

**STRUCTURAL BARRIERS AND EQUITY CONSIDERATIONS IN SUPPORTING
IMMIGRANT ACCESS TO HEALTHCARE: BUILDING CAPACITY WITH LOCAL
IMMIGRATION PARTNERSHIPS (LIPS) IN ONTARIO**

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PREFACE

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ABSTRACT

Meeting the healthcare needs of immigrants is crucial to ensuring their wellbeing and successful integration. In the late 2000s, Canada deployed a novel approach to settlement governance and coordination by creating Local Immigration Partnerships (LIPs), starting in Ontario. While evidence exists on LIPs' role and capacity in improving settlement services, more research is needed to understand their contributions within the health sector. This thesis aims to advance knowledge of the LIPs' role in facilitating immigrants' access to primary healthcare services. The study relied on a mixed quantitative-qualitative methodology and applied an integrated Social-Ecological Model and Health Equity/Access to Care framework. A scoping review was undertaken to investigate if and how 'non-medical' settlement coordination organizations support access to healthcare services; a quantitative questionnaire was administered to LIPs in Ontario to examine their capacities to support diversity, equity and inclusion considerations in access to healthcare efforts; and a qualitative case study comprised of interviews, a focus group, and a complementary document analysis was undertaken to uncover the experiences of an established Ontario LIP within the health sector. The findings are presented in an article-format thesis. Our scoping review found 10 publications that revealed local settlement coordination organizations support access to primary healthcare services for immigrants at the individual, relationship and community level. Survey findings suggested that 18 of 22 global health competencies were relevant to LIPs; participants had higher confidence in competencies that involved communication skills, leadership, building coalitions, creating opportunities to access local communities and authorities; they, however, had lower confidence in technical tasks such as analyzing policy, planning, implementing and/or evaluating health programs, and creating opportunities to access higher-level decision-makers. Case study results identified four themes outlining areas where the Ottawa LIP supports healthcare access: cross-sectoral coordination and collaboration; advocacy and policy influence; engaging and empowering communities; and building capacity and informing service delivery. Findings demonstrated the challenges around resource constraints, governance and organizational structure, and relationship management. LIPs support access to primary healthcare services by addressing structural barriers and equity challenges. Including LIPs in collaborative actions towards improving equitable healthcare access may provide more scope to respond to healthcare gaps.

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CHAPTER 1: INTRODUCTION

1.1 Overview

Meeting the healthcare needs of newcomer¹ immigrants is recognized as crucial to ensuring their wellbeing and successful integration (Beiser, 2005). In the late 2000s Canada deployed a novel approach to settlement governance and coordination by creating Local Immigration Partnerships (LIPs), starting in the province of Ontario. Since then, LIPs — which function as locally based community councils — have served as a key resource in the development and coordination of settlement services (Esses et al., 2023). While research exists on their role and capacity in improving newcomer settlement services (Veronis, 2019; Walton-Roberts et al., 2019), less is known about their contributions in supporting immigrants' access to primary healthcare services. The main aim of this thesis is to investigate the role of LIPs, which constitute 'non-medical' settlement coordination organizations, in facilitating immigrants' access to primary healthcare services.

Chapter 1 begins with a description of the Canadian healthcare system and general knowledge about immigrant health in Canada. Thereafter, the chapter presents an overview of the settlement model in Canada with specific background on LIPs in Ontario. This is followed by a detailed problem statement and rationale, and the research objectives of this thesis. Discussions on the key theoretical and conceptual frameworks, as well as the thesis methodology are also included. The chapter concludes by outlining the thesis organization.

¹ A nationally agreed upon standard definition of “newcomer” does not exist. The Canada Revenue Agency considers an individual a newcomer to Canada throughout the first year in which they are a resident of Canada (CRA, 2025). Newcomers include individuals who arrived as sponsored refugees.

1.2 Context

1.2.1 The Healthcare System

The Canadian healthcare system is complex. A single national plan does not exist. Instead, Canadians have what is referred to as Medicare: a publicly funded healthcare system in which each province and territory (PT) has its own healthcare insurance plan (Government of Canada, 2023). This system allows for shared roles and responsibilities for healthcare services in Canada. The federal government has overarching responsibilities within the health system, such as providing national standards policies (i.e., setting and administering policies with reference to the Canada Health Act); providing healthcare funding to PTs (e.g., through fiscal transfers such as the Canada Health Transfer) and additional supportive funding; and taking a larger role in the delivery of health care services for certain groups (e.g., for some refugee claimants through the Interim Federal Health Program) (Government of Canada, 2023; Government of Canada, 2024b). Managing and organizing the delivery of healthcare services falls under the purview of PT governments.

In general, this type of publicly funded, privately delivered health system allows Canadian residents to access medically necessary health services without paying out-of-pocket. But it is important to note that each PT may define their own basket of medically necessary services, for healthcare insurance in accordance with the Canada Health Act, and in consultation with their respective professional health professional bodies (Government of Canada, 2023). Some healthcare services are not typically covered under the publicly funded system, although some groups, such as seniors, may receive supplemental coverage; these healthcare services may include ambulatory care, dental care, long-term home care, and vision care.

For most Canadians, engaging with the healthcare system initially happens through contact with primary care services. Primary healthcare services refer to a wide spectrum of comprehensive,

person-centered healthcare services to meet the health needs of Canadians, throughout their lifespan: these include supports for care from diagnosis to recovery, preventive care, end-of-life care, disease management, mental health, health promotion and education activities, and coordination of care across the health system (e.g., movement into and out of specialized care) (Canadian Institute for Health Information, 2024a; Government of Canada, 2023).

Although there are strengths and benefits to the Canadian healthcare system, and it is a source of pride for some, Canadians today face a system with significant challenges. Across the country, the health workforce supply is strained, there is a lack of accessible family doctors, particularly in rural areas, and hospital emergency rooms are overwhelmed with new or returning patients (Health Canada, 2024). Health system planners and decision-makers must account for a changing and growing demand on the system — including due to an aging population and higher population growth related to increased immigration admissions (Immigration, Refugees and Citizenship Canada, 2024; Islam & Gilmour, 2024), while trying to solve issues around patient care coordination and the modernization of health infrastructure and information systems towards secure and efficient sharing of data (Canadian Institute for Health Information, 2024b).

1.2.2 Immigrant Health

In addition to the existing challenges within the healthcare system that can impact the health and healthcare needs of all Canadians, immigrants² encounter a specific set of experiences and difficulties that can further affect their health outcomes. Over time, the health advantages,

² Note, for clarity, the term *immigrant* will follow the Statistics Canada (2023) definition:

Immigrant refers to a person who is, or who has ever been, a landed immigrant or permanent resident. Such a person has been granted the right to live in Canada permanently by immigration authorities. Immigrants who have obtained Canadian citizenship by naturalization are included in this group (Statistics Canada, 2023, paragraph 1).

referred to as the “healthy immigrant effect,” that immigrant populations initially possess (upon arrival) compared to the Canadian born population decline (Vang et al., 2015). Consequently, these groups experience higher rates of chronic conditions such as diabetes, arthritis, and heart disease (McDonald & Kennedy, 2004). Nevertheless, for a number of groups, such as some racialized³ immigrants, those who arrive as refugees⁴ and/or with existing health conditions, the initial “healthy immigrant effect” is not evident (Gushulak et al., 2011; Mental Health Commission of Canada, 2016). It is important to note that the health outcomes of immigrants are shaped by immigration status (e.g., entry class), pre-migration experiences such as trauma and/or discrimination (Beiser, 2005), and post-migration experiences given that resettlement increases the probability of stressors related to unemployment, poverty, and lack of access to services, as recent immigrants tend to have fewer resources to draw upon (Beiser, 2005; Newbold & Danforth, 2003).

Moreover, immigrants are at a disadvantage with regard to structural determinants that influence health outcomes. Socio-economic arrangements, broad political influences, and ethnocultural factors (e.g., lower proficiency in the languages of English or French; lack of basic social support and social capital; inadequate housing, employment, income, cultural dissonance) not only increase the likelihood of exposure to risk factors for disease, but also compromise access to diagnostic services/treatment and quality of care (Beiser, 2005; Pottie et al., 2015; Pottie et al., 2008). Evidence has shown significant health outcome differences between immigrants and native-born Canadians when compared on the basis of income adequacy, working status, home

³ The Canadian Cancer Society (2023) states that racialized communities “refers to people who have racial meanings attributed to them as a group in ways that negatively affect their social, political and economic lives. Race is a social construct that can change over time and place.”

⁴ In Canada, immigrants include resettled refugees who are granted permanent residence status due to a well-founded fear of persecution in their home country. Resettled refugees in Canada are sponsored for a limited time through three main sponsorship programs under the Refugee and Humanitarian Resettlement Program: Government-Assisted Refugees (GARs), Privately-Sponsored Refugees (PSRs); and Blended Visa Office-Referred Refugees (BVORs) (Government of Canada, 2024a).

ownership, gender, and age — immigrant populations typically reported poorer health outcomes than the non-immigrant counterparts (Newbold & Danforth, 2003).

Structural determinants create disadvantages among immigrant populations that strongly shape access to healthcare and ultimately health outcomes (Wiedmeyer et al., 2024). For example, immigrant health research shows that immigrants are less likely to be screened for diseases such as cancer (Howlett et al., 2009) or receive pap tests (Lebrun & Dubay, 2010); and, compared to the native-born population, they are less likely to undergo testing for chronic disease conditions (Lum et al., 2016). A recent scoping review by Tsai & Gharari (2023) on immigrants' experiences accessing healthcare services in Canada demonstrated that the most common barriers include communication (e.g., language proficiency) and cultural and socioeconomic factors. In a literature review, Ahmed et al. (2016) confirmed the above common barriers to access primary care while in addition, identifying issues relating to lack of immigrant knowledge of the healthcare system's complex structure.

1.2.3 Canada's Settlement Model and the Local Immigration Partnership Model

Canada's Settlement Model. Canada's complex settlement 'model' encompasses a variety of services, programs, and actors working at federal, provincial, municipal and local levels to support newcomers' integration into Canadian society. This dynamic system involves a range of stakeholders such as governmental bodies, educational institutions, businesses, Service Provider Organizations (SPOs), healthcare providers and social service providers, community-based organizations, and ethnic and faith-based groups, all contributing to newcomers' adjustment and integration into Canadian communities (City of Ottawa, 2025; Immigration, Refugees and Citizenship Canada, 2025; Praznik & Shields, 2018a).

The delivery of settlement services in Canada is primarily a shared responsibility between federal and provincial/territorial governments (Cockram et al., 2021). Each level of government funds different types of services for diverse newcomer groups (Immigration, Refugees and Citizenship Canada, 2025). The federal government, through Immigration, Refugees and Citizenship Canada (IRCC), administers two notable programs. The first program is IRCC's Settlement Program. Through grants and contributions, the Settlement Program provides both direct and indirect settlement services to address integration barriers and settlement needs of newcomers that meet the eligibility criteria, including permanent residents, protected persons, and some temporary residents (Immigration, Refugees and Citizenship Canada, 2025). The second program, the Resettlement Assistance Program (RAP), supports Government-Assisted Refugees (GARs) and other individuals meeting eligibility criteria, upon arrival by providing them with some financial income and access to funded SPOs that can deliver rapid essential settlement services (Immigration, Refugees and Citizenship Canada, 2021).

Complementing federal efforts, provincial and territorial (PTs) governments fund and deliver additional settlement services specific to local needs and priorities. These may include language training services, labor market integration or employment services, and other integration programs that address PT requirements (PTs have responsibilities in areas such as health, education, and social services) or address gaps in federal-level programming (Cockram et al., 2021; Praznik & Shields, 2018c).

While municipalities in Canada do not have a formal constitutional responsibility in the domains of immigration and settlement, they are crucial in supporting newcomers' successful integration into local communities within their jurisdiction (Praznik & Shields, 2018b). Municipal governments provide targeted resources to address the specific needs of their diverse communities

and neighborhoods. Municipalities are able to coordinate with local school boards, post-secondary training or academic institutions, healthcare facilities, local public health organizations, social housing and public transportation systems, and other localized institutions that offer specialized programs and services to create inclusive environments (City of Ottawa, 2025; Veronis et al., 2024).

Canada's settlement system also includes various community-based organizations. Service Provider Organizations (SPOs) deliver a range of settlement services — both sector-specific and intersectoral collaborative programs—that support newcomers' integration into the socio-cultural, economic, and political aspects of life in Canada (Immigration, Refugees and Citizenship Canada, 2025). These services cover areas such as language training, health assessments, employment assistance, and community connections (City of Ottawa, 2025). Additionally, ethnic and faith-based community groups often provide culturally appropriate supports that complement formal services.

The Local Immigration Partnership Model. Canada's Local Immigration Partnerships (LIPs) are funded under the IRCC Settlement Program as indirect services (Cockram et al., 2021; Walton-Roberts et al., 2019). LIPs emerged in Ontario in 2008 following the signing of the 2005 Canada-Ontario Immigration Agreement (COIA). Developed through a partnership between Citizenship and Immigration Canada and the Ontario Ministry of Citizenship and Immigration (Elmi et al., 2017), LIPs are community-based council planning bodies that are a part of a multi-level governance system (Praznik & Shields, 2018b; Walton-Roberts et al., 2019). Their role is to mobilize, convene and coordinate local actors and services to address newcomer and immigrant needs. LIPs do not provide direct services, although they may do so in rural areas where there are no settlement organizations. LIPs are also active in research and innovation (Walton-Roberts et al.,

2019). They engage with multiple sectors and stakeholders including organizations from the settlement sector, health sector, employers, professional bodies and associations, school boards, ethnocultural groups, faith-based community groups, and government officials from all levels (Citizenship and Immigration Canada, 2013). They are also part of the broader movement of creating “Welcoming Communities,” an initiative to assist with planning communities such that they provide adequate support to assist with the settlement and integration of newcomers and immigrants (Pathways to Prosperity, 2025).

Currently, there are over 80 LIPs in Canada (except for the province of Quebec) (National LIP Secretariat, 2024), the majority of which (35) are in Ontario, the province where they were first implemented (National LIP Secretariat, 2024). The size, governance and organizational structure of LIPs can vary; typically, LIPs are housed within municipalities or community-based organizations (Citizenship and Immigration Canada, 2013). In terms of governance, LIPs can have an executive committee, a leadership committee, and a council committee, with additional subcommittees for strategic support (National LIP Secretariat, 2024). Some LIPs have created working groups or sector tables relating to different aspects or dimensions of immigrant settlement and integration (e.g., services, housing, employment, etc.) that serve to identify needs and gaps, and to coordinate service planning and delivery processes (National LIP Secretariat, 2024).

Although LIPs can vary in their organizational structure and day-to-day activities, there have been efforts to detail promising or best practices of an effective LIP model. According to Elmi et al. (2017) and Long et al. (2016), these practices focus on: governance models and frameworks; the role of research and evaluation; approaches to priority setting; action plan implementation; the process of settlement strategy development with diversity considerations; fundraising and resource acquisition strategies; alignment with the host organization within which

the LIP is housed or with which it is associated; autonomy in decision-making; operational transparency via effective communication; and driving community engagement and ownership of resettlement and welcoming initiatives. While these promising practices have been identified by Elmi et al. (2017) and Long et al. (2016) as broad potential ways to optimize the effectiveness of LIPs, Long et al. (2016) make a point to recognize the range of strengths and diverseness of LIPs across Canada in their ability to tailor their skills and activities to the varying needs of local contexts. Further, LIPs function in environments nuanced by funding and multi-level governance coordination challenges that require a level of skill through which to successfully navigate (Citizenship and Immigration Canada, 2013).

In 2015, LIPs were tested during the mass Syrian refugee resettlement in Canada. The LIPs presence and work proved that they are valuable, even if indirectly involved, in local resettlement efforts (Walton-Roberts et al., 2019). As testament to their diversity, LIPs played different roles in each community to advance Syrian refugee resettlement initiatives. For example, the Hamilton LIP was relied upon by the municipal government to organize and align community-level responses (Dam & Wayland, 2019; Walton-Roberts et al., 2019). The LIP serving Ontario's Waterloo Region took on responsibilities related to the Refugee Resettlement Steering Committee overseeing multiple working groups that worked in collaboration with community partners to assist with Syrian refugee resettlement (Cullen & Walton-Roberts, 2019; Walton-Roberts et al., 2019). The Ottawa LIP (OLIP) coordinated sector-table meetings, by bringing key stakeholders into discussions, where the work sparked the formation of Refugee 613 — a local initiative of partners focused on Syrian refugee resettlement (Veronis, 2019; Walton-Roberts et al., 2019). The resettlement of Syrian refugees was a defining moment for many LIPs during which they were able to successfully demonstrate their unique roles within communities.

During the global outbreak of COVID-19, LIPs such as OLIP played a role in collecting and disseminating pertinent research. OLIP engaged with partners to gather and use disaggregated data, allowing health professionals and academic researchers to identify health disparities in the community and understand the COVID-19 risks that challenged health outcomes for racialized and immigrant groups in Ottawa (OLIP, 2020). The COVID-19 outbreak in 2019 was an opportunity for LIPs to become visible key players in collaborative activities supporting the health and wellbeing of immigrants.

Many of the LIPs have health sector tables, health working groups, or health committees. For example, the Simcoe County Local Immigration Partnership (SCLIP) hosts an Immigrant Health Steering Committee which includes experts and those with an interest in health. Committee members establish work priorities and develop action plans to address identified healthcare gaps (County of Simcoe, 2025). The Toronto North LIP has a dedicated Health and Wellbeing Work Group. This coalition of professionals from the healthcare sector is focused on bridging healthcare service gaps and improving the health of newly arrived immigrants in the community (Toronto North LIP, 2025). OLIP's Health and Wellbeing Sector Table focuses on supporting immigrant health through health-equity enhancing service provision initiatives, health sector capacity-building activities, and knowledge-sharing among stakeholders (OLIP, 2025). These health sector tables, working groups, and committees show that LIPs have an active interest in supporting the health sector with regard to immigrant and newcomer health.

In Canada, Local Immigration Partnerships (LIPs) are federally funded indirect settlement services that support the integration of newcomers. As community-based bodies, LIPs bring stakeholders together to focus on improving a community's capacity to support newcomers. Many

LIPs have created forums for partners and interest-holders to engage with one-another on health and health system challenges.

1.3 Problem Statement and Rationale

Canada relies on immigration for its wellbeing and prosperity. A rapidly aging population and declining birth rates continue to challenge its demographic and economic growth. Immigration is a key strategy for strengthening Canada's labor force and economy (Government of Canada, 2024c). As Canada welcomes large numbers of immigrants, while aiming to align immigration levels with community infrastructure capacity, the importance of meeting the socio-economic and health needs of newcomers is increasingly recognized (Rose & Preston, 2017; Tsai & Gharari, 2023). For example, Canada's 2025-2027 Immigration Levels Plan is informed by interest-holders and communities involved in the settlement and integration of newcomers (Immigration, Refugees and Citizenship Canada, 2024).

Moreover, in the post-COVID-19 pandemic context, there has been a renewed emphasis on ensuring that entire populations, including newcomers and immigrants, can access healthcare services, prompting medical experts to explore intersectoral links between the health sector (e.g., medical institutions, hospitals, community health centres, clinics) and community settlement organizations (Gruner et al., 2022; Tsai & Gharari, 2023). Local non-medical organizations and settlement coordination organizations, which support the integration of newcomers into communities, have the networks to bring together key actors across sectors, and thus are well positioned to facilitate intersectoral collaborations (Bradford & Andrew, 2010; Schmidtke, 2019). There is a clear need for coordinated multi-sectoral action to address health system gaps and inequities in access to healthcare that disadvantage immigrant and newcomer populations. (Kontunen et al., 2014; Papademetriou, 2014; Tsai & Gharari, 2023).

As mentioned, the Local Immigration Partnerships (LIPs) in Canada represent a key resource in the coordination and provision of settlement services for many communities, bringing together all sectors and actors involved in settlement and immigrant-related services in order to help coordinate amongst them (Citizenship and Immigration Canada, 2014; Esses et al., 2023). While non-medical settlement coordination organizations, such as the LIPs, are known to support immigrants' access to primary healthcare services, the specific mechanisms and opportunities through which they achieve this have not been thoroughly investigated or clearly defined. Understanding these mechanisms is crucial for improving, even optimizing the support provided to newcomers and immigrants and ensuring their successful integration into the healthcare system. Existing qualitative research has highlighted various LIPs' competencies, particularly in their core roles and areas such as leadership, community organizing and connecting, mobilizing stakeholders in research and community planning, and coordination of social services (Veronis, 2019; Walton-Roberts et al., 2019). However, there has been little quantitative research to measure and evaluate their competencies and effectiveness within the healthcare sector.

Although existing qualitative research provides valuable insights into how LIPs collaborate with key sector players (Cullen & Walton-Roberts, 2019), there remains significant room for more in-depth examination into the specific experiences and mechanisms through which LIPs connect with the health sector and its key actors. Furthermore, the outcomes of LIPs in facilitating access to healthcare access have not been extensively studied. While some quantitative baseline measurements of community socioeconomic landscapes before the introduction of LIPs exist, these include indicators of accessible and suitable healthcare (Ravanera et al., 2012), significant gaps are left in understanding the full impact of LIPs.

Thus, a more detailed examination of the LIPs and their relevance within the health sector is needed. Addressing these knowledge gaps will help to better establish the roles, capacity, and achievements of settlement coordination organizations, such as the LIPs, in supporting immigrants' access to primary healthcare services.

1.4 Research Objectives and Questions

The aim of this study is to investigate how the Local Immigration Partnerships (LIPs) in Ontario facilitate and contribute to the inclusion of immigrant equity considerations within the local health system, particularly in terms of healthcare access. Specifically, this thesis addresses the following three research objectives and questions:

1. To identify the ways in which LIPs and settlement organizations engage with the health system and key health sector agencies to enhance healthcare access for immigrant populations.

Corresponding research question: How do settlement coordination organizations, such as the LIPs, engage with the health sector to improve access to healthcare for immigrants?

2. To assess and establish the cross-cultural global health competencies of LIPs aimed at supporting and operating within the healthcare sector.

Corresponding research question: What cross-cultural global health competencies are needed for LIPs to support and operate within the healthcare sector?

3. To examine the experiences and achievements of the Ottawa LIP (OLIP), within the health system, in terms of facilitating and supporting immigrants' access to healthcare.

Corresponding research question: What are the experiences and accomplishments of a LIP in Ontario in terms of facilitating and supporting immigrants' access to healthcare?

1.5 Theoretical and Conceptual Frameworks

This thesis draws on existing theories to develop a conceptual framework. By incorporating the Social-Ecological Model and Health Equity/Access to Care theories, the research, analysis, and outcomes of this thesis are situated within the broader context through the Social-Ecological Model and interpreted with a focused perspective on health equity and inequities in access to care.

1.5.1 Theoretical Framework: Social-Ecological Model

The Social-Ecological Model (SEM), introduced in the 1970s by Urie Bronfenbrenner (Bronfenbrenner, 1977) and continually revised (McLeroy et al., 1988), takes a systems-based approach to understanding health. This model examines how environmental characteristics influence individual health (McLeroy et al., 1988) and describes multiple levels of influence, or enabling environments, including intrapersonal, interpersonal, organizational, community, and societal/policy systems (Harper et al., 2018). Through this model, risk factors can be addressed, prevention strategies can be implemented, and barriers to healthcare access can be conceptualized (Valentin et al., 2023). Researchers have emphasized that a multilevel approach to primary care access and utilization is more effective than a single intervention (Harper et al., 2018; Litchfield et al., 2021).

Recently, Lin (2022) explored the connection between the Social-Ecological Model, the WHO's Social Determinants of Health paradigm (WHO, 2010), and Andersen's Behavioral Model of Health Service Use (Andersen, 1995). Lin's integrated, multi-level socioecological framework addresses social stratification and power imbalances, individual characteristics, and enabling resources. This framework serves to underscore the complexities of access to healthcare, highlighting the interplay between individual-level factors and the multi-level environmental influences (Lin, 2022).

1.5.2 Health Equity and Access to Care

Health equity entails the elimination of avoidable, unfair, and unjust disparities among different populations (WHO, 2024). Viewing health through the lens of equity emphasizes that it is a fundamental human right. The World Health Organization (WHO, 2024) states:

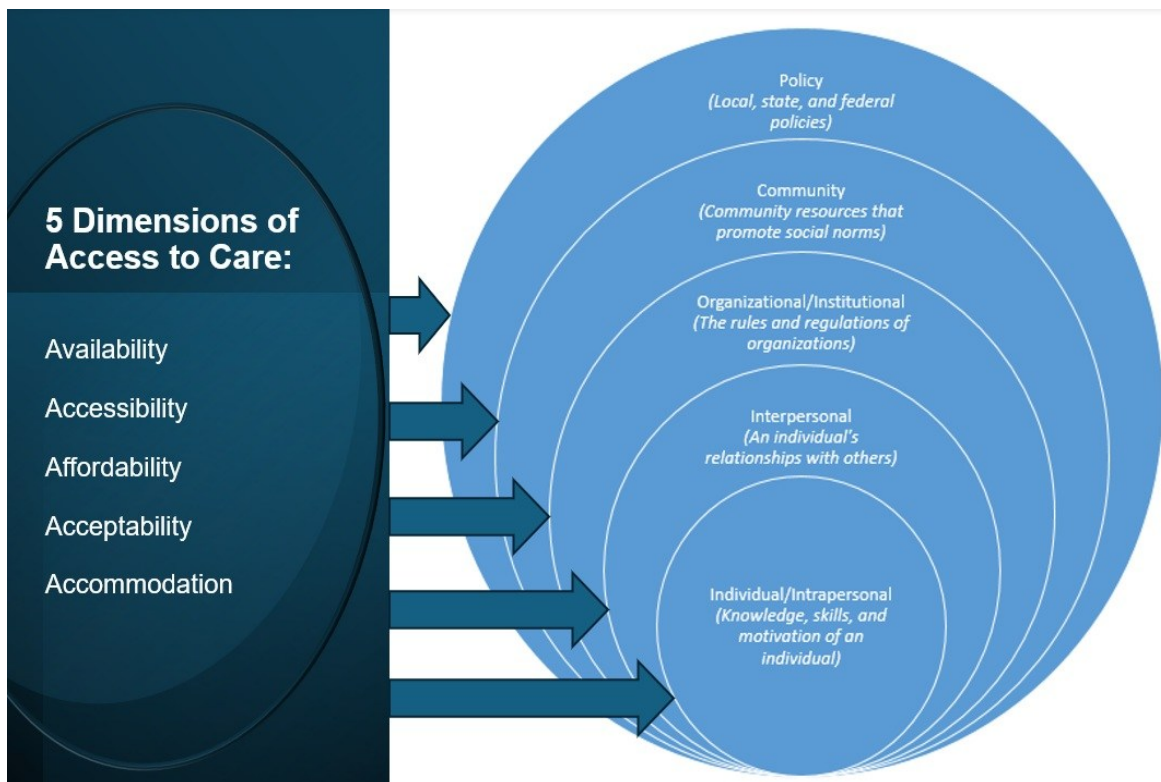
Health equity is achieved when everyone can attain their full potential for health and wellbeing. Health and health equity are determined by the conditions in which people are born, grow, live, work, play and age, as well as biological determinants. Structural determinants (political, legal, and economic) with social norms and institutional processes shape the distribution of power and resources determined by the conditions in which people are born, grow, live, work, play and age.

The concept of healthcare access is multi-dimensional. First, it involves service availability, which means having an adequate supply of healthcare services when needed by individuals or populations. This can refer to the time it takes for a client to meet a doctor or, from a health professional's perspective, having the technology, equipment and personnel to meet the patient's needs (Bowen, 2000; Gulliford et al., 2002). If services are available, gaining access to them requires the right "fit" between the individual and healthcare system, while also addressing barriers that impede access (Gulliford et al., 2002). Therefore, healthcare access further includes several dimensions: accessibility (i.e., the geographic location of the service); affordability (i.e., client's ability to pay and the reasonableness of the price); acceptability (i.e., the provision of culturally-appropriate services); and accommodation (i.e., the ease with which clients can receive services, such as the availability of an interpreter for those having difficulty communicating in English) (Durkin, 2019; Jacobs et al., 2012).

By applying the SEM to meet the thesis’s research objectives, I am able to elicit a more nuanced understanding of LIPs supporting access to healthcare with regard to the SEM’s multiple levels of influence and highlight the importance of broader social and environmental factors that impede or allow LIPs to engage with the health sector. Likewise, the access to care framework is a foundation for this research to draw on to better untangle the challenges and examine the experiences and successes of LIPs in supporting immigrant access to healthcare. The concept of healthcare access and its components provide a lens to assess LIP competencies relevant to supporting the inclusion of immigrant equity considerations in health. Figure 1 shows the adaptation and integration of the Social-Ecological Model (SEM) (Bronfenbrenner, 1977) with the access to healthcare concept (Gulliford et al., 2002).

Figure 1

The Social-Ecological Model with Access to Care at Each Level



Source: SEM image is from Seeds of Hope (2025).

1.6 Methodological Approach

This thesis aims to advance knowledge of the LIPs' role in facilitating immigrants' access to primary healthcare services. The study relied on a mixed quantitative-qualitative methodology. A scoping review (Chapter 2) was first completed to investigate if and how settlement coordination organizations support access to healthcare services (see corresponding research objective 1). This scoping review identified and mapped the types and characteristics of approaches and interventions that immigrant settlement organizations undertake to support access to primary healthcare for clients. Ten publications were found by searching relevant databases; extracted data and research findings were mapped onto a template using the Social-Ecological Model framework. The scoping review findings highlighted the importance of a settlement organization's capacity to engage with health sector actors at various SEM levels of influence.

Informed by the scoping review, we then developed a cross-cultural global health quantitative questionnaire with the help of LIP advisors (Chapter 3). The questionnaires were administered to LIPs in Ontario to examine their capacities to support diversity, equity and inclusion considerations in access to healthcare efforts (see corresponding research objective 2). Ontario was selected because LIPs were first developed in this province and it has the largest number of LIPs. Data from 28 participating LIPs was analyzed using SPSS software. Survey findings established core cross-cultural global health competencies for settlement coordination organizations working with partners in the health space to support newcomers and immigrants towards health equity and access to healthcare.

The third and final research project, a qualitative case study (Chapter 4) involving interviews, a focus group, and a complementary document analysis, aimed to uncover the experiences of an established Ontario LIP within the health sector (see corresponding research

objective 3). The Ottawa LIP (OLIP) was chosen for this case study based on pre-developed selection criteria (e.g., factors included network size, time since establishment, existing health table). Data from the interviews, focus group and complementary document analysis were assessed using a thematic approach. Initial predetermined codes were informed by dimensions of access to healthcare. Data triangulation was conducted by searching for convergences and divergences among the three data sources and categorizing them to form themes based on their commonalities, characteristics, and complementary aspects. Emerging themes were mapped on the SEM. We identified four themes that show OLIP's supports and influence on factors around access to healthcare for immigrants through their efforts at the intrapersonal, interpersonal/relationship, community, institutional/organizational, and the broader society/policy levels. Together, the three research designs — a scoping review, a survey, and a case study — formed a comprehensive approach to provide complementary perspectives towards a coherent and integrated whole narrative on the engagement and capacity of LIPs in the health sector with respect to supporting access to healthcare for immigrants.

1.7 Thesis Organization

This is an article-based thesis, comprising three articles that address each of my research objectives respectively. It is organized as follows:

Chapter 2 addresses the first research objective relating to the identification of ways in which LIPs and settlement organizations engage with the health system and key health sector agencies. The chapter presents the findings of a scoping review that aimed to identify and map the types and characteristics of approaches and interventions that settlement organizations undertake to support immigrants' access to primary healthcare. A total of 10 articles were found and reviewed. Framework analysis, informed by the SEM, was used to map extracted data. The research findings

from this study suggest that settlement organizations support access to primary healthcare services, often at the individual, relationship, and community level. This study contributes to academic literature by expanding our understanding and awareness of how settlement organizations engage with the health sector. We also demonstrate the use of the SEM as an approach to inform framework analysis. Based on these findings, we then aimed to uncover the competencies that underpin settlement organizations' abilities to engage with the health sector.

Chapter 3 addresses the second research objective on assessing the cross-cultural global health competencies of LIPs. This chapter presents a quantitative study aiming to identify and establish cross-cultural global health competencies relevant to Local Immigrant Partnerships (LIPs) in Ontario. We developed, piloted and tested the validity and reliability of a structured, self-administered, quantitative questionnaire used to survey the cross-cultural global health competencies of LIPs in Ontario. Data was analyzed using SPSS software. In total, 28 LIPs across Ontario participated in the study. The results reveal that principles such as equity, diversity, and inclusion are integrated in the development and pilot testing of a global health competencies capacity-building tool for these settlement coordination organizations. This study gives LIPs in Ontario a tool to understand relevant cross-cultural global health competencies for their work within the health sector. Further, it allows them to assess their strengths and identify skill and knowledge gaps. Similar settlement coordination organizations may choose to adapt this tool or use it as a foundation to build their own cross-cultural global health competency instrument.

The focus of Chapter 4 is on the third thesis research objective: to examine the experiences and achievements of the Ottawa LIP (OLIP), within the healthcare system, in terms of facilitating and supporting newcomers' and immigrants' access to healthcare. This chapter presents a qualitative case study based on interviews, a focus group, and complementary document analysis.

It examines the experiences and impacts of a LIP in Ontario, focusing on its engagement with the health sector to support immigrants' access to healthcare. The analysis focuses on the perspectives of LIP partners, associates, and internal members to inform the research. The SEM was used to organize and guide the thematic analysis. The findings suggest that OLIP was successful in engaging and collaborating with health sector actors. Moreover, study findings provide insights that can be used by partner's and other health sector actors in Ottawa (e.g., professional associations, community health centres, hospitals) to know how best to effectively and meaningfully engage and collaborate with this settlement coordination organization.

Together, these three chapters provide complementary perspectives that form a cohesive narrative. The research findings first demonstrate whether and how settlement organizations are working within the health sector. Recognizing the important role of capacity in enabling effective engagement, the study then identifies the cross-cultural global health competencies that LIPs require within the health sector. It concludes with a detailed examination of a specific LIP's experiences, achievements, challenges, barriers, and lessons learned regarding their engagement with the local health system.

From a conceptual perspective, the study demonstrates adequacy of the SEM to identify LIPs' levels of influence on immigrant health and diverse barriers and facilitators within the health system. From a public health and healthy equity perspective, the study demonstrates the strengths (and challenges) of LIPs within the complex health system. LIPs advance and improve immigrants' access to healthcare while championing principles of diversity, equity, and inclusion in their work. LIPs also have a key role, and are well-placed, to connect the health sector with other sectors of newcomer and immigrant settlement and integration.

Chapter 5 synthesizes the results of the three studies (chapters/papers) and provides an overall discussion. It concludes with a comprehensive examination of the thesis' contributions to knowledge and the findings' implications for research and practice in the fields of immigrant health and health equity and offers recommendations for future research.

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CHAPTER 2: ARTICLE 1

2.1 Article Overview

Article Title

How Are Non-Medical Settlement Service Organizations Supporting Access to Healthcare and Mental Health Services for Immigrants: A Scoping Review

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Conflicts of Interest

The authors declare no conflict of interest.

2.2 Abstract

Following resettlement in high-income countries, many immigrants and refugees experience barriers to accessing primary healthcare. Local non-medical settlement organizations, such as the Local Immigration Partnerships in Canada, that support immigrant integration, may also support access to mental health and healthcare services for immigrant populations. This scoping review aims to identify and map the types and characteristics of approaches and interventions that immigrant settlement organizations undertake to support access to primary healthcare for clients. We systematically searched MEDLINE, Social Services Abstracts, CINAHL, and PsycInfo databases from 1 May 2013 to 31 May 2021 and mapped research findings using the Social-Ecological Model. The search identified 3299 citations; 10 studies met all inclusion criteria. Results suggest these organizations support access to primary healthcare services, often at the individual, relationship and community level, by collaborating with health sector partners in the community, connecting clients to health services and service providers, advocating for immigrant health, providing educational programming, and initiating community development/mobilization and advocacy activities. Further research is needed to better understand the impact of local non-medical immigrant settlement organizations involved in healthcare planning and service delivery on reducing barriers to access in order for primary care services to reach marginalized, high-need immigrant populations.

Keywords

Immigrants; refugees; primary healthcare access; settlement service organizations; health equity.

2.3 Introduction

Given the growing numbers of culturally and linguistically diverse newcomers settling in Canada annually, pressure is being placed on provincial and federal governments to involve local non-medical immigrant settlement organizations in the development of accessible equitable healthcare and welfare services to meet the complex needs of expanding marginalized populations such as immigrants and refugees [1,2]. Asylum seekers also often have significant healthcare needs, due to premigration and post-migration experiences, yet tend to have low participation in primary healthcare systems [3,4]. Further, there is a growing need to support migrants' access to mental health services, as research has shown that they are at a higher risk for mental health problems compared to the general population but are less likely to seek care [5].

The focus on access to quality primary healthcare services is important, since these populations may be vulnerable and often experience considerable barriers to accessing quality primary healthcare, including limited English language proficiency, culturally inappropriate care and varying health beliefs, transportation difficulties, a general lack of social support, health system and health literacy issues, and high service costs [2,6–9]. Additionally, many health professionals report increased complexity on their end when serving migrant and refugee clients, relating to factors such as language interpretation difficulties, social determinants of health that require a multi-sector response, as well as difficulties for clients in understanding various health service entitlements [10]. Since the COVID-19 pandemic reduced community settlement services, primary care practitioners reported a corresponding reduction in access to primary healthcare for refugees and newcomers [11].

Local non-medical immigrant settlement organizations that support immigrant integration can facilitate collaborative efforts to increase access to mental health and healthcare services for immigrants. They can also support information sharing by acting as a platform to connect various actors horizontally across sectors and vertically within sectors. These partnerships create a social space where civil society, businesses, private-sector stakeholders, local municipalities, and other stakeholders can discuss priority issues [12]. Variations of local immigrant settlement organizations and partnerships can be found globally; for example, the Strategic Migration Partnership in London, Local Immigration Partnerships (LIPs) in Canada, and the Mayor’s Offices for Immigrant Affairs in Chicago, are a few well-established groups [12]. In Canada, LIPs play an essential role in immigrant settlement and integration [13,14]. Led by municipal or regional governments, or community organizations, LIPs are broad, cross-sectoral convening bodies that integrate newcomer needs into a city’s community planning [13]. The LIPs play a central role in supporting immigrant populations by increasing local stakeholders’ engagement in newcomers’ integration processes, supporting community-level research and planning, and improving service coordination [15].

There has been some mixed-methods research, conducted with providers, refugees and interpreters, to gain insight into how these non-medical immigrant settlement organizations collaborate with the health sector [16]; however, to the best of our knowledge, the ways and opportunities through which these non-medical immigrant settlement organizations are supporting immigrants’ access to mental health and other healthcare services have not been thoroughly examined or defined [17]. We aimed to address this knowledge gap by establishing how these “untapped resource” organizations contribute to improving immigrant access to primary health care services to create more health-enhancing environments for communities and marginalized

populations. To guide our review, we asked the following research question: How do non-medical, local immigrant settlement organizations support access to healthcare services (i.e., primary healthcare services and/or specialized healthcare services) for immigrant populations in high-income countries? Our objectives were to identify and to map the types of approaches and interventions that non-medical immigrant settlement organizations use to support primary care access for immigrants. To inform our analysis and mapping approach, we adopted the Social-Ecological Model [18].

2.4 Materials and Methods

2.4.1 Protocol

We developed a protocol for this scoping review using Arksey and O'Malley's 2005 five-stage methodological framework [19], and refined stage 5 as per recommendations made by the Joana Briggs Institute [20]. This scoping review included the following five key stages: (1) identifying the research question; (2) identifying relevant studies; (3) study selection; (4) charting the data; and (5) collating, summarizing, and reporting the results. To map and organize our data, we used an Excel data extraction sheet informed by the Social-Ecological Model [18]. To report our findings, we replaced Arksey and O'Malley's approach with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Scoping Review (PRISMA-ScR) checklist (see File S1 in Supplementary Materials 1: PRISMA-ScR Checklist) [21]. The final version of the protocol is available upon request.

2.4.2. Data Sources and Search Strategy

In consultation with an expert health sciences librarian (LS), we developed a strategy to systematically search — using keywords, MeSH terms, major subject headings and/or the thesaurus functions — the following four electronic databases from 1 May 2013 to 31 May 2021:

MEDLINE, Social Services Abstracts, PsycInfo, and Cumulative Index to Nursing and Allied Health Literature (CINAHL). An expert social sciences research librarian (PL) reviewed our social services abstracts search strategy, which consisted of terms such as refugee, immigrant, asylum seeker, local, community, partnership, organization, collaboration, primary healthcare, clinical care, health services accessibility, mental health services, Canada, United States, and Australia; the search terms were combined using Boolean operators (see File S2 in Supplementary Materials 2: Search Strategies for all Databases). Moreover, the search query was tailored to the specific requirements of each database. Lastly, we scanned references of the included articles for any relevant studies.

2.4.3 Eligibility Criteria

We included articles that met the following criteria: (1) included refugee, asylum seeker, or immigrant populations; (2) described local non-medical immigrant settlement-type organizations that support immigrant access to primary or clinical healthcare services; and (3) were conducted in industrialized countries with demographic, economic, political, and social characteristics comparable to those of Canada, and that are ranked on healthcare system performance by the Commonwealth Fund (see Table 1 for full inclusion criteria) [22]. Moreover, we used the United Nations High Commissioner for Refugees (UNHCR) definitions for asylum seekers and refugees as criteria for paper inclusion, while relying on Statistics Canada's definition for the term immigrant [23–25]. Specifically, we included studies that focused on refugees, asylum seekers, and immigrants 16 years of age and older; those that examined populations of any other age were excluded due to methodological challenges around the design, conduct and reporting of pediatric systematic reviews. For feasibility reasons, studies on undocumented migrants, transient migrant workers, foreign temporary workers, and foreign students were excluded. Organizations

that did not conduct settlement-type work for immigrant populations, were not local, or were medical organizations were excluded. Lastly, countries that were not ranked by the Commonwealth Fund on healthcare system performance were excluded [22].

Table 1

Selection Criteria for Studies Included in the Review.

Inclusion Criteria	Description	Exclusion Criteria
Population	Asylum seeker (16 years and older) “Someone whose request for sanctuary has yet to be processed” [23].	All populations other than immigrants, refugees and asylum seekers of all ages. Exclude for feasibility reasons the following: undocumented migrants, transient migrant workers, foreign temporary workers, and foreign students.
	Refugee (16 years and older) “Someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion” [24].	
	Immigrant (16 years and older) “Immigrant refers to a person who is, or who has ever been, a landed immigrant or permanent resident. Such a person has been granted the right to live in Canada permanently by immigration authorities. Immigrants who have obtained Canadian citizenship by naturalization are included in this group.” [25].	
Intervention/Phenomena of Interest	Non-medical (nonclinical) local immigrant settlement organizations that support immigrant population’s access to healthcare services (i.e., health caring being primary healthcare or clinical care services)	All other organizations
Context	Industrialized countries with demographics and/or country characteristics comparable to Canada that are ranked on healthcare system performance by the Commonwealth Fund: Australia, Canada, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland, UK, USA [22, 26].	All other countries
Research Type	Research publications (methods, data and analysis) quantitative, qualitative, or mixed-method documents published in peer-reviewed	Exclude literature reviews, grey literature
Year of Publication	Last 8 years (since March 2013)	Prior to the last 8 years
Language of Publication	All languages	No exclusion

Due to resource constraints, we applied restrictions to select articles that were most relevant. Literature reviews were excluded since, by nature, they are not primary data research publications; gray literature was excluded because the diverse formats and audiences of these texts can present a significant challenge in a systematic search for peer-reviewed evidence. We also excluded studies that were published prior to the last 8 years after reviewing Waleed M. Sweileh et al.'s 2018 paper “Bibliometric analysis of global migration health research in peer-reviewed literature (2000–2016)” in BMC Public Health, since it analyzed peer-reviewed literature in global migration health published worldwide [27]. Based on two key findings from the Bibliometrics, we applied the assumption that much of the global migration health research performed from 2014 onwards has taken into consideration prior research in earlier years; these key findings are as follows: the Bibliometrics’ Figure 1 analysis demonstrates an up-tick in global migration health publications from 2014–2016 (approximately one third of the retrieved documents in the analysis were published in the last 3 years of the study); and the Bibliometric reference list includes publications that focused on access to healthcare services and community organization support for migrants that were published between 2015–2017 — for example, Taylor J.’s 2017 systematic review of social determinants of health on access to healthcare [28]. Therefore, since this “explosion” of migrant access to healthcare research occurs around 2014, we decided to limit our study’s search to publications from 2013 and onwards.

2.4.4 Study Selection Process

Search results were imported into COVIDENCE, an online systematic review software [29]. The inclusion criteria were used for screening titles and abstracts during level 1 screening and reviewing full-text articles during level 2 screening. Two reviewers (AR and SS) independently screened the title and abstract of each article for inclusion. Reviewers connected

with one another throughout the screening process to resolve conflicts and discuss any uncertainties that arose during the selection process. All articles deemed relevant after title and abstract screening were included for full-text screening. Using the same process, the two reviewers (AR and SS) subsequently screened the full text of potentially relevant articles to determine eligibility. Disagreements were resolved through discussion between the two reviewers. Once agreement was reached, the full-text articles chosen for inclusion in the study were reviewed for data extraction.

2.4.5 Data Extraction

A standardized data extraction template, informed by framework analysis using the Social-Ecological Model, was developed with input from the entire review team [18]. We chose the Social-Ecological Model because it is a commonly used population health framework to conceptualize health broadly, taking into consideration that health is affected by dynamic interactions among various personal and environmental factors [18]. At minimum, results for our study were extracted as they applied to the framework analysis (individual level, relationship level, community level, societal level) and study criteria. For all of the articles included in the final analysis, data were extracted on the following variables: (1) author and year of publication, (2) source origin (i.e., country where the study took place), (3) aim/purpose of the study, (4) list of organizations that participated in the study, (5) study population/sample size/study participant description (i.e., participant characteristics), (6) methodology, (7) intervention type, (8) concepts or phenomena of interest, (9) outcomes measured, and (10) key findings/author conclusions/implications. In order to ensure the validity of the data extraction form, it was piloted by two reviewers (SS and SB), and accuracy of the content was reviewed by a third reviewer (AR). For all articles, two reviewers extracted data in duplicate and independently (SS and SB). Results

were compared and disagreements were resolved by discussion or with help from a third reviewer (AR) (see File S3 in Supplementary Materials 3: Data Extraction Sheet).

2.4.6 Methodological Quality Appraisal

We did not appraise the methodological quality or risk of bias of the included articles, which is consistent with guidance on scoping review conduct [20]. As a scoping review, the purpose of this study was to aggregate the findings and present a mapping of the research rather than to evaluate the quality of the individual studies [19]. Therefore, a critical appraisal of the methods for the strength of the evidence was not performed.

2.4.7 Data Mapping and Synthesis

As Carroll et al., 2013 recommended, we used a framework analysis method to structure our results [30]. Specifically, the theoretical Social-Ecological Model was applied to map and group findings into themes and identify and explain outliers [18]. Results are presented in a table summarizing the characteristics of included studies with narrative descriptions. We discuss the application of findings to the broader context and discussion on non-medical immigrant settlement organizations supporting access to healthcare service and provide conclusions/implications for policy research and practice. We also identify and discuss strengths and limitations of the scoping review.

2.5 Results

2.5.1 Literature Search

A total of 3299 records were identified through database searching. After removal of duplicate citations, 1799 records were screened by title and abstract. Title abstract screening resulted in the exclusion of 1760 records, leaving 39 potentially relevant full-text articles that were sought for retrieval and assessed for eligibility using the inclusion criteria. Figure 1 presents the

details of the search process. From these, 29 full-text articles were further excluded due to relevance to setting, irrelevant intervention or wrong population. The remaining 10 articles were included in this review: Chadwick and Collins, 2015 (study 1) [31]; Cheng et al., 2019 (study 2) [32]; Frost et al., 2018 (study 3) [33]; Isaacs et al., 2013 (study 4) [34]; Isaacs et al., 2013 (study 5) [35]; Koehn et al., 2019 (study 6) [36]; McMurray et al., 2014 (study 7) [37]; Salami et al., 2019 (study 8) [38]; Torres et al., 2013 (study 9) [39]; and Torres et al., 2014 (study 10) [7]. Characteristics of included studies are summarized in Table 2.

Figure 1

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses Study Flow Diagram

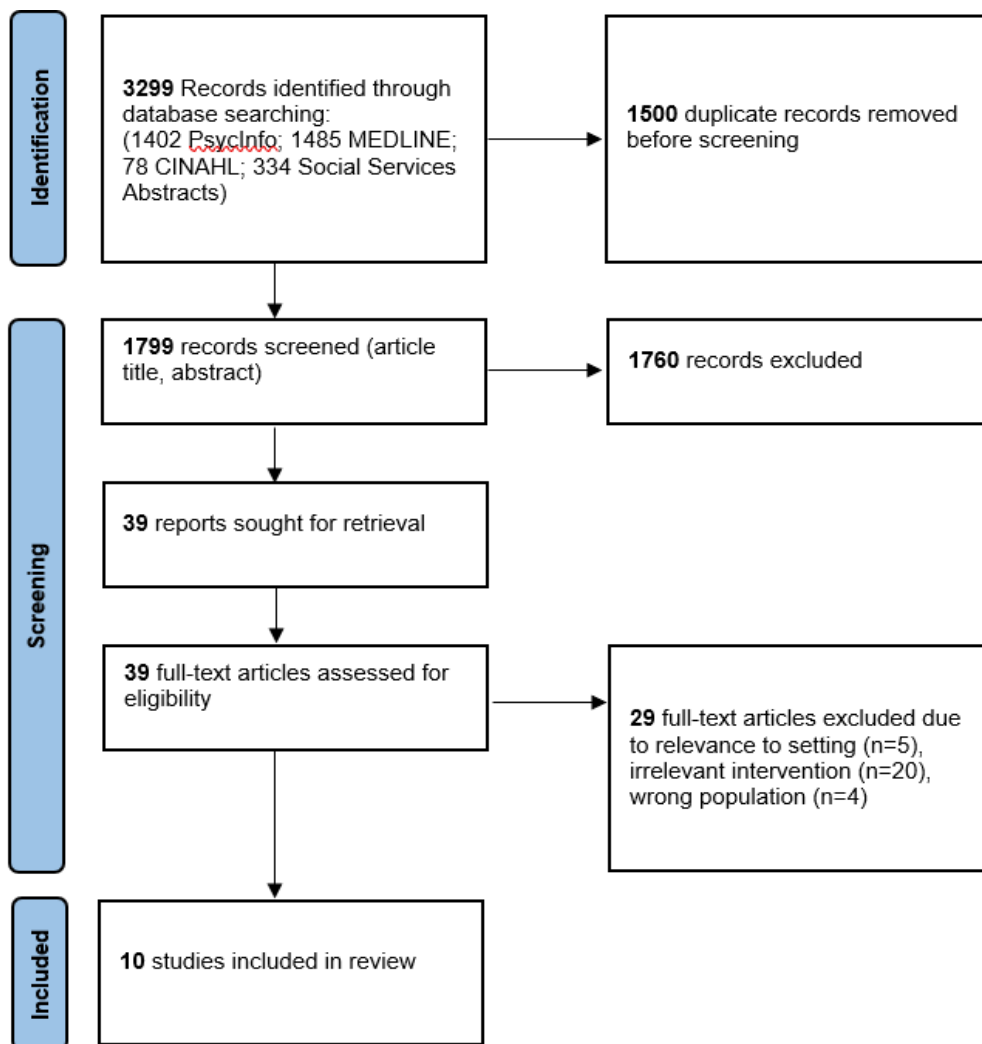


Table 2*Characteristics of Selected Studies.*

Study #	Authors/Year	Source Origin	Study Design	Local Non-Medical Settlement Organization	Study Population	Outcome: Approach to support access to primary healthcare services for immigrants	Social-Ecological Model Level
1	Chadwick et al., 2015	Canada	quantitative survey analysis; qualitative interviews	settlement service organizations	recent immigrants in large or small urban centers	connects to healthcare services/collaborates with health sector institutions (via resources to services such as appointment accompaniment and referrals to external community service providers, delivery of group programs)	Individual, relationship, community
2	Cheng et al., 2019	Australia	community-based intervention development	local settlement support agencies	asylum seekers newly released from detention in South Eastern Melbourne	connects to healthcare services/collaborates with health sector institutions (via the development of the asylum integrated healthcare pathway)	relationship, community
3	Frost et al., 2018	United States	exploratory, post hoc, single-group only research design with interviews	local refugee resettlement agency	Burmese-speaking refugee women in Houston Texas	provides health promotion programs (via health education program)	individual
4	Isaacs et al., 2013a	Canada	qualitative case study includes survey and interviews	community-based organization	recent immigrant families in an urban center in Atlantic Canada	connects to healthcare services/collaborates with health sector institutions (via role as broker organization)	community
5	Issacs et al., 2013b	Canada	qualitative case study includes surveys and interviews	community-based organization	recent immigrants and/or families in an urban community in Atlantic Canada	connects to healthcare services/collaborates with health sector institutions (via cultural competence trust with network)	relationship
6	Koehn et al., 2019	Canada	qualitative case study includes	immigrant-serving agencies	Punjabi and Korean -	connects to healthcare services/collaborates with health sector	relationship

			focus groups and interviews		speaking older immigrants	institutions (via capacity to connect with services and provide culturally responsive health information and navigational support)	
7	McMurray et al., 2014	Canada	before/after repeated survey design	local receiving center	government assisted refugees (primarily coming from Northwest Africa, the Middle East, and Southeast Asia) in Ontario	connects to healthcare services/collaborates with health sector institutions (via partnership between a dedicated health clinic, a local reception center, and community providers)	individual, relationship, community
8	Salami et al., 2019	Canada	qualitative descriptive design includes interviews, focus groups	immigrant serving agencies	immigrants, refugees in Alberta	connects to healthcare services/collaborates with health sector institutions (by identifying client needs, referring clients to specialized mental health services)	individual
9	Torres et al., 2013	Canada	qualitative and quantitative case study includes direct observation, interviews, document & database analysis	community-based organization	at-risk immigrant and refugee women and their families in Edmonton	provides health promotion programs (e.g., perinatal program intervention through innovative Multicultural Health Brokers Co-op); undertakes community capacity building and policy advocacy activities (e.g., perinatal program intervention through innovative Multicultural Health Brokers Co-op)	Individual, relationship, community, society
10	Torres et al., 2014	Canada	qualitative and quantitative case study includes direct observation, interviews, document & database analysis	community-based organization	new immigrants, refugees, and their families in Edmonton	connects to healthcare services/collaborates with health sector institutions (via role as cultural health broker through innovative Multicultural Health Brokers Co-op); provides health promotion programs (via educational outreach on disease management through innovative Multicultural Health Brokers Co-op); provides ‘on the ground’ assistance to clients (e.g., transport to clinics, accompanies clients to doctors)	individual, relationship, community

appointments when language difficulties
are present)

Note: Studies 4 and 5 derive from the same research and research team but have different objectives. Studies 9
and 10 derive from the same research but also have different objectives.

2.5.2 Study Characteristics

Of the 10 articles, eight were carried out in Canada (study 1, 4–10), one was in the USA (study 3), and one was in Australia (study 2). Three studies were published in 2019 (study 2, 6, 8), one in 2018 (study 3), one in 2015 (study 1), two in 2014 (study 7, 10), and three in 2013 (study 4, 5, 9). Study designs included qualitative interviews (study 1, 3–6, 8–10), qualitative surveys (study 4, 5), quantitative survey analysis (study 1), intervention development/piloting (study 2), before/after repeated survey design (study 7), focus groups (study 6, 8), and other research methods such as direct observation, document/database analysis (study 9, 10). Local non-medical immigrant settlement organizations in the 10 studies were described as settlement service organizations (study 1), local settlement support agencies (study 2), local refugee resettlement agency (study 3), community-based organizations (study 4, 5, 9, 10), immigrant-serving agencies (study 6, 8), and local receiving center (study 7).

In the 10 articles reviewed, the local non-medical immigrant settlement organizations' priority populations served included recent immigrants in small or large urban centers (study 1); asylum seekers newly released from detention (study 2) (note: 93% of the clients were men, 54% of clients were aged between 22 and 34 years, countries of origin included Afghanistan (30.4%), Sri Lanka (25.3%), Iran (19.2%), Pakistan (10.7%), Other (6%), Stateless (3.7%), Vietnam (3.3%), and Iraq (1.4%)); Burmese-speaking refugee women (study 3), recent immigrant families in urban centers (study 4, 5); Punjabi and Korean-speaking immigrants (study 6); government-assisted refugees (study 7) (note: study population included males (50.9%) and females (49.1%) with a large percentage under the age of 18 (49.2%), primarily coming from Northwest Africa, the Middle East, and Southeast Asia); immigrants and refugees (study 8); and at-risk immigrant and refugee women and their families (study 9, 10).

2.5.3 Approaches to Support Access to Primary Healthcare Services for Immigrants

The findings from our study are presented below according to the various levels of the Social-Ecological Model [18]. The first level, individual, identifies personal and biological factors that directly or indirectly impact health outcomes, while the second level, relationships, consists of close social environment factors that may influence the health outcomes of an individual. The community level of the Social-Ecological Model refers to the various factors associated with the setting in which a person goes about their daily life. Lastly, the societal level looks at broad social, economic, and political factors that influence a person's health status [18].

2.5.3.1 Individual Level. Two studies fell under this theme. Study 3 evaluated a pilot health education intervention delivered to Burmese-speaking refugee women, clients at a resettlement agency in Houston, Texas. Developed in partnership with the University of Texas Health Science Center, the intervention provided learning events to develop new skills to navigate health services, held discussions on health topics and question and answer (Q&A) sessions with medical providers, and disseminated health education resources. The increased opportunities to practice English and develop vocabulary allowed participants to be more confident in executing skills such as calling a doctor's office to make appointments or taking the bus. The study noted that lack of compatibility and agency buy-in were two main barriers to creating a feasible and sustainable intervention.

Next, study 8 focused on service providers' perceptions of immigrant and refugee access to and use of mental health services. Findings showed that immigrant-serving agencies played a significant role in identifying clients experiencing a crisis or struggling with mental health conditions and connecting these individuals to mental health services. Further, these providers also evaluated the fit of an interpreter or cultural broker (brokers provide education and cultural

translation support) with a client. In terms of challenges, the participants noted a desire for increased mental health training on identifying client needs and referring clients to specialized mental health services.

2.5.3.2 Relationship Level. Relationship level was examined in two studies. In study 5, the focus was on community-based organizations' trust in the cultural competency of other local service providers and its influence on meeting the complex healthcare needs of recent immigrant families. Cultural competency in this study referred to the ability and preparedness of a service organization to understand and respond to the health needs of immigrant families. Competence trust among service organizations was key for families to have access to healthcare services, whereas a lack of trust led to constrained workflow within the system, more avoidance behavior, and less interaction. The study found settlement service organizations to be exemplars of cultural competency.

Study 6 explored immigrant-serving agencies' roles as partner organizations to dementia service institutions and in facilitating access to dementia diagnosis and care services and supports provided by dementia service institutions. Findings from focus groups with older immigrant adults showed that the immigrant-serving agency connected with immigrant clients and was able to engender trust and provide culturally responsive health information as well as support in navigating the health system. The immigrant-serving agency lacked specific knowledge on dementia (a barrier to aligning their messages with clients' perceptions).

2.5.3.3 Community Level. Study 4 addressed community-level relations by uncovering the role of settlement service organizations as broker organizations supporting a network of community-based services that meet the primary healthcare needs of immigrants. For example, settlement services in this study function as brokers by acting as a hub for health information for

immigrant clients, by being a source of referral to primary care services for immigrant families, and by fostering collaboration in service delivery to high-needs immigrant families while building system competencies with partners. Further, compared to other service sector organizations, immigrant settlement services in this study were found to have the greatest numbers of strong ties to partners in their community network. Barriers for settlement service organizations to assume the broker role included funding issues or capacity-building resource issues.

2.5.3.4 Multiple Levels. While no study examined relations solely at the society level, a total of five studies addressed healthcare issues at multiple levels. Study 1 covers individual, relationship and community levels. Specifically, it examined the relationship between recent immigrants' self-perceived mental health and social supports available for them. Findings revealed that each settlement service organization provided social support by engaging in private meetings with clients or providing referrals to community agencies, local organizations for psychological/clinical counseling, or community group programs. Settlement service organizations in small urban centers offered more tangible social supports compared to those in large urban settings; these included resources to primary healthcare services such as appointment accompaniment and additional referrals to healthcare service providers outside the clients' community. A limiting factor to being able to provide these social supports was the amount of dedicated staff time needed.

Study 10 explored the successes of community health workers at the individual, relationship and community levels in facilitating access to healthcare for recent immigrants and refugees through a case study of a Multicultural Health Broker Co-op collaborating with a health services public health unit. Findings from this study show the complementary role that multicultural health brokers and community health workers fill within the health system.

Multicultural health brokers and community health workers work towards breaking down barriers (such as language, economic conditions, systematic discrimination) to accessing healthcare services for immigrant and refugee families. For example, multicultural health brokers/community health workers accompany clients to appointments or clinics, organize community development initiatives, and offer educational outreach programs on chronic disease prevention and management. A challenge for these community health workers and multicultural health brokers is not being formally recognized as part of the human health resource workforce.

As another study considering the individual, relationship, and community levels, study 7 assessed the impact of a refugee health clinic's partnership with a local refugee receiving center and community providers on referrals and wait times. The refugee health clinic model uses integrating mechanisms to deliver culturally appropriate and responsive primary care. Within this partnership model, gateway services are provided by the local receiving center's case workers/settlement workers and professionals from the family practice (e.g., nurse, resident physician). The health clinic delivers comprehensive care via family physicians; interpreters (if needed) are funded by the refugee receiving center. The model also includes ancillary services that are delivered in a community setting by providers willing to treat government-assisted refugees. Study findings demonstrated a 30% decrease in wait times for an appointment with a healthcare provider; an 18% increase in government-assisted refugees securing a permanent family doctor within a year after arrival; and almost a doubling of referrals to non-physician primary healthcare providers (e.g., dentists, optometrists). The study notes that this partnership model is built on goodwill; no formal contracts or funding beyond regular settlement services support was pursued.

Study 2 describes the Asylum Seeker Integrated Healthcare Pathway, an intervention influencing factors on the relationship and community levels, created to improve linkage to health

services for asylum seekers newly released from detention. The Pathway consists of settlement support agencies in partnership and collaboration with local primary and emergency healthcare services in Melbourne. The Pathway intervention embeds a clinical health screening and triage process, facilitated by settlement support agencies, into existing community orientation programs for asylum seekers. Findings showed agencies supporting the coordination of healthcare appointments; assisting clients to appointments; and linking clients with culturally responsive care options. Through this initiative, clients had timely access to services. The study noted that an ongoing consideration for the success of this intervention is the capacity of the primary healthcare practices to meet the unique health needs of asylum seekers.

Study 9 addressed individual, relationship, community, and society levels. It discussed the community health worker role in a Multicultural Health Broker Co-op (MCHB Co-op) that supports at-risk immigrant refugee women and their families by contributing to their settlement and integration into communities. The study aimed to better understand the health promotion functions and programs of the MCHB Co-op model and health brokers practice and found that both are able to offer a variety of supports to immigrant and refugee families; the Co-op provides educational support to help them realize their rights in order to overcome access to care barriers as patients (e.g., asking doctors for health information), as program users (e.g., seeking services from the health system), and as citizens (e.g., voicing their concerns to policy decision-makers). Two factors that could have negative implications on the community capacity-building programs and the services delivered by the MCHB Co-op were unstable funding and heavy caseloads.

2.6 Discussion

Findings from this scoping review show that local non-medical immigrant settlement organizations in the 10 articles had established approaches/interventions to support immigrants'

access to primary healthcare services. Further, most of the studies show that mental health support was an important component of the established approaches/interventions. These include: connecting to healthcare services and/or collaborating with health sector institutions; providing health promotion programs; undertaking community capacity building and policy advocacy activities; and providing ‘on the ground’ assistance to clients. Using the Social-Ecological Model to map these approaches [18], we found that most occurred at multiple levels (individual, relationship, community, and/or society) (study 1, 2, 7, 9, 10); two studies applied approaches/interventions that influence factors to access healthcare services at the individual level (study 3, 8); two studies applied approaches/interventions that influence factors to access healthcare services at the relationship level (study 5, 6); one study applied approaches/interventions that influence factors to access healthcare services at the community level (study 4); and no studies applied approaches/interventions at solely the society level (this may be because societal factors that favor or impair healthcare access, such as health/economic/social policies, require significant intersectoral action to reduce socioeconomic inequalities to healthcare service access).

Out of the 10 studies included in this review, eight were Canadian; this highlights the uniqueness of the Canadian settlement model and long experience of the settlement sector in collaborating and partnering with organizations both within the sector and across other sectors. A case in point is the creation and deployment of LIPs since 2008, and the work they have done to coordinate service provision, for example, by launching numerous innovative initiatives, some focused on primary healthcare, during Canada’s Syrian Refugee Resettlement Initiative in 2015-2016 [15].

As seen in this scoping review, local non-medical immigrant settlement organizations support immigrant access to primary healthcare; however, the scope and quality of services available to immigrants may not be uniform across settlement organizations. Settlement service organizations in Canada receive funding from multiple sources including the federal and provincial governments [40], which can influence or limit a settlement organization's mandate and/or resources. Further, a lack of responsive and forward-planning federal policy coordinating the provision of settlement services can also lead to disparities in the quality and range of settlement service organization programming between regions where settlement organizations operate [41,42]. Although community-based organizations often enjoy functioning with less bureaucratic control and with organizational structures that can be adapted to social/economic/political contexts to allow for more tailored programming to address inequities and specific marginalized population needs within their communities, these organizations often face challenges of overextended staff with limited resources/funding [43]. Despite the challenges, these organizations are uniquely positioned 'on the ground', where they are able to identify the healthcare needs of immigrant populations within the community and closely work with clients (e.g., via community health workers) to address health concerns (e.g., education programming internal to the settlement organization), support healthcare system navigation, provide referrals to health services, and partner/collaborate with health sector institutions to delivery health programs and initiatives [44]. These functions and roles are consistent with literature outlining successful organizational 'building blocks' to improve access to primary healthcare for marginalized populations [45].

Local non-medical immigrant settlement organizations may not be structurally or financially able to take on extensive activities to increase access to primary healthcare themselves, however, they have a place in the health system. Consistent with previous literature, community-

based organizations are increasingly recognized for their importance in primary healthcare; their unique closeness to immigrant populations and their ability to understand and respond to these populations makes them a valuable partner, source of knowledge, and gateway to marginalized populations for primary healthcare providers and institutions [3,46]. Health systems and services could benefit from including these community-based organizations in their future plans to address the health needs of immigrant populations. There is a need for in-depth research on community collaboration for health equity.

2.6.1 Implications for Research

This scoping review contributes to the literature by making visible the work that local non-medical immigrant settlement organizations do to advance health equity. Nevertheless, more international consensus is needed on terms for community settlement programs and more research on the collaborative relationships that exist or do not exist between community programs and community primary healthcare clinics to explore the impact on health outcomes for immigrant populations. Future research and development in this area is needed to better understand the impact of local non-medical immigrant settlement organizations involved in healthcare planning and service delivery on reducing barriers to access in order for primary care services to reach marginalized, high-need immigrant populations. Further studies could also look at what local non-medical immigrant settlement organizations do to advance health equity in areas linked to the determinants of health, which influence the health outcomes of individuals. This work requires multi-sector response, including but not limited to dealing with migration status, food security, and discrimination. Lastly, it would be beneficial for future research to build on this review by specifically considering the addition of gray literature from different countries and their local non-medical immigrant settlement organizations; gray literature can be very current, detailed,

geographically specific, and in essence provide a rich and balanced picture of approaches/interventions to complement these foundational review findings.

2.6.2 Strengths and Limitations of This Scoping Review

Strengths of this scoping review include its methodological approach — that is, using a predefined protocol aligned with Arksey and O’Malley’s framework and the JBI guidance, along with the use of predefined eligibility criteria by two reviewers when selecting the articles [19,20]. There also are a number of limitations, however, that ought to be noted: reviewers did not appraise the quality of the evidence; the scoping review was limited to published peer-reviewed studies; the broad concept of local non-medical immigrant settlement organizations may not have captured all organizations that perform local settlement work with immigrants; the language and terms used in the search may not have been internationally used, and thus, we predominantly identified Canadian-only publications; and many of the studies lacked details on organizational structure, capacity, and programming, which would have been useful to better understand how these organizations are able to support access to primary care.

2.7 Conclusions

Using a Social-Ecological approach, this scoping review mapped and highlighted current approaches/interventions relating to how local non-medical immigrant settlement organizations support access to primary healthcare services for immigrant populations. Although these findings may not be globally representative and, therefore, not generalizable, they suggest that these organizations are able to support access to primary healthcare services by collaborating with health sector partners in the community network, connecting clients to health services and service providers, advocating for immigrant health, providing educational programming, and also taking on community development/mobilization and advocacy activities to promote access to healthcare.

Including these local non-medical immigrant settlement organizations in healthcare planning and service delivery may provide more scope to respond to and reach marginalized, high-need immigrant populations. Strategies to encourage the involvement of local non-medical immigrant settlement organizations in healthcare planning, implementation, and service delivery are needed. Although most of the articles in this review were Canadian, other countries may consider adapting the approaches and interventions identified to their context and needs. As a next step, we recommend a critical assessment of each identified approach/intervention to better understand the feasibility to implement the necessary elements (e.g., human resources required, cost, acceptability of approach), and the extent of its effectiveness. A critical assessment can help relevant stakeholders decide if the identified approaches/interventions in this review are worth adapting.

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Supplementary Material

Supporting information can be downloaded at:

<https://www.mdpi.com/article/10.3390/ijerph19063616/s1>

Supplementary materials are available upon request from the corresponding author and include File S1: Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist; File S2: Search Strategies for all Databases; and File S3: Data Extraction Sheet.

Supplementary Materials 1: PRISMA-ScR Checklist

File S1 [[download here from IJERPH](#)] or [[download directly from the author via Google Drive](#)]

Supplementary Materials 2: Search Strategies for all Databases

File S2 [[download here from IJERPH](#)] or [[download directly from the author via Google Drive](#)]

Supplementary Materials 3: Data Extraction Sheet

File S3 [[download here from IJERPH](#)] or [[download directly from the author via Google Drive](#)]

Supplementary Materials 1

Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping

Reviews (PRISMA-ScR) Checklist

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
TITLE			
Title	1	Identify the report as a scoping review.	1
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	1
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	2
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	2
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	3
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	3
Information sources*	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	3
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	3
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	3
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	5
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	4
Critical appraisal of individual sources of evidence§	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	na
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	6

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	6
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	7
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	na
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	7
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	10
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	10
Limitations	20	Discuss the limitations of the scoping review process.	12
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	11
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	13

JBIG = Joanna Briggs Institute; PRISMA-ScR = Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews.

* Where *sources of evidence* (see second footnote) are compiled from, such as bibliographic databases, social media platforms, and Web sites.

† A more inclusive/heterogeneous term used to account for the different types of evidence or data sources (e.g., quantitative and/or qualitative research, expert opinion, and policy documents) that may be eligible in a scoping review as opposed to only studies. This is not to be confused with *information sources* (see first footnote).

‡ The frameworks by Arksey and O'Malley (6) and Levac and colleagues (7) and the JBI guidance (4, 5) refer to the process of data extraction in a scoping review as data charting.

§ The process of systematically examining research evidence to assess its validity, results, and relevance before using it to inform a decision. This term is used for items 12 and 19 instead of "risk of bias" (which is more applicable to systematic reviews of interventions) to include and acknowledge the various sources of evidence that may be used in a scoping review (e.g., quantitative and/or qualitative research, expert opinion, and policy document).

From: Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation. *Ann Intern Med.* 2018;169:467–473. doi: [10.7326/M18-0850](https://doi.org/10.7326/M18-0850).

Supplementary Materials 2

Search Strategies for all Databases

Search Strategy: PsycInfo

1. immigrant*.ti,ab.
2. Immigration/
3. immigrat*.ti,ab.
4. refugee*.ti,ab.
5. Human Migration/ or Refugees/
6. (foreign adj1 born).ti,ab.
7. (foreign adj1 national*).ti,ab.
8. (asylum adj1 seeker*).ti,ab.
9. Asylum Seeking/
10. migrant*.ti,ab.
11. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10
12. coalition*.ti,ab.
13. Community Services/ or Collaboration/
14. partnerships.ti,ab.
15. partnership.ti,ab.
16. Cooperation/
17. network.ti,ab.
18. networks.ti,ab.
19. groups.ti,ab.
20. group.ti,ab.
21. organization.ti,ab.
22. organizations.ti,ab.
23. organisations.ti,ab.
24. organisation.ti,ab.

25. Nonprofit Organizations/ or Religious Organizations/ or Faith Based Organizations/
26. service.ti,ab.
27. services.ti,ab.
28. collaborat*.ti,ab.
29. Teams/
30. institute.ti,ab.
31. institutes.ti,ab.
32. institutions.ti,ab.
33. institution.ti,ab.
34. center.ti,ab.
35. centers.ti,ab.
36. centre.ti,ab.
37. centres.ti,ab.
38. 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35 or 36 or 37
39. local*.ti,ab.
40. Community Involvement/
41. communit*.ti,ab.
42. Communities/
43. civic.ti,ab.
44. region*.ti,ab.
45. city.ti,ab.
46. cities.ti,ab.
47. Urban Environments/
48. municipal*.ti,ab.
49. integrated services/ or outreach programs/
50. 39 or 40 or 41 or 42 or 43 or 44 or 45 or 46 or 47 or 48 or 49
51. health*.ti,ab.

52. Health Promotion/ or Preventive Health Services/ or Public Health/ or Community Health/ or Health Care Access/ or Health/ or Public Health Services/
53. equit*.ti,ab.
54. Equity/
55. inequit*.ti,ab.
56. Health Care Policy/ or Health Care Services/ or Health Disparities/
57. (health adj1 service*).ti,ab.
58. Community Mental Health/ or Mental Health Services/ or Health Care Delivery/ or Health Care Utilization/ or Community Mental Health Services/
59. (primary adj1 care).ti,ab.
60. (primary adj1 healthcare).ti,ab.
61. (primary adj1 health adj1 care).ti,ab.
62. Primary Health Care/
63. medicine.ti,ab.
64. medical.ti,ab.
65. (clinical adj1 care).ti,ab.
66. 51 or 52 or 53 or 54 or 55 or 56 or 57 or 58 or 59 or 60 or 61 or 62 or 63 or 64 or 65
67. canada.ti,ab.
68. (united adj1 kingdom).ti,ab.
69. france.ti,ab.
70. germany.ti,ab.
71. (united adj1 states).ti,ab.
72. switzerland.ti,ab.
73. sweden.ti,ab.
74. australia.ti,ab.
75. (new adj1 zealand).ti,ab.
76. netherlands.ti,ab.
77. norway.ti,ab.
78. 67 or 68 or 69 or 70 or 71 or 72 or 73 or 74 or 75 or 76 or 77

79. 11 and 38 and 50 and 66 and 78

80. limit 79 to last 8 years

Search Strategy: CINAHL

#	Query	Limiters/Expanders
S1	"(immigrant*) OR (immigrat*) OR (refugee*) OR (foreign born) OR (foreign national*) OR (migrant*) OR (asylum seeker*)" OR (MH "Transients and Migrants") OR (MH "Immigrants") OR (MH "Emigration and Immigration")	Expanders - Apply related words; Apply equivalent subjects Search modes -Boolean/Phrase
S2	"(local*) OR (communit*) OR (civic) OR (region*) OR (city) OR (cities) OR (municipal*)" OR (MH "Regional Centers") OR (MH "Community Health Services")	Expanders - Apply related words; Apply equivalent subjects Search modes -Boolean/Phrase
S3	(MH "Great Britain") OR(Canada) OR (MH "Canada") OR (United States) OR (MH "United States") OR (France) OR(MH "France") OR(Germany) OR (MH "Germany") OR (United Kingdom) OR(Switzerland) OR (MH "Switzerland") OR(Sweden) OR (MH "Sweden") OR (Australia)OR (MH "Australia") OR(New Zealand) OR (MH "New Zealand") OR(Netherlands) OR (MH "Netherlands") OR(Norway) OR (MH "Norway") OR (MH "United Kingdom") OR(MH "Virgin Islands of the United States") OR (MH "Southwestern	Expanders - Apply related words; Apply equivalent subjects Search modes -Boolean/Phrase

	United States") OR (MH "Southeastern United States") OR (MH "Northwestern United States") OR (MH "Midwestern United States")	
S4	(MH "Community Health Centers") OR (coalition*) OR (partnership*) OR (network*) OR (group*) OR (organization*) OR (service*) OR (collaborat*) OR (institut*) OR (center*) OR (centre*)" OR (MH "Health Maintenance Organizations") OR (MH "Rural Health Centers")	Expanders - Apply related words; Apply equivalent subjects Search modes -Boolean/Phrase
S5	(MH "Primary HealthCare") OR (MH "Alternative Health Facilities") OR (MH" Health Care Delivery, Integrated") OR (health*) OR (equit*) OR (inequit*) OR (health service*) OR (primary care) OR (primary healthcare) OR (primary health care) OR (health care) OR (medicine) OR (medical) OR (clinical care) OR (MH "Multidisciplinary Care Team") OR (MH "Rural Health Personnel") OR (MH "Healthcare Disparities") OR (MH "Health Care Delivery")OR (MH "Medical Care")OR (MH "Tertiary Health Care") OR (MH "Secondary Health Care") OR (MH "Preventive Health Care") OR (MH "Outcomes (HealthCare)") OR (MH "Health Services Accessibility") OR (MH "Community Mental Health Services") OR (MH "National Health Programs") OR (MH "Physicians, Family") OR	Expanders - Apply related words; Apply equivalent subjects Search modes -Boolean/Phrase

	<p>(MH "Community Health Centers") OR (MH "Adolescent Health Services") OR (MH "Ancillary Services, Hospital") OR (MH "Rural Health Services") OR (MH "Child Health Services") OR (MH "Emergency Medical Services") OR (MH "Community Health Services") OR (MH "School Mental Health Services") OR (MH "Urban Health Services") OR (MH "Mental Health Services") OR (MH "Health Services") OR (MH "Allied Health Organizations") OR (MH "Multiskilled Health Practitioners") OR (MH "Cancer Care Facilities") OR (MH "Hospitals, Psychiatric") OR (MH "Mental Health Personnel") OR (MH "Hospitals, Public") OR (MH "Hospitals, Pediatric") OR (MH "Specialties, Allied Health") OR (MH "Psychiatric Care") OR (MH "Health Promotion") OR (MH "Health Policy") OR (MH "Community Health Workers")</p>	
S6	S1 AND S2 AND S3 AND S4 AND S5	<p>Limiters - Published Date:20130501-20210531 Expanders - Apply related words; Apply equivalent subjects Search modes -Boolean/Phrase</p>

Search Strategy: MEDLINE

1. immigrant*.ti,ab.
2. "Emigrants and Immigrants"/
3. immigrat*.ti,ab.
4. "Emigration and Immigration"/
5. refugee*.ti,ab.
6. Refugees/
7. (foreign adj1 born).ti,ab.
8. (foreign adj1 national*).ti,ab.
9. "Transients and Migrants"/
10. (asylum adj1 seeker*).ti,ab.
11. migrant*.ti,ab.
12. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11
13. coalition*.ti,ab.
14. Health Care Coalitions/
15. partnerships.ti,ab.
16. partnership.ti,ab.
17. network.ti,ab.
18. networks.ti,ab.
19. group.ti,ab.
20. groups.ti,ab.
21. organization.ti,ab.
22. organizations.ti,ab.
23. organisations.ti,ab.
24. organisation.ti,ab.
25. service.ti,ab.
26. services.ti,ab.
27. collaborat*.ti,ab.

28. institute.ti,ab.
29. institutes.ti,ab.
30. institution.ti,ab.
31. institutions.ti,ab.
32. center.ti,ab.
33. centers.ti,ab.
34. centre.ti,ab.
35. centres.ti,ab.
36. 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35
37. local*.ti,ab.
38. communit*.ti,ab.
39. Community Health Services/
40. civic.ti,ab.
41. region*.ti,ab.
42. city.ti,ab.
43. cities.ti,ab.
44. municipal*.ti,ab.
45. 37 or 38 or 39 or 40 or 41 or 42 or 43 or 44
46. health*.ti,ab.
47. Health Care Sector/ or Mental Health Services/ or Health Services/
48. Health Policy/
49. equit*.ti,ab.
50. inequit*.ti,ab.
51. Health Status Disparities/ or Health Equity/ or Health Services Accessibility/ or "Delivery of Health Care"/
52. Public Health/
53. Health Promotion/
54. (health adj1 service*).ti,ab.

55. (primary adj1 care).ti,ab.
56. (primary adj1 healthcare).ti,ab.
57. (primary adj1 health adj1 care).ti,ab.
58. medicine.ti,ab.
59. medical.ti,ab.
60. (clinical adj1 care).ti,ab.
61. 46 or 47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 or 56 or 57 or 58 or 59 or 60
62. Canada.ti,ab.
63. (united adj1 states).ti,ab.
64. france.ti,ab.
65. germany.ti,ab.
66. (united adj1 kingdom).ti,ab.
67. switzerland.ti,ab.
68. sweden.ti,ab.
69. australia.ti,ab.
70. (new adj1 zealand).ti,ab.
71. netherlands.ti,ab.
72. norway.ti,ab.
73. Germany, East/ or Germany/ or Germany, West/
74. South Australia/ or Australia/ or Western Australia/
75. Caribbean Netherlands/ or Netherlands/ or Netherlands Antilles/
76. 62 or 63 or 64 or 65 or 66 or 67 or 68 or 69 or 70 or 71 or 72 or 73 or 74 or 75
77. 12 and 36 and 45 and 61 and 76
78. limit 77 to last 8 years

Search Strategy: Social Services Abstracts

Name:

Social Services Abstract May 31 2021Edit name

Searched for:

(AB,TI(immigrant* OR emigrant* OR immigrat* OR refugee* OR "foreign born" OR ("foreign national" OR "foreign nationalities" OR "foreign nationality" OR "foreign nationals") OR transient* OR migrant* OR ("asylum seeker" OR "asylum seekers")) OR MAINSUBJECT.EXACT("Immigration") OR MAINSUBJECT.EXACT("Immigrants") OR MAINSUBJECT.EXACT("Migrants") OR MAINSUBJECT.EXACT("Refugees")) AND (AB,TI(coalition* OR partnership* OR network* OR group* OR organization* OR organisation* OR service* OR collaborat* OR institut* OR center* OR centre* OR local* OR communit* OR civic OR region* OR city OR cities OR municipal*) OR MAINSUBJECT.EXACT("Nonprofit Organizations") OR MAINSUBJECT.EXACT("Community Organizations") OR MAINSUBJECT.EXACT("Organizations (Social)") OR MAINSUBJECT.EXACT("Nongovernmental Organizations")) AND (AB,TI(health* OR equit* OR inequit* OR "accessibilit*" OR "primary care" OR medicine OR medical OR "clinical care") OR MAINSUBJECT.EXACT("Health Care Utilization") OR MAINSUBJECT.EXACT("Mental Health Services") OR MAINSUBJECT.EXACT("Health Care Services") OR MAINSUBJECT.EXACT("Health Policy") OR MAINSUBJECT.EXACT("Primary Health Care") OR MAINSUBJECT.EXACT("Health") OR MAINSUBJECT.EXACT("Health Care Services Policy") OR MAINSUBJECT.EXACT("Community Mental Health") OR MAINSUBJECT.EXACT("Public Health")) AND AB,TI(Canada OR "United States" OR France OR Germany OR "United Kingdom" OR "Britain" OR Switzerland OR Sweden OR Australia OR Norway OR "New Zealand" OR Netherlands) AND pd(20130501-20210531)

Databases:

- Social Services Abstracts

CHAPTER 3: ARTICLE 2

3.1 Article Overview

Article Title

Identifying Cross-Cultural Global Health Competencies of Local Immigration Partnerships in the Context of Supporting Access to Healthcare for Immigrants: An Ontario-Wide Quantitative Survey.

Authors

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Journal

A version of Chapter 3 (article 2) is ready for submission to the Journal of Immigrant and Minority Health.

Funding

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Conflict of Interest

None to declare.

Ethics Approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the University of Ottawa's Research Ethics Board (certificate of ethics approval number H-02-19-2410) and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Acknowledgements

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3.2 Abstract

Objective: The study seeks to identify and establish cross-cultural global health competencies for equity, diversity and inclusion relevant to Local Immigration Partnerships (LIPs) in the province of Ontario, Canada; focus is placed on the development approach and piloting of a global health competencies capacity-building tool for these settlement coordination organizations. **Methods:** We developed, piloted and tested the validity/reliability of an 18-minute structured, self-administered, quantitative questionnaire used to survey cross-cultural global health competencies. Data was analyzed using SPSS software. **Results:** 28 LIPs across Ontario participated in the study; all participants agreed that 18 of 22 global health competencies were relevant to their role and work. Participants tended to have higher confidence in competencies that involved communication skills, leadership, building coalitions, creating opportunities to access local communities and authorities; they, however, had lower confidence with respect to technical tasks such as analyzing

policy, planning, implementing and/or evaluating health-centred programs, and creating opportunities to access higher-level decision-makers. Correlations and associations and group differences concerning demographic items and competencies were also found. Conclusion: This study establishes core global health competencies for settlement service-type organizations working with partners in the health space to support immigrants.

Objectif : L'étude cherche à identifier et à établir des compétences interculturelles en santé mondiale pour l'équité, la diversité et l'inclusion pertinentes pour les Partenariats Locaux en matière d'Immigration (PLI) en Ontario ; l'accent est mis sur l'approche de développement et la mise à l'essai d'un outil de renforcement des capacités en matière de compétences en santé mondiale pour cet organisme de soutien en établissement. Méthodes : Nous avons élaboré, piloté et testé la validité et la fiabilité d'un questionnaire quantitatif structuré et auto-administré d'une durée de 18 minutes pour évaluer les compétences interculturelles en matière de santé mondiale. Les données ont été analysées à l'aide du logiciel SPSS. Résultats : 28 PLI de l'Ontario ont participé à l'étude ; tous les participants ont reconnu 18 des 22 compétences en santé mondiale comme étant pertinentes pour leur rôle et leur travail. Les participants avaient tendance à être plus confiants dans les compétences qui impliquaient des aptitudes à la communication, au leadership, à la création de coalitions, à la création d'opportunités pour accéder aux communautés et autorités locales ; cependant, ils étaient moins confiants en ce qui concerne les tâches techniques telles que l'analyse des politiques, la planification, mise en œuvre et/ou évaluation de programmes centrés sur la santé, et la création d'opportunités pour accéder à des décideurs de haut niveau. Des corrélations et des associations ainsi que des différences entre les groupes concernant les éléments démographiques et les compétences ont également été constatées. Conclusion : Cette étude établit les compétences de base en matière de santé mondiale pour les organisations de type fournisseurs

de service d'établissement qui travaillent avec des partenaires dans le domaine de la santé pour soutenir les nouveaux arrivants et les immigrants.

MeSH keywords: access to healthcare, global health competencies, immigration settlement services, public health.

Mots clés MeSH : accès aux soins de santé, compétences en matière de santé mondiale, services d'aide à l'établissement des immigrants, santé publique.

3.3 Introduction

Since 2015, Canada is experiencing an increase in refugee and immigrant arrivals. In 2019, Canada ranked 1st out of 26 countries in global refugee resettlement (UNHCR, 2022). Under its 2023-2025 Immigration Levels Plan, Canada is set to admit over 460 000 new permanent residents each year — the highest immigration levels in Canadian history (Immigration, Refugees and Citizenship Canada, 2024). This influx of people heightens the responsibility of the public healthcare sector and health services to ensure equitable access to quality services for all populations. Equity consideration should be given to immigrant populations which often have unique health needs upon arrival (Pottie et al., 2011); factors such as cultural differences, varying levels of English/French proficiency, limited social networks and lack of familiarity with the Canadian health system, can be barriers for those trying to access primary healthcare services (Pottie & Gruner, 2023). Globalization processes influence immigrant settlement and public health priorities and require innovative community responses to ensure equitable and sustainable health outcomes (Labonte, 2018). The increased pressure placed on provincial healthcare professionals and resources to deliver quality primary healthcare to all has brought health system gaps to the forefront of provincial governance. A renewed focus on the importance of entire populations being able to access post COVID-19 healthcare services has led some researchers to call on the medical

community to explore intersectoral links to newcomer and immigration services and resettlement organizations (Gruner et al., 2022).

Local non-medical organizations that support the integration of new immigrants into communities have the network to bring together key actors within and across sectors; such organizations may also be well positioned to facilitate intersectoral collaboration. Different types of local immigrant-supporting partnerships exist globally: the Strategic Migration Partnership in the United Kingdom (East of England Local Government Association, 2020), Local immigration partnerships (LIPs) in Canada (Walton-Roberts et al., 2019), and the Office of New Americans (ONA) in Chicago, USA (City of Chicago, 2023) are examples of established groups.

In Canada, the Local Immigration Partnerships (LIPs) represent a key resource in health settlement for many communities. LIPs originated from the 2005 Canada-Ontario Immigration Agreement (COIA). Although diverse, LIPs are broad cross-sector community councils aimed at facilitating and coordinating local collaborations to support the integration of newly arrived populations into communities. Typically, LIPs are hosted by community organizations, municipal or regional governments. Following the COIA, LIPs were first piloted in Ontario starting in 2009 as a result of collaborative efforts between Citizenship and Immigration Canada (CIC) and the Ontario Ministry of Citizenship and Immigration (MCI). The City of Toronto and the Association of Municipalities of Ontario (AMO) also contributed to the development of LIPs (Veronis, 2019; Walton-Roberts et al., 2019).

Existing qualitative research has outlined some of the LIPs' competencies with respect to their core roles (e.g., leaderships skills, organizing and mobilizing local communities and key actors, connecting stakeholders in research and community planning, and supporting the coordination of social services (Veronis, 2019; Walton-Roberts, 2019). With time, LIPs have taken

on more roles that go beyond the scope of their mandates. Some partnerships have been supporting access to public health and primary healthcare services by collaborating with health sector partners in the community, connecting health service providers, and initiating health-related community mobilization activities (Ratnayake et al., 2022). But so far, there has been little quantitative research focused on the competencies of LIPs to work within the healthcare space, and to do it effectively, which can affect how successful these entities are at supporting immigrant access to healthcare services (Veronis, 2019; Walton-Roberts, 2019). An understanding of LIPs' cross-cultural global health competence (i.e., the ability of LIPs to understand diverse groups of people, communicate with people from different backgrounds, and effectively interact with others across cultures and within the healthcare context) can be helpful in establishing LIPs as a supportive resource in the Ontario health system.

3.4 Objective

Results from Ratnayake et al.'s 2022 scoping review showed that competency capacities of non-medical immigrant settlement organizations were a factor in supporting immigrant's access to healthcare services. As this is the first survey we are aware of, to attempt to identify global health competencies of the LIPs in Ontario, an approach was selected to provide an overview of the current state. In this study, we seek to identify and establish cross-cultural global health competencies relevant to LIPs in Ontario, with a focus on the development approach and piloting of a global health competencies capacity-building tool for LIPs in Ontario. This tool aims to help LIPs and other settlement coordination organizations identify existing and potential global health competencies of their staff. By doing so, LIPs can enhance their community response and better define the knowledge, skills, and attributes needed within their organization and support the health sector to improve immigrant populations' access to healthcare services.

3.5 Methods

3.5.1 Study Design

This paper outlines the development, piloting and validity/reliability testing of an 18-minute structured, self-administered, quantitative questionnaire used to survey the cross-cultural global health competencies of LIPs in Ontario.

3.5.2 Tool Development Approach

Several sources of work informed the development of core cross-cultural global health competency questions for the questionnaire tool. The work by Jogerst et al. (2015) on interprofessional global health competencies for health professionals, across disciplines, was foundational to building the core quantitative questions relevant to LIPs — most of our content questions were adapted from this work. Other sources include a report on Community Health Worker (CHW) skills, roles and qualities (Rosenthal, Rush, and Allen, 2016); a report by Citizenship and Immigration Canada (2014) identifying priority areas for LIP work; a journal article by Carter (2011) identifying factors that influence the capacity of organizations to engage in policy work; and research by Briggs et al. (2015) identifying knowledge mobilization skills. The questionnaire content also considered and built on CHW research by Torres et al. (2014), and research demonstrating LIP capacities and roles by Veronis (2019) and Walton-Roberts (2019).

Stakeholder engagement was key to developing the cross-cultural global health competency questionnaire tool. We collaborated with four LIP Advisors. LIP Advisors were individuals employed at different LIPs in Ontario, self-identified as being senior or experienced in their role, had some research or academic background, and were able to connect to a larger network of LIP employees in the province. Prior to drafting the initial questionnaire, we hosted an informal webinar with all LIPs in Ontario to share our project idea and gain insights/feedback. Feedback

from the webinar helped shape the purpose of the tool and drive the content development for the initial questionnaire; researchers AR and KP were able to shortlist 35 cross-cultural competencies from Jogerst et al. (2015) larger list of 52 global health competencies that were most likely meaningful to LIPs. Next, the initial questionnaire underwent four rounds of consultation and revision with LIP Advisors to optimize content relevance to LIPs (e.g., by rephrasing, tailoring text); brainstorming discussions and iterative content development occurred throughout the consultation process. After four rounds of discussion among the LIP Advisors and researchers, 22 cross-cultural global health competencies were finalized for inclusion in the questionnaire (Supplement 1).

3.5.3 Piloting the tool in Ontario: Recruitment and study sample

Since LIPs vary in their governance structure and, by nature, have diverse and somewhat fluid human resources (e.g., those that contribute to the partnership may not always be directly employed by it), it can be tricky to pinpoint an official number of LIP personnel in Ontario. Therefore, this pilot study defined the population of interest as LIPs in the province, with 35 LIP units operating in Ontario at the time of study. The sampling strategy was an organizational community-based approach where we purposively aimed to recruit the 35 LIPs to participate. LIP advisors reached out to Ontario LIPs using their personal networks. The researchers also reached out formally with an initial invitation to participate sent to each LIP's public web addresses (Supplement 2). In addition, the researchers recruited LIPs from existing personal networks and using word of mouth at conferences and events. Follow-up emails were sent one week after initial contact to non-responders. LIP members who responded to the invitation and showed interest (i.e., contacted the primary researcher) were emailed the questionnaire & information/consent form. Participants were asked to complete the questionnaire within a two-week period. We used aspects

of the Dillman Total Design Survey Method (Dillman, 1978) for those who missed the submission deadline, by sending out gentle reminders one week after the deadline, and replacement questionnaires three and seven weeks after the initial questionnaire was sent to participants (Hoddinott and Bass, 1986). LIPs were offered a small donation upon completion of the questionnaire. As this exercise was about identifying cross-cultural global health competencies of LIPs in Ontario, we asked that those who complete the questionnaire on behalf of their LIP self-identify as a senior LIP member, review the completed questionnaire with their staff (for consensus), and obtain approval for the completed questionnaire from their senior management team. Participant data was de-identified by assigning each questionnaire a unique number on tracking documents. All tracking documents (used to monitor communication, status of completion) and project documents were stored in compliance with Research Ethics Board standards.

3.5.4 Data Analysis

The main goal of the data analysis was to describe the current state of the LIPs with regard to demographics and global health competencies. An additional aim was to uncover correlations and associations (i.e., reveal trends, patterns) by examining the descriptive statistics. For the survey data analysis, descriptive statistics were calculated using IBM SPSS Statistics version 28 (Supplement 3). Predictive statistics were out of scope for this study/research question. Most of the survey analysis process follows the methodology prescribed in Heeringa et al. (2017)'s *Applied Survey Data Analysis*, Second Edition. We consulted guides from Laerd Statistics (2023) on IBM SPSS Statistics calculating and reporting procedures. The statistical analysis was done by AR in collaboration with an experienced statistician KB (Supplement 4).

As a first step, the following survey metadata was assessed: response rate (including contact rate and cooperation rate) (Statistical Consulting and Survey Research Unit at the University of Waterloo, 2023), reliability (Lavrakas, 2008), and content validity (Bolarinwa, 2015; Rodrigues et al., 2017). Content validity assessment followed the guides set out by Yusoff (2019) and Rodrigues (2017) and included three expert jurors volunteers from different LIPs rating the clarity, relevancy, and essentiality of each of the 22 global health competencies (Supplement 5). Next, we performed univariate analysis for each survey question to gain frequency data (along with measures of central tendency, and measures of dispersion/variation where possible) on LIP staff demographics and LIP staff's perceived level of confidence on the 22 global health competencies (Heeringa et al., 2017). Bivariate analysis was done to further describe the data looking at correlations and associations between LIP demographic factors and the 22 competencies (Heeringa et al., 2017); tests include Spearman rank correlation and Rank-biserial correlation (Glass, 1966; Khamis, 2008). Lastly, bivariate analysis was done to describe the data with regard to group differences, specifically, differences between demographic groups across the 22 competencies; tests included the Mann-Whitney U test and the Kruskal-Wallis H test (Heeringa et al., 2017).

It is important to note that Section 2: Part 1 of the questionnaire (Supplement 1) contained open-ended questions. LIPs' responses to these questions were used to inform the selection of the case study for A. Ratnayake's third PhD research project. They also served to develop a compendium to share-back with LIPs; this was not done, however, because identifying information was included in many responses. Lastly, this data was meant to help LIP staff think about their activities in the health sector as a warm-up exercise before completing the competencies chart of the questionnaire.

3.6 Results

Thirty-five LIPs were found to operate in Ontario. The contact rate for this study was 94% and the cooperation rate was 85%. The response rate was 80%. The questionnaire consisted of 22 global health competency items ($\alpha = 0.957$) (Supplement 3). All competency items had an I-CVI considered to be excellent (except competency number 17) and overall, demonstrated content validity (S-CVI/UA = 0.95, S-CVI/Ave = 0.98) (Supplement 5).

3.6.1 Demographics

Table 1 provides the descriptive statistics (percentages and frequencies) of questions/items on the demographic composition of LIPs in Ontario. The table shows the number and percentage of total respondents selecting (yes) or not selecting (no) the question/item. The majority of LIPs indicated that they correspond to a mix of urban/rural communities (64.3%), followed by urban areas (25%). Within the health sector space, LIPs tend to mostly work with Public Health Units compared to other health partners, followed by community health centers and others. For languages spoken other than English, respondents specified 29 different languages; French, Arabic, Spanish and Hindi were identified the most frequently, by participating LIPs. Moreover, LIP staff have diverse backgrounds of origin although, at the time of this survey, those from the Oceania region were not represented. In terms of gender, all LIPs have staff members that identify as female; half of LIPs have staff that identify as male, and a small percentage of LIPs have staff who prefer to self-describe.

Table 1

Descriptive Statistics: LIP demographic nominal data in percentages.

Demographic Item	Response
LIP Community	
Is the community your LIP covers primarily urban, urban/rural mix or primarily rural?	Urban = 25% (N= 7) Urban/rural= 64.3% (N=18)

	Rural= 10.7% (N= 3)
Working within the healthcare space	
Does your LIP work with organizations in the healthcare space (i.e., Ontario Health Teams)?	Selected= 53.6% (N=15) Not selected= 46.4% (N=13)
Does your LIP work with organizations in the healthcare space (i.e., Public Health Ontario)?	Selected=17.9% (N=5) Not selected= 82.1% (N=23)
Does your LIP work with organizations in the healthcare space (i.e., IRCC)?	Selected= 82.1% (N=23) Not selected = 17.9% (N=5)
Does your LIP work with organizations in the healthcare space (i.e., Public Health Unit)?	Selected= 85.7% (N=24) Not selected = 14.3% (N=4)
Does your LIP work with organizations in the healthcare space (i.e., Other – can include community health centres)?	Selected = 71.4% (N=20) Not selected= 28.6% (N=8)
Age	
Age ranges of LIP staff (place an “x” beside all options that apply): less than or equal to 40 years old	Selected= 85.7% (N=24) Not selected= 10.7% (N=3)
Age ranges of LIP staff (place an “x” beside all options that apply): 41 to 60	Selected= 67.9% (N=19) Not selected = 28.6% (N=8)
Age ranges of LIP staff (place an “x” beside all options that apply): equal to 61 or more	Selected = 3.6% (N=1) Not selected = 92.9% (N=26)
Gender	
Gender of LIP staff (place an “x” beside all options that apply): male	Selected= 50.0% (N=14) Not selected= 50.0% (N=14)
Gender of LIP staff (place an “x” beside all options that apply): female	Selected = 100% (N=28)
Gender of LIP staff (place an “x” beside all options that apply): other, prefer to self-describe	Selected =3.6% (N=1) Not selected= 96.4% (N= 27)
Language	
Spoken languages of staff, at home or at the LIP, other than English: French	Selected=32.1% (N=9) Not selected= 67.9% (N=19)
Spoken languages of staff, at home or at the LIP, other than English: Arabic	Selected= 21.4% (N=6) Not selected= 78.6% (N=22)
Spoken languages of staff, at home or at the LIP, other than English: Spanish	Selected= 21.4% (N=6) Not selected=78.6% (N=22)
Spoken languages of staff, at home or at the LIP, other than English: Hindi	Selected= 17.9% (N=5) Not selected= 82.1% (N=23)
Staff region of origin or birth	
Staff region of origin or birth (place an “x” beside all options that apply): Africa	Selected= 32.1% (N=9) Not selected= 67.9% (N=19)
Staff region of origin or birth (place an “x” beside all options that apply): Americas not including Canada	Selected= 25.0% (N=7) Not selected= 75.0% (N=21)
Staff region of origin or birth (place an “x” beside all options that apply): Canada	Selected= 85.7% (N=24) Not selected= 14.3% (N=4)
Staff region of origin or birth (place an “x” beside all options that apply): Asia	Selected=46.4% (N=13) Not selected= 53.6% (N=15)
Staff region of origin or birth (place an “x” beside all options that apply): Europe	Selected= 25.0% (N=7) Not selected= 75.0% (N=21)
Staff region of origin or birth (place an “x” beside all options that apply): Oceania	Not selected= 100.0% (N=28)

Table 2 presents results of the LIP demographic data analysis for ordinal/continuous data. Note that the “number of spoken languages of LIP staff at home or at the LIP other than English” was not an original question on the questionnaire; this additional item counts the number of languages that LIPs voluntarily specified when answering question 1.11 of the questionnaire (M= 2.11 (N=28; Range=8)). LIPs in Ontario have been supporting access to healthcare services for many years (M= 7.96 (N=28; Range= 16)). The average year of LIP establishment was found to be 2010. LIPs had an average full-time equivalent staff of 2.34 (N=28; Range=8), and average part-time equivalent staff of 1.00 (N=27; Range=4).

Table 2

Descriptive Statistics: Mean value of LIP demographic continuous/ordinal data.

Demographic Item	Mean Value
Year when your LIP was founded	2010.25 (N=28; Range= 14)
Number of years the LIP has been supporting access to primary healthcare services	7.96 (N= 28; Range= 16)
How many FTEs (full time equivalents) are on staff with your LIP?	2.34 (N=28; Range= 8)
How many PTEs (part time equivalents) are on staff with your LIP?	1.00 (N=27; Range= 4)
Number of spoken languages of LIP staff at home or at the LIP other than English	2.11 (N=28; Range=8)

3.6.2 Global Health Competency Confidence Ratings and Relevance

Table 3 provides percentages of confidence as rated by participating LIPs with regard to the listed 22 cross-cultural global health competencies.

Competencies with the highest “high confidence” selection include the following:

- (Competency 14) Skills to build coalitions to work collectively on access to healthcare issue (71.4% (N=20));
- (Competency 18) Exhibit interprofessional values that demonstrate respect for, and awareness of, the unique cultures, values, roles/responsibilities and expertise represented by other groups that work in the healthcare space (71.4% (N=20));

- (Competency 16) Skills in communication (e.g., to help create and operate immigrant & newcomer health campaigns and awareness-building material) (67.9% (N=19)); and
- (Competency 19) Apply leadership practices that support collaboration and team effectiveness (67.9% (N=19)).

Competencies with the highest “no confidence” selection include the following:

- (Competency 8) Skills to create opportunities to access federal decision-makers concerning health services for immigrants and newcomers in the community (17.9% (N=5));
- (Competency 7) Skills in policy analysis and policy development for immigrant access to healthcare services (14.3% (N=4));
- (Competency 9) Skills to create opportunities to access provincial decision-makers concerning health services for immigrants and newcomers in the community (14.3% (N=4));
- (Competency 5) Describe the Ontario health system and its policies and effects on provision of healthcare for immigrants (10.7% (N=3)); and,
- (Competency 6) Knowledge of the roles and relationships of the major entities influencing your communities’ health and development (10.7% (N=3)).

The 28 participating LIPs were asked to determine the relevance of each of the 22 global health competencies to their work and role (considering current role and potential role in the healthcare services space). Most competencies, other than those listed below, were deemed 100% relevant:

- (Competency 8) Skills to create opportunities to access federal decision-makers concerning health services for immigrants and newcomers in the community (3.6% (N=1) selected not relevant);

- (Competency 9) Skills to create opportunities to access provincial decision-makers concerning health services for immigrants and newcomers in the community (3.6% (N=1) selected not relevant);
- (Competency 21) Conduct a community health needs assessment and identify partners in the service provision ecosystem that are best positioned to support this task (7.1% (N=2) selected not relevant); and
- (Competency 22) Plan, implement, and evaluate an access to healthcare program (10.7% (N=3) selected not relevant).

Table 3

Descriptive Statistics: Level of confidence in global health competencies in percentages.

Competency	No confidence	Slight confidence	Moderate Confidence	High Confidence	Not Relevant
1. Knowledge about issues that affect the health of immigrants/newcomers (e.g., major causes of disease and death) via credible sources (e.g., professional bodies, peer-reviewed research)	0	21.4% (N=6)	42.9% (N=12)	35.7% (N=10)	
2. Understand major social and economic environmental factors that impact access to and quality of health services within your community (e.g., education, income, social support, physical environment) and how these factors can influence immigrant health	0	7.1% (N=2)	28.6% (N=8)	64.3% (N=18)	
3. Articulate barriers to healthcare in low-resource settings locally and describe factors that contribute to this, and strategies to address this problem	3.6% (N=1)	17.9% (N=5)	46.4% (N=13)	32.1% (N=9)	
4. Describe how cultural context influences perceptions of health and disease	3.6% (N=1)	10.7% (N=3)	50.0% (N=14)	35.7% (N=10)	
5. Describe the Ontario health system and its policies and effects on provision of healthcare for immigrants	10.7% (N=3)	28.6% (N=8)	35.7% (N=10)	25.0% (N=7)	
6. Knowledge of the roles and relationships of the major entities influencing your communities' health and development (e.g., Ministries, departments, corporations)	10.7% (N=3)	21.4% (N=6)	25.0% (N=7)	42.9% (N=12)	
7. Skills in policy analysis and policy	14.3%	25.0%	35.7%	25.0%	

development for immigrant access to healthcare services	(N=4)	(N=7)	(N=10)	(N=7)	
8. Skills to create opportunities to access federal decision-makers concerning health services for immigrants and newcomers in the community	17.9% (N=5)	21.4% (N=6)	39.3% (N=11)	17.9% (N=5)	3.6% (N=1)
9. Skills to create opportunities to access provincial decision-makers concerning health services for immigrants and newcomers in the community	14.3% (N=4)	28.6% (N=8)	28.6% (N=8)	25.0% (N=7)	3.6% (N=1)
10. Skills to create opportunities to access municipal decision-makers concerning health services for immigrants and newcomers in the community	3.6% (N=1)	7.1% (N=2)	42.9% (N=12)	46.4% (N=13)	
11. Skills to create opportunities to access organizational/ community/other decision-makers concerning health services for immigrants and newcomers	0	17.9% (N=5)	21.4% (N=6)	60.7% (N=17)	
12. Develop approaches to gain access to immigrant communities served	3.6% (N=1)	21.4% (N=6)	25.0% (N=7)	50.0% (N=14)	
13. Demonstrate diplomacy and build trust with community partners working in the health sector	0	0	35.7% (N=10)	64.3% (N=18)	
14. Skills to build coalitions to work collectively on access to healthcare issues	0	14.3% (N=4)	14.3% (N=4)	71.4% (N=20)	
15. Cocreate strategies with the community to strengthen community capabilities, and contribute to reduction in health differences and improvement of community health	0	17.9% (N=5)	28.6% (N=8)	53.6% (N=15)	
16. Skills in communication (e.g., to help create and operate immigrant and newcomer health campaigns and awareness-building material)	0	3.6% (N=1)	28.6% (N=8)	67.9% (N=19)	
17. Skills for knowledge brokering	0	3.6% (N=1)	50.0% (N=14)	46.4% (N=13)	
18. Exhibit interprofessional values that demonstrate respect for, and awareness of, the unique cultures, values, roles/responsibilities and expertise represented by other groups that work in the healthcare space	0	0	28.6% (N=8)	71.4% (N=20)	
19. Apply leadership practices that support collaboration and team effectiveness	0	0	32.1% (N=9)	67.9% (N=19)	
20. Implement strategies to engage marginalized and vulnerable populations in making decisions that affect their health and wellbeing	0	14.3% (N=4)	53.6% (N=15)	32.1% (N=9)	
21. Conduct a community health needs assessment and identify partners in the service provision ecosystem that are best positioned to support this task	3.6% (N=1)	14.3% (N=4)	57.1% (N=16)	17.9% (N=5)	7.1% (N=2)

22. Plan, implement, and evaluate an access to healthcare program	7.1% (N=2)	25.0% (N=7)	42.9% (N=12)	14.3% (N=3)	10.7% (N=3)
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3.6.3 Correlations, Associations and Group Differences

Table 4 lists the correlations found between demographic items (continuous data) and the global health competency items (ordinal scale data). Table 4 lists the demographic items with the most correlations first, to demographic items with the least correlations last. The “number of years LIP supporting access to primary healthcare services” demographic item has the largest number of global health competency correlations, followed by “number of spoken languages of LIP staff at home or at the LIP, other than English.” Correlations with global health competencies were also found for the item “how many PTEs are on staff at your LIP” and the item “year when LIP was founded.”

Table 4

Correlations Between Demographic Items and Global Health Competency Items.

Demographic Item	Global Health Competency	Correlation Coefficient (Spearman’s rho)
Number of years the LIP has been supporting access to primary healthcare services	(Competency 1) Knowledge about issues that affect the health of immigrants/newcomers (e.g., major causes of disease and death) via credible sources (e.g., professional bodies, peer-reviewed research)	r(28) = .449*, p = .016
	(Competency 2) Understand major social and economic environmental factors that impact access to and quality of health services within your community (e.g., education, income, social support, physical environment) and how these factors can influence immigrant health	r(28) = .438*, p = .020
	(Competency 3) Articulate barriers to healthcare in low-resource settings locally and describe factors that contribute to this, and strategies to address this problem	r(28) = .599**, p < .001
	(Competency 5) Describe the Ontario health system and its policies and effects on provision of healthcare for immigrants	r(28) = .507*, p = .006
	(Competency 6) Knowledge of the roles and relationships of the major entities influencing your communities’ health and development (e.g., Ministries, departments, corporations)	r(28) = .458*, p = .014
	(Competency 7) Skills in policy analysis and policy development for immigrant access to healthcare services	r(28) = .512**, p = .005
	(Competency 8) Skills to create opportunities to access federal decision-makers concerning health services for immigrants and newcomers in the community	r(27) = .449*, p = .019

	(Competency 9) Skills to create opportunities to access provincial decision-makers concerning health services for immigrants and newcomers in the community	r(27)=.533**, p=.004
	(Competency 10) Skills to create opportunities to access municipal decision-makers concerning health services for immigrants and newcomers in the community	r(28)=.581**, p=.001
	(Competency 11) Skills to create opportunities to access organizational/ community/other decision-makers concerning health services for immigrants and newcomers	r(28)=.462*, p=.013
	(Competency 17) Skills for knowledge brokering	r(28)=.483**, p=.009
	(Competency 18) Exhibit interprofessional values that demonstrate respect for, and awareness of, the unique cultures, values, roles/responsibilities and expertise represented by other groups that work in the healthcare space	r(28)=.473*, p=.011
	(Competency 19) Apply leadership practices that support collaboration and team effectiveness	r(28)=.405*, p=.032
Number of spoken languages of LIP staff at home or at the LIP, other than English	(Competency 1) Knowledge about issues that affect the health of immigrants/newcomers (e.g., major causes of disease and death) via credible sources (e.g., professional bodies, peer-reviewed research)	r(28)=.607**, p<.001
	(Competency 2) Understand major social and economic environmental factors that impact access to and quality of health services within your community (e.g., education, income, social support, physical environment) and how these factors can influence immigrant health	r(28)=.476*, p=.010
	(Competency 3) Articulate barriers to healthcare in low-resource settings locally and describe factors that contribute to this, and strategies to address this problem	r(28)=.545**, p=.003
	(Competency 5) Describe the Ontario health system and its policies and effects on provision of healthcare for immigrants	r(28)=.575**, p=.001
	(Competency 5) Describe the Ontario health system and its policies and effects on provision of healthcare for immigrants	r(27)=.448*, p=.019
How many PTEs are on staff with your LIP	(Competency 6) Knowledge of the roles and relationships of the major entities influencing your communities' health and development (e.g., Ministries, departments, corporations)	r(27)=.382*, p=.049
	(Competency 11) Skills to create opportunities to access organizational/ community/other decision-makers concerning health services for immigrants and newcomers	r(28)=-.432*, p=.022

* Correlation is significant at the 0.05 level (2-tailed).

** Correlation is significant at the 0.01 level (2-tailed).

Table 5 highlights associations between demographic items (nominal data) and global health competency items (ordinal scale data). Note that languages in the “spoken languages at home” demographic item are languages identified by LIPs (see Questionnaire, Supplement 1). Table 5 lists the demographic items with the most associations first, to demographic items with the least associations last. Results show that the demographic item “does your LIP work with

organizations in the healthcare space: Ontario health teams” was significantly associated with many of the global health competencies.

Table 5

Associations Between Demographic Items and Global Health Competency Items

Demographic Item	Global Health Competency	Spearman’s rho
Does your LIP work with organizations in the healthcare space: Ontario Health Teams	(Competency 1) Knowledge about issues that affect the health of immigrants/newcomers (e.g., major causes of disease and death) via credible sources (e.g., professional bodies, peer-reviewed research)	r(28)=.467*, p=.012
	(Competency 2) Understand major social and economic environmental factors that impact access to and quality of health services within your community (e.g., education, income, social support, physical environment) and how these factors can influence immigrant health	r(28)=.515**, p=.005
	(Competency 3) Articulate barriers to healthcare in low-resource settings locally and describe factors that contribute to this, and strategies to address this problem	r(28)=.520**, p=.005
	(Competency 4) Describe how cultural context influences perceptions of health and disease	r(28)=.380*, p.046
	(Competency 5) Describe the Ontario health system and its policies and effects on provision of healthcare for immigrants	r(28)=.500**, p=.007
	(Competency 6) Knowledge of the roles and relationships of the major entities influencing your communities’ health and development (e.g., Ministries, departments, corporations)	r(28)=.529**, p=.004
	(Competency 7) Skills in policy analysis and policy development for immigrant access to healthcare services	r(28)=.513**, p=.005
	(Competency 8) Skills to create opportunities to access federal decision-makers concerning health services for immigrants and newcomers in the community	r(27)= .569**, p=.002
	(Competency 9) Skills to create opportunities to access provincial decision-makers concerning health services for immigrants and newcomers in the community	r(27)=.632**, p < .001
	(Competency 10) Skills to create opportunities to access municipal decision-makers concerning health services for immigrants and newcomers in the community	r(28)=.733**, p < .001
	(Competency 11) Skills to create opportunities to access organizational/ community/other decision-makers concerning health services for immigrants and newcomers	r(28)=.604**, p < .001
	(Competency 12) Develop approaches to gain access to immigrant communities served	r(28)=.481**, p=.010
	(Competency 13) Demonstrate diplomacy and build trust with community partners working in the health sector	r(28)=.502**, p=.007
	(Competency 14) Skills to build coalitions to work collectively on access to healthcare issues	r(28)=.491**, p=.008
	(Competency 15) Cocreate strategies with the community to strengthen community capabilities, and contribute to reduction in health differences and	r(28)=.377*, p=.048

	improvement of community health	
	(Competency 19) Apply leadership practices that support collaboration and team effectiveness	r(28)=.433*, p=.021
	(Competency 20) Implement strategies to engage marginalized and vulnerable populations in making decisions that affect their health and wellbeing	r(28)=.458*, p=.014
Staff region of origin or birth: Europe	(Competency 1) Knowledge about issues that affect the health of immigrants/newcomers (e.g., major causes of disease and death) via credible sources (e.g., professional bodies, peer-reviewed research)	r(28)=.450*, p=.016
	(Competency 2) Understand major social and economic environmental factors that impact access to and quality of health services within your community (e.g., education, income, social support, physical environment) and how these factors can influence immigrant health	r(28)=.424*, p=.025
	(Competency 4) Describe how cultural context influences perceptions of health and disease	r(28)=.437*, p=.020
	(Competency 5) Describe the Ontario health system and its policies and effects on provision of healthcare for immigrants	r(28)=.422*, p=.025
	(Competency 8) Skills to create opportunities to access federal decision-makers concerning health services for immigrants and newcomers in the community	r(27)=.402*, p=.038
	(Competency 12) Develop approaches to gain access to immigrant communities served	r(28)=.426*, p=.024
	(Competency 16) Skills in communication (e.g., to help create and operate immigrant and newcomer health campaigns and awareness-building material)	r(28)=.394*, p=.038
	(Competency 19) Apply leadership practices that support collaboration and team effectiveness	r(28)=.397*, p=.036
	(Competency 20) Implement strategies to engage marginalized and vulnerable populations in making decisions that affect their health and wellbeing	r(28)=.482**, p=.009
Does your LIP work with organizations in the healthcare space: Other- includes community health centres	(Competency 3) Articulate barriers to healthcare in low-resource settings locally and describe factors that contribute to this, and strategies to address this problem	r(28)=.422*, p=.025
	(Competency 10) Skills to create opportunities to access municipal decision-makers concerning health services for immigrants and newcomers in the community	r(28)=.405*, p=.033
	(Competency 18) Exhibit interprofessional values that demonstrate respect for, and awareness of, the unique cultures, values, roles/responsibilities and expertise represented by other groups that work in the healthcare space	r(28)=.475*, p=.011
	(Competency 19) Apply leadership practices that support collaboration and team effectiveness	r(28)=.411*, p=.030
Staff region of origin or birth: Canada	(Competency 7) Skills in policy analysis and policy development for immigrant access to healthcare services	r(28)=.415*, p=.028
	(Competency 13) Demonstrate diplomacy and build trust with community partners working in the health sector	r(28)=.548**, p=.003
	(Competency 14) Skills to build coalitions to work collectively on access to healthcare issues	r(28)=.446*, p=.018
	(Competency 19) Apply leadership practices that support collaboration and team effectiveness	r(28)=.375*, p=.050

Is the community your LIP covers primarily urban, urban/rural mix, or primarily rural?	(Competency 1) Knowledge about issues that affect the health of immigrants/newcomers (e.g., major causes of disease and death) via credible sources (e.g., professional bodies, peer-reviewed research)	r(28)=-.596**, p < .001
	(Competency 2) Understand major social and economic environmental factors that impact access to and quality of health services within your community (e.g., education, income, social support, physical environment) and how these factors can influence immigrant health	r(28)=-.484**, p=.009
	(Competency 3) Articulate barriers to healthcare in low-resource settings locally and describe factors that contribute to this, and strategies to address this problem	r(28)=-.399*, p=.035
Does your LIP work with organizations in the healthcare space: Public Health Unit	(Competency 3) Articulate barriers to healthcare in low-resource settings locally and describe factors that contribute to this, and strategies to address this problem	r(28)=.449*, p=.017
	(Competency 17) Skills for knowledge brokering	r(28)=.452*, p=.016
	(Competency 21) Conduct a community health needs assessment and identify partners in the service provision ecosystem that are best positioned to support this task	r(26)=.531**, p=.005
Staff region of origin or birth: Asia	(Competency 3) Articulate barriers to healthcare in low-resource settings locally and describe factors that contribute to this, and strategies to address this problem	r(28)=.444*, p=.018
	(Competency 13) Demonstrate diplomacy and build trust with community partners working in the health sector	r(28)=.395*, p=.038
	(Competency 14) Skills to build coalitions to work collectively on access to healthcare issues	r(28)=.447*, p=.017
Spoken languages at home: Hindi	(Competency 1) Knowledge about issues that affect the health of immigrants/newcomers (e.g., major causes of disease and death) via credible sources (e.g., professional bodies, peer-reviewed research)	r(28)=.422*, p=.025
	(Competency 3) Articulate barriers to healthcare in low-resource settings locally and describe factors that contribute to this, and strategies to address this problem	r(28)=.454*, p=.015
Staff region of origin or birth: Americas not including Canada	(Competency 21) Conduct a community health needs assessment and identify partners in the service provision ecosystem that are best positioned to support this task	r(26)=-.432*, p=.028
Spoken languages at home: Slavic languages	(Competency 16) Skills in communication (e.g., to help create and operate immigrant and newcomer health campaigns and awareness-building material)	r(28)=-.394*, p=.038
Spoken languages at home: Gujarati	(Competency 16) Skills in communication (e.g., to help create and operate immigrant and newcomer health campaigns and awareness-building material)	r(28)=-.379*, p=.047
Does your LIP work with organizations in the healthcare space: Public Health Ontario	(Competency 15) Cocreate strategies with the community to strengthen community capabilities, and contribute to reduction in health differences and improvement of community health	r(28)=.415*, p=.028
Does your LIP work with organizations in the healthcare space IRCC	(Competency 11) Skills to create opportunities to access organizational/ community/other decision-makers concerning health services for immigrants and newcomers	r(28)=.390*, p=.040
Gender of LIP staff: male	(Competency 14) Skills to build coalitions to work collectively on access to healthcare issues	r(28)=.445*, p=.018

* Association is significant at the 0.05 level (2-tailed).

** Association is significant at the 0.01 level (2-tailed).

Tables 6 and 7 highlight findings from the Mann U Whitney group differences test and Kruskal Wallis three group comparison test, respectively, and lists the global health competencies where differences exist across the demographic categories (refer to table 3 for corresponding competency description of competency number listed). With regard to table 7, pairwise comparisons were performed using Dunn's (1964) procedure with a Bonferroni correction for multiple comparisons. Adjusted p-values are presented. Values are mean ranks unless otherwise stated. This post hoc analysis revealed statistically significant differences in competency “1” scores between the rural (mean rank= 3.50) and urban (mean rank= 20.36) ($p = .006$), but not between any other group combination. This post hoc analysis also revealed statistically significant differences in competency “2” scores between the rural (mean rank= 3.17) and urban (mean rank= 17.64) ($p = .008$), but not between any other group combination. Based on the data of the association analysis regarding the demographic variable primarily urban/urban-rural mix/primarily rural and the global health competencies, we can deduce that LIP staff working in primarily urban communities had positive associations with competency 1 and competency 2.

Table 6

Differences Between Two Independent, Categorical Groups When the Dependent Variable is Either Ordinal or Continuous.

Demographic category (yes or no)	Differences found across demographic categories with regard to Competency #
Does your LIP work with organizations in the healthcare space: Ontario Health Teams	1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 20
Does your LIP work with organizations in the healthcare space: Public Health Units	3, 17
Does your LIP work with organizations in the healthcare space: Other	3
Staff region of origin or birth: Europe	1, 4, 5, 8, 12, 20
Staff region of origin or birth: Canada	7, 13
Staff region of origin or birth: Asia	3

Table 7

Differences Between Three Nominal Groups.

Demographic variables	Differences found across demographic categories with regard to Competency #
Is the community your LIP services primarily urban, urban-rural mix, or primarily rural	1, 2

3.7 Discussion

This study establishes core global health competencies for settlement coordination organizations working with partners in the health space to support immigrants. Some components of the 22 global health competencies are similar to those identified in recent health professional frameworks; a medical undergraduate curriculum framework for migrant and refugee health (Gruner, et al., 2022) outlines competency-based learning objectives under the domains of expert, communicator, collaborator, leader, health advocate, professional, and scholar. As LIPs work in collaboratives, it is essential to understand which global health competencies can complement those of a health professional, and where LIPs can provide support in areas where they may be more knowledgeable or skilled (e.g. bridging partners, creating opportunities to access decision-makers).

As we focus on access to healthcare services, we are essentially dealing with aspects of a community health worker (CHW) role within a LIP. Since many LIPs are small in capacity, and due to mandated priorities, they may not be able to hire a designated CHW. Having some CHW competencies reflected within this tool for immigrant-serving settlement coordination organizations is of value (also of value, to note LIP competencies that are specific to settlement-type organizations). A competencies framework for CHWs developed by Covert et al. (2019) establishes CHW competency domains such as: assessment (aligns with global health competency # 21, 22); community health practice (aligns with global health competency #11, 12, 13,14, 15);

communication (aligns with global health competency # 3, 4, 16, 17); diversity and inclusion (aligns with global health competency # 2, 4, 5); professional practice (aligns with global health competency # 7, 18, 19); and disease prevention and management (aligns with global health competency #1). Although overlaps exist, LIPs are uniquely positioned as organizations working within and across multiple sectors. They complement the role of partners such as CHWs by enhancing existing competencies and introducing new skills; for example, LIPs excel in creating opportunities to engage with organizational, community, and municipal decision-makers regarding health services for immigrants and newcomers. CHWs possess skills that LIPs may not require in their wheelhouse — thus, recognizing and integrating CHW competencies and expertise is essential to support healthcare access for immigrants.

3.7.1 Limitations and Future Research

Since this study used purposeful sampling involving all LIPs, it is not random. Future research may consider increasing the overall LIP sample size to support further subgroup analyses (i.e., to explore possible gender demographic items associations with competencies) by expanding the questionnaire to LIPs outside of Ontario and/or to the *Réseaux en immigration francophone* in and beyond Ontario.

3.7.2 Conclusion

Twenty-eight Local Immigration Partnerships across Ontario participated in the study. Participants tended to have higher confidence in competencies that involved communication skills, leadership, building coalitions, creating opportunities to access local communities and authorities. Participating LIPs had lower confidence with respect to technical tasks such as analyzing policy, planning, implementing and/or evaluating health-centred programs, and creating opportunities to access higher-level decision-makers. All agreed that 18 of the 22 competencies were relevant.

Correlations between demographic items are seen (e.g., “number of years LIP has been supporting access to primary healthcare services” and “number of spoken languages of LIP staff at home or at the LIP, other than English” are both correlated with confidence in many global health competencies). This study also found associations and group differences concerning demographic items and competencies. These findings highlight both strengths and gaps that can inform targeted capacity-building strategies for LIPs operating at the intersection of immigrant settlement and health systems.

3.7.3 Contributions to Knowledge

What does this study add to existing knowledge?

- It establishes a baseline of core global health competencies relevant to staff in immigrant settlement coordination organizations (e.g., LIPs) working in collaboration with healthcare service providers.
- It demonstrates how equity, diversity, and inclusion principles can be operationalized within LIP practices to support public health initiatives.

What are the key implications for public health interventions, practice or policy?

- Identifying global health competencies where staff report lower confidence can inform targeted policies and interventions — such as training programs, strategic partnerships, or consultations with organizations that demonstrate strength in these areas — to enhance LIP capacity, including staff skills and knowledge. Enhancing these competencies positions settlement staff to better support collaborative approaches for improving immigrant access to health services.

- Settlement organizations can use the tool developed in this study to assess demographic characteristics (e.g., staff language diversity) that may contribute to higher confidence in global health competencies, informing recruitment and capacity-building strategies.

3.8 References

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Supplement 1

LIP Questionnaire: Global Health Cross-Cultural Competencies

Welcome!

This Questionnaire is part of the study “Local Immigration Partnerships in Ontario: Structural Barriers, and Immigrant Equity Considerations for Local Healthy Public Policy Formation.” This Questionnaire has been developed in collaboration with LIP Advisors and senior researchers from University of Ottawa, Laurentian University and Western University.

Why focus on LIPs? LIPs are diverse in terms of their governance, structure, projects, as well as their staff. LIPs share some commonalities but they are unique in how they approach immigration issues; some of these approaches depend on their context – i.e., partners and structures, as well as community needs and available resources. Although a diverse group, many LIPs have established strengths and characteristics that support initiatives at the local level to improve settlement service provision around access to immigrant health programming services. As community-wide, multi-sectoral partnerships, LIPs are in a position to help address concerns about how marginalized populations experience health inequities. Furthermore, the networks LIPs maintain, to strengthen a community’s capacity to welcome immigrants and improve integration outcomes may also be a useful resource to enhance access to healthcare service.

The questionnaire seeks to identify the existing and potential competencies of LIP staff in Ontario that can enhance levels of engagement with and support to the health sector to improve immigrants’ access to local primary healthcare services. The questions being asked in this survey allow us to better understand the core global health cross-cultural competencies LIPs possess to work within the healthcare space. This understanding will help bring more formal recognition and respect to the under-recognized work and contributions LIPs bring to the Ontario healthcare space. This survey is about LIP competencies (please complete the questionnaire with the assistance of your LIP staff team).

Thank you for your time. I hope the findings of this study are also of interest and use to you.

Sincerely,

Ayesha Ratnayake, PhD candidate

Please place an “X” on the line to:

- confirm a senior member or associate of the LIP (e.g., in a leadership role, or having senior-level experience) is completing this questionnaire as a knowledgeable informer representing your LIP (required)
- confirm this completed questionnaire has been reviewed with your LIP staff (required)
- confirm this completed questionnaire has been approved by your LIP council (required)



Section 1: LIP Demographics

Please type in the best response to describe your LIP.

1.1. Name of LIP and location (city) in Ontario:

Please specify: _____ (name of LIP; city name)

1.2. Where is the LIP housed?

Please specify: _____ (name of organization hosting the LIP)

1.3. Is the community your LIP covers primarily urban, urban/rural mix or primarily rural?

Please specify: _____ (urban, urban/rural, or rural)

1.4. Year when your LIP was founded:

Please specify: _____ (year)

1.5. Does your LIP work with organizations in the healthcare space? _____ (yes or no)

Place an “x” beside all options that apply.

Ontario Health Teams	
Public Health Ontario	
Immigration, Refugees and Citizenship Canada	
Public Health Unit	
Other (please specify, if willing):	

1.6. Number of years the LIP has been supporting access to primary healthcare services

Note: If none, insert “0”. If less than 1 year, insert “less than 1 year”.

Please specify: _____ (number of years)

Staff Demographics.

1.7. How many FTEs (full time equivalents) are on staff with your LIP?

Please specify: _____ (number of FTEs)

1.8. How many PTEs (part time equivalents) are on staff with your LIP?

Please specify: _____ (number of PTEs)

1.9. Age ranges of LIP staff (place an “x” beside all options that apply):

Less than or equal to 40 years old	
41 to 60 years old	
Equal to 61 years old or more	

1.10. Gender of LIP staff (place an “x” beside all options that apply):

Male	
Female	
Other Prefer to self-describe as (please specify)	

1.11. Spoken languages of staff, at home or at the LIP, other than English:

Please specify: _____

1.12. Staff region of origin or birth (place an “x” beside all options that apply):

Africa	
Americas (not including Canada)	
Canada	
Asia	

Europe	
Oceania (Australia and New Zealand, Melanesia, Micronesia and Polynesia)	
Other (please specify)	



Section 2: Global Health Cross-Cultural Competencies

The capacity of LIPs to support access to primary healthcare services of any kind can be enhanced by global health cross-cultural competencies (i.e., skills, attributes, as well as knowledge).

As you complete the questionnaire below, it may be helpful to think of initiatives that your LIP/organization has developed or is working towards for immigrant/newcomer access to healthcare.

PART 1: Open-ended Questions:

1. Describe examples of activities in which your LIP is involved when it comes to increasing access to healthcare for immigrants (e.g., training, webinars, reports published, activities with regional health entities, implemented strategies to engage partners/newcomers).

2. To what degree (in what way) is resourcing a barrier in advocating or acting for increased access to healthcare in your area?

3. Other Comments

Can we contact you to follow-up on the answers provided above?

_____ (yes/no)

PART 2: Please rate your LIP staff’s level of confidence in the following competencies:

Note: These competencies questions have been validated across health professional programs. A global health cross-cultural competencies framework that is adapted to LIPs is useful for LIPs to demonstrate confidence in the healthcare space. This questionnaire may also help LIPs identify competencies that LIP staff may not feel confident in (and seek those competencies, as needed, within their LIP collaborative). A competencies tool can be used in the future as a pre-post training instrument for those seeking to enhance support to culturally and linguistically diverse populations ([see example here](#)). Please use the Not Relevant (NR) option only when you deem the competency is not a useful existing or potential competency for LIPs in Ontario when engaging with and supporting the health sector to improve immigrants’ access to local primary healthcare services. Consider your LIPs’ current and future potential strategic priorities in the health space.

GLOBAL HEALTH CROSS-CULTURAL COMPETENCIES	No confidence	Slight confidence	Moderate confidence	High confidence	NR
1. Knowledge about issues that affect the health of immigrants/newcomers (e.g., major causes of disease and death) via credible sources (e.g., professional bodies, peer-reviewed research)					
2. Understand major social and economic environmental factors that impact access to and quality of health services within your community (e.g., education, income, social support, physical environment) and how these factors can influence immigrant health					
3. Articulate barriers to healthcare in low-resource settings locally (i.e., barriers in low-resource settings may include lack of funds to cover healthcare costs, limited access to medication, equipment, supplies, lack of human health resources) and describe factors that contribute to this, and strategies to address this problem (e.g., immigrants in frontline care roles).					
4. Describe how cultural context influences perceptions of health and disease					
5. Describe the Ontario health system and its policies and effects on provision of healthcare for immigrants (e.g., requires understanding OHIP, Public Health, provincial programs, Ontario Health Teams,					

GLOBAL HEALTH CROSS-CULTURAL COMPETENCIES	No confidence	Slight confidence	Moderate confidence	High confidence	NR
Ontario Health, hospitals, long-term care homes, community care, community support agencies)					
6. Knowledge of the roles and relationships of the major entities influencing your communities' health and development (e.g., Ministries, departments, corporations)					
7. Skills in policy analysis and policy development for immigrant access to healthcare services					
8. Skills to create opportunities to access federal decision-makers concerning health services for immigrants and newcomers in the community					
9. Skills to create opportunities to access provincial decision-makers concerning health services for immigrants and newcomers in the community					
10. Skills to create opportunities to access municipal decision-makers concerning health services for immigrants and newcomers in the community					
11. Skills to create opportunities to access organizational/community/other decision-makers concerning health services for immigrants and newcomers					
12. Develop approaches to gain access to immigrant communities served					
13. Demonstrate diplomacy and build trust with community partners working in the health sector					
14. Skills to build coalitions to work collectively on access to healthcare issues (e.g., being able to build relationships and include representatives of diverse constituencies, from the health space, in community partnerships, and foster interactive learning with these partners)					
15. Cocreate strategies with the community to strengthen community capabilities, and contribute to reduction in health differences and improvement of community health					

GLOBAL HEALTH CROSS-CULTURAL COMPETENCIES	No confidence	Slight confidence	Moderate confidence	High confidence	NR
16. Skills in communication (e.g., to help create and operate immigrant and newcomer health campaigns and awareness-building material)					
17. Skills for knowledge brokering (e.g., how to inform target audiences; link groups with similar goals; build adaptive capacity; work collaboratively with key stakeholders to facilitate the transfer and exchange of health information; facilitates the identification, access, assessment, interpretation, and translation of research evidence into local policy and practice)					
18. Exhibit interprofessional values that demonstrate respect for, and awareness of, the unique cultures, values, roles/responsibilities and expertise represented by other groups that work in the healthcare space					
19. Apply leadership practices that support collaboration and team effectiveness					
20. Implement strategies to engage marginalized and vulnerable populations in making decisions that affect their health and wellbeing					
21. Conduct a community health needs assessment and identify partners in the service provision ecosystem that are best positioned to support this task					
22. Plan, implement, and evaluate an access to healthcare program					

Considerations:

Please reflect on you above answers and provide any considerations around the certainty of your responses.

Refer a Colleague

We would like to include the perspective of other LIPs in Ontario. Please forward the invitation and poster to participate in the survey to interested colleagues.

Thank you for taking the time to complete this questionnaire!

Your responses are greatly appreciated.

Please email the questionnaire back to Ayesha Ratnayake.

If you have any questions or concerns, please contact Ayesha.

Discover more resource tools for LIPs at www.ccirhken.ca

**Please Password Protect your Questionnaire before sending to _____
Text your chosen Password to _____**

Open and save your Microsoft Word document.
Click **File** (the tab in upper-left corner of the Word window)
Click the **Info** tab.
Click **Protect Document**.
Click **Encrypt with Password**.
Enter a password.
Click **OK**.
Re-enter the password, then click **OK**.

Supplement 2

Letter of Information and Consent

Implied Consent

Title of the study: Local Immigration Partnerships in Ontario: Global Health Cross-Cultural Competencies to Help Address Structural Barriers in Access to Primary Healthcare Services

Principal Investigator(s) (Supervisor): Dr. Kevin Pottie
Professor
Department of Family Medicine
Western University
London, ON

Co-investigator (Student): Ayesha Ratnayake, MPH, PhD (c)
University of Ottawa
Ottawa, ON

Invitation to Participate: You are invited to participate in the abovementioned pilot phase for the doctoral thesis project conducted by Ayesha Ratnayake and supervised by Dr. Kevin Pottie.

Participation: If you wish to participate in this study, please complete the attached questionnaire. Your decision to complete and return this questionnaire will be interpreted as an indication of your consent to participate. The questionnaire should take you approximately 15-20 minutes to complete. This questionnaire is in a Word Document format. You do not have to answer any questions that you do not want to answer. Once you have completed the questionnaire, please return it by email to the researcher. We would appreciate receiving the completed questionnaire within the next two weeks. If we do not receive it by said date, we will send you a notice of reminder.

Purpose of the Study: This research seeks to identify global health cross-cultural competencies of Local Immigration Partnerships staff in Ontario that can enhance engagement with and support to the health sector to improve immigrants' access to local primary healthcare services. The questions being asked in this survey allow us to better understand the core global health cross-cultural competencies Local Immigration Partnerships possess to work within the healthcare space.

Benefits: Participants get to add their input to inform research in the academic field. Participants can contribute to the existing literature and research knowledge of Local Immigration Partnerships and their capabilities/roles. The research will contribute to knowledge about the potential of Local Immigration Partnerships to contribute to the health sector.

Risks: The foreseeable harms to the participants are minimal and include possible stress from self-reflection about skills/knowledge; recalling past events; and time-management stress from filling out a questionnaire.

If emotional or psychological discomfort occurs, the participant is free to refuse to answer any questions that may cause such discomfort.

Confidentiality and Anonymity: The information that you will share will remain strictly confidential and will be used solely for the purposes of this research. The only people who will have access to the research data are Ayesha Ratnayake and Dr. Kevin Pottie. Your answers may be used in presentations and publications but neither you (nor your organization) will be identified. In order to minimize the risk of online security breaches and to help ensure your confidentiality we recommend that you use standard safety measures such as signing out of your account; closing your browser; locking your screen or device when you are no longer using them / when you have completed the study; and deleting emails containing data after downloading or sending the completed form. Results will be published in pooled (aggregate) format. Anonymity is guaranteed since your name or any personal information will be kept confidential and will not be disclosed in study findings.

Conservation of data: The surveys will be kept on a password protected laptop and then transferred to a locked cabinet in the office of the researcher. The surveys will be kept in the cabinet for a period of 5 years after the student's thesis defense, at which time they will be destroyed.

Voluntary Participation: You are under no obligation to participate and if you choose to participate, you may refuse to answer questions that you do not want to answer. Completion and return of the questionnaire by you implies consent. You have the right to withdraw from the project at any time; and the right to refuse to answer questions without fear of reprisal or ill treatment. If you choose to withdraw, your data will be removed and destroyed.

Compensation: Compensation will be provided for those who submit their questionnaire- partially or fully completed. Compensation will be in the form of a \$40.00 e-transfer payment.

Information about the Study Results: The research findings will be made available to the research participants. Once a final paper is written, the researcher will post the paper online. Participants are asked to email the researcher for the link to the final publication.

If you have any questions or require more information about the study itself, you may contact the researcher or his/her supervisor at the numbers mentioned herein.

If you have any questions with regards to the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5, tel.: (613) 562-5387 or ethics@uottawa.ca.

Please keep this form for your records. Thank you for your time and consideration.

Name, date and signature of the researcher(s).

Supplement 3

SPSS Outputs - Nonparametric Descriptive Analysis

Please contact the researcher for specific SPSS output files.

[\[Directly download all SPSS Output files via Google Drive\]](#)

Supplement 4

Data Analysis Plan

Step 1: Survey metadata

- Survey response rate (calculation includes contact rate and cooperation rate) (Statistical Consulting and Survey Research Unit at the University of Waterloo, 2023)
- Survey reliability using Cronbach’s alpha to assess reliability (Lavrakas, 2008)
- Survey validity via content validity analysis (Bolarinwa, 2015; Rodrigues et al., 2017)

Step 2: Univariate analysis for each survey question to provide an overview of LIPs.

- Provides data on LIP staff demographics (collected data includes frequencies for categorical nominal data, ordinal data and continuous data)
- Provides data on LIP staff’s perceived level of confidence on 22 global health competencies (collected data includes frequencies for each global health competency)

The simple statistics for univariate continuous data methodology from Heeringa et al.’s 2017 Applied Survey Data Analysis (see Chapter 5 of the book) was closely followed to assess questions with continuous data.

Univariate analysis of categorical data methodology from Heeringa et al.’s 2017 Applied Survey Data Analysis (see Chapter 6 of the book) was closely followed to answer assess questions with ordinal and nominal data.

Step 3: Bivariate analysis to further describe the data using correlations and associations.

Bivariate data analyses and reporting are important as exploratory tools in the development of more complex multivariate models. Nonparametric tests will be used for ordinal data (since the survey uses a 5-point Likert scale).

- Provides data on correlations between demographic factors and 22 competencies
- Provides data on associations between demographic factors and 22 competencies
- Provides data on differences between demographic groups across 22 competencies

Bivariate analysis of continuous data methodology from Heergina et al.’s 2017 Applied Survey Data Analysis (see Chapter 5 of the book) was closely followed to assess the questions with continuous data.

Bivariate analysis of categorical data methodology from Heeringa et al.’s 2017 Applied Survey Data Analysis (see Chapter 6 of the book) was closely followed to assess the questions with ordinal and nominal data.

Correlation and association technique table below shows the tests that were applied:

Data type 1	Data type 2	Technique
Continuous	Ordinal	Spearman rank correlation

Ordinal	Ordinal	Spearman rank correlation
Ordinal	Nominal	Rank-biserial correlation (to estimate the association)

Reference: (Glass, 1966; Khamis, 2008).

Step 4: Bivariate analysis to further describe the data looking at group differences.

Bivariate analysis of continuous data methodology from Heeringa et al.'s 2017 Applied Survey Data Analysis (see Chapter 5 of the book) was closely followed to assess the questions with continuous data.

Bivariate analysis of categorical data methodology from Heeringa et al.'s 2017 Applied Survey Data Analysis (see Chapter 6 of the book) was closely followed to assess the questions with ordinal and nominal data.

The Mann-Whitney U test will be used to see if there are differences between two independent groups when the dependent variable is either ordinal or continuous, but not normally distributed. The independent variable should consist of two categorical, independent groups. Comparison is based on medians because the data is non-normal ordinal.

The Kruskal-Wallis H test is a rank-based nonparametric test that can be used to determine if there are statistically significant differences between two or more groups of an independent variable on a continuous or ordinal dependent variable. A Kruskal-Wallis H test will be used to determine if there were differences in competency score between three groups of participants.

References

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Supplement 5

5a. Instructions and Rating Form for Validation of LIP Competencies Questionnaire

As an expert juror, you are being asked to validate the LIP questionnaire that measures global health competencies of LIP staff in Ontario. Essentially, the questionnaire identifies the existing and potential competencies specific to LIP staff in Ontario that can enhance levels of engagement with and support to the health sector to improve immigrants' access to local primary healthcare services.

In developing this LIP questionnaire we considered a large number of global health competencies, that have been validated across health professional programs, for inclusion in the final version; twenty-two competency items were adapted for this LIP global health cross-cultural competencies questionnaire. A global health cross-cultural competencies framework that is adapted to LIPs is useful for LIPs to demonstrate confidence and participate in the healthcare space. This questionnaire (tool) may also help LIPs identify competencies that LIP staff may not feel confident in (and seek those competencies, as needed, within their LIP collaborative). Further, a competencies tool can be used in the future as a pre-post training instrument for those LIPs seeking to enhance support to culturally and linguistically diverse populations.

INSTRUCTIONS FOR VALIDATING THE QUESTIONNAIRE TOOL:

Kindly review this tool (competencies chart below) and provide your feedback on the following:

- The relevance of each question in the tool (how important is the question)
- The clarity of each question (how clear is the wording)
- The essentiality of each question (how necessary is the question)
- Recommendations for improvement of each question (for future revisions).

PART A: Please use the following scales to select a number and insert into the correct column of the chart below:

Relevant Scale: 1= Not relevant; 2 = Somewhat relevant; 3 = Quite relevant; 4 = Very relevant

Clarity Scale: 1= Not clear; 2 = Item needs some revision; 3 = Very clear

Essential Scale: 1 = Not essential; 2 = Useful but not essential; 3 = Essential

PART B: Please answer the following questions:

1. How long have you been working for your LIP? _____ (e.g. 2 years and 3 months)

2. Where is your LIP located? _____ (city only)

GLOBAL HEALTH CROSS-CULTURAL COMPETENCIES	RELEVANCE (refer to scale above)	CLARITY (refer to scale above)	ESSENTIALITY (refer to scale above)	RECOMMENDATIONS
1. Knowledge about issues that affect the health of immigrants/newcomers (e.g., major causes of disease and death) via credible sources (e.g., professional bodies, peer-reviewed research)				
2. Understand major social and economic environmental factors that impact access to and quality of health services within your community (e.g., education, income, social support, physical environment) and how these factors can influence immigrant health				
3. Articulate barriers to healthcare in low-resource settings locally (i.e., barriers in low-resource settings may include lack of funds to cover healthcare costs, limited access to medication, equipment, supplies, lack of human health resources) and describe factors that contribute to this, and strategies to address this problem (e.g., immigrants in frontline care roles).				
4. Describe how cultural context influences perceptions of health and disease				
5. Describe the Ontario health system and its policies and effects on provision of healthcare for immigrants (e.g., requires understanding OHIP, Public Health, provincial programs, Ontario Health Teams, Ontario Health, hospitals, long-term care homes, community care, community support agencies)				
6. Knowledge of the roles and relationships of the major entities influencing your communities' health and development (e.g., Ministries, departments, corporations)				
7. Skills in policy analysis and policy development for immigrant access to healthcare services				
8. Skills to create opportunities to access federal decision-makers concerning health services for immigrants and newcomers in the community				
9. Skills to create opportunities to access provincial decision-makers concerning health services for immigrants and newcomers in the community				
10. Skills to create opportunities to access municipal decision-makers concerning health services for immigrants and newcomers in the community				
11. Skills to create opportunities to access organizational/community/other decision-makers concerning health services for immigrants and newcomers				

GLOBAL HEALTH CROSS-CULTURAL COMPETENCIES	RELEVANCE (refer to scale above)	CLARITY (refer to scale above)	ESSENTIALITY (refer to scale above)	RECOMMENDATIONS
12. Develop approaches to gain access to immigrant communities served				
13. Demonstrate diplomacy and build trust with community partners working in the health sector				
14. Skills to build coalitions to work collectively on access to healthcare issues (e.g., being able to build relationships and include representatives of diverse constituencies, from the health space, in community partnerships, and foster interactive learning with these partners)				
15. Cocreate strategies with the community to strengthen community capabilities, and contribute to reduction in health differences and improvement of community health				
16. Skills in communication (e.g., to help create and operate immigrant and newcomer health campaigns and awareness-building material)				
17. Skills for knowledge brokering (e.g., how to inform target audiences; link groups with similar goals; build adaptive capacity; work collaboratively with key stakeholders to facilitate the transfer and exchange of health information; facilitates the identification, access, assessment, interpretation, and translation of research evidence into local policy and practice)				
18. Exhibit interprofessional values that demonstrate respect for, and awareness of, the unique cultures, values, roles/responsibilities and expertise represented by other groups that work in the healthcare space				
19. Apply leadership practices that support collaboration and team effectiveness				
20. Implement strategies to engage marginalized and vulnerable populations in making decisions that affect their health and wellbeing				
21. Conduct a community health needs assessment and identify partners in the service provision ecosystem that are best positioned to support this task				
22. Plan, implement, and evaluate an access to healthcare program				

THIS IS THE END. THANK YOU!

Supplement 5

5b. Validity Calculations

[\[Directly download the Excel file containing content validity calculations via Google Drive\]](#)

CHAPTER 4: ARTICLE 3

4.1 Article Overview

Article Title

Achievements and Experiences of a Local Immigration Partnership (LIP) in Ontario Engaging with the Health Sector to Support Access to Healthcare: A Case Study

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Conflicts of Interest

The authors declare no conflict of interest.

Ethics Approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the University of Ottawa's Research Ethics Board (certificate of ethics approval number H-01-23-8818) and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

4.2 Abstract

Introduction: As Canada continues to welcome immigrants and adjust immigration levels to match community capacity, the importance of addressing newcomers' healthcare needs is increasingly recognized. Local Immigration Partnerships (LIPs) in Canada represent a key resource for coordinating community settlement. Established in 2009, LIPs have supported initiatives across various sectors, including health. Yet little attention has been paid to the role, experiences and achievements of LIPs in facilitating immigrants' and newcomers' access to healthcare. **Methods:** We conducted a case study on the Ottawa Local Immigration Partnership (OLIP) using a qualitative approach, including interviews, a focus group, and document analysis. **Results:** Through thematic analysis, we identified four main themes: 1) cross-sectoral coordination and collaboration, including convening partners from diverse disciplines or professions, coordinating plans across or within sectors, and facilitating knowledge mobilization and knowledge transfer; 2) advocacy and policy influence, by supporting inclusive public health policies, advocating for health equity, and connecting with decision-makers in a health advisory capacity; 3) engaging and empowering communities, through community engagement, actions to improve local organizational responses to immigrant health needs, and efforts to break down individual-level barriers to accessing healthcare; and 4) building capacity and informing service delivery, by informing institutional programming, building sector-wide capacity, and supporting

health professional development. Discussion/Conclusion: Findings show that OLIP supports and influences factors related to access to healthcare for immigrants through efforts at the intrapersonal, interpersonal/relationship, community, institutional/organizational, and broader policy levels. Challenges regarding resource constraints, governance and organizational structure, and relationship management are discussed.

Keywords: access to healthcare, health equity, immigrant populations, settlement coordination organizations.

4.3 Introduction

As Canada continues to welcome immigrants and adjusts its immigration levels to match community capacity, the importance of meeting the healthcare needs of newcomers and immigrants is increasingly recognized (Tsai & Gharari, 2023). Canada's 2025-2027 Immigration Levels Plan adopts an inclusive approach, incorporating the perspectives of communities and interest-holders, including those from the health sector, in the settlement and integration of newcomers (Immigration, Refugees and Citizenship Canada, 2024). The renewed focus on operationalizing diversity, equity, and inclusion — by prioritizing access to post-COVID-19 healthcare services for immigrant and racialized populations — has prompted medical experts to explore opportunities for intersectoral collaborations with settlement organizations (Gruner et al., 2022).

Local coordination organizations that support the settlement and integration of newcomers have the networks to convene key actors within and across sectors. Such organizations may be well positioned to facilitate intersectoral collaborations and advance equity considerations at the local level (Bradford & Andrew, 2010; Schmidtke, 2019). In Canada, the Local Immigration

Partnerships (LIPs) represent key resources for coordinating settlement at the community level in many regions.

LIPs began emerging in Ontario in 2008, following the signing of the 2005 Canada-Ontario Immigration Agreement (COIA) (Veronis, 2019). Over time, LIPs expanded their roles beyond their initial mandates and have shown interest in supporting the health sector's involvement in immigrant health (Citizenship and Immigration Canada, 2014; Esses et al., 2023). For example, the London & Middlesex LIP in Ontario developed a guide outlining basic healthcare services and information on how and when to access these services (London & Middlesex Local Immigration Partnership, 2022). Similarly, the Peel Newcomer Strategy Group and Service Delivery Network developed a report outlining the role of the settlement sector in supporting the mental health of immigrants and newcomers, with recommended strategies to improve access to mental health services and supports (Peel Newcomer Strategy Group & Service Delivery Network, 2023). Additionally, the Windsor-Essex LIP, in collaboration with the Windsor-Essex County Health Unit, created a tool to survey partner organizations about clients' needs during the COVID-19 pandemic, aiming to better understand and support the health needs of the newcomer population (Windsor-Essex County Health Unit & Windsor-Essex Local Immigration Partnership, 2020).

Moreover, findings from Ratnayake et al.'s (2022) scoping review demonstrated that local immigrant settlement organizations support access to primary healthcare services at the individual, relationship and community levels. They achieve this by collaborating with health sector partners, connecting clients to health services and service providers, advocating for immigrant health, offering educational programming, and initiating community development/mobilization and advocacy activities. Yet further research is needed to better understand the influence and impact of these organizations on service delivery, healthcare planning, and reducing barriers to access.

Using mostly qualitative methods, several studies provide insights into the core roles of Ontario-based LIPs when collaborating with key stakeholders across different sectors, including health (Cullen & Walton-Roberts, 2019; Veronis, 2019; Walton-Roberts et al., 2019). These roles encompass leadership skills, organizing and mobilizing local communities and key actors, engaging stakeholders in research and community planning, and supporting the coordination of social services. Nevertheless, there is limited research adopting quantitative approaches and socioeconomic measurements of LIP-serving communities and LIP activities, particularly regarding specific indicators of accessible and suitable healthcare (Ravanera et al., 2012). While some studies have examined LIPs' core roles and documented examples of their contributions within the healthcare space, more research is needed to better understand their experiences and outcomes in supporting access to healthcare within the health sector.

This study employs a qualitative case study approach to investigate the experiences and efforts of an established Ontario LIP — the Ottawa Local Immigration Partnership (OLIP) — in engaging with the health sector to support immigrant access to healthcare. By focusing on a single LIP in Ontario, we aim to provide an in-depth examination of its strategies, networks, and outcomes. Specifically, our objectives are to: (1) identify and analyze the strategies and initiatives OLIP implemented to facilitate immigrants' access to primary healthcare services; (2) examine the stakeholder networks and cross-sectoral collaborations developed by OLIP to address healthcare access barriers for immigrants; and (3) identify and deepen our understanding of the outcomes and challenges of OLIP's healthcare-focused activities and their implications for immigrant health equity policy.

To structure our investigation, we employ Bronfenbrenner's (1977) Social-Ecological Model (SEM) as a conceptual framework. The SEM provides a multi-level approach to

understanding how factors at the intrapersonal, interpersonal, community, institutional, and policy levels interact to influence health outcomes and service access. This framework is particularly suitable for examining the work of LIPs, which function across multiple levels of the social ecosystem — engaging with individual immigrants, community organizations, healthcare institutions, and policy environments. The SEM enables us to systematically analyze how the LIPs influence healthcare access through various levels of intervention and collaboration. Levels of influence refer to the individual/intrapersonal level (e.g., individual characteristics and behaviors); interpersonal/relationship level (e.g., formalized or informal supports within the immediate environment); community level (e.g., norms, common standards, networks in existence around a group of people or individuals); institutional/organizational level (e.g., policies, relationships, and structures of institutions/organizations); and policy/societal level (e.g., higher-level, broad societal conditions affecting the individual or group) (Caperon et al., 2022; Family and Youth Services Bureau, 2023).

Examining the achievements and challenges of a LIP in navigating the complex health system through a SEM lens provides valuable insights into multilevel interventions for immigrant healthcare access. By analyzing how a LIP's activities function across individual, interpersonal, community, organizational, and policy levels, this study contributes to our understanding of settlement coordination organizations as bridging mechanisms between sectors. This approach reveals how LIPs operate within the settlement ecosystem to influence various dimensions of healthcare access — availability, accessibility, affordability, acceptability, and accommodation — for immigrant populations. These insights are crucial for settlement organizations, healthcare providers, and policymakers seeking to improve immigrant health outcomes. By identifying successful strategies and areas for improvement at each socio-ecological level, this study

contributes to developing evidence-based interventions and policies that enable LIPs and other community organizations to effectively support newcomers' access to healthcare.

We first present our methodology, including our data collection and analysis methods. Next, we discuss our findings, focusing on four emerging themes. We conclude with reflections on the contributions to research, policy, and practice.

4.4 Methodology

This research employs a qualitative case study approach (Crowe et al., 2011; Stake, 1995) and builds on our previous work (Ratnayake et al., 2022). The Ottawa Local Immigration Partnership (OLIP) was selected for this case study because it met the following criteria: 1) the LIP had been established for over five years; 2) the LIP had a functioning health sector table or working group; 3) the LIP is located in a demographically diverse city in Ontario with a high concentration of immigrants; 4) the LIP has developed a network of local health and social service sector partners; and, 5) the LIP has a total of eight or more senior-decision making members and associates that can speak to health sector activities/initiatives. Supplement 1 provides further details on the case selection process and on OLIP. A.R. sought permission from OLIP on being named as the case subject within this publication. OLIP was provided with draft copies to ensure early feedback; no objections were raised. This study received approval from the University of Ottawa's Research Ethics Board (ethics number: H-01-23-8818).

To address the research objectives, we used semi-structured interviews, a focus group, and document analysis. We adopted a hybrid inductive-deductive approach to thematic analysis (Fereday & Muir-Cochrane, 2006). The analysis was guided by the Social-Ecological Model (SEM) theoretical framework (Bronfenbrenner, 1977) and considered dimensions of access to

healthcare (Gulliford et al., 2002), allowing us to identify how the LIP influences access to healthcare for immigrant populations across multiple ecological levels.

Throughout this study, the primary investigator (A.R.) actively incorporated reflexivity into the research process. For instance, in designing the interview and focus group protocols, A.R. developed a preliminary framework and shared it with the PhD Thesis Advisory Committee (TAC) to solicit feedback on the project's design, methodology, implementation, analysis, and supporting materials. During data collection, A.R. practiced reflexive awareness by documenting emerging assumptions related to positionality by clarifying participant's key messages at the end of each discussion to ensure accurate interpretation. Additionally, LIP participants were given opportunities to review and comment on preliminary findings. A.R. also engaged in ongoing dialogue with her PhD supervisor to critically reflect on and refine the data analysis.

4.4.1 Data Collection: Interviews

We conducted 11 semi-structured in-depth interviews with OLIP members and associates to gain detailed insights into their ideas, practices, and realities within their socioeconomic and political contexts. We used purposeful sampling to recruit both core LIP members (internal to the LIP organization) and LIP associates in the health sector (Palinkas, et al., 2015). Participants included: individuals from all levels of the LIP leadership, including LIP advisory bodies (n=3); technical professionals from LIP-led health-specific working groups (n=4); and known LIP associates (i.e., community partners, collaborators, and those within the LIP network) (n=4). To minimize biases, A. R. was transparent and explicit in detailing the specific characteristics of participants within the case selection criteria (Palinkas et al., 2015) (Supplement 1). Recruitment was done using publicly available contact information and inviting participants (mostly by email)

to take part in a 45-to-90-minute, audio-recorded interview. The recruitment text also included an invitation to participate in a subsequent focus group (Supplement 2).

The interview guide included open-ended questions allowing respondents to clarify responses, provide details, and share experiences (Creswell, 2014; Ivankova et al., 2006). Questions were developed based on guidance from Kallio et al. (2016) and adapted insights from Hodgins' (2021) work on highlighting the diversity and complexity of community health worker (CHW) programs. Additionally, we drew on Shields et al.'s (2016) research on trends and issues of immigrant settlement services. The guide aimed to elicit a rich narrative of “how” and “where” achievements, challenges, and experiences occur — focusing on participants' skills, knowledge, and attributes, and referencing levels of impact (e.g., individual, relationship, community) of local, non-medical settlement coordination organizations (Ratnayake et al., 2022). Participants were given the opportunity to review and provide feedback on the guide (Supplement 3).

During the interview process, the possibility of interview bias and social desirability bias required the researcher A. R. to pay constant attention to her presence, communication style, and behaviours, and to create a welcoming and safe environment where respondents felt comfortable to share their true opinions. Interviews were audio-recorded with consent, lasted approximately 47 minutes, ranging from 31 minutes to 73 minutes, and transcribed verbatim.

4.4.2 Data Collection: Focus Group

Subsequently, one 60-minute, audio-recorded focus group session was conducted (with consent) using the Zoom platform, and later transcribed verbatim. The focus group included three core LIP members, none of whom had been previously interviewed. Although a focus group with three members is small, literature shows that it can be acceptable in exploratory or pilot studies with specialized or hard-to-reach niche groups (Johnson & Christensen, 2003; Krueger & Casey,

2000; Kuzel, 1992; Langford et al., 2002; Morgan, 1997). Based on a preliminary analysis of the interviews and identified issues, the researchers (A.R & K.B.) tailored the original interview guide specifically for the focus group; the aim was to seek new perspectives, additional information, and to further investigate issues or themes that were not sufficiently developed in the interviews (Bender & Ewbank, 1994; Freitas et al., 1998). The primary investigator, A.R., facilitated the focus group session following principles outlined by Krueger (2002). For example, A.R. intentionally managed the discussion to allow space for each participant to share any related experiences or thoughts for each question.

4.4.3 Data Collection: Complementary Document Analysis

As part of this case study, we undertook a complementary document analysis to identify relevant documents to the research question and objectives. For guidance, we consulted Morgan (2022) on conducting a qualitative document analysis, and the works of Bowen (2009), Dalglish et al. (2020), and O’Leary (2014), as needed, to inform the search, collection, and assessment of documents (Supplement 4).

Document collection involved scanning various information channels, including: OLIP’s social media platforms; LIP organizational websites such as the national LIP Secretariat website and OLIP’s home website; national platforms engaging with the LIPs (e.g., Pathways to Prosperity); OLIP partner organizations’ archives and resources; and Government of Canada databases (e.g., archived documents from Immigration, Refugees and Citizenship Canada). Google and Microsoft Edge search engines were used to scan the web. Moreover, interview and focus group participants were asked to share relevant resources. After several rounds of assessment and discussion (detailed in Supplement 4), 20 documents were selected for the study consisting of materials dating from 2012 onwards (Table 1).

Table 1

Overview of Included Documents (documents are presented in chronological order by date of publication)

Item #	Year of publication	Author(s)	Title of Document	Purpose	Type of Document
1	n.d. (Note: last revised date not shown on webpage; webpage copyright states 2024)	OLIP	Knowledge Base	This webpage section on OLIP's main website contains a repository of resources to support OLIP partners. Products include reports, articles, policy and discussion papers, reports, policy papers, and educational training material. For example, under the toolkits tab, there are resources on Language Instruction; these accessible files allow instructors to engage in discussion on priority health topics with newcomer adults.	OLIP webpage This OLIP webpage hosts partner resources (e.g., a toolkit developed by Ottawa Public Health and the Ottawa-Carleton District School Board on Language Instruction for Newcomers to Canada regarding priority health topics).
2	n.d. (Note: last revised date not shown on webpage; webpage copyright states 2024)	OLIP	Sector Table: Health and Wellbeing	This webpage (accessible through OLIP's main website) describes the functions and priorities of OLIP's Health and Wellbeing Sector table.	OLIP webpage
3	n.d. (Note: last revised date not shown on webpage; webpage copyright states 2024)	Ottawa Newcomer Health Centre	ONHC's Story	This webpage text discusses the development of the Ottawa Newcomer Health Centre and roles of collaborative organizations in the process.	ONHC webpage
4	2013	OLIP	The Latest Achievements of the OLIP Partners	This brief report highlights the achievements of OLIP partners and OLIP collaborations.	Report

5	2013	OLIP & Project team (Hindia Mohamoud, Simone Thibault, Caroline Andrew, Suzanne Doerge, Rashmi Luther, Hamdi Mohamed, Rashida Youmouri, Bill Shield, April Carrière)	Better Together: Cultivating Equitable and Inclusive Organizations in Ottawa	This is a summary report on the first phase of the Ottawa Equity Project	Report
6	2015	OLIP	OLIP Progress Report – 2011 to 2015: Health and Wellbeing	This document is a summary of accomplishments of OLIP’s Health & Wellbeing Sector Table that was prepared for a discussion during the 3rd Ottawa Immigration Forum	Report
7	2017	Jane Moloney	The Cost of Not Providing Health Care Interpretation in the Champlain Region	This paper provides a summary of health and healthcare system issues and impacts concerning a lack of language interpretation for patients with limited proficiency in French and/or English and/or when accessing healthcare services.	Report (author is affiliated with OLIP)
8	2017	Jane Moloney, Vivien Runnels, Nathali Rosado Ferrari, Jerald Sabin, Erin Tolley, Lynne Tyler	Ottawa Syrian Refugee Research Initiative	This report describes the research initiative around a community-wide effort to settle Syrian refugees in Ottawa.	Report (affiliated with OLIP)
9	2017	Vivien Runnels	Understanding Immigrant Seniors’ Needs and Priorities for Health Care: A community engagement	This paper reports on a research project on immigrant seniors’ health. Champlain Local Health Integration Network commissioned the work which was carried	Report (affiliated with OLIP)

			research project in the Champlain Local Health Integration Network (LHIN) region of Ontario.	out by OLIP and the South-East Ottawa Community Health Centre. The project gathered data about immigrant senior populations that could be used to inform the planning of healthcare services.	
10	2019	Margaret Walton-Roberts, Luisa Veronis, Sarah V. Wayland, Huyen Dam, Blair Cullen	Syrian refugee resettlement and the role of local immigration partnerships in Ontario, Canada	The paper examines the Syrian Refugee Resettlement Initiative (SRRI) in Canada and role of local immigration partnerships within mid-sized communities.	Peer-reviewed publication
11	2019	Luisa Veronis	Building intersectoral partnerships as place-based strategy for immigrant and refugee (re)settlement: The Ottawa Local Immigration Partnership	The paper examines OLIP's role in Syrian refugee resettlement in Ottawa.	Peer-reviewed publication
12	2019	Jane MacDonald, Siffan Rahman, Jennifer Simpson	Breaking the Barrier – Multicultural Health Navigator Program -Bridge, mediate, advocate-	This report developed by Somerset West Community Health Centre details the development and need for the Multicultural Health Navigator Program in Ottawa	Report
13	2020	OLIP	The Impact of Covid-19 on Immigrants and Racialized Communities in Ottawa: A community dialogue	This summary report on OLIP's Community Dialogue summarizes the discussion content to reflect back information to community leaders; this is also a resource for OLIP partners to build on ways to mitigate health risks in immigrant and racialized groups, specific to Ottawa.	Report
14	2020	Ottawa Public Health	COVID-19 and Racial Identity in Ottawa.	This document provides key messages and findings for audiences to better understand people's lived experience, and to inform solutions aimed at improving access to healthcare services.	PowerPoint Presentation

15	2021	OLIP staff	Coordinated Covid Response with Equity Lens: APRIL 2020 – APRIL 2021	Brief Report on OLIP’s role in the Covid response, written for the OLIP Leadership Group	Report (internal)
16	2022	Ayshan Mammadzada	The Arrival and Resettlement of Afghan Refugees in Ottawa: Exploring Challenges and Possible Policy Remedies for Ottawa	This brief identifies challenges of resettling Afghan immigrants and provides policy recommendations.	Policy Brief (author is affiliated with OLIP)
17	2022	Ayshan Mammadzada	Newcomers’ Challenges in Accessing Healthcare Services in Ottawa: Recommendations for Improvement	This issue brief highlights access to healthcare service challenges as experienced by newcomers in the city of Ottawa.	Policy Brief (author is affiliated with OLIP)
18	2022	Ayshan Mammadzada	Impact of COVID-19 on Immigrant Youth Mental Health in Canada: Exploring Challenges and Possible Policy Remedies for Ottawa	The brief explores the impact of COVID-19 on immigrant youth and discusses a number of factors including access to healthcare services. The brief provides recommendations for policy changes.	Policy Brief (author is affiliated with OLIP)
19	2023	OLIP	OLIP Progress Report: 2022-23	This review provides an overview of OLIP’s accomplishments.	Report
20	2023	OLIP	Ottawa Immigration Strategy and Organizational Alignments	This document outlines long-term priorities in health (from the 3rd Ottawa Immigration Strategy) to direct OLIP’s activities.	Strategic Plan

4.4.4 Data Analysis

Interview Data and Focus Group Data. Verbatim transcripts were produced following guidance by A. Humble (2020), with time stamps inserted for reference. Eleven audio-recorded interviews and one focus group file and their corresponding transcripts were de-identified, with each participant assigned a number code. Files were imported into NVivo15 for data coding. The analysis was informed by the SEM framework while remaining open to emergent themes from the data.

Complementary Document Analysis. The selected documents (Table 1) were analysed using a similar thematic coding approach in NVivo15. Full-text content from each document was imported into the software for systematic coding (Dalglish et al., 2020; Fereday & Muir-Cochrane, 2006). For documents in formats such as webpages or Portable Document Formats (PDFs) containing large graphic files, the text was first extracted — typically by copying into a Word document — before being transferred into NVivo15 for analysis.

Thematic Analysis Process. We adopted a hybrid inductive-deductive approach to thematic analysis, following the data coding stages outlined by Fereday and Muir-Cochrane (2006). This method incorporates both a data-driven inductive approach and a deductive approach guided by the SEM framework, making it applicable to interview data, focus group data, and organizational documents.

Thematic analysis of the various data sources began with the initial coding based on a preliminary review of transcripts and themes emerging from the interview guide with consideration of access to healthcare dimensions (Fereday & Muir-Cochrane., 2006; Gulliford et al., 2002). These codes were also applied to the document data. Using an inductive approach, raw data were encoded with preliminary and additional data-driven codes to identify and develop emerging

themes (Supplement 5). The analysis proceeded in two stages: a vertical analysis, involving in-depth examination of each transcript and document to generate codes and themes; and a horizontal analysis, which compared data across participants and documents to cluster codes (e.g., category construction) and identify broader patterns and themes (Boyatzis, 1998). NVivo was used to facilitate this process (Gaudet & Robert, 2018).

In the final stage, we applied the SEM framework to organize and interpret emerging themes. Following Fereday and Muir-Cochrane's (2006) framework analysis process, we conducted: familiarization (becoming aware and familiar with the whole data set to note key ideas and themes); indexing (identifying sections of text corresponding to the different levels of the SEM); and charting, mapping/interpretation (arranging key characteristics of data into the SEM framework) (Armstrong, 2021; Gale, et al., 2013) (Supplement 6). This approach allowed us to systematically analyze how the LIP's activities and influences facilitate access to healthcare for immigrant populations across multiple ecological levels.

4.4.5 Data Triangulation

Triangulation of data from the interviews, focus group, and document analysis provided a comprehensive understanding of the LIP's experiences (Saks & Allsop, 2019). To enhance trustworthiness, the analysis involved identifying points of convergence and divergence across the three data sources and organizing findings into themes based on shared characteristics and complementary insights (Golafshani, 2003).

To strengthen the validity of the interview and focus group data, the lead researcher (A.R) undertook several measures: 1) ensured that questions were relevant, evidence-informed, and refined through team review and previous research (Article 1; Article 2); 2) allowed sufficient time for open-ended, natural conversations; 3) conducted negative case analysis by actively seeking

divergent participant perspectives; 4) invited team members to independently review themes; and 5) offered participants the opportunity to review draft findings for accuracy and resonance (Bolderston, 2012; Shannon-Barker, 2016).

To ensure reliability, A.R. reviewed all transcripts for accuracy prior to coding, checked for consistency in code and theme application across data, maintained detailed analysis tables for transparency, and engaged in peer debriefing through independent review of findings (Bolderston, 2012).

4.4.6 Data Saturation. Data saturation was likely achieved, as no new themes or insights emerged after the ninth interview, nor during comparison with focus group content and document data (Bernard & Ryan, 2009; Guest et al., 2006; Hennink et al., 2016). This suggests sufficient depth and richness in the data set (Palinkas et al., 2015). According Malterud et al. (2016), fewer participants may be needed in interview studies when the aim is considered narrow, when participants are considered highly specific to the discussion topic and when there is a high quality of dialogue. However, due to time and resource constraints, a formal sampling and re-sampling process to confirm theoretical saturation was not conducted.

As codes/themes were mapped against the SEM, there was recognition that many of the experiences of the LIP, found from the document analysis, were corroborated by interviews with associates/partners of OLIP and by accounts from the focus group with core OLIP staff. The interviews with partners provided rich insights, from an outsider perspective, situating the achievements within the broader political landscape of the time. Meanwhile, the focus group provided deeper context and details from an internal LIP staff perspective, further enriching the findings from interviews and document analysis (e.g., reasons behind certain actions).

4.5 Results

In this section, we present our main findings organized in four themes that emerged from our analysis. Using the SEM as an analytical framework, we examined how OLIP's activities operate across multiple levels of influence — from individual to policy — to support immigrant access to healthcare. This approach allowed us to identify not only what OLIP has accomplished, but also at which levels of the social-ecological system it exerts influence, faces challenges, and generates impact.

The four emerging themes are: 1) cross-sectoral coordination and collaboration; 2) advocacy and policy influence; 3) engaging and empowering communities; and 4) building capacity and informing service delivery. After presenting these themes, we discuss the major challenges OLIP faced — including resource constraints, governance and organizational structure, and relationship management — while also considering how these challenges manifest across different levels of the SEM.

4.5.1. Themes and Findings

1. Cross-Sectoral Coordination and Collaboration. The first main finding is that OLIP has been instrumental in fostering cross-sectoral coordination and collaboration to support access to healthcare for immigrant populations. From the perspective of the SEM, these coordination activities primarily operate at the organizational/institutional level, while creating impacts that cascade across interpersonal relationships between professionals and ultimately to the individual level for immigrant clients. This multilevel influence has been achieved by improving cooperation, coordination, and collaboration among disciplines, various professions, and health professionals, across sectors and within the health sector. Moreover, OLIP has facilitated intersectoral or sector-

wide knowledge mobilization while providing knowledge and insights to advance health equity and access to healthcare priorities.

Our data analysis consistently shows that OLIP, as a convening and coordinating body, linked professionals and health sector players together. These connections led to actionable ideas that supported access to healthcare for immigrants. Interview Participant 9 emphasized the impact of having key members from different teams sitting at tables like the OLIP Health and Wellbeing Sector Table, which facilitated collaboration and coordinated care, especially for disenfranchised communities.

When you're working with an organization, like a hospital, it's a huge endeavor. You may not necessarily be able to reach the departments that you need, but when you have certain members from those teams sitting at tables like, the OLIP Health and Wellbeing Sector Table, it makes an impact on the difference. So that, when you are trying to coordinate care, I know that, for example, I can reach out to x person who works with children outreach or outpatient care...How do we collaborate and work together on providing equitable access to care, especially for communities which are disenfranchised? (Interview Participant 9)

The importance of engaging key leaders and decision-makers was also underscored by Interview Participant 4, who noted that this was an integral part of OLIP's strategy: "...what we got were the key leaders. We didn't just want the city. We wanted the key decision-makers ... So that realization and those kinds of actions are an integral part of OLIP strategy and success."

One notable example of success arising from ongoing partner discussions at the sector table — where needs and gaps in services were identified — is the Ottawa Newcomer Health Centre and its programming, which provides mental health counseling, language access, and health

system navigation. A participant highlighted the effectiveness of having funders attend and engage at the OLIP tables, which led to pilot projects being scaled up and becoming permanent programs:

And so initially we would get some funding from the LHINs, from the partner who was attending those OLIP tables, which was key, like having that funder attend and be engaged, that was really key for all these successes... But I think why it was so effective, and why the pilot projects came to be, you know, scaled up and permanent programs, is because there was that connection with the different partners who were kind of providing their backing and support to this, to all the initiatives, but also having the funder at the table to see. (Interview Participant 10)

Another participant also emphasized OLIP's role as a backdrop to assist, support, and engage other players: "...because OLIP was there, it was a place to bounce ideas off, to provide some kind of research support, you know, engage other players" (Interview Participant 6).

Next, the findings show that OLIP facilitated the exchange of knowledge, strengthening and consolidating the expertise of researchers and health professionals while also bringing in contextual insights, community perspectives, and data pieces beneficial to supporting efforts around access to healthcare for immigrant populations. Participant 7 highlighted OLIP's role in bringing together partners and community leaders to explore data and guide efforts to mitigate the harms of COVID-19 without stigmatizing Canadians: "OLIP helped convene partners and community leaders to create kind of a space to explore that data and see how the data can not be stigmatizing to Canadians, but also direct our efforts to kind of mitigate the harms of COVID" (Interview Participant 7).

Viewed through the lens of the SEM, OLIP's cross-sectoral coordination activities operate across multiple levels of influence. While primarily functioning at the organizational/institutional

level by creating formal partnerships between sectors, these efforts also strengthen interpersonal networks between professionals, enhance community level cohesion, and ultimately improve individual access to healthcare. This multilevel engagement illustrates how OLIP's coordination role creates bridges across traditionally siloed systems, facilitating a more integrated approach to immigrant healthcare access.

2. Advocacy and Policy Influence. Over the years, OLIP has demonstrated its commitment to improving access to healthcare for immigrant populations through advocacy and policy influence. Within the SEM framework, these efforts primarily target the policy and societal levels by addressing structural barriers while also operating at the organizational level through advisory relationships with health institutions. OLIP accomplished this by investigating and recognizing connections between public policies and health and wellbeing to support inclusive policies, advocating for improvements in access to healthcare services for immigrants, and establishing itself as a respected organization and trusted advisor to health professionals, health leaders, and decision-makers.

In collaboration with consultants or in partnership with community organizations, OLIP has produced numerous reports examining the structural barriers, social dynamics, and economic factors affecting healthcare access. These reports provide policy recommendations and suggestions towards inclusivity and health equity for immigrant populations (see documents 5, 7, 8, 9, 16, 17 and 18 in Table 1). For example, Document 18, a policy brief entitled *Impact of COVID-19 on Immigrant Youth Mental Health in Canada: Exploring Challenges and Possible Policy Remedies for Ottawa*, acknowledges the importance of having available economic opportunities, healthcare services, and social integration on mental health; it makes the following suggestion regarding resources: "...prioritization should include funding and equipping healthcare centers with cultural-

sensitive knowledge and resources. Medical practitioners must be informed about cultural appropriateness when administering diagnoses or prescribing management approaches” (Document 18 — Mammadzada, 2022: page 7).

OLIP has also contributed to efforts highlighting the link between healthcare access and structural discrimination. Interview Participant 3 noted OLIP’s role as a key partner in disseminating information and launching research reports on mental health services for immigrant, refugee, ethnocultural, and racialized populations: “... work on mental health services for immigrant, refugee, ethnocultural and racialized populations — we put out several reports, of which OLIP was sometimes a key partner... helping us disseminate information or as part of like the launch of our research reports.”

While not always overt, our findings suggest that OLIP actively advocates for improved healthcare access for immigrants. Participant 7 emphasized that OLIP’s work is driven by the goal of health equity, encompassing activities such as pandemic-related health promotion, amplifying advocacy efforts, and providing a platform to report ongoing initiatives.

The goal of all of this work, really is health equity. Some of the activities is just health promotion. So during the pandemic, we were door knocking, helping people understand the symptoms of COVID, where to get tested, providing resources, masks, rapid antigen tests. Then we leverage OPH [Ottawa Public Health] and the City model to create vaccine clinics within those same neighborhoods so that people wouldn’t have to navigate the website, which is, you know, overwhelming, just to really provide low-barrier access. And so these activities and advocacy were obviously amplified by OLIP. And for OPH to hear it from OLIP as an important part is helpful. And then OLIP is also a space where we would report on that work. (Interview Participant 7)

The interviewee emphasized the importance of OLIP conveying these priorities to key stakeholders, especially Ottawa Public Health (OPH).

An insightful finding that emerged across multiple interviews is the respect OLIP has earned over the years as a trusted source, advisor, and ally to partners and community leaders. Many interviewees attributed this to the dedication and personal relationships built with core OLIP staff. One participant specifically mentioned the strength of OLIP's previous leader, who had an extensive network, allowing her to navigate the system at different levels, advocate, and highlight issues across various spheres:

In terms of approach per se, I think one of the strengths is, I would dedicate it to our previous leader... who obviously there from the beginning when OLIP was created. So she had a lot of contacts, a lot of context, and that somehow allowed her to navigate the system at the different levels and advocate and highlight issues. You know, she was invited to different meetings, to different forums, where she was basically articulating what is available, what is missing, and all of that. (Focus Group Participant 3)

The SEM lens provides a useful framework for examining OLIP's work, particularly advocacy and policy influence — such as health promotion messaging and the development and dissemination of research briefs — at the institutional and policy/societal levels. Additionally, from the SEM perspective, OLIP's careful cultivation of relationships at the interpersonal level has fostered respect and trust among network collaborators. Ultimately, its combined efforts at the relationship, institutional, and policy levels have positioned OLIP as a trusted network partner, capable of effectively advocating for and influencing improvements in healthcare access and health equity for immigrant populations in Ottawa.

3. Engaging and Empowering Communities. OLIP has demonstrated a strong commitment to engaging and empowering immigrant communities to address access to healthcare issues. From a SEM perspective, these activities primarily function at the community level by mobilizing collective action. They also drive impact at the individual level by breaking down barriers to care and at the organizational level by enhancing institutional responsiveness to immigrant needs.

One of OLIP's key activities is engaging with immigrant populations and communities to better understand the disadvantages they face. This constant engagement enables OLIP to maintain relationships and to function as a central resource for communities. Specifically, we found that OLIP engaged with community and health sector interest-holders through the development of their *Ottawa Immigration Strategy* (Document 20), which highlights common priorities for the sectors and the community. Moreover, OLIP engages with community leaders through its flagship annual event, Welcoming Ottawa Week (WOW). Focus Group Participant 2 emphasized that this event helps to "...bring to attention, through its welcoming Ambassador Awards, the idea that welcoming is about doing your bit in your capacity as a member of the community to welcome a neighbor, a friend...".

A recent health sector example of engaging community and community leaders was the OLIP-led COVID-19 Community Dialogue. The goal was to gather insights from communities most affected by the pandemic on the high COVID-19 infection rates among racialized and immigrant groups and to inform OLIP partners' planning for targeted prevention and protection. According to Document 13, *The Impact of Covid-19 on Immigrants and Racialized Communities in Ottawa: A community dialogue*:

The dialogue included presentations from OLIP partners and facilitated discussions about experiences of communities with COVID-19. Ottawa Public Health presented an analysis of disaggregated sociodemographic data on Ottawa residents who tested positive for COVID-19. OLIP provided a preliminary census data analysis of the key factors that may be contributing to the disproportionate impact of the pandemic on immigrants and racialized population. And, the Ottawa Health Team – Équipe Santé Ottawa shared information on targeted prevention and protection measures that are currently underway. (Document 13 — OLIP, 2020: page 3)

In addition, our analysis indicates that OLIP has been working towards building awareness among leaders of health organizations to become more responsive to the needs of immigrant populations. One approach to achieve this was the cross-sectoral Equity Ottawa partnership, a project aimed at fostering equitable and inclusive local organizations by promoting workforce diversification; by reflecting community diversity, staff can more effectively respond to community needs (Document 5).

Another approach involved connecting directly with high-level decision-makers of health organizations to infuse their decisions with equity in mind:

So for the last few years, I've been meeting, actually directly, with the [OLIP] Executive Director, every two weeks or even monthly. And you know, that is more than I meet with any other community partner, but I just found that it was really helpful for me and a priority that we needed to grow work in that area. And so it was important. And [the Executive Director], I guess, thought it was worthwhile, you know, in terms of the kinds of collaboration, the things we're working on. So in those meetings, we would exchange, sort of what we're seeing, ideas for collaboration, best practices. (Interview Participant 11)

An emerging theme from the analysis was OLIP's direct and indirect efforts to improve health outcomes for community members. This includes promoting health education to change behaviours, promoting physically accessible healthcare services, and promoting interpreters in healthcare settings. A participant provided an example of the "off-the-record" type of work OLIP does, such as finding someone at the hospital overseeing language services and bringing them to the table to address challenges and implement improvements in interpretation services:

When we brought that forward as an issue, we didn't even make the link. But I think OLIP found somebody at the hospital who was overseeing... language services, and brought them to the table... And then so, when we were, you know, talking about challenges, they would hear it, and they would, you know, start to implement things. So we did see a shift in that. We did see, you know, frontline staff knowing that, "okay, now I can offer interpretation." Or the bigger thing that was always upsetting to me is that you see an interpreter booked for visit one and a follow-up visit doesn't have an interpreter booked...so those things were improved, much better. (Interview Participant 10)

Through these efforts, OLIP has demonstrated its commitment to engaging and empowering immigrant communities to resolve access to healthcare issues in Ottawa. Through the view of the SEM, OLIP's multi-level impacts to empower immigrant communities towards better healthcare access has been achieved through direct engagement with immigrant populations and communities, organizational actions to improve response to immigrant healthcare issues, and efforts to break down individual-level barriers to accessing care.

4. Building Capacity and Informing Service Delivery. Our analysis reveals that OLIP has played a crucial role in building capacity and informing service delivery within the healthcare sector to better serve the needs of immigrant populations. Viewed through the SEM, these efforts

primarily target the institutional/organizational level by building health professional capacity through communities of practice and training. OLIP's efforts have focused on two key areas: informing institutional and healthcare service planning and programming activities of partners and building health professional capacity and sector-wide capacity.

At an institutional level, OLIP has encouraged key health sector institutions to continuously adapt an equity-lens in improving language supports, removing barriers to care, particularly for mental health services, and adapting culturally competent services in primary care. One interviewee highlighted the impact of OLIP's network on a clinical research partnership that led to improved mental health outcomes for immigrants:

Okay, so they were able to measure and show that actually, these people did better, and they had better feedback, and they were happier with their services when you do a culturally adapted version of cognitive behavioral therapy. So that came out of that [networking at OLIP's Health and Wellbeing Sector Table]. And so in the world of cognitive behavioral therapy, it's a big deal. (Interview Participant 1)

Furthermore, OLIP has advocated for prioritizing immigrant and racialized groups in healthcare architecture policies, as evidenced by Document 6, *OLIP Progress Report – 2011 to 2015: Health and Wellbeing*, which states:

An aspirational objective promoted by OLIP is to amend the LHIN's regulatory priorities, making immigrants a strategic priority on a par with the aboriginal and francophone populations. This would perpetuate support for newcomer health services and aid in the transition from sector projects to on-going programs...The shift from operational to regulatory priorities would institutionalize the mainstreaming of health services for immigrants as a matter of priority. (Document 6 — OLIP, 2015: page 9)

OLIP has collaborated with partners to strengthen the health sector's capacity to address the healthcare access needs of immigrant populations. For example, the Health and Wellbeing Sector Table discussions feature health professional or academic presenters who provide recent research, best practices, or perspective on topical healthcare issues (Document 6). Additionally, OLIP championed the idea of building a Community of Practice for health workers:

So when you do provide service to them, it's a whole different set of issues, and then providers felt quite isolated in providing this care. So OLIP said, "okay, let's do a community of practice." And so these providers are still connecting, you know, talking about cases or approaches, and so I think that was a really good thing for them, for the healthcare workers, to have that community of practice ongoing, you know? And it was started off at OLIP. (Interview Participant 10)

From a SEM perspective, OLIP has strengthened institutional practices — through Health and Wellbeing Sector Table discussions on best practices and issue-specific presentations — while also building the capacity of healthcare professionals, such as by convening a Community of Practice at the institutional/organization level. Through these efforts, OLIP has contributed to the development of a more responsive and equitable healthcare system that better serves the needs of immigrant communities in Ottawa.

4.5.2 Challenges

Beyond OLIP's achievements, participants also identified significant challenges that affected its capacity to support access to healthcare for immigrants. When viewed through the SEM, these challenges manifest across multiple levels of the ecological system, often constraining OLIP's ability to create change at specific levels. These issues are organized into three main themes: resource constraints (primarily affecting organization and community-level capacity),

governance and organizational structure (predominantly impacting institutional-level effectiveness), and relationship management (affecting interpersonal and inter-organization dynamics).

1. Resource Constraints. Interviewees and focus group participants raised issues relating to funding and human resources affecting OLIP's ability to engage in additional health sector-supporting initiatives. From a SEM perspective, these resource constraints primarily limit OLIP's organizational capacity to create change at the community and policy levels, as insufficient resources constrain both the scope and sustainability of initiatives.

I think funding will always be number one, or top, on that list as a barrier. There's a finite amount of funds available, and there are so many issues that need to be addressed, even within the health sector. So funding is always a challenge. (Focus Group Participant 1)

Focus group participants also highlighted concerns about human resource capacity and unfilled roles. High turnover within OLIP's core team, along with frequent changes in key partner organization representatives, disrupted conversations and hindered the ability of OLIP and its partners ability to advance efforts efficiently.

Another unique thing that happened...was just a general high turnover in representation of these key organizations. So even on the partnership side, and advocating to governments, there was just so much change during...there was a lot of sort of restarting conversations or delays because roles were being changed or not filled...even with us right now, we've had quite a lot of change, and having to adjust based on that. (Focus Group Participant 1)

Inconsistent, unpredictable, and insufficient funding has hindered OLIP's ability to make long-term commitments, plan and implement initiatives, and/or expand its engagement in health sector — raising concern among stakeholders. This, combined with the organizational challenges

of high turn over among core staff and community leaders, significantly hinders OLIP's ability to enact meaningful change at the policy and community levels.

2. Governance and Organizational Structure. When discussing general challenges, participants mentioned some aspects relating to OLIP's governance and organizational structure. Within the SEM, these structural issues primarily affect OLIP's ability to function effectively at the institutional level, limiting its capacity to coordinate cross-sectoral activities and influence higher-level policy changes. Governance challenges also affect how OLIP navigates relationships between organizations at the institutional level.

A participant highlighted the limitations of OLIP's governance structure, noting that operating under the umbrella of a larger organization can hinder timely, autonomous action in certain situations.

I think another challenge... it can sometimes be an issue, is...we mentioned that OLIP is not a legal entity. We operate under the umbrella of CCI [Catholic Centre for Immigrants]. So with that, obviously comes certain limitations on what we're able to do on our own. So we could have some ideas about what we want to do and we still have to go through our partner organization to get approval for certain decisions. (Focus Group Participant 2)

Another challenge in OLIP's governance and organizational structure was the excessive number of leadership tables intended to attract key decision-makers. An interviewee noted that the structure was overly weighted with these tables, but the lack of meaningful tasks failed to engage key leaders.

I kept saying this is way too heavy weighted... What was driving them [OLIP] was they wanted the big players...on their governing board. Well, they [key decision-makers and leaders] didn't have time to do that, so they created these other tables, calling them

“leadership tables” and the dilemma was... “we want those people, we can’t get them if we ask them much, so we’re not going to really ask much of anything.” So it’s a meaningless task. So those people know that and they just don’t show up because..., “what am I’m missing” you know? So they kept building more tables. (Interview Participant 2)

Moreover, participants raised several concerns about OLIP’s sector tables, particularly the Health and Wellbeing sector table, regarding its management, attendance, and overall purpose. Interview Participant 10 emphasized the need for better agenda management to enable meaningful participation, noting that the short time between agenda distribution and meetings limits attendees’ ability to prepare for discussions.

Interview Participant 7 highlighted the positive aspect of sector table meetings being open to community organizations, regardless of hierarchy — for example, a director or manager can attend on behalf of a health organization. However, this openness sometimes results in the absence of key decision-makers with the authority to implement change, or inconsistent attendance which disrupts continuity. Interview Participant 2 stressed the need to rethink the meetings’ purpose and structure, suggesting they focus more on eliciting priorities from subject matter experts and advancing collaborations, rather than primarily serving as a platform for information dissemination.

Dissemination of information probably was significantly enhanced by OLIP. But... disseminating information is the worst use of face-to-face time... But that being said, they would have disseminated information to some folks who wouldn’t have known about, say, the interpreters or the navigators. But if actually the goal was to generate more services, more appropriate services, more well-designed services for the people... I think a much lighter, much more informal catalyst-kind of approach would have achieved almost

everything they achieved...So if you were to engage a sector team and you say to the participants, “you are the subject matter experts...We want to distill and *you* decide what the priorities are, and whatever we can do to help you collaborate with *meaningful* partners, tell us.” (Interview Participant 2)

From a SEM perspective, OLIP faces challenges at the institutional level due to its complex governance and organizational structure, which limits its autonomy and ability to respond swiftly to health sector initiatives. Additionally, we uncovered the struggles of OLIP’s Health and Wellbeing Sector Table, particularly with agenda management, balancing open-door discussions with securing decision-makers’ attendance, and shifting beyond information dissemination toward actionable outcomes. These governance and organizational challenges hinder OLIP’s ability to effectively tackle diverse and imminent immigrant health and access to healthcare issues.

3. Relationship Management. OLIP operates within and across sectors, often in the context of limited funding and resources. Through the SEM lens, relationship management challenges primarily manifest at the interpersonal and inter-organizational levels, affecting OLIP’s ability to facilitate collaboration between key stakeholders, ultimately influencing its capacity to create change at community and policy levels.

Interview Participant 6 described a period of heightened tensions among key players following the arrival of Syrian refugees in Ottawa starting in late 2015:

You come to the table, the health task force is looking at services to the Syrians coming in. You’re making decisions now. There were some tense moments... [names key organizations in the settlement and health sector]... they got just focused, laser focused on “how do we get pharmacy, hospitals and paramedics marshaled fast to deal with this

influx?” So there was tensions there. I don’t think it [OLIP] was as nimble as it could have been to support that. They’re not service delivery. (Interview Participant 6)

The account of underlying tensions — rooted in frustration with existing processes, unclear roles, and adapting to new players driving priorities in a shifting landscape — underscored the challenges OLIP faced in navigating delicate relationships toward a common goal. These interpersonal and inter-organizational level challenges contribute to frictions that ultimately can hinder OLIP’s potential to make important changes and improvements at the community and policy levels.

Viewed collectively through the SEM, these challenges illustrate how barriers at one level can cascade throughout the system, limiting OLIP's effectiveness across multiple ecological levels. Resource constraints at the organizational level restrict OLIP's ability to engage in policy-level advocacy; governance issues at the institutional level hinder cross-sectoral coordination; and relationship management challenges at the interpersonal level can impede community-wide service integration. Understanding these multi-level challenges is essential for developing effective strategies to enhance OLIP's future role in supporting immigrant healthcare access.

4.6 Discussion

4.6.1 Access to Healthcare and Levels of Influence

The concept of access to healthcare is multi-dimensional. One dimension is service availability (i.e., having an adequate supply of healthcare services, given the need) (Bowen, 2000; Gulliford et al., 2002) and also includes the dimensions of accessibility (e.g., location of the service), affordability (e.g., cost, financial implications), acceptability (e.g., culturally appropriate service), and accommodation (e.g., the ease of receiving services) (Durkin, 2019; Jacobs et al., 2012).

These 5 dimensions of access to healthcare are reflected across the codes and themes derived from our thematic analysis. Each theme or code provides a direct or indirect way to influence aspects of access to healthcare services; these themes, mapped to levels of the SEM, demonstrate where OLIP has influenced (or has faced challenges in influencing) access to healthcare for immigrant populations.

Applying the SEM lens highlights complex social and environmental interactions (i.e., the themes identified in this study) affecting racialized and immigrant populations on differing ecological levels of influences (Erickson et al., 2024).

Specifically, the SEM framework helps interpret OLIP's multi-level influence on different dimensions of healthcare access by clarifying the connection between the four themes and the ecological levels. Theme 1 (cross-sectoral coordination and collaboration) highlights OLIP's primary role at the organizational/institutional level, with cascading impacts on the relationship level between health sector actors. These collective efforts with network partners ultimately enhance healthcare accessibility. Theme 2 (advocacy and policy influence) encompasses OLIP's engagement at the policy/societal level, with additional activities at the relationship and community levels. These efforts improve healthcare access for immigrants by informing policy reforms through research, fostering trusted bonds with health sector leaders, and promoting equitable healthcare. Theme 3 (engaging and empowering communities) highlights OLIP's efforts at the community level to mobilize collective action while also dismantling barriers to healthcare at the individual level and enhancing institutional responsiveness to immigrant healthcare needs. Finally, theme 4 (building capacity and informing service delivery) demonstrates OLIP's role at the institutional/organizational level in strengthening health professionals' capacity and

development — through training, sharing best practices, and other initiatives — to improve healthcare service delivery for diverse immigrant populations.

4.6.2 OLIP's Experiences in Relation to Existing Literature

Results from this study align with those of Ratnayake et al.'s (2022) scoping review, particularly connecting key players, facilitating collaboration, mobilizing communities, advocating for improved access, and supporting service delivery and healthcare providers. Additionally, this research identified a new sub-theme — OLIP's role as a respected organization and advisor to health professionals, health leaders, and decision-makers — under the broader theme of advocacy and policy influence. This respect appears to indirectly advance efforts to improve healthcare access for immigrants. Furthermore, our research reinforces existing knowledge (Etowa et al., 2024) regarding OLIP's participation in investigative research to inform community health promotion initiatives.

The study findings further support Veronis' (2019) research, which highlights OLIP's role in building local capacity through network consolidation, cross-sector partnerships, and community engagement. Veronis specifically discusses existing settlement and health structures and OLIP's successes in bridging connections across these sectors. Additionally, our research emphasizes OLIP's governance structure, particularly the Health and Wellbeing Sector Table, as a key mechanism for forging intersectoral networks. While Veronis underscored the importance of local solidarity — rooted in trust and collective responsibility — for successful efforts, our findings suggest that this solidarity was tested, leading to some tensions, especially when decisions had to be made quickly in resource-limited settings (Braun & Clément, 2023).

The study findings also underscored a shift in OLIP's focus from the pre-COVID-19 period to the early years of the pandemic. Our document analysis revealed that prior to COVID-19, OLIP

was strongly engaged in equity-focused and policy-informing work, including the development of policy briefs. Beginning in 2019, OLIP pivoted towards convening leaders, decision-makers, and health professionals to exchange information and then to address the emerging challenges of COVID-19, particularly as they affected immigrant populations. During this period, OLIP played a central role in facilitating COVID-19-related discussions and organizing working groups aimed at improving the health outcomes for immigrants. OLIP also became a trusted collaborator with local public health leaders to inform the interpretation of COVID-19 data (applying an equity lens) and to inform health promotion strategies.

4.7 Conclusion

This research investigated OLIP's efforts and experiences engaging with the health sector to support immigrant access to healthcare. Our objectives were to: (1) identify and analyze the specific strategies and initiatives OLIP implemented to facilitate immigrants' access to primary healthcare services; (2) examine the stakeholder networks and cross-sectoral collaborations developed by OLIP to address healthcare access barriers for immigrants; and (3) identify and deepen our understanding of the outcomes and challenges of OLIP's healthcare-focused activities and their implications for immigrant health equity policy.

With respect to objective 1, we found that OLIP supported access to healthcare through: cross-sectoral coordination and collaboration; advocacy and policy influence; engaging and empowering communities; and building organizational and health professional capacity and informing service delivery. Regarding objective 2, the results show that OLIP has formed partnerships and relationships with key health sector actors such as community health centers and clinics, public health agencies, hospitals, mental health organizations, as well as community settlement groups. Concerning objective 3, OLIP's combined efforts (i.e., activities within the four

themes) effectively improved access to healthcare for immigrants; specifically, OLIP's Health and Wellbeing Sector Table has been instrumental in the formation and maintenance of key relationships among health sector actors, allowing for professionals and decision-makers to collaborate on common priorities. We identified several challenges in effectively utilizing the Health and Wellbeing Sector Table to maximize expertise while ensuring the continued engagement of partners and decision-makers. Broadly, OLIP has faced challenges around resource constraints, governance and organizational structure, and relationship management.

Our research found that the SEM framework effectively serves to highlight OLIP's multi-level influence on equitable healthcare access. While OLIP's activities extend across all levels of influence (intrapersonal, relationship, community, organizational, and societal), its primary impact occurs at the organizational/institutional level. Through cascading effects on partners and health sector leaders at the relationship and community levels, OLIP indirectly shapes healthcare access for immigrants.

4.7.1 Contributions to Knowledge

This study highlights OLIP's critical role in advancing healthcare access for immigrant populations. Understanding its function within the healthcare ecosystem offers concrete opportunities to leverage OLIP's work for greater health equity. The four themes — 1) cross-sectoral coordination and collaboration, 2) advocacy and policy influence, 3) engaging and empowering communities, and 4) building capacity and informing service delivery — outline its key areas of impact. This knowledge may encourage sustained resource allocation to support effective, comprehensive, and multi-layered solutions to accessibility challenges. Additionally, our research underscores the challenges OLIP faces in facilitating healthcare access. These insights provide valuable guidance for leadership and governance bodies seeking to make informed

decisions and policy improvements regarding OLIP's governance, funding, and mandate to strengthen its future efforts in the health sector.

Furthermore, this study contributes conceptually to existing knowledge and deepens our understanding in the following areas:

1. The role of settlement coordination organizations within the social-ecological system. Integrating the SEM with Health Equity/Access to Care theories establishes a novel analytical framework for assessing non-medical settlement coordination actors, such as OLIP, in their role in supporting healthcare access. Mapping and interpreting study themes through the SEM enhances our understanding of OLIPs' unique position as a boundary-spanning organization within complex settlement and immigration ecosystems, facilitating connections and bridging previously siloed sectoral actors.

2. The mechanisms through which cross-sectoral collaboration influences healthcare access. Findings highlight OLIPs' role as an "intermediary governance" actor, facilitating cross-sectoral collaboration to improve health outcomes for immigrant populations. Specifically, the study provides insight into OLIP's governance mechanisms — such as the Health and Wellbeing Sector Table — that support cross-sectoral coordination. It also deepens understanding of governance challenges and funding shortfalls that hinder OLIPs' ability to respond to immediate needs and sustain long-term impacts. Additionally, this research offers practical knowledge on effective collaboration models, identifying key barriers and enablers to OLIPs' health equity and access efforts.

3. How LIPs navigate and influence multiple levels of the healthcare ecosystem. Our study extends the application of the SEM framework to a real-world organization, illustrating how OLIP operates across various levels of the social-ecological system. The framework highlights

OLIP's strongest areas of influence — primarily at the organizational/institutional levels — as well as its limitations, particularly at the societal/policy level in addressing healthcare challenges.

Findings provide valuable insights into the practical and policy implications of OLIPs' operations within health sector, as well as conceptual contributions to understanding its role in improving healthcare accessibility through the SEM perspective.

4.7.2 Limitations

Results should be interpreted with an understanding of the limitations of each analysis and data collection method (Supplement 7). The thematic analysis method has an inherent challenge of generalizability. We recognize the nature of semi-structured interviews, focus groups, and document analysis lend to possible biases. The smaller number of participants in this study can also be considered a limitation. Lastly, we acknowledge the challenges of purposive sampling in this research concerning the selection of participants.

4.7.3 Implications and Future Directions

This research has important policy implications and can inform local decision-making on issues on collaborative efforts to enhance healthcare access, optimize resource allocation, and develop effective, equity-focused, and inclusive interventions — ultimately aiming to improve immigrant health and wellbeing. Future studies could assess the impact of OLIP's activities on specific health outcome indicators within the community. Researchers may also consider expanding the participants pool to generate larger datasets and broader insights. Alternatively, this case study design could be applied to examine the achievements of other LIPs in Ontario, helping to identify common successful practices.

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Supplement 1

Defining and Selecting the Case

A LIP was selected based on the following criteria (Crowe et al., 2011):

- Established for over five years: an early adopter of the LIP model can provide perspective of long-term as well as short term accomplishments/challenges and insight on impacts, activities, etc.
- Has a health-focused Working Group or Table.
- Located in a region in Ontario with a diverse demographic population and high concentration of immigrants.
- Is likely to have formed networks and connections with local authorities, institutions, and health and social services.
- Has a total of 8 or more LIP members, including LIP associates/partners from the health sector.
- Potential participants are experienced (i.e., working with the LIP for at least one year) and/or holds a senior decision-making position. Further, potential participants are from the LIP membership (i.e., core staff, leadership, advisory members); LIP's health sector technical body or advisory groups; and/or LIP's network of local health and social services in the health sector.

*Note on selection process: Selection criteria were developed by A.R and K.P. A.R and K.P discussed other possible LIPs for the case study that met the criteria. However, after connecting with a few possible LIPs for the case study, the initial interest shown by OLIP was the deciding factor.

Background Information: Ottawa Local Immigration Partnership (OLIP)

In 2009 the Ottawa Local Immigration Partnership (OLIP) was established by the Local Agencies Serving Immigrants (LASI) and the City of Ottawa (Ottawa Local Immigration Partnership, 2024). This community-based and collaborative partnership is connected to over 60 organizations representing key players across five sectors (Veronis et al., 2024). These sectors are reflected as OLIP's "sector-tables": education, language, economic integration, health and wellbeing, and socio-civic integration (Ottawa Local Immigration Partnership, 2024). OLIP is federally funded by Immigration, Refugees and Citizenship Canada (IRCC); through this, OLIP is mandated to improve attraction, integration and settlement of newcomers and immigrants into

Ottawa. The streams of activity central to OLIP are collective planning with stakeholders and partners; supporting the coordinated efforts and activities of partners; and encouraging leadership and collaborative work (Ottawa Local Immigration Partnership, 2024). OLIP's governance structure consists of the following: a Council, an Executive Committee, a Leadership Group, the Secretariat, five Sector Tables, and the Ottawa Immigration Forum (Veronis et al., 2024). OLIP is housed under, or hosted by, the Catholic Centre for Immigrants. The partnership is welcoming new residents at an increasing pace; data from Statistics Canada shows that since 2016, the city Ottawa has been the 6th fastest growing destination settling recent immigrants to Canada (CBC News, 2022). The Ottawa-Gatineau area in particular has received many new immigrants- an increase in growth to 4.4% (2021) from 3.1% (2016) (CBC News, 2022).

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Supplement 2

Recruitment, Information Letter and Consent Text

Recruitment Text

Dear LIP member,

You are receiving this communication because you have been identified as a valuable member of the LIP.

We would like to invite you to participate in the PhD thesis driven research project, “Achievements and experiences of a Local Immigration Partnership (LIP) in Ontario engaging with the health sector to support access to healthcare: A Case Study.”

The goal of this research is to describe the accomplishments and experiences of members of a Local Immigration Partnership in Ontario with regard to engaging with healthcare decision-makers and the health sector to improve immigrants’ access to local primary healthcare services and advance health equity. In a time where our healthcare system is struggling, this research will describe the value added and role of your LIP within the healthcare space.

This research is being conducted by Ayesha Ratnayake, a PhD Population Health candidate, under the supervision of Dr. Luisa Veronis.

You are being selected because of your current position as a member/associate of a LIP regarded as a key resource to settlement in Ontario- working in a collaborative with sector-specific tables to advance health equity priorities.

Please let us know if you are interested in participating in ONE or BOTH of the following research activities of this project:

1. A Focus Group Discussion

Participation entails partaking in an audio-recorded focus group discussion (via MSTeams). This one-time discussion may take 60 minutes to complete. Participants will be emailed the letter of consent for review.

2. An Interview

Participation entails partaking in an audio-recorded interview (in-person, over the phone, or via MSTeams, Zoom). This one-time interview can take 45 to 90 minutes maximum to complete. Participants will be emailed the letter of consent for review.

For more information, and to participate in this research and obtain a copy of the consent letter, please contact Ayesha Ratnayake.

Sincerely,

Ayesha Ratnayake, MPH, PhD(c)

University of Ottawa

Information/Consent Text (Interview)

Title of the study: Achievements and experiences of a Local Immigration Partnership (LIP) in Ontario engaging with the health sector to support access to healthcare: A Case Study

Principal Investigator:

Ayesha Ratnayake
PhD Candidate
University of Ottawa
Ottawa, ON

Professor (Supervisor):

Dr. Luisa Veronis
Associate Professor
Geography, Environment and Geomatics
Faculty of Arts
University of Ottawa

Invitation to Participate: You are invited to participate in the abovementioned research study conducted by Ayesha Ratnayake. The study is being conducted as part of Ayesha Ratnayake's PhD Thesis under the supervision of Professor Veronis.

Purpose of the Study: The purpose of the study is to describe the accomplishments and experiences of a LIP in Ontario around improving access to healthcare for immigrant populations and advancing health equity priorities.

Participation: Your participation will consist of an telephone, in-person, MSTeams or Zoom interview that may last up to 90 minutes. This one-on-one interview will occur at the date and time of your choosing (the researcher will provide you with options to choose among). The interview will be audio-recorded. You will be asked to provide knowledge based on your own experiences at your current position as a member of the LIP. This interview will be composed of open-ended questions.

Risks: Your participation in this study will entail that you volunteer experiences/opinions, and this may cause you to feel emotional or psychological discomfort. Audio recording the interview may also be another source of discomfort. The research will make every effort to minimize these risks. The researcher will store the audio recording in a secure locked cabinet at her office. Your personal information will not be included in the audio recording (i.e., name, birth date etc.). The researcher

will also choose a location so that the interview can be conducted in an environment that the participant feels comfortable discussing the questions (e.g., away from noisy public places).

Benefits: Possible benefits include knowledge gain, ability to share one's experiences/ideas, ability to inform current research, and exposure to academic findings/involvement in the research process. This participatory case study research will also allow your LIP's accomplishments to be highlighted in reports and publications.

Confidentiality and anonymity: The information that you will share will remain strictly confidential and will be used solely for the purposes of this research. Your confidentiality will be protected. The only people who will have access to the research data are the immediate investigators (Dr. Luisa Veronis and Ayesha Ratnayake) and the University of Ottawa's Research Ethics Board (REB). Your answers to open-ended questions may be used verbatim in presentations and publications but neither you (nor your organization) will be identified. Anonymity is guaranteed since you are not being asked to provide your name or any personal identifying information.

Conservation of data: The data collected in audio recordings of the interviews will be transcribed. These recordings and transcriptions will be kept in a secure manner, in a password protected portable hard-drive in a locked cabinet in the researcher's office for a 5-year period. Thereafter, all the data will be destroyed.

Compensation: Compensation will be provided for those who take part in the interview. Participants will be compensated with a \$150.00 payment. Participants will still receive the compensation should they choose to withdraw.

Voluntary Participation: You are under no obligation to participate and if you choose to participate, you can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If you choose to withdraw, all data gathered until the time of withdrawal will not be used in the research.

Information about the Study Results: The research findings will be made available to the research participants. Once a final paper is written, the researcher will post the paper online. Participants are asked to email the researcher for the link to the final publication.

Acceptance: Please state at the beginning of the audio recording: By partaking in this interview, I agree to participate in the above research interview conducted by Ayesha Ratnayake, Faculty of Health Sciences, at the University of Ottawa, under the supervision of Dr. Luisa Veronis. I have read and understood the consent form and been given a copy of the consent form for my own records. The researcher has answered all of my questions and addressed my concerns.

If you have any questions about the study, you may contact the researcher or her supervisor. If you have any questions regarding the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5/ Tel.: (613) 562-5387 / Email: ethics@uottawa.ca

Please keep this form for your records.

Thank you for your time and consideration.

Name, date and signature of the researcher(s).

Information/Consent Text (Focus Group)

Title of the study: Achievements and experiences of a Local Immigration Partnership (LIP) in Ontario engaging with the health sector to support access to healthcare: A Case Study

Principal Investigator:

Ayesha Ratnayake
PhD Candidate
University of Ottawa
Ottawa, ON

Professor (Supervisor):

Dr. Luisa Veronis
Associate Professor
Geography, Environment and Geomatics
Faculty of Arts
University of Ottawa

Invitation to Participate: You are invited to participate in the abovementioned research study conducted by Ayesha Ratnayake. The study is being conducted as part of Ayesha Ratnayake's PhD Thesis under the supervision of Professor Veronis.

Purpose of the Study: The purpose of the study is to describe the accomplishments and experiences of a LIP in Ontario around improving access to healthcare for immigrant populations and advancing health equity priorities.

Participation: Your participation will consist of one focus group discussion via MSTeams that may last up to 60 minutes. This focus group discussion will occur at the date and time of your choosing (the researcher will provide you with options to choose among). The focus group discussion will be audio-recorded. You will be asked to provide insight on selected emerging themes from the interviews, as a member of the LIP. This discussion will be composed of open-ended questions.

Risks: Your participation in this study will entail that you volunteer experiences/opinions, and this may cause you to feel emotional or psychological discomfort. Audio recording the discussion may also be another source of discomfort. The research will make every effort to minimize these risks.

The researcher will store the audio recording in a secure locked cabinet at her office. Your personal information will not be included in the audio recording (i.e., name, birth date etc).

Benefits: Possible benefits include knowledge gain, ability to share one's experiences/ideas, ability to inform current research, and exposure to academic findings/involvement in the research process. This participatory case study research will also allow your LIP's accomplishments to be highlighted in reports and publications.

Confidentiality and anonymity: The information that you will share with the researcher will remain strictly confidential and will be used solely for the purposes of this research. The only people who will have access to the research data are the immediate investigators (Dr. Luisa Veronis and Ayesha Ratnayake) and the University of Ottawa's Research Ethics Board (REB). Anonymity is guaranteed in publications (no names will be used, organization won't be revealed, etc.). Researchers will keep data confidential, however, they cannot guarantee that other members of the focus group entirely preserve the confidentiality of the information shared. All participants will be asked to keep the discussion confidential.

Conservation of data: The data collected in audio recording of the focus group discussion will be transcribed. This recording and transcript will be kept in a secure manner, in a password protected portable hard-drive in a locked cabinet in the researcher's office for a 5-year period. Thereafter, all the data will be destroyed.

Compensation: Compensation will be provided for those who take part in the focus group discussion. Participants will be compensated with a \$75.00 payment. Participants will still receive the compensation should they choose to withdraw.

Voluntary Participation: You are under no obligation to participate and if you choose to participate, you can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If you choose to withdraw, all data gathered until the time of withdrawal will be used in the study given the collective nature of the group discussion.

Information about the Study Results: The research findings will be made available to the research participants. Once a final paper is written, the researcher will post the paper online. Participants are asked to email the researcher for the link to the final publication.

Acceptance: Please state at the beginning of the audio recording: By partaking in this interview, I agree to participate in the above research interview conducted by Ayesha Ratnayake, Faculty of Health Sciences, at the University of Ottawa, under the supervision of Dr. Luisa Veronis. I have read and understood the consent form and been given a copy of the consent form for my own records. The researcher has answered all of my questions and addressed my concerns.

If you have any questions about the study, you may contact the researcher or her supervisor. If you have any questions regarding the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5/ Tel.: (613) 562-5387 / Email: ethics@uottawa.ca

Please keep this form for your records.

Thank you for your time and consideration.

Name, date and signature of the researcher(s).

Supplement 3

Guide for Interview

Note: The interview will be conducted in person (location of participant's choice), or online (via Zoom or Microsoft Teams)

Introduction: interviewer will briefly introduce study and answer any questions the participant may have.

Audio-recording begins

Consent: Participant will read the acceptance paragraph in the consent form.

The following questions may not be asked in order, and the flow of the conversation will depend heavily on respondent answer (semi-structured interview format):

1. What is (or was) your role within the Ottawa Local Immigration Partnership (OLIP) or What is (or was) your association with OLIP (e.g., partner, collaborator) and relationship? Please describe how have you worked with/interacted with OLIP in the past and/or present?

Probes: Could you explain, at the individual level, in what ways your role/association with OLIP may have supported your work around immigrant integration and access to primary healthcare? Please describe outcomes/results and give examples.

Areas to consider:

- Knowledge (give examples),
- Capability, skills (give examples),
- Network/relationship dynamic within LIP collaborative (give examples),
- Resources around immigrant integration and health.

2. At the community level, and from your perspective, in what ways (directly or indirectly) has OLIP supported initiatives to improve health equity and access to healthcare for immigrant communities? Please think about the work you've done too where OLIP was involved.

Probe: For example, has OLIP contributed to planning, developing or implementing programs or policies to advance immigrant health priorities? Could you provide an example? What were/ are some of the outcomes? (E.g., answers may touch on the arrival of Syrian refugees, or other groups such as Afghans and Ukrainians as a situation where OLIP may have intervened, raised voices etc.)

Probe: What would you say are the factors that made such particular initiative successful (or not) for OLIP?

Probe: What challenges or barriers has OLIP experienced in this regard? Please describe any instances that felt like difficult moments, or maybe examples of negative outcomes or even unsuccessful efforts,

Probe: Looking back, what could have been done differently or better to improve outcomes?

Probe: From your perspective as an expert in your own area of work, are there recommendations you'd have for OLIP to improve their responsiveness/efforts to improve access to healthcare issues and health equity?

3. From your perspective, in what ways is OLIP most effective in improving access to healthcare and health equity, if at all? Please explain. (E.g., via policy discussion, convening tables, leading action-oriented initiatives etc.)

Probe: Why do you think OLIP was able to be effective in this situation? What were their strengths? Limitations? Please consider OLIP's skills, knowledge, capabilities, and attributes (can also consider how the OLIP is structured/its' governance, its' relationships and partnership).

4. From your perspective, what is the current and potential role of OLIP within the health sector? Please describe any barriers or challenges you are aware of and provide examples. How are LIPs a resource for governments and communities to support access to healthcare policy and activities? Please explain and provide examples if possible. (Think about your work and if OLIP would be a resource).

Probe: The relationship between non-profit actors and government is inherently unequal: most non-profit service providers require public funding to realize their mandates; yet government funding often times is insufficient to cover full programming costs and may force non-profits to implement programs that receive funding from the government, but which do not necessarily fully address immigrants' needs. Moreover, the non-profit sector's ability to advocate for equity policies may be restricted by the funding regime. Are you aware of how OLIP dealt with these issues?

Probe: Increasingly, LIPs and other settlement organizations are taking on broader roles to support primary healthcare. The extent to which LIPs play a constructive role supporting access to primary healthcare may depend on their role being well understood and appropriately supported by other organizations in the health sector. How has OLIP navigated relationships with other organizations in the health sector? How has OLIP been received? What strengths did the LIP bring to the collaboration? What limited OLIP in pursuing collaborations with potential partners to support immigrant health equity priorities? Please give examples.

Before closing, do you have any additional comments or remarks relating to the role of the LIP in relation to health (care) access and equity, or any other ideas or suggestions relating to this discussion that you wish to share?

Thank you for taking the time to complete this interview.

Note to interviewer: At the end of the session, the interviewer will also ask if any questions were unclear, did not make sense, etc. and will incorporate this feedback into the next interview.

Supplement 4

Detailed Complementary Document Analysis

To ensure a structured document analysis process, the researcher (A.R.) primarily followed guidance by Morgan (2022) on conducting a qualitative document analysis. Other sources, such as work by Bowen (2009), Dalglish et al. (2020), and O’Leary (2014) were consulted, as needed, to inform the document analysis process.

Parameters

- **Date Range:** This analysis considers documents from 2012 onwards to present day (August 2024) (note: the cut-off of 2012 was chosen because interviewees and focus group participants did not provide significant information about OLIP’s impacts prior to this date).
- **Location/Context:** Documents may originate from the OLIP, OLIP partners, credible outside evaluators or researchers in Canada, or those working in proximity to OLIP (e.g., settlement sector, the city, Government of Canada, the health sector).

Inclusion Criteria

- Documents that contain data pertaining to OLIP’s impacts in the health space.
- Documents that make reference to OLIP as a source of support for, or actor, in improving access to healthcare for immigrants.
- Documents that contain information about the OLIP’s activities and outcomes in support of improving access to healthcare for immigrants.
- Documents containing information to inform the research question, such as OLIP challenges and lesson learned while working towards health equity for immigrant populations in Ottawa.

Categories of sources of publicly available and relevant documents and potential medium (e.g., reports, websites, magazines) to consider **were outlined** (O’Leary, 2014):

- Public records and publications (e.g., official records of activities, such as mission statements, policy directives, handbooks, strategic plans, scientific publications, annual reports).
- Personal documents available to the public (e.g., a first-person account of actions/experiences which can include emails, blogs, social media posts, personal opinion articles).

- Physical evidence available to the public (e.g., artifacts developed by the LIP or by partner organizations. Artifacts may include posters, flyers, calendar invitations, agendas, PowerPoint presentations, handbooks, website material).

What We Searched

A purposeful sampling approach was applied to identify and select relevant and information-rich documents from diverse sources (Cresswell & Plano Clark, 2011; Palinkas et al., 2015). Data collection began with researchers A.R and K.B scanning various information channels such as the following:

- OLIP’s social media platforms
 - Twitter: https://twitter.com/OLIP_PLIO.
 - Facebook: <https://www.facebook.com/OttawaLIP>.
 - YouTube: <http://www.youtube.com/channel/UCPixBbDk08uZ5sE2IH6mA9g>.
 - and OLIP’s Newsletter: <https://mailchi.mp/3c3280c99502/olip-newsletter-april-2020-lettre-dinformation-du-plio-avril-2020?e=ba210624a3>.
- known LIP organizational websites such as the national LIP Secretariat website (<https://thelipsecretariat.ca/>) and OLIP’s home website (<https://olip-plio.ca/>).
- national platforms known to engage with the LIPs such as the Pathways 2 Prosperity webpages (<http://p2pcanada.ca/>).
- OLIP partner organization’s archives and resources available from organizational webpages (see list of OLIP partners here: <https://olip-plio.ca/who-we-are/community-wide-partnerships/>) and Government of Canada databases (e.g., archived documents from Immigration, Refugees and Citizenship Canada).
- Google’s search engine, as well as Microsoft Edge’s search was used to scan the web.
- Participants from the study’s focus group and interviews were asked to share resources they felt were relevant to the research question.

Assessing and Examining the Documents

In selecting the list of documents to analyze, researchers (A.R. and K.B.) considered four factors when examining the text: authenticity (extent of genuineness and unquestionable authorship); credibility (extent to which the document content is reliable, free of distortion and error or internal contradictions); representativeness (this concerns how typical/consistent document material is of existing resources); and meaning (how clear and understandable the document is; surface meaning versus a deeper meaning) (Morgan, 2022). Further to this, and to aid in selecting quality documents, the researchers asked questions pertaining to the author’s agenda and potential biases (e.g. what is the goal of this document? What are the incentives behind developing this document?); background information (e.g., purpose, audience, written/presentation style); other information to understand quality and intent (e.g., whether the document was solicited,

anonymous, or edited; whether the document is a primary source or secondary source; specific circumstances under which the document was produced or consumed; general accuracy; concerns around balance, good faith, the creator's reasoning); and completeness (i.e., how selective or comprehensive the reported data is; whether the document is part of a series) (Bowen, 2009; Daghli et al., 2020; O'Leary, 2014). Documents that the researcher's questioned or doubted, were discussed; the researcher's arrived at a decision together whether to include or exclude from the list of resources to analyze. Once a list was finalized, A.R. did a second-pass through the text, highlighting passages that were of relevance to the research question. Collected documents were organized according to date (Table 1).

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Supplement 5

The Codebook

Code Number	Code Label	Definition (the definition of what the theme concerns) and/or Description (a description of how to know when the theme occurs)
1	Advocate for better funding conditions for primary healthcare initiatives	Broadly speaking, trying to influence (indirectly or directly) higher-level decision-makers and politicians to recognize and improve the funding situation for primary healthcare.
2	Advocating for better resource allocation for immigrant healthcare services	May entail light advocacy-type actions (e.g., through partnerships) around raising awareness and vocalising the need for better resource allocation for immigrant healthcare services.
3	Advocating for government investment or seeking funding from other sources	The organization is seeking (directly or indirectly) further funding or is fundraising to support organizational efforts towards supporting immigrant healthcare.
4	Advocacy through research, evidence-synthesis or dissemination	This entails light advocacy (or indirect) via research findings and recommendations for future practice or policy.
5	Advocacy through written recommendations for policy change	This can be any type of written material (e.g., letter of support for partner organizations) that pushes an issue forward and makes recommendations for enhanced policy, action, or policy change.
6	Build awareness among leadership of organizations	Building awareness among leadership and decision-makers of institutions and agencies in the health sector regarding access to healthcare issues concerning immigrant populations.
7	Building and maintaining social connections and partnerships	This means that these social partnerships are not lost, and that the LIP works to maintain a connection between and among partners.
8	Building evidence resources on healthcare issues and gaps	This can be done as a LIP or through a partnership with other organizations and can involve knowledge transfer activities. For example, resources can take the form of a report.

9	Challenge cultural norms or practices or concepts	In general, activities or efforts to challenge the current beliefs, system practices, or prevailing attitudes around access to healthcare issues.
10	Civic Engagement	Connecting and linking with, and engaging local community leaders and members.
11	Convene dialogs with immigrant communities to inform actionable plans with partners	Use networks and established connections with community to help inform access to healthcare issues through community dialogue.
12	Convening working group meetings or sector table meetings	The action of setting a meeting and bringing together like-minded individuals. Examples include the health and wellbeing sector table, or tables formed during the pandemic.
13	Coordinate or align community responses	This requires a bird's eye view to put together pieces of contributions or efforts from partners to have collective impact without duplicating efforts. Examples would be partners efforts complementing each other, or building on resources of each other, or incorporating ideas/concepts/products from different partners for better overall comprehensive coordination.
14	Coordinating with researchers and academics to improve, enrich data	A form of enriching the current state of knowledge by way of contributing or supporting research efforts.
15	Create, share, maintain local community resources to facilitate healthcare and access	For use by partners and for knowledge dissemination; this entails being a source of information and having some of that information accessible and on-hand.
16	Develop interventions or establish specific approaches to strengthen collaborative networks and coordinated efforts	This may mean the continued revision or nurturing of approaches or strategies to support and strengthen collaborations making sure that are meaningful endeavours.
17	Develop networks with community organizations or community leaders	Form and maintain meaningful networks with community organizations and leaders.
18	Development of cultural competence	Developing culturally competencies in health professionals and those working in the health sector to enhance interactions with immigrant populations they serve.

19	Develop or lead technical working groups or coalitions	These groups might have a more narrowed focus, or goal, and the LIP may take a bit more of a leadership role in the administrative side of forming this group and meetings.
20	Effective organizational governance and autonomy over actions considering capacity limitations	This is regarding the structure and conduct of an organization and its' ability to effectively carry out work to improve access to care issues for immigrant populations.
21	Elicit perspectives to interpret evidence or current issues	The ability to draw out perspectives from interest-holders such as community members or from the health worker community to provide rich interpretations on data.
22	Enhance health literacy among immigrants and refugees	Actions to support health literacy enhancement among immigrants (e.g., toolkits, providing access to health literacy improvement resources).
23	Establish partnerships with immigrant community organizations	Seek and form connections with immigrant community organizations towards the goal of working or acting in partnership.
24	Establishing systems for generating and disseminating knowledge	This is a general concept of creating supportive environments where knowledge can be discussed, generated through additional conversation, and disseminated to participating individuals or to targeted audiences.
25	Examine structural barriers	Examining and discussing general structural barriers at systems level to accessing healthcare.
26	Foster involvement of immigrant groups in programme and policy designs to increase access to healthcare	Bringing in and incorporating immigrant community members ideas and values into programme planning to enhance access to healthcare.
27	Health education and awareness raising	Actively promoting health education, vocalizing the need for health education for immigrant populations.
28	Helping newcomers connect with community social services that support care	This means that the LIP is supporting the community with regard to connecting to services that impact access to healthcare, such as financial aid, transportation services, education, employment, interpreter services.
29	Improve the quality of access to healthcare and population data	This means that the LIP is able to provide knowledge, insight, contextual information to dissect and interpret access to

		healthcare and demographic population health data, for the purpose of making it more usable and understandable.
30	Informing institutional frameworks towards access	This is the general guidance or providing support or advice to inform and institutional (e.g., primary care clinics) approaches towards equitable and inclusive access for immigrants.
31	Informing mental health programs and services	Providing information that can help inform and improve the current state of institutional mental health programs or services for immigrant populations.
32	Informing on linguistic barriers to accessing healthcare	Providing information that can help inform and improve the current state of institutional (e.g., primary care clinics) programs and services with regard to linguistic barriers concerning immigrant populations.
33	Inform on social political climate, society needs of population to support deployment of service resources effectively	Bringing in a perspective that ties in the current social political climate and making connections between society needs and what is possible to support tailored deployment of healthcare service resources effectively.
34	Informing on socio-cultural barriers to accessing healthcare	Providing information that can help inform and improve the current state of institutional (e.g., primary care clinics) programs and services with regard to socio-cultural barriers to accessing healthcare concerning immigrant populations needs.
35	Informing policy and planning frameworks towards access	Informing collaborative action frameworks on equity issues around access to healthcare.
36	Informing the direction of service activities	Using knowledge and contextual insight to help inform appropriate healthcare service delivery efforts.
37	Linking health professionals to enhance actions towards common goals	This can entail making the introduction, or bringing together, or connecting via virtual platforms, two or more professionals, or decision-makers in the health field.
38	Participation and engagement in positive, trusting relationships with health sector colleagues	This means that the LIP is seen as a trusted group among health sector colleagues. Health sectors players may seek out their engagement. Often, interactions with the LIP are seen as

		beneficial and positive towards improving healthcare issues for immigrants.
39	Participating in discussions to inform health professionals and decision-makers	This means that the LIP is actively taking part in discussions, formally or informally, to help advance and inform a certain issue. For example, they could be invited into a discussion to share their insight and express community perspectives.
40	Participating in initiatives around discrimination, racism, social exclusion	Participating in efforts that address stigma, racism, discrimination, social isolation and can affect access to healthcare for certain immigrant populations.
41	Peer advisory and support	This means that the LIP is taking part in relationships where they are seen as a source of support or for partners to go to for advice.
42	Promote efforts to strengthen policies affecting social determinants of health	In general, supporting and where possible, advising on efforts that strengthen policies around the SDOH (e.g., financial security, education, employment) that indirectly impact one's access to healthcare.
43	Promoting health education to change behaviours	Targeted at individual community members; finding approaches and ways to actively promote health education efforts.
44	Promoting inclusive services	The general promotion of healthcare services that target certain demographics and immigrant populations by breaking down barriers faced by individual to healthcare service use (e.g., culturally appropriate service, or gender-response services).
45	Promoting ongoing and effective communication among community agencies	This means encouraging or making it possible to have continued conversations among some of the main players in the health sector (or from other sectors that have relevance in these health-focused discussions).
46	Promoting physically accessible healthcare services	Promoting healthcare services that consider the physical accessibility (e.g., taking into consideration neighbourhood, transportation issues) aspect for a certain immigrant population.

47	Promoting supportive economic integration policies	Promoting economic integration policies that influence access to healthcare for immigrants.
48	Promote supportive social policies and overall social wellbeing	Promoting social policies that influence access to healthcare for immigrants.
49	Providing health educational resources	In partnership, or as a LIP, supporting and making available health educational resources for the community to support health needs and inform the community regarding primary care initiatives.
50	Providing research and academic material to build capacity	Providing opportunities for health professionals to access academic research and materials (e.g., presentations) to build and develop their capacity.
51	Providing resources or forums for health professionals to develop skills, training	Providing forums (e.g., establishing Communities of Practice) for ongoing capacity-building, skill development, training etc.
52	Respected and has power in guidance and leadership	The LIP is able to command the attention of partners, and partners are willing to interact with the LIIP for the purpose of working towards increasing access of healthcare services for immigrant populations.
53	Sharing equity focused resources	Sharing resources on equity or social determinants of health, with partners to contribute to the tools and resources partners can draw on to improve health inequities for immigrants.
54	Source data from trustable organizations to share with partners	Linking, finding data from sources such as IRCC, CIHI for partners to use, for example, to better strategically adapt healthcare interventions.
55	Strengthen and consolidate the expertise of researchers and health professionals	This involves knowledge synthesis, gathering and sharing from various experts to strengthen overall knowledge on a health issue.
56	Support adaption of culturally appropriate care service	Culturally competent and appropriate care adaptation within institutional programming and activities to increase access for immigrant populations.
57	Support adaptation of protocols or procedures to increase access to healthcare services	This can relate to changes within institutions and local health organizations or agencies that are geared towards equitable access for immigrant populations.

58	Supporting data collection to inform partner activities around health equity	Supporting data collection to inform the tailoring or development of planning and programming activities towards targeted population groups for better client response.
59	Supporting diversification of workforce	Supporting partner organizations and promoting diversification of workforce to ensure that community health workers reflect the population diversity and staff are trained to serve and respond to diverse immigrant populations.
60	Support formalization of new roles or functions	This can be, for example, in institutional settings, supporting the addition of interpreters and their function within the clinical setting to increasing access to care for immigrant populations.
61	Support or inform policies or programs influencing health system navigation	For example, this can relate to policies or approaches that are within communities (i.e., that come about from the set-up of the local health system) or institutional policies within the local health system. LIPs may inform on how to create supports to provide immigrants with more opportunities for successful health system navigation.
62	Supporting partner's equity plans towards inclusion of immigrant populations	Supporting or helping to shape partner organization/institution/agency plans or strategies for better inclusion of diverse immigrant populations regarding healthcare activities/programming.
63	Support sharing of learning and best practices among health professionals or those in the healthcare sector	This type of knowledge exchange and knowledge mobilization centres on the act of sharing knowledge that has been put into practice and also connecting results with professionals for the purpose of creating better impacts in the health field.

* Table was developed by drawing on suggestions from Fereday & Muir-Cochrane, 2006. The table includes a mix of open coding, descriptive coding and process coding.

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Supplement 6

Framework Matrix

Themes and Corresponding Codes (within Social-Ecological Levels of Influence)

#	Theme	Corresponding Codes (see Supplement 5) and SEM Level of Influence
1	Cross-Sectoral Coordination and Collaboration	<p>Sub-theme: Facilitate inter-sectoral or sector-wide knowledge mobilization and/or provide knowledge and insight to move forward health equity and access to healthcare priorities.</p> <p><i>(Considers access to care dimensions: accessibility, accommodation, acceptability)</i></p> <p>Codes:</p> <ul style="list-style-type: none"> • Building evidence resources on healthcare issues and gaps <i>(policy level)</i> • Coordinating with researchers and academics to improve, enrich data <i>(relationship/interpersonal level)</i> • Create, share, maintain local community resources to facilitate healthcare and access <i>(community level)</i> • Elicit perspectives to interpret evidence or current issues <i>(individual level)</i> • Establishing systems for generating and disseminating knowledge <i>(institutional/organizational level)</i> • Improve the quality of access to healthcare and population data <i>(institutional level)</i> • Informing the direction of service activities <i>(institutional/organizational level)</i> • Participating in discussions to inform health professionals and decision-makers <i>(relationship/interpersonal level)</i>

		<ul style="list-style-type: none"> • Sharing equity focused resources (<i>community level</i>) • Source data from trustable organizations to share with partners (<i>community level, institutional level</i>) • Strengthen and consolidate the expertise of researchers and health professionals (<i>institutional level</i>) • Support sharing of learning and best practices among health professionals or those in the healthcare sector (<i>community level, institutional level</i>) <p>Sub-theme: Improving cooperation, coordination, collaboration among disciplines, professions and health sector professionals across sectors, and/or within the health sector.</p> <p>(Considers access to care dimensions: availability, accessibility, accommodation, affordability)</p> <p>Codes:</p> <ul style="list-style-type: none"> • Building and maintaining social connections and partnerships (<i>relationship/interpersonal, community level</i>) • Coordinate or align community response (<i>community level</i>) • Convening working group meetings or sector table meetings (<i>relationship/interpersonal level</i>) • Develop interventions or establish specific approaches to strengthen collaborative networks and coordinated efforts (<i>relationship/interpersonal level, community level</i>) • Develop or lead technical working groups or coalitions (<i>relationship/interpersonal level, organizational level</i>)
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		<ul style="list-style-type: none"> • Linking health professionals to enhance actions towards common goals (<i>relationship/interpersonal level</i>) • Promoting ongoing and effective communication among community agencies (<i>community level, organizational level</i>)
2	Advocacy and Policy Influence	<p>Sub-theme: A respected organization and advisor to health professionals, health leaders, and decision-makers.</p> <p>(Considers access to care dimensions: availability, accessibility, accommodation)</p> <p>Codes:</p> <ul style="list-style-type: none"> • Participation and engagement in positive, trusting relationships with health sector colleagues (<i>relationship/interpersonal level/community level</i>) • Peer advisory and support (<i>relationship/interpersonal level</i>) • Respected and has power in guidance and leadership (<i>interpersonal level</i>) <p>Sub-theme: Health advocate for improvements in access to care and healthcare services for immigrants.</p> <p>(Considers access to care dimensions: availability, accessibility, accommodation, acceptability, affordability)</p> <p>Codes:</p> <ul style="list-style-type: none"> • Advocating for better resource allocation for immigrant healthcare services (<i>community level/policy level</i>) • Advocacy through research, evidence-synthesis or dissemination (<i>community level</i>)

		<ul style="list-style-type: none"> • Advocacy through written recommendations for policy change (<i>community level/policy level</i>) • Health education and awareness raising (<i>community level</i>) <p>Sub-theme: Investigate and recognize connections between public policies and health and wellbeing to support inclusive policies towards access to healthcare.</p> <p>(Considers access to care dimensions: availability, accessibility, accommodation, acceptability, affordability)</p> <p>Codes:</p> <ul style="list-style-type: none"> • Advocating for better funding conditions for primary healthcare initiatives (<i>policy level</i>) • Challenging cultural norms or practices or concepts (<i>community level/societal level</i>) • Examine structural barriers (<i>policy level</i>) • Informing policy and planning frameworks towards access (<i>community level, policy level</i>) • Inform on social political climate, society needs of population to support deployment of service resources effectively (<i>institutional/organizational level</i>) • Participating in initiatives around discrimination, racism, social exclusion (<i>community level, societal/policy level</i>) • Promote efforts to strengthen policies that affect social determinants of health (<i>policy level</i>) • Promoting supportive economic integration policies (<i>policy level</i>) • Promoting supportive social policies and overall social wellbeing (<i>policy level</i>)
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3	Engaging and Empowering Communities	<p>Sub-theme: Acting towards breaking down individual level barriers to access to care.</p> <p>(Considers access to care dimensions: accessibility, accommodation, acceptability)</p> <p>Codes:</p> <ul style="list-style-type: none"> • Enhance health literacy among immigrants and refugees (<i>individual level</i>) • Promoting health education to change behaviours (<i>individual</i>) • Promoting inclusive/targeted services (<i>individual level</i>) • Promoting physically accessible healthcare services (<i>individual level/community level</i>) <p>Sub-theme: Engage with immigrant populations and communities to resolve access to healthcare issues.</p> <p>(Considers access to care dimensions: availability, accessibility, accommodation, acceptability, affordability)</p> <p>Codes:</p> <ul style="list-style-type: none"> • Civic Engagement (<i>individual/intrapersonal level, community level</i>) • Convene dialogs with immigrant communities to inform actionable plans with partners (<i>community level</i>) • Develop networks with community organizations or community leaders (<i>community level</i>) • Establish partnerships with immigrant community organizations (<i>community level</i>) • Helping newcomers connect with community social services that support care (<i>community level</i>)
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		<ul style="list-style-type: none"> • Providing health educational resources (<i>community level</i>) <p>Sub-theme: Organizational actions to improve response to immigrant healthcare issues.</p> <p>(Considers access to care dimensions: availability, accessibility, accommodation, acceptability, affordability)</p> <p>Codes:</p> <ul style="list-style-type: none"> • Advocating for government investment or seeking funding from other sources (<i>organizational level</i>) • Build awareness among leadership of organizations (<i>community level, organizational level</i>) • Effective organizational governance and autonomy over actions considering capacity limitations (<i>organizational level</i>) • Foster involvement of immigrant groups in programme and policy designs to increase access to healthcare (<i>institutional/organizational level</i>) • Supporting diversification of workforce (<i>institutional/organizational level</i>) • Supporting partner’s equity plans towards inclusion of immigrant populations (<i>institutional/organizational level</i>)
4	Building Capacity and Informing Service Delivery	<p>Sub-theme: Building health professional capacity and sector-wide capacity.</p> <p>(Considers access to care dimensions: availability, accommodation, acceptability)</p> <p>Codes:</p> <ul style="list-style-type: none"> • Development of cultural competence (<i>individual level</i>)

		<ul style="list-style-type: none"> • Providing research and academic material to build capacity (<i>individual level</i>) • Providing resources or forums for health professionals to develop skills, training etc. (<i>individual level</i>) <p>Sub-theme: Informing institutional and healthcare service planning and programming activities of partners.</p> <p>(Considers access to care dimensions: availability, accessibility, accommodation, acceptability)</p> <p>Codes:</p> <ul style="list-style-type: none"> • Informing institutional frameworks towards access (<i>institutional/organizational level</i>) • Informing mental health programs and services (<i>institutional/organizational level</i>) • Informing on linguistic barriers to accessing healthcare (<i>institutional level</i>) • Informing on socio-cultural barriers to accessing healthcare (<i>institutional level</i>) • Support adaption of culturally competent care service (<i>institutional level</i>) • Support adaptation of protocols or procedures to increase access to healthcare services (<i>community, institutional level</i>) • Supporting data collection to inform partner activities around health equity (<i>institutional level</i>) • Support formalization of new roles or functions (<i>institutional level</i>) • Support or inform policies or programs influencing health system navigation (<i>community level, institutional level, policy level</i>)
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*Matrix was developed by drawing on Social-Ecological Model components as outlined in the work of Caperon et al., 2022; Erickson et al., 2024; and Family & Youth Services Bureau, 2023.

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Supplement 7

Expanded Section on Limitations

Results from chapter 3 should be interpreted with an understanding of the limitations of each analysis and data collection method.

Thematic Analysis Method. The thematic analysis method itself can be considered disadvantaged; for example, an inherent challenge of generalizability exists. Additionally, there is a level of difficulty and subjectivity in identifying and developing themes (risk of incoherence and inconsistency) and assertions concerning language use cannot be made by researchers (inconsistent interpretations) (Braun & Clarke, 2006; Nowell et al., 2017).

Documentary Analysis. Documentary analysis as a research method has some weaknesses. For example, although all documents collected were available for public scrutiny, we noted the possibility of biases, specifically when considering content from documents written and published by the study subject (i.e., lacking an objective lens) (Morgan, 2022). Furthermore, documents in the public realm may not be complete in the sense that ideas or findings may present a partial view of the situation or issue at hand.

Interviews. Due to the nature of semi-structured interviews, bias and limitations were considered, and where possible, actions were taken to limit the extent of these biases throughout the interviewing process. For example, the possibility of interview bias and social desirability bias required the researcher A. R. to pay constant attention to her presence, communication style, and behaviours, and to create a welcoming and safe environment where respondents felt comfortable to share their true opinions. Other possible limitations include interviewee recall bias, and the degree of validity of semi-structured interviews (e.g., difficulty comparing responses, self-reported data can be untrue).

Focus Group Discussion. Limitations concerning the focus group were also identified in advance to minimize or avoid issues. For example, a group setting may make a participant unwilling to speak about their personal experiences. There is also the chance that dominant participants drown out less active participants (Bolderston, 2012). A.R. intentionally facilitated and managed the discussion, to allow space for each participant to share any related experiences or thoughts for each question.

Number of Participants. Regarding the smaller number of participants in this study, we recognize the concerns around determining theoretical saturation. A.R. suggests an iterative sampling and re-sampling approach to confirm the occurrence of theoretical saturation (Palinkas et al., 2015). Also, one can re-visit pre-defined participant criteria to expand to broader partners as potential participants. However, our research likely reached data saturation due to the richness of the data collected, in the sense that, after the 9th interview, no new themes or insights emerged (and when comparing focus group content and document text).

Sampling. Lastly, we acknowledge the challenges of purposive sampling in this research concerning the selection of participants (e.g., the researcher's judgements can unintentionally influence the types of participants contacted for interviews). To minimize biases, the researcher was transparent and explicit in detailing the specific characteristics of participants within the case selection criteria (Palinkas et al., 2015).

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CHAPTER 5: INTEGRATED DISCUSSION WITH CONCLUSION

5.1 Summary of Findings

The main aim of this thesis was to investigate the role of Local Immigration Partnerships (LIPs), which are ‘non-medical’ settlement coordination organizations, in facilitating immigrants’ access to primary healthcare services. LIPs’ origins are based in the 2005 Canada-Ontario Immigration Agreement (COIA); by 2024 there were 80 LIPs nationally (except for the province of Quebec) and 35 LIPs operating in Ontario (National LIP Secretariat, 2024). LIPs have become key actors in the immigrant settlement ecosystem by providing opportunities for intersectoral collaboration and supporting the coordination of service provision and resources that are adapted to the diversifying populations and communities in Ontario and elsewhere in Canada (Citizenship and Immigration Canada, 2013; Veronis, 2019; Walton-Roberts et al., 2019). While research has examined their role and capacity in improving newcomer settlement services, less is known about their contributions to supporting immigrants’ access to primary healthcare services (Ravanera et al., 2012; Veronis, 2019; Walton-Roberts et al., 2019).

The three research objectives of this thesis were: 1) to identify the ways in which LIPs and settlement organizations engage with the health system and key health sector agencies to enhance healthcare access for immigrant populations; 2) to assess and establish the cross-cultural global health competencies of LIPs, with a focus on their support and operations within the healthcare sector; and 3) to examine the experiences and achievements of the Ottawa LIP (OLIP) within the health system, particularly in facilitating and supporting immigrants’ access to healthcare.

The thesis drew on existing theories to form a conceptual framework. By combining the Social-Ecological Model (Bronfenbrenner, 1977) with Health Equity/Access to Care theories (Gulliford

et al., 2002; WHO, 2024), the thesis situates its research, analysis, and outcomes within a broader context while applying a focused lens on health equity and inequities in access to care.

The study relied on a mixed quantitative-qualitative methodology. First, a scoping review was conducted to investigate whether and how such ‘non-medical’ settlement coordination organizations support access to healthcare services (addressing research objective 1); then a quantitative questionnaire was administered to LIPs in Ontario to examine their capacities to support diversity, equity and inclusion considerations in access to healthcare efforts (addressing research objective 2); and lastly, a qualitative case study comprised of interviews, a focus group, and a complementary document analysis was undertaken to examine the experiences of an established Ontario LIP within the healthcare system (addressing research objective 3). This PhD thesis consists of three main articles, each structured around one specific research objective, with a summary of their findings provided below.

For Article 1 (Chapter 2; Ratnayake et al., 2022), we conducted a scoping review to identify and examine existing literature on the ways in which non-medical local immigration settlement organizations support inclusion of immigrant health equity considerations in access to healthcare services (i.e., primary care or clinical care). We systematically searched MEDLINE, Social Services Abstracts, CINAHL, and PsycInfo databases for studies published from 1 May 2013 to 31 May 2021 and analysed the findings using the Social-Ecological framework. The search identified a total of 3,299 citations, but after closer examination and filtering, the research team ended up including a total of 10 published studies. The results of the detailed analysis, mapped onto the Social-Ecological framework, suggest that these organizations support access to primary healthcare services, often at the individual, relationship, and community level, by collaborating with health sector partners in the community, connecting clients to health services and service

providers, advocating for immigrant health, providing educational programming, and initiating community development/mobilization and advocacy activities.

In Article 2 (Chapter 3), we sought to identify and establish cross-cultural global health competencies relevant to LIPs in the province of Ontario, Canada; the focus was on developing and piloting a global health competencies capacity-building tool that operationalizes equity, diversity, and inclusion for these settlement coordination organizations. We developed, piloted, and tested the validity/reliability of an 18-minute structured, self-administered, quantitative questionnaire used to survey the cross-cultural global health competencies. Data was analyzed using SPSS software. In total, 28 LIPs (out of 35) across Ontario participated in the study. We found that all participants agreed that 18 of the 22 global health competencies were relevant to their role and work. Participants tended to have higher confidence in competencies that involved communication skills, leadership, building coalitions, creating opportunities to access local communities and authorities; they, however, had lower confidence with respect to technical tasks such as analyzing policy, planning, implementing and/or evaluating health-centred programs, and creating opportunities to access higher-level decision-makers. Correlations and associations and group differences concerning demographic items and competencies were also found. This study identified crucial core global health competencies for settlement coordination organizations collaborating with health sector partners to support immigrants.

In Chapter 4 (Article 3), we examined the experiences, achievements, and challenges of the Ottawa LIP (OLIP) in facilitating and supporting immigrants' access to healthcare. This study built on the findings from the scoping review (Article 1) and the LIP survey results (Article 2). These findings informed the research question and guided the examination and analysis of OLIP's activities, structure, networks, and initiatives, particularly within the healthcare sector. This

qualitative case study is comprised of semi-structured interviews, a focus group, and a complementary document analysis. The interviews sought to examine “keys to success” (e.g., structure, leadership style, unique position) that enable the LIP to engage with the health sector, as well as perceived challenges and barriers when pursuing health equity priorities. Following this, the focus group session with OLIP core members sought additional perspectives, new information, and was an opportunity to address, in more depth, issues and themes that were not sufficiently developed in the interviews. The complementary document analysis focused on OLIP’s health equity-supporting activities/initiatives.

Through a thematic analysis that drew from the SEM, this study (Chapter 4) identified four main themes: 1) cross-sectoral coordination and collaboration (convening partners from diverse disciplines or professions, coordinating plans across or within sectors, and facilitating knowledge mobilization and knowledge transfer); 2) advocacy and policy influence (supporting inclusive public health policies, advocating for health equity, and connecting with decision-makers in a health advisory capacity); 3) engaging and empowering communities (community engagement, actions to improve local organizational responses to immigrant health needs, and efforts to break down individual-level barriers to accessing healthcare); and 4) building capacity and informing service delivery (informing institutional programming, building sector-wide capacity, and supporting health professional development). Overall, this case study established that OLIP supports and influences factors around access to healthcare for immigrants through their efforts at the intrapersonal level, interpersonal/relationship level, community level, institutional/organizational level, and the broader policy level. We also uncovered challenges concerning resource constraints, governance and organizational structure, and relationship management.

5.2 Implications for Population Health

The findings of this study advance knowledge in the area of population health, pertaining to how and what local ‘non-medical’ settlement coordination organizations — specifically, LIPs in Ontario — are doing to support primary healthcare and access to healthcare for racialized and immigrant populations.

Our research is timely considering that the health of immigrants, including also refugees, is increasingly recognized as a top priority in Canada and globally (Health and Migration Programme, 2022). For newly arrived populations, health outcomes are influenced by multiple determinants, in addition to the social determinants of health (e.g., financial/insurance barriers, health system administrative barriers, socio-cultural discordance) (Health and Migration Programme, 2022). The key to addressing many of these system-rooted issues lies in strengthening and sustaining health systems (Health and Migration Programme, 2022). Particularly important are “partnerships and intersectoral, intercountry and interagency coordination and collaboration mechanisms” (Health and Migration Programme, 2024, p. 11), as well as regional agendas that promote immigrant-sensitive policies to address the lack of access to primary healthcare services, including in the areas of mental health and care, health promotion, and disease-specific prevention and treatment (Health and Migration Programme, 2024). The WHO’s 2025-2028 strategic plan calls for the reorientation of countries’ health systems towards a primary healthcare approach underpinned by values of equity and inclusivity (Director-General, WHO, 2024). This primary healthcare approach focuses on access to healthcare and considers factors affecting access from both a systems and client perspective (Smithman et al., 2020).

Since the WHO is regarded as the global gold standard for norms and standards in population health, their recent focus on marginalized populations, reorientation towards primary

healthcare, sustainable health systems, and strengthened regional and local collaborations and partnerships underscores the value of LIPs in supporting population health. This is especially crucial at a time when many health systems are strained, siloed, and facing human resource shortages.

5.2.1 Contributions to Population Health

This research makes original and significant contributions to knowledge and practice, grouped into three themes: conceptual framework contributions, governance and coordination contributions, and methodological contributions.

Conceptual Framework Contributions. Article 1 employs a Social-Ecological approach to map how local non-medical settlement organizations facilitate access to primary healthcare services for immigrant populations. The findings suggest that settlement coordination organizations operate across various levels of influence, as outlined in the SEM. Article 3 builds on these insights through a case study of the OLIP, illustrating how a LIP operates across multiple levels of influence in practice. Using thematic analysis, the article extends the application of the SEM to examine OLIP's role within the health sector, highlighting its impact at the intrapersonal, relationship, community, institutional, and policy levels. By integrating the SEM with Health Equity/Access to Care theories, Article 3 introduces a novel analytical framework for assessing the contributions of non-medical actors to healthcare access for immigrant populations.

This research broadens our understanding of OLIP's contributions, highlighting its role in healthcare access, health equity, and intersectoral coordination. It also provides insight into governance challenges and funding shortfalls that affect the effectiveness of LIPs. Article 3 further demonstrates how the SEM framework identifies specific areas of OLIP's influence — primarily at the organizational/institutional level — as well as its limitations, particularly at the

societal/policy level, regarding healthcare issues. Together, Articles 1 and 3 provide comprehensive evidence of LIP's contributions across the social-ecological spectrum, reinforcing their role in improving health equity, supporting access to healthcare, and coordinating key intersectoral actors.

Governance and Coordination Contributions. Study findings provide important conceptual contributions to the population health knowledge-base regarding LIPs' capacity and value within the health sector to support access to healthcare for immigrant populations. Our global health competencies framework for LIPs in Ontario (Article 2) demonstrates the cross-cultural skills, attributes, and knowledge of these non-medical settlement coordination organizations. This research on LIPs' global health competencies advances our understanding of their unique position and capacity to work with a variety of actors, across and within sectors, to improve health equity considerations in the settlement and health sector ecosystems and other dimensions of immigrant integration (Article 2). Our research from Article 3 illustrates OLIP's ability as an intermediary governance actor, to bring together partners, build networks and goal-orientated working groups, and raise awareness about access to healthcare issues. The findings show that the involvement of local non-medical settlement organizations in healthcare planning and service delivery may help resource-strained communities better serve immigrant populations. This understanding of LIPs' specific roles in the health ecosystem provides concrete avenues for partners (e.g., professional associations, community health centres, hospitals, public health units) and community leaders to meaningfully engage with and effectively leverage these organizations to improve health equity. For instance, the deep insights gained from this research into governance mechanisms (e.g., the Health and Wellbeing Sector Table) contribute to practical knowledge about effective collaboration models and identifies specific barriers and enablers to LIPs' health equity work (Article 3)

(Ziersch, et al., 2020). Further, understanding LIPs' role and impact in communities can lead to policy implications regarding LIPs' governance, funding, and mandate.

Moreover, this study points to the need for greater integration between local, provincial, and national initiatives that influence the health outcomes of Canadians. It also underscores the importance of enhanced collaboration among primary care, public health, and community services to build a more accessible, effective, efficient, and equitable Canadian healthcare system. LIPs are in a unique position to facilitate collaboration between individual-level care (e.g., primary care) and population-level interventions (e.g., public health) by informing comprehensive and coordinated care through various mechanisms, including:

- Knowledge-sharing networks and Communities of Practice that foster cross-sectoral learning and alignment;
- Development of prevention and health promotion strategies, as demonstrated during COVID-19 when OLIP partnered with a public health unit to identify high-needs populations and co-create outreach solutions;
- Identification and mitigation of health inequities and barriers to care such as through community engagement initiatives organized by LIPs;
- Optimization of health-sector resources, including the mobilization of technical teams for targeted responses (e.g., during the COVID-19 pandemic);
- Local data collection for monitoring and surveillance, supporting evidence-informed decision making; and
- Advocacy for long-term sustainability of health initiatives, leveraging LIPs' unified voice and cross-sectoral connections to influence policy and resource allocation.

This collaborative model can have practical implications for stakeholders across governance levels in Canada. At the federal level, LIPs can help address systemic barriers (e.g., through policy briefs such as OLIP's), support national public health priorities (e.g., COVID-19 primary care interventions), and ensure immigrant populations benefit equitably from Canada's healthcare system (e.g., via data sharing with national immigration and healthcare bodies). At the provincial level, LIPs can enhance health system navigation and promote culturally appropriate care (e.g., by supporting healthcare professionals' training in culturally competent service delivery). And at the municipal and community level, LIPs build resilience in immigrant communities (e.g., through health promotion campaigns), inform public health leaders (e.g., via sector table discussions), foster cross-sectoral networking and responsiveness to arising challenges (e.g., through initiatives like Equity Ottawa), and facilitate virtual connections between community leaders and provincial and federal stakeholders.

From a policy perspective, the governance and coordinator roles that LIPs assume in supporting healthcare access — particularly at the intersection of primary care and public health — are important, especially in relation to the Canada Health Act (CHA) (Government of Canada, 2023). While the CHA remains a foundational piece of legislation for advancing health equity and access to healthcare work in Canada, its principle of accessibility is not always realized in practice. Many immigrant populations, including refugees and individuals with limited social connections, continue to face systemic barriers such as language challenges and inconsistent access to culturally appropriate or comprehensive trauma-informed care. In this context, LIPs play a vital role in identifying and raising healthcare access issues and in mobilizing community-driven solutions. Their position within local networks enables them to advocate for more inclusive healthcare

policies, facilitate access to services, and support the development of culturally responsive care models that align with the principles of the CHA.

Methodological Contributions. This study makes two valuable methodological contributions. The first methodological contribution is the study's mixed-methods approach, which provides a comprehensive view of LIPs' roles in supporting access to healthcare for immigrant populations in Ontario; notably, this comprehensive view has not been captured in previous research. Second, the global health competencies tool, developed in Article 2, contributes as both a research and practical assessment instrument. The tool offers LIPs in Ontario a way to assess and understand relevant cross-cultural global health competencies. These insights can help LIPs identify their strengths and gaps, enabling them to strategically enhance staff competencies, or collaborate with organizations that complement their skills. Furthermore, the questionnaire tool provides a concrete method to evaluate how equity, diversity, and inclusion are integrated into LIP activities and practices within the health system.

While our findings are not generalizable, they provide critical insights into the activities and roles of LIPs within the health system. The lessons, challenges, and key achievements identified offer valuable points of comparison with similar groups. The successes demonstrated in this research can inform and adapt strategies for other settlement coordination organizations and partnership models in the health sector, supporting efforts to enhance health equity and improve healthcare access for immigrant populations (Halaas & Biswas, 2020). For instance, recent research from Slovenia has shown interest in Canada's Local Immigration Partnerships model, particularly in its approach to integrating immigrants into the health system (Durnik, 2020).

5.2.2 Future Research

Based on the thesis findings, several areas for future research can be considered.

First, findings from **Article 1** suggest that including local non-medical immigrant settlement organizations in healthcare planning and service delivery may provide more scope to respond to and reach marginalized, high-need immigrant populations. Settlement coordination organizations are uniquely positioned ‘on the ground’, where they are able to identify the healthcare needs of immigrant populations within the community. Future research may consider investigating the relationship among settlement coordination organizations, such as LIPs, and community health workers and/or community navigators (Shommu et al., 2016; Torres et al., 2017). This may provide more insight into strategies for effective collaboration, particularly around healthcare planning, service delivery and system navigation.

Future research could also focus on critically assessing each identified approach or intervention used by settlement organizations to support access to healthcare (Article 1). Approaches included individual-level interventions (e.g., health education programs, resources to support health system navigation), community-level interventions (e.g., developing community partnerships to provide more integrated care), and society-level interventions (e.g., policy advocacy activities). This assessment would aim to better understand the feasibility of implementing the necessary elements, such as required human resources, costs, and the acceptability of approach. Additionally, it would evaluate the overall effectiveness of these interventions (Ratnayake et al., 2022). Such a critical assessment can help relevant stakeholders decide whether the identified approaches in this review are worth adapting.

Moreover, it would be beneficial for future research to build on this scoping review by incorporating gray literature from various countries and their local non-medical immigrant settlement organizations. Gray literature is often very current, detailed, geographically specific,

providing a rich and balanced perspective on approaches and interventions. This addition would complement the foundational findings of this scoping review (Ratnayake et al., 2022).

Findings from **Article 2** reveal differences in cross-cultural global health competencies among rural and urban LIPs. Coupled with recent research in Canada emphasizing distinct social determinants of health for rural immigrants (Patel et al., 2019), these findings suggest a need for further investigation into healthcare access issues for rural Ontario immigrant populations. Relatedly, it may be important to examine rural LIPs' abilities and skills in supporting to their local health sector.

Furthermore, since the study in Article 2 used purposeful sampling involving all LIPs in Ontario, it is not random. Future research could consider conducting a similar study nationally, including all LIPs across Canada. This would increase the overall sample size and support more detailed subgroup analyses, such as exploring associations between gender demographics and competencies. Another option could be expanding the questionnaire to include the *Réseaux en immigration francophone* in Ontario and in other provinces and territories.

Regarding the questionnaire, it would be valuable to compare the competencies specific to LIPs with those of community health workers who provide services to immigrant populations. This comparison would help identify areas where the fields complement each other and where they differ in terms of competencies. Such insights can be beneficial for advancing common goals and fostering in collaboration (Health and Migration Programme, 2021).

The use of additional research methods to address research objective 3 can add value and provide further perspectives to the findings in **Article 3**. For example, data triangulation with ethnographic research on the Health and Wellbeing Sector Table may offer additional insights into LIP and partner dynamics (Black et al., 2021). Furthermore, future research could focus on

conducting more interviews and focus groups to confirm the study's data using sampling and re-sampling techniques (Vasileiou, et al., 2018). Another option for future research could involve applying complex systems thinking to yield new insights into the relationship dynamics and uniqueness of OLIP's networks and collaborators. This approach could consider non-linear dynamics, various levels of agents and actors, and structures to further identify opportunities and ways in which OLIP contributes to effective policies and community interventions in access to healthcare (Diez Roux, 2011).

Lastly, Article 3 examined OLIP's experiences in supporting access to healthcare services, a key social determinant of health, for immigrants within the health sector. Future research may explore OLIP's impacts on other social determinants of health, as well as commercial determinants of health, in relation to health equity issues for immigrants in Ottawa (Lacy-Nichols, et al., 2023). Moreover, OLIP's effectiveness in supporting immigrant health may vary across the different categories of migrants, such as asylum seekers and undocumented migrants (Campbell et al., 2014; Wiedmeyer et al., 2024).

5.3 Conclusions

The engagement of Local Immigration Partnerships (LIPs) within the local health system, particularly among key actors in the health sector, has positive outcomes for access to primary healthcare for newcomer and immigrant populations. Despite some barriers to engagement, such as governance and funding issues, we recommend the meaningful involvement of LIPs in the health system. LIP's ability to convene partners, build networks, and coordinate attention to pressing healthcare issues while addressing equity challenges for immigrant populations provides a unique advantage to their communities. Additionally, LIPs' position and closeness with grassroots organizations allow them to gain first-hand accounts and insights into new and

developing issues immigrants face. Moreover, their reach across sectors, different levels of government (to an extent), and ability to connect with and bring national-level organizations into discussions is valuable. If thoughtfully utilized and effectively governed, LIPs can be highly dynamic assets with the potential to raise emerging healthcare issues for racialized and immigrant populations on a multi-level and multisectoral platform. Further, they can transfer knowledge that may influence higher-level (structural) policies.

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