

**Uncovering the Role of Community Health Worker/Lay Health Worker Programs
in Addressing Health Equity for Immigrant and Refugee Women in Canada:
An Instrumental and Embedded Qualitative Case Study**

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Abstract

“Why do immigrants and refugees need community health workers/lay health workers (CHWs) if Canada already has a universal health care system?” Abundant evidence demonstrates that despite the universality of our health care system marginalized populations, including immigrants and refugees, experience barriers to accessing the health system. Evidence on the role of CHWs facilitating access is both lacking and urgently needed. This dissertation contributes to this evidence by providing a thick description and thorough analytical exploration of a CHW model, in Edmonton, Canada. Specifically, I examine the activities of the Multicultural Health Brokers Co-operative (MCHB Co-op) and its Multicultural Health Brokers from 1992 to 2011 as well as the relationship they have with Alberta Health Services (AHS) Edmonton Zone Public Health. The research for this study is based on an instrumental and embedded qualitative case study design. The case is the MCHB Co-op, an independently-run multicultural health worker co-operative, which contracts with health and social services providers in Edmonton to offer linguistically- and culturally-appropriate services to marginalized immigrant and refugee women and their families. The two embedded mini-cases are two programs of the MCHB Co-op: Perinatal Outreach and Health for Two, which are the *raison d’être* for a sustained partnership between the MCHB Co-op and AHS. The phenomenon under study is the Multicultural Health Brokers’ practice.

I triangulate multiple methods (research strategies and data sources), including 46 days of participant and direct observation, 44 in-depth interviews (with Multicultural Health Brokers,

mentors, women using the programs, health professionals and outsiders who knew of the work of the MCHB Co-op and Multicultural Health Brokers), and document review and analysis of policy documents, yearly reports, training manuals, educational materials as well as quantitative analysis of the Health Brokers' 3,442 client caseload database. In addition, data include my field notes of both descriptive and analytical reflections taken throughout the onsite research. I also triangulate various theoretical frameworks to explore how historically specific social structures, economic relationships, and ideological assumptions serve to create and reinforce the conditions that give rise to the need for CHWs, and the factors that aid or hinder their ability to facilitate marginalized populations' access to health and social services.

Findings reveal that Multicultural Health Brokers facilitate access to health and social services as well as foster community capacity building in order to address settlement, adaptation, and integration of immigrant and refugee women and their families into Canadian society. Findings also demonstrate that the Multicultural Health Broker model is an example of collaboration between community-based organizations and local systems in targeting health equity for marginalized populations; in particular, in perinatal health and violence against women. A major problem these workers face is they provide important services as part of Canada's health human resources workforce, but their contributions are often not recognized as such. The triangulation of methods and theory provides empirical and theoretical understanding of the Multicultural Health Brokers' contribution to immigrant and refugee women and their families' feminist urban citizenship.

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In one of my colleagues' PhD defense someone said "it takes a village" for a student to complete a PhD. This statement could not have been truer in my journey to finish this program. Words of thanks go to everyone who helped me in so many ways. The participants in my study: the Multicultural Health Brokers Co-op, the Multicultural Health Brokers, Alberta Health Services Edmonton Zone and its health professionals, who let me into their world, shared their stories, and trusted me to share their experiences with others in a scholarly way. I want to specially mention Yvonne Chiu, Executive Director of the MCHB Co-op, who taught me a lot during my study journey, and Lorraine Green of AHS, who made it possible for me to navigate the many research structures of the health system. Thank you.

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Dedication

I dedicate this thesis to my mother who showed me the importance of perseverance, commitment and loyalty in every aspect of my life. Mother you are my source of strength, love and desire to achieve the unachievable.

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Definitions

In this thesis, I have assigned or used the following definitions and meanings for the terms specified below:

Case study

I use an interdisciplinary approach to define case study. A case study is both a process of inquiry about the case and the product of that inquiry (Stake, 2006). I conducted an instrumental case study because the purpose of the inquiry is to go beyond this case (Stake, 2005b). A case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life context, and uses multiple data collection strategies and data analysis to become familiar with the phenomenon, especially when the boundaries between the phenomenon and the context are not clearly evident (Yin, 2003). A case study also benefits from the prior development of theoretical propositions about the phenomenon under study (Gagnon, 2005) to guide data collection and data analysis. Theoretical propositions also guide the case study and their relationship to the research questions (Yin, 2003a).

Embedded case

By embedded mini-cases I mean that the case under study has more than one unit or sub-unit of analyses or programs (Yin, 2003a) that are important to study in order to better understand the case and the phenomenon.

Community Health Worker

I use the American Public Health Association-Community Health Worker Section (2009) definition for CHW. This means that CHWs are frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship

enables CHWs to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities, such as outreach, community education, informal counselling, social support, and advocacy.

Gender

I use the CIHR definition of gender, which states that there are no single agreed-upon definitions of "gender" or "sex", though it is fairly common to associate gender with socially constructed roles, relationships, behaviours, relative power, and other traits that societies ascribe to women and men. Sex is typically understood to refer to the biological and physiological characteristics that distinguish females from males. Gender and sex are interrelated. There is no simple "recipe" for integrating gender and sex in health research (or for accounting for the complex interrelationships between them and other factors or determinants of health) (CIHR 2012/Spitzer, 2007).

Health equity/inequity

Under my definition, health equity is the absence of systematic and potentially remediable differences in one or more aspects of health across socially, demographically, or geographically defined populations or population subgroups (International Society for Equity in Health, 2000). Conversely, inequity in health is the presence of such differences (Starfield, 2006).

Immigrants

Immigrants are defined to be voluntary permanent migrants who come to Canada under economic and business class, family class and special programs (Citizenship and Immigration Canada).

Immigrants generally migrate to Canada because they seek better socio-economic opportunities for themselves or to improve their families' wellbeing or both.

Refugees

Refugees represent a special subgroup of immigrants because, by definition, their perilous migration history often puts them at risk for a number of health issues. The refugee subgroup can be further differentiated into Government Assisted Refugees (GARS), Privately Sponsored Refugees, and in-Canada Refugee Claimants (Pottie et al., 2005).

Marginalized populations

This term refers to immigrants and refugees who are experiencing vulnerabilities owing to factors, such as their lower socio-economic position, a lack of official languages' skills, gendered or racialized status, ethnic background, and physical or mental disabilities, all of which create barriers leading to isolation and marginalization in Canadian society.

Cultural competence

Cultural competence can be described as a set of behaviours, attitudes, and policies that enable a system and individual health care professionals to work effectively with culturally-diverse families and communities (Etowa & Adongo, 2007, p.82).

Racism

Racism is a system of structural inequalities and historical processes, both created and recreated through routine practices (Essed, 1991, p.39).

Anti-racism

Anti-racism is an active and consistent process of change to eliminate individual, institutional, and systemic racism as well as the oppression and injustice caused by racism. It includes developing programs, policies, and activities to uncover and change deeply-held beliefs. Human action is necessary to combat racism and create equality (University of Guelph, Human Rights and Equity Office, n.d).

Social production of CHW

The social production of CHWs means that these workers are part of traditionally female professions, occupying non-standard health jobs, in a gendered, classed and racialized health human resource workforce. In other words, as the conditions that create marginalization for some groups worsens, the number of CHWs attempting to address the health and social needs of these populations increases.

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Chapter 1

Introduction

During some conference presentations I gave on the topic of Community Health Workers (CHWs) in the U.S., people asked, “Why do immigrants and refugees need CHWs if Canada already has a universal health care system?” Abundant evidence demonstrates that despite the universality of our health care system many of our populations, including immigrants and refugees, experience barriers to accessing the system (Beiser, 2005; Etowa & Adongo, 2007; Pottie et al., 2011; Pottie, Ortiz, & Tur Kuile, 2008; Spitzer, 2004; van der Velde, Williamson, & Ogilvie, 2009). Research on the role that CHWs play in facilitating access to health services is, however, lacking. This dissertation offers a rigorous description and analysis of the role of CHWs operating independently of, and in co-ordination with, the public health care system to improve access to health and social services by immigrant and refugee women and their families. CHWs facilitate access by reaching out to marginalized communities instead of waiting for these communities to seek health care providers. CHWs are members of the communities they serve, they understand the issues faced by these communities in accessing health and social services, and their scope of activity depends on their relationship to primary care, or public health, programs and services, or both. CHWs are linked to the mainstream health care systems in two ways. Sometimes they operate within the formal system, and sometimes they operate independently from the formal system.

Specifically, I examine the activities of the Multicultural Health Brokers Co-operative (MCHB Co-op) and its Multicultural Health Brokers from 1992 to 2011 as well as the relationship they have with Alberta Health Services (AHS) Edmonton Zone Public Health, in Edmonton Canada. The research for this study is based on an instrumental qualitative case study design (Stake, 1995). The case is the MCHB Co-op, an independently-run multicultural health worker co-operative, which contracts with health and social services providers in Edmonton to offer linguistically- and culturally-appropriate Multicultural Health Broker services to marginalized immigrant and refugee women and their families. The two embedded mini-cases are two programs of the MCHB Co-op: Perinatal Outreach and Health for Two, which are the *raison d'être* for a sustained partnership between the MCHB Co-op and the public health unit. Through this partnership, AHS Edmonton Zone has funded the Health Co-operative for the last 14 years. The phenomenon under study is the Multicultural Health Brokers' practice.

I triangulated multiple methods (research strategies and data sources), including 46 days of participant and direct observation, 44 in-depth interviews (with Multicultural Health Brokers, mentors, women using the programs, health professionals, and outsiders who knew of the work of the MCHB Co-op and Multicultural Health Brokers), document review and analysis of policy documents, yearly reports, training manuals, educational materials as well as quantitative analysis of the Health Brokers' 3,442 client caseload database. In addition, data also include my field notes of both descriptive and analytical reflections taken throughout the onsite research.

In this dissertation, I provide thick description and theoretical explanations of the case, embedded mini-cases, and the phenomenon under study. By thick description I mean to allow "the case narrative to unfold from the diverse, complex, and sometimes conflicting stories that people,

documents and other evidence” (Flyvbjerg, 2001) told me. By embedded mini-cases I mean that the study of the MCHB Co-op has more than one unit or sub-unit of analyses or programs (Yin, 2003a). For example, in studying the MCHB Co-op and Multicultural Health Brokers practice, I am also giving attention to its/their two sub-unit of analysis: the Perinatal Outreach and the Health for Two programs.

The main research questions that I address in this dissertation are:

How are CHW programs integrated within Canada’s formal public systems of care?

How does this integration influence CHWs ability to improve immigrant and refugee women’s access to health services?

The sub-questions are:

- What CHW models exist, and how are they designed, implemented and evaluated?
- How can these models contribute to public health workforce development?
- How are these models influencing the diversity of the health systems’ labour force?
- How are they influencing the health care systems' competence to respond to demographic changes in Canada?
- How are they addressing the cultural and linguistic health needs of immigrant communities?
- How are knowledge transfer strategies used in getting support for the adoption, implementation and sustainability of CHW programs within Public Health Units?

This inquiry is important because it gives central importance to the experiences of immigrant and refugee women workers acting as CHWs and their contributions to health equity for the populations they serve by facilitating access to health and social services and community capacity building. I

define access as the ability of immigrant and refugee women to seek and receive services without barriers due to language, ethnic and cultural background, racialized, gendered or class status, or physical and mental disabilities. Access is also guaranteed by the openness of health and social services professionals to collaborate with multiple sectors and levels of government to address the health inequities experienced by immigrant and refugees owing to the social determinants of health that hinder or facilitate that access.

In Chapter 2, I present my analytical approach derived from critical population health research practice, which combines theoretical engagement, community engagement and policy engagement (Labonté, Polanyi, Muhajarine, McIntosh, & Williams, 2005). This approach allows one to analyze the CHW field through “a thoroughgoing deconstruction of how historically specific social structures, economic relationships and ideological assumptions serve to create and reinforce conditions that perpetuate and legitimize conditions that undermine the health of specific populations” (Labonté et al., 2005, p. 10). I also refer to the conditions that hinder or facilitate Health Brokers’ ability to improve access to health and social services by immigrant and refugee communities. I use a feminist political economy perspective (Armstrong & Armstrong, 2010b; Jennissen & Lundy, 2011) to illustrate the macro (upstream) social structures that lead to what I call the “social production” of multicultural health brokers. By social production I mean that these workers are part of traditionally female professions, occupying non-standard health jobs, in a gendered, classed and racialized health human resource workforce (Armstrong & Armstrong 2010b; Jennissen & Lundy, 2011). I believe that as the social, economic, and political conditions that create marginalization for some groups worsens, the number of CHWs attempting to address the health and social needs of these populations increases. I draw on micro-meso (downstream) lenses: multicultural health brokering (Ortiz, 2003), health promotion empowerment (Labonté, 1993),

authoritative and experiential knowledge (Davis-Floyd & Sargent, 1997; Jordan, 1983; Ketler, 2000), agency, autonomy and empowerment (Pollack, 2000; Sherwin, 1998), and feminist urban citizenship (Adamson, Briskin, & McPhail, 1988; Andrew, 2008; Briskin, 1991; Holston, 2001) to illustrate how the Health Brokers act as agents of change by positioning themselves between the health and social services systems and helping to build the capacity of immigrant and refugee communities to improve access to health and social services, and to assist them to participate actively in different levels of Canadian society.

In Chapter 3 I describe the literature review of CHW interventions in public health and primary care focusing on facilitating access to health and social services in Canada. In particular, this chapter helps to shed light on the study's main and sub-research questions. It describes what is said about the effectiveness CHW interventions, the size of the workforce and relationship to the health care systems, the trajectory of the CHW movement in the U.S., the scope of practice, training, supervision as well as the recognition of CHWs as health human resources workforce in Canada and in other countries. This chapter also features a brief overview of the literature on co-operatives to provide the background information on the organizational structure through which the MCHB Co-op and Health Brokers operate.

Chapter 4 focuses exclusively on the instrumental and embedded qualitative case study design, including the research questions, the theoretical propositions, the research strategies, the selection of cases, the limitations to case study research, and the transformatory-emancipatory approach I used in conducting my inquiry. I outline the research strategies mentioned above and explain my approach to transcribing the interviews, note-taking, pilot testing and interviewing as well as the process for member checking during writing and analysis of the data.

Chapter 5 focuses on the MCHB Co-op's holistic approach to helping immigrant and refugee women and their families by: a) developing a market niche by implementing culturally- and linguistically-appropriate programming; b) enhancing the internal capacity of the organization; and c) articulating and sustaining the Health Brokers' practice. This chapter also analyzes the "five dimensions" or strategies: one-on-one support; small group development; community organization and community mobilization; advocacy; and policy and practice (advocacy at the system level), which they adopted from Labonté's (1993) health promotion empowerment approach.

Chapter 6 focuses on the relationship between the Health Co-op and Health Brokers and AHS Edmonton Zone public health through the Perinatal Outreach and Health for Two programs — the embedded mini-cases —. In particular, I illustrate health professionals' views in three areas: a) micro: the Health Co-op and AHS Edmonton Zone's partnership that facilitates access and removes barriers to health services; b) meso: health practitioners' attitudes and behaviours towards immigrant and refugee patients as well as their understanding of cultural or religion-specific issues when these patients seek health services; and c) macro: the health system's policies to address health equity and social determinants of health targeting immigrant and refugee communities.

Chapter 7 centres on the practice of the Multicultural Health Brokers — as the phenomenon —. This chapter focuses on what it means for Health Brokers to be intermediaries between immigrant and refugee women and the health and social services systems, especially in two areas: perinatal health and family intervention programs. The intermediary or mediatory role the Health Brokers play in providing culturally- and linguistically-appropriate services for immigrant and refugee women represent the "market niche" that gives Health Brokers a place as members of the health human

resources workforce (although not recognized as such) in Edmonton's health and social services arena.

Chapter 8 focuses on integrating the findings and analytical discussion of the full dissertation. I return here to the fundamental research questions, sub-questions, and theoretical propositions of my inquiry and address them by looking at the case, embedded mini-cases, and the phenomenon. The propositions and questions highlight the relevance of the overall inquiry for the field of CHWs and demonstrate the complexities and contradictions that the Health Co-op and Health Brokers experience in their daily practice. In this chapter, I also reflect on some of the other strengths and challenges that the study revealed about the Health Co-op, so that similar organizations can learn from them. Additionally, I suggest some areas of further research to advance CHWs as both part of the health human resources workforce and actors in addressing health equity for marginalized populations, including immigrant and refugee women. I conclude this dissertation by highlighting for consideration issues, such as the need for intergovernmental and intersectoral collaboration.

In completing the data collection and writing of this dissertation, I am keenly aware that this is part of the beginning of the documentation and analysis of the role of CHWs in our health and social services systems. Throughout my research, however, I started sharing the findings and analysis presented here with health broker colleagues, health practitioners, academics, and researchers, in the hope that together we can bridge the knowledge gap in this area. I endeavor to continue this path upon completing this project.

Statement of the problem

Interest in addressing health and social problems through approaches that involve CHW interventions is seeing resurgence in Western and Southern countries in the 21st century (Lewin et al., 2005; Nemcek & Sabatier, 2003). CHWs play a crucial role in building connectedness between communities experiencing marginalization (Lehmann & Sanders, 2007) and highly stratified health systems (Bourgeault, In progress). In Canada knowledge in the field is emerging (Torres, 2012a) although the practice has existed for over half a century (National Indian & Inuit Community Health Representatives Organization, 2000). CHWs face the problematic that they provide important and valuable services (Rosenthal, Wiggins, Ingram, Mayfield-Johnson, & De Zapien, 2011), but their contributions are often not recognized. The rationale for the lack of recognition is multifaceted, but the lack of systematic documentation of how CHW interventions are designed, implemented, and evaluated (Lewin et al., 2010) contributes to the invisibility of these workers. Many aspects of the practice are unknown or under researched, including: who the people performing the work are; what these workers do; how workers are trained; what theories (if any) influence the work; how health professionals see the work; and how workers, and the models they adopt, interact with mainstream public and primary care health systems. CHWs are known by over 50 pseudonyms, but I use the term CHW because it is "... being considered the more generic term, including professional, paid, unpaid... with varying degrees of formal training such as internationally trained professionals" (R. Labonté, personal communication, July 2, 2012). Multicultural Health Brokers, who are the focus of this dissertation, are CHWs with a focus on migrant and refugee communities. In Canada, we lack information about how CHWs address the cultural and linguistic needs of immigrant communities, how they interact with health and social services providers, and if they strengthen Canada's public health care system's response to demographic changes in the Canadian population.

I attend to this problematic through a rigorous description and explanation of the role of CHWs in helping immigrant and refugee women populations, in particular their work linking Canada's health, social services, and immigration systems. Most studies on CHW worldwide focus on the role workers play as instruments in the delivery of health messages (Balcázar et al., 2011; Lewin, et al., 2005; Lewin, et al., 2010), and tensions exist between centring CHWs' roles on monitoring and supporting interventions for communicable and non-communicable chronic disorders (Giovanella et al., 2011, June) and serving as agents for community development and change (Rosenthal, et al., 2011). I examine the Multicultural Health Brokers' agentic role in enabling health equity for immigrant and refugee women. They foster women's and families' (that is, clients', program users') agency and autonomy as well as empowerment and feminist urban citizenship. While undertaking a rigorous description and analytical exploration of the work of Multicultural Health Brokers at the micro level, I cannot lose sight of the meso level, that is, how these workers are integrated within Alberta's public health care system, and how they might be recognized as part of the health human resources workforce. Also, I must remain cognisant of the macro level, that is, the CHWs social location as a gendered, classed and racialized workforce.

Chapter 2

Theoretical framework

Theorizing the Community Health Worker Field in Canada

The new, modern, and beautiful building of the Art Gallery of Alberta, located in wealthy downtown Edmonton, was inaugurated in 2010. I walked by the gallery many times on my way to conduct field research at the Multicultural Health Brokers Co-op, which was located in the northern part of the city. As I walked quickly through the downtown core, I saw tall, elegant buildings, banks, and large shopping centres. I also crossed paths with men and women, who also generally walked fast, stood straight, wore formal clothes, sported fashionable accessories, and usually carried briefcases. Once I left the district where the gallery is located, and started to reach the north of the downtown core where the Health Co-op is found, the landscape and the populations on the streets changed. I could see small Asian restaurants and other businesses. I met fewer people on the streets, but in some areas, especially around key intersections, people gathered in small groups on corners near dilapidated buildings, disused telephone booths, or benches. Often their clothes looked ragged, their skins broken by the dry cold, and their faces bruised, scarred, and lacking teeth: they were typically men, they appeared to be Aboriginal backgrounds, although there was also the occasional woman who appeared to be Aboriginal and a smaller number of other racialized persons and Euro-Canadians. The office of the Health Co-op is close to this geographical location. This brought home to me how much the work of the Multicultural Health Brokers happens in two contexts: wealth and power on one side, and marginalization and exclusion on the other. The MCHB Co-op sought to break down the barriers creating marginalization for some of the populations, particularly immigrant and refugee women, their families, and their communities, who are excluded from full participation on the other side of the urban landscape.

Introduction

SITUATING MYSELF

My interest in implementing strategies and developing policies to achieve health equity and to empower marginalized immigrant women in Canada has evolved over the last 20 years. Because of my racialized immigrant woman background, I have personally experienced the social, political, and economic barriers to immigrants and refugees' full participation in Canadian society and have seen the health inequities encountered by newcomers in obtaining medical services, accessing health promotion programs, and learning how to navigate the health care system. I have been actively

involved in conceptualizing and implementing community health worker (CHW) programs for immigrant communities, in particular a number of initiatives targeting Hispanic populations in Canada. I assisted in developing a comprehensive CHW training program, training CHWs (and subsequently evaluating that training) and worked with and supervised CHWs in their practice. As a former CHW, I have been taken aback by the inequities in Canadian society, which often exclude certain population groups, such as immigrants and refugees, from economic, social, and political opportunities that are important to individual and community health and wellbeing. My background in international development, especially in El Salvador's rural areas, has also influenced my thinking. In my experience, CHWs in countries like El Salvador invariably exhibit perseverance and commitment to supporting the most marginalized communities and determination to build the capacity of these communities.

When I started this qualitative case study research my inquiry was informed by a health equity framework interconnected to health literacy and knowledge transfer approaches. These approaches were important in framing my study and field work. The International Society for Equity in health defines health equity as "...the absence of systematic and potentially remediable differences in one or more aspects of health across socially, demographically, or geographically defined populations or population subgroups" (International Society for Equity in Health, 2000, cited in Starfield, 2006, pp.12,13). Conversely, inequity in health is the presence of such differences (Starfield, 2006). I first chose a health equity framework (macro), interconnected with knowledge transfer (meso) and health literacy (micro) lenses to conduct this inquiry because I wanted to critically analyze how immigrant women's access to health services were mediated by macro structural context of social determinants of health including education, culture, socio-economic status, gender (Corin, 1994; Grzywacz & Fuqua, 2000; Marmot & Wilkinson, 1999; Moss, 2002; Starfield, 2006). I had chosen

(Starfield, 2006) *Societal Influences on Population Health* framework to guide the macro analyses because it revealed the forces that influence the micro-meso-macro policies impacting CHW interventions. Starfield 2006's framework would have helped me analyze the impact that federal and provincial social policies on immigrant women's health.

Additionally, I wanted to investigate the knowledge transfer processes at the meso level in which CHW interventions were adopted, implemented, and sustained in addressing health inequities experienced by immigrant women. In particular, the *Ottawa Model of Research Utilization* was going to help operationalize this facet of the research (Graham & Logan, 2004). Finally, I wanted to use the *Conceptual Framework for Literacy and Health* because it permitted an analysis of the role CHW interventions played in addressing the cultural and linguistic needs of immigrant communities (Rootman & Ronson, 2005). I initially thought that interconnecting a health equity framework with knowledge transfer and health literacy was a critical analytical strategy to unveil the micro-meso-macro relations influencing CHW interventions targeting health inequities experienced by immigrant women. I came to understand that doing so was not the best approach as an initial study, as I first needed to understand the functioning of the MCHB Co-op, its programming, and the Health Brokers' role in both before proceeding to analyse these other issues. I remain convinced, however, there is merit in pursuing these approaches with follow-up studies.

My change in theoretical approach came about as I obtained a deeper understanding of the MCHB Co-op work (the case), the Perinatal Outreach and Health for Two programs (the embedded mini-cases), and the Multicultural Health Brokers' practice (the phenomenon). Midway through my study, I realised that I needed different theories to understand the case being analysed. My goal in this dissertation remains to uncover how the Health Co-op and Health Brokers address health equity

for immigrant and refugee women and their families; however, my theoretical framework has been modified in response to greater understanding of the context and complexity of the case under study.

Two elements —the “language” and the “strategies”— Multicultural Health Brokers used to describe their work with immigrant and refugee women prompted me to revise my overall theoretical framework. “Language” here, at the micro-level, refers to terms used by the Health Brokers in client relations and derived from multicultural health brokering theory (Ortiz, 2003): they encourage the women to be “independent” and “active citizens”; and see them as “temporarily disempowered human beings” as opposed to “dependent subjects”. At the macro level, the terms used include “barriers”, “families in crises”, “lack of funding”, “work overload”, and “lack of recognition”, which also suggest a social location analysis focusing on the workers, rather than one more oriented to the communities receiving services.

The “strategies” refer to the health promotion empowerment framework (Labonté, 1993) that Health Brokers use in working with women and their families, involving interventions ranging from one-on-one activities and group work to coalition building and mobilization, policy and advocacy activities. This framework was implemented well before my research commenced. Its importance calls for greater analysis of the role of Health Brokers than my previous approach would have allowed.

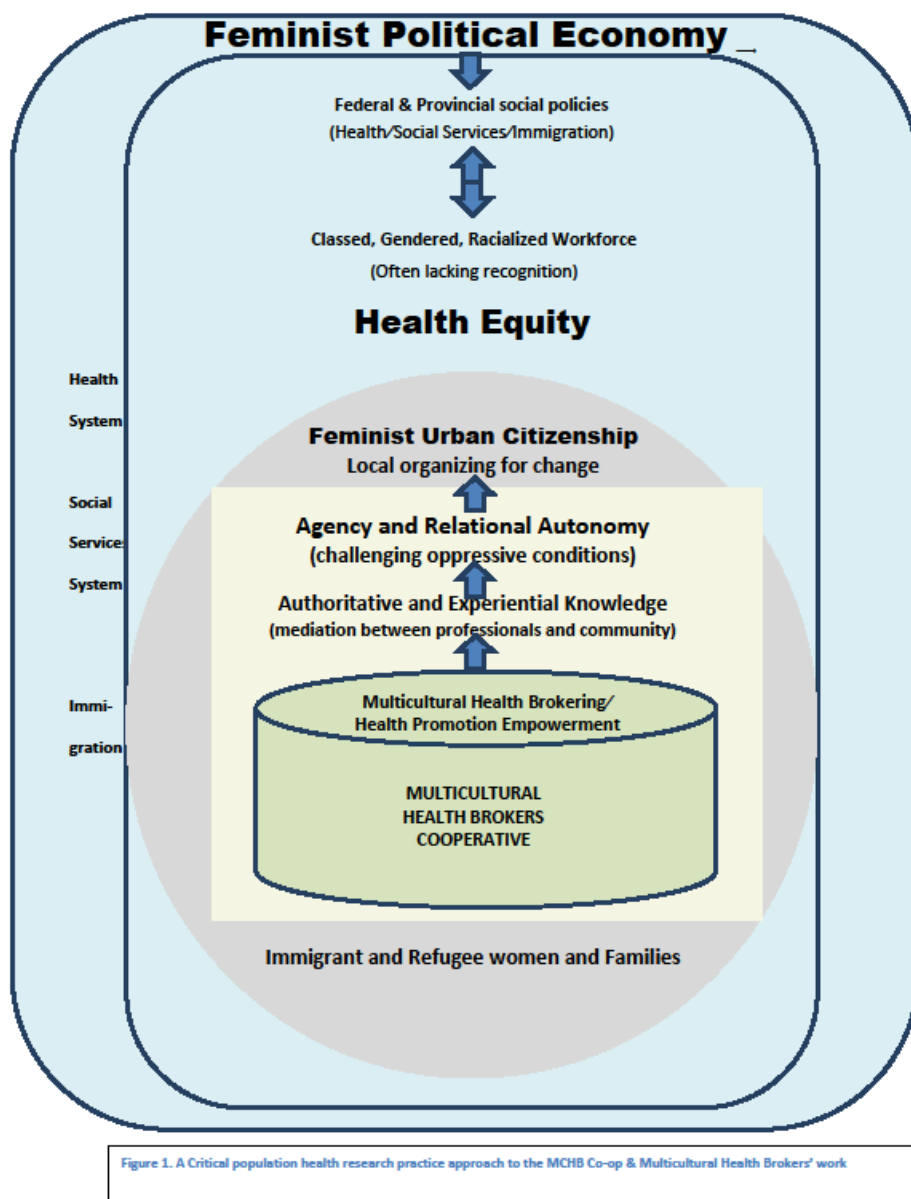
In this dissertation I use the term CHWs to refer to community health workers, lay health workers and synonymous terms found in the literature, and “Health Brokers” (capitalized) to refer to CHWs who are involved in the MCHB Co-op. I also use the term Health Co-op to refer to the MCHB Co-op.

My new analysis builds on the theory and approaches I found in use in the Health Co-op. I theorize further, that while the Health Co-op and Health Brokers are interested in achieving “practical” outcomes, such as access to health and social services for immigrant and refugee women, their “strategic” interest is in establishing equal relationships with women and families (clients and program users) and in achieving social justice, health equity, and system change. These practical and strategic interests fit within middle-range theories of authoritative and experiential knowledge (Jordan, 1983); agency and relational autonomy (Nedelsky, 1989; Sherwin, 1998); and the overarching framework of feminist urban citizenship (Andrew, 2008; Holston, 2001). Refocusing this dissertation on examining the role Health Brokers play at the micro level, allows me to argue that Health Brokers, like other CHWs in Canada, are part of the health human resources workforce. This is because of the role they play in improving access to health services of immigrant and refugee women and families. Their contributions, however, are often not recognized.

I also theorize that a feminist political economy perspective (Armstrong & Armstrong, 2010a; Jennissen & Lundy, 2011) is necessary to illustrate the “social production” of health brokers within Canada’s health, social services, and immigration. By social production I mean that CHWs workers are part of traditionally female professions, occupying non-standard health jobs, in a gendered, classed, and racialized health human resource workforce. In other words, as conditions create marginalization for some groups worsen, the number of CHWs attempting to address the health and social needs of these populations increases. Health Brokers are not only bridging the divide between disadvantaged immigrant and refugee populations and the health and social services systems, but they themselves are also disadvantaged. My analytical approach to the study fits within a critical population health research practice because it combines theoretical engagement, community

engagement and policy engagement (Labonté, et al., 2005). This approach permits “a thoroughgoing deconstruction of how historically specific social structures, economic relationships and ideological assumptions serve to create and reinforce conditions that perpetuate and legitimize conditions that undermine the health of specific populations” (Labonté et al., 2005, p. 10).

My inquiry centres on the conditions that influence the work of the Health Co-op and Health Brokers. I look at both what undermines and what strengthens this work. The work is a continuum of micro and meso strategies and functions with the goal of achieving health equity for immigrant and refugee women and their families. Figure 1 illustrates: the Micro (centre), the Health Co-op, is the foundation from which all areas of the work are designed, implemented, and evaluated: Health brokering and health promotion empowerment approaches together are the first facilitators of access to health and social services of the clients. The meso (middle) represents my theorizing that Health Brokers’ work falls under middle-range theories of authoritative and experiential knowledge. Health Brokers are constantly negotiating access to health and social services between professionals and immigrant and refugee communities. The meso also represents agency and relational autonomy because the Health Co-op and Health Brokers challenge oppressive relationships between clients and professionals. As a result, the next layer reveals Health Brokers’ negotiation between public and private spaces in order to facilitate demand for services (and the associated rights to services), which lead to feminist urban citizenship of immigrant and refugee women and families. The macro (periphery) illustrates a feminist political economy lens applied to the societal context, such as public policies in health, social services, and immigration that facilitate or impede the Health Co-op and Health Brokers’ ability to strive for health equity. This layer also encompasses the gendered, classed, and racialized structures that shape Health Brokers’ participation in the health human resource workforce.



Theorizing Health Brokers' practice

Multicultural health brokering theory

Here I introduce the multicultural health brokering theory because the Health Co-op and Health Brokers developed this micro perspective to conceptualize their own practice. Health Brokers in Edmonton have examined the content and nature of their work since they received their first training in 1992. From the beginning, the Health Co-op and Health Brokers have found themselves in a space “in the middle” negotiating between formal (authoritative) knowledge of health and social services systems and informal (experiential) knowledge of immigrant and refugee communities. As a result, Health Brokers first adopted the “cultural brokering” theory. Culture brokering is a middle-range substantive theory that comes from nursing and anthropology (Jezewski, 1995). Cultural brokering is “the act of bridging, linking, mediating between groups of persons of differing cultural backgrounds for the purpose of reducing conflict and producing change” (Jezewski, 1990, p. 497, cited in (MCHB Co-op, 2009g, p. 6). Conflict arises in “settings where there were differences in values, beliefs, and behaviours between providers and clients concerning the appropriateness and feasibility of treatment plans” (Jezewski, 1995, p. 27). In the presence of conflict in an interaction between a health care provider and client, someone must ameliorate the conflict (facilitate the interaction) or effective health care will not take place (Jezewski, 1995).

Culture brokering, according to Jezewski (1995), occurs in a variety of situations and there is no consensus on the exact role of the culture broker. She argues, however, that “the culture broker role carries with it a set of expected behaviour patterns, obligations, and privileges, but there is considerable variation within the defining attributes that influences how this role is carried out by the broker” (p. 18).

Community-based organizations rarely have the opportunity, knowledge, or desire to conceptualize their practice. One participant (Lavender)¹ explained how after some years of working to help address the perinatal and post-natal needs of immigrants and refugees she learned, through a clinical nurse mentor, that their practice might fall within the cultural brokering theory. Between 2000 and 2002, Health Brokers engaged in a participatory, grounded theory study, through the PhD studies of a member (Ortiz, 2003), to analyze the concept of cultural brokering within their own multicultural practice and context. As a result, they theorized and named their practice “multicultural health brokering theory”. Multicultural health brokering is a relationship-based practice based on trust and confidence established between Health Brokers and the women and communities they help. Multicultural health brokering also “acknowledges the knowledge, skills, talents and gifts of people and communities as vital to the process of providing support and seeking solutions to issues and problems” (MCHB Co-op, 2004e, p. 1).

Multicultural health brokering captures the role in which Health Brokers interact with clients and health professionals. For them, this role happens in four stages: Initiation, Building connectedness, Brokering support, and Achieving equity of access to health (MCHB Co-op, Aylmer Health Co-op, & BC Multicultural Health Services Society, 2008e). The key elements of these stages are as follows: The first stage, Initiation, refers to the intake and referral process. For example, the need for a Health Broker is identified through referrals from nurses, social workers, school counsellors, community members, or the Health Brokers themselves (MCHB Co-op, 2009g). The second stage,

¹ I chose to use the names of flowers and plants as pseudonyms for the majority of study participants who struck me as highly dedicated to their work and, in my view, these names were the best way for me to show this commitment. The choice of pseudonyms might sound strange to the readers, but I also felt that using names of flowers and plants had a calming effect on me during coding and data analysis, especially when face-to-face interview data revealed difficult situations experienced by Health Brokers or their clients.

Building connectedness, follows as Health Brokers create meaningful connections between people, families, and groups within communities through shared language, cultures, and experiences (MCHB Co-op, 2008c, p. 8). In the third stage, Brokering support, the Health Broker mobilizes resources for individuals, families, and groups by helping them to identify and articulate their needs, concerns, and hopes, by exploring the best options with them and connecting them to relevant resources (MCHB Co-op, 2008c, p. 8).

The fourth and final stage, Achieving equity of access, is an outcome of the multicultural health brokering practice indicated by the ability of people and communities to obtain resources to meet the needs to fulfill their hopes (MCHB Co-op, 2008c, p. 9). Culture brokering theory explicates that Health Brokers work within two asymmetrical systems (MCHB Co-op, 2008a): one for mainstream (non-racialized, English or French speaking, of European descent) Canadians, and one for immigrant and refugee communities. The unequal status of these two systems causes tensions and conflict. As much as multicultural health brokering theory focuses on the four dimensions of the practice, Health Brokers and mentors realized that in the arena of social change, which involves the creation of critical consciousness on issues of power, it did not provide the necessary tools. Hence, addressing systemic inequities and injustice was not yet part of their health brokering theory.

A health promotion empowerment approach

In analyzing the contributions of multicultural health brokering practice to the literature and vice-versa, Ortiz came across Labonté's 1993 health promotion empowerment approach (Empowerment Holosphere). For Labonté (1993) empowerment

is the capacity of choice. It includes the ability to define, analyze and act upon problems one experiences in relation to others, and in one's social and environmental living conditions. Empowerment as process describes the means through which internal feelings of powerlessness (hegemonic power) are

transformed, and group actions initiated to change the physical and social living conditions that create or reinforce inequalities in power. (p. 91)

Labonté's 1993 health promotion Empowerment Holosphere sets this out. Through this framework Labonté argues that there is no single path to empowering health promotion practice, so he proposed a model that emerged procedurally during the training workshops he had delivered on the who, what, and why of health promotion. This framework encompasses five spheres 1) personal care, 2) small group development, 3) community organization, 4) coalition building and advocacy, and 5) political action (p. 55). According to Labonté, "no one professional possessed the skills (or time) to work in all five spheres. The Holosphere represents an imperative for the organization as a totality" (p.56).

Ortiz's PhD participatory-grounded theory study, and the Health Brokers involved, realized that the four dimensions of the multicultural health brokering practice (initiation, building connectedness, brokering support and achieving equity of access) paralleled Labonté's Empowerment Holosphere except for the last two spheres – coalition building and political action (2003, p. 168). The Empowerment Holosphere caught the attention of the Health Co-op because it illustrated the fifth dimension that the Health Co-op was not yet addressing. In other words, Labonté's framework helped the Health Co-op to operationalize the four dimensions of the multicultural health brokering practice as well as capture the desire and commitment of the Health Co-op to work for social change. In 2003, following Ortiz's study the Health Co-op incorporated the coalition building, advocacy, and political action dimensions in their operations and adopted the Empowerment Holosphere to guide their strategic work. In a conversation with one participant, she indicated her appreciation of Labonté's analysis because it helped the Health Co-op conceptualize their work by combining individual, group, community, and social change.

Labonté's Empowerment Holosphere became an imperative for the organization as a totality. Multicultural health brokering theory (Ortiz, 2003) and the health promotion empowerment approach (Labonté, 1993) are key to the Health Co-op and Health Brokers' daily operations and health equity goals. Given the literature review and my knowledge of other CHW models in Canada, the Health Brokers' and mentors'² desire to create their own theory and adopt conceptual approaches systematically to guide their work set them apart from other models of CHWs in Canada.

THE MESO

Theorizing authoritative and experiential knowledge

Theorizing the work of the Health Co-op and the Health Brokers highlights a practice that encompasses walking the line between experiential and authoritative knowledge. This is so because Health Brokers provide perinatal information, guidance, and support to mothers who are vulnerable because of socio-economic status, gender, language, cultural, and racialized background as well as migration history in Canada. While health and social services systems possess the authoritative or biomedical knowledge (Davis-Floyd & Sargent, 1997; Ketler, 2000), those who are oppressed and marginalized, including some segments of immigrant and refugee populations, have experiential knowledge that is not recognized.

Davis-Floyd and Sargent (1997) argue that, in many situations, equally legitimate parallel knowledge systems exist and people move easily between them, utilizing authoritative or experiential knowledge sequentially or in parallel fashion for particular purposes. Immigrant and refugee women bring knowledge when they arrive in Canada, but this knowledge is often undervalued or

² The Health Co-op decided to invest time and resources to hire mentors to support the Health Brokers' daily practice. Mentors bring in different skills set that complement those of the Health Brokers.

unrecognized. In practice, both types of knowledge co-exist in Canada without much interference as long as immigrant and refugee communities do not have to interact directly with health and social services agencies. Davis-Floyd and Sargent (1997) argue, however, that frequently one kind of knowledge gains ascendance and legitimacy. A consequence of the legitimation of one kind of knowing as superior is the devaluation, and often the dismissal, of all other kinds of knowing. When immigrant and refugee women seek health and social services, they interact with these systems directly, so the different types of knowledge create cultural clashes. Because the Health Co-op and the Health Brokers act as intermediaries between the women and mainstream systems, they are constantly negotiating between the two types of knowledge. They find that, as clients or patients, women's experiential knowledge is not often recognized by professionals in either the health or social services systems.

According to Davis-Floyd and Sargent (1997), those who espouse alternative knowledge systems tend to be seen as backward, ignorant, and naive, or worse, simply as troublemakers. The Health Co-op and Health Brokers are aware of immigrant and refugee women's experiential knowledge and attempt to create a "third space" where women and their communities feel recognized, but also where the Health Brokers can support the system(s)' goals to provide health and social services for marginalized communities. This third space is reflected in the Health Co-op and Health Brokers' struggle to have the health system recognize that some of the practices of immigrant and refugee communities, although they might be different from mainstream Canadian practices, "do no harm" to patients, and, in fact, contribute to their agency (the making of a choice) and autonomy (self-governance). The third space is the Health Co-op and Health Brokers' recognition of a culture within health culture (Turton, 1997). Weidman (1982) states,

...every culture has within it a health culture...Health culture is defined as "all of the phenomena associated with the maintenance of wellbeing and problems of sickness with which people cope in traditional ways within their own social networks and institutional structures..." It is portrayed as functioning as "an integral and essential part of the cultural tradition of an ethnic group" (Cited in Turton, 1997, p. 29).

The third space that the Health Co-op attempts to build acknowledges not only that the health cultures of immigrant and refugee women maintain and sustain people's health, but also that these communities possess other types of knowledge that are, at times, helpful in maintaining these communities' health and wellbeing. Indeed, Davis-Floyd and Sargent argue that for "any particular domain several knowledge systems exist, some of which, by consensus, come to carry more weight than others, either because they explain the state of the world better for the purposes at hand (efficacy) or because they are associated with a stronger power base (structural superiority), and usually both" (1997, p. 113).

Because the Health Brokers emphasize the value of women's experiential knowledge and the multifaceted social inequality experienced by women and their communities to health professionals, the Health Brokers may be contributing to what Ramsden (1997) defines as Cultural Safety. "Cultural Safety is based on the premise that the term 'culture' is used in its broadest sense to apply to any person or group of people who may differ from the nurse/midwife because of socio-economic status, age, gender, sexual orientation, ethnic origin, migrant/refugee status, religious belief or disability" (Ramsden, 1997, cited in Ramsden, 2002, p. 3). Under Cultural Safety, the outcome of nursing and midwifery education enables safe service to be defined by those receiving the service (Ramsden, 2002, p. 4). Indeed, Health Brokers and mentors argue that in order to address health inequities, the voices of immigrant and refugee women ought to be taken into account in the planning and implementation of service delivery and training of health professionals. None of the

participants mentioned Cultural Safety, but the goals of their practice, and especially their clear acknowledgement of power relationships (Ogilvie, Burgess-Pinto, & Caufield, 2008) between professionals (authoritative knowledge) and clients (experiential knowledge), is similar to this approach.

As some authors argue, “The power of authoritative knowledge is not that it is correct but that it counts ...” [Jordan 1993(1978): 152-154 cited in Davis-Floyd & Sargent, 1996, p. 113). This means that the system’s power, by nature, is structurally superior to the power of immigrant and refugee communities’ experiential knowledge. Health Brokers are, on one hand, constantly attempting to increase immigrant and refugee women’s understanding of authoritative knowledge by explaining how the system works, and how to make sure that physicians or nurses know about their issues. On the other hand, they are expressing their concerns to health professionals so that they also understand the health cultures of immigrant and refugee women. This second element poses the greatest and ongoing challenge to immigrant and refugee women and to the Health Brokers’ practice. In other words, the contextual factors demonstrate the need for structural changes at the meso and macro levels so that legitimizing one way of knowing (the health and social services systems’ authoritative knowledge) does not come at the expense of devaluing other ways of knowing (Sargent & Bascope, 1996) (Immigrant and refugee communities’ experiential knowledge). At the individual and group level it ought not to diminish women’s agency and relational autonomy, which I discuss below:

Theorizing agency and relational autonomy

In this segment I theorize that the work of the Health Co-op falls within agency and autonomy. According to Sherwin (1998), these two words cannot be separated: The first refers to the individual’s ability to make “rational” choices, and the second to the “context” that hinders or

facilitates the process and conditions in making those choices. Sherwin (1998) argues that to exercise agency, one need only exercise reasonable choice; but equating agency (the making of choice) with autonomy (self-governance), while accepting as given prevailing social arrangements, has the effect of helping to perpetuate oppression among those who are marginalized. In the work of the Health Co-op and Health Brokers, the lack of recognition of the experiential knowledge of immigrant and refugee communities is a way of perpetuating these populations' inability to make decisions and exercise autonomy. From this perspective, when health professionals and society limit the analysis of agency to the quality of an individual's choice under existing conditions – for example, by not asking why some people do not seek health services, or do not have access to services even when they ask for them –, the system is ignoring the significance of oppressive conditions that limits choices.

Autonomy, according to Sherwin, can be fully expressed when the context in which individuals operate allows them “to resist oppression—not just act in compliance with it—and be able to refuse the choices oppression seems to make nearly irresistible. Ideally, they should be able to escape from the structures of oppression altogether and create new options that are not defined by these structures either positively or negatively” (1998, p. 33). This is why when the Health Co-op and Health Brokers negotiate authoritative and experiential knowledge and aim to create a third space, they are trying to create new options. These options start by validating the existence of several “health cultures” in Canada, which is a consequence of the demographic and cultural backgrounds of the many immigrant and refugee communities here.

Sherwin proposes a new feminist way of understanding autonomy, in which we look at the supportive social conditions that foster autonomous action. This means focusing on the injustice

that is associated with oppression, which provides “a perspective for understanding a socially grounded notion of autonomy” (1998, p. 26). Sherwin adheres to the concept of relational autonomy. Under this view, “autonomy is best understood to be a capacity or skill that is developed (and constrained) by social circumstances. It is exercised within relationships and social structures that jointly help to shape the individual while also affecting others’ responses to her efforts at autonomy” (Sherwin 1998, p. 36). In relational theory, social being as relational selves are significantly shaped and modified within a web of interconnected (and sometimes conflicting) relationships, including political relationships of power and powerlessness. This interpretation of relational theory “provides room to recognize how the forces of oppression can interfere with an individual’s ability to exercise autonomy by undermining her sense of herself as an autonomous agent and by depriving her of opportunities to exercise autonomy” (Sherwin, 1998, p. 35).

The notion of relational autonomy has been one of the major contributions of feminism to the study of autonomy (Baumann, 2008). Jennifer Nedelsky’s 1989 article *Reconceiving Autonomy: Sources, Thoughts and Possibilities* has been particularly influential. Nedelsky argues that “people do not exist in isolation but in political and social relations” (1989, p. 21). She asserts that feminists and communitarians criticize liberalism because it takes “atomistic individuals as the basic units of political legal theory and thus fails to recognize the inherently social nature of human beings” (p. 8). Her contributions were groundbreaking to the understanding of relational autonomy. As Nedelsky focuses on relational autonomy within the context of law, property rights, and democracy (Nedelsky, 1989), I base my theorization instead on Sherwin’s (1998) work which focuses directly on relational autonomy’s application to health care.

Sherwin's feminist relational autonomy is important for this study because the Health Co-op and Health Brokers understand that in accessing and using health and social services immigrant and refugee women experience certain conditions of vulnerability that restrict their choices to exercise full autonomy. These restrictions include limited economic resources, lack of educational opportunities, unsafe and unaffordable housing, and lack of knowledge of English or French, all of which constitute real limitations on the options available to immigrant and refugee women to act as agents. Relational theory also uncovers how "socially constructed stereotypes can reduce both society's and [the] agent's sense of that person's ability to act autonomously. Relational theory can help us see how such diminished expectations readily become translated into diminished capacities" (Sherwin, 1998, p. 37).

A feminist relational autonomy, according to Sherwin, takes into account the impact of social and political structures, especially sexism and other forms of oppression, on the lives and opportunities of individuals. Under the rubric of relational autonomy, the society, not just the agent, is subject to critical scrutiny. In other words, the best way "to help oppressed people to develop autonomy skills is to remove the conditions of their oppression" (Sherwin, 1998, p. 38). Concretely, Sherwin suggests, for example, that health care providers should spend more time than usual to support patients in the deliberate process of making decisions, and provide them with access to relevant political as well as medical information when they contemplate controversial procedures. I acknowledge that it is not always realistic to expect that the oppressed will get organized to remove their conditions of oppression, but it is imperative to have organizations and individuals willing to remove oppressive structures that limit patients'/clients' agency and autonomy. Feminist relational autonomy calls for a commitment to social justice by those who are socially privileged to modify the conditions that create oppressive circumstances and seek non-oppressive

alternatives that lead to greater autonomy of those who are socially underprivileged. Given the challenges experienced by immigrants, refugees, and the Health Brokers themselves, it is important to acknowledge that in a highly stratified health care system, it is unlikely that health care providers alone would want to remove the conditions of oppression that privileges them in the first place. For Sherwin, however, oppression should not continue “simply because its victims have been deprived of the resources necessary to exercise the autonomy required to challenge it” (Sherwin, 1998, p. 39). While Sherwin (1998) focuses on the importance of paying attention to social and political contexts, she does not support the wholesale neglect of the needs and interests of individuals in favour of broader social and political interests. She suggests that both individual needs and social and political contexts ought to be considered in order to identify and remove the effects of barriers to autonomy that are created by oppression. In this case the challenge is for patients as well to push for changes that enhance their ability to exercise full autonomy. For example, Health Brokers become actors by demanding that health care providers “become sensitive to their own biases and assumptions so that they can better resist the common tendency to deny authority to patients with less social status” (Sherwin, 1998, p. 44). The cultural brokering notion of two asymmetrical systems matches Sherwin’s (1998) relational autonomy because both identify that political changes are necessary to influence factors that are discriminatory (structural inequality).

Sherwin also argues that the patient-physician or patient-health care worker relationship, as much as it ought to be, is not based on a contractual agreement between two fully independent parties, but that both are socially situated, and their options and choices are a reflection of social expectations that may well be oppressive. For Sherwin, increasing autonomy for patients is not just a matter of increasing power relative to their physicians “but of increasing patients’ social power more broadly and restructuring the health care system that is responsive to an appropriate range of

women's needs by removing discriminatory attitudes and barriers and by promoting the necessary knowledge base" (Sherwin, 1998, pp. 41-42). At the micro level, feminist relational autonomy applies to the Health Co-op and Health Brokers because they advocate that health care providers spend more time to fully understand the needs of immigrant and refugee women. In addition, Health Brokers attempt to help women understand clearly the relevant issues, including Canadian social values, health and social services protocols, and procedures. To this end, Health Brokers prepare women and their families before going to see a health care provider so that they know what concerns to raise with their doctors, and how to raise them (MCHB Co-op, 2010b February). At the macro level, feminist relational autonomy is important in this case study because the Health Co-op and Health Brokers' work attempts to make changes at the system level so that discriminatory practices, based on racialization, gender, class, and ethnic origin of immigrant and refugee women, are removed from health care and social service institutions.

Sherwin's relational autonomy is also important for this study because she calls for a more sophisticated analysis of public policy, leading to changes in services so that they no longer reflect and reinforce oppressive social norms that are difficult for those who are oppressed to resist. She urges each citizen to join the political fight to retain a commitment to the principles of universality and equal access in the Canadian health care system, and suggests that, "we consider broadening the definition of health services to make certain that nonmedical services that improve health care are also covered" (1998, p. 44). The notion of broadening the health services definition, so that a wider range of non-medical services are covered by provincial health insurance plans is important for the case study. The Health Co-op and Health Brokers invest time and resources in "brokering support" for immigrant and refugee women, but this work is not funded because it does not fall under the rubric of medical services. They also incorporated a social justice focus in order to address

the structural issues (Ortiz, 2003, p. 134) that restrained women's relational autonomy and mitigated against equity for immigrant and refugee populations.

Theorizing feminist urban citizenship

Several Health Brokers described the Health Co-op and their own work as entailing encouraging clients to be independent and active citizens, and seeing women as human beings interacting within a new city and society and needing temporary support from health and social services systems.

Health Brokers developed their own multicultural health brokering theory to define their role within a multicultural setting. Simultaneously, guided by Labonté's (1993) health promotion empowerment approach, they implemented strategies which involve one-on-one, group work, coalition building and mobilization, policy and advocacy. The Health Co-op and Health Brokers are also constantly negotiating between authoritative knowledge of health and social services professionals and the experiential knowledge of immigrant and refugee communities. In doing so, they are contributing to agency and relational autonomy of these communities.

Here I introduce a broader vision of the work of the Health Co-op and Health Brokers, which leads to women becoming independent and active citizens in Canadian society. I theorize feminist urban citizenship as the overarching framework that may encompass the long-term goals of their work.

The Health Co-op and Health Brokers did not use the term "feminist" in their interactions with me as researcher, but their interests reveal long-term "strategic gender" (Eisenstein, 2009) goals of women's and men's equality in Canadian society. Their work is central to feminist urban citizenship because immigrant women experience urban reality by knitting together public and private, family and school, neighbourhood and community life (Andrew, 2008). I use the term citizenship as "both an ideal type and a process towards attainment of that type" (Lievesley, 2006, p. 7). The ideal type is based on immigrant and refugee women's goal of obtaining citizenship that "delineate[s] a

progression from civil, to political and finally to social rights” (T.H. Marshall, 1950, cited in Mouffe, 1993, p. 139). In the work of the Health Co-op and Health Brokers, the process focuses on women’s participation in the city’s daily life to improve their social and economic opportunities (Andrew, 2008). This entails deep participation (Mitchell & Shields, 2002) of immigrant and refugee women, families, and communities in the city and Canadian society.

According to Lievesley, (2006) “The exercise of citizenship is founded upon rights, responsibilities, obligations and expectations on the part of the individual and the state... Historically, citizenship rights have been regarded as being based upon an abstract and universal conception of the individual citizen but, in practice, many different groups have been prevented from enjoying them” (Lievesley, 2006, p. 7). Citizenship also has a legal dimension (Mouffe, 1993), and becomes an issue in reference to migrants to Canada who are considered non-status (undocumented). Goldring, Berinstein, & Bernhard indicate that “given the implementation of Canadian immigration and refugee policies, people with precarious status also tend to be negatively racialized; this raises questions about the legal production of racialized illegality and precarious migration status as a dimension of social exclusion and/or differential inclusion” (Goldring, Berinstein, & Bernhard, 2009, p. 241).

Although the Health Co-op and Health Brokers are not funded to help non-status migrants, they spend time doing this because they feel an ethical obligation not to let these communities languish without support. Although the political/legal component of citizenship is important, I do not discuss it further. I focus, rather, on citizenship as a process embedded in urban citizenship. This implies that, in negotiating between private and public spaces (Andrew, 2008), marginalization and structural discrimination prevents immigrant and refugee women’s relational autonomy (active

citizenship). This autonomy is also impeded when authoritative knowledge (the view point of the privileged) is listened to by city officials, and experiential knowledge (the view point of marginalized immigrant and refugee women) is disregarded by the same municipal authorities.

I use the term urban citizenship following Holston (2001)'s definition. He proposes that urban citizenship happens when: 1) the city is the primary political community; 2) urban residence is the criterion of membership and the basis of political mobilization; and 3) rights-claims addressing urban experience and related civic performances are the substance of citizenship (Holston, 2001, p. 326). The empowerment strategies used by the Health Co-op and Health Brokers, such as group work, community organization (community mobilization), advocacy (providers and institutional level), policy and practice (advocacy at the system level), have the city as the main site of action to reveal the concerns immigrant and refugee women and fight for health equity. This is particularly important as immigrant-receiving countries ought to consider "a notion of citizenship that makes room for the increasingly multiethnic and multicultural character of the population" (Mouffe, 1993, p. 139). Holston (2001) further explains that urban citizenship does not necessarily supplant or negate national citizenship, but it implies that residents who are non-nationals "can become urban citizens, exercising substantive but not formal (i.e. national) citizenship" (p. 326). This is important because feminist urban citizenship as a process means that immigrant and refugee women and their families who have not obtained political Canadian citizenship are nevertheless involved in shaping the socio-political realities for health and wellbeing. As such, their participation is "... linked to a politics of everyday life and demands for services, programs, and rights that facilitate the complex lives of urban residents, particularly women, in negotiating the interfaces of public and private spheres as they connect to paid employment, use of urban services and family life" (Andrew, 2008, p. 329).

Immigrant and refugee women, many of whom are single mothers, not only have to make strong demands to obtain services, but also are scrutinized by mainstream health and social service providers. In a study by Gurstein and Vilches (2010) of lone mothers in poverty, they found that “lone mothers’ engagement in their city is shaped by the strategies they use to overcome income assistance policies that impede their ability to meet their needs” (Gurstein & Vilches, 2010, p. 423). This is where the Health Co-op and Health Brokers’ broader concept of health, that involves non-medical factors (Sherwin, 1998), plays a role. The Health Brokers accompany mothers to seek non-health services, such as social assistance, because they see those programs as fundamental in women’s agency and relational autonomy. Health Brokers spend significant amounts of time helping women who were originally referred for perinatal support to seek non-perinatal health services, such as resources to address inadequate income, housing or family violence. They not only invest time in getting women together in discussions that begin with the children’s wellbeing, but they also present a chance to further the ultimate goal of building capacity among women to exercise their urban citizenship.

For the Health Co-op and Health Brokers, helping immigrant and refugee women to meet their basic needs is part of removing the barriers that restrain women’s agency and relational autonomy. At this level, like in accessing health services, they negotiate between the particular domain of knowledge that exists (Davis-Floyd & Sargent, 1997) among social services providers (authoritative knowledge) and that which exists among immigrant and refugee women (experiential knowledge). Gurstain and Vilches (2010) state that, in accessing health and social programs for example, the provincial level in Canada is constitutionally responsible for social assistance, but “social policies on housing, childcare and food security are often within the domain of municipal governments to

influence” (p. 422). The Health Co-op and Health Brokers face many barriers in fostering urban citizenship, but it does not deter them from working towards achieving that goal. The barriers and successes they experience in their work falls within (Adamson, et al., 1988) understanding of feminist practice for change, in that it requires maintaining a tension between a “politic” of disengagement and one of mainstreaming.

In the daily work of the Health Co-op, most Health Brokers acknowledge that they have to work within the system in order to address the basic and social needs of immigrants and refugees (mainstreaming), but they are also critical of the system. This stance helps to empower Health Brokers and their communities for social change (disengagement). For example, the Health Co-op and Health Brokers organize events to bring communities together and to gain access to public spaces (mainstreaming), which might otherwise be denied to immigrant and refugee women and their families (disengagement). Smyth (2008, p. 88) argues that, since citizenship as described in the sense of belonging “defined in terms of their ability to use social spaces, is severely compromised by their gender, albeit mediated by other social divisions, such as ethnicity, class, ‘race’, etc.” (Smyth, 2008) that sense of belonging for marginalized populations, such as immigrant and refugee women, is lessened. Indeed, some community centres have refused to rent spaces to some immigrant or refugee communities they consider undesirable (participant observation meeting, May 26, 2010). This type of barrier hinders women’s sense of belonging as citizens in the city, and discourages (but does not deter) Health Brokers urban citizenship from engaging with the health and social services systems and with city officials.

Theorizing Feminist political economy

The main focus of this dissertation is on understanding how integrated Health Brokers are within Canada’s health care system because of the role they play in facilitating and improving access to

health and social services by immigrant and refugee populations (micro/downstream). The underlying reasons Health Brokers and other community health workers exist in Canada, however, stem from policies originating in three main areas: health, social services, and immigration (macro/upstream). A feminist political economy perspective explicates how these policies have an impact on the delivery of health care (Armstrong & Armstrong, 2010a), social services (Jennissen & Lundy, 2011), and settlement and integration services of immigrants and refugees in Canada. While political economy examines the relationships of individuals to society, and to the state (Gourevitch, 1993), feminist political economy questions how policies and changes within systems perpetuate classed, gendered, and racialized social location that disadvantages some populations more than others. In many parts of the world, community health workers are trying to mitigate the effects of the dismantling of welfare states, which started in the late 1970s and early 1980s. By the nature of how health brokers are socially reproduced, they are not only bridging the divide between advantaged and disadvantaged populations, but they themselves are also disadvantaged.

In recent decades, structural adjustment programs, forced on countries by the World Bank and International Monetary Fund to generate resources to repay international debt, have been used to justify greater privatization of health and social programs. From the mid-1990s onwards (Teeple, 2000), as a result of neo-liberal policies, reductions in social, health, and other services in Western nations were justified by an imperative to reduce government deficits and debt. The major cutbacks to federal transfer payments to provinces in the mid-1990s implemented by the Chretien liberal government, and the elimination of the Canada Assistance Plan in 1995 (Andreae, 2002), are examples of such policies. The Chretien government's cutbacks to federal transfer payments started the decline of the federal government's investment in social spending on universal programs, again putting more responsibility on the provinces to cover the cost. These transfer payments "combine

to ensure all Canadians universal health care, income security based on need and free access to educational opportunities to the completion of high school” (Thomlison & Bradshaw, 2002). The programs affected included unemployment insurance and social assistance, income security for the aged, and health care (Stewart, 2002). The transfers to the provinces provided some protection to all populations, but especially to individuals who were living in conditions of vulnerability, such as low-income women, Aboriginals, people with disabilities, and immigrants and refugees. These cuts resulted in deeper poverty, greater marginalization and more exclusion of populations who are disadvantaged because of social structures based on class, gender, culture, and/or racialized background, including immigrants and refugees (Armstrong & Armstrong, 2010a; Jennissen & Lundy, 2011; Spitzer, 2005).

While the federal government was gradually adopting macro policies, such as cuts in social spending and restrictions to universal social programs (Stewart, 2002), it introduced targeted micro interventions to mitigate these cuts including the Canada Prenatal Nutrition Program (CPNP). The CPNP program (PHAC, 2010) was developed in response to the commitment made by the Government of Canada at the 1990 United Nations World Summit for Children, specifically pertaining to its initiatives, objectives and priorities “...concerned with mitigating health disparities and inequities and taking action to promote the health of individuals beginning in the early years” (PHAC, 2010, p. 8). According to CPNP’s 2010 summative evaluation, “the annual budget of CPNP is \$30.8 million. Of this, nearly \$27.2 million goes directly to communities to fund local projects. CPNP funding levels are determined on a provincial/territorial basis that considers the number of children zero to six years of age in each province or territory” (p. 8). The CPNP program is relevant to the study because it has 330 sites serving close to 50,000 women in over 2,000 communities across Canada each year (PHAC Website, 2011), including Edmonton. The Health Co-op and Health Brokers

receive in-kind support from the CPNP's Health for Two program in Edmonton to reach out to immigrant and refugee women who are pregnant or new mothers living in low socio-economic status (SES) until their babies are two months old.

At the provincial level, Alberta Health Services Edmonton Zone (AHS) offers both universal and targeted programs, through the Maternal Child Health area. Targeted programs address the needs of families with social or economic risks to healthy pregnancies or families with specific health risks to full term pregnancies. The Health Co-op and Health Brokers receive funding through the Perinatal Health Outreach program to assist all immigrant and refugee women until their babies are one year old. AHS's targeted programs serves women living in low SES neighbourhoods because these women have a higher rate of low birth weight babies and a higher rate of preterm births than women living in high SES neighbourhoods (GN Predy, Fraser-Lee, Edwards, & Lightfoot, 2008a). The Health for Two and Perinatal Outreach programs are the *raison d'être* for the collaboration between the AHS's Maternal Child Health area and the Health Co-op. The Health Brokers' participation in these two targeted programs illustrates the social production of CHWs in Canada. These workers become the instruments that mitigate the multiplying social consequences of cuts to government spending, which contribute to immigrants and refugees experiencing inequities in access to health and social programs.

Immigration policies are examples of upstream policies, crafted to meet the social and economic needs of a country (Carter, Vachon, Biles, Tolley, & Zamprelli, 2006). About 224,000 newcomers and their families arrive in the country annually, – some having met regular immigration requirements, and some qualifying for humanitarian reasons and entering as refugees. Canadian immigration policy establishes various classes of immigrants with different entry criteria. Immigrants in the

economic class category are selected based on the assessment that they have enough human capital (i.e., are well-educated, skilled, and young) to meet the needs of Canada's growing economy (Beiser, 2005). Refugees, who form a separate class for immigration purposes, are assessed in a different fashion. These populations, especially the ones who are living in conditions of vulnerability, regardless of their English or French language capacity, often require orientation and support to navigate Canada's complex medical care systems and overcome structural barriers to accessing health care services. This orientation and support has historically been provided by provincially- and federally- funded programs delivered at the community level.

Abundant literature documents the important challenges faced by immigrant and refugee populations, including Health Brokers and those they serve. A document summarizing the issues faced by clients of the Health Co-op and Health Brokers indicates, for example, that many of the newly-arrived pregnant refugee women suffer from physical health problems like malnutrition and psychological problems due to the impact of war-rape and other traumas. Refugee families typically also lack health screening and assessment prior to coming to Canada (MCHB Co-op, 2005fr, 2007fr, 2010fr). Health Co-op reports also highlight the increasing number of children with disabilities among refugee families, who, despite of being in Canada for several years, did not receive appropriate support from mainstream services. For example, out of 350 new families served by the Health Brokers, through funding from Children Services, 56 (16%) had children with serious disabilities (MCHB Co-op, 2005fr).

With regard to immigrant families, Health Co-op reports highlight some social concerns, such as the intergenerational conflict experienced by Chinese families (MCHB Co-op, 2007fr). According to the MCHB Co-op reports to AHS, problems are, in part, due to the lack of publically-funded daycare

spaces, which means that when mothers go back to work they bring their parents to Canada to take care of their infants. The Health Co-op reports that due to low socio-economic status, mothers, although sometimes highly educated, often have little choice but to enter the workforce. Frequently they work in menial or entry-level jobs. They typically cannot afford to stay home to take care of the children or to pay for private daycare. The intergenerational conflict is due to different perinatal and childcare practices (MCHB Co-op, 2007fr) as well as the grandparents' isolation, which stems from their lack of knowledge of English or of Canadian society and customs. According to Health Co-op, more and more immigrant and refugee women from an increasing number of countries seek support from the Health Brokers. For example, the number of immigrant and refugee clients of Health Brokers grew from 1,105 families, recorded in the 2005 report (MCHB Co-op, 2005fr), to 2,340 families, documented in the 2010 report (MCHB Co-op, 2010fr). This represents an increase of 211.7 percent in the number of pregnant or new mothers needing support in a five-year period.

The Health Co-op 2009-2010 report also highlights that most of the demand for Health Brokers' services came from the Chinese community, followed by South Asian countries. For example, among 2,037 women enrolled in the perinatal program in 2009-2010, the largest country groups (representing a combined 37.4 percent) come from China, Vietnam and the Philippines. The next largest distinctive group (24.8 percent) originates from regions and countries in Africa, followed by South Asian countries (20.1 percent). The smallest groups represented are from Spanish speaking regions and countries (11.4 percent), followed by Middle Eastern countries (9.2 percent). Of the 2,037 pregnant women or new mothers registered in the perinatal program, almost a third 30.4 percent (n=620) were registered under the Health for Two program. In addition to needing perinatal health information, these women also required material support, such as vitamins, milk coupons, and bus tickets to go to doctors' appointments. The changes in source country are also indicators of

the waves of immigration to Canada, and in particular to Alberta and to the Edmonton area.

According to interview data, the oldest wave of migration came from China and the most recent comes from Myanmar (formerly known as Burma), and saw Karen refugees³ settling in the city.

Further elaboration of the issues faced by immigrant and refugee communities is not the subject of my study.

Cutbacks to social program funding at the federal level, however, have had a direct impact on provinces' spending on social programs, such as unemployment insurance, child-related benefits and income support for seniors (Stewart, 2002), forcing immigrants and refugees to seek services from the Health Co-op and Health Brokers. Cutbacks to social programs have trickle-down effects on local government services, and on the programming of community-based organizations (Thomlison & Bradshaw, 2002) like the Health Co-op. Cutbacks in the provision of services "leave gaps to be filled by private or voluntary organizations or gaps within family or community usually filled by women" (Brendan Martin, 1993 ch 1: cited in Armstrong & Armstrong, 2010a, p. 8). Health, social services and immigration policies play a direct role in creating the conditions that spur the need for Health Brokers across Canada and the classed, gendered, racialized social location of health brokers in the country's health human resource workforce.

THE SOCIAL LOCATION OF HEALTH BROKERS WITHIN CANADA'S HEALTH HUMAN RESOURCES WORKFORCE

As workers, Health Brokers are considered part of what is often called non-standard employment, which has seen colossal growth in the last decade (Armstrong & Armstrong 2010b). Non-standard

³ As of 2005, the United Nations High Commission on Refugees (UNHCR) identified vulnerable segments of the Karen population as being in need of priority resettlement. The UNHCR agreed to refer these refugees, who were living in the camps of the Thai/Burmese border for up to 20 years, to Canada and other Western industrialized countries Citizenship and Immigration Canada. (2007). Backgrounder - Karen refugees. Retrieved January 15, 2013, from <http://www.cic.gc.ca/english/departement/media/backgrounders/2007/2007-02-09.asp>.

employment encompasses “part-time, short-term and contract jobs, certain types of self-employment, and work within the temporary help industry” (Economic Council 1991: 71 cited in Armstrong & Armstrong, 2010b, p. 50). “Part-time work is the most common form of non-standard work. Part-time employment is essentially defined as working less than thirty hours a week” (Armstrong & Armstrong, 2010b, p. 50). The authors’ argument is that the definition of “health care” ought to include not only the medical work done by doctors and registered nurses, but also support work, such as cleaning and laundry, assistance of volunteers who for example read to patients, and care provided by families. As well, it should also take into account of the part played by patients in their own care. On this reasoning, Health Brokers – who accompany patients to doctors’ appointments, take mothers and children to vaccination clinics, accompany women during child labour and delivery, raise women’s and families’ awareness of chronic and infectious diseases, help in prevention of violence against women and children, improve communication and understanding between women and health care providers by increasing the knowledge of the other’s culture and ways of knowing, and most all, increase the chances of the patients’ voices being heard by health professionals – ought to be considered health care workers.

GENDER AND CLASS

The gender segregation of the Health Broker’s work is not only shown in their part-time work, which is overwhelmingly done by women (Armstrong & Armstrong 2010b), but in that their work is invisible to other professions and the health care system. This work is “segregated into jobs similar in nature and/or relations to those they perform in the home” (Armstrong & Armstrong, 2010b, p. 54). Because the Health Brokers’ field is gendered, “work in the labour force often involved a wide range of skills that are invisible in part because so many women have them and in part because women’s work is undervalued.” This means that women’s participation and involvement in this field “are accepted as natural and inevitable rather than as product of history” (Armstrong & Armstrong,

2010b, p. 179). The undervaluing of women's work "does not simply represent ideas; it also represents power" (Armstrong & Armstrong, 2010, p. 66). It should be assumed, therefore, that if the community health worker field becomes more recognized, prestigious and well compensated more men will join the field, and in some instances displace women, as has happened historically in health care. Research by Armstrong and Armstrong (2010a) found that health care literature is primarily focused on men "who make policy decisions, rather than on the women who either do the work or receive the care" (p. 4).

In addition to the challenge of workforce invisibility, a recent sharp increase in the number of clients is another factor health brokers have in common with many nurses and with social workers. Research by Armstrong and Armstrong (2010a) and Spitzer (2004) revealed the pressures nurses in primary care face as a result of the increases in the number of patients under their care. They have less and less time with patients (O'Brien-Pallas & Hayes, 2008), making it difficult even to learn their names (Armstrong & Armstrong, 2010a). Social workers also expressed concern that an increase in their workload, owing to worsening economic and social conditions, has an alarming impact on their wellbeing (Lundy, 2011). A key difference in workload between the three groups is that health brokers spend the most time with clients. Research on community health workers abroad highlights the fact that these workers spend more time with program users than any other health professional (Forrest, Neuwelt, Gotty, & Crengle, 2011). Notwithstanding this factor, health brokers occupy the lowest echelon in the hierarchy of health care provision, and receive the lowest remuneration. In the United States (Massachusetts Department of Public Health, 2009) even with full-time employment, CHWs live in poverty. Workers' wages "place CHWs below ... the federal poverty level (FPL) for a family of four. They are also far below self-sufficiency estimates for a family of four in all regions of the U.S. [Massachusetts]" (MDPH, 2009, p. 31).

The increases in the workload of health brokers, nurses and social workers are part of the health care and social systems' restructuring to cut costs. This is part of a societal trend of diminishing resources for programs that target the most vulnerable, while squeezing workers to do more (Armstrong & Armstrong, 2010a).

Conclusion

I discussed in this chapter how the Health Co-op and Health Brokers developed their own multicultural health brokering theory (Ortiz, 2003) to define their role within a multicultural setting. Simultaneously, they adopted Labonté's (1993) health promotion empowerment approach to guide their work, which involves one-on-one, group work, coalition building and mobilization, policy and advocacy. I also theorized that Health Brokers' work fits within what I categorized as middle-range theories, such as authoritative and experiential knowledge, agency and relational autonomy. For example, Health Brokers negotiate between the authoritative knowledge of the health and social services systems and the experiential knowledge of immigrant and refugee women. In doing so, I argued they aim to enhance immigrant and refugee women's agency relational autonomy. I also theorized the Health Co-op and Health Brokers' work has a broader vision that leads to women becoming independent and active citizens in Canadian society, therefore contributing to feminist urban citizenship. This is the case because the Health Co-op and Health Brokers struggle to meet both the practical gender interest of immigrant and refugee women and families and the strategic gender interests of communities, such as achieving women's equality. I also argued that as they face barriers in their work, they experience contradictions between the politic of mainstreaming or disengaging within the health and social services systems. Finally, I discussed that the Health Co-op and Health Brokers' work is impacted by macro policies in health, social services, and immigration, which shaped the social location of health brokers within Canada's health and human resource

workforce. The macro context, I argued is best explained by feminist political economy because it illustrates both the impact of social policies and also the classed, gendered, and racialized status of health brokers in Canada.

Chapter 3

Literature Review

Who are Community Health Workers and why are they important?

Worldwide we lack knowledge of how the practice of Community Health Workers/Lay Health Workers (CHWs) is conceptualized, the theoretical frameworks used, the research designs and program implementation, and the methods for evaluating effectiveness and community involvement (Andrews, Felton, Wewers, & Heath, 2004; Lewin, et al., 2010). Multicultural Health Brokers' practice is part of the field of CHWs in Canada, the United States, and other countries. These interventions vary across regions, – depending on whether the workforce is recognized in each country's health care delivery model. In Canada, the CHW workforce is not yet recognized, but in Brazil and Iran CHWs are fully integrated into their health care systems. CHWs fall into three categories: the first category are CHWs participating in health promotion and health education activities, such as chronic disease prevention and management, which are part of public health activities; the second category are CHWs providing some form of medical care or clinical support for patients, such as oral care and vaccinations, especially in community settings — such activities are part of primary care; the third category are CHWs involved in caregiving in either homecare or long-term care facilities (Bourgeault et al., 2009), which are also part of primary care. These workers are also known as personal support workers. The main focus of CHWs in the first two categories is to improve access to health, social services, or both, to populations experiencing marginalization. CHWs in the third category support and assist people who are already living with chronic illnesses, who experience temporary lack of mobility or live with a permanent disability (Bourgeault, et al., 2009; Brookman, 2007; Government of Ontario, 2011; Torres, 2012b).

Understanding the role that CHWs play in caregiving in homecare and long-term care is important, but it is not the focus of this dissertation. The primary purpose of this literature review is to identify the types of CHW interventions and discover if and how they are integrated into public health and primary care systems, and their potential to decrease the health inequities experienced by marginalized populations. The secondary purpose is to learn from the experiences of CHW interventions in other countries, especially the U.S. I am giving particular emphasis to the latter because CHWs in Canada could learn from the process by which CHWs have organized south of the border. These processes include developing a strong relationship with the American Public Health Association (APHA), which could inform how Canadian CHWs relate to the Canadian Public Health Association (CPHA). This study was proposed because of the lack of research fully describing the context of CHW interventions in Canada or outlining how these programs actually worked in facilitating access to health services by populations experiencing marginalization.

In this chapter, I also provide a brief, and select overview of the literature on co-operatives and health worker co-operatives in Canada and in other countries. I deal with this literature only to the extent necessary to provide the background information on the organizational structure through which the Multicultural Health Brokers Co-operative (the MCHB Co-op) — the case — operates. This is important for two reasons: a) because Multicultural Health Brokers — the Phenomenon —, who are the focus of my study, created or are members of the MCHB Co-op, and their participation in this organization has a direct influence on their day-to-day work; and b) because the MCHB Co-op has a number of service contracts with the mainstream health and social services systems, which finance aspects of their programs for immigrant and refugee women and their families.

CHWs in Canada are part of a segment of interventions that are being carried out worldwide to reach populations who are experiencing marginalization. Because these populations, including an important segment of immigrants and refugees, are often living in conditions of vulnerability, they are not always responsive to dominant Western models or systems of health care delivery and mainstream health promotion strategies.

METHOD

I identified peer-reviewed individual and review articles through PubMed, the Cochrane Library, Ovid MEDLINE(R), the University of Ottawa's Academic Research (EBSCO), Dissertations and Theses (Proquest), E-Journals @ Scholars Portal, Theses Canada, Women's Studies International, and Google Scholar. I included academic studies from 1977 to the present time. I started the literature search in 2009 and gradually reviewed the sources as the study progressed. Given the dearth of academic literature of CHWs in Canada, I searched for grey literature on the database of Ontario Health Human Resources Research Network (OHHRN) and the Ontario Ministry of Health and Long-Term Care's computerized library database. In addition, I searched grey literature on the websites of provincial ministries including Alberta Health Services, British Columbia Ministry of Health Services and the Ontario Ministry of Health and Long-Term Care. I searched national websites of the Public Health Agency of Canada (Canada Prenatal Nutrition Program, Community Action Plan for Children), the Canadian Institute for Health Information, the Canadian Cancer Society, the Canadian Nurses Association, the Canadian Co-operative Association, Canadian Worker Co-operative Federation, the Health Care Co-operative Federation of Canada, and Metropolis Centres of Excellence. In addition, I searched the websites of organizations doing research internationally, including the World Health Organization, Global Health Equity, the International Co-operative Association, the Secretariat of the 2012 International Year of Co-operatives, Metropolis

International, the American Public Health Association Community Health Worker Section, and the Massachusetts Department of Public Health.

Because there exist over 50 synonyms to refer to CHWs, I searched with a multiplicity of key terms used in North America to identify relevant articles as follows: “Community Health Workers”, “Community Health Representatives”, “Community Health Advisors”, “Community Health Advocates”, “Community Health Aides”, “Community Health Champions”, “Cultural Brokers”, “Family Health Visitors”, “Family Visitors”, “Health Aids”, “Health Brokers”, “Health Outreach Workers”, “Indigenous Health Aides”, “Indigenous Health Professionals”, “Indigenous Lay Workers”, “Lay Health Workers”, “Lay Workers”, “Mentors”, “Multicultural Health Brokers”, “Multicultural Liaison Officers”, “Natural Helpers”, “Natural Leaders”, “Navigators”, “Non-Medical Individuals”, “Outreach Workers”, “Outreach Liaison Workers”, “Paraprofessionals”, “Peer Educators”, “Peers Facilitators”, “Promotoras”, “Public Health Aides”, “Volunteer Health Educators”, “Unregulated Health Professionals”, “Unregulated Health Workers”, and “Unregulated Care Providers”. Of these terms, the ones more commonly found in Grey Canadian literature were: “Community Health Representative”, “First Nations Food Educator”, “Aboriginal Outreach Worker”, “Family Home Visitor”, “Health Educator”, “Community Food Advisor”, “Community Nutrition Worker”, “Multicultural Health Broker”, “Public Health Food Worker”, “Community Health Worker”, “Community Health Advisor”, “Lay Health Worker”, “Outreach Worker”, “Patient Navigator”, “Peer Health Provider”, “Peer Educator”, “Personal Support Worker”, “Public Health Worker”, and “Women’s Health Educator”.

RESULTS

Three sources of data inform this literature review: articles on CHWs, articles on co-operatives, and articles on the theoretical frameworks used. The references on CHWs were published between 1977 and 2012 and focus on the study's main research questions and sub-questions. I am including 57 references on CHWs that were relevant for the study. The inclusion criteria I used in selecting articles for this review was pertinence to those questions, that is: articles that address the effectiveness of CHWs in improving access to health services and health outcomes for populations experiencing marginalization; articles that contribute to the understanding of CHWs as part of health human resources workforce; articles that address CHW interventions through structures that operate independently of the health system and those that operate within the system; articles that focus primarily on Canada and the United States; articles that address the tension in CHWs role between services provision and community development work; articles that describe the role of CHWs in targeting immigrant and refugees women in perinatal health programs; and articles that mention CHWs and patients being racially or ethnically concordant. The exclusion criteria were as follows: articles that only describe CHW clinical interventions, but do not make reference to health human resources issues; articles that use the term "CHWs" to refer to professional workers who are already recognized as part of human resources workforce or refer to CHWs who work in caregiving in homecare or in long-term care facilities; and articles that focused solely on CHWs in low-income countries.

Out of the 57 references on CHWs cited, seven were systematic reviews and one qualitative review was published in the United States; 16 were peer reviewed articles of which eight were also from the United States, two were from Iran, three from Canada, and one from the United Kingdom. The main objective of this review was to find out the state of the literature on CHWs in Canada, and

there is a dearth of peer-reviewed literature in Canada in this issue. Thus, the majority of references cited were 33 grey literature sources. See *Appendix 1: Summary of sources on CHWs included*.

The sources I selected on co-operatives focus on Canada and on some countries in Europe because of the influence the latter had on the creation of co-operatives in this country. In addition, I concentrated the search on health worker co-operatives and those working with immigrant and refugee populations. I could not find a systematic review on co-operatives that was relevant to my study. The vast majority of the 17 references cited in this section are grey literature sources, which provide the necessary background to understand the Health Co-op as the case under study. Grey literature on CHWs and co-operatives included research reports, narrative reviews, conference presentations, standards documents, government and non-governmental organization website information. See *Appendix 2: Summary of sources on Co-operatives included*.

The sources I consulted on theoretical frameworks (feminist political economy; authoritative and experiential knowledge; agency and relational autonomy; and feminist urban citizenship) helped to illustrate the work of the MCHB Co-op within a broader context as well as provide background on health equity issues that influence the work of CHWs. I summarized this literature in Chapter 2. I cited a total of 80 sources in these areas. See *Appendix 3: Summary of sources theoretical frameworks and health equity included*.

Community Health Workers in Canada and in other countries

CHWs are members of the communities they serve, they understand the issues faced by these communities in accessing health and social services, and their scope of activity depends on their relationship to primary care and/or to public health systems. Primary care refers to “Health care, or

medical care, that begins at the time of the first contact between a physician or other health professional and a person seeking advice or treatment for an illness or injury [or condition such as pregnancy]. It is provided by nonspecialized physicians and other health workers” (Last, 2007, p. 300). The second term, public health (Last, 2007), refers to “...a combination of sciences, skills, and values that function through collective societal activities and involve programs, services, and institutions aimed at protecting and improving the health of all the people” (p. 306). Based on these definitions, CHWs’ scope of activity depends on whether they have established linkages with primary care (community health centres, hospitals or clinics) and public health institutions.

I used the following definition of CHWs:

CHWs are frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy (American Public Health Association, 2009).

In low-income countries, CHW models were introduced in the 1950s to address a variety of health issues in communities experiencing marginalization. Werner’s 1977 book *Where there is no doctor* (David Werner, 1977) and Werner and Bower’s 1982 sequel *Helping health workers learn* popularized these workers' roles worldwide (David Werner & Bower, 1982). CHW models have also been also been used in high-income countries to address a variety of health issues (Andrews, et al., 2004; Lewin, et al., 2005), often in traditionally underserved or vulnerable communities (Clark & Surry, 2007; Hodnett ED, 2003; Khanchandani & Gillam, 1999; Rhodes, Long Foley, Zometa, & Bloom, 2007; Swider, 2002). In Canada, CHWs have assisted Aboriginal populations on reserves

since 1962 under the umbrella name of Community Health Representatives (National Indian & Inuit Community Health Representatives Organization, 2006a), and more recently under specialized titles, such as Aboriginal Diabetes Initiative Workers (Dedam-Montour, 2010). In urban centres, Aboriginal CHWs serve these populations under names such as Aboriginal Health Outreach Workers (HOW's) (S. Johnson, 2011 June).

THE MICRO VIEW

EFFECTIVENESS AND IMPROVING HEALTH OUTCOMES

The vast majority of literature on CHW programs focused on describing interventions targeting populations experiencing marginalization as well as analyzing the effectiveness of those interventions (Lewin, et al., 2010; Viswanathan et al., 2009). The Cochrane Review by Lewin et al., (2010) is the most recent review found which evaluates the role of CHWs in primary and community health care for maternal and child health and the management of infectious diseases. The authors indicated that programs in maternal and child health show promising benefits compared to usual care or no intervention options. Improved outcomes include increasing the uptake of immunization in children, promoting breastfeeding, reducing mortality in children less than five years old, and reducing morbidity from common childhood illnesses (Lewin et al., 2010). Earlier studies by the same authors (Lewin et al., 2005) and others indicated that CHW interventions were effective in increasing access to health services as well as increasing knowledge and promoting healthy behaviour among populations experiencing marginalization (for example, racialized women, Aboriginal women, women living on low income) (Andrews et al., 2004; Rhodes et al., 2007; Swider, 2002). The same authors, however, also indicated that there was insufficient evidence on the effectiveness of interventions carried out by these workers.

UNIVERSALITY AND WORKFORCE SIZE

The size of the CHWs workforce and its recognition as health human resources workforce varies depending on a country's health care systems. In Brazil and Iran, CHW programs are universal, making these workers part of health care delivery teams. The size of the workforce is considerable in both of these countries, the former having 240,000 workers (Giovanella, et al., 2011, June) and the latter 31,000 (Javanparast et al., 2011b) CHWs. In Canada, Australia, and New Zealand, CHW programs are not universal, notwithstanding these countries' government-funded universal health care systems; in these jurisdictions, there is also no data on the size of this workforce. In the U.S., which does not have a universal health care system, there are an estimated 121,000 CHWs (U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Health Professions, 2007). In 2010, the U.S. Department of Labor established a CHW Standard Occupational Category — SOC #21---1094 Community Health Worker — recognizing these workers as a distinct occupation (Balcázar, et al., 2011; Federal Register, 2009). In President Obama's 2010 *Patient Protection and Affordable Care Act*, the role of CHWs in achieving the goal of improving health outcomes and containing costs was recognized (Martinez, Ro, William Villa, Powell, & Knickman, 2011).

CHW ACTIVISM IN THE U.S.

In the U.S., CHW interventions have been seen as a less expensive alternative to providing access to health care to the poor and the uninsured. State level initiatives in that country have different arrangements for reimbursement of CHWs. For example, in the State of Minnesota, the Medicaid policy created a sustainable mechanism for financing pro-active outreach work by reimbursing CHWs providers for health education and the coordination of care undertaken by CHWs (Balcázar et al., 2011). These programs have shifted from being experimental in the 1960s and early 1970s to becoming Special Projects funded by short-term public grants from the mid-1970s to late 1980s. In

the 1990s, defenders of CHW interventions pushed for state and federal recognition of CHW roles, but this effort was unsuccessful. Due to extensive lobbying initiatives from 1999 to 2010 several shifts happened at the federal level: a “Patient Navigator Bill” was signed into law, recognizing the use of CHWs and their certification; the APHA officially recognized CHWs’ activities in 2001; and in 2009, CHWs became a Section within the APHA, which was a major achievement in legitimizing their role as part of the public health workforce (Holderby, 2010 June).

The National CHW Workforce Survey conducted across all 50 states and published in 2007 by the U.S. Department of Health and Human Services Health Resources and Services Administration, along with continuous CHWs’ lobbying, had a major impact in the recognition of these workers (U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Health Professions, 2007). More broadly, it can be said that the CHW workforce in the U.S. has moved from not being accorded recognition in the past to being seen as having an important role within the current health care system reform (Balcázar, et al., 2011; Rosenthal, et al., 2011).

SCOPE OF PRACTICE

The scope of CHWs’ practice in low, middle, and high-income countries varies depending on the relationship this workforce has with primary care or public health systems in different jurisdictions. As noted above, three categories of activities characterize these workers’ roles although the nature of these activities differs depending on the environment in each country. The categories are : a) public health interventions, including perinatal health outreach (Alberta Health Services, 2013; Ottawa Public Health, 2001-2013a); b) primary care interventions, such as giving vaccinations or oral health screening (HRSA, 2007); and c) social determinants of health interventions, such as environmental clean-ups, food security and sanitation activities (Labonté, 2011 October). In low- and middle-income countries, CHWs focus their work on both public health and primary care; and in

high-income countries they focus mainly on activities related to public health. In the U.S., CHWs are involved in both primary care and public health activities. Similarly, community health representatives on Aboriginal reserves in Canada might undertake both activities. Independently of the scope of practice, however, several similarities and differences exist among these workers' practices, including in training and supervision as well as in the relationship the communities to whom they provide services.

TRAINING

The training that CHWs receive in Canada and other countries varies. Examples of training regimes include the Massachusetts Department of Public Health in the U.S., which has a CHW Certification Board under its auspices (Mason et al., 2011). This recently-established Board considered CHWs being involved in developing practice standards, determining training, and continuing education requirements with grandfathering provisions for the current workforce as well as a process for establishing requirements for CHW training entities (Mason et al., 2011, p. 2214). Furthermore, Findley et al., 2012 indicates that in U.S., 17 states are currently in the process of establishing standards for CHWs (Findley et al., 2012). In Iran, CHWs (called Behvarz in Farsi) receive a two-year standard training program (Javanparast, et al., 2011b); in Ontario, the Healthy Baby Healthy Children Program (Jack, DiCenso, & Lohfeld, 2002) provides home-visitors with standard training and a single curriculum focusing on maternal and child health . Also in Ontario, the City of Hamilton Public Health Services gives Women Health Educators (WHE) four-day training focusing on chronic disease prevention and management (Black et al., 2007) followed by ongoing training and mentorship with public health nurses (T. Hack, personal communication, August 09, 2012). The Ontario Federation of Indian Friendship Centres (OFIFC) also provides training on alcohol and drug addiction to Aboriginal Health Outreach Workers across the province (S. Johnson, personal communication, October 14, 2010). However, in Ontario as well as in many parts of Canada and the

rest of the world, there is no official coordination among institutions and organizations on the conceptualization, implementation, and delivery of CHW training programs. This means that most entities — public health units, community health centres, and other community-based organizations — develop their training and curriculum independently.

SUPERVISION AND TECHNICAL SUPPORT

Several studies identified lack of supervision and support as a problem for CHWs (Bhutta, Lassi, Pariyo, & Huicho, 2010; Javanparast, Baum, Labonté, & Sanders, 2011a; Lehmann & Sanders, 2007). For example, in Iran, the Behvarzs (CHW) are full-time employees of the Iranian government health system, embedded in an institutional structure to assure program sustainability and make employment attractive (Javanparast, et al., 2011b). Despite this, research conducted by Javanparast et al., (2011a) indicated that Behvarzs faced barriers in doing their work because of poor-quality supervision. The authors stated that in most cases supervisory teams did not provide sufficient technical and emotional support or training (Javanparast, et al., 2011a). Instead, a large number of their respondents stated that supervisors mainly focused on their weaknesses rather than their strengths (Javanparast et al., 2011a, p. 12). A lack of supervision was also found by Bhutta et al., (2010) in their systematic review and in-depth eight country case studies in three different regions of the world: Sub-Saharan Africa (Ethiopia, Mozambique, and Uganda), South East Asia (Bangladesh, Pakistan, and Thailand) and Latin America (Brazil and Haiti). The objective of their review and case studies was to identify CHWs programs with a positive impact on Millennium Development Goals (MDGs) related to health as well as development. The authors found several systemic challenges experienced by workers, a lack of adequate supervision being one of them (Bhutta et al., 2010).

A related issue to supervision is whether CHWs have clear guidance on establishing boundaries with clients. A literature review on peer educators by Alberta Health Services (Alberta Health Services,

2009a-b) highlights the importance of training sessions as forums for discussing the role expectations for workers and ensuring that peer educators are equipped to manage requests for assistance that transcend “role boundaries” (Alberta Health Services, 2009a, pp. 1,2).

SERVICE PROVISION VERSUS COMMUNITY DEVELOPMENT

Research in Brazil by Giovanella et al., identified the need for CHWs to refocus on their role and place greater emphasis on being advocates for communities and agents of social change in order to better address the social determinants of health (Giovanella, et al., 2011, June). The authors argue that as a result of the institutionalization of these workers within Brazil’s health care system, CHWs are more and more moulded around fulfilling a technical role linked to monitoring and supporting communicable and non-communicable chronic disorders rather than focused on addressing the social determinants of health (Giovanella et al., 2011, June). The same trend was found in Iran, where “medicalization” of the role of CHWs was pushed by their health system. For example, while the job descriptions of the Behvarz reveal an increasingly comprehensive approach to primary health care, the long list of basic health care tasks may, in practice, leave little time for these workers to serve as agents for community development and change (Javanparast et al., 2011b, p. 11). I illustrate, in Chapter 5, how Health Brokers in Edmonton feel similar pressures in their work.

The U.S. literature also indicates the need for research studies to recognize and deal with the balance in CHW roles between community action, advocacy, and direct patient role interventions (Rosenthal, et al., 2011) to achieve particular outcomes (Community Resources LLC, 2007). Wiggins and Borbon (1998, p. 45) suggests that “CHWs’ role as agents of social change is, in fact, their most important role... and that ‘the true value-added’ in the CHW model comes when [CHWs] are allowed and encouraged to play this role” (cited in Rosenthal et al., 2011, p. 256).

CULTURAL APPROACH OR CONCORDANCE WORKERS

Some literature indicated that the role of CHWs who share a similar cultural background with immigrant and refugee communities are better able to respond to the health needs of these populations (Wells et al., 2011). Wells et al. (2011) refer to this characteristic as ethnic concordance of workers and clients. Other literature also addressed the role of cultural brokering as a key approach to increasing access to, and enhancing the delivery of, culturally-competent care (National Center for Cultural Competence, 2004). Cultural brokering is important because this is also the approach espoused by the Health Co-op.

A GLOBAL VIEW OF CHWS AS HEALTH HUMAN RESOURCES WORKFORCE

A review paper by Lehmann and Sanders (2007) is the most comprehensive macro perspective I found on the role of CHWs. Their review paper was produced as a follow-up to the *World Health Report 2006: Working Together for Health* (World Health Organization, 2006), which identified the feasibility of successfully engaging community health workers to address the growing shortage of sector workers, particularly in low-income countries, as a research priority (Lehmann & Sanders, 2007, p. 1). The report suggested scaling up the delegation of health care tasks or “task shifting” to CHWs. Task shifting refers to the transfer of tasks in many health care settings from specialized (and therefore scarce) workers to less specialized ones (WHO, 2006, p. 24). Although the trend toward task shifting was particularly highlighted for low-income countries, in the U.S., CHW interventions have been openly presented as a less expensive alternative when providing care to the poor and the uninsured. While it is not within the scope of this dissertation to do an in-depth analysis of task shifting trends in health care in Canada, I discuss briefly, in Chapter 8, the potential effects of task shifting on the work of the Health Co-op and Health Brokers in Edmonton.

Lehmann and Sanders (2007) cautioned about making generalizations on what constitutes a good CHW program. They found five major issues in which the literature reflects consensus about CHW interventions. The first of these was that CHWs can make a valuable contribution to community development and, more specifically, improve access to and coverage of communities with basic health services. The caution here is although these workers can implement effective interventions, “they do not consistently provide services likely to have a substantial health impact, and the quality of services they provide is sometimes poor” (Lehmann & Sanders, 2007, p. 26).

Second, they found CHWs must be carefully selected, appropriately trained, and adequately and continuously supported. For example, large-scale CHW systems require substantial increases in support for training, management, supervision, and logistics. The Brazilian Family Health Programme is an example of a successful large-scale program. This program “has integrated CHWs into its health services and institutionalized community health committees as part of its municipal health services to sustain social participation. This means that community participation does not become an alternative, but an integral part of the state’s responsibility for health care delivery” (Lehmann & Sanders, 2007, p. vi). The Iranian program, on the other hand, also implements a large-scale intervention, but according to Javanparast, et al., (2011b) the supervision of the Behvarzs is a problem.

Third is that CHW programmes are neither a panacea for weak health systems nor a cheap option to provide access to health care for underserved populations. This means that CHW interventions require focused tasks, adequate remuneration, training, supervision, and the active involvement of the communities in which they work (Haines et al., forthcoming, cited in Lehmann & Sanders, 2007, p. 13).

A fourth issue is that CHW programmes are vulnerable unless they are driven, owned by and firmly embedded in communities themselves. “Where this is not the case, they exist on the geographical and organizational periphery of the formal health system, exposed to the moods of policy swings without the wherewithal to lobby and advocate their cause, and thus are often fragile and unsustainable” (Lehmann & Sander, 2007, p. v). In Chapters 5 and 8, I describe and discuss the role of the Health Co-op and as an independent organization, which is grounded in the community, but perhaps remains at the margins of the health care system.

Fifth, and last, the question of whether CHWs should volunteer or receive remuneration in some form remains controversial. Although they are expected to spend only a small amount of time on their health-related duties in many programs, leaving time for other breadwinning activities, community demand often requires a full-time commitment (Lehmann & Sanders, 2007). The tension between models with CHW as volunteers and those under which they are remunerated has come up during the APHA-CHW Section scientific sessions, which I have attended, and the issue is still unresolved. Related to this issue, Lehmann and Sanders (2007) also indicated that community financing is rarely successful unless institutionalized, as in China. Most of the evidence reflects failures of community financing schemes, leading to high drop-out rates and the ultimate collapse of programmes (Lehmann & Sanders, 2007, p. 26). In addition to the five points discussed, Lehmann & Sanders (2007) further suggested that governments could adopt more flexible approaches by planning CHW programs within the context of overall health sector activities, rather than as a separate activity (p. 27). I discuss these issues further in Chapters 5, 6, and 7 of the dissertation. Next, I provide an overview of the different models of CHW programs that exist in Canada.

TYPOLGY OF CHW MODELS IN CANADA

Current research in Canada indicates that depending on the nature of the organization or the funding source of CHW employers, there is a typology of CHW interventions that operate on a continuum from informal to formal models with some overlap among the models (Torres, 2012a):

- At the informal end of the spectrum, CHW models or independent initiatives are mainly offered by volunteer-based community organizations with no formal ties to health or social service organizations or dedicated funding. Examples include groups such as the Latin American Women's Support Organization (LAZO), which targets isolated Hispanic youth (LAZO, 2011) and women (Torres, Estable, Guerra, & Cermeno, 2011) in Ottawa. These interventions are marked by high levels of health promotion activity when funding is available and low levels of activity when funding is unavailable, but nevertheless are characterized by the volunteers keeping a regular presence within the community. The type of organization that offers this kind of service is likely to be eligible to apply for grants from funders like the Trillium Foundation in Ontario (for example, the LAZO group)(LAZO, 2011);
- In the middle of the spectrum, CHWs models feature a formal connection to the public health care system, such as a link to a public health unit, a community health centre, or hospital, but the longevity of the activity depends on funding stability. CHWs in these models are hired part time, on contract or act as volunteers to deliver a particular health promotion intervention, or to recruit and train other CHWs to deliver a particular program. In Toronto, the Peer Education and Action for Community Health (PEACH), based at the Unison Health and Community Services (Unison Health and Community Services, 2011), fits this model. The type of groups working with these models are generally eligible to apply for financing, such as grants from Ontario's Healthy Communities Fund sponsored by the Ministry of Health and Long-term Care (MOHLTC)/Ministry of Tourism Culture and Sport

(MTCS) (Ontario Ministry of Tourism Culture and Sport, 2012). Community Health

Representatives working on Aboriginal reserves fall within this model as well because the scope and longevity of their funding depends on the agreements reached between the Indian Bands and Health Canada (Dedam-Montour, 2010);

- At the formal end of the spectrum, models run through public health units or community health centres and hospitals feature CHWs integrated into the overall programming of the organization. CHWs occupy full-time or part-time salaried permanent positions. The Multicultural Health Team operating under Ottawa Public Health is an example of this type of model. The Woman Alive/Femme Active Program, (Ottawa Public Health, 2001-2013b), is an exercise program targeting women living in low socio-economic status, including immigrant and refugee women. The health unit assigns a public health nurse to run the program together with community organizations, but funding for the program itself is not secure (Informant interview participant, October 8, 2009). The Toronto Public Health Unit also hires CHW workers as peer nutrition workers to reach out to immigrant and ethno-racial communities (Informant telephone interview, October 27, 2010). The REACH Community Health Centre's community developers in Vancouver (Reach Community Health Centre, 2011) fit within this category. The OFIFC's programs, which are delivered by aboriginal health outreach workers, on alcohol and addiction or mental health also fall within this model;
- Another formal model is an independently-run health worker co-operative that acquires regular sources of funding from the local public health unit, a children's services agency or other ministry to undertake a particular or a series of interventions, for example the Health Co-op in Edmonton. In this model, the organization has a formal link to the health care system through accountability contracts and in-kind support from public health nurses, but

all staff, programming, and administrative decisions are made by the organization alone (Torres, 2012a). For example, programming includes CHWs helping clients in areas linked to social determinants of health, for which the health care system does not pay because these are regarded as not having an economic value component.

CHARACTERISTICS OF CANADA'S CHW WORKFORCE

Regardless of the models, the key characteristic of CHWs in Ontario and in Canada generally is that they are unregulated and unrecognized public health workers. This is in part because as a workforce they do not have: an organizing or umbrella body (for example, local, regional, provincial, or national organizations); a single definition for their work; data on composition, competencies and size of workforce; a registry of workers; a national occupational classification (NOC); or a single curriculum; or standardized training, and a common nomenclature.

CHWs involved in formal models, especially within public health units, tend to be better paid, and have more benefits and access to training than those working under semi-formal models. Of the three models, CHWs in informal models are the most disadvantaged due to insecure employment, lack of benefits, and limited access to training opportunities. In most cases, CHWs in formal or semi-formal models tend to seek support from those in informal models to reach out to the most marginalized populations within a particular group. Formal models like the Health Co-op, while having direct contact with the health care system, are also disadvantaged in that their wages do not match those of CHWs who are integrated into the health care system (that is, a CHC or a public health unit). Research in Canada also found very few policies on the role of these workers in targeting marginalized populations. Compared to the U.S. or other countries, where CHW frequently engage in advocacy, the lack of a common voice for this workforce here might be a reason for the absence of provincial policies in Canada. Such policies could not only better define the role of CHWs

in undertaking programs targeting marginalized communities for prevention and management of chronic and infectious diseases, but also identify the part they could play in dealing with health issues within mainstream populations.

Canadian evidence, especially located in the grey literature (Chiu, Ortiz, & Wolfe, 2009; Pottie, et al., 2008; Torres, 2012a), and some academic publications (Black, Frisina, Hack, & Carpio, 2006; Meyer, Torres, Cermeño, MacLean, & Monson, 2003) on the contributions of CHWs to public health and primary care is gradually emerging. But as stated above, Canada lags behind the U.S. and other jurisdictions in research and systematic documentation on CHWs as a workforce as well as in the recognition of this workforce's participation in our public health care system.

Although the literature warns that CHW interventions should not be seen as the panacea for outreach to all marginalized communities on every possible health issue (Lehmann & Sanders, 2007), there appears to be evidence that CHW programs are effective in increasing access to health services for marginalized populations in the prevention of some infectious diseases and in management of chronic illnesses (Lewin, et al., 2010). CHWs confront similar issues in Canada as those faced by their counterparts in other countries. The main difference, however, is that Canada has a universal health care system, which in principle ought to make obsolete the need for CHWs. Yet, as discussed in this dissertation, Canada's federal cuts to transfer payments and the nature of its immigration policies influence the societal context of CHWs and magnify the need for outreach programs to certain communities.

In summary, in Canada there is growing interest in opportunities to train community members to promote health and provide health care services to "hard-to-reach" (Canadian Foundation for

Health Care Improvement, 2007) populations. Independent of the level of recognition, the main focus of CHWs' interventions is to remove or diminish barriers to accessing health services by populations who do not normally benefit directly from the health care systems due to situations of vulnerability. The spin-offs of these interventions include improving access to other essential services, for example, housing, employment, and income security, which are recognized as addressing social determinants of health.

Background on Co-operatives

AN OVERVIEW

2012 is the International Year of Co-operatives, declared by the United Nations to recognize the diversity of the co-operative movement around the world and to urge governments to take measures to support the development of co-operatives (2012's IYC Website, 2011a). According to Hough, Wilson, and Corcoran (2010), "a Co-op is an autonomous association of persons united voluntarily to meet their common economic, social, and cultural needs and aspirations through a jointly-owned and democratically controlled enterprise" (Hough, Wilson, & Corcoran, 2010, p. 5). Six types of co-operatives operate in Canada: financial, retail, producer, worker, service, and multi-stakeholder co-operatives (Co-operatives Secretariat — Government of Canada, 2009). Co-operative activities are organized in a large number of sectors. Some co-operatives are hybrids of two or more types of co-operatives, for example, the Health Co-op merges both service and worker co-operative into one organization.

Financial co-operatives, such as credit unions and insurance co-operatives, offer financial, loan or investment services, and insurance services to their members. Retail co-operatives are owned by consumers and provide goods or services for members' personal use (Craddock & Vayid, 2004;

Sointula Co-operative Association, n.d), such as groceries or outdoor equipment. Producer co-operatives process, market, or process and market their members' products and services, or provide supplies to members' economic activities such as farm equipment (Co-operatives Secretariat — Government of Canada, 2009). Worker co-operatives are defined as:

... businesses that are owned and democratically controlled by the worker/employee members. The main purpose of a worker Co-operative is to provide employment for its members through operating an enterprise that follows the Co-operative Principles and Values. The worker Co-operative is, in principle, designed to provide benefits not just to the founding members but also to all future employee/members. When new employees join the business, after a successful probationary period, they are encouraged to apply for membership and become member/owners (Hough, Wilson, & Corcoran, 2010, p. 5).

Service co-operatives provide services such as not-for-profit housing for their members (The Co-operative Housing Federation of Canada, 2000-2013). Health co-operatives also provide services to Canadians through an approach focused on prevention of illness and user responsibility (Craddock & Vayid, 2004). In Canada, the existence of health co-operatives can be traced back to the health clinics established in the 1940s in Québec and British Columbia and in 1962 in Saskatchewan (Craddock & Vayid, 2004). Health co-operatives also include groups offering ambulance and homecare services as well as “other” health services. Under the category of “other” are such activities as health education and holistic therapy (Craddock & Vayid, 2004). The Health Co-op falls under the “other” health category. According to Craddock and Vayid, (2004) ambulances, homecare, and “other” health co-operatives saw a rapid expansion in the 1960s related to the creation of Medicare.

Currently in Canada, there are approximately 600 worker co-operatives, including 100 health co-operatives. Total worker co-operative membership in Canada is estimated to be over 13,000 (2012's

IYC Website, 2011b). The majority of worker and health co-operatives are situated in Quebec, as indicated by the number of incorporations in that province, or by reporting to the Co-operative Secretariat of the Government of Canada or to the provinces' co-operative central agencies (Craddock & Vayid, 2004).

Co-operatives have a long history in Canada. Throughout the country, from Malcolm Island off the west coast of British Columbia (Sointula Co-operative Association, n.d), across the Prairies, where Saskatchewan is said to be Canada's co-operative province (Fairbairn, 2005), to the eastern part of Nova-Scotia, worker and consumer co-operatives started as a result of local conditions of distress and malaise (Sacouman, 1977). According to Fairbairn (2005) the "Saskatchewan co-operative movement changed radically from 1905 to 1945. It began as an agrarian-interest movement of settlers and owners and ended up as a broader and more inclusive communitarian movement" (p. 8). In Nova Scotia, the Antigonish movement, which arose "in the first decades of the 20th century in response to socio-economic decline in Maritime Canada," (The Coady Institute, n.d) is credited for propelling the creation of all forms of co-operatives and credit unions in Nova Scotia. Fairbairn (2005) indicates that "it was the state that created the possibility of modern co-operatives by introducing legal codes, market economies, and many thousands of new settlers, the majority of whom were steeped in European ideas" (p. 5).

THE EUROPEAN EXPERIENCE

The membership in worker and consumer co-operatives in Europe is large. For example, France has a membership totalling 32.4 million individual co-operative members (ICA Website, 2005-2011b); Italy has a membership of approximately 7,429,847 co-operative members (Wikipedia, 2012); and Spain has approximately 6.7 million co-operative members (ICA Website, 2005-2011b). In Canada,

co-operatives “have more than 18 million members, which means that four of every ten Canadians are members of a co-operative” (Co-operatives Secretariat — Government of Canada, 2011). Co-operatives in Italy, Spain, and France owe their success to several factors, including: the high percentage of co-operatives in those countries in particular sectors or professions; the financial and technical support they receive in their start-up phase; the political influence through their alliances with political parties (Italy) and their other strengths; and the solidarity among worker co-operatives themselves (Hazel Corcoran & Wilson, 2010). These are factors that the Canadian worker co-operative movement generally does not feature, but there is hope that lessons from these countries can inspire Canadian worker co-operatives:

By studying the worker Co-operative movements in Italy, Mondragon [Spain] and France, we can be inspired, and we can find hope. It is inspiring to see the sheer size of the movements, the inter-connectedness of the Co-ops, support by governments, innovation, and resiliency in the face of economic crisis. It is also inspiring to know that their success is based in their values, of co-operation, solidarity and social responsibility. Our hope here in Canada is to find solidarity among the worker Co-ops themselves, and with the broader Co-operative sector and governments to build a comparable system here -- to build a comparable movement of mutually supporting worker Co-ops (Corcoran & Wilson, 2010, p. 34).

PRINCIPLES OF HEALTH CO-OPERATIVES

The Health Co-op is both a worker and health co-operative. Like other co-operatives, it adheres to the *Statement of the Co-operative Identity and Co-operative Principles* (MCHB Co-op, 2009h) of the co-operative movement established by the International Co-operative Alliance (ICA). Co-operatives’ values are based on “self-help, self-responsibility, democracy, equality, equity, and solidarity...Co-operative members believe in the ethical values of honesty, openness, social responsibility and caring for others” (ICA Website, 2005-2011a). Co-operatives also follow seven principles that serve as guidelines by which co-operatives put their values into practice, and that sets their ideals apart from “conventional capitalist business” (Hough, Wilson, & Corcoran 2010, p. 6). These seven

principles are: 1) Voluntary and Open Membership; 2) Democratic Member Control; 3) Member Economic Participation; 4) Autonomy and Independence; 5) Education, Training and Information; 6) Co-operation among Co-operatives; and finally, 7) Concern for Community (ICA Website, 2007). The Health Co-op embraces these principles in policy documents, that is, by referencing them in their bylaws (MCHB Co-op, 2005) and by listing them in their policy handbook (MCHB Co-op, 2009h). See *Appendix 4: Principles of worker co-operatives*.

SUCSESSES IN ESTABLISHING WORKER CO-OPERATIVES

There are several internal and external indicators of the success of worker co-operatives in meeting the goals and mandates set out by their members (Hannley, 2007).

INTERNAL FACTORS

These indicators include: tangible gains by the workers, such as increased worker empowerment, lower unemployment, increased job stability, increased social capital, and increased feeling that workers are on a more equal footing with each other and in control of their destiny (Hazel Corcoran & Wilson, 2010, p. 4). Indicators of success also include the efforts that workers put into the organization; in particular, workers being highly motivated, and founders who follow the values of the co-operative. This means that a “worker Co-op is not just a way of making a living but also a way to bring to their work life their values and social concerns. The Co-ops in many cases have an explicit transformative agenda beyond individual benefit to members” (Hough, Wilson, & Corcoran, 2010, p. 13). Another indicator of success is the worker co-operatives’ learning capacity and a culture within the organization that allows the co-operative to respond to a continuously changing environment while fostering workers’ solidarity and empowerment (Hough, et al., 2010). These internal indicators illustrate that the capacity of the organization and the commitment to the goals and objectives of the organization by its members are key to successful worker co-operatives.

EXTERNAL FACTORS

The external indicators marking successful co-operatives include the business of the co-operative being situated in large economic sectors, which provide the necessary opportunity to develop a sustainable “market niche” based on merit and quality of goods and services. Another external indicator is having appropriate assistance available to workers co-operatives, that is, technical support and industry resources for organizational development and training, in addition to networking and support from others in the co-operative sector. Finally, successful workers co-operatives are also able to access capital (from government or business sources), especially in the start-up phase (Hazel Corcoran & Wilson, 2010), and receive creative financing, including members’ significant commitment to sweat equity (volunteer work) (Hough, Wilson, & Corcoran 2010, p. 18). These external factors reveal that the success of worker co-operatives is influenced by an environment that supports the development of the sector, including technical expertise and public sources of funding in establishing the business, organizational structure and the niche market of co-operatives. Later in Chapter 5, I discuss how the Health Co-op has been successful in creating a market niche by providing culturally- and linguistically-appropriate services for immigrant and refugee women and their families.

CHALLENGES IN SUSTAINING WORKER CO-OPERATIVES

The challenges that worker co-operatives face are not new (Espagne, 1996). They include: the burden of preserving jobs and protecting workers’ economic security; the threat of bankruptcy if entities are unable to invent new techniques to respond to environmental and marketplace challenges; and pressure to be altruistic and reach out to the new excluded and marginalized populations (Espagne, 1996, p. 30). Worker co-operatives are considered the most difficult business entities to sustain for three reasons: first, financing, as workers have low capital to invest in the co-operative and therefore rely on external sources of funding, especially in the start-up phase; second,

the labour-intensive nature of the organization, as the democratic governance of the organization requires that members put in time to work on strengthening the organization's principles and values, much of which is unpaid; and third, a lack of managerial skills among the workers, as often members do not have experience in running businesses and co-operative models are generally not taught in Canadian schools (Hazel Corcoran & Wilson, 2010; Ortiz, 2003).

ETHNOCULTURAL AND IMMIGRANT CO-OPERATIVES

There is a growing interest on the part of national co-operative organizations, such as the Canadian Worker Cooperative Federation (CWCF) and the Canadian Co-operative Association (CCA), in fostering the development of worker co-operatives among ethnocultural and immigrant communities. Research and support of co-operatives among these communities has been conducted by the CCA in coordination with other sectors since 2004 (CCA, 2011). A recent CCA broad-based scan of 73 ethnocultural and immigrant-based co-operatives and credit unions in Canada (excluding Quebec) found that 57 percent of the ethnocultural and 37 percent of immigrant co-operatives are consumer or service co-operatives. These co-operatives offer products and services such as bulk purchasing for small ethnic stores, housing, and health services (CCA, 2011). In Canada, the oldest ethnocultural and immigrant consumer co-operative was created in 1909 by Finnish settlers in Sointula in Western Canada, and remains active today (Sointula Co-operative Association, n.d). The Sointula co-operative was transformed into a broad-based co-operative serving the general public, which explains why it was not included in the CCA's 2011 scan. The CCA (2011) scan also found that the second most used co-operative type (or 27 percent) is a worker co-operative, and that of all co-operatives, 30 percent are new co-operatives that were in the planning stage. Priorities for the CCA in this area include ensuring that new arrivals to Canada have a fair opportunity to meet their social and economic needs through member-owned co-operatives. Many immigrant communities are gradually coming to use co-operatives as a means to preserve their

diversity in Canada's multicultural society (CCA, 2011). CCA's involvement in supporting ethnocultural and immigrant co-operatives is an example in Canada of one of the external factors influencing success of the co-operative development discussed above.

As many ethnocultural and immigrant communities face barriers to finding meaningful employment in Canada, the worker co-operative model is a useful alternative, and is well suited to helping people create their own jobs, as well as having some control of their working conditions (CCA, 2011), "With almost one million Co-ops across the globe, many immigrants arrive in this country already familiar with the potential of the Co-op model" (CCA ,2011, p. 4). The CCA (2011) study documented that close to seven percent of ethno-cultural and immigrant co-operatives are over 60 years old, with many of these being financial, especially credit unions, while the youngest co-operatives are typically less than ten years old (approximately 56 percent), and focus on the non-financial sector. Older co-operatives mainly originated by those from Eastern and Northern European backgrounds, while the newer ones are mostly begun by those from Asian and African regions. As of 2012, the Health Co-op is 14 years old and the only worker co-operative that specializes in providing perinatal (both pre- and post-natal) support as well as other programs, including child intervention support to families. In Chapter 5 I delve into the successes and challenges of this organization, the case, which operates independently of Alberta's health care system. I also discuss what it means for the integration of the Health Brokers' practice within the health system.

Chapter 4

Research Design

Case study is the study of the particularity and complexity of a single case, coming to understand its activity within important circumstances (Stake, 1995, p. xi).

About this narrative

This dissertation features long narrative passages about the case, the phenomenon, and the embedded mini-cases so others can learn from them. The substantial narrative elements allowed me to examine the complexities and contradictions of real life (Flyvbjerg, 2001) as experienced by the MCHB Co-op and Multicultural Health Brokers in Edmonton. Their work unveils a rich problematic that has implications for the CHW field in Canada: Multicultural Health Brokers are part of the health human resources workforce, but their contributions are not recognized as such. In the sections that follow, I explain in detail the research design and strategies I used in conducting this instrumental and embedded qualitative case study. An instrumental case study illustrates a problematic that goes beyond the organization itself (Stake, 1995), in this case the Multicultural Health Brokers Co-operative. I first describe the research design, the selection of the case, the limitations to case study research, and the transformatory-emancipatory approach I used in conducting my inquiry. Second, I outline in detail the research strategies used: participant and direct observation, face-to-face interviews, document review, analysis of archival records, and artifacts. Here, I also explain my approach to transcribing the interviews, note-taking, pilot testing, and interviewing as well as the process for member checking during writing and analysis of the data. Throughout this chapter I use the terms Health Brokers, mentors, and participants to refer to the Multicultural Health Brokers and staff participants I interviewed in the Health Co-op and the term Health Co-op to refer to the MCHB Co-op.

I chose a qualitative instrumental and embedded case study design for my PhD research because it allowed for both thick description and in-depth analysis of the uniqueness and commonalities of a case and the context in which it is situated. The case is the Health Co-op; the embedded mini-cases are the Perinatal Health Outreach and Health for Two programs — which are linked to Alberta Health Services Edmonton Zone Public Health; and the phenomenon under study is the Health Brokers' practice. The case represents an integrated system (Stake, 1995)⁴ that aims to respond to the needs of immigrant and refugee families. Stake (1995) argues that when we have a research question, a puzzlement, a need for general understanding, and feel that we may get insight into the question by studying a particular case, we may call our inquiry an instrumental case study (Stake, 2005b). A case study is both a process of inquiry about the case and the product of that inquiry; I wanted to conduct an instrumental case study because the purpose of the inquiry is to go beyond this case (Stake, 2006). My goal in studying this case is to learn about the uniqueness of Health Co-op and Health Brokers, but also to learn how CHWs are integrated into Canada's public health system of care.

At the beginning of my inquiry, the research design included the analysis of two cases, the MCHB Co-op in Edmonton, and another case in Ottawa. After completion of most data collection for the first case, my thesis committee and I decided that I had enough complexity and analytical data with a single case to successfully fulfil the academic requirements of my PhD program. Following this decision, I informed participants of the second case that I would no longer continue studying their case. They understood the rationale for dropping their case. The change from two cases to a single case did not however, change the instrumental and embedded research design or the nature of the

⁴ Stake' philosophical and methodological approach of case study draws from naturalistic, holistic, ethnographic, phenomenological, and biographic research methods (1995, p.xi). Because no single book can inform all methodological details of how to conduct a rigorous case study, I also consulted authors from these philosophical and methodological traditions (e.g., Denzin and Lincoln 2003, 2005; Glesne 1999) to inform the five research strategies used in my study.

research questions. As explained in figure 2 below, the research strategies sought to answer the study questions by looking at the uniqueness of the case, and also what the data said about the context where the case is situated. In this inquiry, that entailed examining the relationship between the Health Co-op and Health Brokers and Alberta's public health care system in the Edmonton Zone, and the social location of health brokers as part of the health human resources workforce.

Research questions

Given the dearth of information about CHW interventions in Canada and how this work interacts with our public health care system, the questions I investigated were:

How are CHW programs integrated within Canada's formal public systems of care?

How does this integration influence CHWs ability to improve immigrant and refugee women's access to health services?

These main questions were accompanied by set of six sub-questions to provide a broad overview and context for CHW models:

- What CHW models exist, and how are they designed, implemented, and evaluated?
- How can these models contribute to public health workforce development?
- How are these models influencing the diversity of the health systems' labour force?
- How are they influencing the health care systems' competence to respond to demographic changes in Canada?
- How are they addressing the cultural and linguistic health needs of immigrant communities?
- How are knowledge transfer strategies used in getting support for the adoption, implementation, and sustainability of CHW programs within Public Health Units?

CASE STUDY THEORETICAL PROPOSITIONS

Case study theoretical propositions are hypotheses that the researcher holds about the phenomenon under study (Gagnon, 2005), in this case, CHW's integration within Canada's public health care system. Table # 1 illustrates the theoretical propositions I used to guide this instrumental single case study design (Stakes, 1995) and their relationship to the research questions (Yin, 2003a).

Table # 1. Theoretical propositions and their relationship to the research questions

Research Question	Theoretical Proposition
<i>1) How are CHW programs integrated within Canada's formal public systems of care?</i>	<i>Macro level social, historical, political, and economic factors influence the way CHWs are integrated within public health units.</i>
	<i>Public health unit's approaches to health equity and inequities influence the way CHW programs are integrated within their mandates.</i>
<i>2) How does this integration influence CHWs' ability to improve immigrant and refugee women's access to health services?</i>	<i>CHWs and their clients experience health inequities on the basis of many factors — that is, gender, racialized category/ethnicity, disability, sexual orientation, or socio-economic status. These factors hinder or facilitate access to health services by immigrant and refugee women. For example, clients may be reticent to participate in CHW programs if they feel that their cultural health beliefs are ignored by the workers.</i>
	<i>CHWs from racialized backgrounds, who are well compensated, who feel supported and empowered by their employers are more likely to empower other racialized immigrant and refugee communities to be active participants in their own health and in building the capacity of their own communities.</i>
	<i>CHWs who are recognized by other health service providers are well placed to advocate on behalf of immigrant and refugee women for access to health services.</i>
Sub-questions	
<i>1) What CHW models exist, and how are they designed, implemented and evaluated?</i>	<i>CHWs programs exist within a continuum of care that progresses from informal to formal models of care. Informal models that are not fully resourced are less effective in reducing health inequities experienced by immigrant and refugee women from programs that are properly resourced.</i>

2) How can these models contribute to public health workforce development?	<i>CHWs interface between marginalized communities and formal systems of care. In Canada these workers are part of an emerging public health workforce that needs to be recognized and respected by mainstream professional associations and health services providers.</i>
3) How are they influencing the health care systems' competence to respond to demographic changes in Canada?	<i>Culturally-appropriate CHW programs contribute to increasing immigrants and refugees' access to health services by aiding these populations in navigating Canada's health care system and in addressing barriers to access to health. CHW programs also teach health services providers to have a better understanding of the needs of immigrant communities.</i>
4) How are CHW programs influencing the diversity of the health systems' workforce?	<i>CHW programs might lead mainstream health services into believing that they do not need to diversify their workforce because they have multilingual/ethnic CHW workers providing the services at a cheaper rate and through less educated service providers.</i>
5) How are CHW programs addressing the cultural and linguistic health needs of immigrant communities?	<i>CHW programs that are sensitive to the cultural and linguistic needs of immigrant communities value the cultures of these communities. They also develop health education messages that are respectful of these communities' health beliefs, while challenging their health myths/taboo (if any) in a respectful manner.</i>
6) How are knowledge transfer strategies used in getting support for the adoption, implementation, and sustainability of CHW programs within public health units?	<i>Micro-meso-macro forces within public health units have a direct impact on the way CHW programs are adopted, implemented, and sustained. CHWs act as 'knowledge brokers' between the health services providers and immigrant women (Pottie, et al., 2008; Tetroe, 2008 March).</i>
	<i>The strategies and cultural appropriateness used by CHWs to reach out to program users influence these populations' uptake of programs.</i>

I reflect in Chapter 8 how these theoretical propositions were confirmed or disconfirmed by the study findings.

Figure 2 below illustrates the study design and the sources of data to answer the study's main and sub-research questions. Inside the main circle are the five research strategies used for data collection (participant and direct observation, interviews, document review, and analysis of archival records). Between the main circle and the exterior are the embedded mini-cases that are linked to both the Health Co-op and the public health system, through Alberta Health Services (AHS) Edmonton Zone Public Health. The external circles represent the context of the setting in which the case and phenomena are situated. The boxes underneath the circles illustrate the issues that the study seeks to understand (Stake, 2010) as well as indicate the information needed about the work of the Health Co-op and the Health Brokers' practice. The former looks at the broader picture; the latter seeks detailed information.

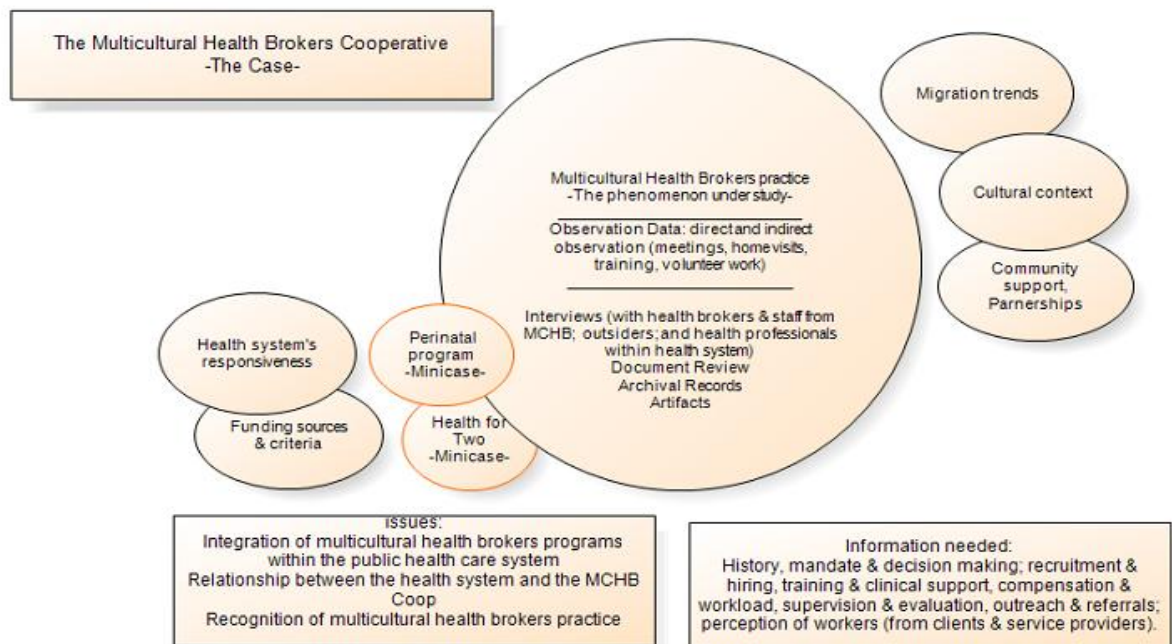


Figure 2. Circle design of the MCHB Co-op's study. Adapted from Stake (2010), Figure 4.5

Because an instrumental case study design aims to go beyond the case, the sources of data from the different research strategies aimed to answer the study questions by being both issue and context-based, and information-based. The issues that I meant to capture involved the integration of Health Brokers programs within the public health care system, the relationship between the health system and the Health Co-op, and the recognition of Health Brokers' practice. The context that the interview guide aimed to capture focused on migration trends to the area, cultural context in which Health Brokers operate, community supports and partnerships available to collaborate with, and ready to assist, immigrant and refugee communities, the health system's response to immigrant communities' needs, and the funding sources for the Health Co-op. The information that I sought focused on: a) the history, mandate, and decision-making of the Health Co-op; b) the recruitment, hiring, training, and clinical support given to Health Brokers; c) the compensation, workload, supervision, and evaluation of Health Brokers and mentors; d) outreach to and referrals of clients; e) sustainability of the Health Broker model; and f) the perceptions about the Health Brokers' role (from themselves program users, and health professionals). Only in the interview schedule for mothers (program users) was information-based and elicited their perspectives on relationships with Health Brokers, eligibility for the program, involvement in program activities, use of community health services, use and comprehension of written, and verbal resource information.

Selection of the Case

Sampling decisions in case study research aim to enable analytical generalization, rather than statistical generalization (Gagnon, 2005; Yin, 2003a). I draw from a purposive sample of cases (Stake, 2005b; Stake, 2006). Because the first criterion in selecting a case should be to maximize what we can learn from it (Stake, 1995) and to understand the phenomenon/program (Creswell, 2007), the selection of the Health Co-op as a case was made under six circumstances:

1) I knew about some of the work of the Health Co-op from the outset of the inquiry (Stake, 2006) because my volunteer immigrant women's organization that reaches out to marginalized Spanish-speaking immigrant and refugee women in Ottawa, Canada had contacted them to seek information about their work; 2) the literature review pointed to Health Brokers as one model that was relevant in understanding the role that CHWs play in addressing health equity for immigrant and refugee women; 3) the relationship that the Health Co-op had with the local public health department had the potential to provide insightful information to answer this study's research questions and sub-questions; 4) the case was "established" enough to presume that it would continue to function throughout the implementation of the inquiry and beyond — which was important because it could allow for further research if needed; 5) the case potentially allowed the inquiry to probe Health Brokers' practice as part of the field of CHWs in Canada (beyond the Health Co-op itself – instrumental design) (Stake, 1995, 2006), and to the development of rich theoretical frameworks (Gagnon, 2005); and 6) the Health Co-op and Health Brokers agreed to participate in the study.

I obtained permission to study the Health Co-op and the Health Brokers' practice after a few months of back-and-forth email and telephone communication, two face-to-face meetings with Health Co-op mentors (managers), and one meeting with the whole membership to present the objectives of the research and the benefits that it would bring to the Health Co-op. Communication with the Health Co-op involved requesting and receiving a letter of support to accompany my application to the Ethics Review Board of the University of Ottawa. The study design also required understanding of the relationship between the Health Co-op and the Health Brokers with AHS Edmonton Zone Public Health — which contracted out the Health Co-op to implement a perinatal outreach program among immigrant and refugee women. For this reason, I sought operational and ethical approval from AHS Ethics Review Board. It took an additional four months of email and telephone contact

and one face-to-face meeting with AHS Edmonton Zone to obtain approval to study the contractual relationship between the Health Co-op and the health unit.

LIMITATIONS OF CASE STUDY RESEARCH

I conducted this case study with the understanding that some authors criticize single case studies because they do not have as compelling and robust evidence as multiple case studies (Gagnon, 2005; Yin, 2003a). Single case study methodologists, however, rebut this argument Stake (1995), indicating that the real business of case study is particularization. The emphasis here is on uniqueness. That implies knowledge of other cases from which the case differs, but the first emphasis is on understanding the case itself (Stake, 1995, p. 8).⁵ In my study of the Health Co-op, my goal is to understand its uniqueness in functioning independently of the health care system, including understanding how it differs from other models that work within the health care system.

Research methodology

TRANSFORMATORY-EMANCIPATORY

I used a Transformatory-Emancipatory research methodology (Denzin & Lincoln, 2003; Mertens, 2003), within the inquiry design because this approach allowed the study to give central importance to the experiences of immigrant and refugee women workers acting as CHWs. The approach calls for understanding that health inequities faced by immigrant and refugee families need to be placed within the political, cultural, historic, and economic contexts that create these inequities. In so doing, I brought to the entire research process a lens focusing on increasing health equity for immigrant and refugee women (Mertens, 2003). As a researcher, I was attuned to two aspects of

⁵ As mentioned above, I dropped the second case for analysis, but I committed myself to make a presentation to their staff on the findings from the data collected on their agency and from my overall study. They also authorized me to write any follow-up articles generated from their data.

the research process: a) the power differentials in the research context (Campbell & Gregor, 2002; Kleinman, 2007; Smith, 1987; Wolf, 1996), for example, the Health Co-op and Health Brokers knew that the findings of my research could potentially expose areas of their work to criticism; and b) the research itself can result in further health inequities if my findings contribute to the dominant discourse presenting immigrant and refugee women as vulnerable victims (Spitzer, 2011), rather than active agents of change. This means that epistemologically, a transformatory-emancipatory approach acknowledged the importance of interaction between the researchers and the participants and required that, as researcher, I develop a level of trust and understanding necessary to accurately represent viewpoints of all research participants fairly (Mertens, 2003).

Methodologically, this approach helped me to have a critical analysis of the biases inherent in the literature reviewed for this study (for instance, depicting immigrant communities as deficient or as a problem to Canadian society) and of the values defining the research problem, through spending time with members of the population of interest to build trust (Mertens, 2003; Rossman & Rallis, 2003).

This study also sought to ameliorate the effects of health inequities by linking the outcomes of this research to activities furthering social action (Kleinman, 2007; Mertens, 2003) and social justice for immigrant and refugee women to Canada. As illustrated in the analytical framework section, this is particularly important because CHWs, like their clients, experience the harsh realities leading to health inequities on the basis of gender, racialized category/ethnicity, disability, sexual orientation, or socio-economic status (Mertens, 2003). For example, with other colleagues, I submitted a proposal to the Canadian Public Health Association (CPHA) to develop a position statement in recognition of CHWs in Canada. In addition, I worked collectively with members of the Health Co-op to give voice to the experiences of immigrant and refugee women served by Health Brokers, and the

Health Brokers themselves through presentations at mainstream conferences and public forums as well as writing various grant proposals to further understand their work and other CHW models in Canada.

Research strategies

I used five research strategies to understand the work of the Health Co-op and the Health Brokers' practice, and the embedded mini-cases (see figure 2). These were: participant and direct observation, face-to-face interviews, document review, examination of archival records and artifacts. See *Appendix 5: Summary Table of Included Literature - Methodological sources*.

PARTICIPANT OBSERVATION

Participant observation activities consisted of observing activities within the setting. Stake (1995) argues that in addition to identification of variables and the development of instruments, qualitative research is about emphasis on “placing an interpreter in the field to observe the workings of the case, one who records... what is happening but simultaneously examines its meaning and redirects observation to refine or substantiate those meanings” (pp. 8-9). The first step in observing the setting was developing trust with Health Brokers and mentors. In field research this is called “entry” because participants need to be willing to open the doors to let you in. The literature indicates that trust is important because entry cannot be taken for granted and has to be continuously negotiated throughout the research (Bailey, 1996; Lofland & Lofland, 1995). As a researcher, I was an outsider trying to get to know the case well (Stake, 1995). When I first entered the Health Co-op, and each time that I went back to the site, I always felt that I needed to reconnect and be clear with participants why I was at the setting and why I had not yet completed my study. I would always say, “I do not have a full understanding of your work yet, so I have to keep coming back until I do...” Due

to the multi-ethnic diversity in the organization, remembering people's names was, at the beginning, one of the hardest things to do. This became easier as I interacted with people. As a person, I always felt at home when I was at the setting. As an observer in the field, I attended regular and special meetings that included workshops, home visits, and training sessions. I wrote 75 entries on participant observation activities covering approximately 158 hours.

DIRECT OBSERVATION

Direct observation allowed me to do volunteer work for the Health Co-op by implementing tasks the Executive Director assigned to me. The goal of spending time in the setting was to gain a better understanding of the work (Glesne, 1999) that the Health Co-op and Health Brokers did as well as the social relations embedded in the setting (Lofland & Lofland, 1995). In chapters 4, 5, and 6, I integrate my observations with other data to make some assertions about the case (Stake, 2006). I recorded 12 direct observation entries, documenting activities lasting approximately 147 hours.

In both participant and direct observation activities I spent approximately 46 days observing the setting over an 18-month period (May 2009 to November 2010). The reasons for spreading out my site visits were academic and personal commitments, which forced me to travel seven times between my city (Ottawa) and Edmonton, where the case was located. The *transformatory-emancipatory* approach to the study, however, ensured that I kept in constant communication with the case between site visits and well beyond the data collection period (see member checking section for details).

I attended a total of 87 activities in which I invested a total of 304 hours. See *Appendices 6, 7, 8, and 9 Observation protocols*. In addition, I undertook participant observation activities for the Health for

Two program (training and network meetings) organized by AHS Edmonton Zone Public Health. These included seven activities (n=7) for approximately 18 hours (n=18). I did not do direct observation (volunteer work) with AHS Edmonton Zone because it was not manageable within the scope of the study. In conclusion, between the Health Co-op and AHS Edmonton Zone, I attended 94 participant and direct observation activities, which represent a total of 322 hours or approximately 46 days. See *Appendices 10 and 11: Table # 1 Summary of participant and direct observation activities at the Health Co-op, and Table # 2 Participant observation activities organized by the public health unit.*

FACE-TO-FACE IN-DEPTH INTERVIEWS

SAMPLING

Participants were purposefully selected, using a semi-stratified network sampling approach (Yin, 2003ab). The “strata” (Smith, 2004) were program mentors (managers), Health Brokers, clients, and health professionals within the setting. Participants within each stratum, except for program users, were recruited, using a snow-ball purposive sampling technique. This technique entails canvassing suggestions from participants for additional participants, and building a sample in this way until data saturation is reached. This technique was used because according to Berg (2001), it is sometimes the “the best way to locate subjects with certain attributes or characteristics necessary in a study” (Berg, 2001, p. 33). Program users were recruited through the Health Brokers because I did not have direct access to clients. The different sources of data allowed triangulation of different perspectives (such as workers, program users, funders) on the role that Health Brokers play in improving access to health services by immigrant and refugee women. Outsiders, individuals familiar with the work of the Health Co-op and Health Brokers, were added as a further stratum. I completed a total of 44 face-to-face interviews over the 18-month period. All interviews were guided by a semi-structured

interview schedule (*Appendices 12, 13, 14, and 15: Key Informant interview guides*). The first four (n=4) interviews with Health Brokers and mentors were pilots to test the interview schedule and obtain participants' feedback on the content of the instruments. The remaining 40 interviews were completed as follows: *Health Brokers* and *mentors* (n=16); immigrant and refugee *mothers* using perinatal services (n=10); *health professionals* within the mainstream health system (n=7); and *outsiders* to the organization but who knew about the work of the Health Brokers (n=8). I conducted 35 interviews in English, four in Spanish, and three in French. Two interviews with *mothers* were conducted with the help of an interpreter because I did not speak the mother's native language and they did not know English, French, or Spanish.

OBTAINING CONSENT

I prepared letters of invitation for Health Brokers, mentors, and women, using the perinatal program (clients) explaining the study. Consent for Health Brokers and mentors interviewed happened in two ways: first, I presented the objectives of my research to a membership meeting of the Health Co-op. At this meeting, people were asked to raise their hands if they wanted to be interviewed. A couple of people did, but I did not gather names at the meeting to protect confidentiality of participants; and second, I approached Health Brokers and mentors directly to see if they wanted to be interviewed. Some people said "yes" right away, others asked me to contact them later, and at least one person said "no" because of lack of time. Although I was doing participant observation at the Health Co-op, it took some time before I could start the interviews. The reasons were twofold. First, I expected people to approach me to be interviewed, but that was not the case. One time, the Executive Director asked me if I was being approached for interviews, I said "no", so she offered to send a message to the membership encouraging them to speak with me. I accepted her offer, but told her that participants should feel free to speak with me or not. If

the ED sent the message, I did not notice a surge in interest in people approaching me. Second, I felt I needed to gain people's trust before inviting them to be interviewed, so I continued attending activities to have the opportunity to meet Health Brokers and mentors and gain their trust. Unless it was not possible, and to protect confidentiality, I interviewed most Health Brokers and mentors outside the Health Co-op, including in their homes, in restaurants, and in the place where I was staying. Three interviews were also conducted by telephone.

Obtaining consent from women who received services also happened in two stages. First, I had to ask Health Brokers to find participants who might be willing to speak with me because I had no direct contact with their clients; and second, if women agreed, the Health Brokers gave me their contact information and I then followed up to arrange a convenient time and location for the women. All these interviews were conducted in the women's homes. I protected the women's confidentiality from the Health Brokers by not mentioning the results of my conversations with the women. Also, in writing this dissertation I did not mention the country of origin or any specific details about the women that may allow the individual Health Broker to identify the client.

Obtaining consent from health professionals also happened in two phases. The Health Co-op suggested some names of people in AHS Edmonton Zone who knew about the work of the Health Co-op. Then, I contacted these health professionals, and if they agreed to being interviewed, I arranged times and locations for the interviews. I interviewed these participants at their work, or in work-related settings, except for one health professional who preferred to be interviewed by phone and one who came to the building where I was staying. In all interviews, I explained or read in full the consent forms and gave interviewees some time to read the materials on their own. I had two copies of consent forms, one my records and one for their records.

Obtaining consent from outsiders was more informal because it was based on verbal agreement or informal communication. I met outsiders at meetings of the Health Co-op or through another participant suggesting that I interview them. These interviews happened organically as most of these participants offered to share their knowledge with me. Because these participants were outside the Health Co-op or the Health system, I did not feel the need to have them sign consent forms. I did, however, ask them if I could audio-tape their interviews for my records, and all gave verbal consent. The content of these interviews informed my research, but I am not including these findings as a separate section of my dissertation.

TRANSCRIPTION OF INTERVIEWS AND NOTE TAKING

The vast majority of participants agreed to be audio-recorded during interviews, therefore I took minimal notes. Three participants (two *mothers* and one *Health Broker*) did not agree to audio-recording; and as a result, I took extensive notes during these interviews. I had funding to hire trained help to transcribe 32 out of the 41 interviews recorded. The remaining nine interviews (six *outsiders* and three *Health Brokers*) were not transcribed, but I listened to the interviews repeatedly and took extensive notes. The content of these interviews is also part of the findings reported in Chapters 5, 6, and 7. In-depth interviews with *Health Brokers and mentors* as well as with *health professionals* lasted between 51 minutes and just under two hours. The exception was one *Health Broker* interview which lasted about 38 minutes because something else came up in her schedule and we could not reschedule afterwards. One *health professional* from AHS was interviewed twice at the beginning of the research and twice at the end of the project, as part of member checking. Similarly, one *mentor* at the Health Co-op was interviewed twice during the pilot test and three times at the end of the project, to validate the findings. Two other *mentors* at the Health Co-op were interviewed twice during the project, as were two *Health Brokers* who participated in the pilot

test. The other thirteen *Health Brokers* were interviewed once only. In total, 38 participants were interviewed only once. The reason for this was the limited time and resources available to me as a researcher and to them as participants. The majority of interviews with *outsiders* who knew the work of the Health Brokers and *mothers* using perinatal services lasted under one hour, with the exception of one *outsider* who spoke with me for almost two hours.

PILOT TESTING AND INTERVIEWING

I used an interview guide for all interviews. During the pilot interviews I tried to ask as many questions as possible, but this led to interviews being too long. For the remaining interviewees I did not attempt to cover all the interview schedule questions, but rather focused on key areas dealing with issues, context or information about the work of Health Brokers. As explained above, see figure 2, most interview schedules (except for program users) were both issue- and context-based, and information-based. At face-to-face interviews, participants completed a demographic questionnaire (personal information form PIF) that allowed me to understand the background of participants. See *Appendix 16*. Note that I did not ask *outsiders* to complete PIFs because their interviews happened spontaneously as I met them in participant or direct observation activities and they offered or agreed to give me details about their knowledge of the work of the Health-Coop or Health Brokers. Interviews with outsiders provided contextual background on the work of the Health Co-op and Health Brokers.

DOCUMENT REVIEW

I reviewed documents from both the Health Co-op and AHS Edmonton Zone in parallel with the other research strategies. My focus during the review of the Health Co-op documents was on understanding the historical and contextual factors influencing the structure of the Health Co-op and the Health Brokers' practice. The documents reviewed included: policy and procedures

manuals; formal studies of the organization's programs; guiding principles in relation to the cultural competency approach and human resources practices; project reports; and, databases of Health Brokers' caseloads with statistics. The documents I reviewed from AHS Edmonton Zone Public Health included: Annual Reports of the Perinatal Outreach program funded through the Health Co-op from 2004 to 2010; training modules for the Health for Two program; handouts to be given by the Health Brokers to the women users of the program; strategic plans for the Health for Two program. I received numerous materials in hard copy, a good number of documents via email, and others I found through internet searches. I reviewed some documents on site, but the majority were done at my home office. See *Appendix 17: Research techniques data sources*.

ARCHIVAL DATA

HEALTH BROKERS CASELOAD DATABASE

I received the data on the caseloads of 46 Health Brokers and some mentors (entailing 3,442 clients) from the Health Co-op as a Microsoft Word document. I requested the data in its original software format, but this was not possible at the time. This meant that in order to analyze the data, I had to transfer it into Excel via Notepad. This part of the research was very labour intensive, so I sought support from three individuals who were knowledgeable with Excel to help me complete the formatting and analysis of this caseload database.

The process to transfer the data from word format into Excel was as follows: extraneous data was discarded after relevant data (information pertaining to 10 key fields) was consolidated.

Consolidation entailed moving data from the latter parts of entries into the main record line. Errors were detected through visual review of the data at various stages of the transfer. The records were then formatted as comma separated values (CSV). The fields used were Last Name, First Name,

Client Number, Address, Phone number, Country, Community, Activity, Start Date, and End Date. Of these, Last Name, First Name, Address, and Phone Number were dropped during analysis to ensure anonymity. The data for the six remaining fields was transferred electronically to a separate spreadsheet. Data in the Start Date and End Dates fields had to be refined electronically before it was transferred to the second spreadsheet. This refinement was required because some dates were in text format and needed to be converted into date format in Excel.

In this new MS Excel file the Data Filter feature was used to create a list of all values in the Country, Community, and Activity fields. An edit was then done to eliminate inconsistent usage (for example, the same activity was spelled two slightly different ways) and replace data lost through transfer. This was done by visual inspection of the original MS Word data document. The client number was then made unrecognizable by electronically transforming some of the characters. The dates were then scanned for End Dates that were earlier than Start Dates. Errors in End Dates were corrected where possible, (by visual inspection of the original MS Word data document) but in cases of data entry mistakes or failure to enter dates the field could not be analyzed.

Data Limitations: In a small number of cases, flaws in the data were evident during formatting or analysis. Actual or potential corruption of data for the following reasons was identified: a) Health Broker data entry error for background information or related to service provided (typos or incomplete entries); b) different clients having the same Client Number (misallocation of an existing client number); c) different client numbers for the same individual owing to working with different Health Brokers (duplication across workers); and d) different client numbers for the same individual with different activities (duplication across activities). I discuss, in Chapter 7, the measures that the

Health Co-op took to address these errors. I have used Health Brokers' caseloads numbers and percentages based on this database and my analysis of it throughout the dissertation.

THE CHOICE OF PSEUDONYMS

I chose to use the names of flowers and plants as pseudonyms for the majority of study participants who struck me as highly dedicated to their work and, in my view, these names were the best way for me to show this commitment. The choice of pseudonyms might sound strange to the readers, but I also felt that using names of flowers and plants had a calming effect on me during coding and data analysis, especially when face-to-face interview data revealed difficult situations experienced by Health Brokers or their clients.

CODING AND ANALYSIS

I used QSR Nvivo8 Qualitative Data Management software program to manage most of my qualitative interview data. I created one single project folder for my thesis. Then, I imported all transcripts into the internal "sources" file. I designed one codebook for the Health Brokers and mentors interview transcripts, and another codebook for the health professionals' interviews. I coded all interviews by themes generated from the data and I created the codebook's "three nodes" interactively as I coded the interviews. I created "parent tree nodes" to reflect a major theme, for example, the role played by health professionals in the formation of the Health Co-op and "children three nodes" to elaborate what the health professionals did in this role, such as being champions within the system who promoted the Health Broker model. Because I conducted the study in different phases over 18 months and I travelled to the research site for each stage, it was impossible for me to code interviews in Nvivo8 right after completing them or receiving the transcripts. Although I read most of the interviews, took notes, and coded them in hard copy, after receiving the transcripts, sometimes it took a long time before I coded them in Nvivo8. Therefore, when coding in

Nvivo8, I had to re-listen to the digital recordings. This parallel process became the best way for me to capture the tone of voice of participants. In most cases, participants' voices reflected passion for their work, at other times they reflected frustration or resentment at a particular situation they considered unfair.

I wrote detailed descriptions in the tree node properties' interface to remind me what the codes were about, and I also wrote extensive memos of my analytical thoughts generated by the data. These memos later became the central source for my analysis and writing of the dissertation. I also used the QSR models function to provide visual representations of the data, which I have included in several chapters in the dissertation. I conducted 20 interviews of Health Brokers and mentors, but I decided to code in detail in Nvivo8 only nine (n=9), which I considered to be the best sources of data and insight knowledge of the Health Brokers and of the Health Brokers' practice. I read transcripts and re-listened carefully to the remainder eleven interviews (n=11), coded them by hand and took extensive notes to make sure that I did not miss any important elements these participants might have raised, and selected quotes to illustrate the findings from all interviews. I also did text queries of all interviews if I needed to corroborate findings and to ensure accuracy in my descriptions of the findings. My methodological choice of not coding, in Nvivo8, eleven of the interviews was based on hand-coding of these interviews being enough to incorporate their findings in my study. I paid attention in all interviews for negative cases (disconfirming cases). These strategies ensured that the data "depicted the reality" (Silverman, 2003) of the life of the organization and the day-to-day work of Health Brokers. Chapter 5 and Chapter 7 reflect the findings from interviews with Health Brokers and mentors. Next, I coded all seven (n=7) interviews with health professionals, including six with AHS staff and one with a former staff member. Findings from interviews with health professionals are reflected in Chapter 6.

THEORETICAL TRIANGULATION

I discussed above the multiple methods (research techniques and data sources) or triangulation (Berg, 2001; Denzin & Lincoln, 2003), which I used in an attempt to secure in-depth understanding of the case, the embedded mini-cases and the phenomenon. I also used theoretical triangulation (Berg, 2001), which means incorporating various overarching theories or multiple theoretical lenses to interpret the research findings at various stages of the data analysis of my study. I felt the need to use multiple theories (feminist political economy; authoritative and experiential knowledge; agency and relational autonomy; and feminist urban citizenship) in order to better explain the particularity and complexity (Stake, 1995) of the work of the Health Co-op and Health Brokers.

FIELD NOTES

Field notes are the backbone of collecting and analyzing field data (Bailey, 1996; Glesne, 1999; Lofland & Lofland, 1995). I used field notes to systematically document the study for most of the research process. Field notes included mental notes (when it was not prudent for me to write in front of the participants). For example, in my first meetings with Health Brokers, I noticed them looking at me each time I wrote something, so I decided not to write in front of them. In this case, I jotted notes (in private or in public when I was travelling from one interview or meeting to another). I always attempted to write full field notes (Lofland & Lofland, 1995), especially at the beginning of the participant observation activities (when there was less demand on my time at the research site). It was more difficult to write full notes towards the end of the study because I was undertaking many more tasks. This meant that I was invited to participate in more and more meetings or do particular tasks for the Health Co-op at or after these meetings. This consumed the time I would have otherwise had to prepare field notes. My observation notes, however, are descriptive and analytic. Among the activities these notes detail are interactions between mentors and Health

Brokers and dealings between the Health Co-op and the public health unit. I strove for accuracy, while avoiding being judgmental (Glesne, 1999).

ENSURING SCIENTIFIC QUALITY/TRUSTWORTHINESS

Because I chose a transformatory-emancipatory approach for this research, I made sure that participants had the opportunity to give me plenty of feedback on the findings. I conducted several member checking activities (B. Johnson & Turner, 2003; Olesen, 2005) with the Health Co-op and Health Brokers. I also applied critical reflexivity (Olesen, 2005; Wolf, 1996), which in this context is particularly important in articulating voices of the Health Brokers, women using the programs, and health professionals without exploiting or distorting them (Mertens, 2003; Olesen, 2005). Glesne (1999) argues that researcher credibility influences confidence in the truth of data. I have an audit trail (Olesen, 2005; Stake, 2006; Yin, 2003b) of how I moved from the interview data, to coding of the interviews, memos and analysis and the writing of the main findings, which I present in Chapters 5-7. I used critical reflexivity by writing in my field notes observations that triggered any feelings about my personal experiences as a racialized immigrant woman trying to access health services, and as a former CHW advocating on behalf of immigrant women accessing health services. I shared with Health Brokers and mentors and health professionals my own experiences as a former CHW trying to work for health service access for women. As well, I am clear in the dissertation on the rationale of the theories that underlie the theoretical framework of the study.

MEMBER CHECKING

Stake (1995) refers to member checking as the actor being requested “to examine rough drafts of writing where the actions or words of the actor are featured, sometimes when first written up but usually when no further data will be collected from him or her” (p. 115). I received oral and written feedback from Health Co-op participants in two phases: After the first phase I met with them as a

group to discuss preliminary findings eight months after the beginning of data collection (February 2010); this was followed by two one-on-one meetings with one mentor (September 17 and 18, 2010). I met them as a group a second time (August 2011), followed by three consecutive group telephone meetings in September and December 2011 and in January 2012. For the December meeting, participants had received the drafts of two of the dissertation chapters, which focused on the work of the Health Co-op and the Health Brokers' practice.

The second phase consisted in sending the individual interview transcripts to 15 out of 20 participants. I was unable to contact five of the 20 Health Brokers and mentors as a result of timing and owing to personal limitations. For example, one participant had left the organization when I wanted to contact her, and I was so overwhelmed with my work that by the time I noticed I had not contacted the other four participants, I felt that it was too late to do so. On the other hand, because I conducted several member-checking activities as a group, I felt that at least two participants of the four had had the opportunity to give feedback on the findings in that way. Of the 15 participants whom I contacted, thirteen received the transcript by email and two in person. From the individual transcripts, I received communication from seven people as follows: three participants gave me oral feedback: the first one asked that I nuance her comments because she did not want to sound as critical as she did, the second participant had just one question for clarification and the third person found that she could not understand the interview. In part this was because I had used pseudonyms for all participants and organizations mentioned, so she found it hard to follow the transcript. She asked me if I had understood the interview, and I told her that I had, which was the case. Three other people promised to send feedback, but never did. One more person approved the transcript as received. The other eight people did not respond at all. At the time of the interviews, most participants indicated a desire to see the transcripts, but I expect that their busy schedules limited

their ability to answer my request. Several participants did not respond to me at the individual level, but attended the member-checking activities in group sessions.

The first member checking session as a group, which focused on the internal capacity of the organization, provided lively feedback. At this meeting (February 2010), participants responded strongly to findings that might be perceived as negative about of the Health Co-op's capacity and explained the contextual aspects of these challenges. One person said after the meeting that although the comments sounded negative, they helped to improve the Health Co-op's work. Another participant later wrote to me indicating that the feedback was meant "to help others understand the context of why things are the way there are, and what we have tried, but [that we have not yet been] able to find better approaches." (Personal communication) Member checking meeting number two (August 2011) focused on the work that Health Brokers do and how women see the work of the Health Brokers. My findings discussed at this meeting were well received. I felt, however, that my analysis in one area (homebirth versus hospital birth) did not reflect the reality of the women. Input from the telephone meeting in September was positive, but I was challenged to explain in what way the Health Co-op and Health Brokers would gain from my study. During the telephone meeting held in December, I reviewed section by section the findings for Chapter 5, except for one last section, which was postponed for review at a new meeting in January 2012. I learned from the group that they were happy with the way I described the Health Co-op, but they were concerned about the description of some issues, that, although true to their work, would make the organization look bad. We reached a compromise in which I agreed to add a preamble to the findings to indicate that the issues they face are inherent to the work of a health worker co-operative and that other organizations might face the same challenges in similar circumstances. I also agreed to make some other comments more nuanced.

There were two final member-checking activities with the Health Co-op in January 2012. These included one small meeting on January 6, which was in preparation for a larger meeting on January 18, but also provided feedback in-and-of-itself. In the first meeting I learned more about the final changes to the Health Co-op's family intervention program, which I used to revise that section of my thesis. In the second meeting participants confirmed their agreement that I, as a researcher, had to highlight the good aspects of their work but also had to be critical if there were elements of their activities that could be improved. They agreed that they wanted other CHW groups to learn from their experience. Given this, it was important to provide detailed accounts of both the successes and challenges of the work.

In regard to member checking with health professionals, I had four meetings with one of the participants to verify findings (two meetings in person and two by telephone). I received descriptive comments on the accuracy of the facts presented about the role of the health system and comments on my analytical perspective. This participant agreed with some parts of my analysis but disagreed with others. Overall, owing to time constraints, I consulted with only two out of seven participants interviewed, one of whom did not provide any feedback after the initial contact.

As with the Health Co-op and Health Brokers, the health professional who provided extensive feedback, and I agreed that I should provide a positive account on the areas that are promising, but that I should be critical of the areas that need improvement. I provide details on these interactions in Chapter 5.

Overall, I had very cordial and friendly discussions with Health Brokers and mentors as well as with health professionals.

METHODOLOGICAL STRENGTHS AND DRAWBACKS

A strength of my methodological approach is that I completed the inquiry over a period of 18 months, which gave me the time to understand how the different elements of the case, embedded mini-cases and phenomenon changed over time. In addition, I was able to conduct all member checking activities over a similar time period giving longitudinal relevance to my understanding of the case.

A drawback of the case study is, being an out of town researcher, there was not much opportunity to attend Health Brokers' activities where I could be in direct contact with women users of programs and develop trust with them in order to recruit participants for interviews. This meant that the women recruited were those selected and invited by Health Brokers to participate in my research. The limitation here lies in that Health Brokers might have recommended women with whom they had successful relationships and would therefore speak positively about their work. On the other hand, one woman interviewed was not shy about criticizing her Health Broker for not having been able to obtain the support she sought, raising questions about how significant an issue my being from out-of-town was.

CRITICAL REFLEXIVITY

As a former CHW, an activist, and an aspiring academic who believes in the transformatory-emancipatory nature of research, I felt during my study pulled between my activism and my need to be an unbiased scholar (Ogilvie, et al., 2008). The former caused me to empathize with the positive aspects of the work of the Health Co-op and Health Brokers and to be angered about the inequities I

encountered; the latter compelled me to restrict myself to empirical documentation of interactions or interventions even where it appeared no amount of effort would resolve or improve the situation. I remember sharing these thoughts with my thesis committee members and being reminded that it was normal to feel that way, but that in my role as a researcher I ought to be able to present the findings in a way that was both supportive and critical. I remember later sharing this notion with participants so they were clear that I had to be supportive of their work but also critical where criticism was warranted. On the other hand, I also felt that as I was doing research about marginalized populations being served by workers who are themselves outside the mainstream, I did not want my findings to create further marginalization of either clients or workers. This is why the findings of my study, while critical of some aspects of the Health Co-op's operations and the Health Brokers' practice, focuses on the strengths rather than on the weaknesses of the work.

Chapter 5

The Multicultural Health Brokers Co-operative: The Case

Targeting health equity by integrating theory, practice, and democratic principles

In May 2009, I entered the Health Co-op office for the first time. At this place, an old house turned into an office, I felt as if I had entered a United Nations building. I found myself in the middle of women (and a few men) of all ages from many parts of the world: East and West Africa, East and South Asia, Latin America, the Caribbean, the Middle-East, Northern Europe and North America. I saw small groups of people meeting in different corners of a large and long space, which could have been the main living room of the original house. They carried on their meetings in low voices, which at times sounded like whispers, because no one wanted to interrupt another group's meeting. The Multicultural Health Brokers work daily with immigrants and refugees from approximately 80 countries, speaking 29 different languages categorized in 18 different ethno-specific communities. I have worked all my life with Latin Americans and other immigrants in Canada, but never with people of such diverse cultures and so many language backgrounds in the same room striving towards the same common goal. In this case, the Multicultural Health Brokers' goal was a social purpose: to attain optimum health, equity, and social justice for immigrants and refugees and to guarantee meaningful employment for its members. This fascinated me.

A holistic approach

The Multicultural Health Brokers Co-op (MCHB Co-op) and Multicultural Health Brokers assert that they are building a different practice and vision to address the adaptation, settlement, and integration of immigrants and refugees into Canadian society, but are they? The MCHB Co-op sees itself as an organization with a holistic approach to helping immigrant and refugee women and their families. This means that the MCHB Co-op and the Multicultural Health Brokers do not just concentrate on a single presenting problem, for example, pregnant women at risk of having low birth weight babies, but they also attempt to tackle any related problems impacting women, such as lack of housing, food insecurity, and isolation to maximize the long range chances for these women

and their families' health and wellbeing. According to the Dictionary of Public Health Last (2007), the concept of holism implies that "the properties of the parts are influenced or determined by their relationship to the whole entity" (Last, 2007, p. 168). This chapter centres on the MCHB Co-op's work because the Multicultural Health Brokers' work is shaped by their membership to the MCHB Co-op. In addition, the worker co-operative structure facilitates the organization's ability to function independently of the health and social services systems so that it can work towards fulfilling its social goal of achieving optimum health, equity, and social justice for immigrant and refugee women.

According to study participants, the Health Brokers needed to have an independent organization in order to implement a holistic pre-natal and post-natal program grounded in the needs of immigrant and refugee women and their families, and not limited by Alberta Health Services (AHS) Edmonton Zone's guidelines. When the Health Co-op was established, the health unit was only interested in supporting pre-natal work, which the Health Brokers knew was not enough to address post-natal and other needs of immigrant and refugee women. As well, the Health Brokers and the health unit had developed a relationship of trust, which was a prerequisite for moving from discrete contracts with six individual Health Brokers to a Health Co-op administered single omnibus contract. This health contract was the crucial start-up capital in the organization's initial phase and allowed the Health Co-op to develop its market niche of culturally- and linguistically-appropriate services. In addition, this contract provided the relatively stable funding from which the Health Co-op applied to other funders, such as social and youth services ministries to meet other needs identified by Health Brokers and immigrant and refugee communities.

I provide a thick description and thorough analysis of the case as an integrated system by exploring the complexities and contradictions that the Health Co-op and Health Brokers experience in applying a holistic approach to their work. Some of the complexities and contradictions are internal, such as those relating to articulating and sustaining Health Brokers' practice, others are external, such as the lack of secure funding. I address these complexities and contradictions by answering the study's main research questions: how the Multicultural Health Brokers' practice is integrated within Canada's formal public systems of care and how this integration influences the ability of these workers to address health equity of immigrant and refugee women.

HOW THIS CHAPTER IS ORGANIZED

I organize this chapter in four sections. First, I describe the gender composition of the Health Co-op members and workers (non-members). Then I present three aspects of the holistic work of the Health Co-op and Health Brokers' practice. Dividing these findings into three parts risks fragmenting their work, but this is helpful in providing the necessary thick description (Flyvbjerg, 2001; Stake, 2005a) of this work. The three elements encompassing the Health Co-op's holistic work are: a) developing a market niche by implementing culturally- and linguistically-appropriate programming; b) enhancing the internal capacity of the organization; and c) articulating and sustaining the Health Brokers' practice. Here I illustrate that the Health Co-op's programming and Health Brokers' practice are complex, with all three elements having to grow in parallel. This means that while the Health Co-op develops and builds its internal capacity, the Health Brokers have to develop and strengthen their skills to respond to needs of their clients as well as the pressures from the health and social services systems. Second, I discuss and theorize that the Health Co-op and Health Brokers in assisting in the adaptation, settlement, and integration of immigrant and refugee women into Canadian society are building a different type of practice that contributes to feminist urban

citizenship. Third, I reflect on how my personal background as a researcher influenced the way I analyzed the findings. And finally, I conclude this chapter by highlighting the relevance of the work of the Health Co-op for CHWs, policy makers, researchers and academics as well as community-based organizations interested in addressing health equity for marginalized populations including immigrant and refugee communities.

GENDER COMPOSITION OF HEALTH CO-OP MEMBERS AND WORKERS

In 2012, the Health Co-op has 54 members and workers (non-members), who carry out its programs, the vast majority of whom are Health Brokers. Of the 54 members and workers five are male Health Brokers. The predominance of women in the Health Co-op can be explained by two factors: first, the Health Co-op was created to work in perinatal health outreach, which is traditionally a female occupation; and second, as the number of programs in the organization has grown, the Health Co-op has attempted to recruit male Health Brokers, but in the words of one participant, “it has been hard to recruit and retain” them. At the June 2012 Annual General Meeting, which I attended, the Health Co-op proudly announced that fourteen years after its creation, they had five male Health Brokers. From my participant observation activities I noticed that male Health Brokers were mainly involved the youth programs and in the New Canadian Health Clinic, which I describe below:

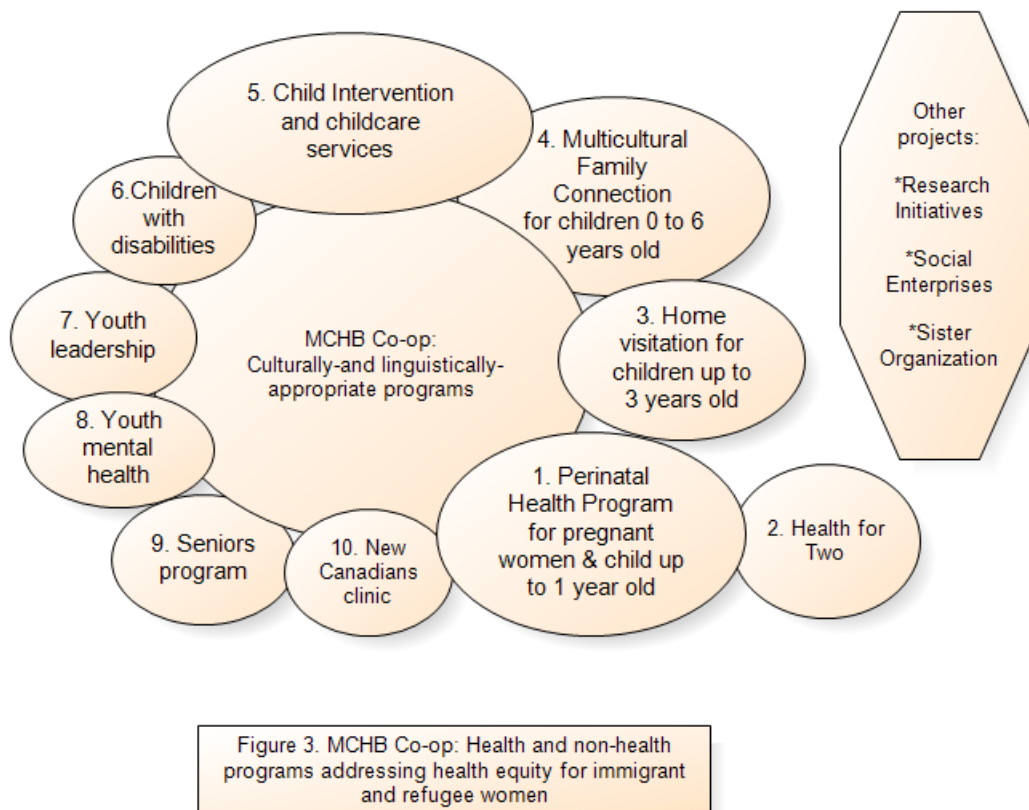
a) Developing a market niche

The Health Co-op and Health Brokers’ holistic work centres on developing and implementing ten culturally- and linguistically-appropriate programs, participating in research initiatives, creating small social enterprises, and establishing a sister organization with charitable status. The Health Co-

op and Health Brokers believed that the problems experienced by immigrant and refugee women and their families should not be confined to silos; instead they understood that individual problems interacted to create situations of vulnerability for these populations. At the beginning, the Health Brokers' main work and funding focused on providing perinatal health education and support for immigrant women. As the Health Brokers interacted with women and their families and developed trusting relationships within communities, they uncovered families struggling with inadequate income, poor housing, mental health issues, or family problems, including intergenerational conflict. The Health Brokers learned that they had to help women deal with those problems before mothers were able to turn their full attention to perinatal health or other health issues. The literature also corroborates this finding (Jack, et al., 2002). In addition, Health Brokers found that some mothers had children with disabilities, and in several cases, there was family violence, such as child abuse. These types of problems forced Health Brokers to support families for a number of years, in various areas — not only in perinatal health.

According to participants, in the early-2000s two other factors changed the scope of Health Brokers' work; a high influx of international refugees and internal displacement of immigrants and refugees from other parts of Canada looking for jobs in the province's booming economy. These factors dramatically changed the scope of demands for all health and social services, placing pressure on Health Brokers' services and support for newly-arrived communities. As a result, the Health Co-op invested a considerable amount of time and resources in writing funding proposals and working collaboratively with other organizations to create new programs to respond to the emerging needs of the new arrivals. These efforts produced significant results. For example, the Health Co-op's revenue for 2008-2009 fiscal year reached 2.1 million dollars. Figure 3 provides an overall view of

the ten programs and other projects undertaken by the Health Co-op. The oval shapes represent their core health and non-health programs. The octagonal shape represents other projects undertaken by the Health Co-op to both document the needs of immigrant and refugee women and communities and to create alternative funding generation activities.



HEALTH CO-OP'S PROGRAMS SUMMARY

Data for this summary came from two sources: the first is a narrative report of the 2009-2010 Health Co-op's projects (MCHB Co-op, 2010pr), and the second is the Health Brokers' caseload database for the twelve month period between September 2009 and September 2010 (MCHB Co-op, 2010db). The database contains the caseloads of 46 Health Brokers (and some mentors), totalling 3,442 clients over that time period. Tables 2 to 6 summarize the ten programs.

The first two programs are the Perinatal Outreach and Support and the Health for Two programs. These provide health education as well as support for immigrant and refugee mothers who are having a child for the first time or a first child born in Canada.

Table # 2. Perinatal outreach programs

#	Program	Description	Population & Funding
1	Perinatal Outreach and Support	This program provides ongoing perinatal support to immigrant and refugee women and their families. The Health Brokers' practice supports ten percent of births in Edmonton. See Chapter 5.	Funded since 1997 by Alberta Health Services. The 2009-2010 contract was \$317,502.56, with yearly renewal. This represents 50 percent of all Health Brokers' caseloads. See Chapter 6.
2	Health for Two	The Perinatal program is supplemented by this in-kind program, which supplies milk coupons and vitamins to pregnant mothers who are at risk of low birth weight or pre-term births. Mothers receive support from this program until the baby is two months old.	This program is run by Alberta Health Services in coordination with 35 community-based organizations. This program is funded by the Public Health Agency of Canada's Perinatal Nutrition Program (CPNP). Fourteen percent of the Health Brokers' caseload is invested in this program. See Chapter 5.

The third and fourth programs target pregnant women and new mothers experiencing harsh social and economic circumstances who contact the Health Co-op for perinatal support. These women are registered for the intense Home Visitation or the Multifamily Connections program. These programs target families with children zero to six years old facing complex situations, which put the health of a child at risk. One mentor explained the connection between these two programs as follows: "...so both programs are to work with families who have children under the age of six... And the target in these programs is the child who is under the age of six..., but the primary client is, the mother... So we work with the mother, we work with the child to ensure... at the end of the day to ensure the wellbeing of the child..." (Geranium). A fifth, somewhat distinctive program also falls with this

category. The Intervention Support program targets situation where children are experiencing violence or neglect.

Table # 3. Home visitation and parenting programs

#	Program	Description	Population & Funding
3	Culturally Responsive Home Visitation Program	Intense home visitation involves holistic family support, early parenting, and early childhood development support for families over a long period of time (up to three years).	Started in 2002. The 2009-2010 contract was \$224,148, with yearly renewal. Five percent of all Health Brokers' caseload falls within this program.
4	The Multicultural Family Connection	This program focuses on providing early parenting and early childhood development support for families with children zero to six who are experiencing complex situations that put the health of the child at risk.	Started in 2004. The 2009-2010 contract was \$216,360, with yearly renewal. Thirteen percent of all Health Brokers' caseload falls within this program.
5	Intervention Support and Childcare Services	This programs targets refugee and immigrant families in crisis, where child welfare authorities have been called as a result of family violence involving children or child neglect. The purpose of this program is to provide help so that families understand how to navigate the range of childcare services available in the city and to explore culturally-affirming practices with the daycare sector.	This program started in 2008. The 2009-2010 contract was for \$384,480. Renewal was not guaranteed at the time of this research, but I learned in my data validation sessions that it was indeed renewed. Four percent of the all Health Brokers' caseload falls within this program. See Chapter 6

The sixth and seven programs focus on Health Brokers' work with women and other family members, including children with disabilities and seniors.

Table # 4. Children and seniors' programs

#	Program	Description	Population & funding
6	Multicultural Family Support for Children with Disabilities	Although the program focuses on families from five communities with a high incidence of children with disabilities: Afghan, Kurdish, Chinese, Vietnamese and Sudanese, it also helps families from other communities.	This program has been in existence since 2007. The 2009-2010 contract was for \$131,280, with yearly renewal. Four percent of all Health Brokers' caseload falls within this program.
7	Multicultural Senior Outreach Program	The Health Co-op started to work formally with immigrant seniors in 2007 because they believed that their needs were not well understood and addressed by health and social services systems.	The 2009-2010 contract for this program was \$39,640, with yearly renewal. Four percent of all Health Brokers' caseloads fall within this program.

The eighth and ninth programs focus on Health Brokers' work with youth because the Health Co-op believes in working with the new generation of immigrant and refugee communities in order to help them participate in Canadian society.

Table # 5. Youth programs

#	Program	Description	Population & Funding
8	Multicultural Youth Mentorship and Leadership	The youth programming was created because Health Brokers worried that some immigrant and refugee youth were falling through the cracks of health and social services.	The program started in 2006. The funding is \$50,000, with yearly renewal.
9	Immigrant and Refugee Youth Mental project	This project supports leadership and mental health among immigrant and refugee youth by assisting community-directed youth programming in recreation, arts, and mentoring.	The program started in 2009. The yearly funding is \$300,000 for three years.

The tenth program focuses on helping immigrants and refugees who have specific clinical needs requiring attention through specialized services. The Health Co-op became involved in this program because Health Brokers learned that refugees needed special support. This clinic runs independently

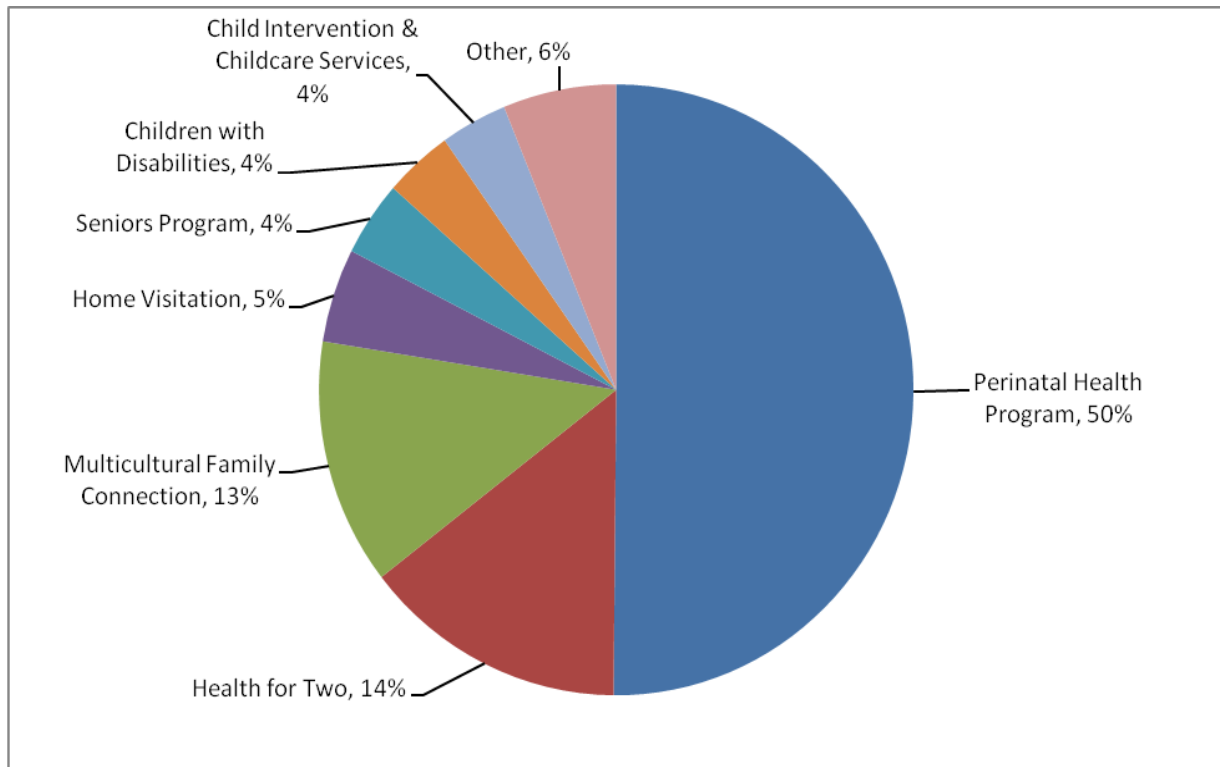
of the Health Co-op, but the Health Brokers have an arrangement with the clinic to support their clients.

Table # 6. The New Canadians Health Clinic

#	Program	Description	Population & Funding
10	The New Canadians Health Clinic	The clinic provides appropriate health screening and assessment for newcomers from refugee backgrounds to secure primary care services to meet their initial health needs. The Health Brokers offer linguistic and cultural support and help clients to navigate the health and social service systems as they settle in their new homeland.	This program started in 2007. It is funded by Alberta Health Services. The funding is \$50,000, with yearly renewal.

Figure 4 illustrates the Health Brokers' caseload percentages of programs one to seven, which I derived from the caseload database (MCHB Co-op, 2010db). Even though programs eight to ten are part of the Health Co-op's core programming, it was not possible to determine from the caseload database the percentage of the Health Brokers' caseload represented by these programs, so I included these programs under "other" in Figure 4.

Figure 4. Health Brokers' client caseload database



Cumulatively, the ten programs of the Health Co-op reached approximately 2,300 immigrant and refugee families from 80 countries, speaking 29 different languages, categorized into 18 different ethno-specific communities. Most of the programming is based on project funding; hence most of the Health Brokers' work is subject to the withdrawal of funding. In the overall funding of the Health Co-op, the Perinatal Outreach program is the one that has the highest number of Health Brokers involved. In normal circumstances, perinatal health is the most straightforward program to deliver because: a) it has a clear beginning and end date that involves supporting mothers from pregnancy until the baby is one year old; and b) it is generally associated with a positive event for the mothers and families. In percentage of funding, however, this program (\$317,502.56) only represents approximately 15 percent of the 2009-2010 funding of the organization. Yet when the MCHB Co-op

was created fourteen years ago, this program was its main source of funding. The perinatal contract became the start-up capital for the formation of the MCHB Co-op, which allowed it to develop its market niche by providing culturally- and linguistically-appropriate services. One participant said, “perinatal health was the bread and butter” of the Health Co-op (Eremurus).

The perinatal health program is the main entry point for clients to be referred to Health Brokers or the Health Co-op. On the other hand, clients might be referred to Health Brokers because families are experiencing violence. In this case clients are enrolled in the Intervention Support and Childcare Services program as they require specialized services and intensive support. This program represents only four percent of the Health Brokers’ caseload. Also, the number of Health Brokers implementing this program is lower than the number of workers delivering the perinatal program. The funding for this contract In 2009-2010 was \$384,480, representing the biggest source (18 percent) of project funding for the organization (MCHB Co-op, 2010fr). In other words, depending on the needs or difficulties experienced by clients when they seek the assistance of the Health Brokers, clients are enrolled in the program that best addresses their needs. Similarly, the caseloads of Health Brokers per program depend on the severity of each case.

PARTICIPATING IN RESEARCH WITH ACADEMIC INSTITUTIONS

The Health Co-op and Health Brokers believe in documenting the realities of immigrant and refugee women and their families. For example, the Health Co-op was involved in two pilot projects on child development (2007-2010), led by academic institutions and public health authorities. The first pilot project was an Inter-cultural Early Learning initiative, involving three-and a half and four-year-old immigrant and refugee and Canadian-born children to promote early literacy with home languages and culturally-affirming activities (MCHB Co-op, 2010b February). The funding for this three-year

project was \$39,640 per year, plus a one-time funding of \$50,000 in 2010. The second pilot project was Pre-School Developmental Screening (Community-University Partnership for the Study of Children Youth and Families, 2008), designed to improve the capacity of parents to identify child developmental problems and connect families to a multidisciplinary team of professionals, if children manifested delayed speech, motor, or social-emotional skills (MCHB Co-op, 2010b February). The funding for this three-year project was \$110,000 per year. What is important about this Health Co-op's strategy is that Health Brokers are trained as researchers for each project, which contributes to enhancing the skills of these workers as well as the Health Co-op's capacity in general. The literature has documented both the importance and the challenges of CHWs' involvement in research within their own communities (Meyer, et al., 2003; Terpstra, Coleman, Simon, & Nebeker, 2011; van der Velde, et al., 2009).

CREATING SOCIAL ENTERPRISES (SMALL BUSINESS)

Since 2009, the Health Co-op also zeroed in on a second funding strategy geared to creating social enterprises to respond to the needs of the community and remove barriers that the Health Brokers encountered when serving women and their families. One of these initiatives was a multicultural child-care centre. Immigrant and refugee working mothers expressed the need for child-care services that offered multicultural programming and extended hours of services. In February 2010, the Health Co-op, with external expertise and support, opened a multicultural daycare centre with a capacity to receive 24 children from zero to twelve years of age (Woman7). The centre is now open from 6:00 am to 6:00 pm, offering longer hours than any other Edmonton childcare facility (HG memo, p. 19). The daycare spaces filled up very soon after it opened. The centre is self-sustaining and offers a slightly lower monthly rate than other daycares. Low-income immigrant and refugee parents are eligible for municipal daycare subsidies.

The Health Co-op continues to explore other ideas for social enterprises, which can be self-sustaining. These enterprises are important because they improve the social and economic wellbeing of immigrant and refugee communities, and meet the needs of members and workers of the Health Co-op.

CREATING A SISTER ORGANIZATION WITH CHARITABLE STATUS

When the Health Co-op sought funding from not-for-profit sources, it found that it was ineligible because it had been registered as a “for-profit” corporation. In 2006, the Health Co-op spearheaded the creation of a not-for-profit sister organization with charitable status: the Multicultural Family Resource Society. The Society seeks funding from foundations or not-for profit-organizations for community development activities, after which it sub-contracts with the Health Co-op to provide the programming, working directly with parents and children in activities aimed at building the capacity of the community. At the time of my research, most activities of the Society generated modest and unsystematic funding to undertake work within its mandate. It did not, however, receive enough funding to support all community capacity building activities that the Health Co-op wanted undertaken on its behalf.

The multiple programs undertaken by the Health Co-op and Health Brokers illustrate a systematic approach to programming that is holistic. If they find a problem that needs to be addressed, they seek funding to work on it. At times, they started programs even if they lacked funding. The following quotation explains how one participant described the role of Health Brokers and how they responded to the needs of the communities:

... [they are] unique... they are not just doing what the funder asks them to do. They do more than the funder asks them to do. If they see a problem, for example, in the home visitation program... they [the clients] say. "Oh I'd like to apply for EI [Employment Insurance], but I don't know how to do the paperwork, and I have no money." You [the Health Broker] will go, "Okay let me just apply and do the paperwork for you..." And you [the Health Co-op] get funding for that? No. This holistic thing, we [the Health Co-op & Health Brokers] are doing something — we help the family to feel better. But ... you cannot get the funder to look at it this way (Agave, May, 27, 2010).

Over the years, the Health Co-op has been successful in obtaining multiple-year project funding to support immigrant and refugee women and their families. Despite this success, it is important to note the complexities related to project funding. Funds are insufficient to offer full-time employment across the board or provide reasonable wages and health benefits to employees working 73 hours per month or less. The side effect is that while the Health Co-op can offer new programs to families, increasing services has implications for the Health Brokers' workload. Concretely, they must handle more cases of families in crises, their stress levels increase, and they must keep themselves updated on available health and social services resources. As well, they must undertake increased lobbying on behalf of clients within a potentially larger number of mainstream institutions. New projects also raise challenges for mentors because the number of Health Brokers, communities, and languages spoken is increased. As a result, mentors have to identify more support systems for Health Brokers and their clients as well as monitor mechanisms to foster high quality work. Health Brokers from refugee backgrounds require additional support from mentors to help them understand paperwork in Canada, such as completing income tax forms.

b) Enhancing the internal capacity of the organization

One participant indicated that the main reason Health Brokers wanted to stay independent of the health system was "...if [we] became part of the system and we are absorbed into the system, it will

be hard for us individually to try and review where the system is not working ... And some [Health Brokers] were worried that their holistic practice could be affected...” (Lavender, July, 14, 2009). The Health Co-op became an official entity in 1998 following several years of conversations among the Health Brokers and organizational experts to determine the best structure for their work. Since then, the Health Co-op has sought support from professional consultants in co-operative development to help the Health Brokers understand co-operatives structures and organizational development issues, including business plans, hone practice skills and competencies as well as foster internal leadership and managerial skills (Ortiz, 2003). This professional support also included guidance on how to set-up social enterprises, like the daycare centre described earlier (Cardamom, September 13, 2010). Obtaining such technical support is one of the internal indicators associated with the success of co-operatives (Hough, et al., 2010).

The Health Co-op appears to be well known in both the health co-operative and worker co-operative movements in Canada. They are mentioned in several studies on co-operatives and listed as collaborators or participants on other initiatives outside the co-operative sector. When I asked Health Brokers and mentors about the origins of the Health Co-op and its ability to exist and expand its programming as well as articulate and sustain the Health Brokers’ practice, I received various answers. One of the participant’s answers caught my attention. This participant stated, “We have existed for pure stubbornness or sheer determination.” The persistence and determination to respond to immigrant and refugee communities’ needs came across as the heart of the Health Co-op’s work.

The complexities and contradictions that the Health Co-op and Multicultural Health Brokers experience in their operations are linked to the principles to which workers’ co-operatives adhere, including democratic governance versus the intensity of the

work, organizational capacity, financial sustainability, and the blend of entrepreneurial and social objectives (Ortiz, 2003).

DEMOCRATIC GOVERNANCE VERSUS INTENSITY OF THE WORK

The Health Co-op's articles of incorporation state that the organization is "...owned and operated by employees and contractors of the Co-op and [it] will support immigrant and refugee individuals and families to attain optimum health through health education, community development and advocacy" (MCHB Co-op, 2004aa, p. 4). According to their bylaws, workers must work for the Health Co-op for two years in order to become a member. This requirement gives the members and workers enough time to determine if they embrace the goals of the organization and are willing to become permanent members (participant observation meeting, May 4, 2009). Members have three roles: employees, owners, and decision-makers.

Members are responsible for a) achieving the Health Co-op's mandate and sustainability; b) abiding by their staff role; and c) overseeing the governance, management, and administration of the Health Co-op to ensure the overall wellbeing and functioning of the organization. Non-members may work for the organization for an indefinite time without becoming members; they are welcome to participate in all the decisions of the Health Co-op but cannot vote.

COLLECTIVE DECISION-MAKING

Major decisions are made at membership meetings. Members and workers who have not yet qualified for membership are encouraged to attend meetings, which occur twice a month. Although the content at some meetings overlaps, the intent is to have one meeting dedicated to the governance (policies and procedures) of the Health Co-op and the other meeting focused on programming and staff development activities (service delivery). Documents for discussion at

meetings are generally circulated beforehand, but some are distributed the day of the meeting. Items are raised by Health Brokers, mentors, or the project team presenting an issue, followed by discussion. Decisions are facilitated by the chair of the meeting who asks those present for a show of hands to support or oppose a position on the issue being discussed (participant observation meetings). The Health Co-op generally seeks consensus. If this is not reached, decisions are made by majority vote.

The Health Co-op's philosophy is based on non-hierarchical relationships between members and workers. Furthermore, they also follow the seven principles of worker Co-ops. When the Health Co-op was formed, it had only twelve members from six different immigrant communities. Twelve years later, it had 54 members and workers, the majority of whom were Health Brokers from 18 different immigrant or refugee backgrounds. At present, the Health Co-op has the following categories of members and workers: full-time permanent positions (n=13), part-time permanent positions (approx n=34), and other staff on contract (approx n=7). Of these, 30 are members (56 percent), and the rest of the workers are not members (44 percent). According to a participant, the government requires the Health Co-op to have 75 percent of workers as members (email communication, July, 26, 2012), but this is not currently the case. The lower percentage of members can be explained by the increased number of Health Brokers hired within the last two years. The Health Co-op grew from 40 members and workers in June 2010 to 54 in July 2012. As noted above, staff must work at the Health Co-op for at least two years before becoming a member, and at the time of my research, a number of workers had not yet reached the two-year mark.

The Health Co-op has a Board of Directors composed of five to nine members. The Health Co-op's board executes and monitors how policies are implemented. The Board also represents the

organization and maintains relationships with strategic partners and funders (high-level relationships) (MCHB Co-op, 2009h). Strategic directions of the organization are made through collective decision-making. The Members make policies on working conditions, organizational matters, and administration procedures. Most of the participants interviewed celebrated the Health Co-op's democratic participation and collective decision-making. This entailed fostering members and workers' participation in the overall functioning and planning of the organization.

Because of the intensity of the Health Co-op's work, it is always difficult to find adequate time for organizational activities (Ortiz, 2003). Of course, tensions still exist when not enough members attend meetings or when members need more time to reflect on issues before making a decision or to research background material for discussion at the meeting. All these factors influence the speed at which decisions are taken. Some members do not put their names forward for leadership positions because they are overwhelmed by their work or because they only see themselves as workers instead of owners and decision-makers of the Health Co-op (HG memo, p. 18, p. 25). This means that members and workers might prefer to wait for the Board, executive leadership or mentors to take the initiative rather than take it upon themselves (HG memo, p. 27). As a participant observer in one of the meetings (May 4, 2009), I noted a focus on what it meant to be a member of the Health Co-op. At this meeting, participants were reminded of the importance of attending meetings because decisions made affected everyone afterwards. They also discussed that additional hours were required from everyone to ensure that the new members learned to work within a collective decision-making culture. Most participants interviewed acknowledged, however, that as the organization grew, newly-hired Health Brokers and mentors constantly had to learn about the functioning of the Health Co-op. Learning was as simple as taking turns to prepare dinner for everyone and eating together before each membership meeting, or as complex as

understanding that the work of the Health Co-op was immersed in a context of “ambiguity”. Unlike in a hierarchical organization, where workers might be required to report to a manager or supervisor only, at the Health Co-op, the worker is also expected to learn about policies and procedures and governance for the whole organization. According to one participant, for some participants, this learning created the greatest challenge for governance, especially succession plans for newer members and workers to carry out the mandate and goals of the Health Co-op over the long term.

CULTURAL DIVERSITY

The vast majority of Health Brokers (like their clients) were immigrants and refugees who spoke several languages and had various cultural origins. This richness in cultural diversity and backgrounds posed challenges in establishing the Health Co-op. For example, workers had to learn and educate each other about the concept of participation and democratic decision-making. Health Brokers from some cultures were not used to participating at meetings or being involved in the democratic processes required in a health worker co-operative, or accustomed to the notions of democracy in Western countries (Ortiz, 2003). In addition, Health Brokers had different levels of knowledge of English, so they had to learn to communicate in effective ways to ensure open feedback, appropriate discussion of sensitive issues, and accurate interpretation of the information discussed (Ortiz, 2003). Thus the Health Brokers had to learn about how to run a workers’ co-operative and function in that structure within a multicultural and multi-language context. In addition, they had to develop their individual skills to implement the Health Co-op’s mandated services.

FRONT-LINE WORK VERSUS OVERHEAD COSTS

The management of the Health Co-op is responsible for preparing plans that reflect strategic directions; securing resources for programs and services, including project development and contract management; allocating resources for programs and services (financial management); hiring workers; guaranteeing that standards of work and practice are met and supported; ensuring that workers' welfare is addressed; and representing the organization as well as liaising with funders and service organizations (MCHB Co-op, 2009h). Management shares information at membership meetings and celebrates successes, such as approvals of new projects, timely submissions of reports to funders, completion of projects, moving to a bigger office, and so on.

Management's role in collective decision-making has some challenges. For example, while mentors — who are part of Management — have programming responsibilities, they cannot always make decisions because the line between a group and an individual decision is sometimes blurred. If mentors want to make programming decisions they might have to wait for membership approval. For some participants, these programming decisions shift between too much or too little process. As a result, some decisions are made without consultation and others might take too long to approve. Because of these processes, some mentors interviewed appeared impatient with the Health Co-op's democratic decision-making and felt frustrated when some decisions took longer to be approved than it would otherwise take in a hierarchical organization.

Management's role in allocating resources for programs and services, however, is key to guaranteeing the strategic direction for the organization. For example, the Health Co-op learned over the years that if they used all their project funds in front-line work, they would not have

resources for monitoring and ensuring the quality of the services offered to communities. As the Health Co-op received more funding, it gained more flexibility in shifting funds from front-line work to cover overhead costs in order to build its organizational capacity. One success in moving funds from front-line to infrastructure was accomplished a few years ago by providing resources for unemployment insurance benefits for members and workers, which was subsequently supplemented by guaranteeing basic health benefits for employees hired for 75 hours or more per month. This latest change came into effect in early 2011.

FINANCIAL SUSTAINABILITY

Overall, shifting funds to strengthen the capacity of the organization appeared crucial in sustaining the growth of the Health Co-op. This was important because the Health Brokers learned that health workers co-operatives were the least sustainable of all types of co-operatives (Ortiz, 2003). A number of reasons are documented in the literature, but financial stability is key. Although the Health Co-op has been receiving support from various provincial and national funding sources over the years, the issue of financial sustainability has marked the experiences of the Health Co-op from its formation. According to participants the lack of financial sustainability has meant that the Health Co-op has relied on funding from public sources for short-term contracts lasting one to two years, making it vulnerable to changes in political and economic priorities of governments. According to Ortiz (2003), the Health Co-op's uncertainty in financing reflected the lack of commitment to health equity and cultural diversity from health and social services funders, who did not provide sustainable funding to programs, such as the Multicultural Health Brokers (p. 156).

Despite the funding difficulties, the Health Co-op has been committed to keeping both members and (non-member) workers on the organizational payroll whenever possible. For example, in cases

where there have been funding shortages the membership decided to reduce the number of hours equally among themselves rather than laying off people (HG memo, p. 17, p. 41). According to some participants, the lack of financial stability may bring the membership to overlook workload concerns. For example, a standard per hour rate for members and workers was set up by the membership when the Health Co-op was officially registered. This hourly rate, however, has not changed in accordance with inflation since 1998 and appears to be a source of dissatisfaction among several participants. Health Brokers receive the same hourly rate regardless of their level of education, seniority, or complexity of workload.

One issue was raised by two participants related to who had “privileges” in the Health Co-op. A Health Broker felt that long-time members were the only ones with permanent full-time positions regardless of their workload, while newer members had only part-time or contract work, resulting in less stability for new recruits (Tritoma). Another Health Broker felt that newer Health Brokers with less experience should not be receive the same hourly-wage as those with experience and seniority (Begonia). Most Health Brokers and mentors wished that the level of funding could be higher so that the Health Co-op could change to a wage scale for Health Brokers. Mentors, for example, make slightly higher wages than Health Brokers. The rationale for this is in order to attract people with required skills wages have to be competitive within the sector. Even then, mentors make lower wages at the Health Co-op than at similar organizations. In one of my data validation sessions, Health Brokers and mentors asked how representative the above findings were of the overall satisfaction of Health Brokers (Meeting, December 11, 2011). I indicated that the majority of people interviewed expressed a desire for better wages. We agreed that the dissatisfaction expressed about wages was not indicative of the participants’ unhappiness with their membership in the

Health Co-op, but rather a reflection on the lack of meaningful remuneration to Health Brokers, arising from their social location within Canadian society.

At some meetings, and in face-to-face interviews, most Health Brokers and mentors spoke passionately about the organization's favourable work environment as well as the friendship and collegiality with colleagues. The vast majority spoke of being committed to the organization and the work they did for women and their families. In one participant observation activity, however, two Health Brokers indicated that if they had an offer of more money or a better job elsewhere they would leave the Health Co-op. Although only two Health Brokers expressed this feeling, this is revealing of the societal context in which Health Brokers are considered part of what is often called non-standard employment. Given this, it is not unreasonable for Health Brokers to aspire to better wages or full-time employment and benefits.

BUILDING A BUSINESS ENTERPRISE WITH SOCIAL OBJECTIVES

Another challenge the Health Co-op faces related to financing, comes from its commitment to blending what Ortiz (2003) refers to as an "entrepreneurial" [business] objective of providing employment to its members, while addressing the social objective of achieving equity of access for the community. This is a central concern for the Health Co-op because project funding allocated for perinatal education, for example, is defined within strict confines of the health system, and does not cover other areas of the Health Brokers' work (Ortiz 2003), such as mediating between family members, and connecting women to community groups. A case in point is the perinatal "support" Health Brokers give on a one-on-one basis to immigrant and refugee women and their families. Health Brokers and some public health nurses disagree on how much time should be dedicated to each client. The disagreement and tension lie in differing perspectives about how to address the

pressing needs of immigrant and refugee women and their families. Some health professionals indicated that Health Brokers' close relationships with clients or overtime work with them indicated a failure to set client-professional boundaries. The Health Co-op and Health Brokers believe, on the other hand, that they have to support clients when they need them the most. For Health Brokers the problem lay with the health and social services' systems not providing enough services, especially on evenings and weekends, often forcing Health Brokers to support clients beyond the hours stipulated in their contracts. The literature also identifies this as a problem faced by CHWs in other parts of the world. In a study about CHWs working with indigenous Māori people in New Zealand "CHWs referred to time as a gap in service because people's issues didn't occur between 9 to 5 and felt after-hours support and care were needed" (Forrest, et al., 2011).

Health Brokers undertake extra work, often unpaid, because of their commitment to women and their families. They do so as well because they are organized within an independently-run co-operative, which allows them more latitude in carrying out their work with clients. Several of these tasks have not always been regarded as having economic value that is measured in units of time. Health Brokers and mentors are aware that they would not be allowed to operate in this way if they were embedded in the health system. This is an example of how health care restructuring has had an impact on the "political economy of time"(Spitzer, 2004)(D. Spitzer, personal communication, September 11, 2012).

c) Articulating and sustaining Health Brokers' practice

How does the Health Co-op support Health Brokers in carrying out the ten programs for immigrant and refugee women and their families? According to participants, providing support to Health Brokers is particularly important for two reasons: Health Brokers possess different levels of skills,

knowledge, and expertise; and the practice itself is multifaceted, requiring workers to understand and master, in principle, several areas of competence, many of which they learn and apply as they do their jobs. Table # 7 illustrates these areas, which include theory, personal growth, skills, relationships with clients, and organizational development.

Table # 7. Multicultural Health Brokers' areas of competence

Area	Expertise Sought
Theory	Understand the four stages of the theory of being a multicultural Health Broker (Ortiz, 2003); and Comprehend and apply the five dimensions of practice as reflected in the health promotion empowerment approach (Labonté, 1993).
Skills	Learn the specific content of a particular program and participate in ongoing training opportunities; Know the resources available in the systems, including health, social services, housing, and immigration; and Keep records of their caseloads in the computerized client electronic database in order to meet funders' requirements.
Relationship With Clients	Strategize the best way to address the needs of their clients; Learn about Canadian culture, traditions, and systems; Understand the cultures and traditions of their clients and peers and reflect on how these match or differ from Canadian culture, and traditions; and Build solidarity with their clients, as most Health Brokers have experienced similar barriers and challenges in migrating, settling, and adapting in Canada.
Personal Growth	Learn to solve their personal crises without interfering with helping women, families, and communities. This happens when some Health Brokers, like their clients, experienced tragic events before migrating to Canada.
Organizational Development	Comprehend and participate in the democratic processes to strengthen the internal capacity of the Health Co-op.

I discuss, in Chapter 7, how Health Brokers use multicultural health brokering theory in their daily practice.

Given the different backgrounds of the Health Brokers and the complexity of mastering the different areas of competence, the Health Co-op decided to invest time and resources to hire mentors to support the Health Brokers' daily practice. Mentors bring in different skills sets, such as empathetic listening, knowledge of the Canadian system, knowledge of immigrant and refugee communities'

macro and micro issues, writing and reporting expertise, and most of all, a commitment to serving both the Health Co-op and the communities. Like Health Brokers, mentors need to be, as one participant called it, “kindred spirits” who accompany the Health Brokers in their journey to support the communities. Table # 8, illustrates the mentors’ areas of competence. Mentors support Health Brokers in four main areas:

Table # 8. Mentors’ areas of competence in supporting Health Brokers’ practice

Area	Expertise
Theory	Know/Learn the of theories of health behaviour and society (e.g., psychology, community development, social work); Comprehend and apply the four stages of the theory of being a multicultural Health Broker (Ortiz, 2003); and Understand and apply the five dimensions of practice as reflected in the health promotion empowerment approach (Labonté, 1993).
Skills	Identify and address the needs of clients; Write reports for funders; Write grant proposals; Have knowledge about Canadian systems; and Have knowledge about issues faced by immigrants and refugees.
Relationship With Health Brokers	Help the Health Broker address her/his own crises; and Respect Health Brokers’ views and practice.
Organization Development	Strategize on ways the Health Co-op can develop systems to improve the work of Health Brokers — for example, training and staff development opportunities; and Open up spaces for collaboration and partnerships with mainstream organizations.

MENTORS’ BACKGROUND

All the Health Co-op’s mentors were women. I interviewed five mentors. The educational background of the mentors interviewed ranged from bachelors to masters and PhD degrees. Two mentors worked full time for the Health Co-op and three worked part time. Two of the five mentors had a household income of over \$80,000, the other two had household income between \$70,000 and \$79,000 and one mentor’s household income was between \$60,000 and \$69,000. The number of family members in the households of mentors ranged between two and five. Three of the

mentors were racialized women who lived in Canada between 14 and 37 years and spoke English as their second language. Two mentors had Euro-Canadian background who spoke English as their first language. In this sample racialized mentors made up 60 percent of respondents, but I learned from interviews and from participant observation activities that the majority of Health Co-op's mentors were from Euro-Canadian backgrounds, some born in Canada others born in Europe. The reason for my current sample is that not all mentors were available for interviews when I did my field research. I am not providing the specific countries of origin or languages spoken to protect their confidentiality.

Mentors developed strong relationships with Health Brokers, but sometimes tensions occurred, especially if they disagreed on methodological or organizational issues, such as reporting on the Health Brokers' practice. One mentor explained how, at the onset of working with Health Brokers, some mentors who have trained in bureaucratic organizations, most of whom came from mainstream society, focused their work on monitoring the workers from a control point of entry, rather than offering support. This was not well received by Health Brokers who wanted to develop a different type of relationship. Mentors gradually learned to establish relationships with Health Brokers based on collegiality, equality, and support.

At present, they work well together because Health Brokers have in-depth knowledge of the communities and the mentors know the health and social services systems inside out. Their work is complementary and they trust and challenge each other to fulfil the organization's mandate to improve the lives of immigrant and refugee women and their families.

STRENGTHENING GROUP BONDS

For membership meetings, members and workers take turns preparing dinner — often an elaborate indigenous recipe — or purchasing a mainstream meal, such as pizza. The atmosphere is always festive and people graciously thank those who provided the meal. As well, at some meetings I attended, one of the mentors offered a 10-15 minute meditation sessions before starting the meetings. In one of the meditation sessions I noticed that one Health Broker had difficulty containing her tears. Following the meeting, I learned that a woman from her community had been brutally killed by her husband.

The Health Broker was trying to figure out how best to support the bereaved children and the rest of the victim's family. At the same time, she was working with other members of her own community to find short-, medium-, and long-term strategies to prevent violence against women. This is an example of some of the complexities and traumas Health Brokers' experience. In such circumstances, the whole Health Co-op must act quickly to support the Health Broker and the community affected. A crisis like this reinforces the Health Co-op's vision for social transformation. It serves as a reminder of the societal and systemic barriers faced by women and by their communities.

MENTORING BY PUBLIC HEALTH NURSES

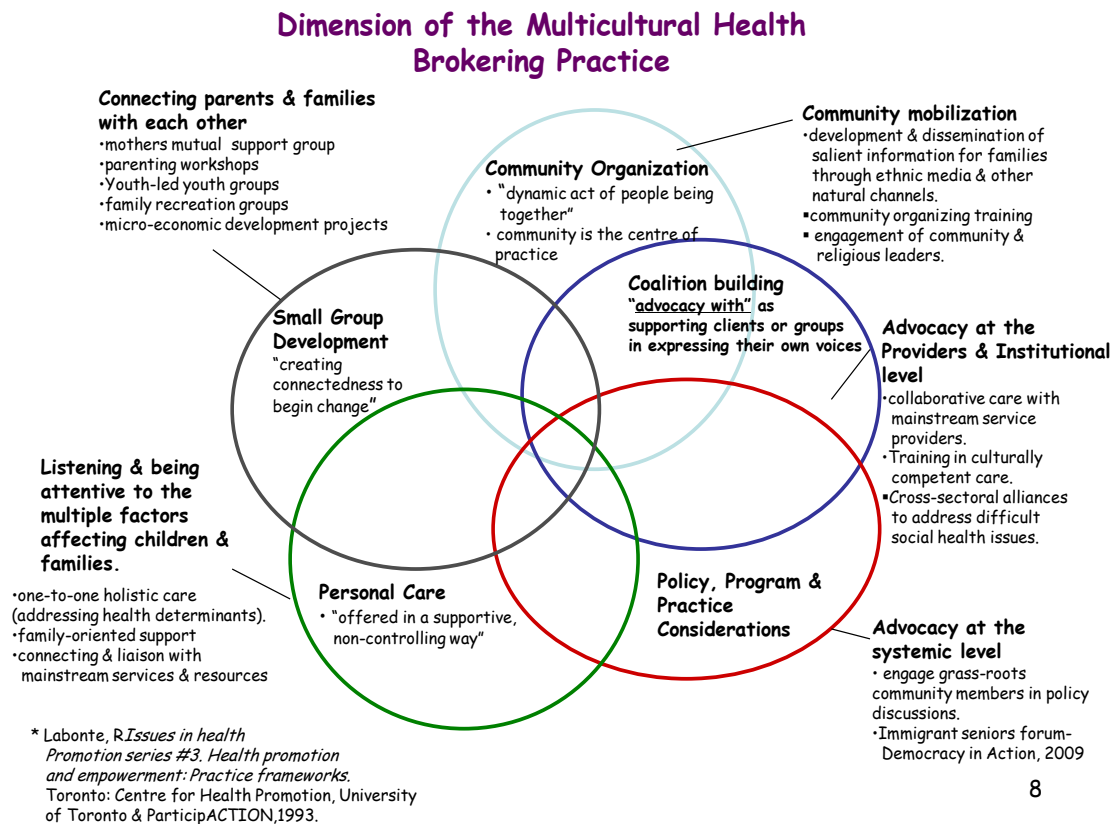
Another source of mentoring for Health Brokers is the public health unit's public health nurses. The Health Co-op and Alberta Health Services (AHS) Edmonton Zone Public Health work closely in two areas: Health for Two's public health nurses provide training in perinatal health to the Health Brokers, such as labour, birth and breastfeeding information, and they offer ongoing clinical support to pregnant women or new mothers seen by Health Brokers. Although AHS had initially required

that a public health nurse be based at the Health Co-op, this requirement was met only from 1998-2009. During my study at the Health Co-op, I learned that from early 2009 to February 2012 no public health nurse had been based on the site, which has raised some concerns on the need for systematic mentoring of Health Brokers by public health nurses.

APPLYING A HEALTH PROMOTION APPROACH IN DAILY PRACTICE

The Health Co-op also applies a holistic approach to their work by combining theory and practice. Ortiz (2003)'s study indicated that the four stages of the multicultural health brokering practice were insufficient to address the social change components of the Health Co-op's mandate. She recommended that the Health Co-op "begin to operate in the fifth dimension [Labonté, 1993] of building solidarity with broad-based organizations that have the resources and capacity to mobilize actions that would have societal impact" (p. 134). Since then, the Health Co-op has adopted Labonté's (1993) health promotion and empowerment approach. According to Ortiz (2003), this meant that the Health Co-op decided to have a collective mandate to advocate with communities as well as to leverage resources for creating change in the larger society. Currently, the Health Co-op describes its work in "five dimensions" or strategies: Personal care (one-on-one support); small group development (parents and families); community organization (community mobilization); advocacy (providers and institutional level); and policy and practice (advocacy at the system level) (Labonté, 1993). Figure 5 illustrates how the Health Co-op and Health Brokers use Labonté's approach to conceptualize their work.

Figure 5. Empowerment Holosphere, dimensions of the multicultural health brokering practice. Source: MCHB CO-op 2008a.



8

The first strategy in this approach focuses on one-on-one work, which ought to be "offered in a supportive way, not limited by the resources of the agency, and its explicit goal is empowerment of the individual" (Labonté, 1993, p. 56). The Health Co-op and Health Brokers' practice fully adheres to this approach, as I witnessed from my interviews, documents reviewed, and participant observation activities. I observed that, for the Health Co-op, providing one-on-one support to women and their families involved "moving people from a place of isolation to a place of connectedness where they can find affirmation and support" (MCHB Co-op, 2008a).

The second strategy in Labonté's (1993) health promotion empowerment approach is small group development:

"Community" is often presented as the engine of health promotion, the vehicle of empowerment. But it may be more accurate to say that the small group is that locus of change, that vehicle of emancipation... The group is where we create our purpose. Only in interacting with others do we gain those healthful characteristics essential to empowerment: control, capacity, coherence and connectedness. (p. 58)

Group work is important because the Health Co-op operates organizationally, and more understanding of group work is needed before it can be applied across the board. The Health Co-op is aware that one-on-one work is the driving force of most Health Brokers' practice, and endeavors to dedicate time and resources to form groups with the objective of building the capacity of the community. The Health Co-op is keen to get funding for community development projects from the Society (its sister organization), which has given the Health Co-op modest funding for parenting groups working on capacity building issues in recent years. One participant explained that the Health Co-op expects the newly-formed parenting groups to develop their own consciousness of the communities' needs (Chrysanthemum, December 15, 2009). The Health Co-op is also aware that they "... must be patient.... It often takes between one and two years before the first 'group' squiggle may form from the disconnected individual dots, group formation occurring when individuals self-identify as 'group members'" (Labonté, 1993, p. 58). The Health Co-op is also conscious that in order to build the capacity of immigrant and refugee communities, it must be willing and able to support this process over the long term, with or without funding.

The third health promotion strategy influencing the Health Co-op is community organization and mobilization. "Community organization describes the process of organizing people around problems

or issues that are larger than group members' own immediate concerns" (Labonté, 1993, p.61). The Health Co-op recognizes the need for immigrant and refugee communities to find their voices and advocate for their own interests. For example, the organization secured funding in 2000 to train 15 immigrant and refugee leaders in community animation. Today, many of them are still involved in community building and leadership development work with all levels of government (Laflor, December 30, 2011). These leaders became so engaged in making their voices heard that they continued their involvement beyond the project funding. During the following two years, the Health Co-op continued to accommodate the community leaders by offering them a meeting space, food, and mentoring until 2004 when they were ready to form their own organization: the Multicultural Coalition.

The third strategy also focuses on how communities position themselves. Labonté (1993) indicates:

While community organizing may strive for inclusivity in community-building, for agreement amongst as broad a collection of community groups as possible, relatively powerless groups usually seek to correct their imbalance by limiting the power other groups have over them. These groups only create their group-identity as a "community" in opposition to or conflict with those groups that are more powerful than themselves. (p. 61)

The Health Co-op positions itself in the middle between health and social services organizations and immigrant and refugee communities. The Health Co-op argues that their culturally- and linguistically-appropriate approach to working with communities sets it apart from health and social services providers, who are not yet able to or willing to work to develop approaches that are culturally sensitive to immigrants and refugees. It also argues that it teaches communities how to understand health and social services organizational culture and procedures.

The fourth and fifth strategies: advocacy and policy-making at the system level, engage service providers and decision makers in recognizing the health inequities experienced by immigrant and refugee communities (MCHC Co-op, 2008a). One participant describes the Health Co-op's belief in getting other people involved in the work and movement. She states:

... at the same time we need to work together ...we all have the same issues, ...how can we help one another to solve our problems, ... you know the kind of work we do at the same time, because you have to do grassroots movement, as well as you know, as well as... policy makers, so in order to get there [make change], now they need all kinds of levels, right? ... this cannot be done by me, ... alone or the few of us that are at the [Health Co-op], it would be impossible...there are too many things that you have to do, you are helping the family when they need you, and when they need help in accessing the services, and eventually, in the long term we want to make a difference, ...but also [changing] the system ...you need to have more people who are going to be on your side (Bird of Paradise, Part II. July 22, 2009).

The fourth and fifth strategies of Labonté's (1993) approach are best captured by the work of the Multicultural Coalition that focuses on lobbying and advocacy, and targets elected officials of the City of Edmonton. The Coalition is now well known, and the City consults them on immigrant and refugee issues. Coalition members, however, face barriers in making their voices heard. One of the challenges they encounter includes the lack of funding. During my data validation meetings (February 2012), I learned that the Coalition had lost its funding and had to let their staff go. For the Health Co-op and the Coalition members the withdrawal of this funding — which had previously been provided by the municipal government — indicated a lack of responsiveness at the local level to immigrant and refugee issues.

BALANCING THE FIVE DIMENSIONS OF THE WORK

In their daily practice the Health Co-op and Health Brokers apply the dimensions (strategies) that best fit the members and workers' skills. Despite Labonté's (1993) statement that no one

professional possessed the skills (or time) to work in all five dimensions, the organization now strives for Health Brokers' caseloads to reflect work across the five dimensions. Balancing the five strategies, however, has also created tensions between one-on-one support of clients, considered as service delivery, and group work and coalition building, considered as community development. The concern is which strategy is more effective in servicing clients: one-on-one work or community development. Funders tend to favour one-on-one work over community development. Some Health Brokers mainly do group work and community development, while others feel comfortable working only in one-on-one situations. One mentor indicated that group work was more and more encouraged by the Health Co-op because of the Health Brokers' increased caseloads (Eremurus). The hope is that as Health Brokers learn to deliver programs through group work, they will foster and strengthen clients' support networks. If successful, this will also result in decreased Health Broker travelling time to individual clients who are spread across the city.

Unfortunately, most funders are not interested in financing community development, advocacy, and policy work. As a result, the Health Co-op and Health Brokers find it challenging to work across (the) five dimensions. This means that Health Brokers attempting to work across the five dimensions must also volunteer their time to ensure all aspects of the approach are addressed. Another drawback is that because many Health Brokers have developed expertise in only one dimension of their work, this has led to compartmentalizing their role into different programs, such as as a "perinatal health worker" or as a "home visitation worker", instead of them identifying themselves as Health Brokers who do perinatal programming. This compartmentalization is in part due to project funding dedicated to particular programs; for example, 75 hours slotted for this program and 50 hours for that program. The Health Co-op prefers Health Brokers to see themselves as Brokers rather than program workers.

During my data validation session (August 16, 2011), I learned that the Health Co-op had changed its hiring policies to reflect Health Brokers' role and not the program role. New Health Brokers would be hired to work across dimensions and not in a particular program only. Health Brokers who are highly focused on a specific program are encouraged to change their mindset and see their work across multiple areas. One participant stated that Health Brokers should not say, "I only work in perinatal health, no, [she/he should say] 'I am a Multicultural Health Broker'. And 'I get paid by the multicultural Health Co-op to do that work'" (Eremurus). Articulating and sustaining the Health Brokers' practice in a holistic way and through the five dimensions reflected in Labonté's (1993) health promotion approach is an ongoing and dynamic process. It requires that the Health Co-op and Health Brokers think creatively about the best strategies to help the families, and that funders support their work towards health equity.

Discussion

My research did not set out to test the multicultural health brokering theory or the health promotion empowerment approach, but to understand how the Health Brokers' practice is integrated into public health systems of care, and how this integration influences the ability of Health Brokers to address health equity of immigrant and refugee women. The answers to this study's research questions are as multifaceted as the Health Brokers' practice. Understanding and describing the Health Co-op and the Health Brokers' practice has not been an easy task. The more I learned about the Health Co-op and the Health Brokers' practice, the more complex it all became. I mentioned to the participants throughout my research that when I started, I thought I knew what the organization and the practice were about. There were times during my research, however,

where I felt completely lost. It was only by going back and forth to the literature (Stake, 2006) and my thesis committee that I my learning process was reaffirmed. Stake's 2006 statement illustrates my intellectual despair in figuring out my understanding of the case, the phenomenon, and the embedded mini-cases: "... whether everything actually is part of everything, or whether we have a human capacity to seeing everything as part of everything, it all becomes more complex as it becomes better known, it cries out for being still better known. It becomes increasingly worthy of being included in the study" (p. 7).

My first understanding of the complexity of the work of the Health Co-op came in May 2009 as I entered its office for the first time. At this place — an old house turned into an office — I felt as if I was entering a United Nations building. I have worked all my life with Latin Americans and other immigrants in Canada, but never in a context in which there were so many cultures and languages in the same room seeking a common goal. In this case, the goal had a social purpose of attaining optimum health, equity and social justice while guaranteeing meaningful employment for the members and workers. The Health Co-op and Brokers interact with immigrants and refugees from 18 different ethnic communities from over 80 countries, speaking over 29 languages. This fascinated me.

The Health Co-op has been successful in establishing a market niche by obtaining contracts from Alberta Health Services Edmonton Zone and other government ministries to implement culturally- and linguistically-appropriate programming. Funds, however, are not enough to cover all the work hours of Health Brokers or deliver all of the programs needed by the communities. The deficiency in resources represents a disconnect between the Health Co-op's long-term goals and the health system's approach. The Health Co-op believes in prevention work and grassroots development to

strengthen the capacity of the community. The health system believes in addressing immediate problems rather investing in long-term solutions to prevent problems. For example, the system skews funding, so the Health Co-op is more prone to use the funding they receive for the immediate needs of newly-arrived immigrants and refugees, rather than devoting it to preventing problems in more established communities. The Health Co-op believes it is important to help newer communities, however, they worry that immigrant and refugee families who have lived in Canada for longer periods are still at risk of falling through the cracks. For example, mothers who came to Canada years ago might experience problems with teenage children who are socially inactive and spend excessive time on the computer or those who are involved in gangs. Some participants explained that although the system does not see the older communities as the priority, the Health Co-op believes that these communities require assistance in becoming healthy, active citizens in Canada. This concern was raised in Ortiz's 2003 study, and remained unresolved in 2011.

The lack of funding, however, does not deter the Health Co-op and the Health Brokers from working towards their desired social goal: health equity and social justice. According to Corcoran (2009),

This type of broader social goal can generally only be adequately met if outside funders are committed in a significant way to the project. The primary challenge for these social co-ops with broader goals is that the target client base does not have the resources to support the worker Co-op business in a market-driven model. The needs which the fledgling worker Co-op wants to meet are very real, however, pursuing one of these ideas as a worker Co-op that provides a living wage to its members presents a huge and usually insurmountable challenge...unless there is clear availability of ongoing outside funds, i.e. non-market income. Unless there is government or other intervention, there is no way to create living-wage jobs in the entities proposed (Hazel Corcoran, 2009, pp. 10,11).

SWEAT EQUITY VERSUS EMPLOYMENT MARGINALIZATION

Health Brokers realize that volunteer work is necessary for the Health Co-op. Co-operative literature points out that in addition to financing, considerable commitment of all members to sweat equity is crucial to establishing and maintaining co-ops successfully (Hough, et al., 2010). When volunteer work, which is supposed to be “optional”, becomes mandatory because of insufficient resources, tensions arise. Although some Health Brokers appeared to be completely satisfied with their level of volunteer commitment, others were overwhelmed by it because they found it difficult to balance work and family life. One mentor saw the number of hours Health Brokers put into volunteer work as exploitation. In my view, this is where members and workers are torn between wanting to have normal work weeks and maintaining their commitment to the Health Co-op and their communities. Indeed, part of the Health Co-op’s success is due to their commitment to sweat equity.

BUT, HOW ABOUT INTEGRATION WITHIN THE HEALTH CARE SYSTEM?

The Health Co-op and Health Brokers are proud of working independently of the health care system, but would like their holistic work to be better recognized by: a) acknowledging Health Brokers as a health human resource workforce, which involves having sufficient funding for full-time employment for current and future Health Brokers to ensure that they have normal caseloads and time for administrative tasks, or allowing them to take time off or be compensated for overtime work; b) establishing a more egalitarian type of relationship with immigrant and refugee communities and organizations. Because the Health Co-op’s perinatal programming is “contracted in”, this relationship places the Health Co-op as well as their communities under a non-equal power relationship with the health system; and c) Providing sufficient interpretation and health brokering support at hospitals or other health care facilities, especially on evenings and weekends.

Theoretical conceptualizations

FEMINIST URBAN CITIZENSHIP

Both the multicultural health brokering theory (Ortiz, 2003) and the health promotion empowerment approach (Labonté, 1993) provided the foundation for the Health Co-op's conceptualization of their work towards health equity for immigrant and refugee women. I argue that in targeting health equity, both of these approaches contribute to marginalized immigrant and refugee women's urban citizenship. My assertion is based on the notion that Health Brokers, as predominantly women, are a part of and central to the analysis of feminist urban citizenship. Health Brokers are central to urban citizenship because urban citizenship, as presented by Andrew (2008) "...is linked to the politics of everyday life and demands for services, programs, and rights that facilitate the complex lives of urban residents, particularly women, in negotiating the interfaces of public and private spheres as they connect to paid employment, use of urban services and family life" (Andrew, 2008, p. 329). While none of the Health Brokers or managers named feminism in describing their work, I see their practice falling within the principles of feminist theory.

Feminist theory reflects different views of the world and offers various positions on what is good for women as espoused by liberal, socialist, radical, postmodern feminism, and anti-racist/Black Feminist thought (Adamson, et al., 1988; Eisenstein, 2009; Hill Collins, 2000; Hooks, 1984; Tong, 1989). Feminist theory also "attempts to describe women's oppression, to explain its causes and consequences, and to prescribe strategies for women's liberation" (Tong, 1989, p. 1). I do not want to conflate gender with women here, because I believe that men are also exploited and oppressed, but because over 90 percent of the Health Co-op's members and workers are women, my focus in this research is on women. The Health Co-op and Health Brokers educate immigrant and refugee

women on their rights as patients, program users, and citizens. As patients, they learn that they have the right to ask their physicians for information; as program users, they learn that they have the right to seek services and obtain these from health and social services systems; and as citizens, they learn that they have the right to make their voices known to policy makers, such as officials of the city and members of the legislature. As citizens, they also learn to use different strategies to make their voices heard.

By researching the Health Co-op's mandate and Health Brokers' practice, I have come to see that their multifaceted approach applies to feminist practice. They constantly negotiate between the public and private spheres in order to address health equity for immigrant and refugee women and their families. If mainstream Canadian women's urban citizenship informs the complex lives of women in negotiating between the public and private spheres, this concept is even more necessary for immigrant and refugee women. Andrew states that: "Women, particularly immigrant women, experience the urban reality in an especially intense fashion, as it is they who are largely responsible for knitting together public and private, family and school, neighbourhood and community" (Andrew, 2008, p. 243). In their daily work, the Health Co-op and the Health Brokers' practice in Edmonton are knitting together spaces to decrease the burden that immigrant and refugee women experience in settling in and feeling welcome in the city. Because many of the women lived in rural areas in their countries of origin or were refugees in a third country before arriving in Canada, the Health Co-op and Health Brokers facilitate the transition between public and private spaces as immigrant and refugee women adapt and find new meaning in their urban reality. This adaptation on the one hand includes changes to gender roles in the new society, which as Spitzer (2011) argues complicates the women's "...attempts to navigate the shifting terrain of life in Canada...in particular as they intersect with expectations of productive and reproductive labour" (Spitzer, 2011, p. 246).

The Health Co-op and Health Brokers acknowledge that immigrants and refugees women lack a political voice in the city. As result, they are reaching out (or accompany the women they work with in outreach efforts) to municipal decision makers and health and social services providers to help them understand women's realities. The task for Health Brokers is then to be careful not to stereotype immigrant and refugee communities, cultures, and experiences. Instead, they must challenge the "...dominant discourse that often constructs a singular immigrant experience marked by lack and vulnerability" (Spitzer, 2011, p. 247). This is where feminist theory of urban citizenship helps to conceptualize the Health Co-op's work and the Health Brokers' practice.

The Health Co-op and Health Brokers link women in communities and the Municipality, even if this is "in part conflictual." As argued by Andrew (2008):

...one of struggle — a struggle to make ends meet, to negotiate the successful entry of family members into the new society, to make claims for services, and to develop the sense of entitlement necessary to confidently make such claims. But at the same time, it is a link of identity, a creation of new opportunities and new solidarities, even if initially it often exists between people and within organizations, who belong to the same communities. (p. 242)

The "in part conflictual" link described by Andrew is what compels the Health Co-op and Health Brokers on the one hand to work and organize immigrant and refugee communities so that the systems recognize their voices and address their needs, and on the other hand to strengthen immigrant and refugee communities to support each other. Supporting each other is particularly important because smaller communities, especially the most vulnerable ones, might bring rivalries from their countries of origin and be unwilling to collaborate and create new solidarities with members from their communities, who are of a different religious, political, or cultural backgrounds, even if they are living together in a new city and country. As well, the vulnerability of these

communities might make some of them fall into crime-dominated gangs, which according to one participant “not only makes the Health Brokers’ work challenging, but also unsafe” (Lavender).

The conflictual link discussed by Andrew also happens when the Health Co-op or Health Brokers strive for structural changes to the health and social services systems. For example, the Health Co-op and the Multicultural Coalition are joining efforts to involve senior women (and men) in what I call feminist urban citizenship through annual Seniors Forums in which the seniors meet city officials, service providers, and key politicians to discuss issues that matter to them. Some of these issues are better and affordable transportation, housing, English as a Second Language training, and social enterprises to improve their lives in Canada. I consider this activity part of Health Co-op’s feminist urban citizenship because in the preparatory meetings for the Seniors Forum, and during the Forum, the Health Co-op and Health Brokers encouraged seniors to speak up to the city officials and provincial members of parliament attending the Forum. At times, however, the Multicultural Coalition members themselves face barriers to exercising their right to have a voice, such as insufficient funding for programming, defunding for the Coalition, or the inability to book a room because some community centres refuse to rent spaces to some immigrant and refugee groups whose behaviour they consider “inappropriate” (CaribbeaHeliconea). As a result, the Health Co-op, the Health Brokers, and the Coalition sometimes feel frustrated by the lack of responsiveness from the City in addressing immigrant and refugee needs.

A POLITIC OF DISENGAGEMENT AND A POLITIC OF MAINSTREAMING

Like feminism, which tries to reconcile the different strands on what is good for women and faces the major challenge of reconciling “the pressures for diversity and difference with those of integration and commonality,” (Tong, 1989, p. 7) the Health-Co-op struggles to value using multicultural health brokering to recognize the uniqueness of the cultures and experiences of immigrant and refugee women as well as health promotion strategies to help them to participate and integrate into Canadian society. The successes and challenges that the Health Co-op, Health Brokers, and the Coalition experience in their desire for social change ranges from feeling empowered in pushing for “mainstreaming” of immigrant and refugee issues within the city to feeling frustrated and “disengaged” due to the lack of responsiveness from the system. For Adamson et al., (1988) in feminist practice, these are “...the two essential elements of making change: what we call a ‘politic of disengagement’ and a ‘politic of mainstreaming’” (p. 166). When looking at the Health Co-op’s goals for women’s equality from within the system, one would think that they see “the social and economic system as fundamentally acceptable” (Adamson et al., 1988, p. 11); however, when Health Brokers speak of social justice, system transformation, and argue that “equality of opportunity can never be achieved in Canadian society as long as there are fundamental differences in wealth, privilege, and power...” (Adamson et al., 1988, p. 11), one would consider that they espouse working outside the system.

Regardless of whether Health Brokers adhere to liberal or socialist feminism, Adamson, et al., argue that feminist practice for change requires maintaining a tension between a politic of disengagement and a politic of mainstreaming (Adamson, et al., 1988). This is evident in the Health Co-op’s daily work. Most Health Brokers acknowledge that they have to work within the system to address the basic social needs of immigrants and refugees (mainstreaming), but they are also critical of the

system, which helps the Health Brokers to empower themselves and their communities for social change (disengagement) (Briskin, 1991). Often, they feel that their voices are not heard by city councillors or members of the Alberta Legislature, which makes them feel disenfranchised (Young, 2002). For Adamson et al., (1988) this means “...relating to the specific concerns and beliefs of women, and thus to existing institutions and practices, as well as maintaining a critical distance from these same structures as part of the overall perspective on social change” (p. 177).

The Health Co-op and most Health Brokers are therefore key to feminist urban citizenship because they pay attention to municipal decisions, which have a direct impact on women (Andrew, 2008), in particular, to immigrant and refugee women. In addition, they pay attention to how they can influence change at the city and system levels. From a critical population health research practice, they foster immigrant and refugee women’s urban citizenship by combining multicultural health brokering (Ortiz, 2003) and the health promotion empowerment approach (Labonté, 1993). Yet the Health Co-op often struggles to reconcile being an independently-run health workers Co-op (disengagement) and wanting their work and the Health Brokers’ practice to be recognized within the system (mainstreaming). Although they must mainstream because their clients need access to the health and social services offered to mainstream society, they guard against institutionalization of the Health Brokers’ practice. Their dilemma is therefore what Briskin (1991) refers as to the complex strategic interplay between “marginalization and invisibility on the one hand and co-optation and institutionalization on the other” (Briskin, 1991, p. 34).

The Health Brokers’ practice is central to women’s urban citizenship and revealing this is an important contribution that this study makes to the field of CHWs in Canada and other countries. Only through the struggles to achieve a broader societal goal can CHWs sustain the resilience

necessary to continue their struggle despite the conditions that undermine their work. In chapter 8 I discuss the macro context of Health Brokers' social location in Canada and theorize that, as a workforce, they are gendered, classed, and racialized. They have to use their "own time" to undertake many so-called non-health activities to support immigrant and refugee women and their families, which effectively lowers their wages. Within a feminist political economy perspective, this is a reflection of the invisibility and undervaluing of women's work and their exploitation based on gender. Health Brokers' work is also classed and racialized, and may be devalued, since the populations they serve are also racialized and marginalized. As discussed below, while they struggle for practical gender interest at the micro and meso levels, Health Brokers' social location can only be addressed by pursuing strategic gender interests.

CRITICAL REFLEXIVITY

I now draw on one personal political experience that makes me believe the organizational structure (in this case, a health workers Co-operative) combined with a visionary politicized leadership (social change) drives and sustains the Health Brokers' practice. This experience was in international development for El Salvador, through SalvAide (El Salvador Aid). This work, which occupied the first two decades of my life in Canada, allowed me to understand that political organization and civic participation are the glue that keeps marginalized communities involved and motivated to work for social change. The Health Co-op is committed to social change as a means to improving the lives of immigrant and refugee women in Edmonton. In the most remote areas in El Salvador, communities' engagement and determination propels them to find solutions to their problems. Since the early 1980s, these communities have achieved meaningful gains in living standards with the help of international funding, but with practically no support from their central government during most of these years. One of these communities is Guarjila, located in the northern part of El Salvador.

Project findings (Labonté, 2011) reveal how the Guarjila community progressively ameliorated its own basic conditions of life by: constructing a potable water system, houses, and latrines; establishing their own food production system; creating an education model of popular teachers; and developing a health model of community agents to promoting health and rehabilitation, using midwives, and utilizing groups of volunteer women (Labonté, 2011 October). The key aspects of involvement here are local committees looking at all social and economic aspects of the community and adopting an intersectional approach involving community members at various levels of decision-making, including a local assembly to make decisions of greater importance for the community. This example is relevant for the Health Co-op and Health Brokers in Edmonton because they also adhere to principles of democracy and participation as well as ensure that their programming is responsive to the needs of the communities and not necessarily to those of the workers.

From a feminist urban citizenship perspective, my work with women in El Salvador, including those from the Guarjila community, helped me to understand that, in their daily struggles for economic and political survival, they fought for what Maxine Molyneux calls practical and strategic gender interest. The Health Co-op and Health Brokers also struggle for both strategic and practical gender interests. Strategic gender interest seeks to “overcome women’s subordination...the removal of institutionalized forms of discrimination, the attainment of political equality...the adoption of adequate measures against male violence and control over women” (Molyneux, 2001a 34, cited in Eisenstein, 2009, p. 214). Women formulate their practical gender interests “by virtue of their place within the sexual division of labour as those primarily responsible for their household’s daily welfare”(Eisenstein, 2009). The plight of women in El Salvador transcended, and still transcends,

many boundaries because they involved strategic and practical gender interests. Strategic interest, such as class struggles to eliminate a poverty; political freedom, by ending the war and building peace and democracy; and gender struggles for equality, especially when men on the left resisted and derided the women's revolutionary struggles (Torres, 1993). The women's struggles were also practical in that they sought funding to open daycare centres or for access to land and credit (Torres, 1993). The Health Co-op and Health Brokers focus most of their work on practical gender interests, such as their holistic and culturally- and linguistically-appropriate programming, but they do not lose sight of their strategic gender interests for social justice, health equity, and women's equality. I return to this point in Chapter 8.

THE RELEVANCY OF THIS CASE

The Health Co-op and Health Brokers are in constant communication with health and social work practitioners, policy makers, academics and researchers as well as with other community-based organizations. What can these audiences learn from this case? How is this research relevant to them?

This case is relevant to health and social work practitioners because the Health Co-op and the Health Brokers are a research laboratory of innovative approaches targeting health equity for marginalized populations (in this case immigrant and refugee communities). Health Brokers demonstrate that health and social problems experienced by marginalized women and families interact to create situations of vulnerability for these populations; therefore, Health Brokers seek solutions by using multiple strategies, seeking multi-sectoral involvement, and obtaining support from multiple ministries. Despite their challenges, the work of the Health Co-op illustrates clearly

the need for community-based organizations and practitioners to work together to address health equity for marginalized populations.

This case is relevant to policy makers because it illustrates that policies addressing health equity for marginalized populations ought to integrate the concerns and solutions proposed by communities experiencing marginalization, including immigrants and refugees. Further, the case illustrates the need for policy makers to develop health policies that address broad social determinants of health, rather than only looking at health as a series of discrete problems. This case is relevant to researchers and academics because it shows the strength in community-based organizations when they use theory to guide their work for health equity in a systematic way. The case also illustrates that researchers and academics can build alliances with community-based organizations and learn from each other. The former have the tools and resources to document the needs of communities experiencing marginalization; the latter know the community in a way not available to outsiders.

This case is relevant to CHW and other community-based organizations because it illustrates the importance of a broader vision of society guiding work in support of marginalized populations. It also provides an example of maintaining a long-term commitment despite gaps in funding and other challenges with organizational development. This case is relevant to immigrant and refugee-based organizations because it demonstrates the importance of working within and across cultures in order to help with the adaptation, settlement and integration of these communities into Canadian society.

Conclusions

The Health Co-op and Multicultural Health Brokers feature a unique blend of theory, practice, and democratic principles as well as utilizing unparalleled sweat equity to achieve optimum health and social change for immigrant and refugee women in Canada. They are like no other CHW model found to date in Canada. I came to this realization as I understood the three elements of MCHB Co-op's holistic approach, which I discussed in this chapter: a) developing a market niche by implementing culturally- and linguistically-appropriate programming; b) enhancing the internal capacity of the organization; and c) articulating and sustaining the Health Brokers' practice. This last element included the five dimensions or strategies: one-on-one support; small group development; community organization and community mobilization; advocacy; and policy and practice (advocacy at the system level), which the Health Co-op and Health Brokers adopted from Labonté's (1993) health promotion empowerment approach.

I also argued in this chapter that the Health Co-op's commitment to supporting immigrant and refugee women and their families and working on community development, despite their lack of funding, was due to being a co-operative with a social purpose and having a highly visionary leadership committed to social justice. I stated that none of the participants mentioned the word feminism, but to my view their goals and ideal contribute to feminist urban citizenship. I corroborated this when I travelled to Edmonton for data validation in August 2011. As I entered the Health Co-op's new office, I found a large and beautifully decorated room — a public school library turned into an office — and felt as if I had re-entered the United Nations building, only this time most people recognized and hugged me. Through my data validation process, one participant remarked, "Now, you know our work, so what? How will this help us?" With my activist and

research hats on, I answered, “We will work on policies to recognize CHWs in Canada”. To do so we will start with the Canadian Public Health Association, and we will also need to continue our

research in this area and build a movement of CHWs within our public health care system, I added.

To this I received a positive response, and we committed to collaborating in the future.

Chapter 6

The Perinatal and Health for Two programs: Embedded mini-cases

The partnership between Alberta Health Services Edmonton Zone and the MCHB Co-op and Health Brokers

I got off the bus and crossed the street to meet the health professionals who had agreed to discuss the work of the Health Co-op and Multicultural Health Brokers. The building was situated in a well-to-do neighbourhood with trendy shops, restaurants, and cafés. The professionals' offices were on the third floor of a multi-story building. After crossing the spacious main lobby and taking the elevator, I arrived at my destination. Immediately, I introduced myself to the receptionist who was sitting behind a huge circular desk in front of the elevator. She announced my visit to the first health professional I had to interview and instructed me to write my name and time of arrival in the visitors' book. Then she asked me to sit on the chairs aligned against the left wall of her desk. Except for the receptionist, I could not see anyone else in the corridors because walls enclosed the offices. The layout and physical appearance of the building was very formal and cold. I imagined that this was how immigrants and refugees felt when they sought access to health services....I waited until the first health professional came to see me. I was not sure how the health professionals would perceive my research, so I was a bit anxious about interviewing them.

Introduction

Alberta Health Service (AHS) Edmonton Zone Public Health programs and the Multicultural Health Brokers Co-op (MCHB Co-op) have partnered for over twelve years to deliver a Perinatal Health Outreach program for immigrant and refugee women in Edmonton, Canada. This business arrangement is beneficial to both organizations because it allows AHS Edmonton Zone to fulfil its mandate to provide perinatal information to all women, including those who are experiencing marginalization, such as immigrants and refugees. It also allows the Health Co-op to provide employment for its workers while targeting its social goals, such as health equity for immigrant communities. The Maternal Child Health area, which deals directly with the Health Co-op and Multicultural Health Brokers, is housed in the division of Primary Care Chronic Disease Management

of AHS Edmonton Zone Public Health Programs.

This partnership entails the support of three jurisdictions (municipal, provincial, federal) to address perinatal health of populations experiencing vulnerability, and is the focus of this chapter. I provide a “thick description” of the embedded mini-cases from the perspectives of health professionals within AHS. Interviewing these health professionals was important because of what the mini-cases revealed about the integration of the multicultural Health Broker programs within Canada’s formal public systems of care. The interviews also disclosed the influence of this integration on the Health Brokers’ ability to address health equity for immigrant and refugee women. Throughout this chapter I use the terms health professionals and participants to refer to the health professional participants I interviewed in the AHS, the term Health Co-op to refer to the Health Co-op, and the term Health Brokers to refer to the Multicultural Health Brokers.

HOW THIS CHAPTER IS ORGANIZED

The chapter is divided into four sections. Section one provides the history of how the Perinatal Outreach and Health for Two programs — the embedded mini-cases — came about, the funding path and administrative requirements for both of these programs, as well as the training program for perinatal outreach workers, including Health Brokers. Section two describes the perspective of health professionals within AHS on the system’s and Health Brokers’ perinatal work as well as on the relationship between AHS and the Health Co-op. In section three, I discuss health professionals’ potential to reclaiming their agency, autonomy, and empowerment in addressing health equity for immigrant and refugee communities. In section four, I reflect on my personal background in relation to some of the findings. I conclude this chapter by highlighting the relevance of the embedded mini-cases for our public health care system’s perinatal programs delivered through community-based

organizations targeting marginalized populations, including immigrant and refugee women and their families.

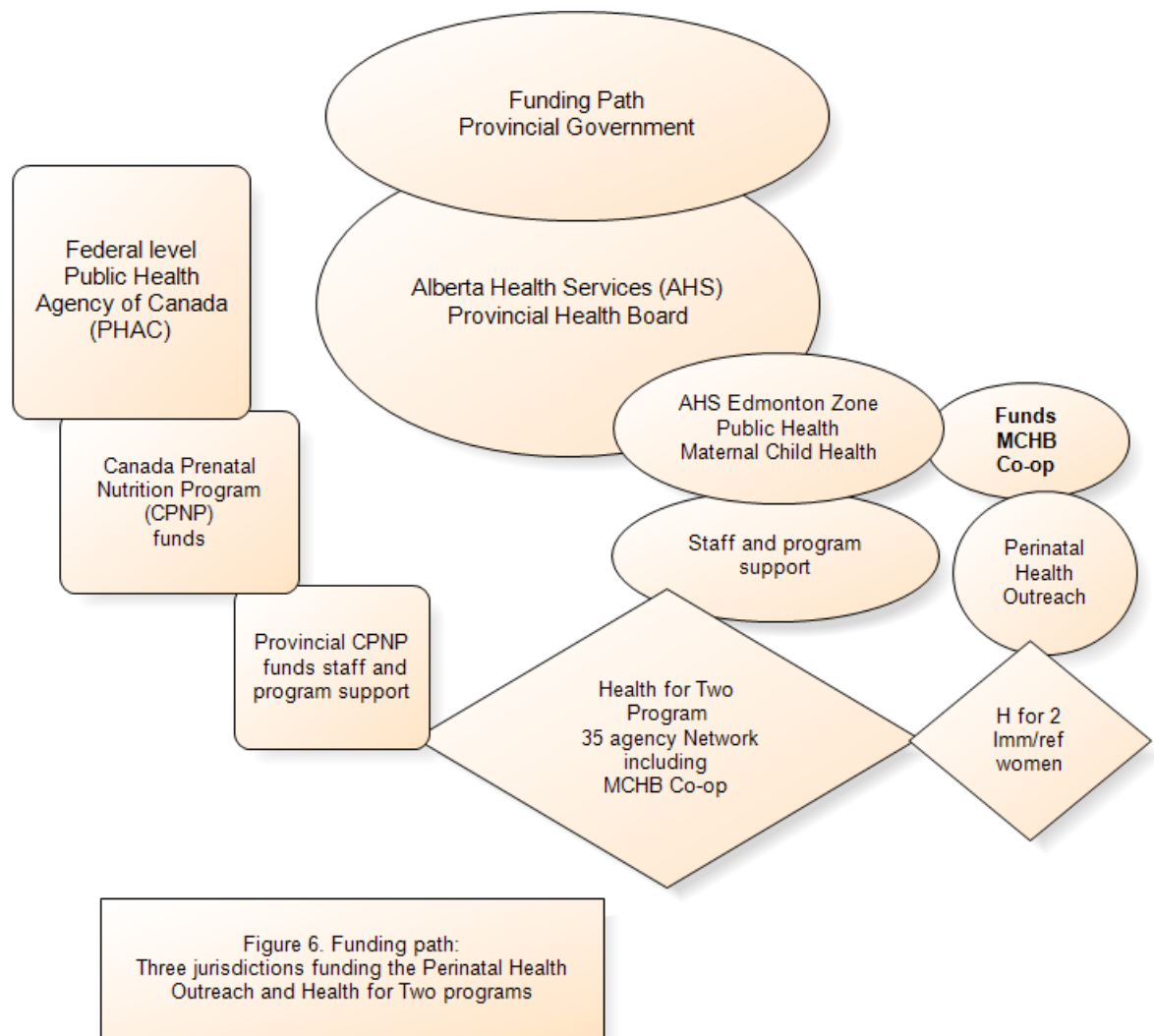
The Perinatal Health Outreach

The Perinatal Health Outreach and the Health for Two programs illustrate the collaboration between three jurisdictions, AHS Edmonton Zone and the Health Co-op (local level), AHS as a whole (provincial level), and the Canadian Perinatal Nutrition Program and the Public Health Agency of Canada (CPNP/PHAC) (federal level). The Health Co-op contract for the Perinatal Health Outreach program among immigrant and refugee women is the responsibility of the Program Manager, Maternal Child Health in the division of Public Health programs, AHS Edmonton Zone. Perinatal Health Outreach is the first embedded mini-case that I describe and analyze in this chapter. This initiative is a targeted program to support women experiencing marginalization so that they can have healthier pregnancies and healthier babies. This program is funded entirely by AHS at the provincial level. This Funding covers the Health Brokers' work to remove the barriers women face when accessing health services by: providing group prenatal classes, by giving one-on-one prenatal education, breastfeeding support, organizing hospital tours, distributing prenatal tape recordings, translating materials into different languages, and mounting health education campaigns through ethnic media (MCHB Co-op 2005fr).

Despite the changes and restructuring in Alberta's health system in the last 20 years, the funding for this program has been maintained. Under the 2009-2010 contract the Health Co-op received \$317,502.56 to serve 2,340 families, covering approximately ten percent of the births in Edmonton.

The level of funding for this intervention⁶, however, has not changed significantly since 1998, despite the 211.7 percent increase in the number of pregnant or new mothers needing support from 2005 to 2010. No additional funding has been provided to deal with the increased demand. According to one health professional, every year the Maternal Child Health area scrambles to make sure that they receive the funding to renew the contract, and “if there is money in the budget”, to provide for a cost-of-living increase, which has been approximately three percent in recent years (Azucena). The Maternal Child Health area, however, considers the Health Co-op Perinatal Health Outreach a core-funded program. Figure 6 illustrates the funding path for both the Perinatal and Health for Two programs.

⁶ During my research I could not find any data to compare regular AHS’ costs for perinatal activities not offered through the Health Co-op. This is an area, which I identify for further research.



The Health for Two Program

The Health for Two program is the second embedded mini-case that I describe and analyze in this chapter. This program began in 1995 and provides support to mothers in Edmonton who are at risk of having pre-term babies or newborns with unhealthy birth weights. The program is funded by the CPNP, which allocates \$571,000 per year, re-assessed on two-year renewal cycles. The Health Co-

op's clients served by Health Brokers receive in-kind material support from this program. This means that each mother received one four-litre jug of milk (\$4.59) per week during pregnancy and until the baby was two months old. In addition she received multivitamins and bus tickets for medical appointments. For example, almost a third (n=620) of mothers enrolled in the Health Co-op's Perinatal Outreach program were also registered under the Health for Two program (MCHB Co-op, 2010fr). Health professionals and Health Brokers acknowledged the material support given to women was the "hook" that enticed the most disadvantaged pregnant women or new mothers to seek and accept enrolment in perinatal programs.

Although the level of funding has remained the same since 2001, the administrators of the Health for Two program have been creative in working with flat funding despite the changing needs of the population (Azucena). CPNP's projects description (CPNP, 2007) indicates that "...there is no "cookie cutter" or "one size fits all" approach to program delivery. The principle of *flexibility* [not my emphasis] has nurtured a climate where projects are encouraged to respond to emerging issues" (CPNP, 2007, p.10). Indeed, the Health for Two program has a unique structure among Alberta's CPNP funded projects because it is delivered by a partnership of over 35 community agencies, including the Health Co-op, all of which constitute the Health for Two Network (Network). The Network meets regularly to co-ordinate the work and to identify areas for staff development. CPNP's goals are to support comprehensive, community-based services that build upon existing prenatal health programs or establish them where they do not exist (PHAC, 2010). The Health for Two program and its Network is a community-based program. The Health Co-op determines which Health Broker attends which meeting. Health Brokers provide updates on the work of the Health Co-op on issues faced by immigrant and refugee women to the Network, and they are also expected to feed the information from the Network back to the Health Co-op and Health Brokers.

Health for Two Network is managed by a community health agency, the Boyle Street Community Services, in coordination with AHS Edmonton Zone Public Health. CPNP funding covers both program-related costs and staff salaries. Program costs include milk coupons, prenatal vitamins, and bus tickets for medical appointments. Staff costs include: a) salaries for four permanent part-time (4 x .5FTE) Network coordinators, who support member agencies on the northern, southern, western, or central parts of the city; b) one full-time nurse (1FTE), in charge of addressing the health needs of pregnant women or new mothers and their babies, according to geographic area; and c) one full-time and one half-time support worker (1.5FTE) to assist clients of Network member agencies who need referrals and accompaniment to health centres or related medical appointments. The Network's agencies, including the Health Co-op, benefit by obtaining infant care and prenatal information for pregnant women and new mothers (Alberta Health Services, 2009a-a). Through their work, Network agencies contribute in-kind support to the Network, which helps CPNP and AHS to meet their mandates.

THE HEALTH FOR TWO PROGRAM'S IMPORTANCE FOR THE HEALTH CO-OP & AHS

The Health Co-op is the only organization in the Network that receives direct funding from AHS Edmonton Zone to deliver the Perinatal Outreach program and in-kind support to undertake the Health for Two program for immigrant and refugee women. This means that the Network's public health nurses are available to provide clinical support to clients served by Health Brokers. In other words, the Health Brokers help AHS fulfil its mandate to provide perinatal information to all women in Edmonton, including those who are experiencing marginalization, such as immigrants and refugees. In turn, delivering the Health for Two program, allows the the Health Co-op to advance its

social goals, such as health equity for immigrant communities. In 2011, the Health Brokers served ten percent of the births in Edmonton— often more than other Network agencies combined— so the Health Co-op was practically considered “a Network” within the Network. Figure 7 illustrates the organizational structure of the Network.

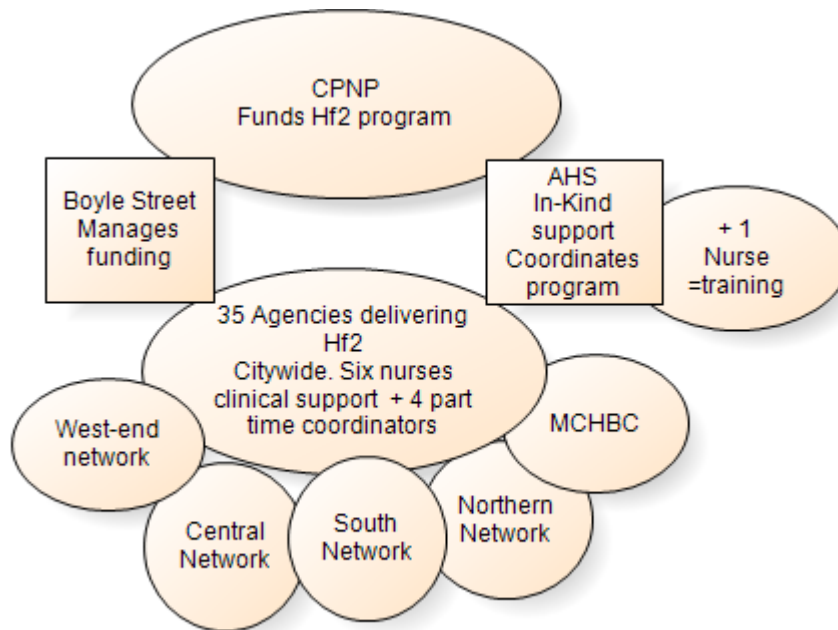


Figure 7. Organizational structure of the Health for Two program

Fourteen percent of the Health Brokers’ caseload falls within the Health for Two program (MCHB Co-op, 2010db), which means that in the 2009-2010 fiscal year, 620 immigrant and refugee pregnant women required material support in order to address their risk of low-birth weight or pre-term babies (MCHB Co-op, 2010fr). The Health for Two program also acts as a mechanism that facilitates AHS Edmonton Zone’s ability to: deliver a single perinatal training program for perinatal outreach workers and Health Brokers within the Network and provide them with standardized written materials translated into several languages (for example, Spanish, Chinese, French). For example, I observed a drop-in session where pregnant women or new mothers came to see a Health

Broker to receive their milk coupons and vitamins. Some came alone, some came with their spouses. In this session, one pregnant woman had queries about the stage of growth of her baby and the Health Broker was able to use the pregnancy charts provided by the Health for Two program to show the mother the different stages, by trimester, of the baby's growth as well as the changes in the mother's body.

AHS EDMONTON ZONE'S SUPPORT FOR HEALTH FOR TWO

Because the success of CPNP programs is in part based on backing received from provincial governments, AHS provides significant in-kind support to the Health for Two program and its Network. This support matches the contribution by CPNP, both for program-related costs (vitamins and educational materials) and staff time (program coordination, training, and nurse resources for prenatal visits). The staff support includes: a) one full-time (1FTE) coordinator for Health for Two across Edmonton, who is in charge of reporting and accountability to CPNP; b) one part-time public health nurse (.7FTE), who delivers the Learning Together Perinatal Outreach Training to Network agencies (discussed below); and c) three full-time (3FTE) registered nurses, who respond based on geographic area to the health needs of Health for Two pregnant women or new mothers and their babies. Program support also includes necessary educational materials and other resources for the Network. The integration of the Health for Two program within AHS is shown by the institutional support that AHS provides to it. For example, the coordinator and the public health nurses are all staff of AHS. This is unlike the flat contract that AHS signs with the Health Co-op, where the Health Brokers are employees of the Health Co-op and not of AHS. This means that there is different treatment of staff within the two programs: AHS staff have employment security and higher wages while the Health Brokers do not.

ACCOUNTABILITY AND REPORTING

For accountability and statistical purposes, the Health for Two program must submit yearly reports to PHAC, which administers CPNP. All Network agencies, including the Health Co-op, must submit quarterly reports to the Health for Two Coordinator, who in turn submits yearly reports to PHAC. Quarterly reports are used to internally monitor progress. All agencies receive a single half-day basic orientation session on how to fill in the required paperwork. I attended one of these sessions and not a single Health Broker was present. My understanding at the time was that there were no new Health Brokers hired by the Health Co-op, and other Health Brokers already knew how to fill in the paperwork. All perinatal outreach workers, including the Health Brokers, are expected to keep track of data and fulfil two specific tasks: keeping a master list of participants involved in the program and providing quarterly reports on women using the program to the Coordinator. Workers also have to follow ethics protocols, such as obtaining written consent from women to participate in the Health for Two program and to transfer the women's Health for Two record from the agency serving the mother to the Health for Two Program Coordinator. Another protocol applies to obtaining written consent that the mothers undertake to receive and manage the prenatal vitamins appropriately.

The second task perinatal workers must fulfil is to keep demographic data and other information about clients. This task includes completing the following forms: a) the women's "Welcome Card", which registers demographic information and features pregnancy assessments in order to determine what factors might affect the women's pregnancies; b) the postnatal interview assessment form – this form helps the worker keep a record of the baby's birth and the mother's health during pregnancy; c) the "Mother's Checklist" – this list facilitates keeping track of the daily services provided per program participant; and d) the Welcome Card "summary of services" – this records the overall number of services rendered to the mother over the course of the Health for

Two Program (Alberta Health Services, 2009a-a). The perinatal outreach workers and Health Brokers have to keep statistics for the women during their pregnancies and until babies are two months old. Depending on when some of these women joined the program, the record-keeping may last from two to nine months. I learned in my participant observation activities that Health Brokers found that the paperwork took too much time of their work with clients. This meant that several Health Brokers did not complete their reports on time. This lateness had an impact on the Health Co-op's ability to provide timely reports to funders. I observed in a couple of meetings, that this created some tension for Health Brokers and that the Health Co-op was trying to set-up mechanisms and supports to facilitate Health Brokers submitting client reports on time.

During one of my data validation sessions (February 13, 2012), I learned that some of the forms outlined above were changed or discarded because PHAC no longer requires, as it did in previous years, quarterly reports. It now requires only yearly reports. As well, some of the forms were revised because the information unnecessarily duplicated the workers' reports. For local purposes only, however, the Health for Two program still collects quarterly reports and demographic data to monitor the progress of their program.

TRAINING FOR PERINATAL OUTREACH WORKERS AND MULTICULTURAL HEALTH BROKERS

Health professionals interviewed indicated a vivid interest in providing perinatal training to the Health Brokers. Indeed, this is something AHS had done over the years. The first training of Health Brokers, formerly called Multicultural Childbirth Educators, took place in 1992. This training was unique because Health Brokers, public health nurses, and nurses from Maternity Wards in the three major Edmonton hospitals took the training together. At that time, the notion was that nurses and Health Brokers needed to learn from each other. The former had to learn what it was to be a

mother from an immigrant or refugee background using the health system, and the latter had to learn clinical information and prenatal care health promotion. Currently, the training is only given by public health nurses to Health Brokers and perinatal outreach workers in the Alberta Health Services Edmonton Zone. The Maternal Child Health area offers a training course called *Learning Together Perinatal Outreach* (Alberta Health Services, 2005). The main objective of the training is to provide a framework for perinatal outreach work for Health for Two families through the completion of self-study modules from the Learning Together program (Alberta Health Services, 2010a).

This training was developed by the Maternal Child Health unit to standardize the knowledge and expectations of perinatal outreach workers and Health Brokers. During seven weeks of half-day training, participants receive six standard training modules as well additional perinatal educational materials as needed (Alberta Health Services, 2008; Capital Health, 2006). I observed six different training and refresher sessions to familiarize myself with the perinatal information that Health Brokers needed to master. I received a copy of the training manual that the participants receive, which I come back to later in the chapter. Each module covers different areas of perinatal health, as follows: a) Module One addresses the concept of perinatal health and the role of the perinatal outreach worker (or Multicultural Health Broker); b) Module Two focuses on the challenges of working with culturally diverse families, such as Aboriginals, immigrants, and refugees, and teen mothers and fathers involved in perinatal outreach programs; c) Module Three features a Transtheoretical Model of Change, dealing with the perinatal stages women go through, such as pregnancy, labour, and birth; d) Module Four covers health and nutrition during pregnancy; e) Module Five provides practical demonstrations of labour, birth, and breastfeeding issues; and f) Module Six addresses the supports that mothers and babies need after the baby comes home and offers tips for the self-care of the perinatal outreach worker. Although there is no evaluation of

trainees' knowledge after completion of the course, the Health for Two nurses are available on an ongoing basis for consultation and support to clients and Health Brokers as required.

FREQUENCY OF TRAINING

All perinatal outreach workers from the 35 agencies delivering the Health for Two Program in the Edmonton Zone, including the Health Co-op, receive the Learning Together Perinatal Outreach training. The perinatal outreach workers and Health Brokers are expected to take part in this training when they start to work for their agencies. Senior perinatal outreach workers or Health Brokers are also encouraged to take refresher courses. This training is delivered by a Health for Two Resource Nurse. Guest speakers, such as nutritionists, provide information on a specific area, for example, introducing food solids to babies. The trainees are mainly women and some men from different ages, backgrounds, and experiences. The training is free of charge. Network agencies also receive a "resource box" to keep as a reference tool, so agencies' staff is aware of the information the perinatal outreach workers and Health Brokers must have. All materials given in the training are approved by Alberta Health Services. The Health Brokers are generally the only trainees whose main focus is immigrant and refugee mothers and families. Table # 9 summarizes the content of the six modules by outlining the learning focus of each module. Health Brokers and perinatal outreach workers are expected to apply the training knowledge in their daily interactions with pregnant women and new mothers. One health professional remarked, and I also noticed, that issues dealing with perinatal health for immigrant and refugee women were mainly discussed if Health Brokers were present at the training. This can be interpreted in two ways, which I return to later in the chapter: a) that perinatal outreach workers (other than Health Brokers) attending the training often did not have any exposure to clients from immigrant and refugee backgrounds, and/or b) that the trainer only considered it important to address those particular issues if there were Health Brokers

attending the training. As discussed later, Health Brokers attending or not attending the training was being negotiated between the Health Co-op and the AHS at the time of my research.

Table # 9. Summary of Six-Module training for Perinatal Outreach Workers and Health Brokers

Module	Learning focus	Challenges faced by women	Task of the perinatal outreach worker
One Title: Outreach worker	▪ Framework and philosophy of perinatal outreach ▪ Circumstances and challenges experienced by women ▪ Personal values of outreach workers and relationships with families ▪ Outreach workers' skills: support advocacy, referral information sharing & home visitation	❖ Financial barriers ❖ Isolation ❖ Addictions ❖ Relationship problems ❖ Illness and mental health issues	✓ Establish trusting relationship with women ✓ Practice self-reflection (warmth and respect) ✓ Be aware of: women's realities, benefits of home visits, stages of change
Two Title: Families	▪ Families from different cultural backgrounds (biases & values): Aboriginal history traditions & values Immigrants and refugees populations (voluntary versus forced migration, cultural competence in the system) Teenage mothers Fathers' involvement	❖ Same challenges as in Module One plus: Cultural & language barriers Oppressive policies Negative stereotypes, discrimination and racism Mistrust of health professionals & institutions Ambivalent or absent fathers	✓ Be aware of: history & culture of Aboriginal people; pregnant teens issues ✓ Provide culturally-competent services ✓ Involve fathers ✓ Understand and respect differences (immigrants, refugees)
Three Title: Supporting Change	▪ Stages of Transtheoretical Model of Change ▪ Motivational interviewing techniques ▪ Assisting women in change process ▪ Alcohol, smoking, and substance abuse ▪ Abuse on women and violence ▪ Stress and relaxation techniques	❖ Information alone is not enough ❖ High risk of delivering alcohol or drug-exposed babies ❖ Low birth weight babies ❖ Desire to quit addictions ❖ Physical or emotional abuse ❖ Sexually transmitted infections ❖ Stress, anxiety, fear of danger	✓ Develop goals together with women ✓ Assist women in recognizing substance abuse ✓ Do not be judgemental ✓ Help women identify their stages of change ✓ Identify signs of abuse

Four Title: Health and Nutrition	▪ <i>Three trimesters of pregnancy and changes for the mother & the baby</i> ▪ <i>Healthy eating and quality of food intake</i> ▪ <i>Healthy weight gain during pregnancy</i> ▪ <i>Regular prenatal care and oral care</i> ▪ <i>Prenatal exercise-physical activity</i>	❖ <i>Body image (Restricting food intake to avoid weight gain)</i> ❖ <i>Physical discomfort (nausea, constipation, backache, swelling)</i> ❖ <i>Emotional changes (anxiety)</i> ❖ <i>Missed physicians visits</i> ❖ <i>Lack of dental care & resources</i> ❖ <i>Diabetes or high blood pressure</i>	✓ <i>Share information about: pregnancy & growth of baby, good nutrition; emotional changes</i> ✓ <i>Encourage: visits to physicians, dental care</i> ✓ <i>Identify warning signs of medical needs</i>
Five Title: Labour, Birth and Breast-feeding	▪ <i>Stages of labour</i> ▪ <i>Natural births and caesarean sections</i> ▪ <i>Supporting women during labour and birth</i> ▪ <i>Breastfeeding and infant formula</i>	❖ <i>Women do not have anyone to accompany them during labour</i> ❖ <i>Giving up breastfeeding (fear that baby is not eating enough)</i> ❖ <i>Unhealthy eating while breastfeeding</i>	✓ <i>Encourage and promote breastfeeding</i> ✓ <i>Not perpetuating myths</i> ✓ <i>Share up-to-date information & referrals</i> ✓ <i>Respect woman's choice</i>
Six Title: Support After Baby Comes Home	▪ <i>Physical and emotional issues</i> ▪ <i>Care of newborns (feeding, crying)</i> ▪ <i>Parents learning new role as parents</i> ▪ <i>Grief and loss from unexpected outcome (cultural differences)</i> ▪ <i>Birth control & postnatal sexuality</i> ▪ <i>Introduction of solid foods for babies</i> ▪ <i>Perinatal outreach workers' self-care</i>	❖ <i>"After-pain" contractions, bloody discharge, fatigue, breast engorgement</i> ❖ <i>The blues, post-partum depression</i> ❖ <i>Detachment from baby, anger</i> ❖ <i>Mothers feeling lonely and overburdened</i> ❖ <i>Perinatal outreach workers' stress</i>	✓ <i>Encourage, support, and inform women</i> ✓ <i>Offer referral services</i> ✓ <i>Share information with parents</i> ✓ <i>Key birth control messages</i> ✓ <i>Practice self-care</i>

Voices of health professionals

I asked health professionals within AHS (n=7) to describe the relationship they had with the Health Brokers involved in the Perinatal Outreach and Health for Two programs. I started all interviews by asking participants to speak about themselves and how they became involved with the Health Co-op and Health Brokers. I also asked them about the history of the programs and how these fit within the mandate of AHS, the training provided to Health Brokers, the issues faced by immigrant and refugee women in the area, and the responses from the health system to those issues. I present their views in three areas: a) micro: the Health Co-op and AHS Edmonton Zone's partnership that facilitates access and removes barriers to health services; b) meso: health practitioners' attitudes and behaviours towards immigrant and refugee patients as well as their understanding of cultural or religion-specific issues when these patients seek health services; and c) macro: the health system's policies to address health equity and social determinants of health targeting immigrant and refugee communities.

THE MICRO

Health professionals' perceptions about Health Brokers' practice

All participants thought it was necessary to have the Health Brokers as partners in order to reach and work with immigrant and refugee communities. They reflected on how the relationship of the Health Co-op and the Health Brokers with the health unit was built over time. The benefits of this relationship appear twofold: the Health Brokers help the health unit meet its mandate to serve immigrants and refugees; and the health unit's staff and managers learn about immigrant and refugee communities from the Health Brokers. The knowledge exchange normally happens through progress reports, but mainly through daily interaction between Health Brokers and health

professionals. One health professional indicated that, initially, some health professionals feel challenged in helping these communities because the approaches required with immigrants and refugees or “cultural families” differ from what they are accustomed to with “regular”, “North American”, or “majority group” families (Spray). Another health professional explained that simple things like whether to accept water at a home visit must be well thought through:

...just to be a bit more respectful when you're meeting with somebody, maybe there's some cultural things you need to learn, like, you know, in some cultures, if you don't accept that glass of water, that's really quite rude, [- -] whereas, from a safety point of view, we say, if you go on a home visit, really, you shouldn't be accepting things from a family, right? [- -] But, if I were to go to such and such a type of family, that's very rude not to take some food or [- -] something like that, right? So, just to learn those kind of things and [- -], how do you handle that situation and, kind of thing (Ivy, February 8, 2010).

Health professionals have also learned from Health Brokers about the importance of avoiding pigeon-holing immigrant families. According to one health professional, the Health Co-op's leadership has warned them to be careful with labels. For example, just because one family behaves in a certain way does not mean that they should categorize all families in the same way. This is especially important if this characterization leads to stereotyping and discrimination for immigrant and refugee families from that particular culture. All the health professionals interviewed indicated that the Health Broker program was a valuable. The reasons they gave for this included Health Brokers' knowledge of the different cultures; the cultural appropriateness of their work; and their ability to help clients in different areas. One health professional stated:

Well, I don't think we could do our work without them....I think that they're hugely influential in the outcomes...I mean certainly there's a role for both of us [public health and Health Brokers] within helping that family with health outcomes, but...we really depend on them [the Health Brokers]. And like I said it's not just about the language, it's about the whole cultural appropriateness and navigating the system. Yeah (Viburnum, February 25, 2010).

HEALTH BROKERS HELP PATIENTS TO BE UNDERSTOOD

One participant (Violet) explained that many immigrants and refugees who are seen by health professionals without the support of a Health Broker are misunderstood, especially when they did not speak the language fluently. She had seen cases where the patients' charts indicated that everything was fine, but as the women shared more information with Health Brokers they realized that health professionals had been unable to capture all the problems the women were experiencing. These included poverty, which restricted patients' ability to meet their basic needs. In addition, health professionals explained that Health Brokers helped the mothers to integrate into Canadian society without losing the cultural traditions from their own countries (Spray, December 17, 2009).

A PARADIGM SHIFT

One health professional stated that because the Health Broker model is culturally- and linguistically-appropriate, it has been successful in making a "paradigm shift" within some parts of the health system. According to this health professional, because of this paradigm shift, now most health services providers in the city understand the need to look at "culture" when serving immigrants and refugees. This participant stated: "... I think the Health Brokers have really done, and maybe they don't realize it – but they've done a pretty remarkable job at encouraging a paradigm shift in Edmonton and area, of really coming from a – you know this isn't just about translating a resource, it's about understanding the cultural framework" (Daisy, May 10, 2010). Indeed, as discussed in Chapters 5 and 8, this is the market niche that the Health Co-op and Health Brokers have been able to create for themselves in Edmonton's health and social services programs.

CHAMPIONS SUPPORTING THE HEALTH BROKERS PRACTICE WITHIN THE HEALTH SYSTEM

Some health professionals spoke of the role other key staff and managers (champions) had played in

advocating within the system to sustain funding for the Health Brokers to deliver the Perinatal Outreach program to immigrants and refugees. These champions understand both perspectives: the issues immigrant and refugee communities face in accessing health and social services and the health system's responses to addressing the needs of these communities. By promoting the Health Broker model within Alberta Health Services in Edmonton, the health professionals interviewed often had become advocates and champions from within. Championing the model to nurses based at community health centres helps these nurses to be more receptive to the role of the Health Brokers and to address the needs of the clients brought to the centres by the Health Brokers (Azucena Part II. January 18, 2010).

One participant explained that it was important for nurses and other health professionals who understood the Health Broker model to inform their peers about it in order to build trust for it. As health services providers understand and trust the role of Health Brokers, the credibility of the model increases (Azucena). This means that health professionals play a "brokering" role within the system and make it possible for Health Brokers to mediate between health service providers and immigrant and refugee communities. By increasing awareness of the Health Brokers' role within the system, health professionals also learn about the cultural and specific needs of these populations and how their needs can be addressed in culturally- appropriate ways. This also means that the health unit and Health Brokers' work is synchronistic: while the health professionals at the health unit build trust in the Health Broker model within the system, the Health Brokers build trust about their own practice within immigrant and refugee communities. One health professional stated:

... I would certainly hope that...front-line providers, whether they be in a physician's office or [working as] an ultrasound technician, or a community health nurse [- -],

that they learn through the Brokers as much as women and community members learn through the Brokers [- -]. And, within the system, um, I think we also have a role – we being persons like myself or [my colleague] or the manager of our area... [have] a responsibility as well to try to increase understanding of the need to work with a group like the Brokers... (Azucena, Part II. January 18, 2010).

Another way to make the Health Broker model known among health professionals is to have the Health Brokers speak at orientation sessions for new medical staff at hospitals or community health centres. I learned during my research, however, that the health unit was reviewing ways to address immigrant and refugee issues at these orientations sessions. The reasons were: a) the number of orientation sessions was high; and b) there was insufficient funding to cover the Health Brokers' time to speak at all sessions.

SUSTAINABILITY OF THE HEALTH BROKERS' PRACTICE

During my research, the provincial government had just completed a major restructuring of the delivery of health services across Alberta by consolidating oversight of the health system into a single province-wide board of health (AHS) (Alberta Health Services, 2009b, 2012). This major restructuring had implications for the multicultural Health Broker model in Edmonton in two ways: a) it created a sense of uncertainty about whether the current funding arrangements for frontline work would continue; and b) it removed the decision-making power the local health unit previously had as an autonomous local body. The health professionals saw this restructuring as a positive change because it allowed a common strategy for the province. One participant explained that the restructuring in AHS had not caused any changes to frontline programs, but there was uncertainty about what would happen:

...we have continued with sort of the same framework as we had [previously], the focusing on healthy birth weights [- -], breastfeeding initiation, um, nutrition in the first year, mother's health around post-partum depression screening, all that falls

under this whole healthy babies area. But, just what type of, how will those goals be framed within Alberta Health Services, we don't know that yet ... (Azucena).

During my data validation over a year later, I asked if AHS Edmonton Zone was more certain about the future of the Health Brokers' Perinatal program. I learned that the funding for the program had remained the same (Meeting, October 18, 2011). The restructuring of the health system, however, raises questions about the integration of the Perinatal program within AHS, particularly if the champions who support the program leave and other staff and managers come in. One health professional stated:

... right now the Brokers have a strong connection to health, because they've always had a nurse, and because [we are] quite aware of them. [- -] The other agencies don't get this kind of support, right? ... and I really feel that it's our responsibility, to help the Brokers stay on track, so they keep that funding, [- -] and to make sure their job's getting done, right? In the way that health would say, "Yeah you're doing a good job, and we'll keep the funding going." [- -] So we really feel that strong commitment, if we're gone, if we're gone, how does health handle that funding, will the Brokers get the funding from health still? Will they see it as important? (Spray).

A HEALTH BROKER MODEL EMBEDDED IN OR INDEPENDENT OF THE SYSTEM?

I asked the health professionals to share their thoughts about having the Health Broker model embedded in the health system, instead of being independent as it currently is. Their responses varied. One health professional felt that it was good for the Health Brokers' practice to be independent because the current arrangement worked well for both the health unit and the Health Co-op. Some participants thought that being independent gave the Health Co-op the liberty to implement their program as they saw fit to meet the needs of immigrant and refugee communities. If Health Brokers were embedded in the system, however, decisions might not be made as quickly or efficiently for Health Brokers because of bureaucracy. For example, approving perinatal resource

materials would take longer than it does now for the Health Co-op (Viburnum). Another participant indicated that Health Brokers' practice that is independent from the system has allowed the Health Co-op the opportunity to seek contracts and engage in areas beyond mainstream health. Another health professional indicated that the Health Co-op's independence from the system had facilitated the growth of the organization and the broadening of its mandate. These points were corroborated in my interviews with Health Brokers and mentors.

From the perspective of the health unit, it is cost-effective to contract out the Perinatal program to the Health Co-op. The health system has funded the program at the same level for many years, because as an independent entity the Health Co-op is expected to carry out the work even if funding does not keep pace with demand. One participant stated that it would also be possible to have the Health Brokers' practice embedded within the system, but that it would require creativity when designing a suitable model to integrate the work into mainstream organizations. For example, the system would have to consider many aspects, such as creating a new classification for these workers, who are not trained as nurses (Azucena). Several health professionals mentioned a model used in past years in which Health Brokers were embedded as permanent part-time workers at every hospital in Edmonton. Due to funding cuts, however, all but one of these positions was eliminated. One health professional explains:

...at each of the hospitals there used to be a Multicultural, um...person, I don't know what they called them. ... as funding has been cut... that Multicultural person has been cut from the program... But the hospitals are cutting that funding, so you don't have those positions anymore either, [- -] ...a big thing in health to have informed consent [- -]. That's huge. People have to understand what's going to happen to them [- -]. And yet, they don't speak the language, and we go ahead and we do the procedure anyways. [brief pause] Yeah!! [- -] Because they can get away with it. So... (Spray, Part I. December 17, 2009).

The only remaining part-time permanent Health Broker position, based at the Grey Nuns Hospital, which was funded initially through private foundation dollars, is now integrated into (and funded by) the public health system (Anonymous interview, March 15, 2011). This Health Broker also works at the Health Co-op and refers other women who need post-partum support to the Health Co-op's Health Brokers.

HEALTH BROKERS AS PART OF HEALTH HUMAN RESOURCE WORKFORCE

I asked health professionals for their opinions about Health Brokers as part of the health human resource workforce. All the health professionals recognized the important role Health Brokers played in the public health system and that there would be a gap in the delivery of services to immigrants and refugees if they were not there. One health professional referred to Health Brokers' contributions to the health system as one of saving lives. This participant said: "...when a family has a cultural Broker, all the different pieces of the health care system are put into place, they don't do the immunization, they don't do the ultrasound, but ...without the cultural Brokers, people don't have access. [- -] We saved lives..." (Violet, February 5, 2010). This participant continued:

I'm completely convinced that every single newcomer to the country should have a health broker, I mean, I have no doubts about that [- -], from the point of view of the immigrant families manage fairly well in comparison to the refugee families, but the refugee families really struggle and should, do need that kind of support, I feel quite strongly (Violet).

Another health professional explained that Health Brokers played a tremendous role in the workforce in public health because they taught immigrant and refugee families how the health care system worked. This participant also indicated, however, that Health Brokers were not paid at the same level as other staff in the system doing similar jobs. For this health professional, many Health Brokers came from professional backgrounds in their own countries, but their credentials were not

recognized. These professionals became Health Brokers because they were not able to find employment in their fields. She stated:

Well, I think that they do a tremendous job, but they don't get paid for the work that they do, they don't get paid well-enough for what they're doing. [- -] I, I really do, because...most of these – and most of them are women,... are very well-educated in their own countries, and they just can't get other jobs here, and so they go into these cultural brokering jobs, which are huge, important jobs [- -], but they don't, they just don't get paid the same ...as someone who grew up here and had the same training (Ivy).

Another health professional did not know how much the salary of a Health Broker was but assumed that they were paid less than a public health nurse. According to her, a nurse in Category Two would be paid \$42 per hour. In regards to Health Brokers' hourly wage, this participant stated, "... but the Brokers, how much are they paid, \$17 an hour? I don't know, between \$15-20 an hour, so you look at that [- -], and they do, way more work, because they put in so much overtime..." (Spray). In my interviews with Health Brokers, they indicated that their hourly wage was fixed in 1998 at \$20.00 and had not increased in the last 14 years. Health Brokers also corroborated that their hourly rate was much lower than other workers in the same or similar field.

Another issue raised about the compensation of Health Brokers' work was that although their role in providing "units" of perinatal services was recognized, the other work they did "to support" immigrants and refugees was not fully acknowledged. Potentially, one participant said, the system could put measures in place to count "support" instead of only units of perinatal services, but this is not currently done (Azucena, December 14, 2009).

TRANSFERRING THE MODEL BEYOND EDMONTON

I asked whether other health professionals knew about the Health Broker model. Generally participants indicated that most of the public health unit's staff, which worked with the Health Brokers, knew about the model, but they doubted that health professionals outside Edmonton did. Some indicated that the most logical way to make the model known outside Edmonton was to work through higher level decision-makers and have managers share their knowledge up the ladder, which could then be disseminated at the provincial level. There did not, however, seem to be opportunities to do this in a systematic way. Some health professionals knew of provincial policy makers who were familiar with the Health Broker model because in the past they had worked at the city level. Other than this, no mechanisms were in place to make the Health Broker model known to the upper echelons of the health bureaucracy. I also asked if the Health Broker model was known across Ministries. One health professional believed that social services in Edmonton knew about the model because the Ministry of Youth and Children Services supported the Health Co-op's Home Visitation program. Other than these examples, health professionals could not comment on how well the Health Broker model was known beyond Edmonton or the health system.

INTERPRETERS VERSUS BROKERS

All health professionals understood that Health Brokers were different from interpreters. They stated that language interpretation was just one part of the work Health Brokers did to increase the opportunity for immigrant and refugee communities to use health services. For the participants, the Health Brokers not only ensured access to perinatal health services, but they also addressed other health concerns that arose. For them, interpreters typically just do literal translation of the health messages between the health professional and the patient. One health professional described the roles of the interpreter and Health Broker in the following way:

...the interpreter only comes with me, and helps me speak with the client, [- -] but doesn't do any referrals or, doesn't help the woman connect with others in her community or [- -], that they're just something to help us communicate, a service to help us communicate, whereas the brokers do much more, the brokers will go with women to doctors appointments, take them there, help them, invite them to groups through the brokers and things like that, so they, get quite a bit more support; the interpreters are not for support, they are just strictly for translation (Hibiscus, February 11, 2010).

Some health professionals acknowledge that doctors might see Health Brokers solely as interpreters. If doctors do not understand the cultural issues, they will not understand that the Health Brokers' role is much more than interpreting.

CHALLENGES EXPERIENCED BY HEALTH BROKERS

One health professional also spoke of the importance of providing emotional support for Health Brokers. According to this participant, working with clients who had complex needs could affect workers' own mental health. This participant explained that for instance nurses received training to help them deal with the impact of working hard and facing complex cases, but she did not know if Health Brokers received the same support:

... we meet regularly to talk about either situations and how we felt about the situation, or brainstorm around ideas and resources for clients in a particular situation. So we have tried to build that in. But I don't know if the Brokers have something like that. [- -] But it's thought not to be very valuable for individuals that are in high-stress situations, and some of the families that the Brokers work with. It's very difficult in terms of abuse and, cultural differences, you know, around abuse, and how that's viewed in the home country vs. here and the woman seen as more at risk and isolated here, doesn't have her family support system [- -], or if she leaves her husband to be estranged, all on her own here, and isolated as well as estranged from her family, community, in her home country..." (Hibiscus).

I learned through my research that Health Brokers also receive some support for their mental health.

WORKING WITH CLIENTS VERSUS REPORTING ON WORK DONE

Some health professionals mentioned that Health Brokers had problems reporting their practice systematically. For one participant, however, the Health Brokers' role was not about paperwork, but about understanding the situations in which families lived. This health professional indicated that Health Brokers should not be investing too much time in paperwork, because their primary role was to communicate and establish trust with families. For this participant, Health Brokers should be more concerned about helping the families meet their basic needs, such as food or housing. Another health professional understood that community agencies, like the Health Co-op, had different styles of working and reporting. This participant indicated that nurses, on the other hand, had been trained to work in a very structured way. They had to follow certain procedures or they were questioned about it, particularly with respect to safety issues. She also acknowledged that because Health Brokers had different levels of education and experience, reporting on their practice or identifying health concerns might not be a priority for them. Nonetheless, not reporting systematically could affect the "clinical" care patients might need. For example:

...When you're working with an agency, and I don't think [the Health Brokers] are alone on this at all, I think a lot of community agencies work like this, ... So, when ... you're concerned about ...that they've [the Health Brokers] documented well, or that they've followed up on things, because what if ... the mum says she has her, you know, a bit of pain in her breast, you know, she's nursing her baby, she has a bit of pain in her breast, she just kind of casually says it. Well, [the] nurse would pick it up right away, right? And you'd want to refer a check on her, a Broker might be more concerned about – which is fair – they don't have any food to eat. So what are [- -] all the pieces you have to follow up on right? So a nurse wants you to be able to write down... (Spray, Part I. December 17, 2009).

Another example of the impact of the lack of systematic reporting is that referrals from Health Brokers to nurses have decreased. As a public health nurse no longer works from the Health Co-op's office, follow-up without a paper trail is more difficult. Beyond this a decrease in referrals given the

current economic crisis and job losses in the province as well in light of the poverty issues faced by many immigrants, was, according to some health professionals, unlikely. The hypothesis from one health professional was that, owing to less emphasis being placed on systematic reporting, Health Brokers might be forgetting or failing to identify some health concerns of women and other family members.

CLINICAL SUPPORT FOR CLIENTS SERVED BY HEALTH BROKERS

The expectation that a public health nurse should be based at the Health Co-op dates from when the organization was incorporated as an independent entity in 1998. Since then, except for a number of months before I started my research in the spring of 2009, a nurse had worked part time at the Health Co-op to provide clinical support to clients seen by Health Brokers. According to some participants, the main reasons for the Health Co-op not having a public health nurse onsite anymore are threefold: a) the position being part-time, but the work demands being equivalent to full-time work; b) the wages the Health Co-op paid not being as high as what nurses would make at a hospital or in another community setting; and c) the work setting requiring a great deal of flexibility in the hours of work, which nurses might not have. One participant explained that the first nurse who had worked with Health Brokers stayed there for a long time because she had understood the nature of the work very well. Other nurses who had joined the Health Co-op since then had not been as good a match for the culture of the Health Co-op and vice-versa. As a result, some health professionals interviewed were looking for alternative ways to provide public health nurses' support and expertise to Health Brokers and their clients. Two options were considered during my research (2009-2010), which were confirmed during my data validation in November 2011. These two options were: a) having the public health nurse, who is also the resource person for the Health for Two program, give updates on perinatal health at all Health Brokers' monthly meetings; and b)

having the Health for Two public health nurses provide ongoing support to Health Brokers by geographic area of the city (north, south, west, and central). For example, nurses whose catchment area is the north supporting Health Brokers whose clients live in that area.

The Health professionals [whom] I interviewed suggested it was crucial for a nurse to work closely with Health Brokers to ensure that the perinatal health care needs of the pregnant women and new mothers and their infants are met. One participant indicated that having a nurse based at the Health Co-op increases other health professionals' ability to understand the gravity of health issues that clients might be experiencing (Ivy). This participant explained that if a nurse called from the Health Co-op on behalf of a client, a health professional would be more likely to help that client than if a Health Broker called. For this health professional, the Health Brokers' role is not recognized in Canada's highly structured health care system. One recommendation put forward by the Health Co-op to address the need for a nurse to be based at their organization was for AHS to fully finance that position. This recommendation has been brought to attention of the health unit by the Health Co-op, but AHS has not allocated resources to create this position.

HEALTH BROKERS ARE AT MAXIMUM CAPACITY

One health professional believed that because of the high demands on Health Brokers' time and the lack of funding to support their work, Health Brokers are at "maximum capacity". This means that even if the Health Co-op wanted to promote their work and seek more referrals for Health Brokers, they would not have the capacity to meet the need. One participant explained:

...But, how to...you know, I think that Brokers are not in a space to be able to advertise right now, because they are already stretched to do, to try and cover the roles that they have [- -] time-wise, so, and I've had clients who say "Well, I'd really like the Broker to come with me to the doctor's appointment, but she doesn't have time," or the Broker has another job in the morning, and then does the brokering in

the afternoon, and the obstetrician is only open in the morning, and the family right now ...could really benefit from the Broker helping during the physician appointment, but the Broker can never come because of her, other, [commitments]... (Hibiscus).

For a Health for Two Network nurse it is a challenge if a Health Broker does not show up for an appointment with a client. Because the nurse often does not speak the language, she is not able to work with the client, resulting in time being wasted.

CRITICISM OF THE HEALTH BROKERS' PRACTICE

One criticism of the Health Broker model stems from Health Brokers' role within their communities. According to a health professional interviewed, because Health Brokers are focused on their own ethno-specific communities, they may lose sight of the "whole" picture or larger context. One example related to missing the full context is the failure of Health Brokers to fully share information they learn through the Health for Two Network meetings. According to one participant, a Health Broker might communicate such information solely to her community, but not see a need to pass it on to other Health Brokers and through them to other communities. This health professional stated:

...it was [x Broker's] responsibility to take that e-mail on to the rest of the Brokers, and pass on the information, that doesn't always happen. [- -] Ok, because again, they're focused on their community, so they let their community know what's going on, but [fail] to see the bigger picture [- -], they're not always there (Spray, Part I. December 17, 2009).

I asked the health professionals if Health Brokers could be hired as Network coordinators. One health professional stated that they could. This participant, however, indicated that it might be difficult for a Health Brokers to work on behalf of all communities, including mainstream Canadian ones, and not just with their own group. The argument here was that because Health Brokers were

so passionate about their communities, it might be challenging to work across communities. This health professional stated:

... A Broker usually works with the community, if they were a coordinator, they would not be working with their community, their community would be the north, and so, it would be all the agencies in the community [- -], ok? ...so, for a Broker to come in, [- -] who was equal all across the board, might be difficult to do because they still have their passion for their community, right, so they'd have to break away from that community, but the community would still see them as theirs, and their helper, so, if you had a Broker in, it would be great to have them as a network coordinator, because they'd give that balance, there [- -], one of the coordinators is aboriginal, she has aboriginal roots [- -], so that gives us a grounding there, which is really nice, but the other three are very Canadian... (Spray, Part II. December 17, 2009).

I return to this point in Chapter 8.

Another criticism voiced by health professionals is that some Health Brokers do not see taking the Perinatal training or refresher training on as part of their job, so they do not take it. This was a concern for some health professionals because they would like all Health Brokers to be up to date on perinatal health information. This concern, however, might be at least partly addressed by adoption of the recommendation above — that health professionals give perinatal updates at the Health Brokers' monthly meetings.

HEALTH BROKERS DO NOT WORK AS TEAMS

Another criticism identified by health professionals was that the Health Broker model was based on each Health Broker working independently with her or his community, so they did not necessarily see the importance of working together as a team. An example of this is not all Health Brokers attend the Health Co-op's monthly team meetings, so they miss opportunities to learn what is happening with other communities. This means that there sometimes is not enough communication among Health Brokers on what they are doing in their communities. One participant stated:

... because they don't ever come to the meetings, because, in their mind, their work is working with the family and that's what's important, they [- -] don't realize that working with each other, is integral to their job, and for them to stay healthy, and for them to be working with their families, with a better perspective, too, right? Because if you're isolated, this is your perspective [- -], you don't hear the other stories, so I think that's the biggest challenge, to me, working from the outside, that would be the biggest challenge... (Spray, Part I. December 17, 2009).

This concern was corroborated in my interviews with Health Brokers and mentors.

LACK OF BOUNDARIES AND HIGH TURNOVER

A point of tension in the relationship between Health Brokers and the public health unit is the issue of boundaries. Some health professionals argued that Health Brokers, especially the older ones, did not place enough boundaries in their work with clients. One participant acknowledged that other community agencies faced the same issue in some of their work. She noted one aspect of this issue, particularly relevant in this case: senior/older Health Brokers tended to work long hours, which could put them more at risk of burnout than junior/younger Health Brokers. This participant wondered whether young Health Brokers, like young workers in other agencies, would put in fewer hours and place more boundaries when working with clients. This health professional said:

You know what's interesting now, though? You've got younger Brokers starting now [- -], and I'm really interested to see how they will work with the families, to see if they will put more boundaries on themselves, [- -] you know, because they're young, like, early 2000s kind of thing [- -]. So I'm really interested to see that, because, I'm finding that with the agencies too, the older people will get burnt out. Because they try to do everything for everybody at all times, while the younger workers are saying, "No, this is, this is what I can do, this is what I'm paid for," and I have another life too, that I want to do things other things, like, whether I have a family or if I want to go on holidays, whatever [- -]. So I'm interested in that generational change too, because, most of the Brokers have been older right? [- -] Yeah (Spray).

In my participant observation activities and data validation processes, I learned that the Health Brokers and the Health Co-op disagree with health professionals' assessment that they lacked boundaries in their relationships with women and their families.

A related issue, according to one health professional, is the high turnover of Health Brokers in the health Co-operative. In my interviews with the Health Co-op's mentors, however, they indicated that they had a high retention rate of Health Brokers. Through my participant observation activities, I noticed that two young Health Brokers left the Health Co-op during my research. One asked for a leave of absence to work for another agency, and the other found the brokering role was too difficult for her to do for personal reasons. This might indicate that younger Health Brokers do indeed leave the Health Co-op faster than older Health Brokers.

NURSE-CLIENT RELATIONSHIPS

In my interviews with Health Brokers, they insisted on the importance of developing equal relationships with clients. One health professional, however, also spoke of developing relationships with clients as an opportunity she had, which other health professionals did not have. This health professional practices in a way similar to many Health Brokers. She accepts clients who are referred to her by another client; she accompanies some of them to doctors' appointments (if time permits); she coaches the clients on how to call or seek services from other agencies; and she helps some of her clients to find subsidized housing. This health professional explains:

... one of the things that's a huge issue is housing, and so we support them to get into the subsidized housing, the public-funded housing, and so the client that, so I will see one tomorrow who ...who lived in the inner city core while she was pregnant and now she was successful in getting subsidized housing so now she lives in the far north-east... (Hibiscus).

THE MESO

Health professionals' views of the health system

Most health professionals acknowledged the health system was responding well to the perinatal care needs of existing immigrant and refugee communities, but the system was not responding

adequately to funding additional cohorts from new cultural groups arriving in the city. As a result, the Health Co-op has had to divide funding received from AHS Edmonton Zone to stretch resources and serve more communities (Azucena, Part I. January 18, 2010).

One health professional also recognized that health professionals, staff, and managers knew of gaps in services and the lack of response from the system to meet the needs of immigrants and refugees. Health professionals were also aware that the health system had to address the competing demands from various populations, and they did not want to risk losing their jobs by being too critical of the health system or advocating too aggressively. For some health professionals, the opportunities to advocate within the health system were limited. One participant stated:

...we certainly speak to it [- -] when the opportunity comes, but...within, I think – and this is going to sound somewhat judgmental – the opportunity to advocate within the system is sometimes very limited. [Int: oh...because?] Well, I don't know if it's just an issue of power so much as it is of communication...[- -] And it's very, it's difficult to, also sound critical of an existing system when you're part of that system. I don't know if I'm describing that very well...[- -] but, because you can certainly advocate in a very positive way, too, without just saying, "Oh we're not doing a good job with the culturally-diverse communities" but ...I wouldn't say that we've had a lot of opportunities to advocate (Azucena, Part II. January 18, 2010).

Most health professionals indicated that they cannot have a large influence on major changes within the health system, such as remedy the lack of interpreters. They did acknowledge, however, that they were able to have an impact on small issues among individual or local cases. One health professional explained, for example, that nurses had stopped using the “growth charts” to monitor the development of Vietnamese babies because the charts had been created to measure the growth of Euro-Canadian babies (Spray). When nurses used these charts to measure Vietnamese babies, they found that the babies were small and assumed they had health problems. The mothers of

these infants felt frustrated that their perfectly healthy children were considered to have health problems because of their smaller stature.

Another participant was also critical of having a workforce that did not reflect the culturally-diverse backgrounds of the communities the health system was supposed to serve. This comment raised questions about the health system's lack of recognition of credentials for foreign-trained health professionals. This participant argued that:

...it's that whole principle of having a workforce reflect the community they serve...how to, how to have our own workforce be more reflective of a culturally-diverse community [- -]. And, I'm not an expert in how people's credentials are assessed or, [- -] and I know that there's many many hurdles to that [- -], but, one hurdle is having their experience recognized. So, to...even to be able to advocate more strongly in our system for the need to have a culturally-diverse workforce. And I don't think we've done a really good job of that (Azucena, Part II. January 18, 2010).

In this regard, another health professional acknowledged that within the public health unit, the composition of the managerial and professional staff was mainly European (white), while the makeup of the support staff had more racialized diversity (non-white) (Spray).

IMMIGRANT COMMUNITIES CONSULTED LAST

Some health professionals explained that with the creation of AHS's provincial health board, initiatives would be developed and rolled out throughout the province. For example, AHS staff was working on province-wide educational materials. According to one participant, they were seeking feedback on writing these materials from mainstream populations first, and would then adapt the materials for immigrant and refugee populations. The thought behind consulting the mainstream population first is "universal messages" ought to be developed for the whole population, followed by consultations with immigrant and refugee communities. One participant explained:

...so, initially what we will be doing is developing universal messages and materials. But over time, we know that we will have to target immigrant refugee and aboriginal families more specifically, so that materials are more culturally-appropriate for them. So that pattern, of work, is likely to fall across a number of the initiatives that [AHS will] be working on (Daisy, May 10, 2010).

This practice implies on the one hand that AHS is committed to having culturally-appropriate materials; however, immigrant and refugee communities will not be involved at the outset of this initiative, but at a secondary stage.

At the community and health professional level, the most prominent barrier mentioned was the inadequate language skills of patients. This was coupled with health professionals not understanding patients' pre-migration, migration, and post-migration histories. One participant explained how an immigrant woman went to a hospital emergency room with terrible pain, and the doctor examined her. The doctor gave the woman a prescription and a form to get blood tests, which she put in her pocket, without understanding anything about the doctor's instructions. Because she could not follow them, she did not buy the medicine or get the blood tests. As a result, she returned to the emergency room shortly afterwards. When the same doctor treated her again, he was frustrated because the woman did not follow his previous recommendations. This is just one example of the barriers immigrants, especially refugees, experience when they attempt to access the health system.

BARRIERS AT THE COMMUNITY LEVEL

One health professional mentioned that barriers to accessing health and social services also stem from racist and discriminatory practices among different ethno-specific communities or gender relations within some of these communities (Daisy). According to this participant, ethno-specific

racist barriers refer to some divisions among different groups who do not want to be involved in the same activities as other ethno-specific groups. Gender discriminatory practices refer to males from some cultures who forbid women from going out independently, limiting their opportunities to find employment and establish social support networks. This participant acknowledged that discrimination by mainstream groups towards minority groups existed, but she placed more emphasis on contentious practices within and across ethno-specific groups.

Another health professional explained that in order to reach and work with certain immigrant and refugee communities, it was important to respect views or practices of those communities. Some communities do not want to be involved with other communities on religious grounds, even if they speak the same language. This participant explained that some cultures, for example, would not want to work with a Health Broker from the same geographical area, who speaks their own language, if she practiced a different religion. Such communities wanted to work with a Health Broker who shared the same religion even though the Health Broker spoke a different language.

...one of the things that we learned too is that, sometimes it doesn't matter what language you speak, it's more about the religion, and that happened with [two client] families right [- -], because from where they come in Africa, there's...they don't mix, right. But ... our Broker ... couldn't break in and start working with those families because she was a different religion. So [- -], you know, yeah, so, you know, it's not just about the culture that you're from, it's also about religion, so we need to be respectful of that, so we learned that...(Ivy, February 8, 2010).

I return to these points in Chapter 8.

ACCESS TO HEALTH SERVICES

I asked health professionals to define access to health services and health equity and inequity. All health professionals acknowledged the impact of social determinants on health in access to health services, health equity, and apparent inequities. These included: low socio-economic status,

insecure housing, and lack of food security. For some health professionals, “access” to health services was synonymous with “health equity”. For example, one participant defined access as the ability of clients to fully cope with various aspects of obtaining health services. This involved clients’ need for knowledge on how to seek the services available and make informed consent on whether to receive services:

... so access I think is, has many different facets to it, and ...so, to my mind it has aspects of people knowing what services are available, knowing how to get them, feeling comfortable in receiving them, [- -] and being able to provide informed consent or to, not follow, to take a service. And that they're able to be consulted in their own care. So that those might all be different components, of “access” (Azucena, Part II. January 18, 2010).

The same participants suggested that merely having translation and interpretation services, for example, does not always lead to health equity; rather it is important to have people in leadership positions who can push for the work to have an equity framework. This health professional stated:

... we had...a division director who challenged us to look at health status from the perspective of providing equity...but I don't know that we had a definition so much as we worked with that as a concept, saying that, to have equity meant that..., it doesn't necessarily mean that you're going to provide a parallel service [- -] so that you have, say, translated services or a translated book, so that people could get this [- -]. That that might not provide equity, that you still, that to really have “equity” you might need to shift resources to provide greater opportunities for access, you might need to, work more from a community base (Azucena, December 14, 2009).

UNIVERSAL AND TARGETED PROGRAMS

Most participants acknowledged that the availability of ostensibly universal programs alone did not address the needs of vulnerable groups because factors such as lower socio-economic status had an impact on these populations. For one participant, for a program to be truly universal, special provisions should be in place to target populations, such as aboriginals, immigrants, and refugees.

This health professional stated:

Okay, that might work for 60-70% of our population, but what about our marginalized population, what about different language needs... Because I think even if we say that it's a universally-targeted program/resource, whatever, we always recognize that that still doesn't mean 100% of the population, because we've got either the language barriers, the cultural barriers, the determinants of health that can be barriers, so that's always a consideration, like "Who are we really targeting here?" because universal probably doesn't truly mean universal (Viburnum, February 25, 2010).

CULTURAL PERCEPTIONS ABOUT IMMIGRANTS AND REFUGEES

As well, some health professionals acknowledged that many professionals had their own assumptions about immigrant women's child birthing experiences. This means for example, that for health professionals it is up to immigrants themselves to learn about the health system. One health professional explained that a major challenge immigrants and refugees face is the system, which has been created for mainstream Canadians. Immigrants and refugees must "fit into" the system; the system resists changing to accommodate aboriginal or immigrant and refugee cultures. Some health professionals mentioned that at one point the health unit provided training on social determinants of health during new health professionals' orientation sessions. This training aimed to expose these health professionals to social determinants of health and their impact on new families. Due to funding cuts and system re-structuring, however, the funding sources for this training have been eliminated. This type of training is no longer deemed necessary, and instead resources are more likely to be devoted to clinical training, which is considered more important. Lack of training in these areas, however, has a direct impact on the way these professionals relate to immigrant and refugee patients. One health professional stated:

...people don't understand the needs of multicultural families [- -], right, when you're getting someone who's born here, trained in a Canadian system, if the system doesn't address multiculturalism or [- -] expose the students, the medical students,

the dental students, the nursing students to aboriginal culture, to life on-reserve, off-reserve [- -], to multicultural families, then they grow up with a very straight idea, and narrow idea, of what happens ok, [- -] so when you go into the hospital, this is the routine in the hospital, we don't change it [- -], we don't change it for anybody, it doesn't matter if you're a senior, our younger, or older, and so, they expect people to fit into the system, right?... (Spray, Part I. December 17, 2009).

For this professional, one example of the importance of learning about the different cultural practices in maternal child health is female circumcision. Not all doctors know how to help women in labour who have undergone female circumcision. For example, some of these doctors fear women who have been circumcised. If doctors are not trained about female circumcision, they may not know how to deal appropriately with women who have been exposed to this procedure, leading these women to have more difficult experiences during delivery. One participant said:

...not understanding, there's a real fear of women if they've had ... [sigh] a circumcision, if they've, that women have had a circumcision, to deliver the baby, the doctors here aren't knowledgeable about circumcision for women [- -], so to deliver the baby, you have to be very careful, there's different ways to deliver that are easier; the midwives all know that, the doctors don't, here, don't know that. So if [- -] they only have had ever had one woman, that's new to them, they don't know what to do. Right? ... (Spray).

In the case above, gender and cultural practices create barriers for immigrant and refugee women. The same health professional also indicated that a lack of cultural competency training for medical staff was seen as one of the key factors that had created the barriers encountered by immigrants and refugees. For this participant, training on cultural competency should also be made available to non-health professional staff within the system, including administrative staff, such as receptionists. These workers are the first point of contact between the health system and immigrant populations. If frontline staff, in this case administrative staff, do not receive training in cultural competency, or the system does not have clear policies on dealing with clients who do not speak English, the lack of

training and policies create additional barriers to accessing health services for immigrants and refugees. At times, these barriers even hinder or thwart the work of the Health Broker, who tries to mediate between an immigrant or refugee mother and the health system. The experiences of immigrants and refugees with the health system are therefore marked by what they encounter at the frontline services level. This health professional stated:

...Like receptionists, too, like, receptionists are the first people that, when you walk in, they're the first ones, and if they don't greet you [- -], if they don't make eye contact, if they don't understand why the person in front of them isn't making eye contact,...you've, because they're the gate-opener, and if they're not open and friendly and accepting of people [- -], then the person doesn't feel loved, accepted, cared for, and then when they go to see the nurse they're going to be more closed-in also [- -], right? So, it goes for everybody (Spray).

At the system level, health professionals stated that barriers to accessing perinatal and other health services included the shortage of physicians. One participant expressed her frustration at not being able to find doctors for her clients because the doctors were either not taking new clients or screening out patients with multiple or complex issues, including newcomers who needed interpretation. This participant stated:

...the doctor's office is telling me, well "Either, we're not taking new patients or; we're taking new patients, they must come in for an interview first and then we'll decide if we're taking them or not" [- -] And I was just sick, I thought, "How do I?" you know, I didn't even want to tell the interpreter that, to tell the family that. So, families could be screened out of having physician care, so... (Hibiscus, May 10, 2010).

THE MACRO

HEALTH EQUITY AND SOCIAL DETERMINANTS OF HEALTH

Most health professionals acknowledged that immigrants, and refugees, or aboriginal populations experienced health inequities. One participant explained:

...well, immigrant and refugee populations — they probably don't have great health equity because they're often lower socio-economic as well — those things start to compound on them so it makes it a lot more difficult, so that yes, there needs to be, in order for a service to be truly universal, you need to have pieces that are specialized for immigrant refugee aboriginal and other marginalized groups, right? So, those services and program pieces I think that are targeting some of those groups are really important, in order to start to bring health equity into play (Daisy, May 10, 2010).

RACISM AND DISCRIMINATION RELATED BARRIERS

I asked health professionals about the role of racialized status amongst immigrants and refugees accessing health and social services. Some health professionals reported that some communities (and the Health Brokers themselves) experienced racism and discrimination from health service providers. Those who stated that Health Brokers experienced racism or discrimination thought it might not be openly revealed to the Health Brokers themselves, but disclosed in conversations among health professionals (Violet). For example, one health professional indicated that, depending on the Health Broker's look,— i.e., colour of skin, head scarf, tone of voice, or a combination of these characteristics —, some practitioners “felt afraid” of that Health Broker. This health professional found such revelations surprising because in her opinion Health Brokers were very gentle people. Another health professional stated that some communities, depending on the colour of skin, were discriminated against more than others. One health professional did not believe that immigrants and refugees experienced discrimination due to their racialized status. This participant

thought that language barriers were the reason for discrimination, rather than cultural background.

Discussion

As a researcher, I felt empowered by the passion with which most health professionals in this study spoke of the issues faced by immigrant and refugee families. I also felt their commitment to supporting the Health Co-op and Multicultural Health Brokers' work to help these families. As I heard their voices, attended some of perinatal training sessions, and read the reports submitted by the Health Co-op and background documents about Alberta Health Services (AHS), and interpreted the findings, I kept thinking of two questions: What do these data tell me about the integration of Health Brokers within the AHS public health care system? And how can the passion and commitment of health professionals be shifted from downstream actions to upstream struggles for health system changes?

In this section, I attempt to answer the questions above by analyzing the perspectives that health professionals have about the role that the Health Co-op and Health Brokers and the health system play in addressing immigrant and refugee women's perinatal health needs: a) the elements for the success of the partnership between a community-based organization and the health care system in implementing the programmatic activities of the Perinatal and Health for Two programs (micro); and b) the role that health professionals can play in working side by side with the Health Co-op and Health Brokers targeting system change to address health equity for immigrants and refugees through urban citizenship.

The health professionals and Health Brokers' relationship

Here, I focus on the “small picture” issues arising in the daily interaction between the Health Co-op, the Health Brokers, and health professionals. This relationship is crucial to improving health outcomes for immigrant and refugee women at risk of pre-term birth or low birth weight babies. Health professionals spoke highly of the work of the Health Brokers, and they did not shy away from identifying the issues that created tensions in their relationship. This was corroborated in the interviews with Health Brokers and mentors and in the literature, for example Labonté (2010) notes the importance of paying attention to the quality of the relationships that occur between health care workers and patients, and more broadly between health systems and the communities they serve (p. 65).

From the outset, it looked as if the daily interactions and partnership between health professionals and Health Brokers related to the programmatic activities in the Perinatal and Health for Two programs were based on trust. This trust seemed to be the “glue” that kept health professionals supporting the Health Brokers’ practice for so many years. Indeed, organizations like PHAC, which funds the Health for Two program, might not have realized the impact that trust has had on the partnership, when it provided the first pilot funding in the early 1990s. Another element that contributed to the strength in the relationship was the better health professionals knew and understood the complexity of immigrant and refugee lives, the more they appreciated the work that Health Brokers did. Also, the more they understood the work that the Health Co-op and Health Brokers did, the more they realized that the health care system was not ready or able, within its current structure and policies, to support a model like the Health Brokers being fully integrated in the health care system.

A critical challenge to the relationship between the Health Brokers and health professionals is the support the latter provided is at the local level, and has not yet reached higher levels of the bureaucracy. This means that if current managers or key contacts were to suddenly leave, it could not be guaranteed that the new people would support the Health Broker model in the same way.

In Chapter 5, I discussed the work of the Health Co-op and Health Brokers from their perspectives, and I asserted that their multifaceted approach applied to feminist practice. This is especially seen in the notion that Health Brokers, as women, are part of and central to the analysis of urban citizenship. How can the passion and commitment of these professionals be shifted from downstream actions to upstream struggles for health system changes? A key point in answering this question is that the health professionals interviewed came across as very committed to supporting the Health Broker model and to providing services to immigrants and refugees at the local level. Their ardour seemed to dissipate, however, in dealing with the higher structures within the system. To some degree, they hoped that their work influenced the upper reaches within a complex bureaucratic system, but they had no mechanisms or collective vision to ensure that this happened. This means that health professional successes in supporting the Health Co-op and Health Broker model should be celebrated, but more emphasis ought to be placed on working towards influencing the senior officials within the health system to be more responsive to other social factors affecting immigrant and refugee health. As Labonté states, “Health workers are citizens, regardless of their functional role within health systems. Our ability to promote greater health equity is not simply a function of our jobs. It is a responsibility of our citizenship” (2010, p. 73). Part of being responsive entails health professionals working with the Health Co-op and the Health Brokers so that the

women and their families are not seen as passive victims of inequities, but as citizens and agents of change.

Health professionals within the system could also examine the power imbalance that exists between communities and the health system and strategize on ways to address this inequity. The literature corroborates the need to address power imbalances with better communication between communities and different systems (Laterveer, Niessen, & Yazbeck, 2003) by facilitating “consultations with the poor and socially vulnerable to better understand the constraints faced by marginal groups and to better structure effective programmes” (Laterveer et al., 2003, p.144). The literature (Amaratunga & Hockney, 2003) also calls for having communities at the centre and creating inclusive circles: linking the elements—policy makers, service providers, local leadership, volunteer organizations and researchers (Amaratunga & Hockney, 2003, p.15). Earlier the health professionals confirmed the role that “champions” played, within the local level system, to secure funding for the Health Broker model espoused by the Health Co-op. It remains an open question how willing these champions are to push for changes in provincial level decision-making.

For health professionals, to shift from the local level to push for changes at the upper level, they must recapture their agency and gain autonomy and empowerment. I use the term “recapture” because these professionals come across as empowered in their work with the Health Brokers, but do not seem to feel that way as they look at the changes needed at the higher levels of decision-making. I argue that if health professionals could recapture their agency, autonomy, and empowerment, they could share their resulting citizenship with immigrants and refugee communities. Labonté argues that where champions are lacking, health workers face an ethical imperative to help in creating them, with failure to do so likely to lead to a morally indefensible

increase in health disparities (2010, p. 74). This is the paradox that health professionals face: because they work within the system, they receive the benefits and protection that the system offers, but they are not directly affected by the inequities that immigrants and refugees face. Neither are they directly affected by the lack of resources that the Health Co-op and the Health Brokers confront daily. In the current Alberta Health System's structure, for instance, frontline workers and project coordinators have to influence middle managers, executives, and regional directors before ultimately reaching the CEO of AHS. The CEO in turn reports to the board. And, if health professionals wish to reach the Minister of Health, they have to first gain support from the president of the AHS board of directors.

In other words, because frontline workers are so removed in the chain of command, the likelihood that more senior decision-makers get exposure to frontline workers' knowledge of the intricacies of how inequities impact immigrants is small. The reality is that there does not seem to be that much communication flowing between different levels of the system. These are real barriers within the system that prevent internal mobilization. As a result, the health system's bureaucracies tend not to provide opportunities for advocacy from within the system; rather the onus is on health professionals and staff themselves to create these opportunities. This requires health professionals to have a willingness "to rock the boat". As Labonté questions, "how do health workers and health systems engage with community groups in a process of social change, in which the powers and authority of their respective positions are brought separately, but in concert, to bear on the policy issue?" (2010, p. 73). Through my interviews, participant observation activities or data validation sessions, however, I did not get the impression that health professionals intended to rock the boat.

How could health professionals recapture their agency, and gain autonomy and empowerment to play a leadership role in advocating within the system for immigrant and refugee women's health equity and citizenship? The starting point here is to build on the trust that organizations and individuals have developed at the local level to foster solidarity and strategize together on ways to influence a highly bureaucratic system. Commonality of interest could be centred on gender, racial solidarity, and citizenship. For example, health professionals interviewed (n=7) were Euro-Canadian women, most of whom were public health nurses. In terms of agency, given the hierarchical nature of the health system (Spitzer, 2004), the health professionals' political agency (Pollack, 2000) must be generated by themselves because it is not given to them by the system. As nurses and women, for example, their political agency is circumscribed by struggles of invisibility within the health field (Mercer Ray, 2009), owing to the subordinated rank they occupy in the gendered hierarchy (Spitzer, 2004) of the health care system. Thyler (2003) recognizes the challenges that nurses face in the field because their voices are not recognized, so she speaks of the importance of nurses striving for transformational leadership styles in their workplaces. According to Thyler (2003) transformational leadership might give nurses "... the key to transforming health care and dragging it into the 21st century in terms of work practices and reform. This is because nurses are visionary, creative, involved in decision-making at patient level and have gender based qualities, and communication strategies that the health care sector needs" (Thyler, 2003, p. 73).

In terms of autonomy (self-direction), these struggles could hinder the ability of nurses and other health professionals from developing the skills necessary for achieving political agency (Pollack, 2000). Doing so, as argued by Sherwin (1998), "would entail making the type of choice in question, the experience of being respected in their decisions, and encouragement to reflect on their own values, which may be at odds with their prior situation" (Sherwin, 1998, p. 37). Sherwin (1998)'s

concept of relational autonomy (attention to social and political contexts) is particularly important in building solidarity between groups that are privileged and those who are marginalized. She states:

A relational approach can help move autonomy from the largely exclusive preserve of the socially privileged and see it combined with a commitment to social justice in order to ensure that oppression is not allowed to continue simply because its victims have been deprived of the resources necessary to exercise the autonomy required to challenge it. (p. 39)

Oppression in this case is immigrant and refugee women's lack of voice and marginalization due to their social stratification in Canadian society. The key point, however, is that health professionals can build alliances with communities, in this case with the Health Co-op and the Health Brokers, to strive for change in the system.

Based on the way in which the Perinatal and Health for Two programs in both agencies (the Health Co-op & AHS Edmonton zone) have evolved, health professionals could potentially foster agency, autonomy, and empowerment at three main levels: personal, group, and community. According to Raeburn and Rootman "... the most potent level at which to work is that of the community, which allows us to be oriented both 'up' to the larger systems of society, and 'down' to the intimate and personal" (Raeburn & Rootman, 1998, p. 79). Indeed, while most health professionals interviewed work directly with communities, their focus is on individual behaviours rather than collective action. There are five main opportunities in which health professionals could work towards community empowerment: a) the Health for Two Network meetings where representatives from 35 agencies working with marginalized communities, including the Health Brokers and Aboriginal communities, gather regularly; b) the Health for Two *Learning Together* training that is given twice per year (for

seven weeks/three hours per week) to representatives from the Network agencies; c) the six-module *Learning Together* training manual, which perinatal outreach workers and Health Brokers ought to use in their daily practice; and d) the Health Co-op's monthly meetings in which a Health for Two Network nurse has the opportunity of speak directly and privately with Health Brokers. I describe the fifth opportunity below.

To date the first four opportunities have been excellent venues for identifying the risk factors for women during pregnancy, labour and birth as well as encouraging perinatal outreach workers and Health Brokers to be attentive and warm towards women. These opportunities, however, have not been used by health professionals and Network member agencies to strategize for system change. For example, if one reflects on the training sessions addressing the perinatal health issues of immigrant and refugee women mainly when Health Brokers are present one might think that care for these populations is considered an add-on to training rather than an integrated component of it. In other words, how can all sectors of society, in this case, all perinatal workers address health equity for immigrant and refugee women if they are not systematically trained on the issues that matter to these populations? There is an important opportunity here for the hiring of a senior Health Broker to co-deliver the training with AHS Health for Two program's nurse. By doing so, all perinatal outreach workers and newly recruited Health Brokers would have the opportunity to learn about perinatal health education for all women, including immigrant and refugees, in a systematic way. If AHS Edmonton Zone adopted this strategy, immigrant and refugee women would have more chances of being served by all agencies, rather than there being an expectation that the Health Co-op deal primarily with these cases, even though it does not have sufficient resources to service all the need of these populations.

The fifth missed opportunity is the atomistic overall theoretical approach used to frame the Health for Two program. As summarized in Table # 9, the theoretical approach used through these encounters is centred on the Transtheoretical Model of Change (TTM) (Alberta Health Services, 2005), which focuses on individual behavioural change, rather than community or societal change. The main approach in addressing diversity is cultural competency. While, the training manual's module on families emphasizes the role of outreach workers in understanding and respecting the differences when dealing with immigrants and refugees, a broader challenge exists. That challenge is how to address these issues in a systematic way for all outreach workers, given that many times Health Brokers are not at these sessions, and that this topic tends to be addressed only when they are present. I return to these points in Chapters 7 and 8. A potential opportunity for health professionals to move from this theoretical model to a plan for action and social change would be to build an alliance with the Health Co-op based on the two groups adopting the health promotion empowerment model of Labonté (1993). I provide details in Chapter 5, but to summarize, the Health Co-op uses this health promotion model because it presents empowerment as a continuum, with five "dimensions" consisting of personal care, small group development, community organization, coalition building and advocacy, and political action (Labonté, 1993; MCHB, 2009). Through the Health for Two program and Network, health professionals are in constant communication with perinatal outreach workers, Health Brokers, and women. According to the health promotion empowerment approach Labonté (1993) health professionals could use these opportunities to shift from a focus on personal care and small group work to a broader focus. Within a broader focus, health professionals could accompany immigrant and refugee communities' organizing around their issues and concerns, even if these issues put them in conflict (p. 61) with their own health system. Health professionals could also join coalitions and advocate for issues that are important to communities, which will also increase the strength of their own political voices (p.

69). Finally, health professionals could be involved in political action through larger social movements (p. 71), which would extend to the regional and provincial levels. It is important to note that these processes are not linear and that Labonté acknowledges that conflict would certainly arise at some point. By using a broader approach to the practice, which combines behavioural change (the TTM) with a health promotion empowerment approach, health professionals could empower themselves and immigrant and refugee women and communities to strive for more egalitarian relationships with the health system.

The paradox that health professionals face in recapturing their agency, and gaining autonomy, and empowerment, is that it puts their jobs at risk, as discussed earlier. Also, health professionals might be hesitant in adopting an empowerment approach or establishing equal relationship with patients. As indicated by Sherwin (1998) — health professionals potentially derive some personal benefit from oppressive structures that create health inequities. This means that they may have jobs and status, at least in part, because there are groups and communities experiencing disempowerment. On the other hand, health professionals are well aware that the system wants to avoid the chaos of communities protesting about not being served, so they could opt to support communities in making their voices heard among policy makers and encouraging their citizenship.

CRITICAL REFLEXIVITY

Each time I conducted an interview or field visit for this inquiry, I asked myself “what did I learn from this interaction?” In my experience as a racialized immigrant woman in Canada, I highly valued the role of CHWs who helped me navigate the health system when I first arrived in this country and the assistance of health and social services professionals who provided me with health and social services. I mentioned at the beginning of this chapter that I was anxious because I did not know how

health professionals would perceive my research. My hesitation gradually disappeared as I started to interview them. I learned that health professionals were proud of their role in supporting the Health Co-op and Health Brokers and that they had no reservations about identifying the pros and cons of Health Brokers' work. I felt that they did not tailor their message to what I wanted to hear, rather they spoke about what they wished would happen to improve the perinatal health outreach to immigrant and refugee communities. In other words, they were supportive of Health Brokers, but also critical if they did not agree on issues about how the work was done.

Upon analyzing the data, however, I identified an issue that resonated with my experience as a racialized minority woman in Canada, which for some health professionals was incidental to the work, but for me was a major consideration. This was lack of understanding of how racism operates to hinder the role of Health Brokers within AHS's stratified health human resources workforce. Three examples are worth mentioning. First, an example cited by a health professional of some health professionals, notwithstanding their being aware that they are dealing with compassionate individuals, being afraid of certain Health Brokers because of their physical appearance or because they wear a headscarf. In anti-racism literature, being afraid of other cultures is in itself an indication of racism. Second, I encountered the belief during an interview with another health professional that racism toward minority communities is more prevalent within immigrant and refugee communities themselves than within the mainstream Euro-Canadian community. Although this might be true in some countries, (for example, I was raised believing that Aboriginal and Black people were somehow inferior to Euro-Colombian descendents), in Canada this often constitutes a convenient excuse to deny the existence of racism in mainstream Euro-Canadian society. I also learned from my anti-racism training in Canada that this type of comment reveals a denial that mainstream society discriminates against minority communities on the basis of racialized

background, ethnic origin, and religion. From a population health perspective, this comment reveals a lack of understanding of racism as a social determinant of health. I come back to this point in Chapter 8. Third, the perception of one health professional that Health Brokers could not be hired to be Health for Two Network Coordinators because they were so focused on their own communities that they would not be able to work outside those communities. This perception reminded me of my early years in Canada trying to work in international development. In those years I had staff from some mainstream Canadian international non-governmental organizations telling me that I could not be hired to work for their organizations because of my Colombian background. According to them, I would have been too biased to work in Latin American countries. In other words, only Euro-Canadians could be 'objective' enough to do international development work, or in the case of the Health for Two Network, only Euro-Canadian workers could work for all pregnant and new mothers in the Edmonton area. These three examples are but illustrations of the enduring societal divisions owing to racism and colonial history (Williams, 2001) that health professionals, Health Brokers and allies, such as myself, must continually work to overcome.

THE RELEVANCY OF THE EMBEDDED MINI-CASES

The Health Co-op, Health Brokers and practitioners within AHS' public health unit, community health centres, and hospitals interact regularly to meet the perinatal health needs of immigrant and refugee pregnant women and new mothers. How relevant are the findings from these embedded mini-cases to them? This research is relevant because it provides AHS' practitioners involved in the study a medium to express their views on both the role that Health Brokers and the health system play in facilitating access to health services and health equity of marginalized populations as well as their strengths and shortcomings. This research is relevant for the public health system because it demonstrates that arm's-length models work in helping public health units meet their mandates of

implementing targeted perinatal health outreach programs to marginalized populations, including immigrant and refugee communities. And, in the words of some health professionals, this type of financial arrangement is “cost-effective” for the public health system.

This research also illustrates that community-based organizations, public health units, and community health centres can coordinate efforts in a systematic way to address health equity for hard-to-reach and underserved populations. In addition, this research demonstrates that in order to address health equity for immigrant and refugee populations, who are new to Canada, or do not speak English or French, it is important to offer services in the languages of those populations. By offering services in native languages delivered by workers from the same or similar cultural backgrounds as those being served, the health system ensures that these populations needs are met in a timely way, avoiding further costs due to preventable health and social problems being undetected.

Conclusions

I illustrated through the two embedded mini-cases (the Perinatal Outreach and the Health for Two programs) that AHS public health in Edmonton acknowledges the contributions that Health Brokers make to the perinatal health of immigrant and refugee communities. I also illustrated that by funding the Health Brokers’ perinatal activities, AHS is responding, to some degree, to the needs of the communities. Health professionals and the Health Co-op recognized, however, that AHS is not fully responsive to those needs, the way it should be. AHS is not mandated, for example, to fund the Health Brokers’ work related to the social determinants of health. In contrast, the commitment of champions within the local health unit has resulted in long-term support for the Health Co-op’s

perinatal work. It is unclear whether the multicultural Health Brokers' practice would be better if it were fully integrated within AHS. Given the level of recognition and support for the Health Broker model at the local level as well as the length of time that the Health Co-op and AHS have been working together, one could say that the Health Brokers' practice is effectively integrated in the health system, despite the Health Brokers operating out of an independent organization. On the other hand, because the Health Co-op is an independent organization and must accommodate any shortfalls in funding, and because AHS does not deal with staffing or administrative issues, it is fair to say that currently the Health Brokers' practice is not adequately acknowledged and does not fall entirely within the formal health system. As a result, the Health Co-op and the Health Brokers are vulnerable to funding cuts or arbitrary decisions, yet the Health Co-op is proud of functioning as an autonomous body.

From a macro perspective the two embedded mini-cases, although focusing in one city only, show that immigrants and refugees face systemic barriers that are based on gender, racialization, religion, and ethnic origin. From a meso perspective these mini-cases reveal the complexities when attempting to deliver culturally-competent services when AHS is not providing enough training for current and new health professionals or sufficient funding. From a micro perspective, the Health Co-op has been recognized by health professionals for raising awareness among health services providers about the importance of culture when working with immigrant communities. The Health Co-op and the Health Brokers themselves need to be careful of the risk of portraying immigrant and refugee communities as the "other". Health professionals, on the other hand, are called upon to work with immigrant and refugee communities as allies in building equitable relationships with the system. This requires health professionals to recapture their agency, autonomy, and empowerment to strive for system changes at higher decision-making levels.

Chapter 7

Multicultural Health Brokers' practice: The Phenomenon

Interlocutors and mediators: Complexities and rewards of securing access to health and social services for at-risk immigrant and refugee women

A Health Broker and I arrived at a pregnant woman's house for a home-visit. We rang the bell and the person who opened the door indicated that the mother lived in the basement, so we should instead knock on the side door of the duplex. Because it was summer, a couple of children were playing on the driveway, so my colleague asked one of them where the woman was. One child went to the basement, and then the mother asked us to come down. We descended the steep and uncarpeted stairs and took off our shoes at the bottom of the staircase. We then walked through a narrow hallway to get to the kitchen. The mother, who looked very pregnant and sweaty, was waiting for us sitting on a chair on the left hand-side of a kitchen table placed against the north wall of the room. Above the table, we could see a high, small window, which provided some light to the dark and crowded room. We sat in two chairs at the table. This room was the common family area. One big couch stood against the south-side wall behind us, and a big television sat on a small table on the westside wall facing the mother, who had her back to the kitchen counter, which looked like a bar or island separating the small kitchen from the living room. This mother had contacted the MCHB Co-op because she was a refugee claimant expecting to have her first Canadian-born child. She was worried about several issues: the health of the unborn child, her immigration status, her financial situation, and the oral health of one of her two children, both of whom were less than ten years old. This situation typifies what Health Brokers confront in their day-to-day practice.

Introduction

This study's research questions focus on how integrated Multicultural Health Brokers' practice is within Canada's formal public systems of care, and how this integration influences the ability of these workers to address health equity of immigrant and refugee women. In this chapter, I respond to these questions, from the perspectives of Multicultural Health Brokers (Health Brokers), mentors, and women served by the Health Brokers. Health Brokers exercise an "intermediary" or "mediatory" role between immigrant and refugee women seeking access to health and social services and the health professionals and institutions providing the services. The intermediary or mediatory role the

Health Brokers play in providing culturally- and linguistically-appropriate services for immigrant and refugee women represent the “market niche” that gives Health Brokers a place as health human resource workforce in the Edmonton’s health and social services arena. In other words, the Health Brokers provide a service that other health and social services agencies are unable to provide. I use the terms participants, Health Brokers, and mentors to refer to the workers who agreed to be interviewed. In this chapter, I use the term women or mothers to refer to the women who used the services of the Health Brokers and agreed to be interviewed.

HOW THIS CHAPTER IS ORGANIZED

This chapter is organized in four sections: The first section describes the demographics of Multicultural Health Brokers who participated in the study. These data provide an overview of their ages, education, and household income, which is important in understanding their social location in Canada. The second section describes the standards and practice guidelines that the Health Brokers are expected to follow in their daily work with women and their families. This section illustrates also the mechanisms that the MCHB Co-op has in place to document the work of the Health Brokers. The third section presents the voices of Health Brokers, mentors, and program users in two areas: perinatal health and family intervention programs. Both areas look at what it means for Health Brokers to be intermediaries between immigrant and refugee women and the health and social services systems. In this role, they transmit formal (biomedical) and informal (experiential) knowledge between the two and strive to reduce barriers to access. Notwithstanding the central focus of this thesis on the work of Health Brokers in perinatal health, I have added to this chapter a description and analysis of their Collaborative Family Intervention Program, which is where child welfare authorities have been called as a result of family violence involving children or child neglect.

This is important because it provides a clear example of how Health Brokers address areas linked to social determinants of health.

Finally, in part four, I discuss and analyze how Health Brokers straddle the line between authoritative knowledge (formal systems-based) and experiential knowledge (informal women-based) in addressing health equity for immigrant and refugee women. In this part I also reflect on how my personal background influenced the way I analyzed the relationships between Health Brokers and their clients. I conclude this chapter by highlighting the relevance the Health Brokers' practice has for CHWs and for health and non-health professionals.

Demographic data

HEALTH BROKERS' BACKGROUND

I interviewed a total of 15 Health Brokers, all but one of whom were women. One participant was a former Health Broker. I will not report on the data from the male or the former Health Broker separately to protect their anonymity. I asked each of them to complete a Personal Information Form (PIF) at the time of the interview. The PIF asked Health Brokers' country of origin, age, years living in Canada, and their level of education. In some cases they were not willing to disclose certain personal information, as is reflected in the tables below. The following percentages are derived from available information and are calculated based on fifteen responses.

One third of Health Brokers were born in various countries in Africa, another third were born in Asian countries, with the remaining third drawn from the Americas and the Middle East. The largest cohort again, representing one third of the interviewees (n=5) fell in the age group 35 to 44, with 20 percent (n= 3) in the 25- to 35-year-old age range. None were younger than 25 but thirteen percent

(n=2) were 55 or over. The remaining 26 percent (n=4) were between 45 and 54. In other words, the majority of the Health Brokers interviewed were over 35 years old. Although highly concentrated in the older age groups, the participants varied widely in the number of years they had been in Canada. Forty-six percent (n=7) had been in Canada for 20 years or more, about 27 percent (n=4) had been Canada between 15 and nineteen years (n=7), and another 20 percent for 14 years or less. Of this 20 percent, a single interviewee had been here less than five years. Almost three quarters of Health Brokers had post-secondary education. Of all interviewees, two-thirds (n=10) had Bachelor or Graduate degrees. Just thirteen percent (n=2) had only completed high school, with the rest having a college diploma, and another one at least some college or university courses.

Table # 10. Demographics — regions, ages, years in Canada and education

	Health Brokers
Regions (15)	Asia = 5 Africa = 5 Latin America = 2 North America = 2 Middle-East= 1
Ages (15)	25 to 34 = 3 35 to 44 = 5 45 to 54 = 4 55 plus = 2 Not available = 1
Years in Canada (15)	Less than 5 = 1 5 to 9 = 1 10 to 14 = 1 15 to 19 = 4 20 to 24 = 2 25 to 29 = 2 30 to 34 = 2 35 to 39 = 1 Not available = 1
Education (15)	High school = 2 (1 completed in Canada) Diploma = 1 Some courses =1 Bachelors = 7 (two completed in Canada) Graduate = 3 Not available = 1

The PIF also asked Health Brokers to disclose the length of time they worked as Health Brokers, their employment status, their household income, and the number of people living in the same household. At the time of the interviews, there was a wide variance in the length of time Health Brokers had spent in their roles. One third of participants (n=5) had been Health Brokers between ten and 19 years. Of the remaining group, a full one third (n=5) had been working as a Health Broker between one to four years, with the rest (n=3) either having less than a year's (n=2) or between five and nine years' experience (n=1). As to employment status, about two-thirds worked part time (n=9), with the remaining third having full-time positions. There was wide variance in household income, although interviewees were fairly well distributed among income categories. One-quarter (n=3) of those who responded to this question had household income of under \$50,000, just over forty percent (n=5) fell in the \$50,000-\$69,999 categories, and the remaining group (n=4 or about one-third) had incomes exceeding \$70,000. In considering the household incomes for these interviewees, it should be noted that just over 50 percent had more people living in the household than the average Canadian family. For instance, just under 31 percent of respondents to this question (n=4) had six or more people in their households. Less than one quarter (n=3) had household of four people. Almost one quarter (n=3) had households of three people, which is the typical size of a Canadian family (Statistics Canada, 2007). And the remaining percent (n=4) had less than three people. This means that the average Health Broker's family is larger than the Canadian norm.

Table # 11. Demographics — years of work, income, and people in household

	Health Brokers
Years as Health Brokers (15)	Less than one year= 2 1 to 4 = 5 5 to 9 = 1 10 to 14 = 2 15 to 19 = 3 Not available = 1
Employment status (15)	Full- time = 5 Part-time = 9 Not available = 1
Household Income (15)	30 K to 39.9 K = 2 40 K to 49.9 K = 1 50 K to 59.9 K = 2 60 K to 69.9 K = 3 70 K to 79.9 K = 2 Over 80 K = 2 Not available = 3
People living in the same household (15)	One person = 2 Two people = 2 Three people = 3 Four people = 3 Five people = 0 Six people = 2 Seven people = 1 Eight people = 1 Not available = 2

Applying the multicultural health brokering theory to the daily work

PRACTICE STANDARDS AND GUIDELINES

One mentor highlighted one of the best achievements in the Co-op's work as "naming their practice" (Laflor). The multicultural health brokering practice (Ortiz, 2003) is based on the principles of social justice, equity, and democracy. This means a dedication to empowering people and communities, rooted in the wisdom, knowledge, and culture ways of people (MCHB Co-op, 2004e). The worker Co-op structure facilitates the Health Brokers' ability to follow and advocate for these

principles. The Health Co-op's health brokering approach states that "there are disparities or differences in opportunities for different groups of people because of age, gender, racialization, culture and ethnicity and socio-economic status. Because of this, the practice is directed towards addressing the broad determinants of health at the level of the individual, family, and community" (2004e, p. 5). Their competency framework indicates that Health Brokers are accountable to individuals, families, groups, and communities who have sought their support and assistance as well as to the Health Co-op and the funders who support their programs (MCHB Co-op, 2004e, p. 6). This was also corroborated by some participants in the interviews. I discuss in this chapter how the Health Co-op and the Health Brokers attempt to operationalize the competency framework, including the accountability component.

According to the MCHB Co-op's 2004 competency framework, (MCHB Co-op, 2004e) Health Brokers are committed to fulfilling their obligations to clients and colleagues, the Health Co-op, and their own practice. Their obligations to clients include acknowledging the power relations between themselves and the clients, while being respectful and non-judgmental, honoring confidentiality, being responsive to people's needs, being mindful of people's strengths and capacities, evaluating and accepting feedback as well as adjusting their work according to the needs and perspective of immigrant and refugee communities. Health Brokers' obligations to their colleagues in the Health Co-op include openness to understanding others and resolving conflicts, willingness to learn about each other's work, readiness to support each other's efforts, especially in difficult circumstances, and exhibiting caring for each other. Health Brokers' obligations to the MCHB Co-op as an organization include making decisions in the best interest of the Health Co-op, articulating the Co-op's mandate to others, participating in the organization's decision-making, contributing time to the Health Co-op as well as demonstrating the principles of the practice. Finally, Health Brokers'

commitment to their own practice includes being responsible and accountable for their own actions, being committed to personal growth, and seeking balance between devotion to work and family (MCHB Co-op, 2004e, pp. 6-8).

The Health Brokers attempt to follow practice standards that are holistic and informed by the priorities of the women, families, and communities they serve. The holistic nature of their practice gives Health Brokers the tools to deal with immigrant and refugee women, families, and communities in crisis. Their vision is that the health system will realize that:

*... there is a sector of the population who will not be served adequately by current programs and services because of barriers and circumstances rooted in social inequalities. Thus the need for a **unique kind of worker** [my emphasis] grounded in the realities and concerns of the community he/she serves and who has the skills to mediate two differing realities – that of his/her community and that of systems and institutions. Only then can we say that health is indeed for all (MCHB Co-op, et al., 2008e, p. 22).*

Since the early 2000s, the Health Co-op and Health Brokers have drawn links between the Health Brokers' practice and other established fields and professions, such as social work and health promotion. In health promotion, for example, they follow (Labonté, 1993) a health promotion and empowerment approach. In the elements of their practice that resembles social work (MCHB Co-op, 2004e, pp. 8-17), they partially follow the Standards of the Alberta College of Social Work Practice (Alberta College of Social Workers, 2007). The practice standards of Health Brokers capture both the principles and values of Health Brokers as follows:

The practice standards are specific guidelines to guide Multicultural Health Brokers in their day-to-day practice. [They] demonstrate the values and principles of the multicultural health brokering practice. The practice standards are codes of conduct that will help support decisions and actions of the worker in an ethical and appropriate manner (MCHB Co-op, 2004e, p. 8).

When I compared the Health Brokers' standards and practice guidelines with those of the Alberta's College of Social Work, however, I found that while Health Brokers have adopted several terms and practice guidelines from the College, the Health Brokers' competency framework is conceptually different from that of the College. The main difference in conceptualization falls in the "nature of the relationship" between worker and client, families, or communities. For example, when Health Brokers define the terms client and /or participant in a "client-worker relationship", they stress the egalitarian role and shared control between Health Brokers and clients, (MCHB Co-op, 2004e, pp. 8-9) whereas the Alberta College of Social Workers' standards, indicate that "shared control" between the client and worker only happens if it is feasible and permitted by legislation and regulation. The College states that, "mutual/mutuality means that the helping process, when feasible and subject to relevant legislation and regulation, will involve shared control between the client and the social worker toward the achievement of agreed to or acknowledged goals" (ACSW, 2007, p. 5). It is important to note that owing to the Health Brokers' work in violence prevention and child intervention they receive training in these areas from Children Services, so they are aware of their legislative responsibilities as workers. My emphasis here, however, is on their approach to establishing relationships with their clients.

For the Health Brokers, the client-worker relationship means "...a relationship between the client and the MCHB, that is equal and non-hierarchical. In this relationship, it is assumed that client and worker have knowledge, skills and expertise that are valuable in achieving successful outcomes" (MCHB Co-op, 2004e, p. 8). From the outset, Health Brokers see clients on equal terms. Their broad goal in doing so is to share control in the working relationship. The concept of developing non-hierarchical relationships with clients is entrenched in the Health Brokers' philosophy and is seen as a means to achieve social justice, equity, and democracy as well as work in participatory and

democratic processes that reflect the issues, needs, concerns and aspirations of participants (MCHB Co-op, 2004e, p. 16). This distinction is fundamental in the way Health Brokers work with individuals, families, and communities, and a distinction that is obvious in the minds of Health Brokers and mentors.

Some of the provisions in the practice guidelines for Health Brokers include obtaining consent from clients for interventions, advocating for clients with service providers, acknowledging conflict of interest issues, referring clients to appropriate services as needed without charging or accepting payment, and giving professional opinions about clients to other agencies only if Health Brokers have enough information related to the client. In addition, the guidelines outline protocols for keeping systematic and legible records of clients, explaining to clients why Health Brokers need to keep demographic-specific information on them, respecting confidentiality of clients (subject to circumstances where Health Brokers may be obliged to disclose client information), and setting out the reasons for terminating service of a client (MCHB Co-op, 2004e).

In addition, the practice guidelines specify other aspects of Health Brokers' codes of conduct, including not stereotyping clients and not misrepresenting qualifications or services or products offered. The guidelines have special provisions for Health Brokers' practice, such as the timeframe to respond to referrals (one-on-one support) as well as the participatory and democratic processes to be used when working with groups (group-work). The guidelines also call for respecting autonomy of communities as well as describing the collaborative relationships to be undertaken when working with service providers in order to catalyze change (coalition building). Finally, the guidelines encourage Health Brokers to be attentive to the issues that might lead to non-adherence

to the practice guidelines and to seek support from colleagues and the MCHB Co-op in adhering to the guidelines.

MECHANISMS AND CHALLENGES IN DOCUMENTING HEALTH BROKERS' PRACTICE

MCHB Co-op and Health Brokers developed practice standards and guidelines and also needed to create mechanisms to document and monitor referrals to Health Brokers. For the first 10 years of the Health Co-op, it did not have a central office; as a result, all referrals went directly to Health Brokers. At the beginning of my research in 2009, the MCHB Co-op had just completed a centralized referrals system. The referrals coordinator was finally able to systematically manage the intake of clients, to assign them to Health Brokers, and to monitor whether the clients had been helped by Health Brokers. According to participants the largest percentage of referrals came from community members (approximately 70 percent) and the remainder of referrals came from health centres, health and social services agencies, hospitals, and immigrant and settlement organizations (30 percent). When a referral came to the MCHB Co-op, clients were immediately assigned by the referrals coordinator to Health Brokers. The first criterion was to assign Health Brokers from the same or similar linguistic background, and/or from the same country of origin or continent as the clients. For example, a Persian-speaking Health Broker would serve women and/or family members from Turkey, Iran, Afghanistan, and Azerbaijan; and an Urdu-speaking Health Broker would work with women and their families from Pakistan, Sri-Lanka, India, Bangladesh, Nepal, and the Fiji Islands. The second criterion in assigning Health Brokers to clients was their expertise in certain issues, for example, family violence prevention. The third criterion was the ability of the Health Broker to manage an additional case. In the fall of 2010, however, the referrals coordinator left the Health Co-op, which created a new challenge for the organization. Instead of hiring a new coordinator, the Health Co-op divided the referrals coordinator's tasks among four mentors.

Subsequently, one participant shared a concern that the intake and assignment of clients to the Health Brokers could gradually become disorganized because too many people, who were already over-extended, were handling the referral process. Another concern was the number of referrals from hospitals as well as from some health centres to the Health Co-op had recently diminished. This could mean that health professionals from these institutions did not know about Health Brokers' work, or thought that Health Brokers did not have the capacity to take on new clients (HG memo, p. 29).

The second mechanism the MCHB Co-op developed was an electronic database to keep records of and monitor the services provided by Health Brokers to clients and their families. They needed the database to facilitate timely reports to funders and to keep statistics on the workloads of Health Brokers and the services Health Brokers provided to clients. The client database categorized clients as active or inactive. Active referred to clients receiving services, and inactive meant former clients potentially needing other services in future. The Health Co-op felt it was important to keep records of inactive cases because Health Brokers would often close cases of women receiving the Health for Two program, only to find that soon afterwards the same women needed support from other programs or for family members (Geranium, August 16, 2011). The challenge that the Health Co-op faced at the time of my research was that not all Health Brokers were diligent or consistent in entering information or statistics in the database immediately after client encounters. Mentors knew of the difficulties some Health Brokers had in using computers, so sometimes they offered to enter the data for the Health Brokers. At a meeting, one mentor said, "You can come to the office and dictate the information to me and I will enter it in the computer for you" (Gardenia, Field note, May 4, 2009). Keeping the database current, therefore, was a source of tension among Health Brokers and mentors. The latter felt the pressure to produce timely reports to funders, while the

former sometimes believed that, given their limited time, it was more important to devote their time to serving the client than to keeping a paper trail of their work (Field note, May 4, 2009).

My analysis of the Health Brokers' electronic caseload database (MCHB Co-op, 2010db) revealed that in a small number of cases, there were flaws in how the data was entered. During my August 16, 2011 data validation session, I discussed the actual and potential errors found in the database, and was informed that the following measures had been taken to minimize further errors in the future: a change in the database provider and software; and replacement of client numbers with clients' proper names; availability of a search function to establish if the client was already in the database; and a change of the names of the program activities to better distinguish the various types of work.

The third mechanism the Health Co-op developed was a system to keep signed client consent forms. Mentors wanted to ensure these were kept in the clients' files. According to the Health Co-op's policy, Health Brokers were to take back signed consent forms to the office within a certain time. One mentor explained that some Health Brokers did not do this in a timely manner and the organization "was very lenient about this" (Geranium, December 15, 2009). In some instances, it might take up to six months for consent forms to reach clients' files. This behaviour, according to two mentors, would not be acceptable in another agency and might result the worker being fired. I raised this issue at my first data validation meeting with Health Brokers and mentors (February 25, 2010). At this meeting participants explained that Health Brokers typically first noted "oral" consent as well as "being allowed" into people's homes as a sign that clients agreed to receive the help of the Health Brokers. Health Brokers indicated that they wanted to obtain consent in a way that did

not make the clients afraid. One participant stated, “if you are permitting me to give services to you, it is a way of providing consent” (Bird Of Paradise).

Participants at this data validation meeting (February 25, 2010) argued whether my findings reflected their experience. They indicated that the Health Co-op policy allowed scope for Health Brokers to obtain signed consent forms on subsequent visits, or at worst, within a six-month period. They noted, however, that in some circumstances Health Brokers altogether forgot to obtain written consent. In contrast, when Health Brokers had to speak to external agencies on women’s behalf, for example, while assisting to find housing, they had to obtain consent right away. One participant explained that written versus oral consent illustrated Health Brokers mediating two different realities: The people’s consent, which is oral, and the system’s consent, in which only the written is valued. At an individual interview, one participant referred to obtaining consent as a power issue between the Health Brokers and the clients. She indicated that women and their families were so much in need of help that they seldom questioned the consent form process. This meant that clients consented because they felt they had no other choice if they wanted help from the Health Brokers (Amaryllis).

The fourth mechanism the Health Co-op considered was to systematize the evaluation of Health Brokers and mentors’ work and programs. For example, when funding was available, the Health Co-op had evaluated some programs by bringing in external evaluators (participant observation meeting, November, 2009). In the cases of regular activities, Health Brokers gathered participants’ written input on programs, such as Health-for-Two. Health Brokers, however, questioned the purpose of client satisfaction evaluation for such programs, which was required by funders (HG

memo, p. 20, p. 31). The issue here was that women participating at events, such as prenatal classes, received the evaluation forms from the Health Brokers who delivered the course. Because the forms were in English and many women spoke languages other than English, the Health Brokers had to translate the questions and mark the women's responses on the evaluation form. The Health Brokers considered this a biased process because the women were unlikely to criticize the class when in practice the Health Brokers were completing the evaluation form. Some Health Brokers decided to skip the process altogether. At the data validation meeting (February 25, 2010) participants agreed that the Health Co-op needed to find an unbiased process for evaluating program sessions. They acknowledged that it would be impossible to translate evaluation forms into all languages served by the Health Co-op because answers would have to be re-entered in English in order for funders to understand them. In addition, if forms were translated into other languages, this would mean added work for the Health Broker. One possibility identified would be to have another Health Broker (who did not deliver the session) available to fill in the evaluation form at the event. This would, however, entail additional hours for the second Health Broker who already had enough work with her own community (HG memo, p. 32).

The evaluation of the performance of the Health Brokers and of the mentors started before I commenced my research. It consisted in a self-evaluation process. Under this process, Health Brokers discussed their self-evaluations with mentors, and the evaluations were then kept in the Health Brokers' files. Mentors, on the other hand, discussed their self-evaluations with other mentors and evaluations were kept in the mentors' files (HG memo, p. 20, p. 31, p. 42). For one participant, Health Brokers' self-evaluations were a step forward, but the organization still lacked mechanisms to make the Health Brokers' practice accountable to peers, mentors, and leadership (HG memo, p. 26, p. 31). For one participant, the lack of systematic evaluation of the Health

Brokers' work was an indicator that the Health Co-op needed to consider its style of leadership. According to this participant, Health Brokers were not asked to be accountable to the organization, and the Health Co-op's work was negatively affected by this. For example, reports were not submitted on time, data was not accurate, and errors were not corrected promptly enough (participant, February 10, 2010). In one of my data validation sessions one participant emphasized that, although it was difficult to put fully into practice, it was important for the Health Co-op to develop its own own collective, democratic mechanisms in which Health Brokers had the opportunity to reflect on their own practice (self-evaluation), rather than having mechanisms based on domineering approaches that mimic the hierarchies with the system (Participant, November 18, 2011).

The voices of Health Brokers, mentors and women

In this section I present the voices of Health Brokers, mentors, and program users in two areas: perinatal health and family intervention programs.

WORKING FROM THE HEART

All the participants spoke of "being a health broker" as something done from the "heart" and out of dedication to improving the lives of individuals, families, and communities as well as committing to making the city a better place for immigrants and refugees. One Health Broker said that she did this work for "her soul" (Begonia). In my data validation feedback process, one mentor indicated that when a Health Broker articulated that she was doing her work from the heart, it really meant is that "...a Broker must be someone with a strong compassion for people and a deep sense of empathy for those who have experienced social injustice. It is what drives them to be persistent in changing the lives of their clients and conditions in their communities" (Laflor, February 4, 2012). Laflor also

corroborated what several Health Brokers and mentors indicated: it will be hard for anyone to become a Multicultural Health Broker if he or she has conservative and reactionary views of the world as well as rigid thinking. To be a Health Broker one must be willing to mediate the differences and flourish in a constant state of tension and ambiguity.

For Health Brokers and mentors the features of Health Brokers were: passion about her/his work; trust of her/his community; open mindedness and appreciation of all cultural backgrounds; and culturally-appropriate knowledge about her/his own community. As one Health Broker stated, this is important in order “not [to] make assumptions” (CBlossom) about the communities. Indeed, Health Brokers came from the communities they serve, and many have lived through the challenges of being newcomers. As immigrants or refugees, Health Brokers had often experienced barriers in Canada due to language or racialized minority background. For example, internationally-trained Health Brokers have often experienced discrimination because their credentials have not been recognized and have been unable to secure jobs in their fields, owing to, as they have been told, their lacking “Canadian” experience.

HONOURING THE PRINCIPLES OF THE PRACTICE

Health Brokers honour the core principles of their practice, such as respect for clients’ abilities to make their own decisions. They let clients guide Health Brokers’ practice without imposing their own views. Several Health Brokers spoke of expecting clients to make informed decisions and providing them with information so that they could make their own choices and take responsibility for those decisions. On the other hand, most Health Brokers also spoke of establishing a “non-client relationship” with women. In a conversation with one health broker, she said that “I do not want to play the system’s game,” in which clients were at one end and workers at the other. “No”, she said,

“we are people and we want to treat women and their families like people” (Bird of Paradise). For her, it was dehumanizing to see people as clients.

Health Brokers and mentors indicated that the key feature of their work lay in their knowledge and understanding of the different communities and of the health and social services systems as well as their commitment to guide their practice based on the needs of the communities. In the long term, their goal was to help these communities become successful in settling and living permanently in Canada. In one of my data validation sessions, one mentor indicated that “integration”, “achieving good health or better quality of life” (Laflor, December 30, 2011) were long-terms goals the Health Brokers’ practice aimed to achieve. For example, a Health Broker would sit down with a mother to identify a pressing problem and make a list of the goals she wanted to meet in the short, medium, and long terms to improve her situation. One Health Broker described how she had helped a mother first with perinatal information and support, and then with enrolment in English as a Second Language classes. After the mother completed English classes, the Health Broker helped her enrol in an early childhood education program, which led her to finding a full-time childcare job. Afterwards, she learned how to drive a car, and later on she purchased a car. Now this mother is actively volunteering, helping other mothers to improve their situations.

The Health Brokers’ holistic approach means that most Health Brokers are always looking for ways to support women and their families including, for some, being available on a 24-hour basis to assist with problems other than those medical issues identified, diagnosed, and/or treated. This also means that once the Health Brokers establish a relationship with women and their families, they will be available to help them over the long term (HG memo, p. 23). The long term for Health Brokers involves coaching women, families, and communities to become independent over months or years,

if necessary. This is different from a traditional agency in which, after a meeting between workers and clients, the workers do everything possible to minimize contact with clients.

As an evolving practice, the Health Brokers and mentors spoke of working from their hearts and following the principles of their practice. They also felt proud of the knowledge they had of the communities they served and their desire to help women integrate into Canadian society.

Perinatal health outreach program

The strategies used by the Health Brokers to support pregnant mothers, include prenatal classes, hospital tours, and home visits. The Health Brokers work in coordination with public health nurses to support women in cases of a high-risk pregnancy or post-partum health concerns of the mother or the baby. The Perinatal Health program representing 53 percent (n=1062) of all caseloads among fourteen of the fifteen Health Brokers interviewed (MCHB Co-op, 2010db). Although the Health Brokers first goal is to deliver pre-natal and post-natal support to pregnant women and new mothers, they indicated that they helped with non-health issues, such as finding housing and childcare, helping mothers obtain birth certificates for their newborns, or assisting with employment insurance applications for mothers. In addition, when women were experiencing isolation they sought to link these mothers and their families to members of their communities. Such activities, however, are not funded under the perinatal contract. Also when mothers were experiencing socio-economic hardship, Health Brokers enrolled them in the Health for Two programs. The Health Brokers' caseload database revealed that this program represented 18 percent (n=370) of the Health Brokers' caseloads (MCHB Co-op, 2010db), signaling that pregnant women or new mothers are experiencing economic marginalization and require additional material support with vitamins and milk coupons in order to minimize the risk of low birth weight babies.

These coupons are only given during pregnancy and until the babies are two months old. Some Health Brokers indicated a preference for working on the Perinatal Outreach and Health for Two programs when the cases were straightforward, but if circumstances for women were dire and the families were experiencing crises (complex or critical cases), some preferred to pass these cases on to other Health Brokers. One participant indicated that no one wanted to take some of the clients that were troublesome, but Health Brokers felt obligated to do so. She indicated, "...we don't like it, we hate it, but we have no choice" (participant, December 8, 2009). Another participant indicated that some Health Brokers from the same cultural background worked very well together so they just agreed among themselves who would take on only perinatal health cases and who would take on more complex or critical cases (Eremurus).

Through perinatal activities, the Health Brokers are the bridge between immigrant and refugee mothers and health service providers. Most participants spoke of sharing medical information, or what I call authoritative knowledge with women and their own experiences as mothers or daughters, while being respectful of women's own understanding or experiential knowledge. One Health Broker stated, "We're incorporating our culture to the Canadian culture, right?" (Baby's-Breath) She also indicated that they were letting mothers decide whether they wanted to *adopt* Western perinatal practices, *merge* their perinatal cultural practices with Canadian practices, or decide to consider Western perinatal practices. Baby's-Breath affirmed: "there's nothing wrong, eh, if they don't – it's just, they can do whatever... they're free to do whatever, ... this is what's done here, and this is what's done back home...but we don't tell them what to do...Yeah, if you do it, we respect what you want to do!"

Another example of the Health Brokers' role in bridging women's knowledge with the health system's knowledge is the following: One Health Broker (Osta) explained that, in breastfeeding practices, public health recommends that newborns be fed frequently to support healthy growth and prevent jaundice, but women from some Middle Eastern countries believe that a certain type of herbal tea is good for the baby because it helps the baby sleep for longer periods of time. Osta indicated that this practice contradicted public health recommendations to feed newborns frequently, even if the mother had to wake up the infant. For Osta, it was important for the Health Broker to be able to share the public health knowledge with the mother and encourage her not to give such herbal tea to the infant without causing the mother to refuse the services of the health broker.

PERSPECTIVES FROM WOMEN (MOTHERS) ON THE ROLE OF HEALTH BROKERS

Mothers spoke of Health Brokers sharing knowledge about pregnancy, the development of the foetus, and care for the new infant. All the mothers interviewed (n=10) expressed gratitude that Health Brokers provided information and accompaniment, especially when they were pregnant for the first time or when they had their first children in Canada. One mother affirmed that the first contact she received from the broker was "like giving her new hope" (Woman7). Another mother felt very thankful for the support the Health Broker gave her. She said:

... that day she treated me as their daughter. She hugged me, I was crying because like there was no one. Of course I missed my mother too and everybody, right? And she hugged me and gave me some (glass thing?) thing like that. And she said don't worry if you need any help, you can call me, anytime day and night, when I get like depressed or something like that... I call her and talk to her because after delivery there, sometimes it's, like people get depressed. Or post or like I don't know, like post or after, I don't know what is kind of depression. But she helps me in that way too. Yeah (Woman10).

Mothers also valued the Health Brokers' guidance in understanding where to go for help, when Health Brokers accompanied mothers to appointments for their physical check-ups or their babies' vaccinations. Most mothers felt alone because they did not have extended family or friends nearby, because they were new in the city, or because they did not speak English. They felt reassured by being able to call the Health Brokers at any time if they needed help, even if the assistance was not related to the health of the child. One mother said:

Ahh...like one time... I have a problem with the baby, he's crying so much and, I don't know what to do...so I can call her anytime. And then one time... I think [he is] five or four months..., my mother died ... And I need somebody to talk to, because I was...so lonely, and I feel I may have some depression..., you know, because I'm just, you know [- -] really...and she sat once here, and many times she visited me..., yeah. It helps (Woman1).

Nine out of ten mothers interviewed felt that they could count on the Health Brokers for perinatal support, and in some cases, for help on issues beyond perinatal health. Almost all mothers trusted Health Brokers to share their concerns and sought their guidance on specific problems or stressors, including the death of parents, marital problems, lack of food, or children's illnesses. For several mothers, the Health Brokers became part of their social network, and they felt that Health Brokers were their friends. None of the mothers spoke of the broker as their "worker". One mother, however, felt disillusioned at the Health Broker's inability to help her in areas outside of perinatal health: specifically, finding an alternative source of income. In this case, the mother had asked her Health Broker to help her apply for social assistance because she had been experiencing severe back pain and felt unable to continue working in her low paying job. The Health Broker was very supportive and told the mother that "She will not have a problem getting social assistance" (Gladiolus, participant observation, February 25, 2010). When the Health Broker and the mother met with the social worker, however, the mother was denied social assistance because her income

was just above the threshold to qualify for it and her physical pain was not considered severe enough for disability support. In this case, had the Health Broker consulted with a mentor or another Health Broker first, or researched the requirements for obtaining social assistance, she would not have raised the mother's expectations. I use the term "mother's expectation" because upon interviewing this mother, she was disappointed at the Health Broker's inability to change her situation. This is an example of the structural barriers that, even with the best intentions, Health Brokers are unable to overcome.

CHILD BIRTHING EXPERIENCES

When speaking about mothers' birthing experiences, Health Brokers emphasized the importance of helping mothers understand the birthing process in order to reduce their fears of giving birth in Canada or to reduce their anxieties of having their first child ever. One Health Broker explained:

Three days ago I was with a mom [at the hospital] who had twins and one of the twins is here and the other one ... this baby is breeched...[the] head is not coming down face down, [the doctor said] we will have surgery...I explained this to the the mom and she was furious. And she said "oh my god what are we going to do?" And I ask the doctor, "Please, can you give us some tips? She [the mother] can help do it, what she is doing to make that child come down his head or something like that." And [the doctor] explained to me and I was explaining this to her [the mom] (Pied'allouette).

Some mothers confirmed this by indicating that some physicians and nurses were impatient at their cultural behaviours after birth. Two mothers spoke of having frustrating experiences with nurses in the post-delivery room. For instance, one African mother who had given birth to other children already felt that a particular nurse was impatient with her. This mother stated that the nurse wanted her to do everything for the baby instead of resting, so she made the mother feel that she should not have bothered to give birth at the hospital as she already knew what to do with a

newborn. After the interaction with the nurse, this mother felt so bad that she asked her physician to release her right away, instead of waiting longer to be released. She left the hospital with a very low morale and attributed her post-partum depression to her negative birthing experiences (Woman9). The same mother was referred to a Health Broker afterwards, but she felt so depressed that she refused to accept the Health Broker's help.

RELATIONSHIP BETWEEN HEALTH BROKERS, MOTHERS, AND HEALTH PROFESSIONALS

HEALTH BROKERS VERSUS INTERPRETERS

Overall, Health Brokers spoke of successful communication with service providers when negotiating on behalf of mothers and their families. Some stressed their impartiality in the face of their clients' needs and believed that immigrant and refugee communities had the right to access health and social services, and that those rights should be honoured and respected. Some participants indicated that as bridges between health professionals and clients, they felt the tension between being seen as "interpreters" versus as "Health Brokers". This tension frequently arose as a challenge that Health Brokers confronted in their practice because health services providers, who were unfamiliar with their role preferred them to act as (language) interpreters, and not as Health Brokers. Health professionals who were familiar with Health Brokers' practice saw the added value of health brokering and were pleased with the relationship between the Health Brokers and their organizations.

As the Health Brokers' task is to help mothers navigate the health care system, they often accompany pregnant or new mothers who do not speak English to a doctor's appointment. In these interactions, Health Brokers interpret "the clinical" information described by physicians, for example, medication, dose, or lab tests required, but if necessary, they also provide information

about “contextual” factors, such as cultural interpretation of the meaning of tests and procedures, which mothers might need in order to understand the doctors’ instructions as well as encourage the clients to ask questions. Some physicians have asked Health Brokers to abstain from providing additional information and just interpret the medical directions. The Health Brokers stated that, if interpretation alone was not enough for mothers to understand physicians’ instructions, and cultural barriers contributed to mothers’ lack of understanding, they had the responsibility as Health Brokers to ensure that clients understand the recommendations while in the presence of the doctors, and thereby encourage the clients’ compliance, informed decision making, and control of their own healing. As part of my direct observation activities, I had to write some stories illustrating the relationship between doctors and women accompanied by Health Brokers to medical appointments. One Health Broker explained the visit to the doctor’s office as follows:

As the Health Broker interpreted for the mother, the doctor felt impatient and told the Health Broker to explain about the tests and the next appointments after they had finished the medical appointment. The Health Broker felt that it was important to explain those issues to the mother in front of the doctor in case the mother had questions, but the doctor seemed rushed and just wanted to do the physical check-ups and finish the consultation. In setting up the new appointment for instance, the doctor did not see the need to ask the mother about it. The doctor insinuated, because the mother was not working and did not speak English, and the Health Broker had accompanied the mother, that the opinion of the mother was not what mattered, but whether the Health Broker was available. The doctor’s body language and gestures made the Health Broker feel that the mother was not worth his attention. The mother also saw the doctor’s expressions and did not like it, because in her country of origin, it was different: doctors took the time to listen, talk, and answer questions about the patient’s concerns (Perinatal story 1, May 2, 2010).

Some health professionals interviewed also acknowledged that the doctor might see the Health Brokers only as interpreters. These participants stated that if doctors did not understand the cultural issues, doctors would not understand that the role of the Health Broker was broader than that of an interpreter.

DIFFERENT CULTURAL PRACTICES

Other Health Brokers spoke of another type of tension in their relationships with the health and social services providers and their clients, regarding different perceptions and cultural practices.

One participant indicated that the tension occurred because health services providers and communities had different expectations of each other on what services ought to be provided and delivered. One mentor stated that health and social services agencies “...believe they know better than the women and their families about how to address the presenting problems” (Eremurus). One Health Broker spoke about mainstream services providers not being interested in learning how to understand multicultural communities, but expected immigrant and refugee communities to adapt to the ways of mainstream health services providers. This was corroborated by one of the mothers because of her experience with childbirth. For example, a mother from South Asia, who is vegan, explained how her hospital food had eggs, which she could not eat. She felt that the nurse was unsympathetic at her refusal to eat the food. In this case, when the Health Broker visited the mother at the hospital she explained to the mother that other food was available in the patients’ kitchen, which made it finally possible for the mother to eat. The often-troubled relationship between nurses and racialized new mothers is corroborated in the literature. For example, Spitzer documented how calls for assistance went unheeded and visible minority women, observing the lack of attention from nurses and staff, were “compelled to interpret this behaviour within the context of history and everyday racism” (Spitzer, 2004, p. 503).

Health Brokers believe that both the health services providers and communities can learn from each other’s cultures and traditions and use culture-based approaches in helping the women and their families. For one participant, this concept meant “interculturality”. (Lavender) Indeed, feedback from data validation with participants indicates that more recently, the “MCHB practice goes

beyond practicing multiculturalism; it demonstrates the concept of interculturalism as a more active and educated approach to learn and work with different cultures” (Laflor, February 4, 2012). Thus, the Health Co-op adopted a cultural-competency approach in which they gave training to health services providers to aid them in designing culturally sensitive programs and services. For example, they knew that clients arriving late for appointments had been a source of conflict. Therefore, when offering cultural-competency workshops, Health Brokers explained that the treatment of time, and emphasis on punctuality, was not the same in some other cultures as it was in Canada, and that these communities were gradually becoming accustomed to Canadians’ approach to time. They encouraged service providers to be more sensitive to these issues when dealing with immigrant clients and coached immigrant clients to understand the importance of arriving for appointments on time. Also, service providers were encouraged to be more sensitive to making the needs of families and communities more central to their work.

Health Brokers provide training to some hospital staff on immigrant and refugee health or on cultural practices and inform mothers about their rights. In some Asian cultures, for example, it is not customary for mothers to bathe or shower right after delivery for fear of becoming ill. When women from some Asian countries give birth, the Health Brokers tell them that they have the right to refuse if nurses ask them to take a bath right after the birth, but the Health Brokers also explain that in Canada women do not typically get ill from washing after birth. One Health Broker explained:

Say, back home... after you give birth, you don't take a bath or wash your hair for a month, right, but here, we encourage mums... climate is different, because back home we don't have a hot water system..., you know, [if] you want to have a hot bath, you have to boil the water and then, inside the house you don't have heating system, so, in the wintertime it's really cold, of course, we don't take bath, right, because it's cold... ..we think, when you are wet...[it is] very easy to catch cold...not because of the bacteria, or the virus or whatever or the immune system, it's simply because it's the weather is cold, so you get cold...but here, we say, “Well, you know,”

here because inside we... have heating system, you have hot water, you just turn on the water then it's hot, then after you take your bath you just dry your hair, you just dry yourself well, and then blow dry your hair, then that's it ...,but back home, you don't have a blow dryer, and then your hair will be wet for an hour, and it's cold, so, of course you get sick easily, but here, it's, you don't (Anemone).

When scheduling appointments, Health Brokers suggest to health and social services providers that a mother with four or five children, who has to rely on public transportation, or is new in the city, should not be given a 9:00 a.m. appointment because the likelihood that she cannot make it is very high. Instead, an appointment later in the day will mean that the mother will have more time to prepare and travel with the children and arrive on time for the appointment.

In the next section, I discuss the Health Co-op and Health Brokers' holistic work in family intervention, and how they enhanced their work on perinatal health by including other issues and areas linked to the social determinants of health.

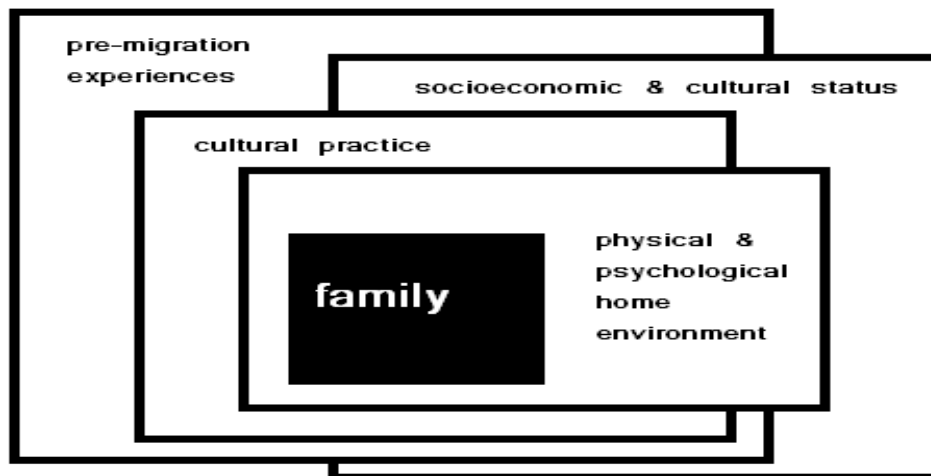
Collaborative family intervention program

WHY FAMILY INTERVENTION

For almost a decade (2002 to 2011) Multicultural Health Brokers complemented their perinatal health education work by supporting immigrant and refugee families through early parenting and child development for children zero to six years old. This work entailed the Health Brokers visiting women in their homes and learning in depth about the socio-economic realities of their families. They also learned that family violence and child neglect were a problem for immigrant and refugee families, so they used pro-active strategies to address those problems. Two participants indicated that it took a long time for Children's Services to acknowledge that Health Brokers did collaborative child intervention work with immigrant and refugee families and that this work needed funding.

Finally, the MCHB Co-op received pilot project funding in 2008 from Children’s Services to undertake a Culturally-Responsive Collaborative Family Intervention program, that is outreach where child welfare authorities had been called as a result of family violence involving children or child neglect. This pilot contract involved developing a “collaborative care” model with staff at the city’s four neighbourhood centres with high caseloads of immigrant and refugee families (MCHB Co-op, 2010a). The holistic nature of the work meant that Health Brokers involved in the Culturally-Responsive Collaborative Family program recognize the struggles and difficult social and economic circumstances experienced by immigrant and refugee families. The characteristic of the Collaborative Family program (see figure 8) is to address the struggles in the context of the pre-migration and post-migration experiences and cultural values of the families.

Figure 8: The many layers affecting immigrant and refugee families. Source: MCHB Co-op, 2009f, p. 1.



Under the Collaborative Family approach, the Health Co-op and the Health Brokers see the circumstances which lead to violence against women and children, or child neglect, as derived from

a combination of pre-migration experiences and socio-economic and social status in post-migration as well as cultural practices, and the physical, psychological, and home environment of families (MCHB Co-op, 2009f, p. 1). This means that Health Brokers do not start their casework by blaming families for the presenting issues (violence), but by understanding the underlying circumstances which created the problems faced by the families (culture, marginalization, migration).

In the Collaborative Family program, Health Brokers are, therefore, intermediaries between immigrant and refugee families and neighbourhood centres or other key actors, such as the police, schools, and women's shelters, who become involved in cases of family violence or child intervention issues. Health Brokers and mentors intercede in three specific roles where outside parties call for their support: Cross-Cultural facilitators, Culturally-relevant family support workers, and Support (trainers) for frontline staff to develop a culturally-competent practice. The three main foci of Health Brokers are to: a) ensure collaborative relationships and avoid or deal with misunderstandings between families and neighbourhood centres; b) provide culturally-relevant parenting, mental health, and conflict mediation support to families within holistic case management; and c) organize workshops for services providers and front-line staff on culturally-appropriate practices as well as parenting groups for families and information on foster care and kin care (MCHB Co-op, 2010a). Table # 12 below summarizes Health Brokers' roles:

Table # 12. Culturally-Responsive Collaborative Family Intervention program (MCHB Co-op, March, 2010a).

Role	Intervention process
Cross-cultural Facilitators	Health Brokers are involved throughout the process of assessment, goal setting, and intervention to ensure that optimal understanding and collaborative relationships are developed between the families and the neighbourhood centre staff. Health Brokers helped mediate cultural misunderstandings and addressed any cross-cultural conflict that may emerge in the process.

Culturally-relevant Family support workers	Health Brokers provide culturally-relevant parenting support, child and youth work, and holistic case management. Health Brokers actively seek out and engage special resource people within immigrant communities in the areas of culturally-responsive mental health and family counseling as well as conflict mediation and foster care.
Support for Staff to Develop Culturally-competent Practice	Health Brokers organize workshops and reflective dialogues for front-line staff to develop culturally-competent practice. Health Brokers strengthen bi-cultural parenting skills & knowledge with parenting groups for families most affected by child intervention in five vulnerable communities. Health Brokers support community engagement and development involving immigrant and refugee families interested in foster care and kin care.

The Health Co-op's 2008-2009 report to Children Services on the Collaborative model indicates the successes and challenges experienced by the Health Brokers when they work with case workers from the four Neighbourhood Centres involved in the project. The optimum goal is to find the best solution for children and parents. According to the 2008-2009 report, the successes are linked to the Health Brokers' involvement in a case from when the family first comes into contact with Children's Services. In these instances, caseworkers and Health Brokers together plan the best strategy to deal with the violence situation by using the Health Brokers' knowledge of culturally-appropriate methods and their understanding of the family context. The 2008-2009 report also indicates that the challenges are linked to the Health Brokers being called in at the very end of a child intervention case after all other attempts by Children's Services staff have failed and communication between that agency and the family has broken down. When Health Brokers are called in at the very end, it often takes a significant amount of time for them to build or re-establish trust between the families and the Children's Services staff. The length of time needed by Health Brokers to find a solution to the case is dependent on the level of disagreement between the families and the caseworkers (MCHB Co-op, 2009f, p.3).

THE RISK OF LOSING THE INTERVENTION FUNDING

Towards the end of the 2009-2010 fiscal year, the Health Co-op and the Health Brokers were informed that the Collaborative Family program funding might not be renewed because the financing, administration, service delivery, and other elements of Alberta's provincial Child Intervention System were under review (Government of Alberta, 2009). At that time, the province's Child Intervention System was moving to allocate funding to support programs following an Outcomes Based Service Delivery (OBSD) model adopted from the United States (FCS Group, 2005), which the Health Co-op did not follow. This raised great concern for the Health Co-op and the Health Brokers because they believed that the mainstream agencies were not offering culturally- and linguistically-appropriate services to immigrant and refugees families in crisis.

BUILDING NEW PARTNERSHIPS FOR FAMILY INTERVENTION WORK

While the provincial Child Intervention System was under review (Government of Alberta, 2009), the MCHB Co-op with their academic partners submitted a research proposal to systematically document the Health Brokers' Collaborative Family intervention model. One of the academics involved in the research proposal (Girasol), introduced the multicultural Health Brokers' model to Sweetgrass, a champion involved in the Aboriginal child protection work through the Creating Hope Society. Sweetgrass was interested in creating a different model for Aboriginal child protection, which instead of being intrusive and punitive, would reclaim and restore Aboriginal families (Creating Hope Society, 2010b), so Sweetgrass embraced the Health Co-op Collaborative Family model and agreed to include it as part of a new proposal the Aboriginal organization was about to present at a meeting with Alberta's Deputy and Assistant Deputy Ministers of Child and Youth Services. Before this, Sweetgrass had had several meetings with Health Co-op's representatives to re-draft the proposal to build on the Health Co-op's Collaborative model so as to extend it to

support child intervention with Aboriginal women and their families (Creating Hope Society & MCHB Co-op, May, 2010a; participant observation meeting May 27, 2010). The meeting went well and the two decision-makers committed to seeking a meeting with the Minister of Child and Youth Services (Email communication, June 2, 2010).

THE RIGHT PROPOSAL, THE RIGHT TIME, AND THE RIGHT POLICY WINDOW

Although the Child and Youth Services' Minister was replaced, the Deputy Minister and Assistant Deputy Ministers continued to be interested in the Health Co-op and Aboriginal Collaborative Family model, so they sought a meeting with their new provincial Minister. Several factors combined to provide the right timing, the right policy, and the right policy window for the Minister to support the Joint Aboriginal and the Health Co-op model titled "Leveling the Playing Field for Aboriginal and Ethnic Minority Women Involved in the Child Protection System" (Creating Hope Society & MCHB Co-op, 2010a). As a result, the Collaborative Family model became the medium for the Minister to show that something worthwhile was being done to address the needs of Aboriginal and immigrant and refugee families who were in contact with the Child Welfare System (data validation meeting, January 18, 2012). The factors leading to the recognition of the Collaborative Family model were: a) The support from high level officials, such as the Deputy and Assistant Deputy Ministers and from the Regional Officer of Children's Services, who funded the Health Co-op's child intervention collaborative model; b) The support from Sweetgrass, a former Assistant Deputy Minister of Child and Youth Services who had Aboriginal roots; c) The involvement of two critical populations in the proposal, Aboriginals and immigrant, and refugee families; d) The high number of immigrant and refugee families in contact with Child Welfare in Calgary; e) The review of the Child Intervention System then in progress, which indicated the necessity for a major overhaul of the system to address Aboriginal child intervention services as well as develop preventive services for immigrant

and refugee populations; and f) The willingness of the Minister to highlight the success of one model of child intervention services. I reflect on these factors in Chapter 8.

Currently, the Health Co-op, the Aboriginal Organization, the Children's Services Regional Office, and the provincial Ministry representatives are working together to develop a Project Charter based on "co-learning". This process aims to create innovative ways of doing child intervention work and specifically to: a) improve treatment of Aboriginal and ethnic minority women by the Child Welfare and Justice Systems; and b) assist in developing helping systems to be more attuned to the cultural needs and aspirations of Aboriginal and ethnic minority women (Creating Hope Society & MCHB Co-op, 2010a, p. 1). As a result of this initiative, funding for the Health Co-op's Collaborative Family intervention model was not withdrawn, as initially feared. Rather, it was maintained, and at least one participant hopes it will be increased (Lavender, data validation meeting, January 18, 2012). In addition, the Health Co-op obtained \$150,000 to document their Collaborative Family model and co-learning process as well as their interaction with Children's Services. This is a major success because more resources are currently being invested at the various stages – pre-child intervention, during intervention, or post-child intervention – in early prevention work.

One example of the investment in pre-child intervention and intervention work is a new "collaboration agreement" to share the Health Co-op's Collaborative Family model with two mainstream Neighbourhood Centres, with high caseloads of immigrant and refugee families. Investment in post-child intervention work would involve, for example, support for children and families after a case is closed, that is, the child is not at risk anymore. In addition, a crucial element in the co-learning process mentioned above is that it will inform the outcome-based service delivery model (OBSP) adopted by the province as a result of the Child Intervention System Review (data

validation meeting, January 18, 2012). In other words, instead the OBSD model replacing the Health-Co-op's Collaborative Family model, the latter would inform OBSD in order to improve child welfare work across the spectrum of agencies and in the Ministry.⁷

Health system's structural barriers and Health Brokers' responses

INCREASE IN REFERRALS AND PRESSURES ON HEALTH BROKERS

All Health Brokers, mentors, and health professionals acknowledged that the service gaps within the health system contribute to increased referrals for Health Brokers. While one health professional interviewed acknowledged that the Health Brokers, especially the ones who had worked for the Health Co-op the longest, might burn out as a result of doing too many extra hours of work. The same health professional acknowledged that the system was also “pulling back services”, for example, using automated answering services instead of people to answer calls in health or social services, which was inappropriate for immigrant and refugees who did not speak English. Because the health system has not been able to improve its business practice to make services more accessible to immigrant and refugee communities, the number of referrals from the community to the Health Brokers has increased.

The Health Co-op's approach is to help every client who is referred to the agency because of its commitment not to leave anyone without needed services. This means that the Health Co-op has a policy of not keeping a waiting list. For some Health Brokers, this creates tension as they see their

⁷ As a researcher, and as part of the direct observation (volunteer work) component of my studies, I was asked to summarize two key documents produced by the Alberta Child Intervention System Review Panel for internal use of the MCHB Coop. I was also asked to prepare a draft briefing in response to the System Review Panel Survey and to participate in a telephone meeting which the MCHB Co-op had managed to secure with the Panel Review Convener.

client loads increasing, especially if these cases involve families in crisis. This has reduced the overall hours available to be spent on each client, potentially affecting the Health Brokers' own health. As a result, Health Brokers take longer to do a follow up on their regular clients and attend to the needs of new clients. One participant said:

... I have so many [clients], I can't do a good job, because I just don't have the time to... you know, really pay attention to my client, and, I can't help it, right? ... And sometimes it really affects my, even my daily living, because when you are sleeping and you it's, "Oh, my God! I haven't called this client for so many weeks, oh! How are they doing? Oh!" ... and then... you got a new client again, and he is in crisis, and then you have to help them and then, so ... things never finish, and, I don't like it ... (Anemone).

The constant increase in referrals is an indication that Health Brokers are known by the community, which results in the number of clients increasing regardless of whether the Health Co-op has received funding to service those new needs. This situation, however, has not changed much over the years, which have been marked by growing gaps in access to health and social services. As a result, the Health Brokers are therefore still in high demand because they understand both the communities and the health and social service systems and know how to navigate both worlds with very limited resources. The Health Co-op must, therefore, bring in diversified funding in order to address the needs of communities it serves and to provide full employment for its workforce. For their part, Health Brokers must develop expertise in more than one area. This may mean that they have to work in areas where they might not be comfortable, for example, child intervention.

Integrating theory and practice

Both the Health Brokers and mentors also acknowledged that because the Health Brokers' practice is holistic in order to respond to the complexity of cases and needs of women, families, and communities, the Health Brokers' practice must be a hybrid of peer support, settlement counselling,

social work, and friendliness or friendship and mentoring. One study participant also said, “We are generalists because we are able to help women in more than one area” (Anemone). For example, in health education, Health Brokers are familiar with both perinatal health and violence prevention; they often need to target more than one system, such as health, social services, and immigration; they often need to use more than one strategy, including one-on-one support, group work, and lobbying and advocacy (Labonté, 1993); and they often support more than one immigrant or refugee community. The same participant said that at times they were not sure how to describe their practice to clients:

... people ask me, “What do you do” and then I said, “Oh I don't know!” people said, “Are you a social worker?” I said, “No, I'm not a social worker.” People said, “Are you nurse,” I said, “I'm not a nurse.” But, “Are you doing, what do you do?” I said, “Well, I'm kind of doing like social worker's work, but in the meantime I do some, like health education [- -], health promotion, those kinds of things, I, I'm not so sure what I do...” (Anemone).

The above quotation highlights the need for Health Brokers not only to continue theorizing the practice, but also to reflect on the commonalities of their practice with more established fields and professions, such as social work, health promotion, and traditional peer and social support counselling. Bridging the links between these fields and the multicultural health brokering practice needs to be continually built upon, as Ortiz's 2003 participatory-grounded theory study identified.

Although the MCHB Co-op received its first pilot funding to work on family intervention in 2008, the Health Brokers had known long before that their function was linked to social work. For example, in Ortiz's 2003 study she identified the contributions that multicultural health brokering practice could make to the field of social work. Ortiz 2003 argued that the practices of Health Brokers and social workers were congruent because they served groups of the populations who were disenfranchised

and disempowered. Ortiz further suggested, “To be able to address external forces that create problems for individuals for the community, perhaps social workers and Multicultural Health Brokers must work together to achieve the desired positive outcomes and more importantly to create lasting social change” (p. 165). In the day-to-day relationship, however, social workers and Multicultural Health Brokers’ approaches have clashed, owing to both sides at times disagreeing on the best way to empower women and their families in which children are at risk or experiencing violence or neglect.

On the other hand, the Health Co-op and the Health Brokers do not have as much time as they would like to reflect on their work because the work Health Brokers do is very complex. For example, a typical day for a Health Broker involves using the morning to accompany a client to a doctor’s office, then helping the client obtain the medication prescribed by the physician or dealing with some complex non-health related issue that the client might be facing, then attending a working lunch at the Health Co-op for her particular program, followed by an afternoon half-a-day training, and then going back to the Health Co-op to participate at the Health Co-op’s membership meeting in the evening. Later that evening the Health Broker might receive a call from a mother or her family who needs urgent support. When the Health Broker can finally rest, she may have to address pending issues for her own family. This means that she/he does not have the time and energy to write down all that happened that day, let alone to reflect on her practice.

Mentors acknowledged that because of the heavy caseloads Health Brokers carried, it was a challenge to discern Health Broker theory. In other words, the large caseloads limited the Health Brokers and the Health Co-op’s time for collective reflection and knowledge creation. During my data validation (December 11, 2011), some Health Brokers disagreed that they did not have time to

reflect on their practice. After some discussion, most agreed that although some individual Health Brokers managed to have time to reflect on their practice, as a group, they should all be trying to create more opportunities for collective thinking and reflection. I come back to this point in Chapter 8.

NEGOTIATING BETWEEN CHILD WELFARE AND IMMIGRANT AND REFUGEE FAMILIES

The Health Brokers argued they were constantly negotiating with Children's Services workers, and many times felt they had to defend some immigrant or refugee communities' cultural practices. A number of these, according to the Health Brokers, ought to be respected (where possible, appropriate, and without breaking any laws) in order to find the best solution for the children – even in cases where parents were being accused of physically punishing their children. For example, if mainstream Children's Services workers received a complaint from a school, signalling that children were being abused, their protocol was to speak to the children without the knowledge or consent of the parents (authoritative knowledge). This protocol was contrary to what some countries' cultures follow. For example, in some African cultures (experiential knowledge), strangers were not allowed to speak to children without the knowledge or consent of the parents. Health Brokers believe that in order to achieve collaboration between some immigrant or refugee parents and the Child Welfare system, Child Welfare workers must respect these cultural protocols.

This means that if a Child Welfare worker wants to speak with the children of some African parents they have to get the parents' consent. According to Health Brokers, if this protocol is not respected, Child Welfare is transferring the authority from the parents to the children, therefore undermining the parents' authority and possibilities of finding the best solution for the children. The Health Brokers believe that most parents were willing to obey Canadian rules about not hitting their

children, but those parents needed to have Canadian rules explained to them, while respecting the protocols of their indigenous cultures. The Health Co-op report (MCHB Co-op, 2009f) cites a Health Broker suggesting protocols need to be followed in dealing with parents as well: “In the culture we come from, they don’t like that kind of surprise; they feel suspicious. Please let them know that you will come from x to y time on this day, and they can expect you that day and not like just drop in” (p. 3). Health Brokers indicated that they had very good relationships with many social workers, but when these tensions arose, both sides had to be willing to compromise.

THE PUSH FOR ACCREDITATION

Because of the relationship between the Health Co-op, Health Brokers, and the Child Welfare System, some discussions are taking place on whether the Health Co-op should move towards accrediting the Health Brokers’ practice. The Health Co-op knows that they have little choice but to seek accreditation in order to undertake further work in this area. The rigidity of mainstream accreditation, however, is something the organization is dreading. For one participant the trepidation about accreditation of the Health Brokers’ practice was related to losing contact with the communities the Health Brokers served. She stated:

...the danger of following the path of other professionals is once a practice is truly professionalized it that it often loses the innate, for lack of a better words, the community way...you see where I am coming from it...once you professionalize it, it enters the sphere of the system, the system wants to narrow down things, keep them compartmentalized... (Lavender, September 18, 2010).

In the past, the Health Co-op always considered accrediting their practice, but time constraints, plus the fear of how much this process could interfere with their practice stopped them from doing so. At the time of my research, however, out of necessity the MCHB Co-op seems ready to embark on the accreditation process. For the same participant, the Health Co-op had to be vigilant and think

creatively to be able to meet the system's requirements, but at the same time honour and respect their holistic and community way of working. This participant stated:

This process will put us in a major clash between our way and the system's way. But, we cannot just not try because we are so much involved in child welfare work...As we tackle each policy, each requirement, I hope that we are strong enough and have enough clarity, to not to give in so quickly, that we can find out our own solution, that meets the intent of the policy (Lavender, September 18 2010).

For the Health Brokers and the Health Co-op, the ideal accreditation would make their practice visible and easy to replicate. In the words of one participant, she hopes the right accreditation offers the opportunity “ ... to make Multicultural Health Brokers' practice so visible, so articulable, so replicable, that any group of colleagues who gets the training, who does the work to gain the lived experience, would be accredited ... as Multicultural Health Brokers. That would be great” (Lavender, September 18, 2010).

A fundamental difference between multicultural health brokering and social work, which I addressed in the introduction to this chapter, is that some Health Brokers see themselves as friends and mentors for their clients, which is discouraged in traditional client-social worker helping relationships. I revisit this point in Chapter 8.

Discussion

When I started this study, I focused my inquiry on the “technical/descriptive aspects” of the work of Health Brokers including outreach, referrals, follow-up, monitoring, caseload, training, clinical support, compensation, and evaluation. Over the course of the interviews and my field observations, however, I noticed that Health Brokers and mentors were less interested in the

technical aspects of the work, Health Brokers' tasks per se, and more interested in the "philosophical" and "relationship-based" aspects of their practice. This means that they were fully centred on the relationship they established with their clients. While only a few participants specifically spoke of developing, or wanting to develop, or feeling the pressure to develop "standards and practice guidelines", their philosophical and relationship-based approach to practice was ingrained in their oral and written language. The Health Brokers' practice is a guide for behaviour, self-reflection, and empowerment: a shared, agreed philosophy to which the Health Brokers and mentors refer in order to guide their work and assess the appropriateness of their actions in favour of the adaptation and integration of immigrant and refugee women and their families into Canadian society.

The Health Co-op and Health Brokers follow this philosophy throughout all their ten programs. In this section, I interpret and discuss the application of the Multicultural Health Brokers' practice. I argue that their practice encompasses Health Brokers straddling the line between experiential knowledge (immigrant and refugee women-based) and authoritative knowledge (biomedical-based) (Davis-Floyd & Sargent, 1997; Ketler, 2000). I do so by analyzing their work in two areas: The perinatal work and family intervention work. In both these areas, Health Brokers help women who live in vulnerable conditions because of their socio-economic status, gender, language, cultural and racialized background, and migration history. This analysis provides the basis for identifying the multicultural Health Broker practice as being uniquely positioned to foster equal relationships with immigrant and refugee women, without stigmatizing women into the permanent state of "client".

I would like to characterize the "perinatal experience" for immigrant and refugee mothers in two ways: The biomedical/authoritative and the informal/experiential perinatal knowledge that Health

Brokers share with mothers. The Health Brokers learn the authoritative knowledge through the training provided by public health nurses, education manuals, independent training sponsored by their Health Co-op, or on their own initiative, time, and resources. They learn the experiential knowledge in their capacity as Health Brokers, mothers, daughters, and women from the same or similar racialized background, who experienced the same process of migration, settlement, and adaptation into this country. They also gain this experiential knowledge through the challenges they face in accessing health and social services in the city. Both authoritative and experiential knowledge is about redistribution of power and addressing health equity for/with perinatal immigrant and refugee women.

REDISTRIBUTING POWER

Sherwin (1992) challenges the biomedical model for taking over the power to decide on women's reproduction and denying women's control over their bodies, a phenomenon that is more pronounced for racialized minority women (Sherwin, 1992). Jordan discusses the concept of authoritative knowledge in reference to a biomedical system that values the medicalization of birth while devaluing other systems of birthing that maintain women's power, as found, for example, in the Mayan culture (Jordan, 1983). The power a woman has by being able to have a child is corroborated by one mother interviewed. She said "...I think [a] wom[a]n is that strong who can give birth to a child, right? So if a woman wants to do anything... nobody can stop her, nobody can stop her... she is not that weak. Only the situation, only the circumstances that will make her weak, otherwise she is not that weak". Valuing women's power is where the strength of Health Brokers' practice lies. They believe in distributing power by not treating mothers as clients or patients, but as equals and human beings who are experiencing a transitory stage of difficulties and a set of negative circumstances in their process of adaptation in Canada. The concepts used by both mothers and

Health Brokers to refer to their equal status included: friendship, hope, accompaniment, and trust. From my participant observation activities and analysis of the data I believe that it is crucial that mothers understand that Health Brokers provide short- and medium-term support to make their perinatal experiences less stressful. It is also important that Health Brokers seek to support women in their long-term goal of becoming active citizens in Canadian society.

Health Brokers believe in establishing short, medium, and long-term relationships with women and their families. This is contrary to the biomedical model of seeing clients as patients and for choosing not to establish relationships with clients and their communities. In other words, mainstream health professionals exercise authoritative status by keeping distance from “patients” — in this case immigrant and refugee mothers. As discussed by Davis-Floyd and Sargent, the label “authoritative” is intended to draw attention to its status within a particular social group and to the work it does to maintain the group’s definition of morality and rationality. “The power of authoritative knowledge is not that it is correct but that it counts...” (Jordan, 1993 [1978]: 152-4 cited in Davis-Floyd & Sargent, 1996 p. 113). Health Brokers resist this authoritative model by creating “less formal” boundaries between mothers and workers. They do not shy away from saying that they value the mothers’ diverse cultural backgrounds or use of their own personal experiences in their perinatal education work. On the contrary, they assert that they value all cultures and insist that experiential knowledge from women’s cultural backgrounds has to be recognized and combined with Western authoritative knowledge. As one Health Broker stated, “...we're incorporating our culture to the Canadian culture...but, we don't tell them what to do. [- -] Yeah, if you do it, we respect what you want to do!” (Baby’s-Breath).

This means that for Health Brokers, legitimizing one way of knowing (the health and social services agencies' way of knowing) should not come at the expense of devaluing other ways of knowing (Sargent & Bascope, 1996), in this case, the immigrant and refugee communities' way of knowing. Health Brokers are therefore advocating a model that could lead to fruitful accommodation between authoritative and experiential models. As Jordan (1983) explains in her study of birthing practices in four cultures, "The modified model is to include not only an analysis of Maya practices according to the criteria of medical obstetrics, but also an analysis of medical obstetric practices according to the criteria of the indigenous system" (p. 48). The Health Brokers also acknowledged that on some issues there are commonalities between their cultures and Western cultures, so they just help mothers identify those features that are common to both cultures.

Health Brokers work with women and families from so many cultures, the Health Co-op as an organization attempts to facilitate fruitful accommodation between authoritative and experiential knowledge in several ways: a) through the issue-based training provided to Health Brokers; b) in the collective thinking, reflection and writing done by Health Brokers and mentors; c) as part of the conversations and interactions they have with public health nurses from the Health for Two program; and d) through the partnerships they have with researchers outside and within academic institutions.

A critical view of the Health Brokers' practice is that it accepts the perinatal biomedical knowledge at face value. The Health Brokers teach women what they are taught by public health nurses or other health professionals and do not appear to question the assumptions about hospital births. For example, most participants spoke of hospital tours, but none of the Health Brokers, mentors, or mothers spoke of choosing homebirth. This might be the case because homebirth in Canada is

expensive; mothers, especially newcomers, are often struggling financially, and do not have the social networks and support necessary for homebirth. This might also be due to both the Health Brokers and mothers trusting the medical models and being afraid of complications at home. Fleuriet (2009) argued that in the United States there was a trend for undocumented women to receive prenatal care delivered in a holistic approach at a family centre, but they tended to go to a hospital for child birth because they trusted the medical model. As a result, some were opposed to having the baby at the family centre with formally trained midwives (Fleuriet, 2009). In one of the data validation meetings, Health Brokers and mentors made it clear that homebirth was a class issue for immigrant and refugee women for two reasons: Their socio-economic conditions did not give them the opportunity to “think” about homebirth, and many₂ have had such poor access to health services in their home countries that they considered giving birth at a technically advanced hospital, with no charge, a big achievement (meeting, August 17, 2011).

APPROACHES TO ADDRESSING HEALTH EQUITY

CULTURAL COMPETENCY

The literature highlights the structural inequalities in health care in which immigrant women in Western countries do not receive the same medical care as native-born women (Akhavan & Lundgren, 2012; Etowa & Adongo, 2007). One reason for these inequities is identified as the lack of cultural competence, cross-cultural knowledge, or anti-racism training among health professionals, and an ethnocentric medical model of birth. (Jordan, 1983) argues that cross-cultural studies are necessary

in order to expose the range of human variation in ways of doing birth, so that we can overcome the restrictive, unexamined assumptions and policy implications of our ethnocentric medical model of birth. And above all, they must be biosocial, that is to say, they must address the interface between the panhuman biological function of parturition and the culture-specific social production of the event. (p. 90)

Multicultural Health Brokers believe in training health professionals in cultural-competency to understand different cultures and to be more open to understanding mothers' perinatal experiences. McGibbon and Etowa (2009) argue, however, that cultural competence is a step forward, but it is not in itself enough to address health inequities. According to these authors, cultural competency helps to increase health professionals understanding without changing the power structures which lead to health inequities (McGibbon & Etowa, 2009).

ASSUMING THE COST ON INEQUITIES

As mentioned above, the Health Brokers' caseloads continue to increase due to increasing needs in immigrant and refugee communities. This translates into inequities in women's birthing experiences as corroborated by most the Health Brokers and mentors, health professionals, and women interviewed. For example, the Health Brokers and mentors spoke of funding being allocated to transmitting the "perinatal health information or perinatal tasks" (authoritative knowledge) as determined by the medical model, but funding is not provided for other tasks related to "social support and accompaniment" as well as non-health issues (housing, food) or addressing social issues (experiential knowledge). One health professional interviewed stated that the health system was better at counting services than at counting support. This participant also acknowledged that, without the support and relationships Health Brokers established with mothers, it would not be possible to do the perinatal work. This means that the health system relies on the Health Brokers' abilities to develop trusting relationships with women "on their own time", so that they are subsequently able to transfer the perinatal information the health system is required to provide to all women, including immigrants and refugees, in order to fulfil its mandate. In other words, this can be seen as exploitation and lack of recognition of Health Brokers' work by AHS (personal communication, September 7, 2012). I come back to this point in Chapter 8.

The inequities are particularly salient where Health Brokers must help mothers on their own time to address the social determinants of health, such as income security, poor housing, mental health, family problems, or intergenerational conflict before the mothers are able to turn their attention to perinatal health. Investing their “their own time” explains why the Health Co-op and the Health Brokers started their work in family intervention long before they had received funding from Alberta’s Child Intervention System. This approach also illustrates that the Multicultural Health Brokers are “generalists” in their practice because they work in more than one area (home visiting, child intervention, and perinatal health); they are familiar with more than one system (health, social services, and immigration); and they use more than one strategy (one-on-one support, group work, and community mobilizing).

STRADDLING TWO TYPES OF KNOWLEDGE AND MULTIPLE SYSTEMS

In the Health Brokers’ perinatal work, they straddle the authoritative knowledge of health professionals and the experiential knowledge of pregnant women and new mothers. In their Collaborative Family Intervention work, Health Brokers take on the same mediating role. In doing so, they negotiate between the formal knowledge of social workers and caseworkers and the informal knowledge of women as well as their spouses or immediate family members. Sometimes Health Brokers have to negotiate, simultaneously, between the types of knowledge (authoritative and experiential) of and multiple systems, such as health, child intervention, immigration, and social services. This knowledge negotiation with multiple systems, for example, happens when mothers with newborns are in crisis owing to a combination of factors: they live in low socio-economic conditions; they are experiencing spousal violence; and their infants and older children are also victims of that violence.

GETTING SUPPORT FOR SOME BUT NOT ALL WORK

Health Brokers spoke of supporting mothers during labour and delivery, but not in a systematic way, mainly due to lack of compensation for this activity. Although some Health Brokers offered to accompany women during labour, they opted out if the mother was able to find alternative support. Jordan (1993) argues, "It may well be the case that the presence of a culturally-appropriate birth attendant is particularly important for women who have to give birth in unfamiliar surroundings or who are otherwise under stress" (p. 47). The mothers interviewed, newcomer women for whom hospital births are unfamiliar, would have benefitted from having Health Brokers present during their birthing experience. An expansion of Health Brokers' role to include this activity in a systematically compensated manner will improve quality care for immigrant and refugee birthing mothers. This model already exists in the form of *doulas* (Kane Low, Moffat, & Brennan, 2006). The Health Brokers' practice shares some commonalities with doulas, such as cultural competence, dedication to mothers, and knowledge of birthing processes, and hospital settings (Akhavan & Lundgren, 2012). The main difference is that doulas are hired by couples (or single women) who can afford to pay for the service and their role is restricted to the perinatal experience. Health Brokers attend births mainly in a volunteer capacity, which is unsustainable, and their vision of their potential role is much broader. One article suggests that doulas should become part of the community health worker field. In this case, an agency would pay for their work or would coordinate them as volunteers (Kane Low, et al., 2006). In one of my data validation meetings with Health Brokers and mentors they indicated that it would be wonderful if they could be fully compensated for accompanying women during labour and delivery (participant observation meeting, August 17, 2011).

CRITICAL REFLEXIVITY

What did I learn from my interviews of Health Brokers and how does my social work training influence the way I see their practice? The literature argues that an added value of CHWs is that they come from the communities they serve. I argued in Chapter 2 that Health Brokers are not only bridging the divide between disadvantaged immigrant and refugee populations and the health and social services systems, but they also are themselves disadvantaged. Because Health Brokers and clients are members of the same communities, which is a strength of their practice, and Health Brokers believe in treating clients as equals and friends, this presents two issues to consider. First, the opportunities to meet clients outside the work setting fall within Health Brokers' notion of "relationship-based" practice. For Health Brokers relationship-based means they see clients as equals and they do not hesitate to interact with clients outside their office hours or believe they are breaking any client/worker rules if they become friends with clients. Health Brokers are potentially in constant communication with their clients because they frequently use the same ethnic food stores, shop at the same businesses, and participate in the same ethno-cultural activities as their clients. Even if Health Brokers want to avoid meeting their clients outside of their regular work hours, they may not be able to do so. Mainstream Canadian workers serving immigrants and refugees, on the other hand, have many more options for shopping or socializing or attending cultural activities, so if they prefer not to be exposed to clients outside their office setting they are usually able to avoid contact.

In my own experience, I remember a physician telling me that he would not frequent places where he was likely to find his clients because he did not want people to be asking him medical questions outside of his practice. This is a luxury that many Health Brokers do not have, often because of

socio-economic status or since it is not practical to avoid sites frequented by their clients. The social stratification of Health Brokers, therefore, has an impact on their lives outside the work setting. Analysis of the dimensions of the Health Brokers' practice, for example, one-on-one, group work, coalition building and mobilizing, which they adopted from Labonté's (1993) health promotion empowerment approach, reveals that their work goes beyond a "therapeutic" relationship between workers and clients. Their larger goals are building the capacity of groups and communities, to have good health outcomes, and assist their clients to integrate fully into Canadian society. To do so, Health Brokers are learning and applying principles of community empowerment and social change in their daily practice. In the words of one participant, the Health Co-op and Health Brokers are also "supporting the system to shift". From an empowering social work perspective I completely agree with the Health Brokers' approach. Indeed, in my past life as a social work university lecturer, I taught students to have a better understanding of theory, methods, and practice of anti-oppressive community development work (Torres, 2003). I wanted students to gain a fuller and deeper understanding of the way that communities function, and the limits and possibilities of accomplishing inclusive, anti-oppressive communities.

A second issue is: how might traditional social work see the egalitarian approach that Health Brokers want to establish with clients? Social work practice identifies boundary crossing as "... activities with the client such as going for (a) hike, exchanging inexpensive gifts or non-sexual embraces, sending cards, watching a client perform in (a) show, and accepting an invitation to attend a client's wedding or graduation" (Lundy, 2011, p. 138). Becoming friends with a client falls within the definition of dual relationships. Dual relationships "occur when social workers enter into more than one form of relationship with clients" (Lundy, 2011, p. 137).

The Health Co-op and Health Brokers also include the term “dual role relationship” in their Competency Framework developed in 2004. They define this as “a working relationship where the MCHB and the clients also have a present or previous familial, social, sexual, financial, supervisory, administrative or legal relationship” (MCHB Co-op, 2004e, p. 9). The Framework explains clearly that if a dual role relationship occurs before or during the dealing with the client-worker, the MCHB shall: inform the client of the dual role relationships and the possible consequences; terminate the relationship and explain the reasons; assist the client in obtaining services from another MCHB or agency; and document the reasons in the client record (MCHB Co-op, 2004e, p. 13). This definition does not prohibit Health Brokers from becoming friends with clients. Social work literature (Lundy, 2011) also acknowledges that dual relationships:

are more likely to occur in small geographic communities, or when a social worker belongs to an identity-based community such as the disability or the gay/lesbian community. In these settings social workers and their clients may attend the same social events, share mutual friends, and have membership in common health, religious, or cultural venues. (p. 137)

Because of the social context in which Health Brokers operate, I would say that it becomes unavoidable for them to establish dual-role relationships or boundary-crossing relationships. As a researcher, I experienced a situation that involved boundary-crossing. In one of my participant observation activities, I attended a gathering organized by Health Brokers. At this event, one community member greeted and spoke to me as if she knew me, and then introduced me to her family, so I replied in an equally friendly manner. At the beginning, I could not place who she was, but as she spoke, I realized that I had been to her house for an in-depth interview about the role of Health Brokers. In re-listening to her interview she indicated a desire to keep in touch, and offered to help me with any research activities. After the interview, she sent me email invitations to events

and information about different issues, which I did not follow up on. After a while she stopped sending messages. Unlike the Health Brokers, I lived in another city; it was easy to keep my role as a researcher separate. In my Latin American international development work or community health worker role with the Hispanic community in Ottawa, and as a student, I have had occasion to invite my professors to fundraising events. This puts them in situations that force them to consider whether they want to cross the student-professor boundary.

I did question Health Brokers and mentors on the notion of boundary crossing and dual relationships and was told at the last data validation session on June 14, 2012 that Health Brokers were very clear where to draw the boundaries with clients. According to these participants, when they speak of “being friends” with clients it does not mean that the Health Brokers share all their issues and concerns with their clients, but rather that they seek to establish trust with clients in a way that is respectful to them.

Conversely, because Health Brokers see clients as ‘equals’ and ‘friends’, the concept of dual relationships, represents a source of tension between Health Brokers and social workers and health professionals. For example, in their perinatal work, Health Brokers are pressured to follow the standards they developed with public health nurses from the public health unit to guide their Perinatal Health Outreach and Health for Two Programs. Indeed, I attended a meeting between health professionals and Health Brokers and mentors in which health professionals discussed the need to review the perinatal standards to make sure they reflected the current practice. At one point, health professionals alluded to Health Brokers having problems establishing boundaries with clients. I could see from Health Brokers’ and mentors’ body language that they disagreed with health professionals’ perspectives, but they only expressed their disagreement after the health

professionals had left the meeting (meeting, January 28, 2010). Given my social work training and commitment to empowering communities while providing quality services to clients, I feel that Health Brokers must continually deal with the tension between what the literature refers to as protecting professional status (setting boundaries) and adopting action-oriented positions on social problems (Jennissen & Lundy, 2011), which require establishing equal, non-hierarchical relationships with clients.

THE RELEVANCY OF THE PHENOMENON

At any particular time, Health Brokers are in constant interaction with more than 1,000 immigrant and refugee women and their families from over 80 countries in order to facilitate their access to health and social services. How relevant is the Health Brokers' practice for women and the health and social services professionals who are there to support them? The Health Brokers' practice is relevant because in the words of one health professional, "they save lives", and alleviate other health concerns. Their practice is also relevant because they approach their work by looking at the strengths that immigrant and refugee women have as opposed to the weakness created by the social and economic conditions they experience due to pre-migration, migration, settlement, and adaptation in Canadian society. Their practice is also relevant because they value the cultural backgrounds of women and communities as well those of Canada's society and attempt to reconcile the two. In other words, the culturally- and linguistically-appropriate nature of the Health Brokers' practice reinforces what the literature refers to as clients/patients racialized and ethnic concordance with their workers (Wells, et al., 2011).

The Health Brokers' practice is also relevant for other CHWs in Canada and in other countries because it systematically combines health, social work, and social activism. These three

characteristics mean, in their practice, that Health Brokers bring a holistic approach to identifying the presenting health and social problems. They seek multi-faceted solutions to such problems by drawing on resources from multiple government ministries as well as health and social service agencies and by enlisting women in supporting each other and their communities. The literature indicates that CHWs can make a valuable contribution to community development and, more specifically, improve access to and coverage of communities with basic health services (Lehmann & Sanders, 2007). Health Brokers' practice is also relevant because it demonstrates that community-based organizations composed of non-health professionals (or internationally-trained professionals whose credentials are not recognized in Canada) can develop health and social work innovative models of practice. These models may be influenced by practices in other professions, but can also themselves influence both health and non-health professions. The Health Brokers practice is also relevant because it has the potential to bridge the gap between CHW evidence-based practices that work in other countries and those approaches applied by CHWs in Canada.

Finally, the Health Brokers' practice illustrates that when community-based organizations have a vision of their work, programs that reflect that vision, partnerships and collaboration with health and social services systems and allies as well as a strong independent voice, there is potential to achieve systematic change. This is possible because with these elements in place such groups are positioned to take advantage of policy windows (Mason, et al., 2011). For example, the Health Co-op's Collaborative Family Intervention model, as described above, won support from the Minister of Child and Youth Services because it was the right proposal, had the right partners, and was proposed during the right policy window. This example is similar to the three streams policy process that J.W. Kingdon (1995) identifies: "Policy entrepreneurs must define a compelling problem to secure the attention of policymakers, they must offer a viable proposal to solve that problem, and

they must take advantage of political dynamics to force action on their agenda" (cited in Masson et al., 2011, p. 2211). This applies in this instance because the Ministry was open to innovative approaches owing to widespread criticism of the chronic dysfunction in the child welfare in dealing with marginalized populations, especially Aboriginal youth and families.

Conclusions

In this chapter, I illustrated Health Brokers' standards and practice guidelines and the mechanisms they have in place to monitor their work with women and their families. Health Brokers are not yet recognized as part of health human resource workforce in Canada, but functionally they are health care workers. They play this role as providers of perinatal information, as supporters of women throughout their pregnancy, labour (when possible), and the post partum phase, and guides for women in navigating the broader health system. Health Brokers believed that mothers responded positively to their health brokering approach, as reflected in the number of client referrals received from community members and positive client feedback they heard. They gauged their success on their ability to help clients move from a crisis situation to stabilization and on seeing mothers achieve their goals in adapting to and participating in Canadian society. This includes the mothers getting involved in helping other clients and in initiatives that benefit their communities as a whole.

The work Health Brokers do in family intervention is just one example of the different strategies they use to target the social determinants that have a direct or indirect impact on immigrant and refugee women's health and well being. The Health Brokers initially worked in Family Intervention without funding; however, eventually, Children's Services began to finance their work and is now supporting expansion of their unique Collaborative model. A new iteration of the model will see it extended to support child intervention with Aboriginal women and their families. Development and

expansion of this collaborative model illustrates the Health Co-ops and Health Brokers' vision of working not only on perinatal health, but also on the different needs they identify in immigrant and refugee communities. This is also a good example of the success of the Health Co-op and Health Brokers' ability to identify and fill a market niche by providing culturally- and linguistically-appropriate services.

Health Brokers experience complexities and contradictions in their role as intermediaries between health and services providers and their clients. They straddle the authoritative knowledge of health and social services providers and the experiential knowledge of immigrant and refugee communities. They, however, do not give up in the face of two factors: a) the unwillingness on the part of some health professionals to undertake the steep learning curve to understand the needs of immigrant and refugee communities; and b) the systemic access barriers reflected in the shortfalls in both the quality and quantity of health and other services available to immigrant and refugee communities. Health Brokers are, on the contrary, contributing to fostering equal relationships between community users of services and health and social services professionals delivering those services. Through these means they are potentially addressing health equity for immigrant and refugee women.

Chapter 8

An integrated analysis

If by looking at the ‘big picture’ we get discouraged, let’s focus on the ‘small picture’ to find the courage and the strength to continue the struggle

I was the first person to arrive at a meeting of health and social service providers, school representatives, university researchers, and multicultural Health Brokers to discuss the findings of a project on pre-school screening of immigrant and refugee children. The meeting was held in the boardroom of a mainstream health organization, which I had visited before as part of my field work. I sat at the table, so when other people started to arrive, I greeted them. One person who sat across from me asked if “other” Health Brokers were coming to the meeting. I said, “Yes, they should be arriving at any minute.” I did not say anything else, but I found it surprising how without asking who I was, this participant assumed I was a Multicultural Health Broker. When everyone arrived, I noticed the racial and gender composition of people in the room. The large majority were White, English-speaking, and female. A minority were “racialized” participants, including female and male Health Brokers, a former Health Broker representing another agency, and myself. Then I understood something: in this city, if a room is filled with staff from mainstream agencies working with immigrants and refugees, racialized woman participants are expected to be Health Brokers from the MCHB Co-op. The paradox in this perception is that Health Brokers have created a niche for themselves in this city.

A critical population health research practice approach

In a highly stratified health care system, Multicultural Health Brokers provide an important service, yet their practice is often invisible and unrecognized because the populations they serve (largely immigrant and refugee women) are also invisible and unrecognized. The question is, what can a small health worker co-operative employing fewer than 60 Health Brokers teach us about health human resources workforce planning with respect to people experiencing marginalization? The answer is twofold. First, independent models of CHWs are facilitating access to health and social services of underserved populations. Secondly, these models can give voice to clients (potential

patients) and citizens who otherwise have no voice. CHWs are exemplary citizens, agents of social change (Rosenthal, et al., 2011), taking on the role of caring for the health and wellbeing of their own communities despite their lack of resources. They are also models of community capacity building and collaboration between communities and local systems, advancing a common goal of breaking the isolation and marginalization that some populations face stemming from, among other factors, macro structural changes to reduce costs in health and other social programs.

Seen in that context, the Health Co-op's work and the Health Brokers' practice are fluid and in constant renewal. The fluidity is evident in their innovative programming and combining of theory and practice. Their constant renewal is evident in their perseverance and struggles for practical and strategic gender interests (Eisenstein, 2009). Practical gender interests are those related to access to health and social services of immigrant and refugee communities, and recognition of CHWs as part of the health human resource workforce; strategic gender interests include such concerns as eliminating violence against women, and achieving women's equality within immigrant and refugee communities and within Canadian society. Key to empowering women is to make their voices heard, first through negotiation between authoritative knowledge of health and social services providers and experiential knowledge of immigrant and refugee women (Davis-Floyd & Sargent, 1996), and second through encouraging women's agency and relational autonomy (Sherwin, 1998). Fostering agency and relational autonomy leads to empowering women to become politically active in Canadian society, and to what I am calling "feminist urban citizenship" (Andrew, 2008). The ultimate goal is to obtain optimum health through health education, community development, and advocacy (MCHB Co-op, 2004aa). The experience of the Health Brokers themselves is shaped by the existing inequities in health in Canadian society.

In my member-checking sessions with the Health Co-op, Health Brokers, and health professionals, I told them that as a researcher I had to highlight the “good” aspects of their work, but also had to be critical if there were elements of their activities that could be “improved”. I seek to be both supportive and critical in the text that follows by examining what the Health Brokers’ practice reveals about the Health Co-op, the Health Brokers, the CHW field, and the health system’s role in addressing health equity for immigrant and refugee women in Canada.

HOW THIS CHAPTER IS ORGANIZED

This chapter is organized in three sections. First, I return to the case study theoretical propositions (premises) I hold about the phenomenon under study (Gagnon, 2005), and their relationship to the two fundamental research questions and the six-sub-questions of my inquiry. The propositions and questions highlight the relevance of the overall inquiry for the field of CHWs and demonstrate the complexities and contradictions that the Health Co-op and Health Brokers experience in their daily practice. These issues result largely from big picture (upstream) system factors they confront in helping their clients. The experience from the case study makes clear that in our society taking small picture (downstream) actions at the local level in collaboration between community-based organizations and frontline health and social service providers is fundamental to fostering health and wellbeing of populations experiencing vulnerability and essential to long-term system change. Second, I reflect on some of the strengths and challenges that the study revealed about the Health Co-op, so that similar organizations can learn from them. Third, I suggest some areas of further research to advance CHWs as both part of the health human resources workforce and actors in addressing health equity for populations experiencing marginalization, including immigrant and refugee women. I conclude this dissertation by highlighting issues for consideration, such as the need for intergovernmental and intersectoral collaboration.

Returning to the research questions and their theoretical propositions

The work of Health Brokers in the Perinatal Health and Health for Two programs is the focus of my research since they: a) illustrate the role of Health Brokers as part of health human resources workforce; b) demonstrate the collaboration between the formal system of care (AHS Edmonton Zone public health) and a community-based organization (the Health Co-op); c) demonstrate the market niche (culturally-competent and linguistically-appropriate services) that the Health Co-op and Health Brokers established for themselves within Edmonton's health services; d) provide the medium for the Health Co-op to receive stable funding, from which they reflect and define their cultural brokering practice and health promotion empowerment approach — these programs are not their biggest source of income any more, but still provide a tool for Health Brokers to enter family's homes at crucial times in women's lives, specifically pregnancy and childbirth; and e) identify and address "non-health"-related needs, such as violence against women and children. The Health Co-op's Collaborative Family Intervention Program provides a clear example of how they support women and children who, in addition to living in conditions of socio-economic vulnerability, are victims of spousal or parental violence. Although this Collaborative Family Intervention model is a downstream intervention, it has the potential to influence upstream policy change because of interest on the part of the Ministry of Human Services (Children and Youth) in supporting, learning, and transferring the model to Aboriginal families in Edmonton.⁸

Main research questions

1) How are CHW programs integrated within Canada's formal public systems of care?

Theoretical Proposition 1a: Macro level social, historical, political, and economic factors influence the way CHWs are integrated within public health units.

⁸ While I sought approval to interview social workers at Children's Services so that I could include this model as a third mini-case for my study, the agency was undergoing restructuring of their programs, so my request was not granted.

Let me address first the issue of integration. CHWs are linked to the mainstream health care system in two ways. Sometimes they operate within the formal system, and sometimes they operate independently from the formal system. In both models, CHWs are part of the health human resources workforce, although in Canada, they are often not recognized as such. Regardless of where the CHWs are situated, the health care system has some form of relationship with marginalized populations, including immigrant and refugee communities, so some of their needs and interests can be brought into the system. The characteristics of each model may be explained by several features.

A) WITHIN THE SYSTEM: CHWs are staff within public health units, community health centres, or hospitals. Their wages and benefits reflect those of other workers within the system. A situation similar to this currently exists for CHWs (called Women's Health Educators) within Hamilton's Ontario Public Health division (Black, et al., 2007), where these workers are well paid and have good benefits as well as reasonable work hours and caseloads. A second example is a single part-time permanent multicultural health broker position, based at the Edmonton's Grey Nuns Hospital Maternity Ward, which is funded through that hospital's budget (Anonymous interview, March 15, 2011). In normal times CHWs and their health professional allies in public health units reach out to marginalized communities with key messages. In situations of pandemics, they orchestrate specific campaigns to ensure that contagious diseases do not spread among these populations. CHWs in hospitals do not tend to do outreach to marginalized communities outside their institutions; rather, they identify patients who need support from within the hospital system. They do, however, refer patients to agencies, like the Health Co-op, to support them once they are released from hospital (Begonia).

Issues to consider here will be: how the system governs CHWs activities; how these workers are integrated into health care delivery and interprofessional teams; and how to foster collaboration with CHWs to ensure health equity for marginalized communities. Interviews with participants and communication with other health professionals throughout the course of my study (personal communication), indicate that some system rules may hinder the scope of activities that CHWs can perform. For example, it might take some time for particular CHWs actions to be implemented due to the many system levels that need to be involved to gain approval for the work to move forward. The overall concern here is that working within the health care system may make it difficult to reach the most marginalized populations because of the rigidity of working within a bureaucratic structure. In addition, the literature, and my interviews with Health Brokers and mentors, revealed a tension — especially in public health units — between CHWs being seen as instruments of service delivery and agents for community development, with their clinical role often trumping their capacity development role.

B) INDEPENDENT OF THE SYSTEM: CHWs are funded to deliver their services independently of the public health care system. Under this approach, the size of the contract received by the organizations delivering the program is determined by funders. Organizations have complete autonomy on the conceptualization and programming for working with marginalized communities. The Health Co-op and Health Brokers fall at the independent end of the spectrum. As demonstrated throughout this dissertation, Health Brokers and mentors have a close and trusting relationship with the local public health unit's maternal child health area, but many aspects of Health Co-op's perinatal operations remain far from ideal. Because of the direct link that Health Brokers have to marginalized communities, workers carry more than normal caseloads, do not have enough paid time for administrative tasks, and often cannot afford to receive time off for overtime work,

especially evening or weekend overtime. The wages and hours to deliver the services available are not equivalent to those paid within the formal health care system, although funding allows for a mixture of part-time and full-time employment for CHWs. For example, the Health Co-op service contract is not adequately compensated, leading to Health Brokers feeling overburdened by the number of clients they support without full payment. As well, there is no compensation for certain aspects of their work. Failure to support clients owing to funding issues, however, would leave the families to fall through the service gaps in the health system. Instead, additional work leads to burnout and is a manifestation of the inequities faced by workers and immigrant and refugee populations.

On the other hand, the concern about independent models, which health professionals identified in my study, and that non-study health professionals have also raised, is these models might have less accountability, supervision, and less training. Such models, therefore, might make it more difficult to evaluate service outcomes. Key to overcoming this drawback will be to have clear and close collaboration with the funding organization, as revealed in my inquiry, even if the project is not co-located with the funding agency (T. Hack, personal communication, August 9, 2012). As well, independent CHWs models ought to have enough professional expertise within the organization (or through outside consultants) to establish the necessary mechanism for accountability, training, supervision, and reporting of the work done. Data from the Health Co-op reveals that the organization has been gradually establishing mechanisms to address these issues, but they have lots of work ahead of them to ensure that these tools are learned and mastered by individual Health Brokers and mentors as well as by the organization as a whole.

Returning to the question of how integrated the Health Brokers are within the public health care system, we can look at it in two ways. Because the Health Brokers provide a mainstream service for immigrant and refugee women, which has been financed for over twelve years, and they have a strong relationship with AHS Edmonton Zone public health, one could say that the Health Brokers' practice is integrated with AHS's main programming. Although the Health Co-op operates as an independent organization, AHS does not have to worry about the daily practice of the Health Brokers and/or about dealing with personnel or organizational issues. From this perspective, given the hands-off role that AHS plays in the daily implementation of the health Co-op programming, it can be said that the Health Brokers' practice is not integrated within the health system. Under this structure though, the Health Brokers' practice is in practice just one more service contracted out, which could, although not without huge political costs, be cut by the system or contracted out to other organizations. This is perhaps why some participants referred to the "subservient" relationship between the Health Co-op and the health system.

In the current system, contractual relationships between the health care system and independent community-based organizations put the organizations and communities under a non-equal power relationship. One participant referred to the current relationship between the Health Co-op and the public health unit as subservient to the system (Participant, September 17, 2010). The lack of meaningful financial support for the services offered by Health Brokers is at odds with health professionals' views that these workers are providing important (mainstream) services. Funding allocated indicates that these services are seen as non-essential or of marginal importance (sub-services).

The Health Co-op and Health Brokers example shows, however, that the independent models can work closely with local public health units and deliver the needed services. From my inquiry I identified some benefits and challenges, which I illustrate in Table # 13, of independently-run CHWs models.

Table # 13. The considerations in the relationship between the health system and CHWs' independent models

Considerations	Benefits to the CHW model	Challenges to the CHW model	Benefits to the public health unit	Challenges to public health unit
Decision-making	CHWs make own decisions Write own policies	Inability to influence system from within	Detached from day-to-day operations	Restricted ability to influence programming
Monitoring	CHWs are either members or staff in organizations	Self-monitoring of CHWs' practices	No efforts invested in monitoring of CHW practices	Restricted ability to ensure CHWs' accountability
Cultural approach	Freedom to choose cultural or philosophical approach to practice	System might not agree or be interested in CHW approach	CHW could provide training on needs of communities	Gaps in approach to working with CHWs
Funding	Funding is secure. Wages are comparable to CHWs operating within the system	Funding is limited and potentially unstable	CHW hired at cheaper rate	There is no multi-sector collaboration with agencies linked to CHWs

Let me now address a second issue, the macro perspective. The integration of CHWs as part of the health human resources workforce reveals that these workers are socially produced within the context of Canada's health, social services, and immigration systems. CHWs workers are part of traditionally female professions, occupying non-standard health jobs, in a gendered, classed, and racialized health human resources workforce. From a political economy perspective, cutbacks to health and social programs by the Liberal government in the mid-1990s, changed, at least for the foreseeable future, the way the federal government invested in social programs across the country. This change had a direct impact on provinces' spending, resulting in trickle-down effects on local

governments' services and on the programming of community-based organizations like the Health Co-op. Another factor that influences the social reproduction of CHWs is need for health, social, and settlement services due to immigration. Canada accepts immigrants because, among other reasons, they counter the negative effect that low-birth rates have on the economy and on the population growth of the nation. On humanitarian grounds, it also accepts refugees and asylum seekers, many of whom come from war-ravaged countries, whose health needs are greater than those of the general Canadian population. These macro factors shape the socio-economic context in which the Health Brokers' and other CHWs' practice is situated.

Another aspect of the social reproduction of CHWs is that, according to the study participants, it is cheaper for the health care system to provide perinatal outreach services to immigrant and refugee women and their families by contracting out this work to Health Brokers than for the public health unit's staff to deliver the services themselves. By contracting out the Health Co-op at the same level of funding for the last ten years, while continuing to support ten percent of the births in the city in the face of rising demographics, the system is reducing its costs on the backs of immigrant and refugee communities. Effectively, Health Brokers are expected to provide services at a cheaper rate than similar services provided to mainstream communities. This confirms the argument by Armstrong and Armstrong (2010a) that after the 1995 federal cuts to transfer payments provincial governments have been introducing programs structured to make payments to less costly practitioners, such as nurse practitioners or midwives, rather than doctors. The former practitioners "are cheaper not only because they receive lower individual incomes but also because they incur fewer institutional costs" (Armstrong & Armstrong, 2010a, p. 60). This means that in planning service delivery and health promotion activities at the community level targeting immigrant and refugee communities, it is advantageous for the health care system to hire Health Brokers who work

independently of the health system, especially if they continue to be invisible (and therefore undervalued) within the health and social services sector.

I am not arguing that task shifting away from physicians to less costly practitioners is a bad thing, especially if these practitioners, like the Health Brokers, are able to reach the most marginalized, who traditional health professionals may not be interested in or have the ability to reach. My argument is that shifting away from higher paid health professionals — that is, from public health nurses to Health Brokers — cannot be done only at the expense of the Health Brokers themselves. In other words, Health Brokers ought be meaningfully compensated and recognized for the work they do.

To quote one health professional: “...Yeah. [Health Brokers do] So much that even if we tried to understand it, we wouldn’t have the time, the resources... I don’t think we’d have the background to be able to support the families in the same way” (Participant, February 24, 2010). Here I argue that the expertise the Health Brokers bring to delivering the Perinatal Health Outreach program in conjunction with the Health for Two program results in value added that exceeds the payments for these services the Health Co-op receives. If AHS hired and paid its own staff to deliver the program featuring the same scope and quality the Health Co-op offers, it would be much more expensive for the health system. In other words, it is not in the health care system’s interest to recognize the role of CHWs as part of the health human resources workforce. If they do so, these workers, are still cheaper than many other professionals, who would have to be compensated at higher wage levels than the Health Brokers are currently paid.

In addition, employment offered by the Health Co-op manifests the characteristics of non-standard employment because most Health Brokers are paid low wages and receive few benefits.

Furthermore, the vast majority are women. According to Armstrong and Armstrong (2010b) a large number of these workers are defined as low skilled. In the case of the Health Co-op this is debatable, because the majority of its Health Brokers are foreign-trained professionals whose credentials are not recognized in Canada. Indeed, the credentials of Health Brokers interviewed for the study range from college training to bachelor's and master's degrees; only a minority did not have formal education.

When first hired, Health Brokers often start with 40 to 50 hours per month, typically in the hope that new funding will allow the Health Co-op to increase their hours. Of the 50 to 60 employees that the Health Co-op had in 2010, over two thirds (approximately 34) worked part time, 13 worked full time and the remainder were hired casually on contract. The majority of the workers were Health Brokers. This means that non-standard employment is the main source of income for Health Brokers. Interview data reveals that both the Health Co-op and Health Brokers aspire to moving to a full-time standard employment norm; however, given the level of funding for different projects, that is not feasible. In terms of benefits, in February 2011 (over a decade after its creation), the Health Co-op was able to enter into an arrangement with a national co-operative association to provide basic health benefits to Health Brokers and staff who work 75 hours or more monthly for the organization (data validation meeting, August 17, 2011). This means, though, that Health Brokers with 74 or fewer hours of work per month will risk being even more marginalized than other workers.

The Health Co-op offers employment to Health Brokers who might not otherwise find a job in other sectors, but at the same time effectively restricts these workers to non-standard work that offers little opportunity for promotion. This is not solely due to the Health Co-op's decisions, but also to its social location and the social location of Health Brokers within Canadian society.

Main research question

1b) How does this integration influence CHWs' ability to improve immigrant and refugee women's access to health services?

Theoretical Proposition 1b: *Public health unit's approaches to health equity and inequities influence the way CHW programs are integrated within their mandates.*

AHS recognizes that more advanced health care or better access to existing health or community services it is not enough to address health inequities experienced by marginalized communities:

Health inequalities among Edmonton neighbourhoods cannot be resolved merely through the provision of more advanced health care or better access to existing health or community services. They are insufficient. Improving population health in Edmonton by reducing inter-neighbourhood health inequalities will require multi-sectoral long-term commitment, common vision, and consistent collaboration at all levels of government and across all sectors (Predy et al., 2008b, p. 28).

AHS Edmonton Zone is partly addressing health equity of immigrant and refugee populations through targeted programs such as the Perinatal Health Outreach and the Health for Two programs, which the Health Co-op is contracted to deliver to immigrant and refugee women and their families. I interpret equity in vertical terms. For Claeson et al., 2001a, "It is assumed that the poor have a worse health status than the rich, and therefore have more health care needs. Vertical equity in this case implies that more resources should be spent on the poor" (Claeson et al., 2001a, cited in Laterveer et al., 2003, pp. 138-139). From this perspective, I would argue that policy makers need to consider the specifics of the communities the system is intended to serve (Amaratunga & Hockney, 2003). The challenge here is that the provincial health system is responding with a single discrete downstream intervention, such as providing pregnant women and new mothers, at risk of pre-term

or low birth weight babies, close clinical follow-up, milk coupons, and vitamins until their babies are two months old. The rationale behind this intervention is that it costs less to the health system when babies are born full term and at normal birth weight. As a result, little attention has been given to the upstream social determinants of health, such as economic resources, education (Ritsatakis, 2009), and racial discrimination (Krieger, 2008 February). The focus is on downstream interventions while knowing full well that these upstream determinants (Braveman, Egerter, & Williams, 2011b) influence downstream factors and ultimately lead to health effects (p. 392).

Health professionals interviewed acknowledged the provincial health system was responding to the perinatal needs of women, but not to other issues, such as social and economic needs. Although it is understood that the health system does not have the responsibility to address other social determinants of health, this does not mean that the system should not look into working with other ministries so that health and social strategies are in sync with each other. Indeed, Predy et al., argue that multi-sectoral long-term commitment, common vision, and consistent collaboration at all levels of government and across all sectors are crucial to addressing health inequities (GN Predy et al., 2008b).

My argument is, then, that by not addressing the upstream determinants the provincial health system is offloading or disregarding its responsibilities. Collaboration with other Ministries and across sectors must be initiated by the immigrant and refugee communities themselves, and more specifically the Health Co-op. At this point, I argue that the role that Health Brokers' interventions play in the AHS Edmonton Zone's perinatal health strategy for marginalized populations is important, but that it may also be seen as a way of offloading the health system's responsibilities to the immigrant and refugee communities themselves. Let me explain why. Predy et al., (2008b)

indicate that health professionals are aware that ostensibly universal programs are not sufficient to meet the needs of populations who experience marginalization; therefore, targeted programs are necessary to address the needs of these communities. In the case of the Health Co-op, however, it has been receiving approximately the same level of funding for the last ten years, even though the health and social needs, cost, and number of communities have increased. Consequently, the Health Co-op has to divide the 'pie' [flat funding] in smaller pieces in order to respond to the perinatal demands from immigrant and refugee women and their families. This problem is similar to one I described about the Health for Two program receiving flat funding from 2001 until the present time. The main difference here is that during this period AHS increased its in-kind contributions (staff and programming) to the Health for Two program, but did not provide corollary increases to the perinatal health program of the Health Co-op. For example, if AHS had designated a part-time or full-time nurse based at the Health Co-op, this could have provided concrete clinical support to the Health Brokers in their perinatal work. Support of this nature would not have addressed the concerns about the impact of social determinants, but it would have at least minimized the financial stress in the Health Co-op and obviated the need for it to pay for the extra nurse(s) out of its overhead budget.

Theoretical Proposition 1c: *CHWs and their clients experience health inequities on the basis of many factors — that is, gender, racialized category/ethnicity, disability, sexual orientation, or socio-economic status. These factors hinder or facilitate access to health services by immigrant and refugee women. For example, clients may be reticent to participate in CHW programs if they feel that their cultural health beliefs are ignored by the workers.*

Most health professionals acknowledged that racialized status was a barrier to immigrant and refugee communities (and even Health Brokers themselves) accessing health services, and that culturally-competent services would help address these barriers. Racialized status and ethnicity as determinants of health have been well documented in the literature (Amaratunga & Hockney, 2003;

Spitzer, 2011), as has been the importance of cultural competency (Etowa & Adongo, 2007) as a possible solution. "Cultural competence can be described as a set of behavior, attitudes, and policies that enable a system and individual health care professionals to work effectively with culturally diverse families and communities" (Etowa & Adongo, 2007, p. 82). A paradox here is that there is plenty of evidence in the literature that cultural competency alone does change the power dynamics within mainstream health systems (McGibbon & Etowa, 2009).

In one of my data validation sessions, a health professional warned me about using the term 'racism' because some AHS staff might read the term and get turned off by it. She said: "Racism is such a strong word" (Participant, February 13, 2012). It appears, however, that the closer health professionals are to the day-to-day challenges faced by immigrant and refugee women and their families and to Health Brokers, the clearer it is for them how racism and discrimination operates in creating barriers to accessing health services. The opposite is also true, that the farther away these health professionals are from the daily issues faced by these populations and by Health Brokers, the less chance they have in understanding the impact of racism and discrimination. Nevertheless, health professionals generally appear to be open to the notion of cultural competency. This may be, in part, because this term is a "safe" concept to use in characterizing the relationship between multi-cultural communities and the health system.

My study did not address CHWs' views on disability and sexual orientation because I omitted those questions in my interviews, and they were not raised independently by participants. From a self-critical perspective this gap is indicative of my heterosexuality and current able-bodied status. I know from my data, however, that Health Brokers are working with families who have children with disabilities, and have views on that issue. Perhaps because sexual orientation issues are taboo in

many cultures, this issue was not raised in my research without my probing for it. From my knowledge of these issues, ableism and homophobia engender health and other inequities in all populations, and with even more devastating effects among marginalized populations. These issues therefore warrant further research.

Theoretical Proposition 1d: *CHWs from racialized backgrounds, who are well compensated, who feel supported and empowered by their employers are more likely to empower other racialized immigrant and refugee communities to be active participants in their own health and in building the capacity of their own communities.*

When looking at compensation, this inquiry found the opposite. Despite Health Brokers not being well compensated they appear empowered and committed to supporting racialized immigrant communities to be participants in their own health. This means that compensation alone is not the key. Indeed, the lack of funding did not deter the Health Co-op and the Health Brokers from working towards health equity and social justice. The importance of support from employers in empowering workers, however, was corroborated. In this case the Health Co-op's structure contributes to the empowerment of most of the workers. One would think that given the working conditions, Health Brokers might be discouraged from working for the Health Co-op, yet that majority of their comments, either through interviews or participant observation activities, indicated this was not the case. Rather a positive motivation trumps these adverse working conditions. Their main reason for working for the Health Co-op is that Health Brokers "work from the heart" to support immigrant and refugee women and the families that seek their help.

Unlike other non-standard occupations where workers do not have a sense of control over their jobs (Armstrong & Armstrong 2010), most Health Brokers did. Health Brokers could control their jobs because they organized their own schedules, decided on the approaches to use with most of their clients, and did not feel a supervisor's presence controlling their work. A minority expressed

that they felt a lack of control because they saw their caseloads increasing while there was no funding to cover their overtime work. In this case, they either focused their frustration on the system's unwillingness to fund the work in accordance with the increase in the number of clients, or on the Health Co-op's policy to serve every client referred to them as opposed to keeping a waiting list. The majority of workers interviewed did not desire to work for another agency because they loved their work, one reason being if they worked for another organization, they would lose their autonomy. The minority who considered working elsewhere did so because wages at the Health Co-op did not allow them to make ends meet.

Theoretical Proposition 1e: *CHWs who are recognized by other health service providers are well placed to advocate on behalf of immigrant and refugee women for access to health services.*

CHWs' knowledge of both the health and social services systems and the community puts them in a position to negotiate on behalf of the communities. All participants acknowledged that Health Brokers advocated on behalf of their clients. I also theorized that Health Brokers negotiate between authoritative and experiential knowledge and foster immigrant and refugee women's agency and autonomy. According to Health Brokers and mentors, frontline workers tend to be receptive to Health Brokers' work on behalf of immigrant and refugee women and communities. They also acknowledged that these populations confronted some barriers that frontline workers in health and social services themselves could not address without the support of higher decision-making officials within the system. A clear example is the Health Broker who attempted to help a mother to access disability support so she could stop working at a job that she felt was causing her back pain. This Health Broker accompanied the mother to a social worker, but the client was refused disability support because the social worker indicated her back pain was not severe enough to warrant her leaving the job. When I interviewed this mother, she was extremely disappointed that the Health Broker was unable to get her the support to which she thought she was entitled. Another example

of the micro structural barriers experienced by Health Brokers is a local community health centre's refusal to rent space to certain groups of immigrants or refugee communities because they consider their behaviour "inappropriate".

All Health Brokers acknowledged that they facilitated access to health and social services, but also recognized that they were structural barriers linked to the social determinants of health that they themselves could not address. As well, the Health Brokers and mentors do not have access to higher decision-making echelons within the AHS bureaucracy to advocate for upstream measures to advance health equity for immigrant and refugee women. Likewise, health professionals themselves recognized that they had few opportunities to influence the senior officials within the health system to be more responsive to other social factors affecting immigrant and refugee health. Indeed most health professionals indicated that they were able to have an impact on small issues in individual or local cases, but they could not influence or achieve major changes within the health system, such as remedying the lack of interpreters.

Sub-question 1

1) What models exist, and how are they designed, implemented and evaluated?

Theoretical Proposition 2: *CHWs programs exist within a continuum of care that progresses from informal to formal models of care. Informal models that are not fully resourced are less effective in reducing health inequities by immigrant and refugee women than programs that are properly resourced.*

As mentioned above, there are two ways in which CHWs are linked to the mainstream health care system. Sometimes they operate within the formal system, and sometimes they operate independently from the formal system. In countries like Brazil and Iran CHW programs are universal; therefore, CHWs are integrated within the overall mandate of the system. In Canada, CHW models are not universal; therefore, depending on the nature of the organization or the funding source, models of CHW interventions can vary. Informal models are more prone to be run by community-

based organizations, and the term “informal” is used to identify their lack of permanency. Formal models tend to be based in public health units, community health centres, or hospitals, but some community-based organizations, like the MCHB Co-op, have been able to achieve a certain level of permanency and thus can be considered as falling at the formal end of the continuum. They, however, remain at arm’s length from government even though they have managed to secure a number of stable and ongoing service contracts. In this context, the term “formal” means staff positions are permanent and integrated within the bureaucracy of the organization.

In Canada, research on CHWs is only gradually emerging, so there is a dearth of literature on how CHWs are implemented and evaluated. In other countries, like the U.S. or Brazil, there is more documentation on the different models. In the U.S., CHWs have gained recognition as a health human resources workforce and have their own CHW Standard Occupational Category. CHWs in the U.S. still have a long way to go to achieve complete recognition across various states; however, they are gradually gaining more strength as a workforce, something that CHWs in Canada can learn from them. When looking at CHWs’ training, in Canada and the rest of the world, there is no official coordination among institutions and organizations on the conceptualization, implementation, and delivery of CHW training programs. As a result, community-based organizations or health systems — public health units, community health centres, and hospitals— develop their training and curriculum independently. In some cases, like AHS’ Health for Two program, the public health unit provides training to community-based organizations on a regular basis.

Theoretical Proposition 2.a: *CHWs interface between marginalized communities and formal systems of care. In Canada these workers are part of an emerging public health workforce that needs to be recognized and respected by mainstream professional associations and health services providers.*

The “problematic” that Health Brokers face is that they are providing important and valuable services, but their contributions are not recognized as part of the health human resources workforce. While I documented this problematic in previous chapters, I would like to highlight here a Health Broker who eloquently presented the lack of recognition as marking the dichotomy between “mainstream” (dominant) and “non-mainstream” (peripheral) services. The challenge that Health Brokers face in their practice, according to this participant, is that the health system although it ostensibly acknowledges the services Health Brokers provide as mainstream, sets funding for this work as if it were secondary or peripheral (Chrysanthemum). As well as being compensated inadequately for delivering mainstream services, Health Brokers are often not compensated at all for non-clinical tasks, which one health professional described as not being “measureable in units of time”. In part, the devaluation of Health Brokers’ work may be because the populations they serve are marginalized, so their needs are not appropriately valued.

One can also argue that the lack of payment for “non-health”-related tasks is just part of the “market logic of contracting out by specific deliverable” (personal communication, September 7, 2012). If this were the case, however, payments for services ought to have increased to reflect the change in the ratio of clients to Health Brokers. They have not done so. For example, between 2005 and 2010 the number of immigrant and refugee clients grew from 1,105 families in 2005 (MCHB Co-op, 2005fr), to 2,340 families in 2010 (MCHB Co-op, 2010fr). In other words, while the number of pregnant women or new mothers needing support in a five-year period increased by 211.7 percent, no additional funding has been provided to deal with the increased demand.

In a related example discussed in Chapter 7, during my research Health Brokers' Collaborative Family Intervention was warned of funding withdrawal from Children Services unless they followed an Outcomes Based Service Delivery (OBSD) model adopted from the United States (FCS Group, 2005). This again shows a pre-disposition by government towards adopting a service delivery model based on market logic. In this case, however, I discovered during my data validation sessions that the Minister of Children and Youth Services, upon learning that the culturally-appropriate Health Co-op's model Collaborative Family can potentially be transferred to working with Aboriginal communities, decided to continue funding the program, notwithstanding that this program did not follow the OBSD model. In other words, Alberta's Child Intervention System may be gradually acknowledging that working with immigrant and refugee women and their families requires a different approach from working with regular Euro-Canadian families, and provide research funding to better understand the Health Co-op's Collaborative Family model and its transferability to Aboriginal communities. AHS on the other hand acknowledges the contributions of Health Brokers to perinatal health of immigrant and refugee women, but it does not fund the program according to its needs.

Returning to Chrysanthemum's argument, the health system therefore has a double discourse. On the one hand, the health professionals interviewed said they valued the work of Health Brokers; and on the other hand, they recognized that the health system was not providing enough financial support for Health Brokers' work. Health Brokers and mentors indicated that because Health Brokers were meeting an important need, they ought to be part of the health system, but they are not, although some mainstream services that meet similar needs are part of the system. For example, on a one-time research project in which the public health unit and the Health Co-op worked together, funding allocated to the health unit was higher than that for the Health Co-op. As

a result, Health Brokers hired for the project to work under public health unit staff received higher wages than Health Brokers hired by the Health Co-op. Wages were different, even when Health Brokers from both organizations were hired to perform the same job, met the same deadlines, and Health Brokers from the Health Co-op were known to provide additional services to clients over and above those provided by Health Brokers employed by the public health unit (Ivy). In this situation, all positions were contract work, with the Health Co-op's Brokers retained at cheaper rates and with fewer benefits, reflecting their work being unvalued and marginalized.

From a health equity perspective, the Health Co-op ought to receive more funding to reflect the increasing numbers of immigrants and refugees in the city, and also to cover the time spent in non-health support for marginalized communities related to dealing with social determinants of health, such as securing housing for families or daycare for children. Because this is not the case, and since the Health Co-op is contracted out to deliver specific services this "...de-centralization becomes a means of offloading financial responsibility for services to local levels, in the guise of increasing community authority" (Labonté, 2010, p.69). My argument in this section is that by systematically underfunding the Health Co-op, AHS is compelling Health Brokers to devote their own time to seeking supports from other ministries to deal with immigrant and refugee populations' social and economic needs. Organizationally the Health Co-op is developing multi-sectoral, long-term commitments and collaborations with several Ministries and levels of government and across sectors, which Predy et al., (2008b) indicate are essential in targeting health inequities in Edmonton.

Sub-question 2

2) How can CHW models contribute to public health workforce development?

Theoretical Proposition 3: *CHW interface between marginalized communities and formal systems of care. In Canada these workers are part of an emerging public health workforce that needs to be recognized and respected by mainstream professional associations and health services providers.*

Research by Armstrong and Armstrong (2010a) demonstrated that in a highly stratified health care system, health care personnel such as doctors, and registered nurses, were included in many studies, while others working in the system were frequently not even defined as health care workers (p. 4).

Health professionals interviewed acknowledged they work in synchronistic ways with Health Brokers. This means that while the health professionals at the health unit build trust in the Health Broker model within the system, the Health Brokers build trust in their own practice within immigrant and refugee communities. The trust that CHWs build between communities experiencing marginalization and health and social services systems is important because it contributes to these communities' health and wellbeing and saves costs to the system. In other words, CHWs become "boundary workers" (personal communication, December 6, 2011) because they do not only open communication directly between the formal system and communities, but also between health agencies and professionals dealing with immigrant and refugee communities, and between researchers and communities. From a political economy perspective, CHWs are linking "the private and public sectors of the formal economy as well as the household, which themselves have private and public spaces" (Armstrong & Armstrong, 2010b, p. 5).

Indeed, it is the negotiating of the interfaces of public and private spheres (Andrew, 2008) and the connections they forge for communities seeking supports linked to the social determinants of health

that give CHWs a new role within the health human resources workforce, which has yet to be explored and recognized. The role that CHWs play in what I theorized to be feminist urban citizenship is important to consider because it has the potential to energize marginalized communities and workers alike.

Sub-question 3

3. How are CHW programs influencing the health care systems' competence to respond to demographic changes in Canada?

Theoretical Proposition 4: *Culturally-appropriate CHW programs contribute to increasing immigrants and refugees' access to health services by aiding these populations in navigating Canada's health care system and in addressing barriers to access to health. CHW programs also teach health services providers to have a better understanding of the needs of immigrant communities.*

Health professionals interviewed recognized that Health Brokers played a double role: they informed the system about immigrant and refugees' health issues and concerns and taught these populations how to navigate the Canadian system. Health Brokers' role included teaching women about the expectations of health professionals in delivering services. The Health Co-op and Health Brokers focused their approach heavily on making health services providers understand the importance of culture, and one participant credited them with making a "paradigm shift" in the area. This referred to how the Health Co-op and Health Brokers made a change in the system by making many health professionals understand that acknowledging culture is important in working with immigrant and refugee communities.

The challenge the study found is at the meso level. Health professionals acknowledged that while the provincial system had some interest in financing cultural competency training for health professionals, including curriculum for medical students, nurses (Spitzer, 2004) or other health providers, they also recognized that there was an overriding bureaucratic expectation for immigrants and refugees to "fit" into the system. The Health Co-op and Health Brokers, on the other

hand, highly value and are regularly invited to provide cultural competency training. For them, placing the onus of adapting to the system on immigrants and refugees is not best approach. Here I argue that the provincial health system is not addressing barriers to accessing health services based on racialized and ethnic background; it is offloading the “cultural” responsibility to immigrant and refugee communities rather than changing its own structures. This means that it is the responsibility of immigrants and refugees to understand and navigate the health system and how it operates, rather than the system changing to accommodate them. In other words, the health system is not interested in changing or adapting itself to meet the needs immigrant and refugee communities.

Sub-question 4

4) How are CHW programs influencing the diversity of the health system’s workforce?

Theoretical Proposition 4: *CHW programs might lead mainstream health services into believing that they do not need to diversify their workforce because they have multilingual/ethnic CHW workers providing the services at a cheaper rate and through less educated service providers.*

Health Brokers are generally trained or gain experience in brokering work before they join the Health Co-op. They do so by helping their own families and friends, or by being leaders in their communities, or through their personal struggles to access health and social services. Once they join the organization, they learn additional skills on the job by shadowing other colleagues. Their skills are hidden, unrecognized, and considered “womanly” work (Armstrong & Armstrong, 2010b) like in other professions including nursing and social work. Nurses’ work, for example, “involves much more responsibility for patients than formal rules would suggest, given that they are the ones who have the most contact with patients and are often the only ones there” (Armstrong & Cornish, 1992: 12 cited in Armstrong & Armstrong, 2010b, p.66). Similarly, Health Brokers have the most contact with immigrant and refugee women experiencing marginalization, and many times they are the only source of human contact and support for women and their families.

Within a highly stratified health system, Health Brokers' skills are often not recognized. I identified in Chapters 5, 6, and 7 both system barriers (e.g., underfunding) and individual provider barriers (e.g., health professionals wanting to relate to workers as interpreters as opposed to brokers), which perpetuate the lack of recognition of Health Brokers. One participant indicated, for example, that she would not accept work on a case if she were expected to serve as an interpreter and not as Health Broker who could help with interpretation (HG memo, p. 17). At one data validation session, several participants disagreed with this statement and indicated that they would not deny services to clients, even if this meant accompanying them as interpreters as opposed to Health Brokers (data validation meeting, January 18, 2012).

Sub-question 5

5) How are CHW programs addressing the cultural and linguistic health needs of immigrant communities?

Theoretical Proposition 5a: *CHW programs that are sensitive to the cultural and linguistic needs of immigrant communities embrace the cultures of these communities. They also develop health education messages that are respectful of these communities' health beliefs, while challenging their health myths/taboo (if any) in a respectful manner.*

All participants indicated that Health Brokers taught immigrant and refugee families how the health care system worked and they contributed to facilitating access to health and social services for immigrant and refugee women and their families. In addition, the Health Co-op has been successful at developing its market niche by offering culturally- and linguistically-appropriate health and social services to their clients. One health professional indicated that because the Health Broker model was culturally- and linguistically-appropriate, it had contributed to making a "paradigm shift" within some parts of the health system, and most health services providers in the city understood the need to look at "culture" when serving immigrants and refugees. The literature also indicates that CHWs who share similar cultural backgrounds with immigrant communities they serve are better able to respond to the health needs of immigrant populations (National Center for Cultural Competence, 2004; Wells, et al., 2011).

The challenge here is that while health professionals valued the work that the Health Co-op and Health Brokers did to educate health services providers in Edmonton on culture sensitivity, Health Brokers might have been unconsciously perpetuating these communities as the 'other' (Wolfe, 2010). By so doing, The Health Co-op and Health Brokers maintained the status quo, which contributed to the health system's perpetuation (not always conscious) of racism and discrimination against immigrants and refugees. Acknowledging culture also means recognizing that pre-migration, migration, and settlement aspects of communities' experiences ought to be taken into consideration when providing health and social services to these communities.

CREATING THE NICHE

The Health Co-op has been successful in creating a "market niche". As a workers Co-op, the niche they fill is offering goods and services that enable outreach to marginalized populations, and in particular, culturally-competent and linguistically-appropriate programs delivered by Health Brokers. Identifying and sustaining a market niche is crucial in the success of any co-operative. Health Brokers and mentors were proud of the niche they created because of their cultural and linguistic approach to removing barriers to accessing health and social services faced by immigrants and refugees. Health Brokers and health professionals identified language and culture as barriers to these populations' health and wellbeing. From a critical perspective, the niche refers to a narrow and circumscribed area of agreement between Health Brokers and health and social service providers (Wolfe, 2010, p. 9). In Wolfe (2010)'s study of "Middle Woman", who are defined as a grassroots advocates for equality of health and wellbeing of minoritized (im)migrants in contemporary Canada (p. 1), the author argues this type of niche does not address the structural and systemic inequities experienced by minoritized immigrants. ".... the system only recognizes linguistic and cultural barriers. To be sure, the middle women also identify linguistic and cultural

barriers. I am arguing that it is only this narrowly-defined area of overlap – or agreement – that comprises the niche” (Wolfe, 2010, p. 9).

In Wolfe (2010)’s view, the niche contributes to perpetuating marginalization of both the middle women (here, Health Brokers) and the populations they aim to support [here, minoritized (im)migrants]. Because the middle women and human services (health and social services) need each other to work with immigrant and refugee populations, “the middle women are dependent on service providers and the system to get a foot in the door and to mediate an effective response to the people they support...” (Wolfe, 2010, p. 9). As a result, middle women become marginalized because they are: exploited by not receiving enough funding to make living wages; undervalued as part of the volunteer labour pool in the province [partly because it is difficult for them to say no to their communities]; and perpetually pigeon-holed as immigrants. This perpetuation happens as “...the middle women are called upon to define their own unique contribution in terms of cultural insight...cultural uniqueness...cultural identity [which is]... value-able to the human service system” (Wolfe, 2010, p. 14). In other words, the health and social services systems benefit from middle women’s (Health Brokers) emphasis on their cultural identity, and expect them to define themselves that way as well.

Similarly, the niche contributes to marginalization of minoritized immigrant and refugee communities because, according to Wolfe (2010), middle women define communities’ struggles through their *cultural identity* (and linguistic) *differences* (p. 14) from mainstream populations. Middle women, argues Wolfe (2010), struggle between their desire to enhance the capacity of immigrant and refugee communities, and their strategies in ‘selling’ their niche of cultural uniqueness as well as marketing communities’ vulnerabilities. “Although middle women strive to

reinforce and strengthen the capacities of the people with whom they work, the niche requires continually rehearsing minoritized (im)migrants's vulnerabilities and deficits" (Wolfe, 2010, p. 12).

Indeed, my data revealed the emphasis that Health Brokers gave to critical socio-economic problems experienced by many communities. This is not to negate that communities were experiencing these circumstances, but to illustrate that middle women like Health Brokers promoted these vulnerabilities in carving out their market niche. Consequently, middle women's focus on cultural diversity or cultural competency does not fully address the underlying causes of inequities experienced by marginalized communities (McGibbon & Etowa, 2009). On the contrary, the number of middle women has grown, but the barriers and gaps experienced by minoritized communities persist (Wolfe, 2010, p. 14) because their role deals with the effects of marginalization, rather than tackling its roots.

Wolfe (2010)'s interpretation is right in that the niche is a space of agreement between Health Brokers and the health system, but a space that perpetuates immigrant and refugee (minoritized) populations, and middle women, as the other. The reality, however, is that in the highly competitive, stratified, and fragmented health and social services systems, groups like the Health Brokers are forced to carve a niche (here, provision of culturally-competent and linguistically-appropriate services) for themselves and define their roles clearly (health brokering). Wolfe makes a powerful argument, but a failure to frame the Health Co-op's service offering in a way to which the health system is receptive would eliminate the possibility of receiving any support to address immigrant and refugee health equity issues.

Wolfe's (2010) view that the Health Brokers' role emphasizes minoritized (im)migrants's vulnerabilities and deficits is worrisome because, if true, it means they are following the dominant discourse of presenting immigrant women as vulnerable (Spitzer, 2011) subjects rather than active agents of change. My findings on the other hand, reveal an approach to empowering immigrant women and their families by valuing their culture and challenging the system's authoritative knowledge while recognizing the women's experiential knowledge. I also disagree with Wolfe (2010)'s interpretation that the role of the middle women only deals with the effects of marginalization, rather than tackling its roots. In the case of Health Brokers, they are trying to empower women and communities to find their voices and building women's urban citizenship. Wolfe's analysis corroborates my findings with respect to the tension between mainstreaming and disengagement, but that aspect of my research also suggests a potential for the interrelationship between marginalized populations, the Health Co-op and the health system to be more dynamic than Wolfe's analysis contemplates.

THE COMPLEXITY OF THE NICHE ITSELF

The Health Co-op values the importance of respecting communities' cultures, knowledge, and practices. But what if some aspects of these cultures do not lead to health equity, empowerment, or women's urban citizenship? Findings with health professionals revealed that some communities do not want to be involved with other communities on cultural or religious grounds, and prefer to work with Health Brokers who practice the same religion even if they do not speak the same language. One professional and a number of Health Brokers also spoke of some male-dominated minority cultures where women cannot go out of the home unless they have the permission of their husbands. In my participant and direct observation activities, I also learned that in some cultures Health Brokers have to explain and negotiate with some male heads of the household to let the

women attend health-related group meetings or community events. This means that Health Brokers must also seek cultural change in some communities. According to Williams, cultural change refers to the process of challenging and ultimately aiming to change aspects of culture that are considered oppressive or constrain the agency of some or all members of a community (Williams, 2001).

Indeed, some cultural practices have a direct impact on women's agentic role. For example, Williams (2001)'s study among Maori people in Aotearoa/New Zealand found that Pacific peoples experience several layers of marginalization because of being "...positioned within the economic and cultural margins of Eurocentric, male capitalist societies as well as within their own ethnic communities" (p. 98). According to Williams (2001), communities living on the margins experience a power-culture dynamic in which cultural systems both enhance and constrain the agency of peoples "depending in part on the identities and subject positionings available within those cultural systems" (2001, p. 250). This is the case for many clients served by the Health Brokers: immigrant and refugee women and their families who are living in a new country and culture(s), yet continue to experience patriarchal oppressive relations brought from their cultural backgrounds. The challenge for the Health Brokers is then to ensure that dominant power-culture relations, that is, ethno-specific (within a minority culture) or Eurocentric (majority culture) do not mitigate authentic and meaningful participation (Williams, 2001) of immigrant and refugee women in Canadian society, that is, women and their families' feminist urban citizenship.

For instance, at a conference workshop I attended, which was organized by the Health Co-op, health and social services providers asked Health Brokers how they managed to work with communities who although from the same cultural background had rivalries stemming from political, religious, gender, and class (Ogilvie, et al., 2008) divisions in their countries of origin. The Health Brokers

explained that they were able to help these communities because they provided services in a respectful manner, regardless of political alliances, and that Health Brokers gradually developed trust among communities. This was corroborated by Williams (2001) who indicates that organizational legitimacy (the Health Co-op) and people within the organization (the Health Brokers) being considered credible owing to their integrity and trustworthiness were some of the characteristics necessary for communities to begin achieving some desired outcomes (p. 310). In other words, in order for the Health Brokers to successfully facilitate access to health and social services by immigrant and refugee communities, they have to understand the power-culture dynamics at play within their niche, both in terms of relationships within minority communities and as between minority (van der Velde, et al., 2009) and majority communities.

Applying an anti-racism lens, Wolfe (2010)'s analysis that racism exists within health and social services system was corroborated in my study and in the literature (Spitzer, 2004). Racism is a barrier that Health Brokers, women, and their families experience. For example, a Health Broker (racialized non-English speaker) called an agency to make an appointment on behalf of a client and was told that there were no openings available. She spoke to her mentor (Euro-Canadian English speaker) about it, who decided to call the same agency right away to request the same appointment. To their surprise, the mentor was successful at getting the booking immediately. The questions to consider here are: is this an example of racism towards the Health Broker and her client; and what can this example tell us about the challenges that Health Brokers face in their brokering role (unable to secure the appointment) because of their racial background (discrimination)? In my view, the barriers Health Brokers confront daily exemplify the social stratification of Canadian society, in this case, based on racialized and ethnic backgrounds. If this were a situation of a Euro-Canadian English-speaking Health Broker calling an agency to make an

appointment and the person were denied the service for the client, one would discard racism as a possibility and see it as an issue of social status. In other words, by the mentor calling the same agency and obtaining the appointment, her/his social status guarantees that Health Broker's client receives the service.

Although the majority of participants interviewed did not mention racism, the literature has documented for years that racism exists within the human service sector in Canada and other countries. It is not possible to determine what the person on the other end of the line was thinking in the situation above, but the literature raises the possibility that discrimination was occurring and whatever the motivations, without the intervention of the mentor, the client was at risk of not receiving the service. According to James (1996) structural or societal racism is so rooted in the structure and fabric of society, and in the everyday operations of society that "it has an impact on everyone, and the fact that it is expressed in very subtle forms produces devastating results" (James, 1996, p. 27). This example may also be taken to typify the invisibility (Spitzer, 2004) in Canadian society of both Health Brokers and immigrant and refugee women served by them. This incident may be seen from two perspectives: micro and macro expressions of racism. According to Essed (1991), from a macro point of view "racism is a system of structural inequalities and historical process, both created and recreated through routine practices" (p.39). From a micro point of view, Essed argues:

...specific practices, whether their consequences are intentional or unintentional, can be evaluated in terms of racism only when they are consistent with (our knowledge of) existing macro structures of racial inequality in the system. In other words, structures of racism do not exist external to agents—they are made by agents—but specific practices are definition racist only when they activate existing structural racial inequality in the system (Essed, 1991, p. 39).

Denying services to a client as an isolated incident cannot be considered racism; however, Wolfe (2010)'s account of middle women's barriers faced in facilitating access to health and social services for their clients reveals a pattern of structural racial inequality (Essed, 1991). Some Health Brokers and mentors stated that the system discriminated against Health Brokers and their clients. In addition, racism has been identified as a factor that impacts immigrant and refugees communities' health (Amaratunga & Hockney, 2003; CRIAW, 2002; James, 1996; Spitzer, 2004) and more broadly as a social determinant of health.

Sub-question 6

6a) How are knowledge transfer strategies used in getting support for the adoption, implementation, and sustainability of CHW programs within public health units?

Theoretical Proposition 6: The strategies and cultural appropriateness used by CHWs to reach out to program users influence these populations' uptake of programs.

Mentors and Health Brokers invest time informing various systems, such as health and social services, about their role with the goal of negotiating arrangements or opening up opportunities for collaboration to address the needs of communities. Mentors do outreach to mainstream organizations and social services agencies to let them know about the Health Brokers' practice so that these agencies open doors when Health Brokers call on behalf of clients. Mentors and Health Brokers present the model in workshops and meetings of health and social services providers; they also present it at conferences and co-author articles for publications (Chiu, et al., 2009; Pottie, et al., 2008; Vancouver Coastal Health, 2009). Conference presentations and article writing, however, are the Health Co-op's least-used methods for disseminating the Health Broker model because of the high cost of attending conferences as well as the time needed to write articles. Another method the Health Co-op uses to disseminate their model is by delivering "cultural competency" workshops to health and social services providers (MCHB Co-op, 2010b February) as well as securing meetings with intermediate-level decision makers within the city and province. Because the Health Co-op

participates in research projects, their model has been mentioned in some journal articles (van der Velde, et al., 2009). Grey literature on co-operatives in Canada also mentions the Health Co-op, and indicates that they are a successful health worker co-operative. Nevertheless, the Health Co-op recognizes that they need to do more in making their model known among health and social services audiences as well as academics.

Health professionals also spoke of two ways of making the Health Broker model better known within AHS Edmonton Zone. First, they champion the model to nurses based at community health centres who have direct contact with the clients Health Brokers bring to their centres. Second, they invite Health Brokers and mentors to speak at orientation sessions for new medical staff at hospitals or community health centres. The challenge identified with the second strategy is that the health system does not fund Health Brokers or mentors' time for these presentations, and the Health Co-op cannot underwrite Health Brokers or mentors' time to attend all sessions, given the high demand.

Although the model is quite familiar to many Edmonton agencies, outside the city it is believed by the Health Co-op and health professionals to be less well known both among providers and AHS. Some provincial policy makers knew of the Health Broker model because in the past they worked at the city level, but their familiarity remains individual-level knowledge not AHS institutional-level knowledge. In other words, the Health Co-op's model has been adopted and sustained because of support from champions in the local public health unit, not as the result of a provincial-level initiative.

Finally, as part of my participant and direct observation activities and the Transformatory-Emancipatory approach of my research, I worked collectively with Health Brokers and mentors to give voice to their experiences through presentations at conferences and public forums in Canada (Chiu, Wolfe, & Torres, 2010 May; Torres, 2010 June, 2011a June, 2011b June 2011c June, 2012 June) and the United States (Torres, Chiu, Ortiz, & Wolfe, 2010 November). In addition, I have been involved with professors and researchers in writing grant proposals to further understand the CHW field, which when funded will contribute to building further knowledge about the Health Broker model in Canada. In the sections that follow, I highlight some of the strengths and challenges of the work of the Health Co-op.

Strengths and challenges of the Health Co-op

SELECTING A CASE

The case study selected provided a rich narrative, which illustrates the complexities and contradictions of real life (Flyvbjerg, 2001), as experienced by the Health Co-op and the Health Brokers' practice. I argue that this case is simultaneously *instrumental, paradigmatic, and critical*. This case is *instrumental* (Stake, 1995) because it illustrates a problematic that goes beyond the organization itself. The Health Co-op and Health Brokers experience complexities and contradictions in their daily work; some of these are internal to the organization (for instance, no time to reflect on their practice), others are external (such as a lack of funding), originating in the social setting where they are situated.

Nevertheless, the Health Co-op operates as an "integrated system" (Stake, 1995), which allowed for in-depth examination of different parts of its work (ten distinct programs), the relationship with the health system (the embedded mini-cases), and the Health Brokers' practice (the phenomenon). In

understanding the work of the Health Co-op, as an integrated system (Stake, 1995), I discovered that some of aspects worked better than others. For example, their work appears to be successful in implementing their ten programs holistically to address health and social issues of immigrant and refugee women, but it appears to be less successful in finding time to reflect collectively on the Health Brokers' practice, or in having succession plans in place (I discuss this later). I also discovered that the purpose of the Health Co-op is ambitious, entailing providing meaningful employment for its members and workers and achieving social change to respond to the needs of the clients, but, most importantly, that it is a system (Stake, 1995).

As my study evolved and I gained in-depth understanding of the case, I also categorize it as a paradigmatic and critical case. The case is also *paradigmatic* because the Health Co-op and the Health Brokers' work highlights general characteristics of a society (Flyvbjerg, 2001); in this instance, our Canadian society. By general characteristics I mean that this workforce is gendered, classed and racialized. It is gendered because the workers, health brokers are considered part of what is often called non-standard employment, which is overwhelmingly done by women Armstrong and Armstrong (2010b) as well as by their invisibility to other professions and the health care system. The workforce is classed because health brokers occupy the lowest echelon in the hierarchy of health care provision, and receive the lowest remuneration. The workforce is racialized because a large majority of these workers are racialized immigrant and refugee women. In addition, Health Brokers' work unveils a rich problematic that has implications for the CHW field in Canada: Health Brokers are part of the health human resources workforce, but their contributions are not recognized as such.

The paradigmatic case “...transcends any sort of rule-based criteria. No standard exists for the *paradigmatic case* because it sets the standard” (Flyvbjerg, 2001, p. 80). The Health Co-op and Health Brokers set the standards for CHWs in Canada for several reasons: a) the organization is an independent health workers Co-op with a clear “niche” to provide culturally-competent and linguistically-appropriate programming for immigrants and refugee women in areas, such as perinatal health and family intervention; b) the Health Brokers’ practice is highly theoretical and conceptual, for example, they are influenced by cultural brokering theory/multicultural health brokering theory (Jezewski, 1995; Ortiz, 2003) and by a health promotion empowerment approach (Labonté, 1993); and c) they involve more than one system in helping their clients, such as health, social services, and immigration and child intervention.

The Health Co-op is also a *critical case* because it has strategic importance (Flyvbjerg, 2001, p. 78) in understanding the CHW field in Canada and how these workers are positioned within our highly stratified health care system. A *critical case* is also the least likely case (Flyvbjerg, 2001, p. 79) to exist. The uniqueness of the Health Co-op and Health Brokers’ practice causes it to fall within this category. What makes this case unique is the synchronization of the work in more than one area (perinatal health, family intervention, etc.) while striving for community organizing around services, combined with political activism for system change. Most CHW models in Canada (identified by this study), which operate from within public health units or hospitals are focused on chronic care and disease prevention and management (South Riverdale Community Health Centre, Mount Sinai Hospital, & Toronto Public Health, 2010), or mammography screening (Black, et al., 2007), but they do not address collective mobilization of communities around health or non-health issues (Torres, et al., 2011). These models do not work using strategies intersecting with many systems as the Health Brokers do.

Staff operating from within community health centres, especially those focusing on community development, also often encourage community mobilization and may employ strategies involving multiple systems but many times these workers, although doing similar work, are not characterized as CHWs. CHWs operating within community-based organizations, including immigrant organizations, might focus on health or non-health issues, but do not necessarily use strategies intersecting the various systems. The *instrumental*, *paradigmatic*, and *critical case* characteristics of the work of the Health Co-op and Health Brokers provide important insights for the CHW field in Canada.

DOWNSTREAM INTERVENTIONS THAT AIM TO HAVE AN EFFECT ON UPSTREAM INTERVENTIONS

But I think the [Health Co-op] has strategically positioned [itself] for promoting transformation, or to strategically try to shift systems by using partnerships of innovative projects, you know, using a variety of strategies to help the system shift in practice or in program design. That part...I haven't seen in their literature (Lavender).

A further strength of the case is that in undertaking downstream interventions, the Health Co-op and Health Brokers use strategies they hope will have an effect on upstream decisions at various levels. Because their work intersects several systems including health, social services, child intervention, education, and immigration, the Health Co-op and Health Brokers understand that a single structure is neither the cause nor the solution to communities living in conditions of vulnerability. Their vision fits well with an analysis of the influence of social determinants on people's health and wellbeing.

One would think that the holistic approach the Health Co-op espouses would become a double-edged sword. Because the Health Co-op work is multifaceted, it does not focus on only one

downstream single discrete intervention (for example, perinatal support) without targeting other needs of communities, such as housing and violence prevention. Another organization might just implement the perinatal work without looking at other social determinants. The Health Co-op, on the contrary, is always designing and undertaking multidimensional interventions that address multiple factors simultaneously (Braveman, Egerter, & Williams, et al., 2001, p. 393). This means that the Health Co-op through volunteer labour, and funds it obtains from other sources, is assuming (on a micro scale) a government responsibility in a democratic system. From a micro perspective, the Health Co-op and the Health Brokers argue they were created, more than a decade ago, because they filled a gap in services for immigrant and refugee women that the health care system was not able or willing to fill. Currently, the health service gaps continue to exist, and other gaps in systems, such as social services and child intervention, have forced the Health Co-op to work in these areas. As a result, the Health Brokers find themselves not only seeking access to health services for their clients, but also assisting in locating affordable and decent housing, food, and clothing (Armstrong & Armstrong, 2010a) for them.

The support that Health Brokers need and the stresses they experience in implementing the perinatal and family intervention programs are good examples of the practicalities of downstream interventions. However, they also illustrate how frontline work can be shaped by upstream changes, such as the major cutbacks to the federal transfer payments to provinces in the mid-1990s implemented by the Liberal government.

COMPLEXITIES INTERNAL TO THE ORGANIZATION

A challenge for the organization I would like to address relates to the Health Co-op's work as an independent organization. In my view, the Health Co-op and the Health Brokers lack mechanisms

for leadership renewal and succession planning. The social antinomies (the relationship between the base and the leadership) lead to both the strengths and the drawbacks in the Health Co-op's operations. In principle the Health Co-op adheres to collective decision-making and democratic principles, but the pressures of being at the margins of a hierarchical society put this to the test. In order for the Health Co-op to undertake its holistic approach and to survive within a very competitive context, it has adopted clearly defined roles. For example, mentors take on the high-level relationship-building with funders and partners, including collaboration agreements for the Health Co-op and communities, such as the Perinatal Health Outreach contract with AHS Edmonton Zone public health. In other words, mentors are constantly dealing with policy makers, politicians, managers, and directors within the health care and social services systems. Health Brokers are mainly in charge of the low-level relationship-building with frontline health care and social services providers, such as securing an appointment for a pregnant woman's health checkup. This raises the question: if the base is mainly involved in building low-level relationships, and the leadership in high-level relationships, how can Health Brokers develop the skills to become strategic leaders also?

When high-level positions become available, or are created, such as those of program coordinator (mentor), the Health Co-op asks Health Brokers to consider applying for such positions. The contradiction here lies in that while the organization might want to encourage Health Brokers to seek advancement, these positions generally require a certain level of knowledge of grant writing and system navigation in the policy arena that most Health Brokers do not possess and do not have the chance to develop. (Indeed, the majority of Health Brokers had professional training, so if they had time they could develop the required skills). This is not to say that there have not been promotions from Health Brokers to mentors because at least three Health Brokers are also mentors or program coordinators, but this is not the general rule. From my observations, it appears, though,

that most Health Brokers who join the organization in that position will remain in that role. Indeed, not all Health Brokers want to become strategic leaders either. On one occasion when a team leader position opened up within the organization, I was told that none of the Health Brokers were interested in taking on this position. Also, all Health Brokers interviewed spoke with great pride of being a Health Broker and of the role they played in empowering immigrant and refugee women and families. Recognizing this, the Health Co-op still does not appear to have mechanisms in place to train Health Brokers who aspire to taking on strategic leadership roles, and typically relies on bringing in such leaders from outside the organization.

The hierarchical division of tasks between the base and the leadership makes complete sense once their roles are examined. The Health Co-op is there to articulate and sustain the Health Brokers' practice, which is the *raison d'être* of the organization. When Health Brokers are hired, they are expected to have certain skills and knowledge, but the organization is also expected to introduce new recruits to the philosophy of working for a health workers co-op and train them in the practice of being a Health Broker. Some mentors and Health Brokers indicated that the Health Co-op needed to train new Health Brokers to understand the goals and principles of the organization in a speedy manner. The contradiction here lies in that depending on the pace of growth (that is, the number of and size of projects funded), the Health Co-op has to skip some processes, such as personalized Health Brokers' training and focus instead on general group training. By increasing the number of projects, the Health Co-op invests more time in hiring new Health Brokers and articulating and sustaining the Health Brokers' practice, rather than training Health Brokers to take on leadership roles.

For the Health Co-op, it is a sign of success to be able to secure funding for ongoing and new projects because they allow the organization to respond to the needs of immigrant and refugee communities. The success in securing funding is the result of the symbiotic relationship between the Health Brokers, mentors, and the funders, which reflects creative thinking about how to help families in ways that lead to health equity. It is also due to mentors knowing how to “navigate” the idiosyncrasies of the health and social services systems, that is, visioning and having knowledge and ability to secure funders’ commitments for the Health Co-op’s projects. While this is the ideal scenario, if the growth of the organization entails taking on new projects without adequate time to fully train Health Brokers, this could be an Achilles’ heel for the organization and impair its effectiveness. In other words, while it is economically optimal for the Health Co-op to increase its project funding to respond to the needs of communities and provide employment for its workers, if in doing so the organization undermines its capacity to reflect on its practice and create new cadres for the future, this may put its long term health in jeopardy.

At my last data validation session with mentors (June 14, 2012) to discuss my assertions about leadership and succession plans, they acknowledged that the Health Co-op lacked systematic succession planning, but they disagreed that there were tensions in the relations between what I called the leadership (mentors) and the base (Health Brokers). They indicated that although mentors were responsible for dealing with high-level relationships’ in practice the Health Brokers’ role was the most important role in the Health Co-op and the opinions and views of Health Brokers mattered the most because they were the ones who had direct contact with the communities. I indicated that I raised the issues of leadership and succession plans because those were some of the areas where I thought they could improve. They suggested that perhaps a feminist view of their leadership was more appropriate to understanding their collective practice, rather than a

hierarchical lens, which they characterized as informing my analysis. I agreed to look at some feminist authors who have written in this area to see if, indeed, that lens would lead me to a different interpretation. Given my timelines, it will not be possible for me at this time to comprehensively review literature on feminist leadership. Some selected literature (Inter Pares, 2011; Thyler, 2003), raised two points important to this discussion. First, Inter Pares (2011) states that it is very difficult to build an organization “based on equality and parity in a world where the majority of individuals and organizations do not operate on this basis” (p. 42). Indeed, some Health Brokers and mentors made reference to these pressures in the interviews, and I must acknowledge that as a researcher I am also influenced by the hierarchical context in which I operate. For example, some Health Brokers spoke of wanting more structure in their work and found that the Health Co-op’s style of supervision was too fluid. This could mean that for these participants a more managerial or vertical style or transactional (Thyler, 2003) leadership was their preferred option as opposed to the horizontal, collective style that the Health Co-op espouses. Second, Inter Pares asserts that “as much as staff at Inter Pares develop proficient skills in consensus-building, unofficial power imbalances among staff – particularly if they go unnamed and unaddressed – can impair consensus, preventing some people’s active participation or privileging the participation of others” (Inter Pares, 2011, p. 42). Some participants alluded to this point, indicating that sometimes the Health Co-op shifted between too much or too little process. In other words, unconsciously, and because of the rapidity in which some decisions have to be made, the Health Co-op might develop some hidden hierarchies that have yet to be recognized.

I asserted in this dissertation that the organizational structure (in this case, a health workers’ co-operative) combined with a visionary politicized leadership (social change) drives and sustains the Health Brokers’ practice. Because the leadership plays such an important role in the organization,

they need to maintain “a certain ethical stance to practice, one in which the intent of their actions is always to ensure that the clients/groups with whom they work become more powerful as a result of the relationship” (Labonté, 1996, p. 516).

I had the sense through my participant and direct observation activities that leaders, both Health Brokers and mentors, were conscious of their role in teaching other Health Brokers to take on leadership roles. In this context, the Health Co-op is espousing a transformational style of leadership (Thyler, 2003). According to Thyler (2003) “transformational leaders enable followers to be motivated and involved in the vision they create” (p. 70). At least one participant spoke of teaching the youth to become leaders. This participant stated, “...so we're thinking about a succession plan. So how we make sure the youth will be the team leader in the future? And how can they mobilize their community to be a supportive one... the dream is big” (Agave). The Health Co-op and many Health Brokers are aware that they need to have succession plans (Chaland, 2009). The issue here is how to train current Health Brokers and the youth to be the strategic leaders of tomorrow. Succession planning is a key challenge that I believe the Health Co-op needs to invest time in, and is something it will have to reflect on and develop mechanisms to address.

ADVANCING THEIR ROLE WITHIN THE CO-OPERATIVE MOVEMENT AND THE CHW FIELD

There is no doubt from the data that the Health Co-op and Health Brokers are committed to enhancing the capacity of immigrant and refugee women, families, and communities. They invest tremendous amounts of time to ensure that health and social service providers know about the health and non-health issues experienced by these populations. They are also trying to empower women and communities through feminist urban citizenship, and working hard to make their practice more known among health and social services providers in Edmonton. The key questions

this raises include: are they working towards strengthening their role in the Health Co-operative movements; and are they, as Health Brokers, enhancing the role of CHWs in the health human resources workforce? They are participating in the Health Co-op movement through Co-op members serving on the boards of both the Canadian Co-operative Association (CCA) and the Canadian Worker Co-operative Federation (CWCF). During my field work (2009-2010) they were considering dropping their participation in these organizations owing to pressures on their time. In 2011, however, the Executive Director of the Health Co-op joined the board of the newly-formed Canadian Health Co-op Federation, whose goal is to increase the profile of the Health Co-operative sector in Canada (Health Care Co-operatives Federation of Canada, 2011). At the moment it appears Co-op members are interested in being involved in the sector and will continue to serve on different national Co-op associations' boards.

For Health Brokers' involvement in the CHW field to gain recognition as part of the health human resources workforce in Canada will require forming a health broker movement advocating for official status, including the establishment of their own Standard Occupational Category. This work, for which there are currently no resources, is likely to happen, but at a very slow pace. In the U.S. for example, many CHWs themselves want to ensure that the CHW workforce is structured to respond to the demand for services (Findley, et al., 2012). Resistance, however, also exists among American CHWs and CHW groups to standardization and regulation of professional status, as they see this as compromising the independence of their work with communities. Indeed, within professions like social work, divisions exist over the value of official accreditation, which according to Jennissen and Lundy are due to the incompatibility of protecting professional status and taking positions on social problems. They also argued that, "in most cases, profession-building was favoured at the expense of social change" (Jennissen & Lundy, 2011, p. 291). Participants in the

Health Co-op signalled feeling pressured to seek accreditation as a result of their work in Family Intervention and relationship with Alberta's Children Services. They also indicated the need, if the Health Brokers' practice were to be accredited, to be vigilant not to lose their organic relationships with their clients. Again, this is an example of the tension that the Health Brokers face in the politic of disengagement and mainstreaming. They want their practice to be recognized for its role in improving access to health and social services (institutionalization), yet they want to continue being independent (marginalization), or what (Briskin, 1991) referred to as marginalization and invisibility on the one hand and co-optation and institutionalization on the other.

Notwithstanding the challenges ahead, the literature (Gupta et al., 2011) indicates that if we are to monitor "trends in health workforce situation and performance, or for countries to share experiences and best practices, it is necessary to know how health workers are defined and classified in the original information sources" (p. 9). Because knowledge on CHWs' role in public health and primary care in Canada is only emerging, and there is no common nomenclature related to these workers, it will be some time before statistics on this workforce are available. Some work on gaining recognition of CHWs as part of the health human resources workforce in Canada has already been initiated. In one of my data validation meetings, Health Brokers agreed that I had understood their work, but they also asked, "so what? What do your findings mean for us as workers?" I reminded them that together with other colleagues (academics, Health Brokers, researchers) we had submitted a proposal to Canadian Public Health Association (CPHA) to develop a position statement in recognition of programs in Canada (October 11, 2011). Since then, CPHA has responded positively to the proposal, so this summer it will strike a working group to draft the position statement for review at CPHA's board meeting in spring 2013. Some colleagues who signed the submission to the CPHA, including myself, will be assisting in drafting the policy statement.

Because Health Brokers are delivering important services for AHS, they could potentially also work with allies to gain institutional status for their role in Alberta's health care system.

Areas for further research

Further research is needed on the Health Co-op, Health Brokers, health professionals, and the health care system in Alberta. Such additional research would further demonstrate the relevancy of the Health Co-op model for CHWs and the health system in general and its transferability to other CHW models in Canada, the United States, or other countries.

THE HEALTH CARE SYSTEM

Areas to explore include doing a cost-benefit analysis to demonstrate whether serving immigrant and refugee women through a model like the Health Co-op's Perinatal contract is cost efficient and effective. Issues to consider in this analysis include: the number of immigrant and refugee women who receive health and social services because of their connection to the Health Co-op; the health outcomes associated with these services. This research could also entail comparing women served through the Health Co-op and their outcomes with those who receive services from Health for Two Network Nurses, public health nurses, and community health centres, through such programs as the Healthy Beginnings Home Visitation (in which Health Brokers are not involved in the program delivery).

Other possible research would include identifying and analyzing strategies for the health system to target non-health issues linked to social determinants of health. Such research would look at how to secure buy-in from different sectors, ministries, and systems for initiatives dealing specifically with immigrants and refugees, and would likely consider what collaborate efforts are needed to move

beyond reactive treatment of disease or immediate health issues. This might also include exploring reform of payment models, allowing CHW non-clinical tasks to be quantified in measurable units, and adequately compensated.

THE HEALTH CO-OP

Other research might be designed to develop understanding of how the Health Co-op can foster collective reflection on the Health Brokers' practice, leadership, and succession planning. This analysis would examine various relationships between and among different stakeholders including: the Health Brokers themselves; Health Brokers and mentors; Health Brokers, mentors, and the women and families they serve; Health Brokers and their communities; Health Brokers and health professionals in community health centres or hospitals; and finally Health Brokers and social services providers (Children services, housing authorities, schools).

Theory and practice

Research could also be undertaken to analyze how the Health Co-op can establish mechanisms to standardize Health Brokers' practice. This would include exploring the training that Health Brokers receive for each of their core programs, and examining accreditation initiatives for the Health Brokers' practice. Training options and pedagogy related to various aspects of Health Brokers' work, such as multicultural health brokering theory (Ortiz, 2003) and the health promotion approaches (Labonté, 1993) also need to be researched. Understanding how CHWs are using other theoretical models and health promotion strategies to influence women and their families' health behaviour (Hyman & Guruge, 2002) and to build community capacity is another aspect of this question that needs to be probed.

Technological gadgets

Additional research might also explore how the Health Co-op and Health Brokers could make better use of technology and social media to systematize: a) access to information about resources available to clients; b) distribution of information among Health Brokers on how best use these resources; and c) provision of information to clients and health and social services providers on Health Brokers' availability and capacity to take on new clients.

Gender, culture, and religion

Analysis could be done into how CHWs build relationships with mothers and their families in order to understand the agentic and unagentic influences that gender, culture, and religious practices have on immigrant and refugee families' settlement, adaptation, and integration into Canadian society. This is important to understand the uptake of health promotion and violence prevention programs for immigrant and refugees.

Another area for research is analyzing the role that male Health Brokers play (within the Health Co-op) in facilitating access to health and social services of immigrant and refugee women and how their role is similar or differs from that of female Health Brokers.

Health Human Resources Workforce issues

In-depth study is warranted on other CHW models in Canada doing similar or different work. For example, a comparison might be made of the Health Co-op's and similar CHW organizations' home visiting models (community driven) with those of public health units or community health centres (system driven). This comparison will determine if the relationship established between home visitors and families in community-driven models differs from those of system-driven models and

the impact that each model potentially has on the health and wellbeing of at-risk families, including immigrants and refugees.

Finally, research exploring how CHWs in Canada could be organized as a workforce and begin finding a common voice would be worthwhile. This would entail, among other things, researching the views of health and social work professionals who work closely with CHWs in different settings both within the system and in independent models.

Conclusion

In this dissertation I focused on describing and analyzing the “particularization” of the Health Co-op and Health Brokers’ practice with special emphasis on the Perinatal Health Outreach and Health for Two programs and secondary consideration of the Family Intervention program. In discussing the embedded mini-cases, I sought the perspectives from health professionals on the case and the phenomenon (micro) as well as on the health system’s approach to addressing health equity for immigrant and refugee women (meso) and social determinants of health (macro). I illustrated in this dissertation that the micro role of Health Brokers is important because they are: a) establishing equal relationships with women and their families, and more broadly with communities (multicultural health brokering); b) combining strategies dealing with individuals and families, groups, community mobilization, and coalition building (health promotion empowerment approach); c) acting as intermediaries between two types of knowledge – authoritative (formal-biomedical) and experiential (informal-immigrant and refugee women) as well as among different systems (health, social services, child intervention); d) helping women and themselves to make their voices heard in their interactions with health and social service providers (agency, autonomy, and empowerment); and e) contributing to immigrant and refugee women’s active participation in

different levels of Canadian society (feminist urban citizenship). I have focused the dissertation on understanding Health Brokers' small picture actions (downstream) because they offer hope relative to the often glum reality of the big picture policy context (upstream). These actions offer some short-term solutions. Over the medium and long term, however, addressing the policy context is a prerequisite to dealing holistically with social determinants of health and eradicating systemic inequities. Nonetheless, documenting and theorizing the daily challenges and successes Health Brokers experience is an opportunity to give voice to a practice that, despite its shortcoming, is highly innovative in the CHW field in Canada.

I propose recognition of Health Brokers as part of health human resources workforce, as they are currently unrecognized in Canada. Reasons for this non-recognition include the lack of documentation: on how CHW interventions are implemented; about how they are evaluated; and about the frameworks within which they are undertaken. In addition, questions remain about whether they are effective in improving health outcomes for marginalized communities. Other factors include the practice not being fully valued by health professionals, including nurses and doctors, and how these providers see CHWs' role. As well there are macro reasons stemming from their gendered, classed, and racialized status in Canada. Finally, the workers not being organized means that they do not have a common voice to advocate for recognition.

For the Health Brokers' practice to be more effective, it needs the support of other sectors and ministries. This collaboration is crucial in order to achieve to address health equity for immigrants and refugees, instead of offloading the responsibility to the Health Brokers for creating these collaborations themselves. Consistent collaboration at all levels of government and across all sectors

is crucial in order to address the health inequities experienced by immigrant and refugee communities.

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Appendices

APPENDIX 1: SUMMARY TABLE OF INCLUDED LITERATURE (CHWs)

#	Author	Date	Population	Method	Country	Purpose
1.	Werner	1977	Rural workers	Book	World	Identifies role of CHW workers.
2.	Werner and Bower	1982	Rural workers	Book	World	Identifies role of CHW workers.
3.	Andrews et al.	2004	Ethnic minority women	Systematic review	United States	Illustrates that workers are effective in increasing access to health services, increasing knowledge, and promoting behavior change among ethnic minority women.
4.	Lewin et al.	2005	All populations	Systematic review	United States	Assesses the effects of LHW interventions in primary and community health care on health care behaviours, patients' health and wellbeing, and patients' satisfaction with care.
5.	Lewin et al.	2010	Pregnant women All populations	Systematic Review	United States	Assesses effectiveness of intervention delivered by LHWs (paid or voluntary) in primary or community health care and intended to improve maternal or child health or the management of infectious diseases.
6.	Lehmann and Sanders	2007	Community Health Workers	Review paper	World	Revisits questions regarding the feasibility and effectiveness of community health worker programmes. It was commissioned by the World Health Organization as a follow-up to the <i>World health report 2006: working together for health</i> , which identified as a research priority the feasibility of successfully engaging community health workers (p.V).

7.	Clark and Surry	2007	foreign-born African patients	Peer reviewed article	United States	Illustrates a program that centers on the developing world concept of "Health Promoters." program review.
8.	Hodnett	2003	pregnant women	Systematic review	United States	Assesses the effects of programs offering additional social support for pregnant women who are believed to be at risk for giving birth to preterm or low birth weight babies.
9.	Rhodes et al.	2007	Hispanics-Latinos	Qualitative systematic review	United States	Explores how LHW approaches have been used and evaluated within Hispanic/Latino communities in the U.S.
10.	Bourgeault et al.	2009	Immigrant care workers	Research report	Canada	Addresses some gaps in knowledge about the role of immigrant care workers in the care of older adults in the home and long term care sectors in Canada due to labour shortage of care workers.
11.	American Public Health Association	2009	All	Brochure	United States	Defines the term CHWs. I used this definition for my thesis.
12.	Swider	2002	All populations	Integrated literature review	United states	Reviews the effectiveness of CHWs in community health promotion and disease prevention efforts.
13.	Johnson	2011	Urban Aboriginal populations	Conference presentation	Canada	Describes the role of Aboriginal health workers in both health promotion and in long-term care.
14.	Dedam-Montour	2010	Aboriginal populations on Reserve	Personal communication	Canada	We spoke about the history and challenges of CHRs in Canada.
15.	National Indian & Inuit Community Health Representatives Organization	2006 2000	Indian, Inuit and First Nations	Brochure	Canada	Describes the functions that CHRs perform including: Environmental Health, health delivery, medical administration counseling and home visits, education and community development.

	(NIICHO)					
16.	Rosenthal et al.	2011	All populations	Peer reviewed article	United States	Compares and contrasts 3 national studies of the US Community Health Worker (CHW) field spanning 15 years.
17.	Nemcek & Sabatier	2003	All populations	Peer reviewed article	United States	Describes the CHW concept, provides a summary of CHW evaluation literature, and suggests quality care indicators to strengthen evaluation.
18.	Balcázar et al.	2011	All populations	Peer reviewed article	United States	Discusses how to strengthen the roles of CHWs to enable them to become collaborative leaders in dramatically changing health care from “sickness care” systems to systems that provide comprehensive care for individuals and families and support community and tribal wellness.
19.	Balcázar et al.	2006	Latinos	Peer reviewed article	United States	Describes results of year-1 implementation of the Salud Para Su Corazon (Health For Your Heart)-National Council of la Raza (NCLR) promotora (lay health worker) program for promoting heart-healthy behaviors among Latinos.
20.	Giovanella et al.	2011	All	Conference presentation	Brazil	Examines the role and activities performed by CHWs in the Family Health Centers and in the community in four large cities in Brazil and discusses the challenges involved in performing their multiple functions: as mediators linking the community and health services, as community organizers, and as health care providers.
21.	Javanparast et al.	2011	Rural areas	Peer reviewed article	Iran	Explores the perceptions of CHWs regarding their contribution to rural health in Iran.
22.	Javanparast et al.	2011	Rural areas	Peer reviewed article	Iran	Draws on a wide range of information about the Iranian CHW programme and from this analysis draw important lessons on how to improve rural population health

						outcomes through Primary Health Care.
23.	Viswanathan et al.	2009	All	Systematic review	United States	Reviews the evidence on characteristics CHWs and CHW interventions, outcomes of such interventions, costs and cost effectiveness of CHW interventions, and characteristics of CHW training.
24.	Martinez et al.	2011	All	Peer reviewed article	United States	Explains the context in the U.S. and the Patient Protection and Affordable Care Act, which recognizes the contributions of CHWs to health care reform.
25.	Holderby	2010	All	Conference presentation	United States	Explains the history of the evolution of CHWs in the U.S.
26.	Mason	2011	All	Peer reviewed article	United States	Describes the development in Massachusetts of an authentic collaboration between strong CHW leaders of a growing statewide CHW association and their public health allies.
27.	Ottawa Public Health	2011	Pregnant women and new mothers	Website	Canada	Describes the Healthy Babies, Healthy Children program.
28.	Invest in Kids	2008	Home visitors	Website	Canada	Describes the training it gives to Home Visitors of the program Healthy Babies, Healthy Children.
29.	Bhutta et al.	2010	All	Systematic Review	World	Identifies CHWs programs with positive impact on Millennium Development Goals (MDGs) related to health or otherwise.
30.	Alberta Health Services	2009a	Immigrants, refugees (newcomers)	Literature Review	Canada	This paper identifies the variants of the peer educator model, the scope of duties of peer educators, and the applications of the model in historical and current contexts.
31.	LAZO	2011	Hispanic community	Website	Canada	Describes a CHW program with Hispanic young women.
32.	Reach Community Health Centre	2011	Immigrant & refugee communities	Website	Canada	Culturally relevant programs and services to assist members of immigrant and refugee communities to access health and community services and resources.
33.	CHSRF	2007	Policy-makers	Primer	Canada	Describes importance of outreach to hard-to-reach populations.

34.	Pottie, Ortiz and Tur Kuile	2008	Immigrants and refugees	Book chapter	Canada	This article describes preventable health conditions and access barriers that face modern immigrants and outlines the foundation for building our prevention guide.
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35.	Chiu, Ortiz and Wolfe	2009	Immigrants and refugees	Book chapter	Canada	Describes the work of the Multicultural Health Brokers Co-operative (the Co-op), and provides a glimpse into the conditions from which multicultural health brokers arose, and continue to grow in number.
36.	Meyer et al.	2003	Immigrant and refugees	Peer reviewed article	Canada	Describes the roles of CHW/LHWs implementing participatory research in health Promotion.
37.	Meyer et al.	2008	Pregnant women and new mothers	Unpublished article	Canada	Describes how service access barriers (language, trust) were addressed at different levels (system, community, service provider) by involving Family Home Visitors to support Nurse Practitioners in providing pre and postnatal services to linguistic minority women in Ontario.
38.	Black et al.	2006	Immigrant and refugee women	Peer reviewed article	Canada	Describes a project designed to promote cancer screening among immigrant women in a midsize urban center in south-central Canada.
39.	Labonté	2011	All	Research report	The world	Explains the findings of the Teasdale-Corti project.
40.	Public Health Agency of Canada CPNP	2010 2011 2007	Pregnant women and new mothers	Website	Canada	Describes the goals and scope of Canada Prenatal Nutrition Program (CPNP).
41.	Forrest et al.	2011	Aboriginal	Research report	New Zealand	Explores the role of CHWs in the health journey of Māori, by undertaking a case study of a Māori health service provider in the Hutt Valley in the Wellington region.
42.	Massachusetts Department of Public Health	2009	All CHWS	Report-literature review	United States	Offers a direction, a road map of where the MDPH should be headed. Proposes a multi-sector partnership coordinated by the MDPH and supported by the legislature, employers, insurers, educators, advocates, and CHWs alike.
43.	Community-University-	2008	Immigrant and refugees	Report-literature	Canada	Presents information from the research literature and from a project that involved immigrant

	sity Partner- ship for the Study of Children Youth and Families			review		and refugee parents and cultural experts who examined items from a screening tool for cultural appropriateness.
44.	City of Hamilton Public Health and Social Services	2007	Immigrant women	Report	Canada	Describes a project designed to promote breast and cervical cancer screening among immigrant women in Hamilton, Ontario, Canada.
45.	South Riverdale Com- munity Health Centre, Mount Sinai Hospital, Toronto Public Health	2010	Marginalized women	Report	Canada	Illustrates lay health educator program on cancer screening across Canada.
46.	CHW /LHW Policy State- ment National Ad-Hoc Working Com- mittee	2011	Health professionals	Unpub- lished document	Canada	Describes proposal to recognize CHW/LHWs in Canada.

47.	U.S. Department of Health and Human Services Health Resources and Services Administration Bureau of Health Professions (2007) (HRSA)	2007	Employers	Survey	United States	CHW workforce survey.
48.	Community Resources LLC	2007	CHW leaders Researchers	Conference proceedings	United states	Presents results of an invitational conference in January 2007, the first ever to bring together Community Health Workers (CHWs), top researchers and other stakeholders to discuss research needs in the CHW field and to draft a proposed research agenda regarding CHWs.
49.	Federal Register	2009	All CHWs	Legal document	United States	Recognizes CHWs' own Standard Occupational Classification (SOC).
50.	Khan-chandan & Gilliam	1999	Ethnic minority workers	Peer reviewed article	United Kingdom	Evaluations of the role of a link worker trained in health promotion and aspects of chronic disease management.
51.	Jack, DiCenso & Lohfeld	2002	New mothers	Peer reviewed article	Canada	Identifies the supports that paraprofessional home visitors provide at risk-mothers and families.
52.	Wells et al.	2011	Ethnic communities	Systematic review	United States	Illustrates that CHW are effective in increasing screening mammography in certain settings and populations, and also that having concordant CHWs contribute to this effectiveness.
53.	Findley et al.	2012	CHWs & employers	Peer reviewed article	United States	Evaluates efforts in New York to build a consensus between community health workers (CHWs) and employers on CHWs' scope of practice, training standards, and certification procedures.

54.	Gupta et al.	2011	Policy-makers	Peer reviewed article	Geneva	Provides cross-nationally comparable data on HRH availability, distribution, roles and functions from new and existing sources, and information from country reviews of HRH interventions that are associated with positive impacts on health services delivery and population health outcomes.
55.	National Center for Cultural Competence	2004	Policy-makers	Guide for health professionals	United States	Encourages the use of cultural brokering as a key approach to increasing access to, and enhancing the delivery of, culturally competent care.
56.	Terpstra et al.	2011	Academics	Review article	United States	Describe the role CHWs in health promotion research and address the challenges and ethical concerns associated with this research approach.
57.	Torres et al.	2011	Latin American women	Book Chapter	Canada	Describes ways that Latin American women leaders are involved in initiatives to remove service access barriers in Ottawa.

APPENDIX 2: SUMMARY OF SOURCES ON CO-OPERATIVES INCLUDED

#	Author	Date	Population	Method	Country	Purpose
1.	2012's IYC	2011	All co-operatives	Website	Canada	Provides information about the 2012 celebrations and up to date news on what is happening in Canada.
2.	Corcoran	2009	Immigrants	Report	Canada	Discusses strategies and challenges for developing immigrant worker co-operatives.
3.	Hough, Wilson and Corcoran	2010	Worker co-operatives	Report	Canada	Provides an analysis of the current state of the worker co-op movement in Canada with a focus on successful worker co-ops.
4.	ICA	2007	All co-operatives	Website	World	Describes the values and principles of cooperatives.
5.	ICA	2012	All co-operatives	Website	World	Provides statistics on co-operatives worldwide.
6.	Corcoran & Wilson	2010	Worker co-operatives	Report	Canada	Analyzes the public policy environment, capitalization environment, availability of federation support, and the context for the worker co-op movements in each of Italy, Mondragon (Spain) and France.
7.	CCA	2011	Ethno-cultural co-operatives	Report	Canada	Illustrates the development of ethno-cultural and Immigrant Co-operatives in Canada.
8.	Espagne	1996	All co-operatives	Report	France	Provides a history of the co-operative movement in Europe and its challenges.
9.	Sointula	No date	Consumer co-operatives	Website	Canada	Describes the history of this co-operative in Canada.

10.	Co-operatives Secretariat	2009 2012	All co-operatives	Website	Canada	Provide background on the different types of co-operatives in Canada, including statistics.
11.	Craddock & Vayid	2004	Health Co-operatives	Report	Canada	Provides background and the different types of health co-operatives, including statistics.
12.	Canadian Housing Federation	2012	Housing co-operatives	Website	Canada	Provides background information on housing co-operatives.
13.	Sacouman	1977	All co-operatives in Nova Scotia	Electronic book	Canada	Explains the role of what is today the Coady Institute in the formation of co-operatives.
14.	Coady Institute	No date	Antigonish	Webpage	Canada	Explains the role the Coady Institute in the Antigonish movement.
15.	Health Care Co-operative Federation of Canada	2011	Health co-operatives	Website	Canada	Describes health care co-operatives members of the organization.
16.	Hannley	2007	Co-operatives	Book	Canada	Provides overview of health co-operatives in Canada. It also reinforces my understanding of the strengths and challenges of worker co-operatives.
17.	Fairbairn	2005	Saskatchewan	Manuscript	Canada	Provides overview of co-operatives in Saskatchewan from 1905 to 2005.

APPENDIX 3: SUMMARY TABLE OF INCLUDED LITERATURE THEORY/HEALTH HUMAN RESOURCES/EQUITY

#	Author	Date	Population	Method	Country	Purpose
1.	Labonté et al.	2005	Health professionals, Academics	Peer reviewed article	Canada	Argues that population health research practice proceeds from a theoretical engagement (theories of knowledge, society and social change), community engagement).
2.	Labonté	1993	Health professionals, Academics	Mono-graph	Canada	Describes and analyzes health promotion and empowerment practice frameworks.
3.	Labonté	2010	Policy-makers Academics	Peer reviewed article	Canada	Argues the importance of health systems using measures of positive health (well-being), discriminating in favour of historically less advantaged groups and weighing the costs of health care against investments in the social determinants of health.
4.	Labonté	1996	Policy-makers	PhD Thesis	Canada	Explicates how practitioners and their managers in the Toronto Department of Public Health conceptualize and practice community development.
5.	Inter-national Society for Equity in Health,	2000	Health professionals Academics	Website	World	Defines Health equity as the absence of systematic and potentially remediable differences in one or more aspects of health across socially, demographically, or geographically defined populations or population subgroups.
6.	Starfield	2006	Academics Policy-makers	Peer reviewed article	World	Defines equity in a way that facilitates its assessment and monitoring and then summarizes evidence from existing research.
7.	Corin	1994	Academics Cultural groups	Peer reviewed article	World	Looks at culture as a social determinant of health.
8.	Grzywacz & Fuqua	2000	Academics	Peer reviewed article	World	Argue the importance of looking at health from a social ecology perspective.
9.	Marmot & Wilkinson	1999	Academics Policy-makers	Book chapter	World	Describes and analyzes the social determinants influence health.

10.	Moss	2002	Academics Policy-makers Women	Peer reviewed article	World	Explores the interrelationship of gender equity and socioeconomic inequality and how they affect women's health at the macro- (country) and micro- (household and individual) levels.
11.	Graham & Logan	2004	Academics Policy-makers	Peer reviewed article	Canada	Describes OMRU to guide the implementation of clinical practice guidelines in a surgical program of a tertiary hospital.
12.	Rootman & Ronson	2005	Low-literacy individuals	Peer reviewed article	Canada	Reviews current literature and research on literacy and health and identifies priorities for research on this topic in Canada.
13.	Nedelsky	1989	Academics	Peer reviewed article	United States	Develops ground breaking work on concept of relational autonomy.
14.	Bourgeault	In progress	Health professionals, the state	Unpublished article	Canada	Presents a model, which attempts to merge the conceptualization of the State's role in the professions and policy literatures, as a means to better understand the context and process of state and profession relations in the case of health professions and female health professions in particular.
15.	Sherwin	1992	Health professionals, academics, students	Book	Canada	Describes the importance of challenging the biomedical model from a feminist perspective.
16.	Sherwin	1998	Academia, health sector	Book	Canada	Describes the role of agency, autonomy and empowerment in challenging the bio-medical model.
17.	Armstrong & Armstrong	2010a	Academia, health sector labour	Book	Canada	Describes and analyzing the undermining of Canadian health care.
18.	Armstrong & Armstrong	2010b	Academia, health sector women's & labour sectors	Book	Canada	Illustrates Canadian women and their segregated work.
19.	Obrien-Pallas & Hayes	2008	Policy-makers, Academics, health professionals	Peer reviewed article	Canada	Draws upon empirical research and other published sources to discuss nursing workforce issues, the challenges of using health human resource research in policy decisions and the importance of evidence-based policies and practices for nursing care and outcomes.

20.	Ortiz	2003	CHWs Health professionals Academia	PhD Thesis	Canada	Capture the cultural brokering experience of the Multicultural Health Brokers (MCHBS) through the use of grounded theory analysis.
21.	Jennissen & Lundy	2011	Academia Social workers	Book	Canada	Provides comprehensive history of the Canadian social work context (profession, welfare state) from 1900 to 2000.
22.	Andrew	2004	Academia Policy-makers	Book Chapter	Canada	Illustrates women's urban citizenship as a scale of local political action in the twenty-first century, including immigrant and refugee women.
23.	Lievesley	2006	Academia Policy-makers	Book Chapter	United States	Explores different conceptions of citizenship and their consequences for women. In other words, the relationship between women and citizenship.
24.	Spitzer	2004	Academia Health sector	Peer reviewed article	Canada	Discusses health care reform in Canadian hospitals and its impact on patients from culturally marginalized populations.
25.	Spitzer	2005	Academia Health sector	Peer reviewed article	Canada	Discusses the cuts to social programs and their negative impact on women who are marginalized.
26.	Spitzer	2011	Academia Policy-makers Community	Book	Canada	Illustrates engendering health as the interplay between multiple social, cultural, and environmental determinants.
27.	Tong	1989	Academics women's groups	Book	United States	Describes and analyzes feminist theory and the different currents in feminism.
28.	Adamson, Briskin & McPhail	1988	Academics women's groups	Book	Canada	Describes and analyzes the women's movement in Canada.
29.	Briskin	1991	Academics women's groups	Book chapter	Canada	Analyzes the tension between disengagement and mainstream and women's group face.
30.	Young	2000 2002	Academics women's groups	Book Report	Canada	Describes women's participation on political parties. Describes newcomer communities' participation in politics.

31.	Eisenstein	2009	Academics women's groups	Book	United States	Argues that feminism has been co-opted by the global corporate agenda to exploit the word.
32.	Hill Collins	2000	Black women Academics	Book	United States	Discusses Black feminist thought and intersecting oppressions.
33.	hooks	1984	Black women Academics	Book	United States	Discusses feminist theory from the perspective of Black women.
34.	Torres	1993	Women's organizations	Unpublished essay	El Salvador	Analysis the organizing around strategic and practical interest of women in El Salvador.
#	Author	Date	Population	Method	Country	Purpose
35.	Holston	2001	Policy-makers Academics	Book chapter	The world	Explains urban citizenship in a global context.
36.	Jezewski	1995	Health professionals	Peer reviewed article	United States	Describes the evolution of the middle-range substantive theory of culture brokering.
37.	Davis-Floyd & Sargent	1996 1997	Pregnant women and new mothers	Peer reviewed article Electronic book	United States	Describe childbirth and authoritative knowledge in cross-cultural perspectives.
38.	Ketler	2000	Students	Peer reviewed article	Italy	Compares the social settings and teaching organization of two differently structured childbirth education courses in Cagliari, Italy.
39.	Turton	1997	Aboriginal populations	Peer reviewed article	United States	Describes the ways of knowing about health reported by Ojibwe people during an ethnographic inquiry in the Great Lakes region.
40.	Ramsden	2002	Aboriginal peoples	Thesis	New Zealand	Traces a personal history in order that the story of Cultural Safety can be told and the history, theory and the future direction can be gathered into one qualitative work.
41.	Jordan	1983	Aboriginal peoples White women	Book	World	Provides a crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden and the United States.
42.	Baumann	2008	Academics Women	Electronic article	unknown	Raise the question how causally and constitutively relational approaches relate to the fact that we exercise our autonomy over time.

43.	Mitchell & Shields	2002	Non-governmental organizations	Book chapter	Canada	Describes the role of non-for-profit organizations or the third sector.
44.	Goldring, Berinstein & Bernhard	2009	Non-status immigrants	Peer reviewed article	Canada	Analyzes the institutionalized production of precarious migration status in Canada.
45.	Gurstein & Vilches	2010	Lone mothers	Peer reviewed article	Canada	Argue that the 'just city' is one that enables individuals to exercise their citizenship, including making choices to participate (or not) in communal existence.
46.	Smyth	2008	Mothers	Peer reviewed article	Northern Ireland	Situates breastfeeding politics in the context of intimate citizenship, where women's capability to care in a range of social spaces is at stake.
47.	Gourevitch	1993	Academics	Diction-ary	Unites States	Indicates that political economy examines the relationships of individuals, to society, and the state.
48.	Muffed	1993	Academics	Diction-ary	Unites States	Illustrates that the discourse of citizenship has shifted from social rights, to legal status, and to social rights in addition to legal status.
49.	Teeple	2000	Academics	Book	World	Describes and analyzes the erosion of the welfare state due to neo-liberal policies and globalization.
50.	Andreae	2002	Academics Social work practitioners	Book chapter	Canada	Explains the 1995 federal government cuts to Canada's Action Plan.
51.	Thomlison & Bradshaw	2002	Academics Social work practitioners	Book chapter	Canada	Explains the 1995 federal government cuts to Canada's Action Plan and the political context of social spending.
52.	Stewart	2002	Academics Social work practitioners	Book chapter	Canada	Analysis social programs such as the CHST as well as role of the welfare states and resource issues, including funding cuts.
53.	Predy et al.	2008a 2008b	Women in poverty Lone mothers	Report Website	Canada	Describes Alberta's income per neighbourhood, and report on poverty and perinatal health.
54.	Carter et al.	2006	Immigrants	Magazine article	Canada	Illustrates the changes in immigration in Canada and how racial minority populations will be increasing in numbers by 2017.

55.	Beiser	2005	Immigrants & refugees	Peer reviewed article	Canada	Explains the different waves of immigration to Canada.
56.	Laterveer	2003	Poor populations	Peer reviewed article	The Netherlands	Describes pro-poor health policies in poverty reduction strategies. Explains the difference between vertical and horizontal policies and how vertical equity is important in addressing the needs of communities living in poverty.
57.	Amaratunga & Hockney	2003	Policy-makers Academics	Peer reviewed article	Canada	Argue that greater recognition of the differences in the health needs of Canada's diverse communities should shape service delivery.
58.	Pollack	2000	Women breaking the law	Peer reviewed article	Canada	Examines various understandings of "empowerment" and provides a critique of the way it is currently being adopted to describe the needs and experiences of women who break the law.
59.	Mercer-Ray	2009	Nurses	Peer reviewed article	United states	Argues that nurses can play a leadership role in transforming the health care system.
60.	Thyler	2003	Nurses	Peer reviewed article	United states	Argues that in contrast to transaction leadership, transformational leadership and team development has a positive affect on communication and team building. The later style is ideologically suited to nurses and may ensure the future of nurses and nursing in the health care sector.
61.	Raeburn & Rootman	1998	Health promoters	Book	The world	Explicates the role of people-centred health promotion.
62.	Statistics Canada	2007	All populations	Website	Canada	Statistics of the typical Canadian family.
63.	Alberta College of Social Workers	2007	Social workers	Standards	Canada	Outlines the standards of practice for Social Workers in Alberta.
64.	Fleuriet	2009	Mexican immigrant women	Peer reviewed article	United States	Contrasts conceptualizations of authoritative knowledge in pregnancy and birth between U.S. midwives and their Mexican immigrant clients at a religious birthing center in south Texas.

65.	Akhavan & Lundgren	2011	Immigrant women	Peer reviewed article	Sweden	Describes and analyses midwives' experiences of doula support for immigrant women in Sweden.
66.	Etowa & Adongo	2007	Black women	Peer reviewed article	Canada	Discusses the findings of a study that examined Black women's childbirth experiences in one of the Atlantic provinces. Discusses lack of cultural competence and its implications for perinatal health care.
67.	McGibbon & Etowa	2009	Health professionals	Book	Canada	Provides a critic of cultural competency and diversity approaches. Supports anti-racism approaches.
68.	Kane, Moffat & Brennan	2006	Pregnant women	Peer reviewed article	United States	Presents one model in which doulas provide services without charge. Suggest that doulas become part of the CHW field.
69.	Inter Pares	2011	Non-governmental organizations	Report	Canada	Presents a feminist analysis of working in a non-hierarchical organization.
70.	Krieger	2008	Black Americans	Conference presentation	United States	Illustrates how to develop scales to measure the impact of racism on health, and the impact of socio-economic deprivation on health.
71.	Ritsatakis	2009	Cities	Peer reviewed article	World	Attempts to assess how far stakeholders in cities understood the WHO concept of equity in health, had the political will to tackle the issue, and the types of action undertaken.
72.	Braveman, Egerter & Williams	2011b	Children	Peer reviewed article	United States	We review current knowledge about health effects of social (including economic) factors, knowledge gaps, and research priorities, focusing on upstream social determinants—including economic resources, education, and racial discrimination—that fundamentally shape the downstream determinants, such as behaviors, targeted by most interventions.

73.	Wolfe	2010	Immigrant women	PhD Thesis	Canada	Examines the relationship between the gap and the niche through which the middle women carve out a "unique" role for themselves. Argues that both niche and the Middle Woman are discursively produced in / by / through the power relations shaped by state ideologies and discourses.
74.	FCS Group	2005	All	Narrative review	United States	Presents literature searched and agencies contacted in several states and local jurisdictions that have implemented performance based contracting.
75.	Hyman & Guruge	2002	Immigrant women	Peer reviewed article	Canada	Presents information from a literature review conducted for the Ontario Women's Health Council on effective theoretical models and health promotion strategies for women.
76.	Lewis William	2001	Maori people	PhD Thesis	New Zealand	Inquires into how communities at the economic and cultural margins can become self-determining, increasing control over health and well-being. Community development as method of agency in Aotearoa/New Zealand and Canada is investigated.
77.	James	1996	Racialized populations	Book	Canada	Illustrates how racism operates in the health and social services systems.
78.	Essed	1991	Black populations	Book	United Kingdom	Explains everyday racism from both a micro and macro perspectives.
79.	van der Velde, Williamson & Ogilvie	2009	Immigrants	Journal article	Canada	Examines the processes involved in implementing and maintaining a participatory action research (PAR) project by uncovering how theoretical PAR tenets hold up in the reality of a community-based project addressing immigrants' and refugees' mental health needs.
80.	Ogilvie, Burgess-Pinto & Caufield	2008	Researchers and academics	Journal article	Canada	Discusses that approaches to research in newcomer populations include consideration of the insider-outsider status of the researcher(s), sample selection and recruitment strategies, and attention to language barriers.

APPENDIX 4 PRINCIPLES OF WORKER CO-OPERATIVES

(Hough, Wilson, & Corcoran 2010, pp 6-7)

<i>Principle</i>	<i>Description</i>	<i>Comment for worker Co-operatives</i>
1st Principle: Voluntary and Open Membership	Co-operatives are voluntary organizations, open to all persons able to use their services and willing to accept the responsibilities of membership, without gender, social, racial, political, or religious discrimination.	The key service is employment for its members.
2nd Principle: Democratic Member Control	Co-operatives are democratic organizations controlled by their members, who actively participate in setting their policies and making decisions. Men and women serving as elected representatives are accountable to the membership. In primary co-operative members have equal voting rights (one member, one vote), and co-operatives at other levels are also organized in a democratic manner.	Following the co-operative values is essential. It is also essential that the members take their responsibility to participate seriously.
3rd Principle: Member Economic Participation	Members contribute equitably to, and democratically control, the capital of their co-operative. They usually receive limited compensation, if any, on capital subscribed as a condition of membership. Members allocate surpluses for any or all of the following purposes: developing their co-operative; benefiting members in proportion to their transactions with the co-operative; and supporting other activities approved by the membership.	Returns on capital are always subordinate to the primary way of sharing the surplus (profits) between the members, which is based upon the amount of work they have contributed to the co-operative.
4th Principle: Autonomy and Independence	Co-operatives are autonomous, self-help organizations controlled by their members. If they enter into agreements with other organizations, including governments, or raise capital from external sources, they do so on terms that ensure democratic control by their members and maintain their co-operative autonomy.	It is important that any agreement made to secure capital for the co-operative's operations be on terms that ensure the members remain in control of the co-operative.
5th Principle: Education, Training and Information	Co-operatives provide education and training for their members, elected representatives, managers, and employees so that they can contribute effectively to the development of their co-operatives. They inform the general public — particularly young people and opinion leaders — about the nature and benefits of co-operation.	The areas in which the co-operative members must have adequate training are: business management, democratic functioning of the worker co-operative, and their own jobs within the co-operative.

6th Principle: Co- operation Among Co- operatives	Co-operatives serve their members most effectively and strengthen the co-operative movement by working together through local, national, regional, and international structures.	This principle calls upon co-operatives of all types to patronize and support each other.
7th Principle: Concern for Community	While focusing on member needs and wishes, co-operatives work for the sustainable development of their communities.	Worker co-operatives must always remember that they are ultimately dependent upon their larger community and the natural environment.

APPENDIX 5: SUMMARY TABLE OF INCLUDED LITERATURE - METHODS

#	Author	Date	Population	Method	Country	Purpose
1.	Stakes	1995	Academics students, researchers	Book	United States	Describes and analysis how to conduct single case studies.
2.	Stakes	2005 2005b	Academics, students, researchers	Book	United States	Describes qualitative single case study. Describes qualitative 'intrinsic' case study, an instrumental case study, and multiple or collective case studies.
3.	Stakes	2006	Researchers Schools	Book	United States	Describes multiple case study analysis.
4.	Stakes	2010	Academics, researchers	Book	United States	Describes different paradigms in qualitative research methods.
5.	Flyvbjerg	2001	Academics, researchers	Book	United States	Describes and defends the value of conducting qualitative single case studies.
6.	Yin	1993 2003a 2003b	Academics, researchers	Book	United States	Describes quantitative single and multiple case study research design, methods and applications.
7.	Gagnon	2005	Academic Businesses	Book	Canada	Describes how to design, conduct, analyze and report on case study design.
8.	Creswell	2007	Academics	Book	United States	Describes how to design and implement a qualitative research project by choosing one of the five traditions.
9.	Denzin & Lincoln	2003	Academics	Book chapter	United States	This chapter describes qualitative methods and also explains what a transformatory-emancipatory research methodology is.
10.	Mertens	2003	Academics	Book chapter	United States	Outlines the importance of conducting transformative-emancipatory research.
11.	Campbell & Gregor	2002	Students Academics	Book	Canada	Explains how to do Institutional Ethnography.
12.	Kleinman	2007	Academics	Book	United States	Explains how to do feminist fieldwork Analysis.
13.	Smith	1997	Women Academics	Book	Canada	Examines the structure of the everyday world through the lenses of feminist theory, Marxism and phenomenology.

14.	Wolf	1996	Women Academics	Book chapter	United States	Identifies feminist dilemmas in fieldwork and analyzes the power the researcher holds in the process.
15.	Rossmann & Rallis	2003	Academics Students	Book	United States	Explains the issues to consider in conducting a qualitative field research from beginning ending.
16.	Bailey	1996	Students Women	Book	United States	Explains in detail how to guide fieldwork.
17.	Lofland & Lofland	1995	Academics Students	Book	Canada	Provides a guide to qualitative observation and analysis.
18.	Glesne	1999	Academics Students	Book	United States	Provides a guide on how to become qualitative researchers: learning traditional ethnography research, critical ethnography, action research and grounded theory.
19.	Silverman	2003	Academics Students	Book chapter	United States	This text explains how to analyze talk and text to ensure that the data depicts the reality of the life of the organization studied.
20.	Johnson & Turner	2003	Academics Students	Book chapter	United States	Explains major data collection techniques and analysis for Quan and for Qual and for Mixed methods research.
21.	Olesen	2005	Academics Students	Book chapter	United States	Identify the issues dealing with feminist research and its criticism of validity.
22.	Last	2007	Academics Health sector	Book	World	Defines public health terminology. A dictionary of public health.

APPENDIX 6: OBSERVATION PROTOCOL DAILY

Participant Observation (P/ir roleO) Daily

Date: _____ Place: _____ Time: _____

Who was there? _____

What was said? _____

Who left first? _____

How did I feel when the person (s) left? _____

Who was doing what? _____

Who calls (e.g fly members, cty members, health service providers, other?) _____

Who responds to "calls"? _____

What happens to a "call" after it comes in? _____

How does the call get to a CHW/LHW? _____

Which CHW/LHW and why? _____

How is a "call" "translated" into a request for support? _____

By Whom? _____

How does a response take place? _____

How does the person who responds think about the issues? _____

Key phrases _____ Counts (significant/out of ordinary): _____

Status characteristics of people in setting: Gender _____ Racial/ethnic background _____

Class _____ Age _____ Language (s) _____

Trade _____ Professionals _____ Dress code _____

Cultural behaviours: _____ Styles _____ Patterns of style _____

List of materials to include with this observation: _____

Triggers of memory: _____

Comments about study: _____

+++++

Triggers of feelings about my role as researcher

Ideas _____ Feelings _____

Conclusions _____

Impact of my presence in the setting _____

Influences on my thinking _____

APPENDIX 7: OBSERVATION PROTOCOL MEETINGS

Participant Observation (P/O) Meetings

Date: _____ Place: _____ Time: _____ Type of Meeting _____

Who was there? _____

What is the purpose of meeting? _____

Who is facilitating? _____ Verbal behaviour (who does most of the talking) _____

Who interrupts whom? _____ Who defines focus of the discussion? _____

What issues, if any, relate to issues that immigrants (women) experience with health services? _____ What type of services? _____

How are these issues presented or framed by participants? _____

How do facilitators shape this discussion? _____

Are there efforts to shift the focus? If so, by whom and what is the response? _____

Are any actions decided as a result of the discussion? _____

Tone of conversation: Playful) _____ Formal _____ Polite _____ Relaxed _____ Engaged _____

Voices (loud) _____ Soft _____ modulated _____ monotone _____ Words specific to setting _____

Who uses which words _____

Who left first: _____ How did I feel when the person (s) left: _____

Who participates in discussion? _____

Key phrases: _____

Counts (significant/out of ordinary): _____

Status characteristics of people in setting: Gender _____ Racial/ethnic background _____ Class _____ Age _____ Racial backgrounds _____ Language (s) _____ Trade _____ Professionals _____

Dress code _____ Cultural behaviours: _____ Styles _____ Patterns of style _____

Body language _____ facial expressions _____ posture _____

How much space do they take up _____

How do people move? Confident _____ Unsure _____ Eye contact _____

Touching _____

List of materials to include with this observation: _____

Triggers of memory: _____

Comments about study: _____

+++++

Triggers of feelings about my role as researcher

Ideas _____ Feelings _____

Conclusions _____

Impact of my presence in the setting _____

Influences on my thinking _____

Participant Observation (P/O) Women & CHW/LHW interaction

Date: _____ Place: _____ Time: _____ Regular meeting _____

Who was there: _____

What was the purpose of the meeting? _____

What was said: _____

Verbal behaviour (who does most of the talking) _____

Who interrupts whom _____ Power status _____

Words specific to setting _____

Who uses which words _____

Who left first: _____

How did I feel when the person (s) left: _____

Who was doing what: _____

Key phrases: _____

Counts (significant/out of ordinary): _____

Status characteristics of people in setting:

Gender _____ Racial/ethnic background _____ Class _____ Age _____ Racial backgrounds _____

Language (s) _____ Trade _____ Professionals _____ Dress code _____

Cultural behaviours: _____ Styles _____ Patterns of style _____

Body language _____ facial expressions _____ posture _____

How much space do they take up _____

How do people move? Confident _____ Unsure _____ Eye contact _____

Touching _____

List of materials to include with this observation: _____

Triggers of memory: _____

Comments about study: _____

+++++

Triggers of feelings about my role as researcher

Ideas _____

Feelings _____

Conclusions _____

Impact of my presence in the setting _____

Influences on my thinking _____

APPENDIX 9: OBSERVATION PROTOCOL ARTIFACTS

Participant Observation (P/O) Artifacts

Date: _____ Place: _____ Time: _____
Who was there: _____
Size of room _____ Who does what: _____
In which room (s) _____
Office arrangement: _____
Wealth of office setting: Spacious _____ Small _____ Constrained _____ Clutter

Lighting: Soft _____ Subdue _____ Bright _____ Cold _____ Inadequate

How does setting influence how individuals interact with each other

Colour: Neutral _____ Bold _____ Soft _____ Southing _____ Safe
_____ Anxious _____
Smell: Clean _____ Scents _____ Perfumes _____ New _____ Old _____
Pets _____
Children _____ Food _____ Chemicals _____
Sounds: Background laughter _____ Sounds of industrial equipment _____ Construction
work _____
Changes in Sound: Tolerated _____ Ignored _____ People react to changes

Piped music: _____ Telephones _____ Fax machines/printers/photocopies
_____ Silence _____
Objects in space: Plants _____ Furniture _____ Books _____ Tools _____ Storage Units

Signs: language (s) _____ Foreign languages _____
Objects are: Functional _____ Good conditions _____ poor
conditions _____
Political _____ What do object indicate about status: _____
Temperature of room: Cold _____ Air conditioned _____ Warm _____
Weather outside: Does it change mood & behaviours _____ More _____ or Less _____ people
coming to agency _____
People's perceptions of physical surroundings _____
Less people coming _____ Phone calls _____ Phone
cards _____
How much space do people take up _____
How do people move? Accessibility _____ Inaccessible _____
List of materials to include with this observation: _____
Triggers of memory: _____
Comments about study: _____
+++++
Triggers of feelings about my role as researcher
Ideas _____ Feelings _____
Conclusions _____
Impact of my presence in the setting _____ Influences on my thinking _____

APPENDIX 10: PARTICIPANT AND DIRECT OBSERVATION ACTIVITIES AT HEALTH CO-OP OVER 18 MONTHS

Category	Entries	Hours	Purpose
<i>Organizational</i>			
Membership meetings (programming)	4	9:15	Content related to programming
Membership meetings (business meetings)	2	6	Organizational development
Networking meetings (public relations)	1	8	Increase organization's profile
Partnership building meetings (programming)	5	12:30	Seek funding or in-kind collaboration
Staff retreat	1	7	Building cohesion among the group
Training	6	15	First perinatal training for some, & refresher
Project meetings	4	4:50	Monitoring ongoing projects
Research meetings (with partners)	2	4	Update research processes
New grant proposals	5	8:05	See new funding source
Workshop preparation meetings	3	3	Confirm content and roles
Workshops or presentations to other agencies	2	3:30	Describing Health Brokers work
Referral system	2	3:40	Understanding how system works
Board meetings	3	4:40	Oversee work of organization
Briefings (policy makers- members of legislator)	4	10:45	Make voices of communities heard
<i>Health Brokers' practice</i>			
Home visits (with Health Broker)	3	6:30	Monitor women's health & support systems
Health Broker accompanies client to health/social services	3	4:45	Seeking income and childcare support
Health Broker and client meeting (Health for two)	1	2:30	Distributing milk coupons/vitamins
Parenting groups	3	7:15	Learning about Canada/keeping own culture
Prenatal class	1	2:45	What to expect at during labour
Youth group (homework club)	1	1	Support to with school work
Supervision (Health Broker consults with mentor)	1	0:15	Update about status of help with client
Programming (with funders) meeting	1	0:45	Support for Health Brokers – practice standards
Social gatherings with community members	2	5	Christmas celebrations
<i>Other opportunities & visits</i>			
Get to know the office and people	10	13:10	Informal conversations with people- Doc review
Individual meeting-orientation to organization	2	0:55	Learn organizational approach
<i>Join conference presentations</i>			
Preparation of abstract	2	3	Agree on theme and roles
Presentations delivered	2	7	Knowledge transfer re Health Brokers' role
Subtotal Participant observation activities	75	157:30	Approximately 22.47 (7 hour-days)

<i>Direct observation activities (volunteer work)</i>			
Write summary of documents	1	12	Child welfare policy review
Write short briefing	1	10	Organizations violence prevention approach
Literature review	1	28	Issues related to undocumented migrants
Write stories about Health Brokers work	7	80	Illustrate issues faced by communities
Write minutes for meeting	1	3:30	Document issues faced by seniors
Represent organization at meetings	1	13	Identify possible funding sources
Sub-Total Direct observation activities	12	146:30	Approximately 20.9 (7 hour-days)

Category	Entries	Hours	Purpose
Participant observation	75	157:30	Learn about organization by observing
Direct observation (volunteer work)	12	146:30	Learning through implementing direct tasks
Total number of all activities	87	304	Approximately 44 days over 18 months

APPENDIX 11: PARTICIPANT OBSERVATION ACTIVITIES ORGANIZED BY PUBLIC HEALTH UNIT

Category	Entries	Hours	Purpose
<i>Organizational</i>			
Health for Two Network meetings (programming)	2	4	Coordination of program across the city
<i>Training</i>			
Health for Two orientation	1	2	Orientation on administrative requirements
Health for Two sessions, no Health Broker present	2	6	Childbirth and baby feeding
Health for Two sessions, Health Brokers present	2	6	Childbirth and bay feeding
Total number of activities	7	18	Approximately 2.5 days over 2 months

CHW/LHWs Interview Guide

Uncovering the role of Community Health Worker/Lay Health Worker Programs in addressing health equity for immigrant women in Canada: A case study

Time of the interview:

Date:

Place:

Interviewee:

Position of the Interviewee:

Briefly describe the project.

Briefly describe the consent process and obtain written consent using the consent form.

Briefly describe the personal information form (PIF) and ask participants to complete at the beginning of the interview.

I am interested in understanding your perspective on the role of CHW/LHW programs in facilitating access to health services by immigrant women. There are no right or wrong answers. I am interested in your opinions and perspectives.

1. About you

- 1.1. Can you tell me a bit about yourself and how you became involved in immigrant women's health?
- 1.2. Can you describe your role within this program? (____specify name agency)

2. Structure of CHW/LHW program

- 2.1. Recruitment for CHW/LHWs
- 2.2. How did you hear about this job?
- 2.3. Do you feel that your previous training (foreign credentials or Canadian credentials) was recognized?
- 2.4. Can you tell me if your cultural/ethnic background is recognized in your occupation?

Training for CHW/LHWs

- 2.5. Can you tell me about the last level of school/training that you received before becoming a CHW/LHW?
- 2.6. What kind of training did you receive (if any) when you began your current job?
 - 2.6.1. *Probes:* What was the training about? Was it content based? Skill based? Example: how the health system works, health education methods counseling/mentoring techniques, making referrals, cultural competency, health issues, First Aid/CPR, safety, leadership training, management/organizing skills, fundraising/grant writing.
- 2.7. How do you use the skills obtained through this training in your job as CHW/LHW?
- 2.8. How is this training related to the tasks, roles and responsibilities that you are expected to perform as a CHW/LHW?
- 2.9. Do you use the skills learned in your previous school/training within your current job?
- 2.10. Who provides your CHW/LHW training?

- 2.10.1. *Probes:* Your agency, an outside agency?
- 2.10.2. Is the training mandatory?
- 2.10.3. How often do you receive training?
- 2.10.4. How many times per month, year, duration of training?
- 2.10.5. Is the training ongoing?
- 2.10.6. How long is each training session?
- 2.11. Are you paid to attend the training?
 - 2.11.1. *Probes:* If yes, are you paid as full-time worker, part-time worker, contract workers, volunteer worker?
 - 2.11.2. Do you receive any sort of recognition for training?
 - 2.11.3. Such as a certificate, pay raise, ceremony, school credit, etc.?
 - 2.11.4. If no, in what way are you compensated for the time you take to complete the training?
- 2.12. Do you participate in training given by other agencies?
 - 2.12.1. *Probes:* If yes, what kind of training is it? do you use that training within your current job? If yes, can you claim that training as part of your work hours? If not, what makes you take that training?
- 2.13. Can you describe how the training addresses your communication/interaction with program users?
 - 2.13.1. *Probes:* Do you speak with Program users only about your agency's 'official messages' regarding health and access to health services by immigrant women?
 - 2.13.2. Can you discuss any different perceptions that communities may hold about women's health and/or access to health services?
 - 2.13.3. How about if these perceptions are different than your agency's perceptions?
- 2.14. In what way is your work as CHW/LHWs recognized within your agency?
 - 2.14.1. *Probes:* Is CHW/LHW a recognized occupation within your agency?
- 2.15. How do your CHW/LHW qualifications rank within the ranking scales of your agency?
- 2.16. Have you had the opportunity to speak with someone since your last CHW/LHW training?
 - 2.16.1. *Probes:* Have you spoken with family members, friends, coworkers, men, women, or anyone else?

Compensation for CHW/LHWs

- 2.17. How long have you worked as a CHW/LHW?
- 2.18. How long have you been at your current job?
- 2.19. How many different 'CHW/LHW' jobs have you had?
- 2.20. On average, how many hours do you work each week as a CHW/LHW?
- 2.21. Do you have another paid job besides being a CHW/LHW?
- 2.22. Do you feel like you have job security as a CHW/LHW? If yes, can you tell be why? If not, can you tell me why not?
 - 2.22.1. *Probes:* Do you feel you have appropriate living wages, irregular/poor pay, regular work or irregular hours?
 - 2.22.2. Do you feel that your agency has stable funding?

Professional Development

- 2.23. Do CHW/LHWs in your agency regularly get promotions (change in job role, increase in salary, etc.)?
- 2.24. Do you have opportunities to develop professionally (given more responsibility, asked to participate in activities that increase your skills, etc)?
- 2.25. Do you receive any work benefits?
 - 2.25.1. *Probes:* Health Insurance, tuition reimbursement, sick/vacation leave, pension/retirement?

Supervision of CHW/LHWs

- 2.26. Can you tell me about the supervision that you get from your supervisor?
- 2.27. What kind of relationship do you have with your supervisor?
 - 2.27.1. *Probes:* Do you feel that you have the support required to do your job?
 - 2.27.2. Poor (unable to communicate, conflict, unable to see problem the same way), Fair, Good, Excellent (able to communicate and share philosophy of working with women)?
- 2.28. How much experience does your supervisor have working as a CHW/LHW?
- 2.29. On average, how many hours of direct supervision (guidance, technical support, etc) do you receive each week?
- 2.30. Do you consider that you get enough (or not enough) supervision time for you to be effective in your work?
- 2.31. On average, how many hours of indirect supervision (putting you in contact with other resource persons, reading workers reports) do you receive each week?
- 2.32. Do you consider that you get enough (or not enough) indirect supervision time for you to be effective in your work?
- 2.33. What are some of the challenges/problems that you face, if any, with supervision?
- 2.34. Can you tell me about your work environment?
- 2.35. In addition to your supervisor, what people do you usually have contact with while working?
 - 2.35.1. *Probes:* Other CHW/LHWs, administrative staff, clinical Staff within health services organizations (doctors, nurses, etc.), program managers, agency directors, government workers?
- 2.36. What type of working relations do you have with your colleagues?
 - 2.36.1. *Probes:* Poor (unable to communicate, conflict, unable to see problem the same way), Fair, Good, Excellent (able to communicate and share philosophy of working with women)?
- 2.37. What type of relationship do you have with Program users?
- 2.38. What type of relationship do you have with health service providers?
 - 2.38.1. *Probes:* Social service providers? With Settlement agencies?
- 2.39. Not counting your supervisor, who would you most like to improve relations with?
 - 2.39.1. *Probes:* Other CHW/LHWs, administrative staff, Program users, clinical staff within health services organizations (doctors, nurses, etc.), program managers, agency directors, government workers, funders?

Evaluation of CHW/LHWs work

- 2.40. Can you tell me what you expect to achieve in your work as CHW/LHW?
 - 2.40.1. *Probes:* How does your agency decide on the expected results/outcomes of your work?
- 2.41. What proportion of the targeted population is successfully reached by your work?
- 2.42. How often is your work evaluated?
- 2.43. What systems do you have in place to record your work/practice?
 - 2.43.1. *Probes:* Are you expected to produce written, oral (or both) reports? If so, why, or why not?
 - 2.43.2. How are those reports structured?
 - 2.43.3. Are there standard forms with pre-determined questions to be filled in after each of your activities?
 - 2.43.4. Are these forms with open ended questions?
 - 2.43.5. What areas of your work are the focus of your reports?
 - 2.43.6. How often and how much time are you expected to spend in reporting your practice?
- 2.44. How do you get feedback from your supervisor about your practice?
- 2.45. How can you present your reactions to supervisors' or agency's comments about your reports and evaluations of your practice?
- 2.46. How do you get feedback from your colleagues about your practice?
- 2.47. What role do you play in evaluating your own practice and/or program?
- 2.48. What role do you play in evaluating your colleagues practice and/or program?
- 2.49. What criteria does your agency use in determining whether or not your practice is satisfactory/ unsatisfactory?
- 2.50. What does your agency do if it considers that your practice is unsatisfactory?
 - 2.50.1. *Probes:* What kind of remedial measures does your agency have to help you or workers experiencing problems in implementing your/their practice?
- 2.51. Can you please describe the mechanisms (if any) to obtain input from program users about your work?
 - 2.51.1. *Probes:* Do program users fill in written evaluation forms or report verbally about their experiences with your work?
- 2.52. What mechanisms does your agency have to receive feedback from other health service providers about your work?
- 2.53. How do other service providers give you or your agency feedback about the CHW/LHW program?
- 2.54. Do you participate in staff meetings about your work? If yes, how often? If no, why not?
- 2.55. Do you participate in evaluations of your program? If yes, how often? If no, why not?

Perceptions from CHW/LHWs work

- 2.56. What do you think about the role that CHW/LHWs programs play in facilitating access to health services by immigrant women?
- 2.57. What you think people at your agency know about the role that CHW/LHWs programs play in facilitating access to health services by immigrant women?

- 2.57.1. *Probes:* What do people at your agency think of employing CHW/LHWs from various ethnic backgrounds to reach out to communities from the similar cultural background?
- 2.58. What do you consider to be your ethnic/racial background?
- 2.59. From your experience, what do think that community health services think of employing CHW/LHWs from various ethnic backgrounds to reach out to communities from the similar cultural background?
- 2.60. What are your agency's views about employing CHW/LHWs who are credentialed versus non-credentialed workers?
 - 2.60.1. *Probes:* Hiring staff that does not have formal schooling?
 - 2.60.2. In what ways do you use CHW/LHWs who are credentialed versus those who are not?
- 2.61. What difference in practice do you think it makes using CHW/LHWs who are credentialed versus CHWs/LHW who are not?
 - 2.61.1. *Probes:* Would credentialed CHW/LHWs be more effective than non-credentialed CHWs?
- 2.62. Is the use of CHWs/LHW a cost effective alternative to other comparable interventions to reach out to immigrant women?
- 2.63. What is the most effective use of CHWLHWs?
- 2.64. Is it appropriate to use cost as a measure of success?

3. **CHW/LHWs practice**

Work/practice

- 3.1. What proportion of the targeted population are you able to reach?
- 3.2. *On average*, how many women do you serve in any given month?
- 3.3. Which population(s) of people do you most often work with?
 - 3.3.1. *Probes:* Women, adolescents, the elderly, pregnant women/new parents,families, racial minorities, gay/lesbian/bisexual populations?
- 3.4. What age group do you most often work with?
 - 3.4.1. *Probes:* Youth, adults, elderly?
- 3.5. What are the biggest barriers you face doing your work?
 - 3.5.1. *Probes:* How easy or difficult is it for you to do your work? Please explain.
 - 3.5.2. Not enough support, job insecurity, not enough training, lack of services for clients, etc.?
- 3.6. Do you feel you can make a difference?
- 3.7. What kind of things might make your job easier or more effective?
 - 3.7.1. *Probes:* Support, job insecurity, not enough training, lack of services for clients, etc.?
- 3.8. What does the term 'outreach' mean to you? What does it mean to your agency?
- 3.9. Can you describe what type of strategies you use to reach out to immigrant clients?
 - 3.9.1. *Probes:* Do you use word of mouth, telephone calls, ads in the newspaper, home visits?
- 3.10. What activities do you currently do as a CHW/LHW?
 - 3.10.1. *Probes:* Health education/information, case assessment, case finding/recruitment
- 3.11. office work, translation/interpretation, teach classes, provide transportation to clients, health fairs, community organizing, collaborating with other agencies, follow up to

referrals, peer education/mentoring fundraising/grant writing, presenting in schools, community centers, etc.?

- 3.12. What extra activities do you do beyond those you were hired to do?
- 3.13. Can you tell me the reasons why you select each of these strategies?
- 3.14. What is the significance of using these strategies for your work?
- 3.15. How important is it for you to implement these strategies?
- 3.16. What do you think you can achieve by using these strategies?
- 3.17. Where does the person-to-person contact typically take place?
 - 3.17.1. *Probes:* From your home, at work, or any place else?
- 3.18. When you speak to women, do you typically speak to them in groups or one-on-one?
- 3.19. How do you bring up the topic of access to health services?
 - 3.19.1. *Probes:* Do you wear something indicating that you are a CHW/LHW?
- 3.20. Do you mention that you have been trained as a CHW/LHW?
- 3.21. Do you use pamphlets, or use other ways?
- 3.22. Can you tell me why it is important for you to reach out to immigrant women in accessing health services?
- 3.23. How do you know that you are meeting your goal of reaching out to immigrant women?
- 3.24. Is your work restricted to a catchment area within the city or group?
- 3.25. In what setting do you do most of your work? (from the office, community agencies, in rural or urban areas)

Access to health services: Information and referral

- 3.26. What kind of services do women ask you for help in accessing them?
- 3.27. How do you help or guide women into accessing the services they ask about?
- 3.28. What topics have you been talking about?
 - 3.28.1. *Probes:* Child health, maternity care, vaccinations, cancer screening?
- 3.29. In what languages are these materials available?
- 3.30. In what language do you communicate with women?
 - 3.30.1. *Probes:* How do you know that women understand the oral and written information that you are giving to them?
- 3.31. Have you given anyone information about how to access a service provider such as a clinic, a community health centre, a family doctor?
- 3.32. How do you know if the person has acted on your suggestion?

Access to health services: Direct assistance

- 3.33. Have you called a service provider for someone?
- 3.34. Have you given a ride to someone to a health service providers' office?
- 3.35. Have you accompanied someone to a health service provider? If yes, for what reason?

Access to health services: Emotional support

- 3.36. Can you describe a situation (if any) when you felt you needed to give emotional support to someone?
- 3.37. Have you counselled/guided anyone about what they should do?
- 3.38. Access to health services: Worker's Individual empowerment

- 3.39. Could you describe a situation when you felt confident (or did not feel confident) about how you answered questions about your role as a CH/LHW?
- 3.39.1. *Probes:* Was it with family, friends, or neighbours who asked you for a service?
- 3.40. Can you describe changes in your thinking (if any) about how you see CHW/LHWs and your role as a CHW/LHW?
- 3.41. Navigating the system:
- 3.42. How do you know that women are actually accessing the services that you are promoting?
- 3.42.1. *Probes:* Who informs you? The women, the health services agencies, the health care providers?
- 3.43. What tools do you use to help women understand how the health care system works, and how they can access health services?
- 3.43.1. *Probes:* Do you use written materials or audiovisual materials?
- 3.44. Oral presentations?
- 3.45. Are your outreach strategies incorporated within CHW/LHW programs responding to the health needs of immigrant communities?
- 3.46. Are there some activities that you do that motivate immigrant women to participate in the program more than others?
- 3.46.1. *Probes:* Which activities motivate women more? Which ones motivate women less?
- 3.47. Why do you think that is the case?
- 3.48. What changes do you expect to see in the women that you do outreach to?
- 3.48.1. *Probes:* Behavioural change? If so, which components of your work do you think that may lead to that change?
- 3.48.2. If there are behavioural changes, which of these changes can be linked to improvements in access to health services by immigrant women?
- 3.49. Is there community capacity changes? If so, which components of your work will lead to that change?
- 3.50. How important is it for immigrant women to learn about accessing health services? Why?
- 3.51. What are you personally trying to achieve when engaging women in learning about accessing health services? Why?
- 3.52. How can you tell that women are engaged in learning about accessing health care services?
- 3.53. How can you tell when women are NOT engaged in learning about accessing health services?
- 3.54. What would be the implications for women's health if they are engaged in learning about accessing health services?
- 3.55. What would the implications for women's health be if they are NOT engaged in learning about accessing health services?
- 3.56. How realistic is it to expect that women will change their behaviour as a result of your intervention?
- 3.57. Do you think that the work you do contributes to women's health literacy? If yes, why? If not, why not?

Partnerships/networking CHW/LHWs

- 3.58. Do you have opportunities to network with other CHW/LHWs? If no, why? If yes, why?
- 3.59. Are you paid during networking time?
- 3.60. In what way do you network?
 - 3.60.1. *Probes:* Do you participate in coalition work with other agencies? Do you negotiate arrangements for immigrant women with other agencies? Are you encouraged to go to conferences/professional meetings in order to meet other CHW/LHWs?
- 3.61. Are you aware of any CHW/LHW networking organizations in this area?
 - 3.61.1. *Probes:* What other agencies are employing CHW/LHW as your agency is doing?
- 3.62. How often do you have the opportunity (if any) to meet with other CHW/LHWs in order to share information and provide support for each other?
- 3.63. If you do, how useful do you find these meetings?
- 3.64. Do you feel that other health service providers are supporting your work as a result of your partnership/networking? If yes, in what way? If not, why?
- 3.65. Do you know if other health service providers recognize the work you do as CHW/LHWs?

4. Philosophy of underpinning program

Philosophy underpinning

- 4.1. What do you think of how the health care system is responding to the needs of immigrant women to access health services?
- 4.2. In your view, what are some of the challenges that the health care system is experiencing in responding to the needs of immigrant women in accessing health services?
- 4.3. How are CHW/LHW programs strengthening the health care systems' competence to respond to demographic changes in Canada?
- 4.4. How do you know that your practice is culturally appropriate to the communities they are serving?
 - 4.4.1. *Probes:* How does your agency let immigrant women know that it respects their cultural beliefs?
- 4.5. Do immigrant women feel that their own cultural practices to keep healthy are accepted by you and your agency?
- 4.6. How does your agency value the cultural knowledge that immigrant women bring to your work?
- 4.7. How do you or your agency challenge cultural beliefs that might be considered detrimental to immigrant women's health in Canada?
- 4.8. Are there any issues that program users face in accessing health services or in navigating the health care system because of being from different cultural background?
- 4.9. Are there any issues (barriers/discrimination) that you face in your work because of being women? From a different ethnic background?
- 4.10. How are you influencing the diversity of the health system's labour force?
- 4.11. How can CHW/LHW programs contribute to public health workforce development?
- 4.12. What is the racial/ethnic background of CHW/LHW program staff or volunteers in comparison to staff/volunteers in other programs within your agency?

Theoretical framework

- 4.13. What principles guide CHW/LHW programs at your agency?
- 4.14. How would you define 'access' to health services by immigrant women?
 - 4.14.1. *Probes:* What is your ideal form of access to health services by immigrant women?
- 4.15. How do you define health equity?
- 4.16. How do you define health inequities?
- 4.17. In your view, what other factors influence immigrant women's health equity or inequities?
 - 4.17.1. *Probes:* Immigrant status in Canada?
- 4.18. Socio-economic background?
- 4.19. What are, in your view, some of the challenges immigrant women experience in accessing health services or in learning how to navigate the health care system?
- 4.20. What strategies does your agency use to improve women's health that go beyond access to health services?
- 4.21. How are CHW/LHW models addressing the cultural and linguistic health needs of immigrant communities?

5. Adoption, implementation and sustainability

Change loop

- 5.1. Since you have been a CHW/LHW for this agency, can you think of any changes made to the program, or to your job description because you or another CHW/LHW suggested them?
- 5.2. In what ways do you think that your opinions or suggestions are incorporated into the CHW/LHP program?
 - 5.2.1. *Probes:* Do you give suggestions on the content or format of materials to be distributed to program users?
 - 5.2.2. Do you give suggestions on how your practice may change in order to improve it?
 - 5.2.3. Do you give suggestion on how the agency can work with immigrant women?
- 5.3. Would you like to see any changes in the way the program is delivered (although you think that those changes may or may not be possible at the present time? If yes, what would these changes be?
 - 5.3.1. *Probes:* In regards to your own job description?
 - 5.3.2. In regard to immigrant women accessing and using the program?
 - 5.3.3. In regard to how other service providers support the work that you are doing?
 - 5.3.4. Do you have any other comments?

Thank you.

APPENDIX 13: KEY INFORMANT INTERVIEW GUIDES CHW SUPERVISORS

CHW Supervisors Interview Guide

Uncovering the role of Community Health Worker/Lay Health Worker Programs in addressing health equity for immigrant women in Canada: A case study

Time of the interview:

Date:

Place:

Interviewee:

Position of the Interviewee:

Briefly describe the project.

Briefly describe the consent process and obtain written consent using the consent form.

Briefly describe the personal information form (PIF) and ask participants to complete at the beginning of the interview.

I am interested in understanding your perspective on the role of CHW/LHW programs in facilitating access to health services by immigrant women. There are no right or wrong answers. I am interested in your opinions and perspectives.

1. About you

1.1. Can you tell me a bit about yourself and how you became involved in immigrant women's health?

1.2. Can you describe your role within this program? (____ specify name agency)

2. History of the program

2.1. Can you describe what the program is about?

2.2. *Probes:* What is the purpose of your CHW/LHW program? What are the programs goals, and objectives?

2.3. How does this program fit within the overall mandate of your agency?

2.4. How do the program activities fit within overall activities of your agency?

2.5. *Probes:* Is this program part of the core programming for the whole agency?

2.6. Is this program focused within one of the agency's programs or across programs?

2.7. Can you describe how the CHW/LHW program at your agency was created?

2.8. *Probes:* How did you know that this program was needed to reach out to immigrant women and communities?

2.9. What are the reasons behind the creation of this program?

2.10. Can you tell me if your agency learned from other CHW/LHW programs in order to implement this program?

2.11. Do you know of other programs similar to your program?

2.12. How is your program structured?

2.12.1. *Probes:* How is the program governed? Who makes decisions about programs?

Funding

- 2.13. Could you please explain how the CHW/LHW program is funded?
 - 2.13.1. *Probes:* How much funding do you receive and from which agencies?
 - 2.13.2. How are the CHW/LHW positions funded?
 - 2.13.3. Is your funding, core or program funding?
- 2.14. Are funds coming from a federal transfer to the province?
- 2.15. *Probes:* If yes, from which departments?
- 2.16. How often do you receive funding?
- 2.17. Are funds coming directly from the province to your agency?
- 2.18. Is your funding for CHW/LHWs attached to a particular funding cycle?
- 2.19. Are funds coming from the municipal government?
- 2.20. How about private funding from foundations? Which ones?
- 2.21. Are CHW/LHWs positions funded by different sources, if so, how many?
- 2.22. Can you explain if there any strings attached to receiving the funding?
 - 2.22.1. *Probes:* If so, by which level of government?
- 2.23. What are your agency's obligations to the funders?
- 2.24. What role do immigration policies (if any) play in the implementation of the CHW/LHW?
 - 2.24.1. *Probes:* Does immigration status influence Program Users' eligibility to participate in CHW/LHW programs?
 - 2.24.2. Do provincial immigration policies influence your program in anyway?
 - 2.24.3. Is anyone denied access to your program activities because of immigration status?
- 2.25. What role do provincial health policies (if any) play in the implementation of the CHW/LHW?
- 2.26. Do municipal governments influence your CHW/LHW program in any way?
- 2.27. Recruitment of CHW/LHWs
- 2.28. Can you describe how you do recruit CHW/LHWs to your agency?
 - 2.28.1. *Probes:* How do you publicize your job vacancies?
 - 2.28.2. Do you publicize with ethnic media or ethno-specific organizations?
- 2.29. What are the core qualifications that you look for in these workers?
- 2.30. Are they professionals trained overseas?
 - 2.30.1. If yes, are their foreign credentials recognized by your agency?
 - 2.30.2. If yes, in what way are credentials recognized by your agency?
 - 2.30.3. If no, what is the education level required to work as a CHW/LHW for your agency?
 - 2.30.4. If no, what types of credentials are recognized by your agency?
- 2.31. How much do potential candidates have to know about the subject area in which they will be working?
- 2.32. How much do they have to know about the target community, or being a member of that community?
- 2.33. Do they have to speak the language of the target community?
- 2.34. Who is involved in the hiring process of CHW/LHWs?
- 2.35. What criteria do you use in selecting the candidates to be interviewed?
- 2.36. What is the criterion for candidates selected after the interview?
- 2.37. What are the most important qualities and skills you look for when hiring a person to do CHW/LHW work?
 - 2.37.1. *Probes:* Communication Skills (public speaking, appropriate language, etc.) Listening skill/attentiveness, outgoing/friendly/sociable, patience, open-minded/non-

judgmental, caring, cultural sensitivity, committed/dedicated, respectful, honest, bilingual skills, organizational skills, knowledge about the community, open/eager, dependable/responsible, flexible/adaptable, persistent, clinical skills, ability to work in a group, compassionate, confidentiality/discretion, creative/resourceful, networking/coalition-building skills, knowledge about health issues/health care system, capacity building skills leadership, empowerment, etc.

2.37.2. Any other?

2.37.3. What do you expect CHW/LHWs to achieve in their work

2.37.3.1. *Probes:* For the agency? For the community? For the Health Care system as a whole?

2.37.4. In what way do these workers contribute to your agency's mandate?

Training of CHW/LHWs

2.38. Let's talk about the training given to CHW/ LHWs who are involved with your agency on a full time, part time, contract or volunteer basis.

2.39. What kind of training (if any) do you provide to CHW/LHWs?

2.39.1. *Probes:* What was the training about? Is it content based? Skills based? Example: how the health system works, health education methods counseling/mentoring techniques, making referrals, cultural competency, health issues, First Aid/CPR, safety, leadership training, management/organizing skills, fundraising/grant writing.

2.40. How do you know what training CHW/LHWs need?

2.41. How is this training related to the tasks, roles and responsibilities that you expect these workers to have within your program/agency?

2.42. Who provides the training?

2.42.1. *Probes:* Your agency? Is the training mandatory?

2.43. How often are these workers trained?

2.43.1. *Probes:* How many times per month, year, duration of training?

2.44. Is there ongoing training?

2.45. How long is each training session?

2.46. Are CHW/LHWs in your program paid during training?

2.46.1. *Probes:* If yes, what is the difference in payment for full-time workers, part-time workers, contract workers, volunteer workers?

2.47. If no, in what way are workers compensated?

2.48. Can you describe how the training addresses CHW/LHWs communication/interaction with program users?

2.48.1. *Probes:* How much flexibility do workers have in keeping to your agency's 'official messages' regarding health and access to health services by immigrant women?

2.48.2. How much can workers discuss any different perceptions that communities may hold about health?

2.48.3. How about if these perceptions are different than Canadian Health system perceptions?

2.49. What is the difference in training that your agency gives to CHW/LHWs working on an honorarium or on a volunteer basis?

2.50. In what way is the work of CHW/LHWs recognized within your agency?

2.50.1. *Probes:* Is CHW/LHW a recognized occupation within your agency?

2.51. How do CHW/LHW's qualifications rank within the ranking of your agency?

Compensation of CHW/LHWs

2.52. How many CHW/LHWs are now employed by your agency?

2.52.1. *Probes:* How many of these workers are:

2.52.2. Full time workers? On average, how many hours do they work?

2.52.3. Part time workers? On average, how many hours do they work?

2.52.4. Contract workers? On average, how many hours do they work?

2.52.5. Volunteer workers? On average, how many hours do they work?

2.53. What is the financial compensation that these workers receive?

2.53.1. *Probes:* How do you decide on the salary scale for these workers? What is the average salary for CHW/LHW workers?

2.53.2. How do CHW/LHW's salaries rank within the ranking scale of other employees in your agency?

2.54. Is the compensation criteria for workers employed on a full time bases similar to that of workers employed on a part time, or contract basis?

2.55. How many CHW/LHW workers are volunteers?

2.56. How are volunteers encouraged to keeping their commitment to the agency?

2.57. How much time are volunteers expected to dedicate to the agency and for how long?

2.58. What incentives to you give to your volunteers to keep them engaged in working for your agency?

2.58.1. *Probes:* Do they receive an honorarium?

2.58.2. If yes, how many receive a honorarium or financial compensation?

2.58.3. If not, how many do not receive any financial compensation?

2.59. What is the gender composition of your CHW/LHWs?

2.59.1. *Probes:* How many are female vs. male

Work and work history

2.60. How long have you been in your current job/position?

2.61. How many different jobs have you had as a supervisor to CHW/LHWs?

2.62. In addition to being in a supervisory position, do you consider yourself, or have you ever been a CHW/LHW?

2.63. Can you please tell me your job title and describe what a typical work day is like for you?

2.64. In addition to what you just mentioned, could you please describe what other tasks your supervisor job entails?

2.64.1. *Probes:* On average, how many hours per week do you work?

2.65. Do you have another paid job?

2.66. Do you feel that you have a sense of job security in your current position as a supervisor to CHW/LHWs?

2.67. How does your job scale compare with other supervisors within your agency?

Supervision of CHW/LHWs

- 2.68. Can you describe what the CHW/LHWs practice consists of?
 - 2.68.1. *Probes:* What are the tasks that CHW/LHWs are expected to do for immigrant women (program users)? Are the workers required to interpret or accompany women needing access to health services?
- 2.69. How much time are workers expected to spend with each program user?
- 2.70. What do workers have to achieve in every interaction with program users?
- 2.71. How often do workers interact with program users?
- 2.72. How do you decide how much time is enough to spend with program users?
- 2.73. What are the roles and responsibilities that CHW/LHWs have?
 - 2.73.1. *Probes:* What are the expectations about CHW/LHW practice? In regards to your agency? In regards to other CHW/LHWs? In regards to program users? In regards to immigrant communities?
- 2.74. Can you describe how you and or your agency monitor the practice of CHW/LHWs?
 - 2.74.1. *Probes:* Are there peer, group, or individual meetings to reflect and monitor workers' practice?
- 2.75. Are there onsite visits to monitor workers' practice?
- 2.76. Approximately how many CHW/LHWs do you oversee?
- 2.77. How long have you supervised CHW/LHWs (or the name that you use at your agency?)
- 2.78. What activities do you perform that are not part of the CHW/LHW job description in your agency?
- 2.79. In general, how would you rate your relationship with CHW/LHWs in your program?
- 2.80. On average, how many hours each week do you spend providing direct supervision (guidance, technical support, etc.) to each individual CHW/LHW?
 - 2.80.1. *Probes:* Do you believe this is adequate? If "Yes" what does adequate mean to you?
 - 2.80.2. If "No", what would be adequate?
- 2.81. On average, how many hours each week do you spend providing indirect supervision (putting CHW/LHW in contact with other resource persons, reading workers reports) to each individual CHW/LHW?
- 2.82. What are some of the challenges that you face, if any, supervising CHW/LHWs?

Evaluation of CHW/LHWs Programs

- 2.83. What are the expected results/outcomes for your CHW/LHW program?
- 2.84. What are the indicators or standards that your agency considers for a successful CHW/LHW program?
 - 2.84.1. *Probes:* How does your agency know if your CHW/LHW program is doing what is meant to be doing?
 - 2.84.2. How do you decide on the expected outcomes for the CHW/LHW program?
- 2.85. Is it facilitating access to health services by immigrant women?
- 2.86. What role do external forces play (if any) in identifying those outcomes?
 - 2.86.1. *Probes:* Funders? Municipal government? Provincial government? Federal government?
- 2.87. What are the expected outcomes from CHW/LHW practice?
 - 2.87.1. *Probes:* How does your agency decide on the expected outcomes for the CHW/LHW practice?

- 2.88. What proportion of the targeted population is successfully reached by CHW/LHWs?
- 2.89. Do variations exist in levels of successful outreach when using CHW/LHW as an intervention versus other methods of outreach (i.e. case management)?
- 2.90. How often is your CHW/LHP program evaluated?
- 2.91. What changes to you expect to see within the target population?
 - 2.91.1. *Probes:* Behavioural change? If so, which components of the CHW/LHW's role will may lead to that change?
- 2.92. If there are behavioural changes, which can be linked to improvements in access to health services by immigrant women? Which ones can be linked to health outcomes? Is it realistic to link CHW/LHWs interventions to health outcomes?
- 2.93. Community capacity changes? If so, which components of the CHW/LHW's role will may lead to that change?
- 2.94. How often is the practice of CHW/LHWs evaluated?
- 2.95. What systems do you have in place to record CHW/LHWs practice?
 - 2.95.1. *Probes:* Are workers expected to produce written, oral (or both) reports? If so, why, or why not?
 - 2.95.2. How are those reports structured?
 - 2.95.3. Are there standard forms with pre-determined questions to be filled in by the workers after each activity?
 - 2.95.4. Are these forms with open ended questions?
 - 2.95.5. What are the areas of work in which the CHW/LHWs should focus their reporting?
 - 2.95.6. How much time and how often are workers expected to spend in reporting their practice?
- 2.96. How do you provide feedback to worker's practice?
- 2.97. How can CHW/LHWs present their reactions to your report or your agency's reports and evaluations of their individual practices?
- 2.98. What role do CHW/LHWs play in evaluating their own practice and/or program?
- 2.99. What criteria do you use in determining whether or not CHW/LHW's practice is satisfactory/ unsatisfactory?
- 2.100. What do you do if workers' practice is unsatisfactory?
 - 2.100.1. *Probes:* What kind of remedial measures does your agency have to help workers experiencing problems in implementing their practice?
- 2.101. Can you please describe the mechanisms (if any) to obtain input from program users about CHW/LHW practice?
 - 2.101.1. *Probes:* Do program users fill in written evaluation forms or report verbally about their experiences with CHW/LHWs?
- 2.102. What mechanisms does your agency have to receive feedback from other health service providers about the work of CHWLHWs?
- 2.103. How do other service providers give you or your agency feedback about the CHW/LHW program?

Perceptions of CHW/LHWs work

- 2.104. What do you think about the role that CHW/LHWs programs and workers play in facilitating access to health services by immigrant women?
- 2.105. What do you think people at your agency know about the role that CHW/LHWs programs and workers play in facilitating access to health services by immigrant women?

- 2.105.1. *Probes:* What do people at your agency think of employing CHW/LHWs from various ethnic backgrounds to reach out to communities from the similar cultural background?
- 2.106. What do you consider to be your ethnic/ racial background?
- 2.107. From your experience, do community health services think of employing CHW/LHWs from various ethnic backgrounds to reach out to communities from the similar cultural background?
- 2.108. What are your agency's views about employing CHW/LHWs who are credentialed versus non-credentialed workers?
 - 2.108.1. *Probes:* Hiring staff that does not have formal schooling?
 - 2.108.2. In what ways do you use CHW/LHWs who are credentialed versus those who are not?
- 2.109. What difference in practice do you think it makes using CHW/LHWs who are credentialed versus CHWs/LHW who are not?
 - 2.109.1. *Probes:* Would credentialed CHW/LHW be more effective than non-credentialed CHWs?
- 2.110. Is the use of CHWs/LHW a cost effective alternative to other comparable interventions to reach out to immigrant women?
- 2.111. What is the most effective use of CHW/LHWs?
- 2.112. Is it appropriate to use cost as a measure of success?

3. **CHW/LHWs practice**

Work/practice

- 3.1. Which target population(s) do CHW/LHWs in your program most often work with?
- 3.2. *Probes:* Are they men, women, adolescents, elderly, pregnant women/new parents, families, racial minorities, gay/lesbian/bisexual, other.
- 3.3. What is the ethnicity of the groups of clients most often served by CHW/LHWs in your program?
- 3.4. What age group do CHW/LHWs in your program most often work with?
- 3.5. What activities do CHW/LHWs in your agency perform?
 - 3.5.1. *Probes:* Health education/information, case assessment, case finding/recruitment office work, translation/interpretation, teach classes, provide transportation to clients, health fairs, community organizing, collaborating with other agencies, follow up to referrals, peer education/mentoring, fundraising/grant writing, presenting in schools, community centers, etc.
- 3.6. What are the biggest barriers CHW/LHWs face in doing their work?
 - 3.6.1. *Probes:* Not enough support, job insecurity, not enough training, lack of services for clients, etc.?
- 3.7. What kind of things might make your job easier or more effective?

Partnerships/networking CHW/LHWs

- 3.8. Are you aware of any CHW/LHW networking organizations in this area?
 - 3.8.1. *Probes:* What other agencies are employing CHW/LHW as your agency is doing?
- 3.9. What types of strategies for partnerships exist between your CHW/LHW program and workers and other health service providers servicing immigrant women?

- 3.9.1. *Probes:* Do you have any agreements of collaboration between your agency and other mainstream health services providers?
- 3.9.2. Do you have any agreements of collaboration with ethno-specific community based organizations, or immigrant women's organizations assisting immigrant women to improve their health, and or with their settlement in the city? If yes, what do these agreements consist of? If not, why not?
- 3.9.3. Is there funding attached to these agreements?
- 3.10. In what way does your agency support immigrant women's community based organizations' work?
- 3.11. Do you know if other health service providers recognize the work that CHW/LHWs are doing?
- 3.12. Do CHW/LHWs in your program have opportunities to network with other CHW/LHWs? If no, why? If yes, why?
- 3.13. Are CHW/LHWs paid during networking time?
- 3.14. In what way do they network?
 - 3.14.1. *Probes:* Do they participate in group training sessions with other agencies? Do they participate in open discussions with other agencies? Are they encouraged to go to conferences/professional meetings?

4. Philosophy of underpinning program

Philosophy underpinning

- 4.1. What do you think of how the health care system is responding to the needs of immigrant women to access health services?
- 4.2. In your view, what are some of the challenges that the health care system is experiencing in responding to the needs of immigrant women in accessing health services?
- 4.3. How are CHW/LHW programs strengthening the health care systems' competence to respond to demographic changes in Canada?
- 4.4. How do you know that CHW/LHWs practice is culturally appropriate to the communities they are serving?
 - 4.4.1. *Probes:* How does your agency let immigrant women know that you respect their cultural beliefs?
 - 4.4.2. Do they feel that their own cultural health practices are accepted by you and your agency?
 - 4.4.3. How does your agency value the cultural knowledge that immigrant women bring to your work?
- 4.5. How does your agency challenge cultural beliefs that might be considered detrimental to immigrant women's health in Canada?
- 4.6. Are there any issues that program users face in accessing health services or in navigating the health care system because of being from different a cultural background?
- 4.7. Are there any issues that CHW/LHWs face in their work because of being women?
- 4.8. How are CHW/LHWs influencing the diversity of the health systems' labour force?
- 4.9. How can CHW/LHW programs contribute to public health workforce development?
- 4.10. What is the racial/ethnic background of CHW/LHW program staff or volunteers in comparison to staff/volunteers in other programs within your agency?
- 4.11. Are there any issues that CHW/LHWs face in their work because of being racial minority/from different ethnic backgrounds?

Theoretical framework

- 4.12. What principles guide CHW/LHW programs at your agency?
- 4.13. How would you define 'access' to health services by immigrant women?
 - 4.13.1. *Probes:* What is your ideal form of access to health services by immigrant women?
- 4.14. How do you define health equity?
- 4.15. How do you define health inequities?
- 4.16. In your view, what other factors influence immigrant women's health equity or inequities?
 - 4.16.1. *Probes:* Immigrant status in Canada?
 - 4.16.2. Socio-economic background?
- 4.17. What are, in your view, some of the challenges experiencing immigrant women in accessing health services or in learning how to navigate the health care system?
- 4.18. What strategies does your agency use to improve women's health that go beyond access to health services?
- 4.19. How are CHW/LHW models addressing the cultural and linguistic health needs of immigrant communities?

5. Adoption, implementation and sustainability

Adoption/implementation/sustainability

- 5.1. What institutional forces facilitated the adoption, implementation and sustainability of a CHW/LHWs program at your institution?
 - 5.1.1. *Probes:* Were there provincial or federal government policies? Municipal government policies?
- 5.2. What institutional barriers prevented your organization from adopting a CHW/LHW program before? How were these barriers overcome?
- 5.3. What challenges does your agency face in implementing a CHW/LHW program?
- 5.4. How is the sustainability of the program right now? How easy or difficult it is for your agency to sustain the CHW/LHW program?
 - 5.4.1. *Probes:* Do you have funding? For how long?
- 5.5. Do you have board support?
- 5.6. What mechanisms does your agency have in place to inform its members about the work done by CHW/LHWs?
- 5.7. What mechanisms does your agency have in place to inform other service providers about the work done by CHW/LHWs?
- 5.8. What other strategies do you use in getting support for the adoption, implementation and sustainability of CHW/LHW programs within/outside your agency?
- 5.9. How is the information about your program getting to the community?
- 5.10. How are CHW/LHWs able to share the knowledge that they gain in working with immigrant women to facilitate their access to health services with your agency?
- 5.11. How are CHW/LHWs able to share the knowledge that they gain in working with other service providers on behalf of immigrant women with your agency?

Change loop

- 5.12. Since you have been involved with the CHW/LHW program, can you recall any changes made to the CHW/LHW program or practice?
 - 5.12.1. *Probes:* Who initiates changes, managers, supervisors?
 - 5.12.2. What role do CHW/LHWs play in initiating/influencing changes within your agency?
- 5.13. Are there any ways in which you think CHW/LHWs help your agency improve its mandate?
- 5.14. How long does it take for any changes about the CHW/LHW to occur?
- 5.15. Do you have any other comments?

Thank you.

APPENDIX 14: KEY INFORMANT INTERVIEW GUIDES PROGRAM USERS

Program Users' Interview Guide (women)

Uncovering the role of Community Health Worker/Lay Health Worker Programs in addressing health equity for immigrant women in Canada: A case study

Time of the interview:

Date:

Place:

Interviewee:

Position of the Interviewee:

Briefly describe the project.

Briefly describe the consent process and obtain written consent using the consent form.

Briefly describe the personal information form (PIF) and ask participants to complete at the beginning of the interview.

I am interested in understanding your perspective on the role of CHW/LHW programs in facilitating access to health services by immigrant women. There are no right or wrong answers. I am interested in your opinions and perspectives.

1. About you

1.1. Can you tell me a bit about yourself?

1.1.1. *Probes:* What is your country of origin? Mother tongue?

1.2. How many years have you lived in this city, province, country?

1.3. Do you have a family?

1.3.1. *Probes:* If yes, how many people are in your family?

2. Structure of CHW/LHW program

2.1. Recruitment of program users

2.2. Can you tell me how you got involved with this organization?

2.2.1. *Probes:* How long have you been participating at these agency's activities?

2.3. What activities (if any) are you currently involved in with this organization?

2.4. How often do you participate in this organization's activities?

2.5. *Probes:* How many times per month, year?

2.6. How long is each activity that you participate in?

2.7. Do you receive any sort of recognition for participating in this agency's activities?

2.7.1. *Probes:* Such as a certificate, ceremony, school credit, etc.?

2.8. How do you feel when you participate in these activities?

2.8.1. *Probes:* do you feel welcome?

2.8.2. If yes, why? If not, can you tell me why not?

2.9. Can you describe the type of communication/interaction that you have with people at this agency?

2.9.1. *Probes:* When you call, can you talk to anyone?

2.9.2. Can you contact the agency at any time?

- 2.10. What do you do if you want to comment on what you think about the agency's perspectives on issues that matter to you?
 - 2.10.1.1. *Probes:* On health issues? In access to health services?
- 2.11. Do you participate in activities given by other agencies?
 - 2.11.1.1. *Probes:* If yes, what kind of activities are those?
- 2.12. What do you think are the benefits of participating in these agencies activities?
 - 2.12.1.1. *Probes:* Do you have opportunities to develop new skills?
 - 2.12.1.2. If so, which ones, if not, why not?
 - 2.12.1.3. What you expect to gain by participating in this agency's activities?
- 2.13. Do you receive any support to participate in this agency's activities?
 - 2.13.1.1. If yes, what kind of support?
- 2.14. What do you think of this agency's ability to organize the activities that are important to you?
 - 2.14.1.1. *Probes:* Does it have enough funds to run the programs?
 - 2.14.1.2. Enough personnel? Flexible hours?

3. CHW/LHWs practice

CHW/LHWs work/practice

- 3.1. When did you first hear about the work of CHW/LHWs?
 - 3.1.1.1. *Probes:* Can you recall the first time that you became in contact with a CHW/LHW?
 - 3.1.1.2. How did you establish that contact?
 - 3.1.1.3. What were the reasons for the establishing that contact?
- 3.2. What do CHW/LHWs tell you about themselves?
 - 3.2.1.1. *Probes:* Do they wear something indicating that they are a CHW/LHW?
 - 3.2.1.2. Do they mention that they have been trained as a CHW/LHW?
- 3.3. How do they bring up the topic of access to health services?
- 3.4. Do they explain to you what their work is about?
 - 3.4.1.1. *Probes:* Is their work restricted to a catchment area within the city or group?
- 3.5. In what setting do you meet CHW/LHWs the most?
 - 3.5.1.1. *Probes:* (from the office, from work, community agencies, in rural or urban areas)
- 3.6. What do you think that a CHW/LHW can do for you?
 - 3.6.1.1. Translation/interpretation, teach classes, provide transportation to medical appointments, invite you to activities such as health fairs, community events, help you with community organizing, referring you to other agencies, follow up to referrals, peer education/mentoring, letters of recommendation, representing you in schools, community centers, etc.?
- 3.7. How often do you contact a 'CHW/LHW' at this agency?
 - 3.7.1.1. *Probes:* Is it the same CHW/LHW each time? If yes, why? If not, why not?
 - 3.7.1.2. Approximately, how much time do you spend each time that you meet with a CHW/LHW?
 - 3.7.1.3. Is the CHW/LHW a full-time worker, part-time worker, contract workers, volunteer worker for this agency?
 - 3.7.1.4. When the CHW/LHW speaks to you, does he/she typically speak to you one-on-one or in groups?
- 3.8. What topics have you been talking about?

- 3.8.1.1. *Probes:* Health education/information, child health, maternity care, vaccinations, cancer screening?
- 3.9. In what languages are these materials available?
 - 3.9.1.1. In what language do you communicate with a CHW/LHW?
- 3.10. How do you use the information obtained through a CHW/LHW?
 - 3.10.1.1. *Probes:* Do you speak with someone about it? If yes, who was it? A family member, friend, co-worker, or anyone else?
- 3.11. Can you discuss any different perceptions that you may hold about women's health and/or access to health services?
 - 3.11.1.1. *Probes:* If yes, why? If not, why not? How about if your perceptions about an issue are different from your CHW/LHW's perceptions that issue?
- 4. Access to health services: Information and referral
 - 4.1. What kind of services does a CHW/LHW help you gain access to?
 - 4.1.1.1. *Probes:* Direct assistance, such as the CHW/LHW has called a service provider on your behalf? If yes, for what reason?
 - 4.1.1.2. Has given you a ride to a health service providers' office? If yes, for what reason?
 - 4.1.1.3. Have accompanied you to a health service provider's? If yes, for what reason?
 - 4.1.1.4. How does a CHW/LHW help or guide into accessing the services you ask about?
 - 4.1.1.5. Has guided you about how to access a service provider such as a clinic, a community health centre, a family doctor?
 - 4.2. Can you describe how easy or difficult it is for you to understand the information that you get from a CHW/LHW?
 - 4.2.1.1. *Probes:* Which one is easier? Oral or written or both?
 - 4.2.1.2. Which one is more difficult? Oral or written or both?
 - 4.2.1.3. How easy or difficult is it for you to act on the suggestions given to you by the CHW/LHW?
 - 4.3. What are the biggest barriers that you think a CHW/LHW faces in doing her/his work?
 - 4.3.1.1. *Probes:* How easy or difficult is it for him/her to do his/her work? Please explain
 - 4.3.1.2. Not enough support, not enough training, lack of services for clients, etc.?
 - 4.4. What kind of things might make his/her work easier or more effective?
 - 4.5. What difference (if any) does a CHW/LHW make in your ability to access health services? Or in any other health or social services issue?
 - 4.6. Can you describe a situation (if any) when you felt you needed emotional support from the CHW/LHW?
 - 4.6.1.1. *Probes:* A health crisis that you did not know how to react to at first?
 - 4.7. Could you describe a situation when you felt confident (or did not feel confident) about how to proceed with the recommendations/suggestions given by a CH/LHW?
 - 4.7.1.1. *Probes:* Was it about your family, friends, or neighbours who asked you for a service?
 - 4.8. Can you describe changes in your thinking (if any) about how you see CHW/LHWs?

Navigating the system

- 4.9. How difficult or easy is it for you to access the services recommended by a CHW/LHW?
 - 4.9.1.1. *Probes:* Which one is easier? Why?
 - 4.9.1.2. Which one is more difficult?
- 4.10. What tools are at your disposal to understand how the health care system works, and how you can access health services?
 - 4.10.1.1.1. Do you use written materials or audiovisual materials? To you use the internet?
- 4.11. Do you know if health service providers are more open/less open to assisting you if you are accompanied by a CHW/LHW?
- 4.12. How do you feel about the overall strategies used by CHW/LHWs to respond to your health and services access needs?
- 4.13. Are there some activities that you do with CHW/LHWs that motivate you to participate in the program more than others?
 - 4.13.1.1. *Probes:* Which activities motivate you more? Which ones motivate you less?
 - 4.13.1.2. Why do you think that is the case?
- 4.14. What change do you expect to see in your ability to access health services in the future?
 - 4.14.1.1. *Probes:* More access to health services? Less access to health services?
 - 4.14.1.2. If so, which components of the CHW/LHW work do you think may lead to that change?
- 4.15. How about your community's capacity to access health services?
- 4.16. Which components of the CHW/LHW work may lead to that change?
- 4.17. How can a CHW/LHW know that you are learning about accessing health services?
- 4.18. How can a CHW/LHW know that you are not in learning about accessing health services? If this is the case, is there anything the worker can do to improve this?
- 4.19. What do you think are the biggest challenges that you face in accessing health services?
- 4.20. Can you tell me if there has been a change (if any) in your life that can be the result of something that the CHW/LHW has done for you?

Partnerships/networking

- 4.21. Do you have opportunities to network with other women about how to access health services? If no, why? If yes, why?
 - 4.21.1.1. *Probes:* In what way do you network?
 - 4.21.1.2. Do you participate in community groups or agencies?
 - 4.21.1.3. If yes, why? If not, why not?
 - 4.21.1.4. Are you encouraged by your CHW/LHWs to attend meetings with other women or groups?
 - 4.21.1.5. If you do, how often do you attend these meetings?
 - 4.21.1.6. How often do you share information and provide support for each other?
 - 4.21.1.7. How useful do you find these meetings?

- 4.22. Do you feel that you have better/worse access to health services as a result of participating in these activities?
 - 4.22.1.1. If yes, in what way? If not, why?
- 4.23. Can you tell me if there are other organizations, like this one, who hire CHW/LHWs to help immigrant women in accessing health services and in learning how to navigate the system?
 - 4.23.1.1. *Probes:* What other agencies are employing CHW/LHW? Using CHW/LHW as volunteers?

Evaluation of CHW/LHWs work

- 4.24. Have you participated in evaluations of the work of CHW/LHWs?
 - 4.24.1.1. *Probes:* If yes, when was it? How often is evaluated?
 - 4.24.1.2. Can you recall what the evaluation consisted of?
- 4.25. What systems do you have in place to record the encounters that you have with a CHW/LHW?
 - 4.25.1.1. *Probes:* How do you give feedback to a CHW about your involvement in his/her activities?
 - 4.25.1.2. Is the feedback positive? Is the feedback negative? Can you explain why?
- 4.26. What role do you play in evaluating the CHW/LHW that you work with the most?
- 4.27. Do you participate in staff meetings to evaluate the work of CHW/LHWs ?
- 4.28. Do you participate in evaluations of the agency programs? If yes, how often? If no, why not?

Perceptions from CHW/LHWs work

- 4.29. What do you think about the role that CHW/LHWs programs play in facilitating access to health services by immigrant women?
- 4.30. What you think people at your agency know about the role that CHW/LHWs programs play in facilitating access to health services by immigrant women?
 - 4.30.1.1. *Probes:* What do people at your agency think of employing CHW/LHWs from various ethnic backgrounds to reach out to communities from the similar cultural background?
- 4.31. What do you consider to be your ethnic/racial background?
 - 4.31.1.1. From your experience, what do community health services think of employing CHW/LHWs from various ethnic backgrounds to reach out to communities from the similar cultural background?
- 4.32. What are your agency's views about employing CHW/LHWs who are credentialed versus non-credentialed workers?
 - 4.32.1.1. *Probes:* Hiring staff that does not have formal schooling?
- 4.33. Would credentialed CHW/LHWs be more effective than non-credentialed CHWs?

5. Philosophy of underpinning program

Philosophy underpinning

- 5.1. What do you think of how the health care system is responding to the needs of immigrant women to access health services?

- 5.2. In your view, what are some of the challenges that the health care system is experiencing in responding to the needs of immigrant women in accessing health services?
- 5.3. How are CHW/LHW programs strengthening the health care systems' competence to respond to demographic changes in Canada?
- 5.4. How do you know that the CHW/LHW practice is culturally appropriate to the community that you represent?
 - 5.4.1.1. *Probes:* How do you know that this agency respects your cultural beliefs?
- 5.5. Do you feel that your own cultural practices to keep healthy are accepted by a CHW/LHW and your agency?
- 5.6. How does the CHW/LHW value the cultural knowledge you bring to their work?
- 5.7. Have there been any challenges to your cultural beliefs because they do not coincide with those of the agency or Canada's health care system?
- 5.8. Are there any issues that you face in accessing health services or in navigating the health care system because of being from different cultural background?
- 5.9. Are there any issues (barriers/discrimination) that you face in accessing because of being women?
- 5.10. How can CHW/LHW programs contribute to public health workforce development?
- 5.11. What is the racial/ethnic background of CHW/LHW program staff or volunteers of this agency in comparison to staff/volunteers in other programs that you use within this city?

Theoretical framework

- 5.12. How would you define 'access' to health services by immigrant women?
 - 5.12.1.1. *Probes:* What is your ideal form of access to health services by immigrant women?
- 5.13. How do you define health equity?
- 5.14. How do you define health inequities?
- 5.15. In your view, what other factors influence immigrant women's health equity or inequities?
 - 5.15.1.1. *Probes:* Immigrant status in Canada?
- 5.16. Socio-economic background?
- 5.17. How are CHW/LHW models addressing the cultural and linguistic health needs of immigrant communities?

6. Adoption, implementation and sustainability

Change loop

- 6.1. Since you have been a CHW/LHW for this agency, can you think of any changes made to the program, or to a CHW/LHW job description because you or other women suggested them?
- 6.2. In what ways do you think that your opinions or suggestions are incorporated into the CHW/LHP program?
 - 6.2.1. *Probes:* Do you give suggestions on the content or format of materials to be distributed to program users?

- 6.3. Do you give suggestions on how your practice may change in order to improve it?
- 6.4. You give suggestion on how the agency can work with immigrant women?
- 6.5. Would you like to see any changes in the way the program is delivered (although you think that those changes may or may not be possible at the present time)? If yes, what would these changes be?
- 6.5.1. *Probes:* In regards to a CHW/LHW's work?
- 6.6. In regards to immigrant women accessing and using the program?
- 6.7. In regards to how other health service providers support you in accessing health services and in navigating the health care system?
- 6.8. Do you have any other comments?

Thank you

Interview guide for Staff/Managers/Polymakers/Funders Interview Guide

Uncovering the role of Community Health Worker/Lay Health Worker Programs in addressing health equity for immigrant women in Canada: A case study

Time of the interview:

Date:

Place:

Interviewee:

Position of the Interviewee:

Briefly describe the project.

Briefly describe the consent process and obtain written consent using the consent form.

Briefly describe the personal information form (PIF) and ask participants to complete at the beginning of the interview.

I am interested in understanding your perspective on the role of CHW/LHW programs in facilitating access to health services by immigrant women. There are no right or wrong answers. I am interested in your opinions and perspectives.

1. About you

- 1.1. Can you tell me a bit about yourself and how you became involved with health policy and immigrant health?
- 1.2. How long have you been at this job?

2. History of the policy

- 2.1. Can you tell me about your department and its role in relation to immigrants' health in this province?
- 2.2. In your opinion, what are the main health challenges facing immigrants in your province?
 - 2.2.1.1. *Probes:* access to health services, access to social support?
 - 2.2.1.2. Do these challenges differ according to immigrants' country of origin?
 - 2.2.1.3. How do the challenges that immigrants face, differ from the Canadian population?
- 2.3. What challenges does your government and/or your department face when dealing with issues/policies/programs pertaining to immigrant health?
 - 2.3.1. *Probes:* How are those challenges being met?
- 2.4. How is policy relevant to immigrant health developed and disseminated in your department?

3. Structure of department

- 3.1. Can you tell me about the formation of one 'super health board'?
 - 3.1.1. *Probes:* How does it formation impacts your department's policies about access to health services by immigrants in this province?
 - 3.1.2. How is it different from the policies of the previous regional health board?

4. Knowledge about CHW/LHWs programs

- 4.1. Can you tell me if you have ever heard about the work of CHW/LHWs?

- 4.1.1.1. *Probes:* What was the context in which you hear about CHW/LHWs?
- 4.2. What do you think that a CHW/LHW does for immigrants in the province?
 - 4.2.1.1. Translation/interpretation, teach classes, provide transportation to medical appointments, invite you to activities such as health fairs, community events, help you with community organizing, referring you to other agencies, follow up to referrals, peer education/mentoring, letters of recommendation, representing you in schools, community centers, etc.?
- 4.3. Do you have any contact with community agencies which employ CHW/LHWs?
 - 4.3.1. *Probes:* If yes, which ones?
 - 4.3.2. How often do you contact those agencies?
 - 4.3.3. If not, why not?
 - 4.3.4. Which are the immigrant communities served by these agencies?
- 4.4. What are the challenges that you think community agencies employing CHW/LHWs face in implementing their work?
 - 4.4.1. *Probes:* Not enough support, not enough training, lack of services for clients, etc.?
- 4.5. What kind of things might make the agencies' work easier?
- 4.6. What are the challenges that you think CHW/LHW face in doing their work?
- 4.7. What kind of things might make his/her work easier or more effective?

Access to health services: Information and referral

- 4.8. What kind of services/programs (if any) does your department support to improve the health of immigrant communities?
 - 4.8.1. *Probes:* Direct assistance, such as the CHW/LHW calling/advocating on behalf of clients?
 - 4.8.2. CHW/LHWs accompaniment of clients to health service provider's appointment?
- 4.9. What difference (if any) does a CHW/LHW make in a client's ability to access health services?
 - 4.9.1. *Probes:* In any other health or social services issue?
- 4.10. Can you describe changes in your thinking (if any) about how you see CHW/LHWs?
- 4.11. What are the biggest barriers that you think a CHW/LHW faces in doing her/his work?
 - 4.11.1. *Probes:* Not enough support, not enough training, lack of services for clients, etc.?
- 4.12. What kind of things might make his/her work easier or more effective?

Partnerships/networking

- 4.13. How does your department liaise with other provincial departments responsible for immigrant health?
 - 4.13.1. *Probes:* How does it liaise with federal departments?
 - 4.13.2. How does it liaise with municipal governments?
- 4.14. Do you have opportunities to conduct consultations with agencies serving immigrants about access health services by immigrant communities?
 - 4.14.1. *Probes:* If no, why? If yes, why?
 - 4.14.2. In what way do you network?
- 4.15. Can you tell me if you are supported by your department to attend meetings/conferences about immigrant health issues in your city or province, or both?
 - 4.15.1. If you do, how often do you attend these meetings?

- 4.15.2. How useful do you find these meetings?
 - 4.15.2.1. How do you share the information you get with your colleagues or managers (as appropriate)?
- 4.16. Do you feel that your knowledge about immigrant health issues changes as a result of participating in these activities?
 - 4.16.1. *Probes:* If yes, in what way? If not, why?
 - 4.16.2. Can you tell me if there are other departments doing similar work ?

Funding

- 4.17. Could you please explain how your department's programs/policies are funded?
 - 4.17.1. *Probes:* How much funding do you receive and from which sources?
 - 4.17.2. Are funds coming from a federal transfer to the province?
 - 4.17.3. If yes, from which departments?
 - 4.17.4. Are funds coming from the provincial government?
 - 4.17.5. Are funds coming from the municipal government?
- 4.18. How about private funding from foundations? Which ones?
- 4.19. Could you please explain how your department funds community projects?
 - 4.19.1. *Probes:* Is your funding, core or program funding?
 - 4.19.2. How often do you provide funding?
- 4.20. Do you transfer funds directly from your department to a particular agency?
- 4.21. Is your funding for CHW/LHW programs attached to a particular funding cycle?
- 4.22. What is the average grant that you provide to agencies serving immigrant?
- 4.23. Can you explain if there are any strings attached to providing the funding?
 - 4.23.1. *Probes:* If so, what are the conditions that agencies must meet?
 - 4.23.2. What are the agency's obligations your department?
- 4.24. What role do immigration policies (if any) play in the funding you provide?
 - 4.24.1. *Probes:* Do clients' immigration status influence the funding that you provide?

Evaluation of CHW/LHWs work

- 4.25. Have you participated in evaluations of the programs that you have funded?
 - 4.25.1. *Probes:* If yes, when was it? How often are programs evaluated?
 - 4.25.2. Can you recall what the evaluation consisted of?
- 4.26. What systems do you have in place to provide feedback to the agencies that you are funding?
 - 4.26.1. *Probes:* Do you arrange regular consultations?
 - 4.26.2. What systems do you have in place for agencies to provide feedback to your department's program and policies?

Perceptions from CHW/LHWs work

- 4.27. What you think people at your department know about the role that CHW/LHWs programs play in facilitating access to health services by immigrant communities?
- 4.28. What do people at your agency think of employing CHW/LHWs from various ethnic backgrounds to reach out to communities from the similar cultural background?

5. Philosophy of underpinning program

- 5.1. Philosophy underpinning
- 5.2. What do you think of how the health care system is responding to the needs of immigrant communities (women) to access health services?
- 5.3. How are CHW/LHW programs strengthening the health care systems' competence to respond to demographic changes in Canada?
- 5.4. Are there any issues immigrants face in accessing health services or in navigating the health care system because of being from different cultural background?
- 5.5. Are there any issues (barriers/discrimination) that immigrant face accessing health services because of being women?
- 5.6. How do you think CHW/LHW programs contribute to public health workforce development?
- 5.7. What is the racial/ethnic background of staff in your department?

Theoretical framework

- 5.8. How would you define 'access' to health services by immigrant communities/women?
 - 5.8.1. *Probes*: What is your ideal form of access to health services by immigrant women?
- 5.9. How do you define health equity?
- 5.10. How do you define health inequities?
- 5.11. In your view, what other factors influence immigrant women's health equity or inequities?
 - 5.11.1. *Probes*: Immigrant status in Canada?
 - 5.11.2. Socio-economic background?
- 5.12. In what way is your department's programs/ policies are addressing the cultural and linguistic health needs of immigrant communities?

6. Adoption, implementation and sustainability

Change loop

- 6.1. Since you have been at this department, can you think of any changes made to the program targeting immigrant communities?
- 6.2. Do you give suggestions on how your department may change in order to improve access to health services by immigrant communities?
- 6.3. You give suggestion on how your department can work with immigrant (women) serving agencies?
- 6.4. Would you like to see any changes in the way your department's programs/policies are delivered (although you think that those changes may or may not be possible at the present time)?
 - 6.4.1. *Probes*: If yes, what would these changes be?
 - 6.4.2. In regards to a CHW/LHW's work?
 - 6.4.3. In regards to immigrant women accessing health services?
- 6.5. Do you have any other comments?

Thank you

APPENDIX 16: PERSONAL INFORMATION FORMS CHWs AND HEALTH PROFESSIONALS

**Personal Information Form (PIF)
Staff (CHW/LHW, supervisors,
managers/policy-makers)**

**Uncovering the role of Community Health Worker/Lay Health Programs in addressing health equity for
immigrant women in Canada:
A Case study**

Your Contact Information:

1. Name: _____

2. Phone Number (____) _____ Work (____) _____ Home (____) _____

3. Mailing Address

Postal Code: _____

4. Email Address _____

5. Would you like to receive a copy of our findings? Yes ☐ No ☐

6. Today's date _____

The contact information you provided on the previous page will be kept separately from the remainder of this form. We will select a name for you (below) and use it on all transcripts and papers.

Thank you for taking the time to complete this Personal Information Form (PIF).

Pseudonym: _____ (we will complete this)

Demographic, Work and Health Information

In order to provide summary statistics for our study, we would appreciate it if you could provide a few details about yourself. This information will be used for summary purposes only and will be kept strictly confidential.

1. Date of Birth: _____ (Day) _____ (Month) _____ (Year)

2. Female ☐ Male ☐

3. Location and Country of Birth _____

Urban ☐ Rural ☐

4. If applicable, place of residence before coming/returning to Canada

5. Countries where you worked and reside prior to arriving/returning in Canada

a. _____ a.1 Please specify the years _____

b. _____ b.1 Please specify the years _____

c. _____ d.1 Please specify the years _____

6. Year of Migration/latest repatriation to Canada _____

7. Current Immigrant Status

a. Canadian Citizen Yes ☐ No ☐

b. Permanent Resident Yes ☐ No ☐

e. Other? Please specify _____

8. Native Language (which you still speak and understand) _____

9. What other languages do you speak (excluding your native language)?

10. What other languages do you write? _____

11. What other languages do you understand? _____

12. Religious Affiliation _____

13. Current Marital Status

- ☐ Single
☐ Married / Cohabiting in Canada
☐ Separated / Divorced/No longer with spouse
☐ Widowed

14. Number of Children (if any): _____

15. Ages of children

16. Where were your children born?

a. Canada Yes ☐ No ☐

b. Other? Please specify _____

17. Are you are taking any training or are enrolled in post-secondary education?

	Yes ☐	No ☐
Part time	Yes ☐	No ☐
Full time	Yes ☐	No ☐

18. If applicable, how long have you been a student? _____

19. If applicable, please write name of program? _____

20. What is your highest level of education?

- ☐ Grade 9 or lower
☐ Grade 10-12 non-graduate
☐ High school diploma
☐ Some college or university courses
☐ Trade certificate or diploma
☐ University degree (Bachelor) _____ (specify area)

30. How many family members are currently living with you?

Please write number _____

31. On a scale of 1 to 5, where 1 is very inadequate and 5 is more than adequate, how well does your family's current income meet your family's financial needs?

Very inadequate

More than adequate

1

2

3

4

5

32. On a scale of 1 to 5, where 1 is very dissatisfied and 5 is very satisfied, how satisfied are you with your current employment?

Very dissatisfied

Very satisfied

1

2

3

4

5

33. How would you rate your overall health status?

Excellent ☐

Good ☐

Fair ☐

Poor ☐

34. Since working in your current job, has your health....

Improved ☐

Stayed the same ☐

Worsened ☐

35. Does your employer provide ...

Paid sick days

Yes ☐

No ☐

Extended health care

Yes ☐

No ☐

Dental plan

Yes ☐

No ☐

Paid parental leave

Yes ☐

No ☐

Pension plan

Yes ☐

No ☐

Thank you very much for taking the time to complete this information sheet.

We greatly appreciate it.

APPENDIX 17: RESEARCH TECHNIQUES DATA SOURCES

(Yin 2003, pp.83-97; Hick, 1991, pp.59-61)

Type of data	Where this data is available, or who has the information	Timing for data collection
1. Documentat ion <i>Level two data</i>	Policy and procedures manuals, files and records, Case review processes (mandated by office or province)	During data collection phase at each site.
	Strategic plan	
	Formal studies of the 'site' programs (i.e previous studies about CHW/LHW)	
	Policies in relation to ethnicity-multiculturalism or diversity	
	Human resources and policies practices	
	Flowcharting of processes and procedures such as application taking, case reporting, support monitoring and case review, referrals path (Hick 1991, p.67)	
	Databases with clients statistics (provincial regulations)	
2. Archival Records <i>Level two data</i>	2003-2008 service records of all activities, reports by CHW/LHW	During data collection phase at each site.
	Organizational records	
	LHP Program history: re diversity and multicultural targets	
	Budget allocated to these issues/targets	
	- Survey data previous collected about programs - List of names and other relevant items	
3. Interviews (face-to- face) <i>Entry-level data</i>	Managers and service providers - Managers - Coordinators - Programming Staff - Nurses - Lay health workers (paid and volunteers) - Clients receiving services - Staff survey (Managers and workers).	Some interviews & development of a check list will be conducted as pilots;
4. Direct	Field visits to case study sites;	Development and

Observation <i>Entry-level data</i>	• Researcher's log to be used with the starting of data collection;	testing of researchers' log and protocol. Observation protocol for home visits and the training sessions and supervisory meetings.
	• Meetings of managers	
	• Meetings of lay health workers' 'supervisors';	
	• Regular meetings between supervisors and lay health workers;	
	• Training meetings for Lay health workers	
	• Volunteer work for the research site	
5. Participant Observation of 'daily talk' practices of :CHW/LHW, supervisors and managers. <i>Entry- level data</i>	• Records and perceptions of researcher's (diary, and debriefs of meetings with thesis committee);	Write down observations
	• Meetings with sites coordinators to review logistics of data collection;	
	• Training sessions of lay health workers	
	• Educational sessions given by lay health workers to clients ;	
	• Home-visits conducted by lay health workers	
6. Physical artifacts Entry –level data	• Observation of the sites;	No photographs
	• Materials, posters in reception	
	• Language use	

Copyright compliance

Permission to use Figures

The Multicultural Health Brokers Co-operative authorizes Sara Torres to use figures # 5 and # 8 in her PhD thesis entitled *Uncovering the role of Community Health Worker/Lay Health Worker Programs in addressing health equity for immigrant and refugee women in Canada: An instrumental and embedded qualitative case study*.

Figure 5. Empowerment Holosphere, dimensions of the multicultural health brokering practice. Source: MCHB CO-op 2008a.

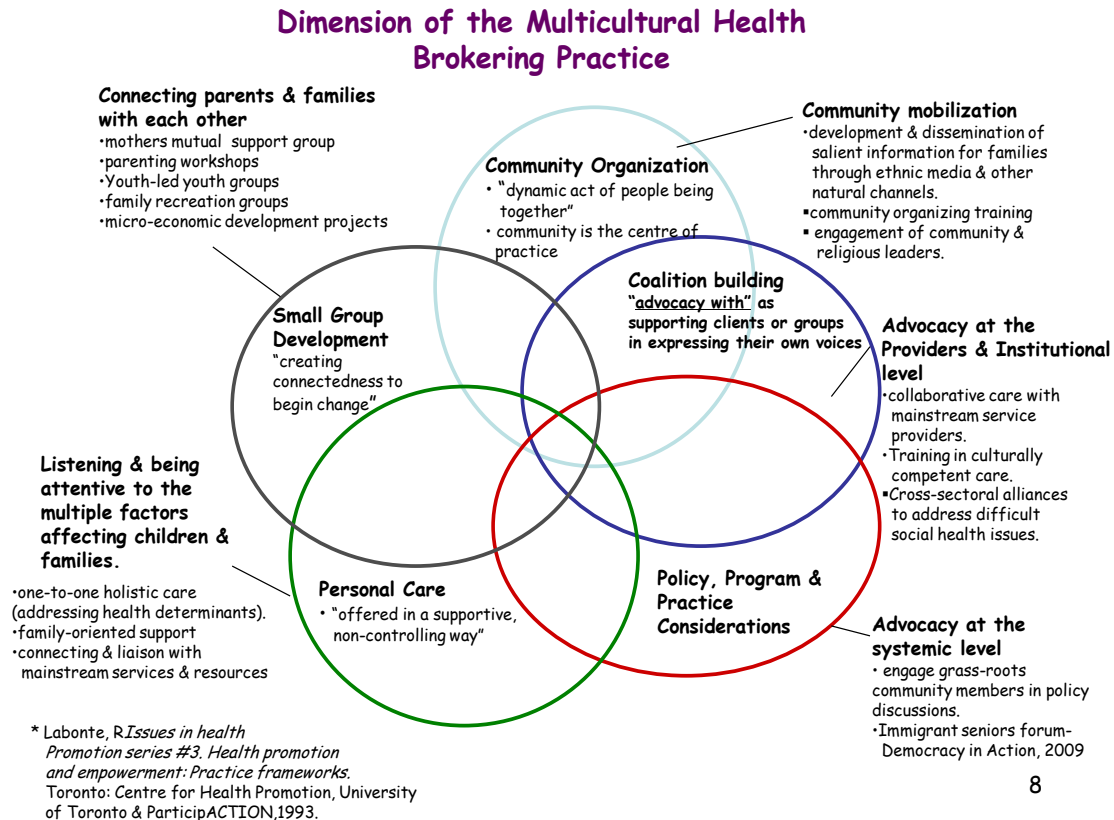
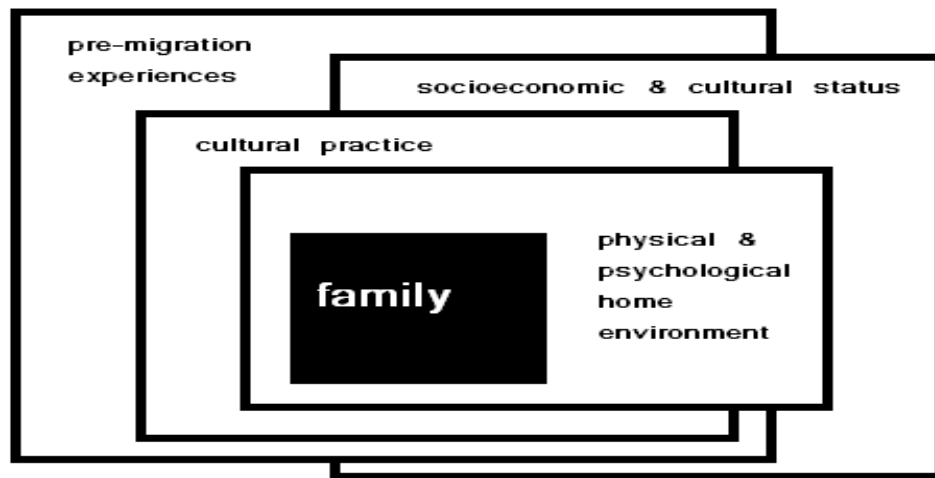


Figure 5: MCHB Co-op. (2008a). The Multicultural Health Brokering Practice: Power point presentation Multicultural Health Brokers Co-operative (MCHB Co-op).

Figure 8: The many layers affecting immigrant and refugee families. Source: MCHB Co-op, 2009f, p. 1.



MCHB Co-op. (2009f). *Responding to Cultural Diversity: Edmonton and Area Children Services & Multicultural Health Brokers Co-op.* (Report from February 2008 to April 2009). Edmonton: Multicultural Health Brokers Co-operative (MCHB Co-op).