interviews they also acknowledged the challenges they faced accessing biomedical care prior to their immigration to Canada as well as shared stories that social
relations in their countries of origin face accessing and using biomedical healthcare. In doing so, they compared these experiences with their experiences with accessing and using biomedical care in Canada. Participants opined that they consider themselves “fortunate” or “blessed” due to Canada’s free universal healthcare services irrespective of some challenges (e.g., wait times) they occasionally face in their access to care in the GTA. Other participants similarly acknowledged the benefits of the country’s biomedical care system and the TCAM remedies they use to address their healthcare needs. Most participants were quick to emphasise that the quality of care both in terms of treatment and services associated with the biomedical treatment have been good or excellent. However, they opined that the biomedical care system offered little or no solution to the health or medical problems where they employed TCAM remedies. Others disclose that they used TCAM mainly to maintain good health or as a health promotion resource.

“The quality of service here is better looking at the health issues that I have gone through, through pregnancy and the surgeries I have had through pregnancies, if I were to be in Ghana, either I would be dead. I still consider myself fortunate because, in Ghana women even die going to give birth. Three months ago, I lost a cousin through childbirth. My mother informed me she bled heavily prior to going into labour and die as they rushed her to hospital … this wouldn’t happen in Canada. Here (Canada) they are careful how they talk to you, what they do to you … they know their roles, what their responsibilities are, they are good … I wonder why as a country (referring to Ghana) we still haven’t gotten some of these things right. In Canada, we are
blessed … I was diagnosed with hypertension when I was pregnant with my second son … even if I do start treating it with pr3k3s3, I can do it for a while and won’t get the pr3k3s3 though it’s at the Ghana store … you go to the Ghanaian shops, sometimes it is there and sometimes they don’t have it … I have been on hypertension medication since my second pregnancy. And it never went away after the pregnancy. So, I wouldn’t want to do that and then if there’s none then what do I do. But if I were to be Ghana, I know that 24/7 you can get it, I would’ve gone off my medication and then take that. ”

(Participant_12, SSA descent, F, 50).

“ … My brother, despite these challenges the healthcare system here is far better than what we have in Nigeria. Here, we can go to the hospital or clinic without paying for it. You know in Nigeria and even in Ghana, you have to pay for your health. And the doctors and nurses here are very professional and caring unlike the ones we have back home” (Participant_22, SSA descent, M, 62)

7.4 Conclusion

This chapter aimed to understand how context, including every day and health(care) contexts, shape people’s construction of social identity and the utilisation of ethnocultural and social resources in addressing health(care) needs. Findings of previous studies on TCAM use in developed countries suggest that the biomedical care system alienates
ethnic and racial minorities through its lack of cultural sensitivity and other structural barriers such as language and discrimination through stereotyping. The literature asserts a sociocultural worldview of TCAM users particularly from ethnic/racial minorities contradicts the biomedical view and approach to health and healthcare (Bodeker et al., 2007; Cassidy, 2006; Kong & Hsieh, 2012; Lai & Chappell, 2007). This view or assertion is usually based on the notion of fixed sociocultural identity that is static irrespective of a person’s interactions through space and time. Using Anthias’ translocational positionality framework as a theoretical lens, the objective of this chapter is to challenge the view of fixed sociocultural identity in health(care) beliefs and behaviour; as well as, interrogate the role of context in sociocultural identity construction and its effects on health(care) seeking behaviour. Insights into participants’ experiences and motivations for using TCAM in the GTA shows the importance of temporal, spatial and social context on the construction of identity or belonging.

In one context, participants’ identity construction is shaped by the process and social conditions that gave rise to their current social position as African-Canadian, Nigerian-Canadian, Ghanaian-Canadian, or Canadian. Among participants of SSA origin, the findings show that migrants’ identity and sense of belonging are built around citizenship and social relationships that transcend national or ethnocultural boundaries. Indeed, this group of Canadians are not homogeneous as they are made up of different cultural and ethnic groups. Studies on Anglophone West African immigrants living in Canada highlight the existence of social and cultural groups based on religious/church affiliation, ethnic background, town or community of origin and high school alma mater (Baffoe,
2012; Manuh, 1998; Mensah, 2005). Similarly, studies on African-Caribbeans in North American and European contexts points to the heterogeneity among these groups of people (George & Fitzgerald, 2012; Nguyen, 2017; Plaza, 2006). Through translocational positionality, we understand the temporal and spatial framework that created their national identities as African-Canadian, Nigerian-Canadian, Ghanaian-Canadian, or Canadian. Even among persons of similar racial or ethnocultural background, the processes or experiences that create these social identities (social position) might be different invariably leading to different forms of identity construction as seen in this study.

While most studies on health and healthcare behaviour of the population in developed countries assume a dichotomous identity classification (visible minorities versus non-visible minorities; persons of European descent versus others), Anthias’ (2008) translocational positionality framework cautions against this form of homogenising people. Likewise, George & Fitzgerald (2012) cautions against the assumption of complete assimilation and integration of European immigrants in “white-majority” countries. They argue such assumptions usually ignore the relevance of their “homeland” cultural norms, values and morals in shaping their identity, including hybrid identities as seen in racial or ethnic minority groups. As a theoretical framework translocational positionality admonishes the researcher to pay attention to the social processes (positionality) that give rise to identities in view of an individual’s agency and social structures that frame such identities. From the findings of this study it becomes clear that there are considerable differences in how participants of similar racial or sociocultural
background (for example first generation SSA immigrants compared to their children or Anglo-Saxon Europeans compared to other Europeans) construct their identities.

Participants’ identities described at the beginning of the interviews transcend other forms of identity that sometimes emerged during their narratives on their health(care) seeking behaviour and experiences. For instance, Participant_3 described herself as an African-Canadian at the beginning of the interview; but evoke her Jamaican identity when sharing information about her TCAM care-seeking behaviour and access the traditional remedies from her country of origin. Likewise, some participants of European descent expressed affinity with health beliefs and practices foreign to their sociocultural background when they talked about their TCAM care-seeking behaviour and experience. Anthias’ translocation positionality as a theoretical framework enables us to understand the plurality and multi-dimensional nature of identity and how individuals may employ some aspects of their identity to meet their healthcare needs.

On the one hand, the spatial context enables the formation of new identity(ies) for health and healthcare needs among residents in the GTA. The GTA as a spatial context creates the environment for such identities to emerge in relation to residents’ health(care) practices and behaviour. Indeed, some studies suggest that the rise in TCAM use among residents in developed is due to increase exposure to alternative forms of health beliefs, practices and healthcare in an increasingly multicultural urban landscape (Coulter & Willis, 2004; Li et al., 2005; Su et al., 2008). In this spatial context, some individuals
may embrace other forms of health beliefs and practices to address their healthcare needs especially when the conventional healthcare system cannot meet such needs.

Also, the narratives of participants of immigrant origin show how health(care) behaviours transcend national boundaries. Participants need not physically be in their countries of origin to access or utilise traditional healing remedies for their health needs in addition to enjoying the benefits of the biomedical care system in Canada. Anthias (2008, 2012) asserts that social locations transcend temporal and spatial dimensions, thus immigrants are still embedded in the social networks and relationships they found in their countries prior to their immigration to Canada. Their social connections with relations in Canada and countries of origin as vital for their access to traditional remedies and healing knowledge. Likewise, participants of immigrant origin also contribute to biomedical care in the countries of origin through individual efforts, such as funds for biomedical treatment and/or through collective efforts with other members through building community health centres, donating hospital beds and other biomedical care equipment (Krause, 2008; Mensah, 2014). The ethnocultural origin or background does not necessarily mean detachment from western norms and values especially when it comes to health and healthcare. Participants in their submission acknowledge the benefits and usefulness of both forms of care to their health(care) needs, be it as triage treatment or avenue for diagnosing unknown health conditions. Anthias’ translocational positionality enable us to appreciate that participants can embody both contemporary and traditional identities, values and norms as well as other forms of identity for health promotion or seeking care for an existing health problem. It also deepens our understanding of the
processes and the context the shape participants ability to transcend these multiple or plural identities. That is, the spatiotemporal context usually informs the evocation of one's ethnocultural identity or embracing contemporary values of health(care). This, challenges the notion of fixed identity that implies alienation of ethnic or racial minorities due to cultural apathy in the biomedical care profession, thus negating the ability of both ethnic/racial minorities and non-minorities to embody different norms, beliefs, values and practices of health.

The findings and the discussions of the findings in this chapter ought to be considered in the view of the limitations of the research method. A key limitation of the study in this chapter is intersubjectivity – that is, participants’ narratives about their identity, experience and motivations for TCAM use cannot be considered as independent of my presence as the researcher. My participants and I were both active in constructing this knowledge and in some cases my identity (be it as a student, African, SSA, Ghanaian or an immigrant) might have shaped the participants’ narratives about identity, sense of belonging and health. This is clearly evident in the interviews of some participants as seen in this chapter. For instance, Participant_3 referred to a possible experiential knowledge (emic) on my part about healthcare-seeking behaviour among persons from Africa and the Caribbean origin when she described her health(care) seeking behaviour:

“… We don’t go to the doctor and you know this, for someone from Africa”

Likewise, my positionality as an immigrant studying in Canada may have informed Participant_9’s description of what it meant to be a Canadian, given the geopolitical
climate at the time of the interview. Invariably intersubjectivity as a research limitation underpins the notion that both researcher and the researched are active participants in the construction of knowledge and possibly the meaning attached to such knowledge, both subjective to spatiotemporal context (Cloke et al., 2012; Mullings, 1999). Thus, the questions posed in the interviews may not elicit similar responses in other context or may not be replicated given potential variability in the context or circumstances that shaped these responses or narratives. The potential non-replicability of this study is also closely associated with another limitation of qualitative studies – that is, non-generalizability of the findings. The findings of this study cannot be generalised for the ethnocultural or racial groups from which the study participants were drawn. The sample of participants is not representative of the groups hence the inability to generalise the findings. Also, the participants of this study are highly homogenous in terms of their socioeconomic characteristics possibly due to selection bias. All participants were highly educated (college or university education) and citizens of Canada; meaning, experiences and views of persons outside these groups were not captured in this study.

One last limitation is that questions were not asked about other forms of transnational health seeking behaviour. For example, we did not discuss travelling to the United States to seek TCAM or traditional medicines that cannot be found in the GTA or how the internet might be used in transnational health seeking behaviour.
Chapter 8

Conclusion

8.1 Introduction

Traditional, complementary and alternative medicine (TCAM) plays a crucial role in the health and healthcare of the population in western industrialised countries. The literature estimates that between 10% to 52% of the population use TCAM, depending on how TCAM is defined (Bishop et al., 2010; Eisenberg et al., 1998; Metcalfe et al., 2010; Thomas et al., 2001; Thomson et al., 2014b). The prevalence of TCAM is even higher among persons with chronic health conditions (Arthur et al., 2012; Boon et al., 2000; Metcalfe et al., 2010). The research and literature on TCAM use among ethnic and racial minority groups in western countries are abundant. However, there is limited knowledge on TCAM usage and behaviour among persons of sub-Saharan African descent living in western countries, albeit knowledge from existing literature shows that the majority of persons living in sub-Saharan African descent rely on TCAM remedies for their health(care) needs. In the view of this gap in knowledge and research, this thesis sought to examine the use of TCAM remedies among persons of sub-Saharan African descent living in the GTA in order to understand whether there is a continuity in the use TCAM after immigration to western countries or not. The thesis also sought to understand how ethnocultural identity influence TCAM care seeking behaviour remedies.

To achieve these aims and the specific research objectives formulated in the introductory chapter, the thesis (Chapter 2) started with a review of existing studies of TCAM in western industrialised countries with a primary focus on Canada. It explored the popular
appeal of TCAM in western countries as well as the motivations for their use. It further discussed the political economy of TCAM in Canada’s universal healthcare system then delved into the relationship between ethnic or racial identity and the use of TCAM. The chapter also introduced the theoretical framework that informed the research. The review helped contextualise the study and identify the gaps in existing studies on the topic – TCAM. In this chapter, I will summarise the main findings of this study and relate these findings to the initial research objectives. I will also delve into the general limitations of this study and its implications for future research. Finally, I will conclude the chapter with a discussion on the contribution of this study to the existing literature on TCAM, as well as, to the broader literature on health and medical geography.

8.2 Re-examining the Research Objectives and the Findings

In order to achieve the research aims of this thesis, I formulated five key research objectives: a) To examine TCAM use and care seeking behaviour of persons of sub-Saharan Africa origin living in the GTA; b) To examine the effect of health, care-related factors and socioeconomic status on TCAM use among persons of sub-Saharan Africa origin living in the GTA; c) To examine the effect of health, care-related factors and socioeconomic status on unmet TCAM use among persons of sub-Saharan Africa origin living in the GTA; d) To examine the effect of health, care-related factors and socioeconomic status on transnational healthcare or medical return use among persons of sub-Saharan Africa origin living in the GTA; e) To understand how ethnocultural identity and context influence healthcare-seeking behaviour of different groups of persons living in the GTA. To accomplish these objectives, I employed a mixed or multi-methods
research approach to examine patterns and determinants of TCAM use among persons of sub-Saharan Africa descent as well as to understand the role of ethnocultural identity in TCAM choice and care seeking behaviour. This methodological approach thus offers a comprehensive knowledge of TCAM use and behaviour among persons of sub-Saharan Africa descent living in the GTA.

Chapter five of the thesis focuses on the first two objectives: “to examine TCAM use and care seeking behaviour of persons of sub-Saharan Africa origin living in the GTA; and to examine the effect of health, care-related factors and socioeconomic status on TCAM use among persons of sub-Saharan Africa origin living in the GTA”. The finding from the primary data analysis shows that both lifetime prevalence (57.14%) and 12-month prevalence (23.81%) of TCAM among persons of sub-Saharan Africa origin living in the GTA is relatively lower than reported estimates for the general population in Canada – over 70% (Bodeker et al., 2007; Esmail, 2017). Likewise, the observed lifetime prevalence is lower than reported estimates of TCAM users in the sub-Saharan African region – about 80% of the population (World Health Organisation, 2013). Although the 12-month prevalence of TCAM was higher than the estimates reported by some studies (Andrews & Boon, 2005; Harris et al., 2012; Metcalfe et al., 2010; Williams et al., 2011), the definition of TCAM are generally restricted to professional or licensed practitioners; while TCAM was broadly defined in this study. I offered some plausible explanations for the low prevalence of TCAM use among persons of sub-Saharan African origin. The first has to do with healthcare financing for TCAM in Canada which is mainly through private insurance, employment benefits or out-of-pocket payment. Given the socioeconomic
challenges that persons of sub-Saharan Africa descent face, I argue they have limited ability to afford TCAM care compare to the general population. The second contextual reason has to do with available of ethnomedicine used by persons of sub-Saharan Africa origin in Canada given the literature mention TCAM remedies use the population in sub-Saharan Africa are mainly sourced from the immediate environment (Pouliot, 2011; Pouliot & Treue, 2013; Van Andel et al., 2012). Thirdly, I argue the low prevalence could also be the result of the sociodemographic characteristics of this group of persons as the research shows that TCAM prevalence is generally low among highly educated persons in Africa (Pouliot & Treue, 2013; Sato, 2012a; Tabi et al., 2006). The nature of Canada’s immigration policy means most respondents are likely to be highly educated – as evident in the sociodemographic characteristics of the survey respondents. The finding also shows that ~49% of lifetime TCAM use among persons of sub-Saharan African origin are remedies based on ethnocultural practices; suggesting potential discontinuation in usage due to unavailability of remedies – as mentioned by some respondents in the interviews and the survey. The finding further reveals that the chronic health status, middle-aged respondents (45-59 years), widowed, separated or divorced persons and previous knowledge or use of TCAM are the main determinants of current (12-months) TCAM use among the study sample.

The third and fourth objectives of this thesis had to do with unmet TCAM need and transnational healthcare behaviour among persons of sub-Saharan African origin living in the GTA. While studies and research on transnational healthcare behaviour among racial minority groups abound, knowledge of such a phenomenon among persons of sub-
Saharan African living in western countries is limited, especially in the context of TCAM. The finding of the primary data – both the survey and the interviews – presented in Chapter Six provides a novel insight into unmet TCAM needs and transnational healthcare behaviour among the target population of this thesis. The finding shows that 1 out of every 5 respondents (~21%) had unmet TCAM need while 2 out of every 5 respondents (~40%) had engaged in transnational healthcare (medical return) seeking in their lifetime. Respondent of the survey mostly cited unavailability of their ethnocultural remedies in GTA and Canada as the major reason for their unmet TCAM needs. To meet their TCAM respondents engage in transnational healthcare-seeking or medical return; that is, they either seek such remedies when they visit their countries of origin. Although respondents rarely return to their home country purposely for treatment, they rely on family and other social relations visiting their country of origin for supplies of ethnomedicine. Some ethnomedicine, particularly remedies that are also food items are sourced from local African shops. The finding of the study shows that chronic health status, perceived quality of biomedical care and its perceived adequacy for one’s health care needs are major determinants of medical return. In terms of socioeconomic factors, the finding reveals that older respondents and persons with lower education are more likely to engage in medical return. The inability of conventional or biomedicine to treatment adverse health conditions is a major motivation for medical return. Sub-Saharan African immigrants may rely on prior knowledge of treatments for these adverse conditions and other health(care) needs thus engaging in transnational healthcare-seeking or medical return.
Lastly, the thesis sought “to understand how ethnocultural identity and context influence healthcare-seeking behaviour of different groups of persons living in the GTA”. Existing studies on health and healthcare behaviour of racial or ethnic minorities in western countries suggest possible alienation of this group of residents due to the paradigm and practices of the mainstream healthcare system – biomedicine or allopathy (Bodeker et al., 2007; Cassidy, 2006). These studies allude to sociocultural difference in health and healthcare practices (and beliefs) between TCAM (or indigenous medicines) and biomedicine. They argue TCAM practices and beliefs are usually embedded in the sociocultural worldview and identity of ethnic and racial minority groups hence its broader appeal to this group of residents (de Medeiros et al., 2016). This argument espouses the idea of a static identity that lacks any affinity with western values or culture. In view of this, the thesis sought to understand how ethnocultural identity informs or influence health(care) seeking behaviour among residents in the GTA using Anthias’ (2002, 2008, 2012) translocational positionality framework. This framework moves from the traditional view of fixed identities and focuses on the importance of context, meaning and time on identity construction. In the case of the thesis, it helps understand the influence of context on how people of diverse ethnocultural or racial background embrace and utilise their identities (including the norms, values, beliefs and practices associated with it), the meanings associated with these identities and the spatiotemporal dimension of such positionalities. Chapter Seven presents the findings of the in-depth interviews on this subject. It challenges the idea of possible alienation of immigrants or persons of ethnic or racial minority background in the biomedical healthcare system. It rather sheds light on how context (spatial context) shape affective attachment to ethnomedicine or TCAM and
the performative of ethnocultural identity in the seeking treatment for health conditions or improving one’s health status. The finding also shows that participants embody both their ethnocultural values of health and western or biomedical values of health and appreciate the role these forms of healthcare in their different health care needs. Thus, through translocational positionality we appreciate participants’ ability to transcend different social identities and utilise their embedded meanings, experiences and practices in seeking healthcare-seeking or improve their health and wellbeing.

8.3 Limitations and Implications for Future Research

The limitations of the research were discussed in the previous chapters, particularly chapters Three, Five, Six and Seven. The discussion in these chapters focused on the methodological and analytical limitations of the thesis. Here, I will focus on the broader limitations of the thesis emanating from my end as the researcher and the conceptual definition of TCAM in the study. I also offer insights for future research on the topic of TCAM. The discussion will focus on limitations in terms of resources, access to participants and time.

Every research requires a substantial amount to resources, especially financial funding, and time in the data collection processes as well as during the access negotiation phase. Lack of funding or resources can severely undermine the research process. In my study, I adopted a quasi-approach of my sampling technique due to the high resource and financial responsibilities associated with RDS. My inability to follow through with the RDS sampling approach raises the issue of potential bias in the study sample as one
group may have been oversampled. Given in the data gathering processes I did not collect data on network size or chain information (a crucial part of RDS), I cannot control or adjust for such sampling bias. Time is relevant in building rapport with study participants, especially when the focus group is a hidden population. However, my research had limited time which meant the benefits of the rapport built with the various social groups for recruitment of participants was not fully realised during the research. The data collection had to be completed within a limited time frame to enable the timely completion of my doctoral program. Future research with adequate funding can utilise the proper RDS technique to reach a more representative sample of persons of sub-Saharan African descent living in the GTA or the general GTA resident. A large sample size acquired through RDS will guarantee representative findings and conclusions on TCAM behaviour among persons of sub-Saharan African descent living in the GTA. Another key limitation of this research is that TCAM was broadly defined in this study. That is, the study did not focus exclusively on traditional African medicines. Future studies can concentrate specifically on this topic or theme, given the lack of research on traditional African medicine use and care-seeking behaviour in Canada and other western industrialised countries. Such studies can provide a more accurate picture of the issue of continuity or discontinuity in African ethnomedicines use among immigrants from the continent. There is a need for future studies to also delve into the issue of transnational healthcare-seeking or medical return among persons of sub-Saharan African descent living in the western world. A study on this issue will foster our understanding of the behaviour pattern, the healers and remedies sought in this cross-border healthcare-seeking.
8.4 Contribution to Knowledge

Canada, like most western countries, is highly heterogeneous with urban space acting as a centre for the conglomeration of diverse socio-cultural knowledge and practices. The multiculturalism of contemporary urban Canada transcends race/ethnicity and encompasses diverse health beliefs and practices among urban residents. The population growth of Canadian residents and immigrants of SSA, as well as, other sub-cultural groups in the country, has contributed to the current pluralism in the health care system. This pluralism is not only confounded by major medical and health traditions such as biomedical, indigenous (aboriginal) medicine and TCAM but exists within each major health tradition. The pluralism in TCAM is mainly a result of the diverse ethnocultural and belief origins encompassed within these individual therapies broadly classified as TCAM. The prominence of TCAM therapies in health care settings in Canada and other western countries has contributed to the large volume of literature on the subject. However, there are unexplored paths and inadequate understanding of the phenomenon, with regards to TCAM use and care-seeking behaviour of persons of sub-Saharan African descent; as well as, how ethnocultural identity influence TCAM behaviour and choice of remedies.

The findings of this thesis make valuable contributions to the literature and research on TCAM in Canada and other western countries. First, it examines TCAM use among a population group highly noted for their dependency on TCAM yet often ignored in the research on TCAM use and behaviour in western context. As postulated earlier, the thesis sought to examine the use of TCAM remedies among persons of sub-Saharan African descent living in the GTA area. This research reveals the potential effect of contextual
factors on TCAM use and behaviour among persons of sub-Saharan African descent, such as unavailability of African ethnomedicines and current TCAM financing system. It also reveals the presence of unmet TCAM needs among persons of sub-Saharan African descent living in the GTA. While studies have explored unmet biomedical healthcare needs of the population in western countries, the literature is generally silent on the existence of unmet needs in the TCAM sector. The thesis shows that for persons of sub-Saharan African descent living in the GTA, unavailability of ethnomedicines is the main reason for unmet TCAM needs. Insights from the interviews show that transnational networks play a crucial role in meeting such needs. It also shows the reciprocal health and healthcare relationship between immigrants of sub-Saharan African origin and their transnational social relations. While immigrants support biomedical care needs of family members in their countries of origin, these family members and social relations also support immigrants in their access to ethnomedicines as well as provide knowledge and information on indigenous healing methods. In geographic sense, the finding shows the role social networks play in cross-border access to health(care) and healthcare-seeking behaviour. The finding of this thesis challenges us as health geographers not to confine our quest to understand health and healthcare behaviour among immigrants and the general population in sub-Saharan African to only national boundaries. We need to explore and examine the intricate relationship that exists within borders and beyond borders and their influence on health behaviour, access and use of healthcare services (both biomedical and TCAM). For instance, future studies can examine the role of transnational remittances on accessibility and utilisation of healthcare services among the population in sub-Saharan Africa; thus, accounting to the role immigrants play in the
health and healthcare behaviour of the population on the continent. Likewise, studies examining or exploring TCAM use and behaviour among immigrants could also consider the influence of transnational relations in these phenomena.

In the thesis, I used Anthias’ translocational positionality concept to interrogate the role of ethnocultural identity on health(care) behaviour. This concept allows us to understand the role of context, meanings and social processes on healthcare experiences and health(care) behaviour. In this thesis, I argue that people’s experience of alienation concerning their access and use of biomedicine is contextual. Likewise, the influence of their ethnocultural beliefs and practices in their health(care) behaviour is also contextual. As health geographers, we need to pay attention to these contexts and processes motivate people to engage with the sociocultural meanings and practices associated with their identities in their access and use healthcare services. The finding shows that people engage with TCAM and biomedicine differently; and this is often context driven, be it by the nature of the illness or disease or connecting with ethnocultural identity to improve one’s health. It also shows how the spatial context (GTA) and its heterogeneity makeup create a situation where people can embrace ethnocultural health beliefs and practices that are different or similar to their origin ethnocultural identity. Understand the role of context, meanings and social processes on health(care) behaviour and experiences are crucial for creating an inclusive healthcare environment for all.
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Appendix A
Research Questionnaire

Questionnaire – Uncharted Paths: Ethnocultural Diversity, Ageing and the Use of Traditional, Complementary and Alternative Medicine (CAM) in the Greater Toronto Area (GTA)

This survey is 8 pages long and should take only 10-15 minutes to complete

Part I: Dwelling and Household Information

1. What is your age? ............

2. What is your sex? ☐Male ☐Female

3. What is your marital status?
   ☐Married ☐Living Common-Law ☐Widowed
   ☐Separated ☐Divorced ☐Single/Never Married

4. How many people live in your household, including yourself? .................

5. What is your highest level of education?
   ☐Less than high school diploma or its equivalent
   ☐High school diploma or equivalent
   ☐Trade certificate or diploma
   ☐College, CEGEP or other non-university certificate or diploma
   ☐University certificate or diploma below the bachelor’s level
   ☐Bachelor's degree (e.g. B.A., B.Sc., LL.B.)
   ☐University certificate, diploma, degree above the bachelor's level

6. How many years of formal education have you had? ......................

7. Are you currently attending a school, college or university?
   ☐Yes ☐No ☐Don’t Know

8. Are you a full-time student or part-time student?
   ☐Full-time ☐Part-time ☐Not Applicable
9. Can you estimate in which of the following groups your personal income falls?
   - ☐ Less than $20,000
   - ☐ $20,000 – $39,999
   - ☐ $40,000 – $59,999
   - ☐ $60,000 – $79,999
   - ☐ $80,000 or more

10. Can you estimate in which of the following groups your household income falls?
    - ☐ Less than $20,000
    - ☐ $20,000 – $39,999
    - ☐ $40,000 – $59,999
    - ☐ $60,000 – $79,999
    - ☐ $80,000 or more

11. Which suburb in the GTA do you reside? .................................................................

Part II: Socio-Demographic Characteristics

12. How long have you stay in Canada since immigration? .................................

13. What is your country of birth? .................................................................

14. What is your immigration status?
   - ☐ Citizen
   - ☐ Permanent Resident
   - ☐ Temporary resident visa
   - ☐ Student visa
   - ☐ Other (Please specify) .................................................................

15. What is your racial, ethnic or cultural origin?
   - ☐ Aboriginal or First Nations origin
   - ☐ Latin American
   - ☐ White (Non-Hispanic)
   - ☐ East Asian (Chinese, Korean, Japanese)
   - ☐ South Asian (Indian, Pakistani, Sri Lankan, etc.)
   - ☐ Southeast Asian (e.g., Vietnamese, Cambodian, Malaysian, Laotian, etc.)
   - ☐ Arab
   - ☐ Black (sub-Saharan Africa origin)
   - ☐ Black (African-Canadian, African Caribbean or African-American)
   - ☐ Other (Please specify)
     .................................................................................................

16. Which language(s) do you speak well enough to conduct a conversation?
   - ☐ English Only
   - ☐ French Only
   - ☐ Both English and French
   - ☐ Neither English nor French

17. Do you own or rent your current place of residence?
    - ☐ Own (by you or a member of this household, even if it is still being paid for)
    - ☐ Renting (Rented, even if no cash rent)
    - ☐ Others (please specify) ..............................................
Part III: Traditional, Complementary & Alternative Medicine (CAM)

18. Have you ever used complementary or alternative medical therapies, such as traditional African medicine, traditional Chinese medicine, Ayurvedic medicine, chiropractic, etc.?
   ☐ Yes       ☐ No       ☐ Don’t Know

19. Does the type of traditional medicine or CAM therapy you use relate to your cultural, social or religious background/worldview?
   ☐ Yes       ☐ No       ☐ Don’t Know

20. What type of traditional, complementary or alternative medical therapy(ies) do you use? ..........................................................................................................................

21. How often did you or do you use this treatment/remedy?
   ☐ Very Frequently    ☐ Frequently    ☐ Occasionally    ☐ Rarely
   ☐ Very Rarely       ☐ Don’t Know

22. In the last 12 months, have you used complementary and alternative medical therapies, such as traditional African medicine, traditional Chinese medicine, Ayurvedic medicine, chiropractic, etc.? (if No, please skip questions 22a to 24)
   ☐ Yes       ☐ No       ☐ Don’t Know
   a. If Yes, how did you pay for it?
      ☐ With a Public Health Insurance Plan
      ☐ With a Private health insurance Plan
      ☐ Directly out-of-pocket
      ☐ No payment – Self-mediated
      ☐ Others (please specify) .................................

   b. What type of treatment did you use? .................................................................

23. Who provided the treatment?
   ☐ Licensed practitioner (e.g., medical doctor, chiropractor, etc. please specify)..............................................................
   ☐ Professional Healer – other licensed practitioner (please specify).............................................................................
   ☐ Self-mediated
   ☐ Family Member/Social Relation
24. If given by professional healer other than a licensed practitioner, is the professional healer located in the GTA?
   ☐ Yes ☐ No ☐ Don’t Know ☐ Not Applicable
   a. If no, where did you go for the therapy?
      ☐ In Ontario ☐ In Canada
      ☐ Outside Canada (please specify) ………………………………………..

25. Have you ever travelled outside Canada or returned to Canada with traditional medicines such as herbs, healing oil or balm and supplements from another country (including your country of origin if applicable)?
   ☐ Yes ☐ No ☐ Don’t Know

26. Was the country you visited to obtain the traditional medicines your country of origin (where you moved from to Canada)?
   ☐ Yes ☐ No ☐ Not Applicable

27. How often do you travel outside the GTA to obtain traditional or CAM medicines?
   ☐ Very often ☐ Often ☐ Sometimes ☐ Rarely

28. During the past 12 months, was there ever a time when you felt that you needed a traditional (e.g. traditional African medicine, traditional Chinese medicine and Ayurvedic), a complementary or an alternative medicine (e.g. chiropractic, massage therapy, acupuncture, homeopathy)?
   ☐ Yes ☐ No
   If yes, why didn’t you get the care?
   …………………………………………………………………………………………………………

Part IV: Health Status and Insurance Coverage
29. Are you covered by any provincial health insurance plan (e.g. OHIP)?
   ☐ Yes ☐ No ☐ Don’t Know

30. Do you have additional health coverage for non-physician or hospital-based care?
   ☐ Yes ☐ No ☐ Don’t Know
a. If yes, what type of health coverage is it?
☐ Government-sponsored plan
☐ Work/Employment Sponsored Plan
☐ Private Plan
☐ Other (please specify) ...........................................
☐ Don’t Know

31. In general, how would you say your health is now?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

32. In general, how would you describe your mental health now?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

33. Do you have functional limitations (for example ability to move around and perform daily activities such as bathing, eating, shopping or travel alone)?
☐ Yes ☐ No ☐ Don’t Know

Part V: Transnational, Sociocultural & Communal Ties
34. Do you have family members or friends living outside Canada?
☐ Yes ☐ No

35. How many times have you visited them in the last 12 months? ............

36. Do you send money or material gifts to family and friends outside Canada?
☐ Yes ☐ No ☐ Not Applicable

37. Do you (or your partner) have property in your country of origin?
☐ Yes ☐ No ☐ Not Applicable

38. Are you a member of any social, cultural or community group(s) in the GTA that is made up of people you share similar socio-cultural heritage with (e.g. people of similar cultural or ethnic background)?
☐ Yes ☐ No

a. If yes, please list by name of the groups.
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
39. Are you a member of any social, cultural or community group(s) in the GTA that is made up of people of different socio-cultural background as you (e.g. people of other cultural or ethnic background)?
   ☐ Yes    ☐ No    ☐ Don’t Know

40. How would you describe your sense of belonging to your local community? Would you say it is?
   ☐ Very strong    ☐ Somewhat Strong    ☐ Somewhat Weak
   ☐ Very Weak

Part VI: Chronic and Multimorbid Conditions

41. Do you have any chronic health problem(s)? (if no skip questions 42 – 47)
   ☐ Yes    ☐ No    ☐ Don’t Know

42. How many chronic health problem(s) do you have?........................................

43. What chronic health problem(s) do you have? (list all if possible)
   ................................................................................................................................................
   ................................................................................................................................................
   ................................................................................................................................................
   ................................................................................................................................................
   ................................................................................................................................................
   ................................................................................................................................................

44. Are you currently receiving treatment for this chronic health condition(s) or problem(s)?
   ☐ Yes    ☐ No    ☐ Don’t Know
   
   b. How long have you been on this treatment?..................................................

45. What type of treatment are you using or receiving for chronic condition(s)?..............................................................

46. How satisfied are you with the treatment you are receiving?
   ☐ Highly Satisfied ☐ Satisfied ☐ Somewhat Satisfied ☐ Dissatisfied
   ☐ Highly Dissatisfied ☐ Don’t Know

47. How do you pay for your treatment (check all that are relevant)?
   ☐ Provincial health insurance
   ☐ Private health insurance
   ☐ Worker’s compensation
   ☐ Out-of-pocket
☐ Other (please list) _____________________________________________

48. Do you have any form of disability?  ☐ Yes  ☐ No
   a. If yes, what form(s) of disability do you have? ..............................................

Part V: Access and Use of Allopathic Care (Hospital or Physician Care)

49. Do you have a regular family doctor (physician)?
   ☐ Yes  ☐ No  ☐ Don’t Know

50. Is your family doctor or health care provider of the same cultural background as you?
   ☐ Yes  ☐ No  ☐ Don’t Know

51. Overall, how would you rate the quality of the health care services you receive?
   ☐ Excellent  ☐ Very Good  ☐ Good  ☐ Fair  ☐ Poor

52. Considering your health care needs, how adequate is the services you receive from your physician or hospitals?
   ☐ Highly Adequate  ☐ Adequate  ☐ Somewhat Adequate
   ☐ Inadequate  ☐ Highly Inadequate  ☐ Don’t Know

53. Would you say your health care provider – family physician or regular health care provider is sensitive to your cultural, social or religious views or needs?
   ☐ Yes  ☐ No  ☐ Don’t Know

54. Considering your cultural, social, or religious background, how comfortable are you with the clinic or hospital environment where you receive care frequently?
   ☐ Very Comfortable  ☐ Comfortable
   ☐ Somewhat Comfortable  ☐ Uncomfortable
   ☐ Don’t Know

55. Have you ever felt disrespected, stereotyped or marginalized when you have used hospital or physician-based service in GTA?
   ☐ Yes  ☐ No  ☐ Don’t Know

56. Did you have any challenges or difficulties in your use of health care services in GTA?
   ☐ Yes  ☐ No  ☐ Don’t Know

57. If you answered yes to Question 55 or Question 56, in your own words can you describe how you were disrespected, stereotyped, marginalized and/or the types of challenges or difficulties you experienced?
“Please insert into the attached envelope but do NOT write your address on the envelope”.

Thank you very much for your Participation in this survey
Appendix B

Interview Guide

Interview Guide for the use of Traditional, Complementary and Alternative Medicine in Canada: Ethnocultural and Ageing Perspective (Ph.D.)

Contact Information: Prince M. Amegbor, Department of Geography & Planning, Queen’s University, Mackintosh-Corry Hall, Kingston, Ontario K7L 3N6, (613) 533-2222 (ext. 75736) or (613) 770-8739 e-mail: 11pma4@queensu.ca

Supervisor: Prof. Mark W. Rosenberg, Department of Geography, Queen’s University

Overview and Instruction

This interview deals with your work experience and motivations for using Complementary and Alternative Medicine (including Traditional or Indigenous Medicine). Please remember that the participation is voluntary, and you do not have to answer the questions that make you feel uncomfortable. The interview will begin only after you have had a chance to read and sign the informed consent form and any questions or concerns about the research project have been addressed. The interview will be recorded on an audio device with your consent. Please feel free to stop me if you are uncomfortable with any question.

Interviewer’s Initial:
Informant’s Code:
Interview Date:
Interview Start Time:
Venue of Interview:

Part I: Socio-demographic Information

a. Informant’s age:
b. Informant’s sex:
c. Informant’s marital status and living arrangement:
d. Informant’s level of education
e. Informant’s Country of birth:
f. Informant’s duration of stay in Canada:
g. Informant’s annual household income:
Part II: Identity Construction and Sense of Belonging

a. How would you describe yourself? In terms of social, cultural or ethnic background? Prompt 1: what does it mean to be …….. (insert whatever identity the informant identifies with). Prompt 2: Does it mean anything else?

b. Is there a socio-cultural view or worldview you ascribe to?

c. In your view where do you perceive as your home?

d. In your opinion, what does being healthy mean?

e. Were there occasions where your conception of health did/did not matter in your decision to seek care or treatment? *

Part III: Transitional and Communal Ties

a. Kindly tell me how you came to live in Canada and the GTA specifically? Prompts – were you born in Canada? When did you immigrate to Canada? and how long have been in Canada? Where did you stay when you first arrived in Canada? If you moved to GTA from somewhere else in Canada after immigrating, why did you move to GTA?

b. Did you receive any help or support from relatives/people of a similar cultural origin when you first moved to Canada or Toronto?

c. As a person of immigrant origin living in the GTA, are you active in any country (e.g., name of an association in the GTA) or ethnic (e.g., name of an association) or religious associations (e.g., name of a religious association)? And how would you describe your participation in such associations?

d. Did you receive any help or support from members of the association when you first moved to Canada or Toronto?

e. How would you describe your relationship with your family members in your country of origin? Prompts – Do you communicate with them or visit them often? Do you send money or gifts regularly? Can you depend on them for help or advice in times of need? House ownership in country of origin?

Part IV: Health Status & Care Seeking Behaviour

a. How would you describe your health? Prompt – do you have any health problems or persistent health problems? (presence of chronic conditions)

b. What do you normally do when you are sick or not feeling well?
c. Are there any things you do on regular basis (e.g. medication, diet etc.) to prevent falling sick?

d. How would you describe your experience using health care services in Canada compared to services you used back home? Prompt – quality of service, attitude of health workers, ability of health workers to understand your health care needs

e. Have you ever felt that care or treatment you received for an ailment did not address the problem?

Part V: CAM Use and Ethnocultural Belief

a. Before moving to Canada, did you use any form of medicine or treatment aside from a hospital or clinic? Follow up – Was this form of treatment the usual form of care you sought or used during times of illness? Was this general for a specific health condition or a general use?

b. Do you still use these medicines or treatments? Follow up – if yes where do you get them?

c. You indicated you use traditional medicine or CAM, is this treatment or medicine self-prescribed or was recommended by someone? (Probe as to whether is a professional care or self-care, source of medicine or treatment, and where informant use this medicine – in Canada or outside Canada?)

d. Why do you use this medicine? Prompts – Is it for a specific health condition(s)? was it effective for your health condition or the purpose of use? Is your GP or family doctor aware of this?

e. Do you face any challenges using this form of treatment?

f. Thank you for all the valuable information. Is there anything else you’d like to add before we end?
Appendix C

Letter of Information and Form for Interview (Survey)

Uncharted Paths: Ethnocultural Diversity, Ageing, and the Use of Traditional, Complementary and Alternative Medicine (TCAM) in the Greater Toronto Area (GTA)

Purpose of questionnaire:
More Canadians are using Complementary & Alternative Medicine (CAM), including traditional or indigenous medicines) today for various health needs – both acute and chronic. This questionnaire aims to capture the influence of ethnocultural origin, identity, and ageing in the choice of CAM practices or therapy.

The information gathered from this questionnaire will provide a basis for discussion about the use of CAM therapies in Canada. The data will be evaluated by the researcher – Prince M. Amegbor, a Ph.D. student at Queen’s University, Kingston ON. Prince is the leader investigator on this project, which is being supervised Prof. Mark W. Rosenberg of the department of Geography and Planning, Queen’s University.

How anonymity is protected:
This is an anonymous questionnaire. Please do not include your name anywhere on the questionnaire unless you answer “Yes” to question 66 and/or volunteer to be further interviewed. This questionnaire has been broadly distributed to members in your community or social association, as well as, members of other associations in the Greater Toronto Area. Should you choose to respond, your questionnaire will be one of many received. To help maintain your anonymity, please return the questionnaire in the attached envelope. Please do not write your address on the envelope. Once all questionnaires have been received, responses will be coded for data entry and later analysis. Information from this questionnaire is intended for academic purposes only such as conference presentations, or journal publications and my Ph.D. thesis.

Informed consent:
Participation in this project is voluntary. You are free to answer only the questions that you are comfortable answering. Returning the questionnaire indicates your consent to participate in this research.

Are there any risks? Although the risks are minimal, some questions may be sensitive or may cause discomfort in answering them. Please be reminded that you can skip any questions you wish or stop completing the survey at any time.

Are there any rewards for participating? This is no reward (financial or others) for participating in this research.

What if I have concerns? Any questions about study participation may be directed to Prince M. Amegbor at (613) 770-8739 or by e-mail at 11pma4@queensu.ca. Any ethical concerns about the study may be directed to the Chair of the General Research Ethics Board at chair.GREB@queensu.ca or 613-533-6081.

After filling the questionnaire, please return it in the enclosed envelope
Interview – Form

If you would like to participate in the second phase of this study (interviews) please provide following contact information in the space below. The interview will be done at a time, date and through means that are convenient (either by phone, in-person or by internet) for you. During the interview, I will ask questions about your experience, motivations or barriers to the use complementary or alternative medicine (including Traditional or Indigenous Medicine). Please remember that the participation is voluntary, and you do not have to answer the questions that make you feel uncomfortable. The interview will begin only after you have had a chance to read and sign the informed consent form and any questions or concerns about the research project have been addressed.

Your Name:
Telephone No.:
Email Address (if available):
Appendix D
Letter of Information

Uncharted Paths: Ethnocultural Diversity, Ageing, and the Use of Traditional, Complementary and Alternative Medicine (TCAM) in the Greater Toronto Area (GTA)

Letter of Information

This research is being conducted by Prince M. Amegbor, a student in the Department of Geography & Planning at Queen’s University in Kingston, Ontario. Professor Rosenberg is the supervisor on this study.

What is this study about? The purpose of this research is to explore and examine how ethnocultural ties and ageing influence the choice and use of Complementary and Alternative Medicine (CAM) in the Greater Toronto Area (GTA). As part of this project, I am conducting a research survey and interviews with GTA residents of sub-Saharan African origin, older people and all other persons of 18 years and above. If you volunteer to be interviewed then I will need your consent to digitally record the interview, but I am also prepared to do the interview without a digital recording.

Is my participation voluntary? Yes. Although it be would be greatly appreciated if you would answer all questions as frankly as possible, you should not feel obliged to answer any questions that you find objectionable or that makes you feel uncomfortable. You may end the interview at any time. There will be no consequences to doing so and all information related to the interview up to the point when it ends will be destroyed immediately. Anytime between the completion of the interview and 6 months when de-identified information is incorporated into any written work for dissemination purposes, you can contact me at the telephone number or e-mail address below and request that all information related to the interview including the digital recording of the interview be withdrawn from the study and be destroyed, and it will be done so immediately.

What will happen to my responses? I will keep your responses confidential. Only Prof. Rosenberg and I will have access to this information. Digital records will be saved to encrypted memory devices in the field. The original digital records will be copied to anonymous files with only a record number to identify each copied file. The original encrypted file will then be stored in a locked cabinet and only used again should the anonymous file be damaged or destroyed to create a new anonymous file. Five years after the completion of the project, the original encrypted files will be destroyed. Material from your interview may be published in professional journals or presented at scientific conferences, but any such presentations will be of general findings, any quotes will contain nothing that can identify the person who made the comment and will never breach individual confidentiality. Should you be interested in any written reports, publications or presentations from the study, they will be posted on my research laboratory study website http://geog.queensu.ca/AFC-Project/ where you will be free to download them. If you cannot download electronic content, you can contact me 11pma4@queensu.ca or call me at (613) 533-6000 ext. 75736 and I will send you copies of whatever reports, publications or presentations you request.

Are there any risks? Although the risks are minimal, some questions may be sensitive or may cause discomfort in answering them. Please be reminded that you can refuse to answer any question you wish or stop the interview at any time. If during the interview, you feel upset or
unnerved by any of the questions and you need help, you contact your local community health
centre or Family Service Toronto at 416.595.9618 (for English services) or (416) 595-0307 ext.
269 (for other language services) for free counselling service. You can also seek advice from or
help from these services before, during or after the interview

**What if I have concerns?** Any questions about study participation may be directed to me –
Prince M. Amegbor (613) 770-8739 or by e-mail at 11pma4@queensu.ca. Any ethical concerns
about the study may be directed to the Chair of the General Research Ethics Board at
chair.GREB@queensu.ca or 613-533-6081.

Again, thank you. Your interest in participating in this research study is greatly appreciated.

Prince M. Amegbor, Ph.D. Student
Department of Geography & Planning
Queen’s University
Kingston, Ontario
11pma4@queensu.ca
Appendix E

Consent Form

Uncharted Paths: Ethnocultural Diversity, Ageing, and the Use of Traditional, Complementary and Alternative Medicine (TCAM) in the Greater Toronto Area (GTA) (Ph.D. Research Project)

Interview Consent Form

Name (please print clearly): ________________________________

1. I have read the Letter of Information and have had any questions answered to my satisfaction.

2. I understand that I will be participating in the study called “Uncharted Paths: Ethnocultural Diversity, Ageing, and the Use of Traditional, Complementary and Alternative Medicine (CAM) in the Greater Toronto Area (GTA)” (Ph.D. Research Project) led by Prince M. Amegbor who is the principal investigator. I understand that this means that I will be asked to participate in an interview.

3. I understand that the interview, it will take 15 to 30 minutes.

4. I understand that digital records will be saved to encrypted memory devices in the field. When the interviewers return to the project office, the original digital records will be copied to anonymous files with only a record number to identify each copied file. The original encrypted file will then be stored in a locked cabinet and only used again should the anonymous file be damaged or destroyed to create a new anonymous file. Five years after the completion of the project, the original encrypted files will be destroyed.

5. I understand that my participation in this study is voluntary and I may withdraw at any time.

6. I understand that every effort will be made to maintain the confidentiality of what I say now and in the future. Only Prince M. Amegbor and his supervisor will have access to my interview.

7. I understand between the completion of the interview and 6 months when de-identified information has been incorporated into any written work for dissemination purposes, I can contact Prince M. Amegbor at the telephone number or e-mail address below and request that all information related to the interview including the digital recording of the interview be withdrawn from the study and be destroyed, and it will be done so immediately.

8. I understand any material from my interview may also be published in professional journals or presented at scientific conferences, but any such presentations will be of general findings, any quotes will contain nothing that can identify the person who made the comment and will never breach individual confidentiality. Should you be interested, in any written reports, publications or presentations from the study, they will be posted on the study website http://geog.queensu.ca/AFC-Project/ where I can freely download them. If I cannot download electronic content, I can contact Prince M. Amegbor at 11pma4@queensu.ca or call him on...
(613) 770-8739 ext. 75736 and he will send me copies of whatever reports, publications or presentations you request.

9. I understand that if I have any questions, concerns, or complaints, I may contact Prince M. Amegbor 11pma4@queensu.ca; Prof. Mark W. Rosenberg mark.rosenberg@queensu.ca (the project supervisor); Head of the Department of Geography and Planning (613-533-6030), or the Chair of the General Research Ethics Board at chair.GREB@queensu.ca or 613-533-6081 at Queen’s University.

I have read the above statements and freely consent to participate in the survey and/or to be interviewed (if I indicate as such), I agree that such interview can be audio recorded.

… Yes
… No

Signature: _____________________________________ Date: _______________________

Please retain one copy of the form and return the second copy to the interviewer.
Appendix F
Research Poster

Uncharted Paths: Ethnocultural Diversity, Ageing and the Use of Complementary and Alternative Medicine (CAM) in the Greater Toronto Area (GTA)

By Prince M. Amegbor

More Canadians are using Complementary & Alternative Medicine (CAM), including traditional or indigenous medicines) today for various health needs – both acute and chronic. This research seeks understand the influence of ethnocultural origin, identity, and aging in the choice of CAM practices or therapy

⇒ Are you 18 years and above?

⇒ Do you live in the Greater Toronto Area (GTA)?

If the answer to any of the questions above is Yes and you would like to fill a survey and be interviewed for my Ph.D. research, please contact Prince M. Amegbor:

Phone: 613 770 8739
Email: 11pma4@queensu.ca

The survey questionnaire will take between 10—15 minutes and interviews will take 15—30 minutes

NB: There is no financial benefit or reward for participation in this research

Department of Geography & Planning

Queens University
Appendix G

Ethics Approval Letter

June 29, 2017

Mr. Prince Amegbor
Ph.D. Candidate
Department of Geography and Planning
Queen's University
Kingston, ON, K7L 3N6

GREB Ref #: GGEOL-224-17; TRAQ # 6021232
Title: "GGEOL-224-17 Uncharted Paths: Ethnocultural Diversity, Ageing and the Use of Complementary and Alternative Medicine (CAM) in the Greater Toronto Area (GTA)"

Dear Mr. Amegbor:

The General Research Ethics Board (GREB), by means of a delegated board review, has cleared your proposal entitled "GGEOL-224-17 Uncharted Paths: Ethnocultural Diversity, Ageing and the Use of Complementary and Alternative Medicine (CAM) in the Greater Toronto Area (GTA)" for ethical compliance with the Tri-Council Guidelines (TCPS 2 (2014)) and Queen's ethics policies. In accordance with the Tri-Council Guidelines (Article 6.14) and Standard Operating Procedures (405.001), your project has been cleared for one year. You are reminded of your obligation to submit an annual renewal form prior to the annual renewal due date (access this form at http://www.queensu.ca/trac/sigmon.html; click on "Events"; under "Create New Event" click on "General Research Ethics Board Annual Renewal/Closure Form for Cleared Studies"). Please note that when your research project is completed, you need to submit an Annual Renewal/Closure Form in Romeo/traq indicating that the project is 'completed' so that the file can be closed. This should be submitted at the time of completion; there is no need to wait until the annual renewal due date.

You are reminded of your obligation to advise the GREB of any adverse event(s) that occur during this one year period (access this form at http://www.queensu.ca/trac/sigmon.html; click on "Events"; under "Create New Event" click on "General Research Ethics Board Adverse Event Form"). An adverse event includes, but is not limited to, a complaint, a change or unexpected event that alters the level of risk for the researcher or participants or situation that requires a substantial change in approach to a participant(s). You are also advised that all adverse events must be reported to the GREB within 48 hours.

You are also reminded that all changes that might affect human participants must be cleared by the GREB. For example, you must report changes to the level of risk, applicant characteristics, and implementation of new procedures. To submit an amendment form, access the application by at http://www.queensu.ca/trac/sigmon.html; click on "Events"; under "Create New Event" click on "General Research Ethics Board Request for the Amendment of Approved Studies". Once submitted, these changes will automatically be sent to the Ethics Coordinator, Ms. Gail Irving, at the Office of Research Services for further review and clearance by the GREB or GREB Chair.

On behalf of the General Research Ethics Board, I wish you continued success in your research.

Sincerely,

John D. Freeman
Ph.D.
Chair
General Research Ethics Board

C: Dr. Mark Rosenberg, Supervisor
   Dr. Heather Castleden, Chair, Unit REB
   Ms. Joan Knox, Dept. Admin.