

COMMUNITY-BASED SERVICES ADDRESSING THE PRIMARY HEALTH CARE
NEEDS OF RECENT IMMIGRANT CHILDREN

HOW COMMUNITY-BASED SERVICES WORK TOGETHER TO ADDRESS THE
PRIMARY HEALTH CARE NEEDS OF RECENT IMMIGRANT CHILDREN

By

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ABSTRACT

Introduction

Canadian health and social service systems need to adapt to new challenges posed by the unique primary health care (PHC) needs of recent immigrant families. Community-based service providers are the first to experience changing responsibilities. Providers in communities with limited experience in working with immigrants may benefit from shared skills and modeled cultural competencies when working with new arrivals.

Purpose

This case study describes how a set of community-based service organizations addressed the PHC needs of recent immigrant families with young children living within a mid-sized urban centre in Atlantic Canada. The roles of organizational brokers and of *competence trust* among service providers were examined to determine their influence on the capacities of the service network overall.

Methods

Methods from social network analysis and descriptive qualitative inquiry were applied in this study. Organizational ecology constructs framed the research questions and propositions. An intersectoral approach to PHC was adopted to define the services network. Results derived from the network survey and key informant interviews were triangulated to develop a final interpretation.

Results

The study network constituted a relatively cohesive group of service providers. Network participation became more selective depending on the issue experienced by families. Network interactions were facilitated by broker organizations; some brokers actively engaged in the development of cultural competency capacities among network members. Trust in the other provider organization's cultural competencies (*competence trust*) with recent immigrant families positively influenced the quality of working relationships.

Conclusions

Broker organizations can play a significant role in network capacity development through the promotion of cultural competencies in partnering organizations and by making connections across service sectors. The cultural competence of partnering organizations is an important pre-condition of trust for service providers committed to the needs of recent immigrant families. Having trusting relationships among providers can facilitate exchange and enable access to services. Nurses have the potential to participate in the advancement of culturally competent service systems.

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There are so many to acknowledge and thank for their support, encouragement and mentorship along this journey. I have those who I've worked with over years within public health, who have been both friends and colleagues, stimulating my thinking, demonstrating for me the value of being slightly 'off centre' in order to challenge assumptions – to see what's been missed. Friends in the ecohealth research arena but also within the employ of the Public Health Agency of Canada have been part of this. I think of – Lisa, Paul, Victoria, Pia, Margaret, David, Dominique, Jamie and many others. Courage to try new things while staying grounded in the reality of how things work for people and communities, has always come from my education and experiences in public health nursing. Nurses who have mentored me – Donna my very first public health nursing manager; Jane, my director and then friend-mentor over many years; and Ruta my steadfast, inspiring thesis supervisor– are a strong part of who I am professionally today.

I have been privileged with a dynamic, creative and overwhelmingly supportive thesis advisory committee. Drs. Bruce Newbold, Margaret Black, Jan Sargeant and most especially, Dr. Ruta Valaitis, have all been there to see me through the saga as a graduate student. I have learnt so much from all of them, but most of all, what it means to be committed to those we nurture in their learning and growth. I am a mature, older woman. It has been a delight to know others will still take seriously my aspirations as a life long learner with that much more to offer within a professional world.

Family and friends have been my rock. Personal challenges have always been there – recovery from health challenges, watching and parenting two teenagers as they bloomed into young adults, and then all those other responsibilities that come with a career in motion while still holding steady on all that can happen on the home front. Rachel and Owen, my two children, must wonder where I’ve been. To the two of you, I most sincerely offer you my thanks and love for the patience you have had with me, and for the privilege it’s been in witnessing who you’ve become. I am immensely proud.

I must thank my employer, the Public Health Agency of Canada, and more directly my work colleagues and managers for all the accommodations made to allow me to pursue graduate studies and complete this work. It was my honor to have received research funding through the Dorothy C. Hall Primary Health Care Nursing Chair, School of Nursing, McMaster University.

Finally, I would like thank all those within Nova Scotia who supported this research – those who participated in the study, but also the many local supporters and colleagues who offered their advise and then their connections, navigating me through the complexity of their health system, my having come from ‘away’. Eastern Canada has always been a magical place for me. The good people of Nova Scotia showed me a conscientious society proud of their heritage, with an attitude of pragmatism when going forward to meet the challenges of life and work. I hope this dissertation will provide some insights into their true strength as a people with heart and compassion, ready to be tapped into as communities shift and the faces of Canadians change.

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Preface

This sandwich thesis includes three manuscripts intended for publication in a peer reviewed journal. Chapter 2 represents a manuscript prepared for future submission. Chapters 3 and 4 have been submitted as manuscripts, each to a different journal, with the reviewers' response pending. The listing of authors is based on the valuable feedback and advice received from all members of my thesis committee. Dr. Ruta Valaitis, as my thesis supervisor, offered a critical appraisal of my approach to qualitative analysis and a review of early coding to ensure rigor during this process. Throughout the study, all committee members were instrumental in offering guidance on study design, recruitment, implementation and analysis and then writing the manuscript.

My contributions to the research are as follows. Conception of the case study and its design were my own, and was based on my interest in understanding how Canadian society, including its institutions, is adapting to a changing population and culture. The use of social network analysis to explore an organizational system was an idea introduced to me by my thesis supervisor, Ruta Valaitis. I sought out opportunities to learn this methodology through self study, attending workshops and conferences, and through expert consultation. Knowledge of qualitative methods was acquired through courses and mentorship, again, from my thesis supervisor.

I committed to the implementation of the study, and was solely responsible for the recruitment of participants, and for conducting all key informant interviews. Recorded interviews were transcribed by a professional transcriber. I committed to coding all transcripts using Nvivo 8. I conducted all the analysis of qualitative data.

The survey instrument design was my own, based on the experiences of other network researchers as shared in the literature. Colleagues offered their advice and also assisted in testing the instrument and survey website. I took responsibility for all data collection and cleaning, and conducted all the analysis of the survey data using UCINET software.

I prepared the original research protocol for ethics approval, and was aided by a research assistant in processing a series of documents in order to receive approvals from four different ethics review boards – McMaster Health Sciences, Health Canada (my employer) and two ethics review boards in Halifax - Capital District Health Authority and the IWK Hospital.

I wrote all manuscripts in this thesis. All manuscripts were reviewed by my committee members – Drs. Ruta Valaitis, Margaret Black, Bruce Newbold and Jan Sargeant – who offered comment to a series of drafts that resulted in this final submitted version.

CHAPTER 1

INTRODUCTION: A CASE STUDY DESCRIBING HOW COMMUNITY-BASED
SERVICES WORK TOGETHER TO ADDRESS THE PRIMARY HEALTH CARE
NEEDS OF RECENT IMMIGRANT CHILDREN

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Problem Statement

Health promotion and illness prevention are salient goals of primary health care (PHC), and act as the cornerstones for the work performed by many nurses and other health care providers in Canada working in both primary care (PC) and public health (PH) settings (Stevenson Rowan, Hogg & Huston, 2007). From a determinants of health perspective, however, and in keeping with the PHC principle of inter-sectoral collaboration, communities need to employ more than just designated health services in order to meet the goals of PHC; social services, non-government organizations (NGOs), schools, social and environmental planners, employers, families and neighbourhoods can all contribute (World Health Organization (WHO), 2008). And quite rightly, researchers have become more inclusive of different forms of community resources when examining and defining health care delivery systems (Huerta, Casebeer & Vanderplaat, 2006; Kwait, Valente & Celentano, 2001; Provan, Veazie, Staten & Teufel-Shone, 2005; Rier & Indyk, 2006).

The effectiveness and success of systems-based mechanisms for delivering PHC depend upon access to needed services for all segments of the population. Newcomers to Canada can present a particular challenge. For example, many recent immigrants from developing parts of the world constitute an at-risk group with unique infectious disease exposures and pre-disposing health risks (Hyman, 2001; Hyman & Guruge 2002).

Further, the literature reports many factors that limit newcomers from seeking or obtaining assistance from Canadian health care and public health systems (Anderson, 1987; Hilfinger-Messias, 2002; Ma, 2000; Xu, Sun, Zhang & Xu, 2001). These factors can include language and cultural barriers, but also mistrust or perceived personal risk when involving official agencies or other forms of authority. Places of settlement can also have impact. Municipalities with established immigrant populations may be better resourced to assist new arrivals (Pitkin Derose, Escarce & Lurie, 2007). However, immigrants to rural regions or to second or third tier communities in Canada, (communities outside of the large urban centres of Vancouver, Montreal or Toronto), may find themselves particularly isolated and consequently further marginalized from existing health enabling supports.

PHC is defined as:

the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process. Primary health care has been used to describe both a philosophical approach to care delivery and to differentiate the types of health services delivered. It can encompass various social institutions, different sets of scientific and professional disciplines and technologies and different forms of practice. (Alma Ata Declaration, 1978, cited in Pan American Health Organization [PAHO], 2007, p. 4)

PAHO's PHC renewal document states: "A renewed approach to PHC is viewed as an essential condition for meeting the commitments of internationally agreed-upon development goals, including those contained in the United Nations Millennium Declaration addressing the social determinants of health and achieving the highest attainable level of health by everyone" (PAHO, 2007, p. iii.). As well, one of the main

messages expressed is the concept of a PHC-based health system: “Such a system is guided by PHC principles of responsiveness to people’s health needs, quality orientation, government accountability, social justice, sustainability, participation and intersectoriality” (p. iii).

To this end and for purposes of this study, *PHC needs* are the health, health risk and illness experiences of individuals and families living in their communities that at times require a connection to a system of services and interventions in order to optimize their health. Interventions include health promotion, illness prevention, or diagnostic and treatment services.

This case study has three objectives. I will explore a) how community-based services within Halifax, a mid-sized urban centre in Atlantic, Canada collectively address the PHC needs of recent immigrant children; b) how PC and PH services and practitioners participate in the broader network of local services available to immigrants and their children; and, c) how participation and collaboration among services can affect access and responsiveness to the health concerns experienced by this population. These three objectives will be addressed using child growth and development and nutrition and diarrheal diseases among the children of recent immigrants as exemplar health concerns. For this study, recent immigrant children are inclusive of children newborn to 6 years old born within or outside of Canada, but whose parents are recent immigrants, having arrived in Canada within the last 5 years. As sensitizing concepts, cultural competency and its relationship to trust and collaboration among organizations will be highlighted for the case.

Background

The following short history of Halifax provides some context for what now exists in this part of Canada where the research for this dissertation was conducted. Halifax has a long history of involvement with immigration to Canada. The early European settlers to Nova Scotia during the 1600's were comprised largely of French, British and Scottish immigrants, followed by a second wave in the 1800's of Scottish and Irish settlers. The province has a formative history of change and upheaval as wars in Europe and North America impacted the population structures of the day. The late 1700's brought to Nova Scotia the Black loyalist settlers - a direct result of the American Revolution. Different populations have been displaced over time – First Nations people, the French Acadians—while others have stayed. In the 1900s, Pier 21 was the first port of entry for many Europeans entering Canada, although many continued to move west to Quebec, Ontario, and the prairies. Today, Nova Scotia's population consists largely of British and Celtic descendants, but with a prominent indigenous Black community that has been in existence for the past 400 years. The Micmac First Nations tribe represents Nova Scotia's oldest settlement community (Beck, 2008).

Immigration to Nova Scotia has been on the increase over the last few years, presenting a very different profile of newcomers than experienced in earlier history (Nova Scotia Office of Immigration, 2007). Between 2005 and 2006, the number of immigrants increased by as much as 34%. The large majority of immigrants entering Nova Scotia are generally destined for Halifax (62.6 % or 5,288 of 8,450 between 2002 and 2006). As in the rest of Canada, new immigrants today are more likely to arrive in Nova Scotia from

many different parts of the world. In 2006, over 65% of immigrants were from Asia, the Middle East, Africa and the Pacific region. Central and South America represent another 5% of new immigrants. A large proportion (33.4%) of immigrants to Nova Scotia, many from Korea and Iran, arrived through the provincial nominee program, a program which allows provinces and territories to nominate individuals who apply and who meet the local government's required skill, education and work experience (Citizenship and Immigration Canada, 2008). Refugees represented 8.4% of new immigrants in 2006, most coming from Afghanistan, the Sudan and Liberia. Although small in number (217 in 2006), refugees are known to present with extreme need - health and social services are often over-taxed and under resourced to address these needs even in the larger Canadian cities (A. Zanczer, Access Alliance, Toronto, & M. Morris, Bridge Clinic, Vancouver, 2007, personal communications). The numbers presented here do not account for the increasing trends in the use of temporary immigrants to address labour market shortfalls (Hennebry, 2007), or for the class of non-status immigrants who are difficult to enumerate but who may also be marginalized from receiving needed PHC services (Kullgren, 2003; Okie, 2007; Perilla, Wilson, Wold, & Spencer, 1998).

There is an acknowledged trend for recent immigrants arriving in Halifax as a first point of entry to then move onto one of the larger centres – Toronto, Montreal or Vancouver - where the benefits of a large, supportive immigrant community can be obtained (Public Health Agency of Canada, Atlantic Regional Office, 2008, personal communication). Still, some will stay in Halifax, even if only for short periods. Immigrants living in locations of low immigrant density are more likely to rely on generic

services, health and social service agencies for example, rather than services that can address the specific needs of this population (Pitkin Derose et al., 2007). In other words, generic services and service providers, in meeting the demands and needs of the predominant population, may not always be attuned to the health concerns of immigrants and the processes of immigration (Asanin & Wilson, 2008; Casey, Blewett, & Call, 2004), and/or may be ill-prepared to work with diverse groups through lack of exposure, training and/or experience (Burcham, 2002; Campinha-Bacote, 2003). Auxiliary resources needed to support care such as interpreters and cultural brokers may be in short supply or non-existent.

Cultural competence is a set of “congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enables the system or professionals to work effectively in cross-cultural situations” (Cross, Bazron, Dennis & Isaacs, 1989). Competencies required in working with new immigrants, characterize not just the health care provider but, more broadly, the health care organization and system within which services are delivered. Pyles and Kim (2006) cite Hyde (2004) in their discussion of barriers to culturally competent practices. “In [Hyde’s] qualitative study of agencies... the major barrier to such challenging work is what she terms the ‘socio-political environment’. This barrier includes not only the larger societal, political and economic forces but also other systems and agencies with which a particular agency interacts” (p.223). Characteristics of culturally competent systems and organizations include policies, programs, staff training and modes of service delivery that can be adapted to the needs of diverse populations (Campinha-Bacote, 2002; Chrisman, 2007).

Access and responsiveness to the unique health needs of immigrant groups and in a manner that is acceptable and respectful of cultural values and preferences, become demonstrations of cultural competence.

Literature Review

Collaboration, Cultural Competency and Trust

PHC needs are often addressed under different service models directed at population health, health promotion or disease /illness prevention and treatment (Stevenson Rowan et al., 2007). Although PHC services may be organized and ‘specialized’ under these groupings, in practice, these are not mutually exclusive constructs. For example, targeted populations will experience illness, health promoting behaviours may enhance resistance to infectious diseases, and people in illness recovery may become part of a health promotion program, and so on. In keeping with our knowledge of the complex nature of health and of health determinants (World Health Organization, Alma Ata, 1978), and of how health needs are addressed (Green, Fryer, Yawn, Lanier & Dvey, 2001), more and more emphasis is being placed on inter-sectoral collaborations to address health needs. This includes not just the health sector, but other types of service agencies intended to meet the diverse needs of a community (Huerta et al., 2006; Kwait et al., 2001). Indeed, collaborative service delivery systems are promoted as mechanisms for improved service effectiveness over all (Browne, Kingston, Grdisa & Markle-Reid, 2007).

How a system of services interacts, however, can vary given different organizational forms as well as variability in the socio-political environment (Ivery, 2007;

Sofaer & Myrtle, 1991). Researchers are currently debating what constitutes effective collaboration, often measured by proxy through the activities of exchange experienced between and among organizations, (Provan, Milward & Isett, 2002; Provan, et al., 2005). Tanjasiri, Tran, Palmer & Valente (2007) demonstrate that, counter to their original expectations, a decrease in the number of interconnections among organizations, the inter-organizational cohesiveness, actually occurred over time in an otherwise functional group of organizations addressing cancer prevention. Valente, Chow & Pentz (2007) found that a decrease in the cohesiveness of a coalition network increased the adoption of evidence-based practices in public health; they argue that a level of cohesiveness is important for network effectiveness but that less dense networks may have weak ties to other organizations and resources for improving practice. Others suggest that adaptation to new situations may, for example, be limited by a strongly cohesive network that blocks innovation (Lin, 2001). Provan and Milward (1995), in their earlier work looking at inter-organizational effectiveness in four community mental health systems, did not find an association between network cohesion and the quality of performance. Clearly other factors may need to be considered when trying to understand how service organizations collectively address client needs. A truly effective services network may indeed be erroneously ascribed when simply counting the frequency of information exchange and referral among a contained group of services.

Several researchers have identified trust among organizations as one of several indicators and facilitators of inter-organizational collaboration (D'Amour, Ferrada-Videla, San Martin-Rodriguez, & Beaulieu, 2005; D'Amour, Goulet, Labadie, San-

Martín-Rodríguez & Pineault, 2008; Ivery, 2007; Martin-Misener, Valaitis et al., 2009; Ryan-Nicholls & Haggarty, 2007; San Martín-Rodríguez, Beaulieu, D'Amour, & Ferrada-Videla, M. 2005; Shi & Collins, 2007). Client referrals and communications among service organizations for example are considered collaborative activities (Provan, Veazie, Teufel-Shone & Huddleston, 2004), but with whom an organization collaborates will depend on several factors – among them, confidence and trust in the competency and accountability of the other agency (D'Amour et al., 2005; Shipilov, Rowley & Aharonson 2006). Pyles and Kim (2006) argue that cultural competency at the interpersonal/provider, organization and systems levels are all required in order to best serve the needs of recent immigrants. Others support the need to address cultural competency at these different levels or scales (Chrisman, 2007; Davis-Murdoch, 2005). Given this, and based on D'Amour's and others' recognition of how competence and accountability affect trust relationships, can we also extrapolate that perceived cultural competence in the other organization is a prerequisite for organizations to form trust with one another and then collaborate when dealing with the needs of vulnerable immigrant populations?

On a different but related approach to this, will clients themselves not feel the need to make judgements about the partnerships formed between agencies given their own feelings of trust or distrust toward one or the other of the partners? “Anyone who enjoys his or her collaborative relationship with an ‘outsider’ can become suspect. Indeed, people who do this often or long can get treated as traitors – ‘the enemy’” (Smith, 1998 citing Mintzberg et al., 1996, p. 134). The literature already identifies public health, a government institution with regulatory authority particularly as this applies to the

management of infectious disease spread (TB, HIV/AIDS, foodborne diseases), as services that are avoided by immigrants. This may be because of earlier negative experiences with authority before leaving their countries of origin (Anderson, 1987; Hilfinger-Messias, 2002; Ma, 2000). Indeed, it could very well be the case that an agency distancing itself from partners less trusted by community members may in fact be perceived by the agency as a way of promoting access!

As another point to consider, nurses have been identified as one of the most trusted of professional groups (Iacono, 2007; Queen's Courier, 2009). Seen as part of a caring profession offering respect and compassion for the individual patient (Meleis, 1997), nurses are perhaps well placed as contributors toward the overall 'makeup' of an organization's competency profile. Still, the cultural competency of individual practitioners is often seen as a specialized set of skills and aptitudes, and as a process with degrees of cultural competency acquired through training, practice and exposure as well as a desire to be competent (Campinha-Bacote, 2002, 2003). Opportunities for developing cultural competency are quite often contextual, perhaps political (Chrisman, 2007; Pyles & Kim, 2006). In communities with highly diverse populations – Toronto and Vancouver for example – developing cultural awareness and competencies through exposure may be an everyday experience – on the job and off. In less diverse communities, the need for training may not be recognized, yet the need, even greater given the lack of opportunity to develop cultural competency within other societal venues.

In considering the cultural competency of an organization or network of organizations toward recent immigrants, one needs to recognize that a system is more than the sum of its parts. Inter and intra-organizational processes and attributes need to be considered (Pyles & Kim, 2006). Policies and programs that support cultural competency practices within an organization, sensitivities within the network and the broader socio-political environment for addressing immigrant needs, practitioner development in competencies – might not all of these have interactional effects that are mutually impactful? In every respect, commitments to ensuring a service delivery system that is receptive and responsive to the needs of new immigrants requires a multi-scaled approach – from the individual practitioner to the broader services system - that recognizes this dynamic process.

‘Trust’ as a precursor and condition of collaboration, needs also to be considered as part of this complexity (D’Amour et al., 2008). However, the concept of inter-organizational trust itself needs clarity. The treatment of inter-organizational trust has been inconsistent in previous research with differences in theoretical definitions, uses of different dimensions or indicators in measuring trust, the lack of standardized tools and approaches, and the lack of consistency in distinguishing between trust among and toward individuals representing different organizations, and trust among and toward the organizations themselves (Seppänen, Blomqvist & Sundqvist, 2007). For example, Mayer, Davis and Schoorman (1995), although they speak to organizational trust, focus their discussion around the interpersonal trust relationships that exist among members of an organization. As a human trait, they describe trust as a willingness to be vulnerable, to

take a risk with another. The trustworthiness of the other in their model requires three things - perceived ability, benevolence and integrity. What is interesting is how they distinguish between trust and confidence. Confidence requires more certainty in the outcome and is much less about risk taking than trust, in their view.

Seppänen et al. (2007) in their review of the literature on inter-organizational trust included only empirical research dealing with trust between or toward private sector organizations, although some papers also consider inter-personal trust. Although only 15 articles were eventually referenced, the antecedents of trust between or toward organizations were multiple and diverse: “credibility, benevolence, confidence, reliability, integrity, honesty, institutionalization, habitualization, ability, dependability, responsibility, likeability, judgement, goodwill trust, contract trust, *competence trust*, fairness, reciprocity, togetherness, predictability, openness, and frankness” (p. 255). The most common traits of *trustworthiness* were reliability and credibility/competence although there was no consensus on the meaning of terms.

We may need to accept the fact that trust remains an ambiguous term operating on different levels, and that its meaning may be highly contextual (Mayer et al., 1995). Still, it may be reasonable to assume that trust within a services network is influenced by the trustworthiness of the individuals with whom one comes into contact, as much as by the trustworthiness of the ‘persona’ of the service organizations overall (Sengir et al., 2004). Indeed, collective activities among organizations may go forward despite the lack of clearly established ties, when informal relationships, based on mutual trust, are a means of addressing a common interest (Bailey & Koney, 1996).

From this scan of the literature, many of the ‘ingredients’ that support collaborative relationships –the interpersonal, the agency and the systemic - could also contribute to a culturally competent system (Allensworth-Davies et al., 2007; Davis-Murdoch, 2005; San Martín-Rodríguez et al., 2005). For example, there could be a funding stream that supports translation services for multiple agencies, or a set of shared values and principles that nurture, systemically, equitable access for recent immigrants and other vulnerable groups. And, of particular importance to this dissertation, systemic cultural competency as a collaborative venture may indeed require trust.

Despite the ambiguity surrounding the term, a measurable definition of trust was needed in order to go forward with this research. Given that competence is an important construct for this dissertation, the concept of *competence trust* will be used, defined as a belief in the other’s ability to do the job or complete a task. Being trustworthy, in this sense, is synonymous with one’s “capabilities” (Black, 2007; Norman, 2002; Wakabayashi, 2003). For service systems working with immigrant families, this will likely have much to do with cultural competence. In the context of this research, *competence trust* is in reference to one’s belief and confidence in the other’s cultural competence.

The Primary Health Care Needs of Recent Immigrant Children

In developing a testing ground upon which to explore systemic competencies and collective approaches for delivering PHC services to new immigrants, I have chosen to focus on recent immigrant families with children under 6 years of age. There are several reasons for this. In our society, and perhaps in others, the primary health concerns of

children are more likely to come to the attention of health care systems (Binns et al., 2007; Truman & Reutter, 2002). This has much to do with the advocacy roles played by parents, and the help seeking behaviours of parents in general when children of a young age are faced with illness (Karwowska, Nijssen-Jordon, Johnson & Davis, 2002; Lipson, Weinstein, Gladstone & Sarnoff, 2003). On the other hand, adults may allow their own illness experiences to self-resolve unless symptoms become persistent (Green et al., 2001). Thus, for recent immigrants, the perceived benefits for their children may override parents' otherwise cautionary approach toward seeking professional services, despite barriers such as cost (i.e. for non-status or recent immigrants without health insurance, or others not understanding how to access), language difficulties, or experiences of racism (Byrne, 2008; Leduc & Proulx, 2004.)

As far as the PHC needs of young immigrant children go, we have an array of primary health concerns – growth and development, nutrition, dental hygiene, speech and language, immunization and vaccine preventable diseases, and childhood exposures to communicable diseases such as ear, nose and throat infections, respiratory and diarrheal/gastro-intestinal infections that are often acquired through daycares and other gatherings. These are largely covered at some level within the standards of practice for both PH and PC services (Stevenson Rowan et al., 2007). A distinction, however, needs to be made when dealing with the health needs of immigrant children – the emphasis of practice may need to shift given the differences in the life course histories of both the parents and their children. Childhood coverage for vaccine preventable diseases, for example, varies by countries of origin and may therefore differ by immigrant status or

experience (Guttmann et al., 2008). Selected racial and/or cultural groups may experience very specific health concerns (Ali, McDermott & Gravel, 2004; Hyman, 2001). Family and social ties with others still living overseas are likely to mean continuing contact for children as they accompany parents to visit relatives and friends in their home country. This means, of course, different cultural and environmental exposures not experienced in Canada that can impact the health of visiting children (Gushulak & MacPherson, 2004). Yet again, the cultural practices of immigrants with respect to the health and wellbeing of their children may differ from the mainstream culture (Yearwood, 2007).

PHC services within Canada are faced with the challenge of how to adapt to these new circumstances. This is further complicated by a condition of the immigration experience given the frequent lack of familiarity with the North American culture around health and of how to access services (Leduc & Proulx, 2004), and consequently a stronger need for advocacy and outreach in order to facilitate service access (Fowler, 1998; Isaacs, 2010; McElmurry, Park & Buseh, 2003). Advocacy groups and services, therefore, become a strong component of the primary health care system for recent immigrants and their children.

Testing the System: Exemplars of Primary Health Care Needs among Recent Immigrant Children

In order to grasp the breadth of the PHC service system for immigrants, we need to define exemplars of primary health care needs that are recognizable to a broad range of services and service providers. Two primary health care concerns for immigrant children

were selected for this purpose: diarrheal diseases and child nutrition. Child growth and development as a broad construct that is traditionally addressed within Canada by a range of community-based service sectors (Butler-Jones, 2009) was also introduced into this research.

Under-resourced regions with poor public health infrastructures as they exist within the continents of South and Central America, Africa and Asia, have exceedingly high rates of gastro-intestinal and parasitic diseases (Caruana, Kelly, Ngeow, Ryan, Bennett et al., 2006; Geltman, Radin, Zhang, Cochran & Meyers, 2001; Stillwaggon, 2005). Intestinal parasites are one of the more frequent infectious disease concerns among immigrants arriving from these regions (Adair & Nwaneri, 1999; White & Atmar, 2002; Winsberg, Sonnenschein, Dyer, Schnadig & Bonilla, 1975). The prevalence of intestinal parasites among immigrant children from Sub-Saharan Africa, for example, is reported to be as high as 49%; 20% of cases have been found to be asymptomatic (Huerga & Lopez-Velez, 2002). In Peru, 48% of children are estimated to have parasitic infections, while 36% of cases are asymptomatic (Carrasco, 2008). In an Israeli study, 80% of immigrants from Ethiopia had at least one helminthic (worm) parasite while 40% had two (Bentwich et al., 1999 cited in Stillwaggon, 2005). Other examples can be found of parasitic diseases experienced by immigrants from parts of Asia. For instance Vietnamese infants arriving in the US in the 1970's were found to be infected with *Giardia lamblia*, *Ascaris lumbricoides* and *Entamoeba histolytica*. In another group from Thailand, 79.3% of male and 94.7% of female workers had parasitic infections, most commonly hookworm and *Opisthorchis* species (Avery, 2001).

As noted, parasitic infections among immigrant children are not always recognized. Although most are easily treated once detected, some infections may persist for years without detection. Indeed, some infectious states may be life threatening (Caruana et al., 2006) while, chronic conditions can lead to malnutrition, and/or micro-depletion of essential nutrients (Stillwaggon, 2005). Local health care practitioners within Canada may not be familiar with the differential diagnostics for parasitic diseases, particularly given the difficulties with laboratory diagnostics (Boggild, Yohanna, Keystone & Kain, 2006). Yet for developing countries, the impact of parasitic and other diarrheal diseases on the nutritional status and development of children is well recognized (Geltman et al., 2001; Stillwaggon, 2005). Most examples of parasitic infection are of immigrant children born outside of Canada rather than those born in Canada to recent immigrants. Still the potential for travel with parents to countries with poor public health infra-structures can create a situation of continuous exposure to diarrheal causing agents.

Various other factors may impact the nutritional status of immigrant children. Lack of familiarity with local foods, the cost of food, and the lack of available traditional foods may decrease family access to nutritional choices. Social stigmatization because of different food smells and appearances may cause older immigrant children to reject nutritiously prepared ethnic foods, who then turn to fast foods that are readily available and more accepted by peers (Health Canada, 2007). As a cyclical concern, poor nutritional status can increase childhood susceptibility to infectious diseases, including gastrointestinal infections (Stillwaggon, 2005).

The above rationalizes, in brief, the importance of these two related issues - child nutrition and diarrheal / parasitic disease, along with child growth and development in general - as exemplars of immigrant health concerns requiring PHC interventions. By choosing exemplars that are likely to engage different service types – child growth and development, nutrition and diarrheal disease - we have an opportunity to explore the dynamics of a service system comprised of member organizations with weak or strong ties to one another, but with connections determined by a shared client community. The system's challenge becomes one of adaptability and systems competency within a broad service sector with potentially limited or fragmented experience in dealing with the PHC needs specific to immigrant groups.

The Researcher

I hold experiences as a public health nurse and manager, originally practicing at the community level for a number of years, and then, for the past decade, as an infectious disease epidemiologist working for the Canadian federal government at the national level. Nine months were spent working within the Health Protection and Promotion Branch of the Province of Nova Scotia while collecting data for this research. My motivations behind the proposed research come from very impactful experiences both as a professional and as a services recipient during formative periods of my life. Table 1 contains excerpts from a personal journal that I hope will demonstrate some legitimacy for doing this work, as much as to demonstrate the biases I have that will inevitably arise, first in the questions posed, and then as the research itself unfolds.

Table 1: Journal Excerpts

...Our gang responded to foodborne outbreaks. I was trained as a nurse, and then as an epidemiologist, even took the federal field epidemiologist internship. So I pretty much qualified for the job. The name of the game was to 'coordinate'. Coordinate response, respecting all the players at the provincial and local levels so that each jurisdiction's role and accountabilities were secured and no one got worried about losing their jobs. Oops. . That was too direct. So that each jurisdiction took ownership, and could respond within the mandates of their respective organizations....it's quite a circus, taking a lot of skill at our end to keep the communication flowing and the information coordinated so that the big picture comes together built upon the many different pieces of the puzzle... We were having an impact in actually protecting the Canadian public. So it seemed. Kept the commitment up, made coming to work a positive experience. [We] developed trust, even love, among those of us pitted together in the trenches, working long hours into the night sometimes, trying to 'crack the case'....

.....

.... Someone forgot to add an age clause. Dave the twenty year old in our group, by power of official adulthood, had gathered the rest of us together to attend a particular meeting where decisions were being made about the governance of our day-camp. The then president of the [Park tenant's] association was a rather large woman, not so bright, liking her spot light, and glowing from the attention she was getting from the suits – mostly men from [established community service organizations] attending the meeting to offer their services in overseeing the camp. We didn't want that.... There was talk about how the camp had given us kids a sense of pride and accomplishment. How this needed to be preserved through a stronger, formalized structure. Why then would these guys need to take it over... take it from us. I raised my hand. "Shouldn't we be allowed to run the camp? Isn't it our camp?" I remember a look of bafflement, as if such a small understated 15 year old could have said something so profoundly true, and until then ignored. No one seemed to have the words to respond. We voted. We had the numbers. We won.

.....

... So I became a public health nurse in the inner city of Hamilton. I had my case load and was proud of the number of people I could see in a day, and how I was able to keep up our team's 'statistics'. But it wasn't long before it occurred to me that I kept going back to the same set of people, my case load, and for those most needy, progress was either little or none. I felt helpless in many ways, even angry at myself for not 'making a difference' it seemed, at least not enough. And so many others not helped, listened to, or at least seen. Me as a young woman, not so dressed up (I knew better), but insecure in dealing with such huge problems. So I jumped ship – went back to school eventually to study epidemiology thinking I could at least learn more about the causes of what I was seeing and then maybe I or someone else, now more informed, could actually help things change. Two years later I did return to work in public health this time as a nurse manager for the mental health and HIV/AIDS teams, experienced management as a misfit, then backtracked again to work out much of my public health career as an epidemiologist. With years behind me, I am now revisiting the 'value' of what I had seen in that visit made to my home by a tiny public health nurse back in my teens.

Development of a Conceptual Framework

Using the original intentions of WHO's Alma Ata resolutions (WHO, 1978) PHC is inclusive of all services and resources that enable individuals and communities to reach their full potential. Designated PHC services, then, such as those delivered by PC and PH providers, are in most respects a sub-set of a broader system of services that collectively address the health and well-being of individuals, families and communities. Building from systems theory (Sills & Hall, 1977), we can begin to guide our analysis of how services respond to the arrival of new immigrants using theoretical concepts derived from organizational theory (Scott, 1961), and more specifically, *organizational ecology* (Freeman & Audia, 2006; Hurley & Kaluzny, 1987; Ivery, 2007). Some basic principles drawn from these latter authors and that apply to organizational ecology include:

- Organizations have a natural state of inertia that enables their survival.
- Organizational structures evolve with unpredicted environmental change.
- Organizations and populations (groups) are the basic units of analysis.
- Functioning is influenced by internal factors (staff, funding), environmental factors (political, economic), and organizational forms (goals, boundaries, activities).
- Environmental challenges and opportunities of one organization, affect other organizations in the community.
- Organizations that are compatible with environmental constraints (e.g. structures and priorities) are more likely to survive.

- Adaptive organizations may have a survival advantage in the face of new constraints (e.g. new policies / new service needs).
- In a competitive environment, strategies for survival include joining formal networks to increase organizational power.
- Organizations are loosely (with self-interest goals) or tightly (with collective goals) coupled within networks.
- Broker or linking organizations support the network by providing communication channels, general services, and by acting as model organizations. They can influence/control the activities of other organizations.

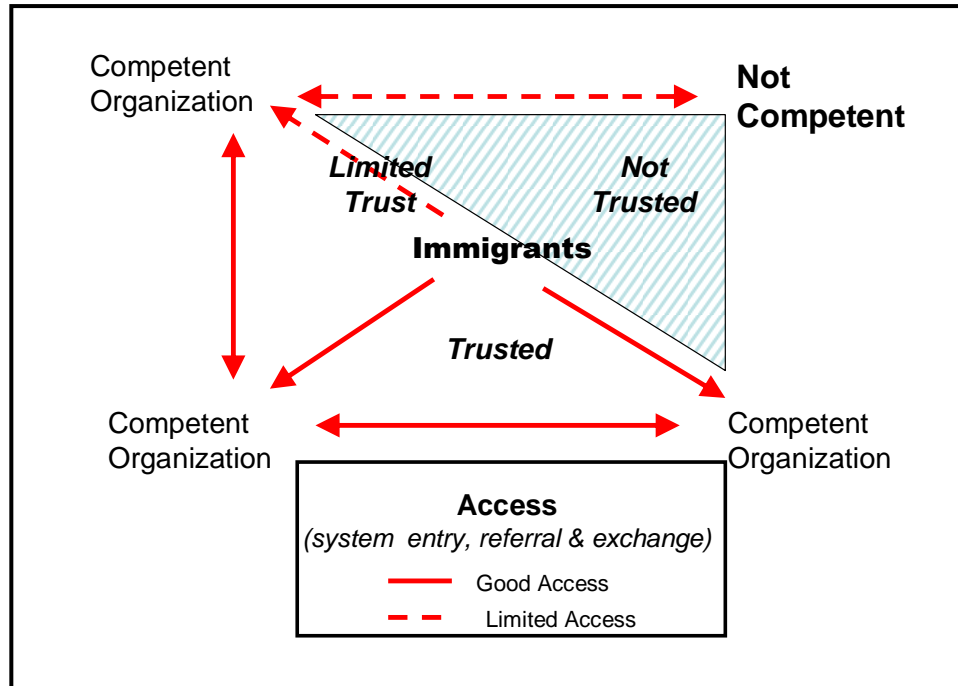
In the context of PHC delivery, as service needs change in response to new ‘constraints’ within the environment - in this case, the arrival of new immigrants with different health experiences and needs - organizations will be challenged to adapt, and consequently adjustments within the network overall need to be expected and prepared for. Change is resisted by the inertia of the dominant organizational structures, already in strong positions of survival (Hurley & Kaluzny, 1987). Champions for addressing new challenges may be needed as internal influences within service organizations and service networks (Bhimani & Acorn, 1998; Bailey & Koney, 1996). Finally, as a fundamental construct of this dissertation, opportunities for improved inter-sectoral collaboration, that is relationships that are strategically formed across sectors, can create assets (social capital) in helping organizations survive (or deal with) these new constraints (Lin, 2001; Shipilov et al., 2006).

Variations of an ecological framework have been promoted by different researchers and theorists interested in the network dynamics of health and social service delivery systems (Browne et al., 2007; D'Amour et al., 2008; Ivery, 2007; Provan & Milward, 1995; Huerta et al., 2006). Key concepts tend to be the interdependencies of organizations, the contextual (socio-political) influences on performance or outcomes, and the need to consider phenomena operating at different scales (e.g. interpersonal/individual, agency and systems). As discussed, adaptation of services to the needs of recent immigrants to be studied in this case may need to include the development of cultural competencies within and among services and service providers (Chrisman, 2007; Jeffreys, 2005). The more recent cultural competency literature goes beyond teaching individuals cultural competent practices, and toward more systemic approaches that support a services' environment of culture competency 'in progress' (Davis-Murdoch, 2005). We have, again, an ecological perspective, tackling an issue at multiple levels (Pyles & Kim, 2006).

Within an ecological framework, we have an opportunity to apply concepts of organizational ecology and its strategies for survival in combination with constructs of cultural competency to describe an organizational service delivery model that addresses the emerging needs of a changing population. In our case, for example, we would expect organizational survival to require relevancy toward the new clients being served. Further, we would add *competence trust* to the model as a linking variable, with trust in the other's cultural competency being the lubricant for forming and sustaining strategic partnerships with other services (Mayer et al., 1995 citing Gambetta, 1988). Figure 1

provides a beginning framework for demonstrating these relationships. While not diminishing other influences over collaboration (Bailey & Koney, 1996; D'Amour et al., 2008; Martin-Misener & Valaitis, 2008), trust, an interpersonal, relational variable in this model becomes our focus. Trust influences how recent immigrants respond to the formal services or organizational forms made available to them (Byrne, 2008; Chin, Kang, Kim, Martinez & Eckholdt, 2006; Leduc & Proulx, 2004). Organizations, sensitized to the fragility and tenuous nature of their own relationships with recent immigrants, may seek to protect these relationship 'assets' through careful selection of the partnerships they create – partnerships they can trust (Shipolov et al., 2006; Smith 1998).

Figure 1: How Services Access for Immigrants could be influenced by *Competence Trust among Service Providers**



**Competence Trust* is one's belief in the other's competence, a form of trust. In the diagram, trust refers to *Competence Trust*. Competence and competent refer to cultural competence and culturally competent.

The concepts of *competence trust* (trust as used in this dissertation) and cultural competency have been discussed in previous sections. The concept of access, simply stated, refers to the ability of consumers to secure needed services (Flett Consulting, 2004). For our purposes, this includes the ability of recent immigrant families to enter into the services system, but also how services facilitate access through referral and interaction with other organizations. In other words, it's not just about entering into the system, but more about getting to the services that are ultimately needed. This requires connections. And connections, in the proposed model, require trust.

The model presented in Figure 1, proposes that the presence of *competence trust* has much to do with the cultural competence of the organizations involved. Where there is cultural competence present in the organizations there is more likely to be a shared trust between organizations servicing recent immigrants, and toward organizations from recent immigrants. Where an organization lacks (or is perceived to lack) competence, relationships are less trusting or non-existent. Access itself follows trust – more trust is equated with more access. In Figure 1, access for immigrants (red lines), either through the first point of contact into the system, or through referral and interactions on behalf of clients, is depicted as 'good' (solid lines) when the organizations involved are culturally competent. Access to less competent services may be limited (dashed lines) and through referral from a competent organization or not at all, as immigrants, and competent organizations seeking to protect their immigrant clients, avoid these relationships. Also depicted is the limited access (and limited trust) immigrants have with culturally

competent organizations when the competent organization interacts with an organization that lacks cultural competence.

As stated, this is a beginning model that is expected to evolve with discovery along with refined definitions and explanations concerning the inter-relatedness of cultural competency and trust and then access to services. More concepts may be added as we explore other potential influences on the relationships that have formed among the organizations to be selected for this study. As demonstrated by D'Amour et al. (2008), there are multiple attributes operating at different scales within an organizational form (individual, agency, system) that can influence collaborative relationships.

Study Purpose

The purpose of this research is to contribute to our knowledge of how best to meet the PHC needs of recent immigrants. This will be considered from an ecological perspective that acknowledges the complexities of health needs and of how health services are delivered. Such a view point is consistent with the inter-sectoral and ecological principles of the Alma-Ata PHC declaration of 1978, and repeated again in WHO's primary health care renewal documents (PAHO, 2007; WHO, 2008). In the evolution of this thesis there will be demonstrations of how inter-organizational trust and cultural competency interplay within a services system to affect the way in which services are provided to children of recent immigrants and the families themselves. A case study is used to explore these issues.

The Case

The case for this study is defined as the network of community-based services within the Regional Municipality of Halifax that collectively address the PHC needs of young children of recent immigrant families living in a geographically bounded neighbourhood comprised of two adjacent municipal planning zones.

The two planning zones (Clayton Park and Fairview) both have a high proportion of immigrants relative to other areas within Halifax, but with contrasting socio-economic descriptions – Clayton Park, as a community with the highest influx of immigrants to Nova Scotia, is described primarily as a middle-class residential district. Fairview represents an area of mixed income, with patches of war-time housing, and a greater than average proportion of single-parent families. It is cited as being one of the more ethnically diverse communities in Halifax (Hill, Miller, McDaid & Farn-Guillette, 2008). Selection was based on different sources of local opinion about where immigrants to Halifax live (public health nurses of Capital Health Public Health Services; Dalhousie Faculty; Nova Scotia Department of Health). Selected demographic information is presented in Appendix B.

Note, although services that were included in this case are not necessarily located within the neighbourhood under study, it is still important to be specific about the area served so that service organizations for inclusion in the study can be defined. The Halifax Regional Municipality (HRM) is a large area with a number of communities and Community Health Planning Boards (Government of Nova Scotia, 2009). Communities, therefore, have potentially different sets of services available to residents depending upon

where they live. A more detailed description of how services were selected and the types that were included in the study is provided in Chapter 2.

Definitions Applied to the Case. Young children of interest in this study are newborn to 6 years of age. This includes children born in or outside of Canada. Their parents as *recent immigrants* are newcomers to Canada having arrived within the past 5 years. *Immigrants* for this study are inclusive of all immigrant status groups – permanent residents, refugees and refugee claimants, temporary residents and undocumented immigrants. The health needs of young children and the wellbeing of their families will not always be distinguished in this dissertation given the dependencies of young children on their family’s wellbeing overall.

Research Questions and Related Propositions

The two research questions and associated propositions as explored in this dissertation are as follows:

Research Question # 1

How do community-based services within Halifax work with one another in order to address the PHC needs of young children of recent immigrants living in the communities of Fairview and Clayton Park? (Chapter 3)

- Organizations designated to provide PHC services (PC and PH) are part of a network of community service organizations that interact with one another when addressing the PHC needs of children of recent immigrants,
- Brokers exist within the network of organizations that assist in connecting services to one another in order to address the PHC needs of immigrant children.

- How organizations interact with one another, and the brokers that enable these interactions, will differ depending on the type of PHC need being addressed (i.e. child nutrition, gastro-intestinal (GI) illness, child growth and development, general health and other concerns).

Research Question # 2

How do the perceived cultural competencies of the different community organizations affect the delivery of PHC services for young children of recent immigrants living in the communities of Fairview and Clayton Park? (Chapter 4)

- The cultural competency of organizations has an important influence on the relationships formed among organizations. Organizations will report greater trust in competent partners and interact more with those trusted.
- Connections to culturally competent organizations increase the reach of PHC services in meeting the needs of immigrant children through advocacy and referral.

Methods Selection: Case Study using Social Network Analysis and Qualitative

Descriptive Inquiry

Case Study

This research follows Yin's approach to case study (Yin, 2003). Case study was selected due to the nature of this enquiry, that is, a desire to investigate complex social phenomena that is contextually based. Case study is also a preferred method of inquiry when 'why' and 'how' questions are asked with the intent to explore, describe, or explain

the phenomena, and in this case, a description of how community based services work together. As a naturalistic approach to discovery of truth, truth being contextual rather than generalizable as implied by statistical inference to a population, its transferability to other situations will be dependent on a rich description of the case and whether or not it is recognizable within another's context. The findings from this research are generalizable to theory.

This is a single case study design using multiple sources and different methods to address the research questions. The methods chosen for data collection and initial analysis - a social network survey with the application of social network analysis techniques, and qualitative interviews with data subject to a process of constant comparative analysis – enable the development of separate results addressing the same questions. These can then be compared looking for convergence and divergence of findings in a process of triangulation, with reinvestigation of rival explanations or observations as these emerge (Yin, 2003). The network analysis results combined with the rich insights offered by the qualitative descriptions bring assurances of rigor and authenticity to the outcome of this study (Anderson, Crabtree, Steele, & McDaniel, 2005). The objective of case study can be to explain, describe or explore a phenomena occurring within real life context; it needs to provide credible and dependable description, enough for the reader to determine its transferability within the context of their own experiences. The following provide more background and rationale behind the methods selected for investigating this case.

Social Network Analysis

A glossary of terms describing social network analysis constructs used in this and subsequent chapters is provided in Appendix.1.2. Derived from anthropological and graph theory (Scott, 2006; Wasserman & Faust, 1994), social network analysis (SNA) methodology can be used to address the contextual complexity of health service delivery systems in ways that traditional empirical methods cannot (Luke, 2005). “In public health, network analysis has been used to study primarily disease transmission, especially for HIV/AIDS and other sexually transmitted diseases; information transmission, particularly for diffusion of innovations; the role of social support and social capital; the influence of personal and social networks on health behaviour; and the inter-organizational structure of health systems” (Luke & Harris, 2007, p. 69). SNA methods provide an opportunity for examining relationships and influential positions within inter-organizational networks, that is, organizations that support communication, exert power over the operations of the network, and/or act as brokers, connecting sub-groups of the network to one another. The role of broker used in this dissertation is equivalent to an intermediary or gate-keeper, managing the exchanges that occur among members of the network (Butts, 2008; Cross & Prusak, 2002; Gould & Fernandez, 1989; Tanjasiri et al., 2007; Valente, 2010). In contrast to traditional empirical methods that measure attributes or characteristics of organizations, the focus of SNA is on the interactions/relationships that exist between and among organizations. Attributes that belong to individual organizations are often considered to explain some of the interactional behaviour and linkages that occur within the defined network.

Different types of relationships can be explored among the members of the same network. For example, some organizations might exchange clients, while a different, potentially overlapping sub-group of the network are connected through information exchange, or because of different mandates. As well, SNA can be used to measure the intensity of these exchanges (Knoke & Yang, 2008). In this study, SNA was used to describe and explore different types of relationships between and among organizations as proxy measures of collaboration on selected PHC needs experienced by children of immigrant families (i.e. child growth and development, nutrition, gastro-intestinal disease and other PHC concerns). Attributes of individual organizations were treated as predictors of the types of relationships formed. The self-reported cultural competency of an organization, for example, was examined for its influence over trust and how this affected relationships across organizations. As well, through these features, an opportunity is presented for examining how relational measures of trust might correlate with different forms of interaction and exchange among network members.

Network membership (or network boundaries) can be very clear –e.g. a group of organizations participating as formal members of a coalition working toward a shared or common purpose (Krauss, Muller & Luke, 2004). In the operations of the day-to-day, however, agencies servicing a community may be connecting on different issues and by varying degree. The ‘network’ may be defined by a functional (sometimes ambiguous) purpose or service population whether or not there is frequent, consolidated activity among its membership (Kwait et al., 2001; Provan & Milward, 1995). In this study, the network examined was theoretically derived based on purposeful sampling to ensure

inclusion of different service sectors. Fragmentation of the network was expected to occur depending on the issue presented and the compatibility of mandates among network members. This enabled a more true to life exploration of how things work for meeting immigrant family needs, knowing that families can have multiple concerns.

An on-line survey was used to collect data for the social network analysis as applied within this case study. More detail concerning data collection, analysis and other methodological decisions, including how challenges to participant recruitment were addressed, are presented in the methods chapter, Chapter 2.

Qualitative Descriptive Inquiry

Qualitative methods bring to the case study contextual information for exploring, describing and explaining phenomena, (Creswell, 1998; Tellis, 1997; Yin, 2003). The goal of qualitative descriptive inquiry is to provide, “a comprehensive summary of events in the everyday terms of those events” (Sandelowski, 2000, pg.337). Under the tradition of descriptive qualitative inquiry as portrayed by Sandelowski (2000), the outcome can simply be a rich account of the phenomena, keeping as close to the data as possible while recognizing the selectivity of what is presented by the researcher as prescribed by the theoretical framework or questions and propositions under study. In other words, factual accounts are presented of what is said or observed; interpretation is low-inference and likely to result in easier consensus among researchers (pg.336). Descriptive qualitative inquiry can set the stage for further study using more sophisticated methods (personal communication, Sandelowski, June 8, 2009). In this case, the utility of qualitative inquiry

as part of a descriptive case study can be synergistic towards a credible representation of events.

Qualitative data in this case study were gathered through in-depth interviews with primary health care providers including PC and PH and other key informants belonging to other service sectors who were knowledgeable about how needed services are delivered to recent immigrant children and their families. The choice of interviews over focus groups or other methods of data collection (e.g. document review, participant observation), had much to do with the sensitivity of this inquiry. More detail is again provided in Chapter 2. Similar to the social network survey, data collected during interviews were intended to create a portrayal of the types of relationships that existed among service organizations in the study and how these functioned.

Thesis Outline Overview and Literature Search Strategy

Chapter 2 describes the application of the methods used in this case study. Chapters 3 and 4 present the results, each addressing one of the two research questions by combining the findings of both the SNA and qualitative inquiry. The final chapter, chapter 5, presents an overview of the research and final discussion. Repetition occurs among chapters as chapters 2, 3 and 4 are intended to be read as stand-alone papers. The following is a synopsis of all chapters to follow:

Chapter 2. This paper provides more detail on how the case study was conducted. This includes a description of the participant recruitment process and the challenges faced. Also included is a description of how data were collected, managed, and then analysed using SNA methodologies for metric data, and qualitative approaches applicable to

descriptive qualitative inquiry. The strengths and limitations of data are discussed, along with the decisions made during the analysis in order to accommodate the limitations. The importance of triangulating findings within and across methods is emphasized as this offers rigor and validation to the results, as well as richness to the final description of the case.

Chapter 3. Chapter 3 relates primarily to research question 1 and its propositions. This paper accepts the premise supported in the literature that collaborative relationships are of benefit to better serve populations. A description is provided of what exists within the case under study, and how well integrated PC and PH are within the broader network of services. Propositions under this research question include concepts of brokerage, and how brokers connect different sectors to one another in order to address the diverse needs of recent immigrant families with young children.

Chapter 4. Chapter 4 relates to research question 2 and its propositions. This paper offers a critique of existing relationships, how perceived cultural competencies are apt to influence relationship formation, but more with respect to the nature of the relationship - *trusting or otherwise* - rather than the lack of relationships at all, particularly if what is offered by the other organization is seen as a necessary service. The introduction and discussion will consider and apply concepts derived from organizational theory: how these relate to systemic cultural competency and *competence trust* among organizations, and how this is expressed through improved access overall for recent immigrant families.

Chapter 5. Chapter 5 provides study reflections and a final discussion, bringing together the elements of Chapters 2, 3 and 4, in order to model a response to the overall study purpose - how community services collectively address the primary health care needs of recent immigrant children and their families, considering the influences of cultural competency and trust. Findings from this case study have led to further theoretical considerations, and are reflected in this chapter as an adaptation to the original conceptual model about access and trust presented in Figure 1 of Chapter 1. A summary of the strengths and limitations of this study are included, as well as a reflection concerning future areas of inquiry and implications for practice.

The published literature reviewed for this research included articles (English only) from multiple disciplines (e.g. social sciences, nursing, other health sciences, political sciences). Peer reviewed publications since 2000 (theoretical, qualitative and quantitative research and methods) were searched using CINAHL and the Web of Science. Other databases were scanned for relevant literature within OVID (AMED, Healthstar, Medline) and Scholar's Portal (Health Science-SAGE, Political Sciences-SAGE, Social Sciences Abstracts). Frequently referenced articles and classic texts were also reviewed. Search terms used were combinations of: cultural competence, organizational theory, primary care, public health, collaboration, trust, access, primary health care, children, immigrants, immigration, social network analysis, social capital, service barriers, nutrition, parasites, qualitative analysis, case study, Canada, organizational ecology, health systems, cultural safety, change agents and nursing, community services networks, nursing values. Original searches were conducted in 2008/09, and updated in 2011.

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CHAPTER 2

**METHODS PAPER - PRACTICAL CONSIDERATIONS WHEN USING SOCIAL
NETWORK ANALYSIS AND QUALITATIVE DESCRIPTIVE METHODOLOGY IN
A CASE OF INTER-ORGANIZATIONAL RELATIONSHIPS**

This chapter has been prepared for publication but not yet submitted.

METHODS PAPER: PRACTICAL CONSIDERATIONS WHEN USING SOCIAL
NETWORK ANALYSIS AND QUALITATIVE DESCRIPTIVE METHODOLOGY IN
A CASE OF INTER-ORGANIZATIONAL RELATIONSHIPS

Introduction

In a perfect world, everyone would be able to speak freely about what they are thinking knowing that what they say will be accepted without judgment. In a perfect research world, everyone would eagerly want to tell their story, knowing that truth is important and that their ideas are highly valued and of consequence. But what if not everyone sees things the same way? What if some have opinions that could be judgmental, even critical about how things are? What if some are sceptical about how others will perceive their own important work, and feel vulnerable if they honestly tell their story? And what if, as a researcher, you actually ‘want’ to know how different groups feel about each other? What if you can’t always guarantee anonymity?

These were some of the challenges faced in conducting a case study about working relationships among a group of community-based service organizations. All were involved in some way with recent immigrant families with young children living in Atlantic, Canada. Indeed, one of the main themes in this study was to determine if perceived cultural competencies in other organizations could influence how organizations worked with each other. In asking these kinds of questions, and knowing the difficulty in maintaining confidentiality within a small network of services, there was a sensitized need in going forward with this research, to gain trust in the research process from the service community overall.

The purpose of this paper is to describe the measures taken at each step in the research process, as applied to this case study, to ensure rigour and trustworthiness in the results achieved. This included the measures taken from beginning to end to gain the confidence of the community involved and to encourage participation and willingness to respond openly to potentially sensitive questions. The research process described in this paper, addresses methods selection and instrument development, researcher entry into the community, ethical considerations and ethics review, processes of sample selection and recruitment, data collection, data analysis, and then the rigor applied to interpretation. As each component of the research process is presented, a discussion of the associated challenges and how these were resolved is also provided. In some cases, selected results are given in order to illustrate how the most salient methodological issues were managed. Timelines for this study are summarized in Table 2. To provide context, a brief overview of the case is first presented.

Table 2: Research Activities and Timelines

Activity	2008	Jan-Mar 09	Apr-June 09	Jul-Sept 09	Oct-Dec 09	Jan-Mar 10	Apr - June 10	Jul-Aug 10	Sep - Dec 10	Jan-Mar 11	
Community consultations pre-study design /proposal development/approval	[Activity bar]										
Ethics Review: Preparation, submission, presentation, approval		[Activity bar]									
Recruitment Preparation: Identify/ consult key informants to identify participants; Prepare organization contact list			[Activity bar]								
Questionnaire: revisions / on-line development			[Activity bar]								
Recruitment of participants: CEO approvals - presentations/discussions.			[Activity bar]								
Data Collection – qualitative interviews 14 interviews, audio taping and transcription; field notes and memoing; interview guide revisions			[Activity bar]	[Activity bar]							
Data Collection - SNA survey: Consent; questionnaire administration; implement intensive follow-up protocol				[Activity bar]							
Data Storage and Management: Nvivo 8; indexing files for audit trail; UCINET entry of SNA data; data quality controls			[Activity bar]								
Data Analysis: <i>Qualitative</i> -refine conceptual framework; data coding; creating categories, data displays; verification – member checking / constraint comparative analysis. <i>SNA</i> – use of UCINET – descriptive / hypothesis testing.				[Activity bar]						[Activity bar]	
Interpretation / results integration: Use of charts and displays for data mergers /triangulation; meta-critique; rich narrative of qualitative findings.									[Activity bar]		
Write-up:							[Activity bar]				

Case Description

The purpose of the case study was to describe how community based services work together when addressing the primary health care needs of recent immigrant families. Primary health care (PHC) needs were intended as a broad construct, taking into account a determinants of health framework (PAHO, 2007, WHO, 2008) when setting boundaries for the case. For this study, PHC needs are characterized by the health, health risk and illness experiences of individuals and families living in their communities. Families may at times require the resources of different kinds of community-based services in order to address their needs and optimize their health. Yin's concepts in case study design (Yin, 2003) were used beginning with two research questions each with a set of propositions intended to elicit a description of relationships among organizations from different service sectors. The questions and respective propositions were as follows:

Research Question # 1

How do community-based services work with one another in order to address the PHC needs of young children of recent immigrants¹ living in the study neighbourhood?

Propositions:

- Organizations designated to provide PHC services are part of a network of community service organizations that interact with one another when addressing the PHC needs of children of recent immigrants.
- Brokers exist within the network of organizations that assist in connecting services to one another in order to address the PHC needs of immigrant children.

¹ Children are newborn to 6 years old. Parents are recent immigrants who arrived in Canada within the past 5 years.

- How organizations interact with one another, and the brokers that enable these interactions, will differ depending on the type of PHC need being addressed, (i.e. child nutrition, gastro-intestinal (GI) illness, child growth and development, general health and other concerns).

Research Question # 2

How do the perceived cultural competencies of the different community organizations affect the delivery of PHC services for young children of recent immigrants living in the study neighbourhood?

Propositions:

- The cultural competency of organizations has an important influence on the relationships formed among organizations. Organizations will report greater trust in competent partners and interact more with those trusted.
- Connections to culturally competent organizations increase the reach of PHC services in meeting the needs of immigrant children through advocacy and referral.

In defining and bounding this case, organizations were selected for the study if the organization provided services to either recent immigrant families and/or to families with young children, newborn to 6 years of age, living within a geographically bounded neighbourhood. Organizations could address different kinds of needs faced by families that contribute to their general health and wellbeing. The study neighbourhood consisted of two city planning zones located within a mid-sized urban centre in Atlantic Canada. The neighbourhood was chosen based on different sources of local opinion (university

researchers and service providers) which helped to identify where the majority of immigrants in the region lived. This selection was corroborated with data from the 2006 Census, (Statistics Canada, 2007).

Methods Selection

Because this study was to consider the functioning of a system of services rather than service organizations individually, methods appropriate for describing the system and the relationships within the system needed to be considered (Anderson, Crabtree, Steele, & McDaniel, 2005). Methods derived from social network analysis (SNA) were selected. SNA is both a theoretical perspective and set of methodological techniques with an aim to understanding the interactions and relationships among sets of actors (Valente, 2010, Wasserman & Faust, 1994). The actors in this case were the organizations themselves. These methods provided an opportunity for examining relationships and influential positions within inter-organizational networks. For example, organizations may have supported communication; exerted power over the operations of the network; and/or acted as brokers, connecting different members of the network to one another (Cross & Prusak, 2002; Gould & Fernandez, 1989; Valente, 2010). Data for the network analysis were obtained through an on-line survey.

In order to understand the meaning behind the observed relationships, more in-depth and contextual information was needed. This was accomplished using qualitative descriptive inquiry (Sandelowski, 2000). Qualitative data were obtained through one-on-one interviews with key informants who worked within the services system under study. The choice of one-on-one interviews over focus groups for collecting qualitative data had

to do with the nature of this inquiry and its potential sensitivity. Focus group participation may have inhibited openness about perceived cultural competencies in other organizations.

Development of the Study Instruments

Instrument development was guided by the study propositions. Both instruments (i.e. the key informant interview guide and network survey questionnaire) prompted responses from participants concerning relationships among organizations from different service sectors. Both methods gathered information concerning each organization's attributes including: perceived cultural competencies, ways of working with other organizations, and trust in the perceived preparedness of other organizations when working with recent immigrant families.

Key Informant Interviews – Interview Guide

Questions used to guide key informant interviews were derived from constructs in the study propositions, and in consultation with research committee advisors with expertise in qualitative research, interview techniques and immigrant health issues. Some changes were made to these questions based on requests for clarification during interviews with the earliest informants. As well, it became apparent that respondents were taking more time to respond to questions concerning the work of their own organizations with less time given to the questions related to the study propositions concerning working relationships. Guidelines were consequently modified, and the interview process tightened to introduce relationship questions sooner. Questions were skipped if they seemed to elicit similar responses. In addition to asking about service

attributes and ways of working with other organizations, key informant interviews also asked about negative and positive experiences with other organizations when recent immigrant families were involved, and how this impacted their relationships with their clients and each other. The interviews further elicited information concerning barriers faced by recent immigrant families in obtaining services. The final interview guide is provided in Table 3.

Table 3: Interview Guide

Domain: 1	ORGANIZATIONAL ROLES & RELATIONSHIPS
1-1.	Could you very briefly describe for me the types of services your (organization/program/practice) provides for young children of recent immigrants? How do these children come to you?
1-2.	What kinds of organizations might you and your co-workers work with in order to help children of recent immigrants and their families? Generally how do you work together? Can you think of examples?
1-3	Think about the primary health care needs of young immigrant children (<i>examples, nutritional needs, infectious illnesses, developmental needs</i> ² .) What organizations in your network deal with these needs? How do these different services work together? How are you involved?
Domain: 2	MAKING CONNECTIONS
2-1.	You may know of some organizations or services within Halifax that are particularly effective in connecting services to one another in order to help young immigrant children. Can you describe what makes their role unique, and how they are able to be effective?
2-2.	Do things work differently depending on the families and their children's needs? (e.g. where they live or where they are from, the type of presenting problem).

² Additional probes were used to focus the participants on GI Illness, growth and development, and then other kinds of concerns faced by recent immigrant families during the settlement process.

Domain: 3	PRIMARY HEALTH CARE ACCESS
3-1.	What barriers or constraints have you or your co-workers experienced in working with recent immigrants and their children?
3-2.	What do you think are some of the barriers faced by recent immigrants when they try to obtain help for their children from your program/service/practice?
3-3.	How have relationships with other organizations helped you and your co-workers to reach recent immigrant families? How does this work? Can you give examples?
Domain: 4	RELATIONSHIP CHOICES & ACCESS
4-1.	What things do you consider when deciding to work with another organization on behalf of immigrant children? How much does trust or confidence in the other organization's ability to work with immigrants affect your choices?
4-2.	Can you think of times when working with another organization has helped children of recent immigrants to obtain the services they need? How did this affect your relationship with the other organization? How did this affect your organization's relationship with the family?
4-3.	Can you think of times when working with another organization could have created problems for immigrant children and their families? How did this affect your relationship with the other organization? How did this affect your organization's relationship with the family?
4-4.	How does the way services are structured in Halifax affect the types of relationships your group forms with others?

SNA Questionnaire Development

A review of previous literature using network methodologies helped to inform question selection, question format and instrument design for the network survey (Eisenberg & Swanson, 1996; Huang & Provan, 2007; Kwait, Valente, & Celentano, 2001; Provan, Milward & Isett, 2002; Provan, Veazie, Staten & Teufel-Shone, 2005; Rivard & Morrissey, 2003; Tausig, 1987). Provan et al. (2005) had a large influence on the final version of the instrument. The survey instrument consisted of two domains. The

first domain collected information about attributes of the respondent's own organization. The second domain asked respondents about their organization's relationships with other community based organizations. Screen shots of the survey are provide in Appendix D.

Domain 1

Respondents were asked brief questions with categorical responses allowed, concerning the type of organization in which they worked, the type of services offered, and the population served. Respondents were also asked to assess their own organization's preparedness in working with recent immigrants and responded, using a 4 point Likert scale, to a set of five questions addressing different attributes of organizational competency in working with recent immigrants (Table 4). Questions were derived from a resource document developed by a cultural competency consultant working within the Canadian health system (Davis-Murdoch, 2005). Similar questions were found to be common among different organizational cultural competency assessment tools (Andrulis, Delbanco, Avakian & Shaw-Taylor, n.d.; Boston Public Health Commission, 2004; Lam & Cipparrone, 2008; National Center for Cultural Competence, 2006). On advice from the same consultant, one general question was added: "Overall, how well prepared is your agency / program for dealing with the unique needs of recent immigrants and their families?" Respondents could answer: not very prepared, somewhat prepared, mostly prepared or very prepared.

Table 4: Survey questions related to self-assessed competency by organizations

C5. These last few questions ask about your organization's / program's preparedness in working with recent immigrants.

On a scale of 1 to 4, please indicate how each of the following statements best describes your agency and/or practice:	1 don't agree	2 somewhat agree	3 mostly agree	4 definitely agree
a) Staff and practitioners are aware of the ethnic diversity within the communities you serve, and of differences that may exist in the health risks and beliefs of different ethnic groups.	1	2	3	4
b) Programs and services have been adapted to respond to the needs and issues of recent immigrants within your service area.	1	2	3	4
c) Resources have been allocated to provide appropriate language and/or outreach services for recent immigrants.	1	2	3	4
d) Staff are provided opportunities for training in empathic listening and communication skills that work across cultures.	1	2	3	4
e) Staff and practitioners are accepting, respectful and responsive in their interactions with recent immigrants.	1	2	3	4

C6. Overall, how well prepared is your agency / program for dealing with the unique needs of recent immigrants and their families?

1-not very prepared 2-somewhat prepared 3-mostly prepared 4-very prepared

Domain 2

A fixed list of organizations to be referenced in the questionnaire was created starting with a list of services attending a local immigrant health fair during the spring of 2009. Other organizations were added to the list from a local services directory referred to by agencies and consumers in the municipality. Two consultants, one working in settlement services for the region and the other with the community health board for the neighbourhood of interest, reviewed the list. They added or deleted organizations depending on whether or not the organization either worked with recent immigrants, or

with families with children, newborn to 6 years of age, living in the study neighbourhood. The final list was vetted by the researcher based on a review of organizational mandates. As the earliest key informant interviews were conducted in the summer of 2009 prior to the launch of the survey in September, these were used as opportunities to refine the list of organizations before being finalized.

To address the study propositions, relationship questions concerning the frequency of interaction with each of the listed organizations, the types of interaction, (refer to, referral from, share information, share resources) and different reasons for interaction (general health, growth and development, nutrition, gastro-intestinal illness, other) were created. Each of the relationship questions required a yes/no response, or an ordinal response to options (1 to 5) provided on a Likert scale. Similarly, the question concerning *competence trust* was asked, “To what degree do you and your co-workers trust each organization's ability to address the unique needs of recent immigrant families with young children?” To respond to this question, respondents were given the options: not at all, somewhat, mostly, absolutely, and unsure. *Competence trust* is defined as a belief in the other’s ability to do the job or complete a task. Being trustworthy, in this sense, is synonymous with one's “capabilities” (Black, 2007; Norman, 2002; Wakabayashi, 2003). Survey questions under domain 2 are presented in Table 5.

Table 5: Survey Questionnaire: Domain 2 Questions.

A) How frequently are you or your co-workers in contact with each organization listed below?					
	Never	<1per year	a few times per yr	every month	every week or more
Org1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Org2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Org3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Org4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Etc.					
B) What type of interactions do you/your co-workers have with each organization in relation to the needs of young children of recent immigrants? (Check all that apply)					
	Send referrals to	Receive referrals from	Share information	Share resources	
Org1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Org2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Org3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Org4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Etc.					
C) Do you or your co-workers ever work with any of the listed organizations concerning the following needs of young children of recent immigrants? (Check all that apply)					
	Health concerns (general)	Growth & Development	Child Nutrition	Diarrheal/Parasitic Diseases	Other
Org1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Org2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Org3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Org4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Etc.					
D) Knowing or trusting the ability of other organizations can sometimes influence how organizations work with one another. To what degree do you and your co-workers trust each organization's ability to address the unique needs of recent immigrant families with young children?					
	Not at all	Somewhat	Mostly	Absolutely	Unsure
Org1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Org2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Org3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Org4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Etc.					

Instrument validation/reliability

Following guidelines by Chambers and Woodward (1986), a paper-based version of the survey was first tested for clarity and readability with nursing students, then created as an on-line prototype and reviewed by four colleagues in epidemiology for face validity of the measurement constructs, and acceptance of the survey layout. Recommendations were incorporated, and the last draft reviewed by a public health manager and community health board member in the study community for comment concerning user acceptability and relevance. A final version of the survey was created and posted on-line after an explanation was added as recommended by the board member, concerning the *competence trust* question and why this was important in understanding relationships.

The website program selected for managing the survey (SNAsurvey.com) had been used before by the researcher in conducting two teaching sessions in social network analysis. Success was demonstrated in respondent usability and data retrieval for analysis. The researcher, with the assistance of colleagues and the website developer, tested the study website on repeated trials to ensure functionality and data reliability in the reports generated.

Ethics

Anonymity & Confidentiality Issues in SNA and Key Informant Interviews

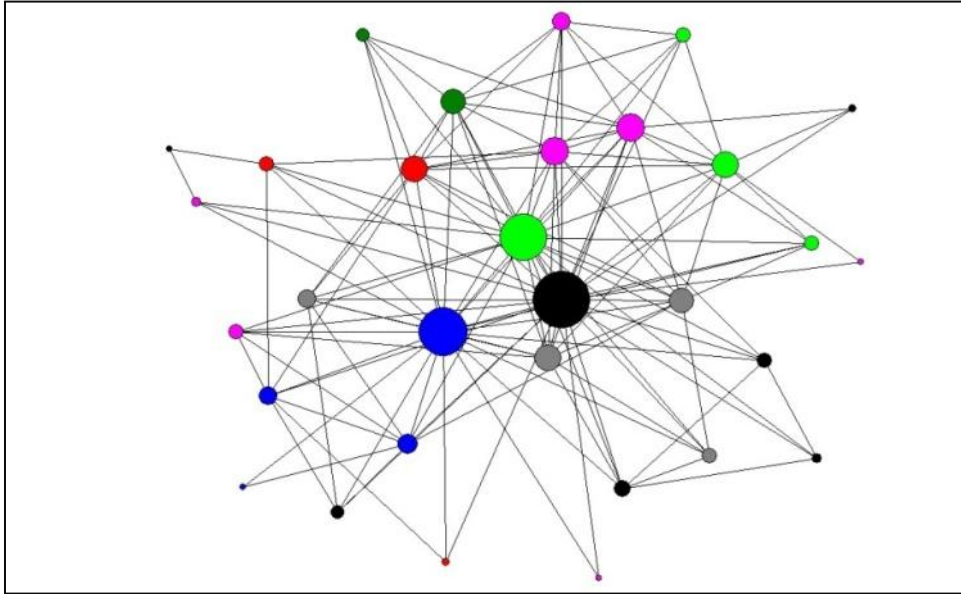
A methodological advantage and important reason for using social network analysis as part of this case study was the opportunity this approach allowed for presenting results as graphical displays able to demonstrate the dynamics of the services network as a whole. These network maps were also highly revealing of the quality of the

network relationships, particularly when considered in combination with data collected during interviews.

Given the familiarity of service providers with one another in this setting, the identities of the organizations in these displays were difficult to mask. This proved to be the most significant hurdle from an ethical standpoint since the researcher using this study design applied to a relatively small network of services, could not guarantee the anonymity of participating organizations. Organization leads, not just individual respondents needed to understand this, with some assurances that organization reputation would be respected. This inevitably meant a two tier consent process – first with organization leads, and then with individuals nominated by the leads to represent their organization. Further, to reassure participants, a protocol was developed whereby the researcher would consult with the leads of participating organizations prior to the release of any results. These consultations were intended to inform leads of the results specific to their own organization and to gain their acceptance of the level of anonymity offered through different ways of data presentation.

Figures 2 and 3 are examples of network maps derived from this work which were shared with participating organization leads prior to further dissemination. Figure 2 represents a ‘regular’ contact network (more than once a month). Figure 3 represents a *competence trust* network based on a response of ‘trust absolutely’ to the question “How well do you trust each listed organization in their preparedness to work with recent immigrant families?”

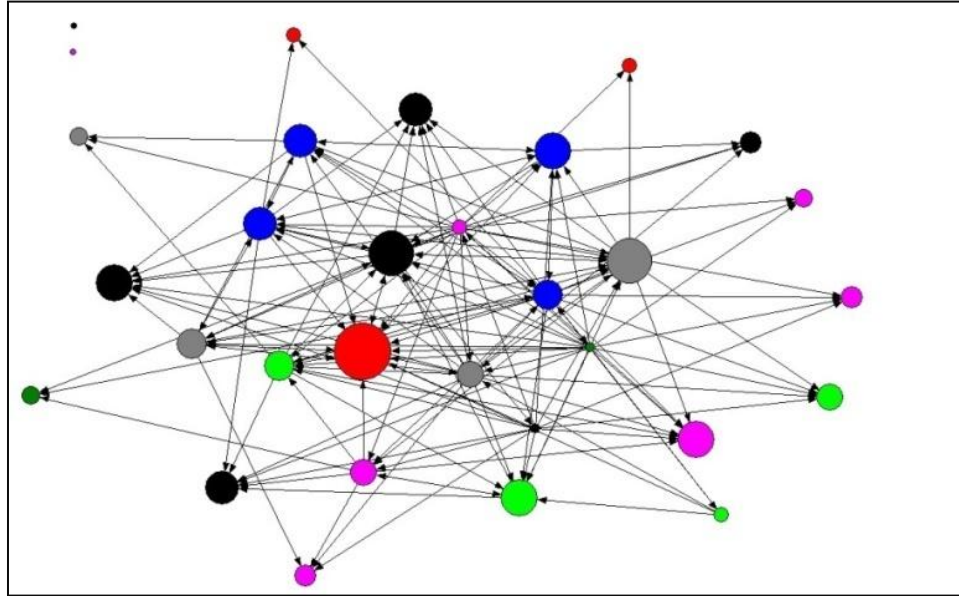
Figure 2: Regular Contact Network



Service Sector:

- | | |
|---------------------------|--------------------------|
| ● Public Health | ● Child & Legal services |
| ● Primary Care | ● Family Counseling |
| ● Immigrant Services | ● Other Services |
| ● Family Outreach/Drop-in | |

Figure 3: *Competence Trust (Trust absolutely) Network*



Service Sector:

- | | |
|---------------------------|--------------------------|
| ● Public Health | ● Child & Legal services |
| ● Primary Care | ● Family Counseling |
| ● Immigrant Services | ● Other Services |
| ● Family Outreach/Drop-in | |

In Figures 2 and 3, each node represents an organization. Colour codes are used to identify different service sectors. Lines indicate regular contact (Figure 2) or *competence trust* among organizations (Figure 3), and the size of the node denotes the relative level of *degree centrality*³ (Scott, 2006) for each organization; centrality indicates each organization's prominence as a regular contact within the network (Figure 2), or as trusted for their competency (Figure 3).

³ Degree Centrality – The sum of all other actors (nodes) that are directly connected to the actor attributed degree centrality. ‘In-degree’ centrality, a directed measure, was used to identify actors with *competence trust*, that is, the sum of all other actors indicating *competence trust toward* the actor.

With just this level of description, distinguishing information can be gleaned about the different sectors represented in the maps. One of the primary care services appeared as the most often ‘trusted absolutely’ by others for its competencies, whereas two organizations actually fall off on this construct from the network entirely. If individual codes for each organization were added to the maps, more information becomes available to determine how, for example, an individual organization is characterized as a regular contact, and then also how it is trusted for its competencies in working with recent immigrant families. Some organizations could conceivably be concerned about the interpretation.

All leads of participating organizations were mailed the selected network maps derived from the survey responses (Figures 2 and 3 without the legend) with a brief overview and invitation to contact the researcher should they have any questions. Individualized mailings identified each lead’s own organization on the map, but no others. The researcher actively met with organization leads individually who, from the researcher’s perspective, may have had concerns to ensure they were comfortable with these portrayals prior to further dissemination. In providing these two graphs to all participating organizations but without other data, the researcher was able to gauge reactions, and then gained acceptance for including organization codes in later displays shared among participants during a member checking event. Overall, data associated with non-responding organizations was minimized to mask their identities within all displays created from the survey data.

Ethics Approval

Four ethics reviews were conducted in advance of the study. This extensive review process was related to requirements of the home university (McMaster), the employing agency of the primary researcher at the time (Public Health Agency of Canada), and the different agencies involved in the study. Support for the study had been gained from local leaders through earlier consultations, who were then willing to offer letters of support for the research. Two ethics boards conducted full reviews. All four boards gave their approval.

Entry into the Community and Community Consultation

Community consultation started during the early phases of the study's conception. The researcher was an outsider and not a part of the service network of interest. Entry and acceptance of the research and researcher required front-end discussions with individuals familiar with the issues faced by service providers and their clients. Other researchers familiar with the community were the starting point for identifying other local consultants. Consultants were selected based on knowledge about how health and social services worked within the municipality, and knowledge about the needs of recent immigrants and their children. Discussions with consultants, primarily local researchers and managers from difference services, took place during 2008 in the months prior to the completion of the study proposal. Discussions, however, were ongoing as the study instruments and case boundaries were further refined to accommodate local context.

Sample Selection

Key Informant Selection

Purposeful sampling (Patton, 1990) was used, aiming to obtain maximum variation in the professional experiences of key informants. This method was done to gain different perspectives on similar questions, creating opportunities for data convergence and divergence with the prospect of improved credibility in the results obtained. A target of 10 to 12 key informants was set, with evidence that a small number of respondents can still provide data saturation and sufficient variability to be informative when using qualitative inquiry (Guest, Bunce & Johnson, 2006). The sample was defined by type of organization and profession of respondents, but limited to priority service sectors for this study – immigrant settlement services, primary care (PC), public health (PH), non-government organizations; then nurses, physicians, settlement workers, and other providers involved in the study organizations. The first few key informants were identified by the local research consultants and from the list of organizations created for the survey. Others were suggested by the earliest key informants, resulting in a snowball recruitment process aimed to fill sampling requirements for variability. The criteria for key informant selection was similar to that of the study consultant, with the addition that key informants were also part of the service community involved with young immigrant families.

SNA Participant Selection

A final list of 31 organizations was created for use in Domain 2 of the survey instrument. Of this list, four represented organizational groups – family physicians, walk-in clinics, day-cares and cultural associations. Adding these groups to the list in the questionnaire was important given the case definition, and since listing individual services and practices from these groups proved not to be feasible. Immigrant families from the neighbourhood were reported to be traveling to different parts of the city for daycare or to see a doctor. It was unclear which cultural associations, located in different parts of the city, were involved with families and which ones were being attended by neighbourhood residents.

The remaining 27 individually identified organizations were targeted for inclusion as survey respondents. These included different public health programs, a community health clinic, drop-in and outreach programs, settlement and other immigrant services, child and legal services, family counselling and other services supporting the basic settlement needs of families (housing, food security, literacy and others).

As applied in creating the list of organizations for the survey instrument, inclusion criteria for responding organizations were as follows:

- i. A community-based service agency supporting the needs of families with young children and/or immigrant families living in the study neighbourhood.

- ii. Organizations could include physician private practices or practice groups; health and social services agencies or programs within agencies, and non-government organizations.

Responding individuals needed to meet the following criteria:

Staff members of the selected organizations who were:

- i. The organization's lead/director OR
- ii. Nominated by the lead/director, AND
- iii. Knowledgeable about their organization's relationships with others in addressing the PHC needs of recent immigrants and their children.

Participant Recruitment

General Approach

Although recruitment processes differed for the survey and key informant interviews, in practicality overlap in participant groups did occur as many key informants were also recruited into the survey when interest was expressed. Ten organizations participated in both components of the study. Both data collection strategies required an intense process of follow-up to accommodate the two-tier process of consent, with multiple points and/or attempts at contact; first, with the organizational leads to obtain organizational acceptance of the study, and second with any staff nominated by the lead to participate as a respondent in the study.

Various approaches, built on social exchange theory as promoted by Dillman (2007), were used to gain the respondents' confidence and willingness to participate. This included acknowledging the importance of the research in all communications, use of

credentialing with support from local leaders and the backing of a university, and building trust in the researcher to follow through with expectations through multiple personalized contacts. This approach was taken with the added belief that respondents should have an opportunity to speak directly to the person most responsible for the study and its interpretation. The survey method used in this study was tailored for the target group - professionals with access to emails and the internet; the use of an on-line questionnaire designed with logical progression through each section reduced respondent burden, that is, completing the survey took less than 20 minutes. Respondents were always thanked for their time.

Interview Recruitment

To recruit for the interviews, an introductory letter describing the study purpose was sent by email to a sub-set of selected organizational leads requesting the nomination of one informed individual to represent their organization in a key informant interview. Phone calls were made within a week of these e-mails, with follow-up calls to confirm or re-schedule appointments as needed based on the availability of the key informant and researcher who needed to travel in from a different province. Recruitment of key informants started in June of 2009 and carried into March 2010. Although a total of 10 to 12 key informants were intended, 14 key informants participated in interviews allowing for sample variability as set out in the sampling protocol. Organizations (and professions) in the sample included two primary health care settings (two doctors and one nurse); three immigrant services (three settlement workers and one interpreter services coordinator);

two public health programs (three nurses); three outreach/drop-in centers (three social workers); and one hospital discharge program (one social worker).

Survey Recruitment

Introductory letters concerning the SNA survey went out by email to the targeted organizations by the 2nd week of August 2009. The introductory letter for the survey requested up to three names of survey nominees per organization. A second letter to responding organizational leads was sent out by email in the middle of September to initiate their participation. Letters to other leads were subsequently staggered to allow time for follow-up with each lead independently and to further recruit nominees for participation as needed. An email reminder was sent a week following the letter if no response was received. First follow-up phone calls were made between 5 and 7 days following the second email. Direct refusals were accepted. No returns from phone call messages or emails after several attempts were acknowledged as non-responses. To achieve the completion of 25 surveys from 21 organizations, an average of 5 follow-up emails were made with either the organization lead or their nominee following the original introduction. All organizations required at least one phone contact with a range from one to four phone calls. The last completed survey was received in March, 2010.

Social network studies have traditionally required a high rate of participation in order to ensure a full account of the network and its characteristics – as much as 90% using the same whole network study design (Huang & Provan, 2007; Krauss, Mueller & Luke, 2004; Provan et al, 2002; Singer & Kegler, 2004). A seventy-eight percent

response rate (21 of 27 organizations) was achieved based on the participation of at least one organizational representative. This drops to a 68% participation rate if the four organizational groups are included in the denominator (21 of 31).

The original intention of the survey had been to recruit multiple respondents for all organizations in order to achieve a more reliable and representative response (average and/or majority response) from each organization. This proved not to be feasible without direct access to all staff in each organization, since all internal recruitment had to be vetted through the organizational lead. Only three of the 27 organizations had more than one respondent to the survey - two had two respondents while one organization had three. Nine organization leads completed the survey themselves. The multiple responses from the three organizations were dealt with by selecting the average value for the Likert scale responses, and the most senior person's response if responses differed within the organization when presented with a yes or no option.

Organizations with a health or settlement mandate, and therefore most likely to have an interest in the health concerns of young immigrant families, were more represented among responding organizations compared to other organizations with different kinds of mandates (Table 6).

Table 6: Survey participating and non-participating organizations by service sector

SECTOR	Organization	Participant	Non-participant
Primary Care	org27	*	
	org29 [#]		*
	org31 [#]		*
Public Health	org06	*	
	org09	*	
	org11	*	
	org14	*	
Immigrant Services	org01	*	
	org04	*	
	org10	*	
	org12	*	
	org15	*	
	org18		*
Outreach	org03	*	
	org17	*	
	org20	*	
	org25	*	
Counselling	org26	*	
	org28		*
Legal/Child Services	org05	*	
	org08		*
	org19	*	
	org22	*	
Other	org02	*	
	org13	*	
	org16		*
	org24		*
	org30 [#]		*
	org32		*
	org33 [#]		*

[#] Org29, 30, 31 and 33 were the organizational groups. i.e. walk-in clinics (org29), day-cares/pre-schools (org30), doctor's offices (org31) and cultural associations (org33).

Data Collection and Analysis

Key informant Interviews

All interviews were conducted by the primary researcher. One-on-one interviews with key informants ran from 45 to 90 minutes. Interviews took place in the respondent's work setting except for two interviews conducted by phone at the convenience of the respondent. All interviews were tape recorded, transcribed verbatim by an assistant and then imported into NVivo8 for analysis (QSR International, 2007). The researcher singularly reviewed and coded all transcripts. A process of constant comparative analysis was used, starting with original propositions to categorize and code data; data were then reorganized, regrouped and cross referenced as new sets of data became apparent, and / or prominent themes began to take hold (Creswell, 1998; Crabtree & Miller, 1999). Sample coding schemes derived from the qualitative data and grouped under categories are provided in Appendix 2.2. The original code list was reviewed and discussed with one of the thesis committee members.

For the most part, key informants were enthusiastic when talking about their concerns for their clients and the work that they do, as indicated in the researcher's field notes. Probes were always required to refocus discussion around working relationships with other organizations as expected given the potential sensitivity of these questions.

SNA Survey

All willing participants to the survey were sent an email with individualized instructions and codes to enable access to the secure website for data entry using the on-

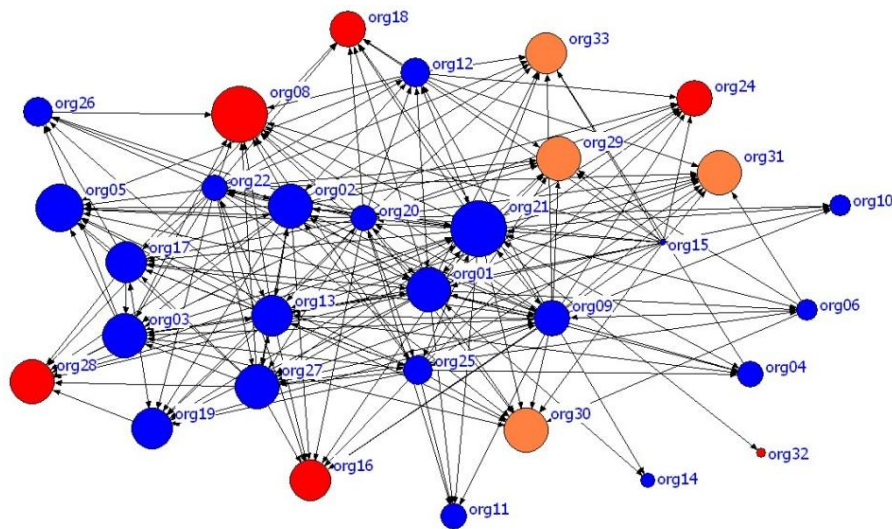
line survey form. Survey completion was monitored by the researcher and reminders sent if needed within 5 days of the instruction email. All survey data were imported from the website into Microsoft Excel and then manually reviewed for inconsistencies or omissions. Selected Excel data were also checked against responses captured in the original survey forms available from the website. Data were reconfigured within Excel into a series of matrix files, and then imported into UCINET and NetDraw for analysis (Borgatti, 2002, Borgatti, Everett & Freeman, 2002). Matrices data were either binomial (0, 1) or ordinal (1 to 5) for Likert scaled responses to Domain 2 of the survey. Missing responses were coded as 0's, consistent with common practices in social network analysis (Scott, 2006). For other analyses involving statistical techniques (correlation or regression) non-responses were treated as missing.

The Use of Data Associated with Non-Respondents

In order to create meaningful interpretation of SNA data given a relatively low response rate in network analysis terms (78% (21 of 27) of organizations solicited for participation; 68% (21 of 31) taking into account the four groups of organizations) decisions needed to be made concerning the treatment of non-respondents and their associated data (Knoke & Yang, 2008). Non-respondents still had data attributed to them by other respondents which could help to demonstrate relationships within the services network under study. An example of the importance of non-respondents to this study is displayed in Figure 4, which depicts a referral network in which respondents are coded as blue, non-respondents are coded as red, and organization types from which responses were not expected, are coded as orange. As shown, only one of the non-respondents,

org32, appears to have limited connection (one line) into the network, while all other non-respondents, as well as the unsolicited organization groups, have multiple ways of connecting. Some, in fact, are relatively prominent members of the network as indicated by the size of the nodes representing *in-degree centrality*⁴ (Scott, 2006.)

Figure 4: ‘Referral to’ Network.



Legend:

● Responding organization ● Non-responding organization ● Non-responding organization group.

Node size represents the relative *in-degree centrality* based the number of times an organization was ‘referred to’ by other organizations in the network.

Based on this form of argument, and the need to respect the original boundaries set for this case study, the decision was made to retain non-respondents in the network analysis. Further choices therefore needed to be made concerning what forms of analysis would be appropriate given the limitations presented by the non-response.

⁴ In-degree Centrality scores for actors in the ‘referral to’ network are calculated based on the number of times an actor was ‘referred to’ by other actors in the network.

The Use of Directed vs. Undirected (symmetrized) Data

One of the approaches used in dealing with non-respondents in a whole network design is to symmetrize the data so that directionality in the data is forfeited; connections between responding and non-responding network members are now assumed to be mutual, even if only one of the dyad responds (Wasserman & Faust, 1994). This then allows for whole network measures (e.g. cohesiveness and whole network centrality) to be calculated. The validity of this approach, however, is weakened the larger the proportion of non-respondents. As a counter position, the directedness of relationships can be valid and useful information when wanting an understanding of the roles played by different actors within the network. There are no assumptions about symmetry of relationships between partners, attributes of centrality (i.e. prominence) assigned to nodes are probabilistically equal as they are simply based on the responses of the same participating organizations, and, as long as key organizations are represented among respondents, the directed maps can still tell a story about important connections. Further, for this case study, most of the critical analysis involved questions concerning trust and other directional constructs. For example, which organizations appeared to be the most trusted by others in their preparedness to work with recent immigrant families, and who were the brokers supporting the flow of work among (to and from) network members on behalf of immigrant families.

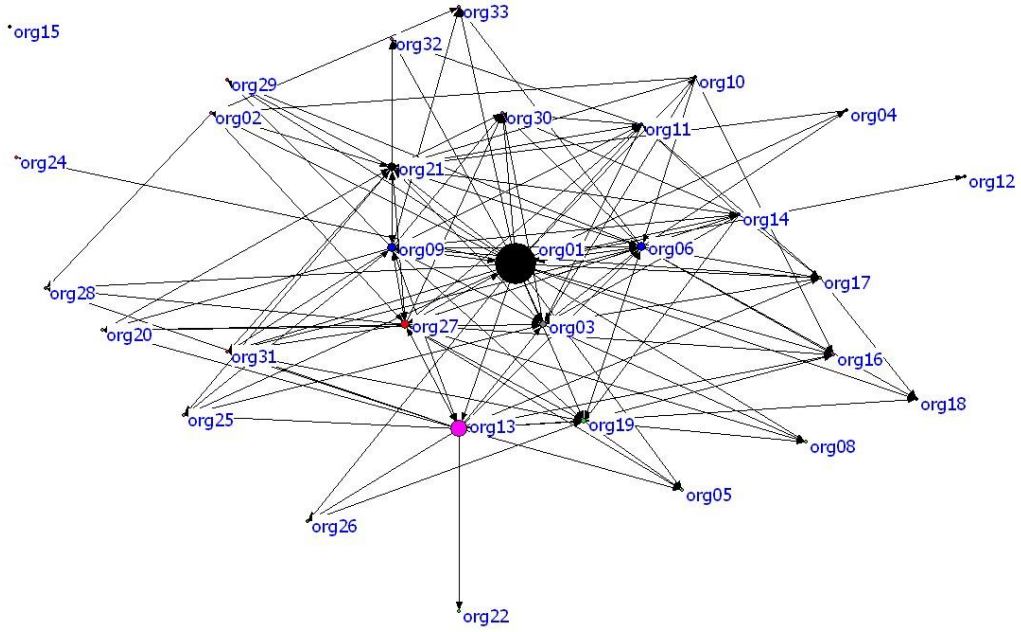
Costenbader and Valente (2003) present supporting empirical arguments comparing different sampling levels from true whole network populations, and the impact this had on the stability of 11 different centrality measures. Their results, using fifty-nine

whole network studies as their data source, demonstrated greatest stability with declining sample size when directed measures were used.⁵

Betweenness centrality is a SNA attribute calculated for each actor in a network by considering its location along the shortest paths between all members of a network. This measure was used to identify broker organizations in this study (Valente, 2010). Two maps are presented in Figures 5 and 6. Figure 5 uses normal (undirected) betweenness centrality to identify brokers, and Figure 6 uses directed betweenness centrality (Wasserman & Faust, 1994). In the first figure, the role of broker is exaggerated in only one organization as indicated by the node size, while in the directed graph brokerage is shared among others in the network. From the qualitative interviews when discussing general health concerns, the brokerage role on general health issues was indeed attributed to more than one actor. In reality, continuity in the direction of flow is important. The first map demonstrates the importance of the central organization, but most likely as a referring agency considering the direction of the arrows, and not as a broker maintaining the flow through the system. Other organizations were needed to help make this happen as described in the second map, and as supported in the qualitative data. Again, the use of directed analysis is supported over undirected.

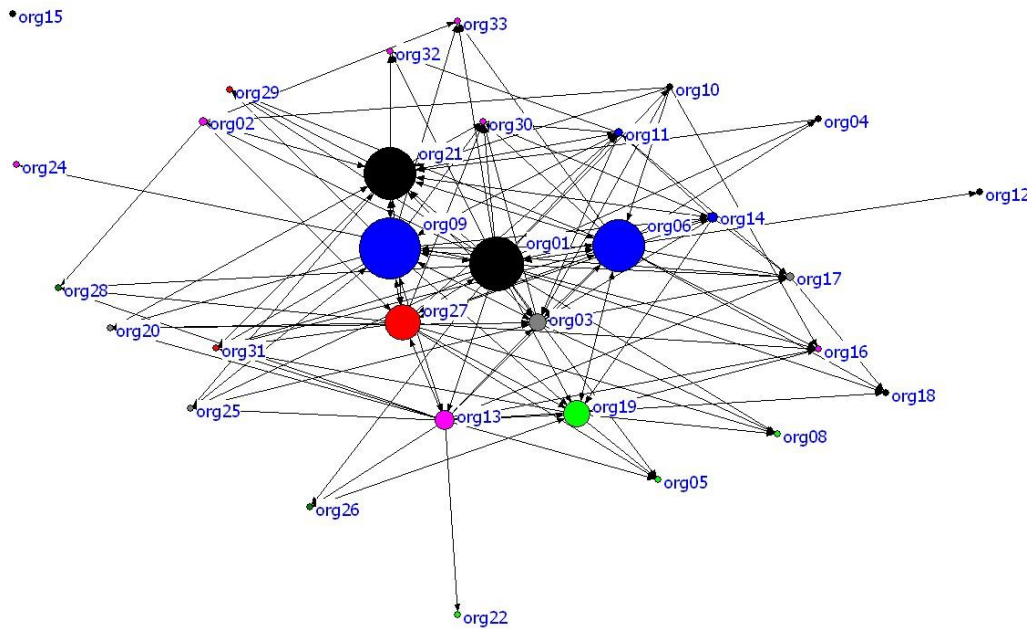
⁵ This was true for *in-degree centrality* and *directed betweenness centrality*. Stability in fact was retained for in-degree centrality when half of the respondents were dropped. The decline was greater for directed betweenness, but still reasonably stable at an 80% sampling level - close to a 0.80 correlation with the true directed betweenness measures for whole networks. (This drops almost linearly – with 70% sampling, the correlation with the true population betweenness measure approximates 0.70).

Figure 5: General Health & Betweenness Centrality



Node size indicates relative betweenness centrality. Colours represent different service sectors.

Figure 6: General Health & Directed Betweenness Centrality



Node size indicates relative (directed) betweenness centrality. Colours represent different service sectors.

Methodological Rigor

Triangulation of the Results

Triangulation of the results obtained through the two different methodological approaches occurred during the writing phase of this work, and involved moving iteratively between writing and further analysis. Results from both data sources were further examined for convergence and divergence within and between themselves (Miller & Crabtree, 1999). Results were accepted once the different sources were considered for their congruency and continuity, either through mutual validation (convergence), by adding explanation to rival theories (Yin, 2003) and/or adding context to observations in the SNA analysis with supporting data from more than one key informant. Coding of the qualitative data was conducted singularly by the primary researcher, without a review of all the data by a second researcher as is often done in order to validate codes (Crabtree & Miller, 1999). This meant that a different method of validation /confirmation was important to accomplish greater rigor in the analysis. The triangulation of results derived from two different methods, demonstrated construct validity and provided the rigor for this study.

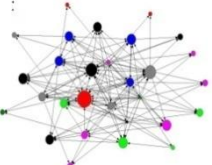
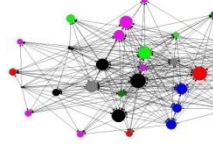
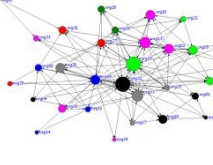
As a primary example: to determine the convergence of survey measures for cultural competency with the qualitative interview data, organizations were selected for review if they fit within the top quartile for one of two different competence self-assessment scores⁶ and one of two *competence trust* scores⁷. Descriptive statements

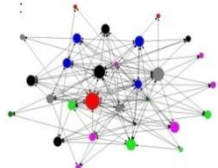
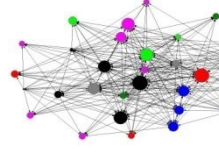
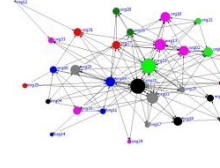
⁶ Two competence self assessment scores were based on responses to questions in Table 4: The two scores were equal to: A) The sum of responses to 5 competency questions creating a composite score; and B) The overall self-assessment score.

concerning these organizations were then drawn from the qualitative data, representing cultural competence constructs as supported by the literature (Cross, Bazron, Dennis, & Isaacs, 1989; Chrisman, 2007; Davis-Murdoch, 2005; May, 1992). The four organizations selected in this way indeed demonstrated qualities of competency and preparedness in working with recent immigrant families (Table 7).

⁷ Two *Competence Trust* scores were equal to: A) The number of times an organization was trusted 'mostly or absolutely'; and B) The number of times the organization was trusted 'absolutely' by others for their ability to work with recent immigrant families.

Table 7: Survey Scores and Qualitative Statements Representative of Cultural Competency Attributes for Organizations in the Top Quartile of Survey Competency Scores

					
Top Quartile	Composite Score	Self-Assessment Score	<i>Competence Trust</i> Score (trusted absolutely In-degree)	<i>Competence Trust</i> Score (trusted mostly or absolutely In-degree)	Regular contact Score* (In-degree Centrality)
Top Quartile Range	17 to 20	3,4	8 to 13	13 to 18	8 to 13
Org01	20	4	8	15	5
	<p>“... our staff team is multilingual so there’s a lot of staff going to each other’s schools to translate for different families.”</p> <p>“... we go to the walk-in clinic and you know that’s something you could do if you’re interested, if you want to get in right away, you know. Do you want to drive over or we can call and make an appointment. ...we don’t mess around... We’re practical.”</p>				
Org03	16	3	10	14	9
	<p>“...if there are parent focus programs we provide [a] children’s component...child development, child care is offered on site free of charge, so parents can be downstairs in a program and children are upstairs with child care staff...we’ve had some families that have come into our centre just because they have seen lots of woman dressed in traditional Muslim dress. So they sort of think this is a place that’s comfortable for me. ...we’ve had a lot of Arabic speaking families so we hired more Arabic speaking staff.”</p>				

					
Top Quartile	Composite Score	Self-Assessment Score	<i>Competence Trust</i> Score (trusted absolutely In-degree)	<i>Competence Trust</i> Score (trusted mostly or absolutely In-degree)	Regular contact Score* (In-degree Centrality)
Top Quartile Range	17 to 20	3,4	8 to 13	13 to 18	8 to 13
Org21	19	4	10	18	13
	<p>“...if you have the time you can listen and you can pick up on the questions people have. You can easier pick up on the cultural differences or you know. And you can build a trust.”</p> <p>“... the majority of the clients I work with don’t speak English, so we use interpreters... So, we have an interpreter service that is a temporary band-aid until the health care system [has] interpreter services for primary health care.”</p> <p>“...they provide interpreters and services that ... just helps getting people to and from appointments. I mean without their services we wouldn’t be nearly as effective with ... the refugees that we have.”</p>				
Org27	17	3	13	17	6
	<p>“... we shouldn’t expect to be able to get the whole story the first time the second visit, the third visit. I mean hopefully these are going to be things that as they gain a certain amount of <i>trust</i> in us and, and learn that we’re a very good door to enter into the health care system and that’s kind of how I view our [] centre as sort of the first door that they can go through to try and navigate the system.”</p> <p>“If I come I can’t afford milk. If I go to the clinic, the nurses are going to give me milk tickets to go to the store to exchange for a free 2 litre milk. Not all doctors’ offices are going to do that. You know you go; you take your child to the doctor, to see the doctor for immunization. It’s that routine thing, right?”</p>				

*Regular contact scores were added to this table for comparison.

The comparative analysis presented in Table 7 was likely sensitive in selecting culturally competent organizations, but not specific, as other organizations outside of the top quartile also displayed positive attributes consistent with the cultural competency literature. One organization in particular stood out as responsive and adept at meeting the needs of recent immigrant families with young children – inclusive of an outreach component, advocacy, cultural interpretation, and linguistic support. However, as a small relatively new program, its interaction with other organizations was reported to be limited, and consequently the program may not have been well known by many others. Many organizations responded ‘unsure’ when asked in the survey about this organization’s preparedness to work with recent immigrants.

The ‘regular contact’ scores for Org01 and Org27 both fell below the top quartile for ‘regular contact’ even though both ranked as culturally competent (Table 7). This challenged an assumption that regularly contacted organizations were more often trusted for their cultural competence. Regression was used to verify the influence of ‘regular contact’ on *competence trust* and to see if self-assessed competence made a difference. Only organizations participating in the survey were considered in this analysis. The two self-assessment scores were highly correlated with one another ($R^2 = 0.57$, $p=0.000$), however, as shown in Table 8, only the overall self-assessment score predicted *competence trust*, ($R^2 = 0.237$ and 0.245 , $p < 0.05$). ‘Regular contact’ was only mildly predictive of *competence trust* when *competence trust* was measured as “trusted mostly or absolutely” ($R^2 = 0.195$, $p = 0.40$). When ‘regular contact’ (contact > once a month) was added to the model with self-assessment, the predictive value was improved, particularly

when *competence trust* was measured as ‘trusted mostly or absolutely’, ($R^2 = 0.425$, $p=0.003$).

In summary, converging SNA statistics with qualitative measures proved to be less useful for identifying newer, less well known organizations for their cultural competence, although qualitative data supported the selection of those that did rank as competent. On the other hand, organizations could still rank high for their ability to work with recent immigrants (e.g. Org27 and Org01), even though many organizations had little direct contact with these agencies. The cultural competency of the organization (as self-reported here) also had an influence on *competence trust* from network members overall, but more importantly the predictability of *competence trust* was greatest when regular contact also occurred with organizations that self-assessed as culturally competent. In all, by combining qualitative and quantitative data, an opportunity was created for questioning observations and creating deeper meaning, with greater potential for interpretative accuracy as an outcome.

Table 8: Regression Analysis -Self-Rated Competency and Regular Contact (contact > once a month) as Predictors of Competence Trust

Independent Variable	Dependent Variable <i>Competence Trust</i> measured as:							
	Trust “mostly or absolutely” (In-degree Centrality)				Trust “absolutely” (In-degree Centrality)			
	Adjusted R-square	R-square	F Value	One-Tailed Probability	Adjusted R-square	R-square	F Value	One-Tailed Probability
Composite Score	0.024	-0.073	0.475	0.515	0.031	-0.066	0.614	0.471
Self-Assessment Score	0.237	0.161	5.904	0.028	0.245	0.169	6.156	0.026
Regular Contact	0.195	0.115	4.610	0.040	0.043	-0.052	0.863	0.367
Self-Assessment Score, Regular Contact	0.425	0.334	6.642	0.003	0.285	0.172	3.579	0.043

Competence Trust – An in-degree centrality score attributed to org[A], indicating the number of organizations trusting org[A]’s preparedness to work with recent immigrant families.

Regular Contact (> once a month) – An in-degree centrality score attributed to org[A], indicating the number of organizations in regular contact with org[A].

The ‘Composite’ score is the sum of scores for 5 questions (range 1 to 4 for each question). The 5 questions addressed attributes of cultural competency in working with recent immigrants. Working with families was not specified.

An Overall Self-Assessment score was based on a response to, “Overall, how well prepared is your agency / program for dealing with the unique needs of recent immigrants and their families?” The response range was 1 to 4: ‘not very prepared’ to ‘very prepared’.

Member Checking

The credibility of the study findings was further assessed from the viewpoint of study participants. Preliminary findings of the survey results were brought to a meeting for member checking (Creswell, 1998; Lincoln & Guba, 1986) with a group of eight respondents representing different participating organizations or programs. Those attending were supportive of the principal messages put forward in the results. That is, the positioning of different member organizations within the network depending on the issue at hand, and the identification of key members as trusted organizations in their ability to work with immigrant families.

Conclusion

A level of trust in the research and the researcher was accomplished, as illustrated by those who did participate. At all phases of the study, opportunities for potential respondents to measure the integrity of the researcher were incorporated. This was particularly important since, apart from the sensitivity of the subject matter, the researcher came from outside the service community, and, in fact, from outside the province where the study occurred. The integrity of the research findings themselves were tested through the triangulation of methods and sources including the comparison of results coming from multiple perspectives. With the use of more than one method having overlapping but different participants, the chances of this research giving a true account of the system under study were greatly enhanced. The presentation of the results from this study will have much to do with its acceptability, meaning and transferability, always to be

determined by the reader - with an eye for rigor manifested in a sense of completion (Lincoln & Guba, 1986).

A few influential factors need to be considered with respect to the study response and the difficulties in recruitment. Disruptions in the continuity of contact occurred as a result of, 1) the use of one researcher running two different streams of research simultaneously, and, 2) the occurrence of the H1N1 outbreak in 2009 which reduced the availability of both the respondents and the researcher. Data collection consequently occurred over several months. Some potential respondents were reluctant to participate, seeing themselves as outside of the health sector even though, from a health determinants framework, their work had much to do with influencing health. It is likely that others may not have wanted to address the research questions at all because of their potential sensitivity (Records & Rice, 2006). Finally, the two-tier approach to recruitment added a layer of complication which may have negatively influenced levels of participation (Weierbach, Glick & Fletcher, 2010; Wray & Gates, 1996). To adjust to a less than optimal response rate and retain credibility, reason and pre-existing empirical evidence were considered when making analytical choices.

One final important observation needs to be made. From the discussions and interactions that occurred between the researcher and various individuals during the conception, development and implementation of the study, it was collectively apparent that providers cared. In the interest of their clients, participants were willing to engage in this research, taking time and over-coming any anxieties they might have had in order to do so. Altruism is a strong motivator for participation in almost all research (Fry, 2008).

We as researchers are ultimately dependent on that altruism. Hopefully, I, as a researcher, will have been able to reciprocate through unfolding a story that credibly portrays a true account of the case, with value and meaning to those who participated.

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CHAPTER 3

BROKERING FOR SERVICES FOR RECENT IMMIGRANT FAMILIES IN ATLANTIC, CANADA

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BROKERING FOR SERVICES FOR RECENT IMMIGRANT FAMILIES IN
ATLANTIC, CANADA

Abstract

In parts of Canada with relatively low levels of immigration compared to large urban centres, service providers may need to collaborate more closely with one another so that cultural competencies and resources are shared. This case study using mixed methods (social network analysis and qualitative inquiry) describes how a network of community-based services worked together to address the primary health care needs of recent immigrant families with young children. Thirty-one organizations were identified in 2009 as part of the network serving a geographically bounded neighbourhood within a mid-sized urban centre in Atlantic Canada. Twenty-one organizations participated in the network survey and 14 key informants from the service community were interviewed. Broker organizations were identified as pivotal for ensuring connections among network members, for supporting immigrant family access to services through their involvement with multiple providers, and for developing cultural competence capacities in the system overall. Network cohesiveness differed depending on the type of need being addressed, as did the organizations playing the role of broker. Service providers were able to extend their reach through the co-location of services in local centres and schools attended by immigrant families and their children. The study demonstrates the value of strong ties across service sectors to ensure the delivery of comprehensive services to young immigrant families challenged with language, cultural and other barriers in an unfamiliar system of care.

Background

Recent immigrants to Canada are faced with a new and unfamiliar health system, (Wu *et al.* 2005, Reitmanova & Gustafson 2008, Guruge & Humphreys 2009). The transitional experiences of new immigrants and their families, requires that services within receiving communities be adaptive to their circumstances (Isaacs 2010, Lebrun & Dubay 2010). Atlantic Canada, with its relatively small immigrant population compared to other parts of the country, has a unique set of challenges. Locations of low immigrant density may not have sufficient services tailored to address the specific needs of new populations (Pitkin Derose *et al.* 2007, Berdahl *et al.* 2007). Providers within the available generic services, in attempting to meet the demands and needs of long standing residents, may not always be attuned to the specific concerns of immigrants (Casey *et al.* 2004, Asanin & Wilson 2008). Opportunities for developing these competencies can be missed simply through lack of exposure (Burcham 2002, Campinha-Bacote 2003).

Cultural competence is a set of “congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enables the system or professionals to work effectively in cross-cultural situations” (Cross *et al.* 1989, pg. 7). In any service system still maturing in its capacities for addressing immigrant needs, sharing the resources and competencies of others in dealing with new Canadians is particularly important – this becomes a prerequisite of a culturally competent system. “The network model is based on the premise that collaboration and cultural competence are each essential to provide appropriate services to racial/ethnic minorities and that these concepts are related” (Whitaker *et al.* 2007, pg. 192).

The purpose of this paper was to describe how a network of community based services collectively addressed the PHC needs of recent immigrant families with young children and how this was supported by a subset of *broker organizations*. *Broker organizations* are organizations that help to move things – information, resources and people – between and across inter-organizational network members (Butts 2008). Broker organizations can also connect services to resources outside of their immediate services sector (Gould & Fernandez 1989, Cross & Prusak 2002). The role of broker is a significant concept in this paper given the premise that access to needed services for recent immigrant families can require negotiating with a variety of different providers.

This case study focused on the network of community-based service organizations providing services to recent immigrant families with young children newborn to 6 years of age living in a geographically bounded neighbourhood of a mid-sized urban centre in Atlantic, Canada. The neighbourhood was identified because of the concentration of immigrants living in this area compared to the rest of the municipality. Three research propositions for this case study are as follows:

- Organizations designated to provide PHC services are part of a network of community service organizations that interact with one another when addressing the PHC needs of children of recent immigrants,
- Brokers exist within the network of organizations that assist in connecting services to one another in order to address the PHC needs of immigrant children.
- How organizations interact with one another, and the brokers that enable these interactions, will differ depending on the type of PHC need being addressed.

PHC services in Canada are inclusive of primary care (PC) and public health (PH) programs and services (Meagher-Stewart *et al.* 2009). PC services are often provided by private practice, fee-for-service physicians paid through government insurance programs, or by salaried health professionals working as part of multidisciplinary teams in settings such as community health centres (CHC). PH programs are government administered services, covering aspects of health promotion and disease prevention within different community venues. The Alma Ata Declaration (WHO 1978) and subsequent related documents which encourage inter-sectoral collaboration to address health (PAHO 2007, WHO 2008) are a natural response to how families recognize and address their own health needs (Van Olmen *et al.* 2010). This broader perspective that is inclusive of different kinds of supporting services, defines a primary health care ‘system’ (WHO 2008).

The PHC needs considered in this study were child nutrition, gastro-intestinal (GI) illness, and child growth and development. These PHC issues were selected because of their relevancy to young children; GI illness was felt to be a potentially under recognized concern for immigrant children arriving from countries with high disease prevalence including chronic parasitic infections that can also affect nutritional status (Geltman *et al.* 2001). Also considered were general health and a category for other concerns.

Method

Two methods of data collection were used to capture information for this case study. This follows Yin’s framework for case study design, wherein either or both qualitative and quantitative approaches can be used to create different sources of data

related to pre-defined study propositions (Yin 2003). Data collection methods used were, 1) an on-line social network survey asking representatives from different organizations about their relationships with other services in the study neighbourhood, and, 2) key informant interviews conducted with service providers working within the service community.

Sample Selection

Sample selection for the study survey followed a whole network approach used in social network analysis. In this approach all network members are targeted for inclusion (Provan *et al.* 2007). Criteria are used for setting the boundaries of the network and defining networking membership. In this case, a network member was defined as an organization serving the neighbourhood of interest and providing services to recent immigrants and/or to families with young children, newborn to 6 years of age. Using these criteria, a list of organizations was created starting with organizations attending a health fair for immigrants in 2009. Organizations were added to this list from a comprehensive reference catalogue of community based services managed by a local agency. A staff member from the study neighbourhood's community health board, and the health coordinator for a local immigrant settlement service both reviewed the list. They were asked to delete or add services based on the network membership criteria. These decisions were vetted by the researcher through a review of each organization's mandates, and during initial contacts with organization representatives.

Twenty-seven organizations were identified in this way for recruitment as survey participants. In addition, four generic groups of organizations – family doctors, day

cares, walk-in clinics, and cultural associations – were added to the organization list. It was decidedly difficult to target specific organizations or practices from these groups given that families from the neighbourhood often traveled across the city for these services. The final list of 31 organizations constituted the study network, and became the list of services appearing in the network survey instrument. Organizations were classified under the following service sectors - public health, primary care, immigrant services, family out-reach and drop-ins, child and legal services, family counselling, and an ‘other’ category involving services such as housing, food banks, cultural associations, and a public library.

Key informants were selected for interviews starting with recommendations from other researchers familiar with the local services offered to immigrants and young families. Other key informants were identified from the organization list and as recommended by the earliest informants interviewed. Selection was purposeful to ensure variation in the types of professions interviewed, and representation of different service types – public health, primary care, settlement services and non-government organizations.

Organizations selected for either arm of the study, were recruited through e-mailed invitation and follow-up phone calls to organization directors or managers. The director or manager either participated themselves or else nominated one or two designates with the criteria that designates be able to respond in an informed way concerning their organization’s activities and partnerships with other agencies.

Data Collection and Analysis

SNA Survey

The survey instrument was developed using the format and types of questions applied in previous service delivery network surveys (Kwait *et al.* 2001, Provan *et al.* 2005). The survey was tested with nursing students for user readability and accessibility, and for face and content validity with four epidemiology colleagues. The instrument was then assessed for relevancy and acceptability by members of two local agencies associated with the study network. The reliability of data summaries was established after running repeated trials of the software program used to create these from capture data.

The survey was made available on-line, took approximately 15 minutes to complete, and consisted of two domains. The first domain addressed attributes of the responding organization, for example, type of organization, type of population served, and types of services offered. The second section listed the 31 network organizations and asked respondents a series of questions about their relationships with each other organization on the list. Respondents were asked “How frequently are you or your co-workers in contact with each organization?” Respondents answered using a 5 point likert scale. They were also asked “Do you or your co-workers work with this organization concerning young immigrant children and []?” substituting [] with the selected PHC needs GI illness, nutrition, growth and development, general health and other concerns. Responses to this latter series of questions were coded as binomial (0,1).

All analyses of the survey data were conducted using UCINET (Borgatti *et al.* 2002) and NetDraw, (Borgatti 2002) software developed to support social network analysis (SNA) applications. The field of SNA considers the structure of the social environment, and has developed a series of methods for measuring and describing “patterns or regularities in relationships among interacting units” (Wasserman & Faust 1994, p.3). The SNA methods used in this study were largely descriptive, using sociograms (network maps) and tables to display relationships among organizations. *Network density* was calculated as a measure of cohesiveness among network members, that is, how often network members connected with one another in response to different questions. Density is equal to the total number of connections observed, divided by the total number of possible connections among network members (Scott 2006, p. 71).

Directed *betweenness centrality*, a value calculated for each network member, allowed for the identification of organizations that acted as brokers, linking network members to one another. Directed betweenness centrality scores were calculated based on how often each member fell along the shortest path (number of connections) between all other members of the network (Scott 2006 p.86). The paths were directional (one way).

Key Informant Interviews

One-on-one interviews with key informants ran from 45 to 90 minutes. Interviews took place in the respondent’s work setting, or as necessary by phone at the convenience of the respondent. An interview guide was used, which included questions relating to types of roles played by different organizations in the network. All interviews

were transcribed verbatim and transcripts imported into NVivo 8 for analysis (QSR International 2007). A technique of constant comparative analysis was applied, starting with original propositions to categorize and code data; these were then reorganized, regrouped and cross referenced as new sets of data became apparent, and /or prominent themes began to take hold (Crabtree & Miller 1999).

Triangulation of Results

Rigor in this study was accomplished through triangulation. Both data sources were analyzed independently, and then results brought together to compare and examine within and between themselves for convergence or divergence of meaning (Miller & Crabtree 1999). Interview data were used to help explain survey findings. As results were compared and as questions arose, further examination of the original data was prompted, continuing the process of constant comparison. Different interpretations were considered for divergent findings until satisfactory explanations and continuity of the discourse was achieved. The qualitative interviews offered context for the relationships observed in the survey results, and interpretation behind the role of broker.

Ethics: Ethics approval was received for this research from the sponsoring university and regional health system ethics review boards. Informed consent was obtained from all participants.

Results

Context of the Case

The study neighbourhood included two adjacent city planning zones, with immigrants represented as visible segments of the population in both (15.3% of zone A

and 8.9% of zone B, Census 2006). Visible minority groups within the neighbourhood, presented in order of magnitude, were Arab and West Asian, African descent, South Asian, and Chinese (Statistics Canada 2007).

Twenty-one of the 27 organizations approached participated in the SNA survey, a response rate of 78%. Fourteen key informants were interviewed, 12 in person and 2 by phone, and included a mix of professionals –one NGO administrator, four social workers (one hospital based, one outreach and two drop-in centres), three settlement workers (two different organizations), four nurses (three from PH and one from PC) and two PC physicians.

Based on both sources of data, organizations participating in the study provided a broad range of services for families with young children. These included health screening and assessment, case management, advocacy, family outreach services, group support and education, medical treatment, interpreter support and language training, and other modes of family support and counselling. Services addressed a broad range of issues – child growth and development, infectious diseases, nutrition, literacy, housing, legal and financial needs, immigration settlement adjustment, mental health and other health concerns.

Network Cohesiveness and the Brokers that Support This

Tables 9 and 10 present the network density and directed betweenness centrality scores (directed) for the network and organizations in this case. In relation to PHC needs, the cohesiveness of the network (Table 9) was highest when dealing with General Health concerns (density score of 0.156; 95% CIs 0.123, 0.189) and lowest for GI illness

(density score, 0.028; 95% CIs 0.013, 0.043). Non-overlapping confidence intervals (CIs) demonstrated a statistically significant difference between the general health density score and all other density scores. Of the organizations listed in Table 10, org09, a public health program, scored the highest as a network broker when dealing with General Health (centrality 102.3), while org06, another public health program, acted as the central broker for GI illness (centrality 71.5).

Table 9: Network Density*and Number of Network Ties given Different Reasons for Connecting

Network Measures	Regular Contact	PHC Need					All PHC Needs
		General health needs	Growth & Development	Nutrition	Gastro-Intestinal Illness	Other PHC Needs	
Density (Stand.Dev.)	0.181 (0.385)	0.156 (0.363)	0.068 (0.251)	0.072 (0.259)	0.028 (0.165)	0.087 (0.282)	0.411** (0.838)
No. of Ties	168	145	63	67	26	81	–
Density Standard Error		0.012	0.008	0.008	0.008	0.009	
95% Lower CI		0.133	0.052	0.055	0.013	0.069	
95% Upper CI		0.179	0.084	0.089	0.043	0.105	

*The density is the total number of ties (connections) divided by the total number of possible ties among network members. **Average density calculated for valued data (5 point Likert scale response). 95% Confidence Interval (CI) = density score +/- 1.96*SE

Table 10: Directed Betweenness Centrality Scores for Organizations in Regular Contact, or when working with others concerning the PHC Needs of Immigrant Children (by Service Sector).

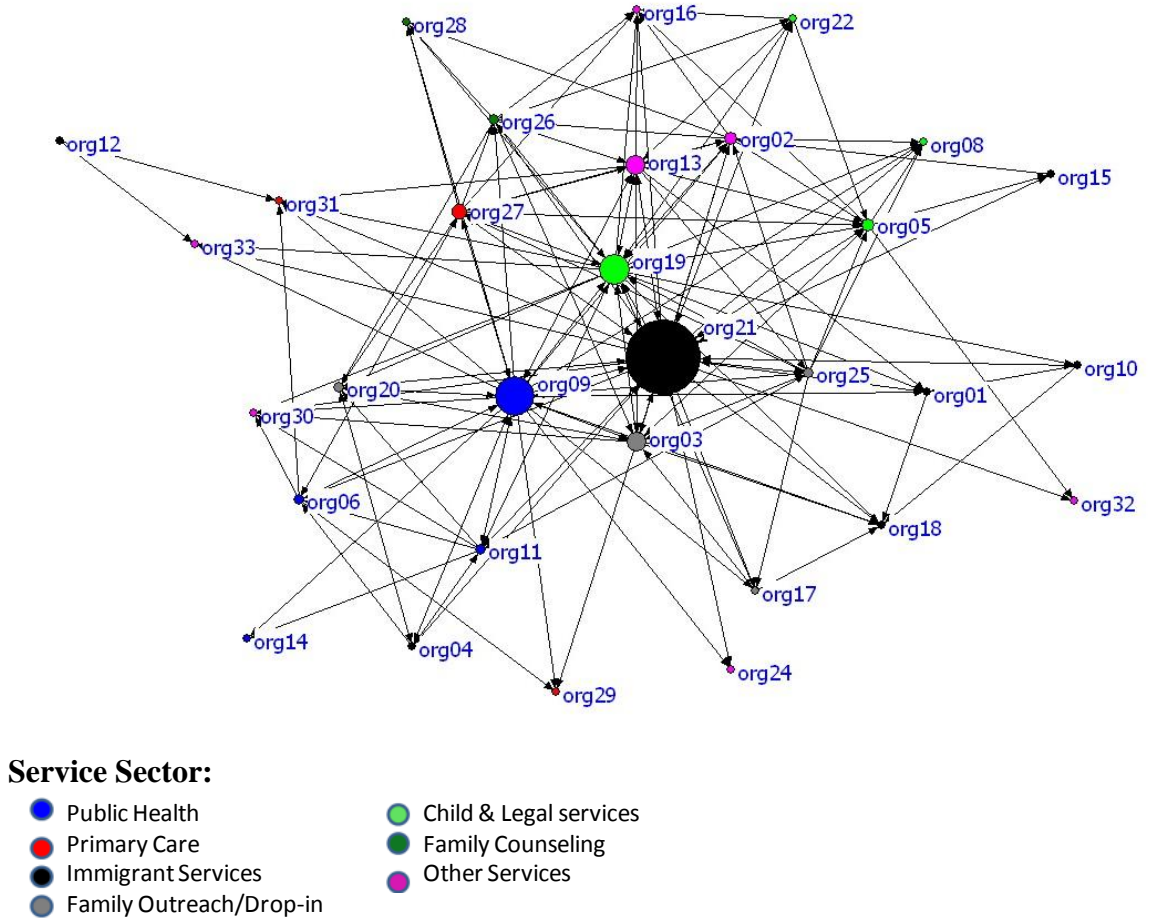
Sector	Org #	Regular Contact	PHC Need					All PHC Needs
			General Health	Growth & Development	Nutrition	GI Illness	Other Issues	
Primary Care	org27	15.9	52.9	8.8	0.3	0.0	0.0	17.7
	org29*	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	org31*	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Public Health	org06	3.3	83.7	0.0	0.0	71.5	0.0	14.7
	org09	70.8	102.3	107.8	69.2	39.5	0.0	37.6
	org11	7.0	1.9	20.8	22.3	0.0	0.0	2.2
	org14	0.0	5.9	14.9	0.0	0.0	0.0	1.2
Immigrant Services	org01	0.2	89.7	0.0	0.0	0.0	0.0	24.4
	org04	1.1	0.0	0.0	0.0	0.0	0.0	0.0
	org10	0.8	0.0	0.0	0.0	0.0	0.0	0.4
	org12	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	org15	0.2	0.0	0.0	0.0	0.0	0.0	0.0
	org18*	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	org21	153.7	86.8	41.6	65.3	23.5	31.9	134.9
Drop-in / Outreach	org03	25.5	19.5	13.7	28.7	1.5	2.3	27.6
	org17	0.2	2.3	11.1	10.0	0.0	0.0	1.3
	org20	7.2	0.3	1.0	1.3	0.0	0.0	0.3
	org25	3.6	0.2	0.0	1.7	0.0	0.0	0.8
Counselling	org26	5.0	0.0	0.0	0.0	0.0	1.3	3.1
	org28*	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Child & legal	org05	12.4	0.0	0.0	0.0	0.0	41.9	49.3
	org08*	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	org19	50.1	37.7	34.3	37.0	0.0	0.0	24.1
	org22	2.2	0.0	0.0	0.0	0.0	8.6	6.1
Other	org02	10.3	2.3	0.0	0.0	0.0	0.0	2.5
	org13	23.5	24.4	0.0	1.3	0.0	0.0	7.7
	org16*	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	org24*	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	org30*	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	org32*	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	org33*	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Mean (SD)		12.7 (30.1)	16.5 (31.1)	8.2 (20.9)	7.6 (18.0)	4.4 (14.6)	2.8 (9.2)	11.5 (25.8)
Maximum		153.7	102.3	107.8	69.2	71.5	41.9	134.9

*Non-responding organizations. 0's are expected since responses are needed to show path direction through these nodes.

Brokers Supporting Regular Contact among Network Members

Figure 7 represents responses to the survey question “how frequently are you in contact with each of the following organizations” and, in this case, maps relationships among organizations where contacts occurred more than once a month. Relationships are represented by lines between nodes (circles); the nodes represent the organizations. The size of each node is a representation of directed betweenness centrality, and a relative indication of how each organization functions as a broker within the network. Based on node size, one of the settlement services, org21, appears as the main broker in this regular contact network. Other minor brokers, a child and legal service (org19) and a public health service (org09), focused on children’s needs rather than immigrants specifically; however, as demonstrated in the network map, each minor broker worked with different sets of organizations directly.

Figure 7: Regular Contact Network* (How frequently are you in contact with each of the following organizations?)



*relative betweenness centrality (directed) scores are represented by node size. Contacts, represented by connecting lines, are considered regular if frequency of contacts is greater than once per month.

From interview data, organizations most noted for their engagement in the needs of immigrant families were settlement services, family drop-in centres, public health and a CHC. Settlement service org21 was the most frequently mentioned organization, acknowledged by interviewees as a lead broker around the needs of immigrants. This organization acted primarily as an intermediary with Canadian immigration authorities for arriving refugees and other high need immigrants, and facilitated the integration of

immigrants into the local society. Their role was to ‘network’ on behalf of immigrants and to connect families to services that could meet their needs:

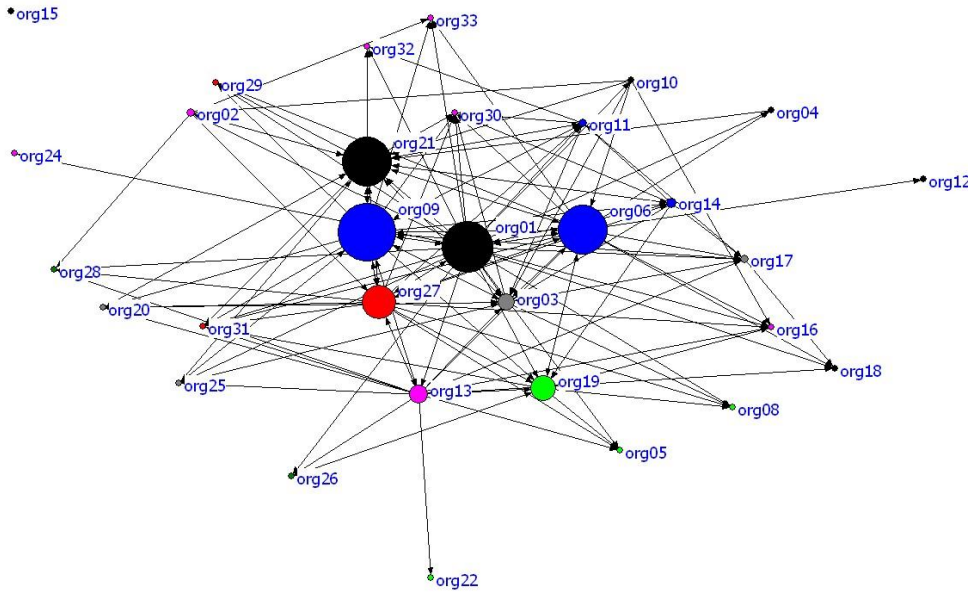
It is important for people to get connected to everything possible... So we help our clients register their children to school. We help them access health care, whether it's the primary health care through family doctors ...even by accompaniment, going to the children's hospital. We even have programs... where parents can learn more about disciplining children within the Canadian context. (Settlement worker 011)

Different Brokers for Different PHC Needs

Reduced network cohesiveness around selected PHC needs as measured by density scores in Table 9, was paralleled with a visible increase in network fragmentation (fewer ties and fewer engaged members) as illustrated in figures 8 to 12. Figure 8 portrays the relationships among network members when addressing general health concerns. Public health (org09 and org06) and settlement services (org21 and org01) are all placed in relatively strong positions as brokers concerning this issue. Org01 was not previously identified as a broker in the regular contact network. Org01 was, however, described in interviews as a source of referral for other organizations dealing with health and related concerns for immigrant families attached to the school system.

Like whatever the family asks about [we] will try to find out. So if they're looking for a job, we would try to access employment services; if they're looking for a house, we would try to get information about housing. (Settlement worker 19)

Figure 8: General Health Concerns Network



Service Sector:

- Public Health
- Primary Care
- Immigrant Services
- Family Outreach/Drop-in
- Child & Legal services
- Family Counseling
- Other Services

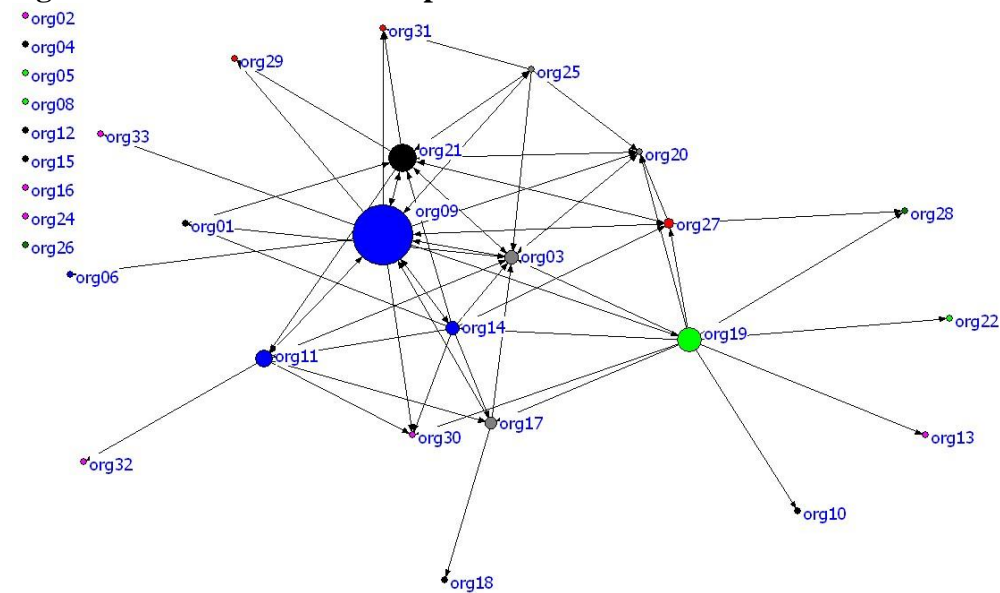
As stated by informants, this school based program had a unique opportunity for connecting with recent immigrant families. Settlement workers were available to the entire family, not just to the children in school. Principals of schools actively identified new arrivals and referred them to settlement staff. Most immigrants with children attending school did not have connections to other settlement services: “they are people that are getting care mostly on their own, that are using the health care system as it is, with not really having immigrant agencies as advocates” (Settlement worker 017).

Orientation to services was still needed by many of the families, with language continuing to be a major barrier: “If a person is not within their mandate and if maybe they don’t speak English, well they might really struggle” (PHN 020). Although families were

connecting to PHC services when children were born locally, families with children born outside of Canada could also be missed.

Figure 9 displays interactions among network members concerning child growth and development. Public health (org09) played a central broker role in addressing child growth and development concerns. Child and legal services (org19) also acted as a broker, that is, as a ‘cutpoint’ bringing otherwise disconnected organizations into the network (Burt 2000, Mueller-Prothmann & Finke 2004).

Figure 9: Growth and Development Network



Service Sector:

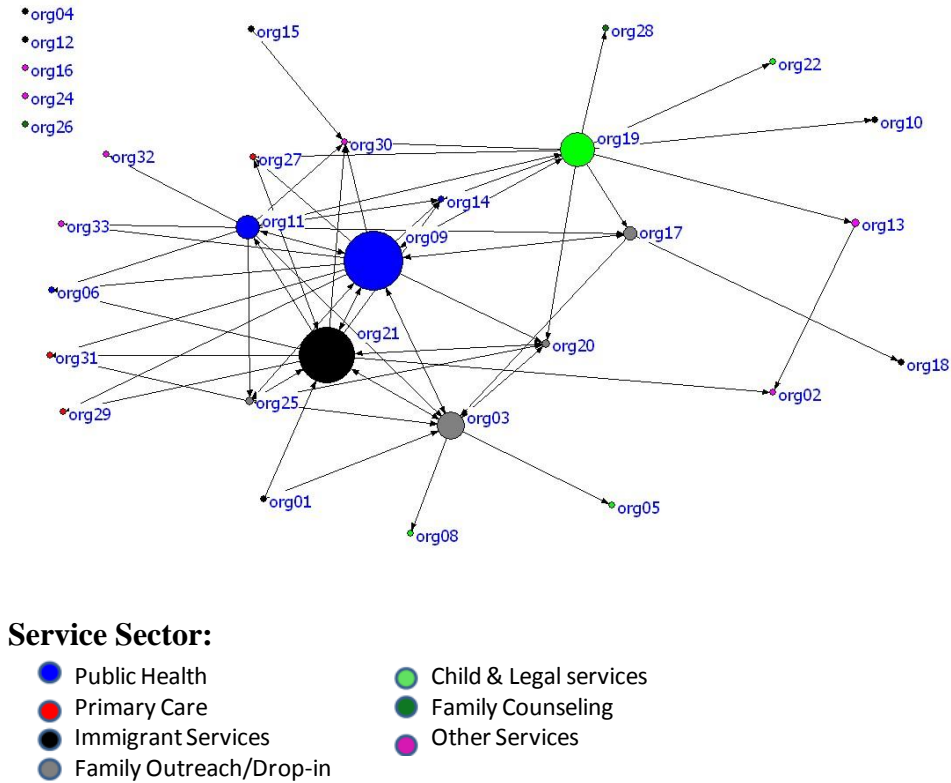
- Public Health
- Primary Care
- Immigrant Services
- Family Outreach/Drop-in
- Child & Legal services
- Family Counseling
- Other Services

Both org09 (PH) and org19 (a child and legal service) were part of larger, established institutions, with broad geographic boundaries for service delivery. Both fell under the administration and mandates of the regional and provincial governments.

Smaller, less historically based programs with reliance on volunteers had less capacity for building relationships. One informant associated with a small, relatively new outreach program stated: “So we go, we network, we tell them about our service but at the same time there’s always this clause that your client may not get a volunteer and they may not get us” (Outreach worker 012).

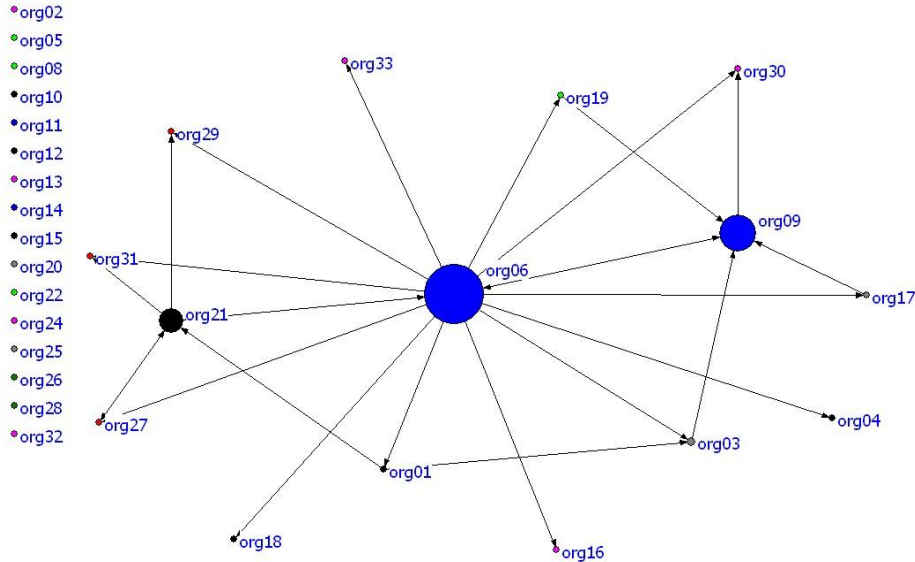
Settlement service org21 and PH org09 also acted as brokers for nutritional concerns (Fig. 10). In addition, one of the drop-in centres, org03, was essential as a cutpoint connecting org08 and org05 into the network. Org21 considered nutritional concerns for refugees, an important reason for seeking out family doctors who would assume the medical care of families with young children: “more and more of what we are seeing is many of them ... have high, complex health issues ... and with the children, malnourishment” (Settlement worker 017).

Figure 10: Nutrition Network



The GI Illness Network (Fig. 11) displays a small number of services engaged around gastro-intestinal diseases affecting immigrant children. The role of broker played by the public health communicable disease team (org06) was critical given the fragmentation of services around this issue. For GI Illness, PH org06 was needed to connect organizations responsible for child growth and development programs (PH org09, and Drop-in Centres org03 and org17) to PC services (org31, org29, and org27).

Figure 11: GI Illness Network



Service Sector:

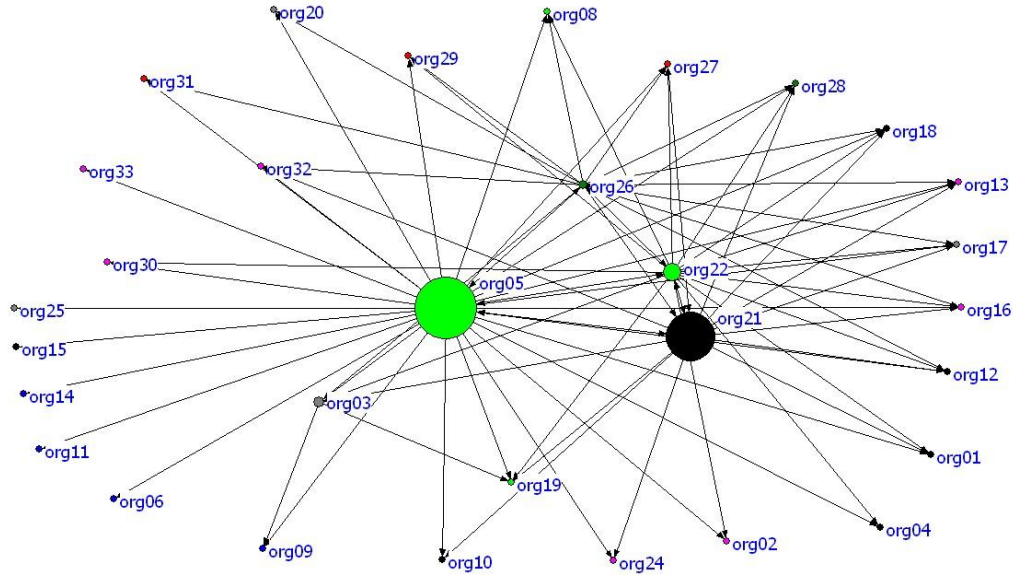
- Public Health
- Primary Care
- Immigrant Services
- Family Outreach/Drop-in
- Child & Legal services
- Family Counseling
- Other Services

Interview participants spoke of infectious disease concerns for immigrant families generally, not just GI illness; however, the broker role of PH was still evident within this broader context: “There would be a flag maybe that this child or the family member needs to see the public health nurse immediately or get connected as soon as possible” (Settlement worker 011). PH often relied on the receipt of a laboratory result as follow-up to a physician’s diagnostic screening before becoming involved with a family. However, according to the interviews, many recent immigrant families found it difficult to negotiate for health services or see a physician on their own. Even when connected to a PC practitioner, interpretation and advocacy was often still needed:

I just had a client that has hepatitis B, [who] came to my office and says ‘I think I’m going to die’. She’s really afraid. ... ‘If I start this medication I’ll have to do it for the rest of my life. It costs a lot of money.’ I didn’t even know that she was not accessing the Pharmacare Program or the Family Program that exists. (Settlement worker 011)

In the Other Needs Network (Fig. 12) one of the legal service organizations, org05, was identified as the most prominent network broker. Settlement service respondents described some of their involvement with legal services. The need to secure immigrant status for family members was a primary concern. Other concerns related to child protection and the need for advocacy and cultural interpretation by settlement workers in these situations, particularly where cultural differences in child rearing practices arose. The central role of legal services in this network of ‘other needs’, and the connections made into the network through this node by almost all other services, attests to the importance of legal concerns for recent immigrant families and their wellbeing.

Figure 12: Other Needs Network



Service Sector:

- Public Health
- Primary Care
- Immigrant Services
- Family Outreach/Drop-in
- Child & Legal services
- Family Counseling
- Other Services

Brokers for PC Services / PC as Brokers

Physicians in private practice tended not to be actively involved in the broader network of services concerned with immigrant families. Availability of time and work for no pay were identified as disincentives for their involvement. Referrals and phone intake, or case conferencing were the most common mechanisms for engaging physicians. Many of these connections were initiated by a PHN and/or settlement worker around a variety of issues requiring the services of a PC physician. “[T]here are situations where we will contact the doctor ... maybe the mom’s milk isn’t coming in or we’re concerned about weight gain, something like that” (PHN 20). In relation to refugees:

because they come with huge needs or maybe concerns because they spent a lot of time in a refugee camp or they had spent a lot of time being displaced ... a lot of parents would require their children to be checked by doctors ... (Settlement worker 017)

PC physicians, despite their lack of engagement in the network, were recognized by respondents as a link to other needed services outside the study boundaries, including diagnostic services and specialists. “I mean you don’t see a specialist just because you’re having a baby. It’s just not the way it’s done here. So, yeah, children see family doctors, not paediatricians generally” (PC Physician 16). In this regard, PC physicians also played a major broker role for the entire network, and were in a controlling position as cutpoints for accessing this alternate network of health resources.

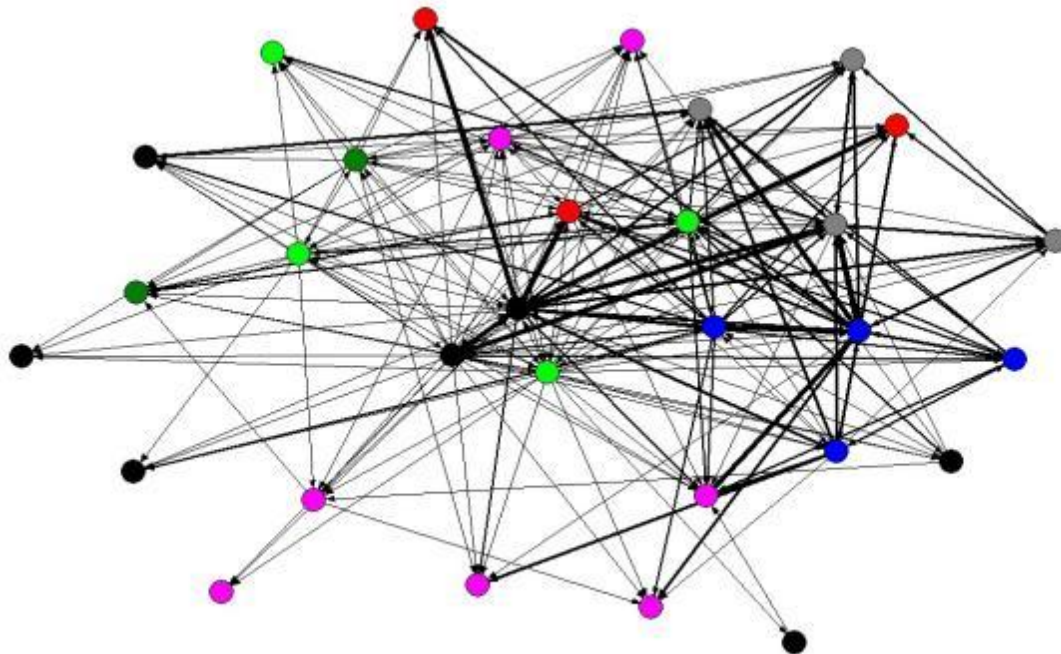
The CHC represented in this study also had a different network of resources other than those identified in the network survey; these resources were co-located services within the CHC contracted with another organization to provide services on site: “We operate within the [district health authority] to share mental health care, which includes a couple of psychiatrists and psychiatric nurses that offer counselling, both for adults and for children. Their services include dieticians. We have occupational therapists (and) physiotherapists...” (CHC physician 30). As a location with access to a different set of services, the CHC was acting as a broker to resources otherwise unavailable, or limitedly so, to the study neighbourhood and the organizations involved.

The Bridge

The information presented so far has illustrated how network members realigned with one another depending on the issue, and how different organizations assumed broker

roles accordingly. Some organizations were engaged in multiple issues and associated relationships with others. The ‘All PHC Needs’ network illustrated in Figure 13 displays the strength of ties between organizations represented by the thickness of the lines linking network members and based on the sum of the PHC relationships so far described.

Figure 13: All PHC Needs (combined) Network



Service Sector:

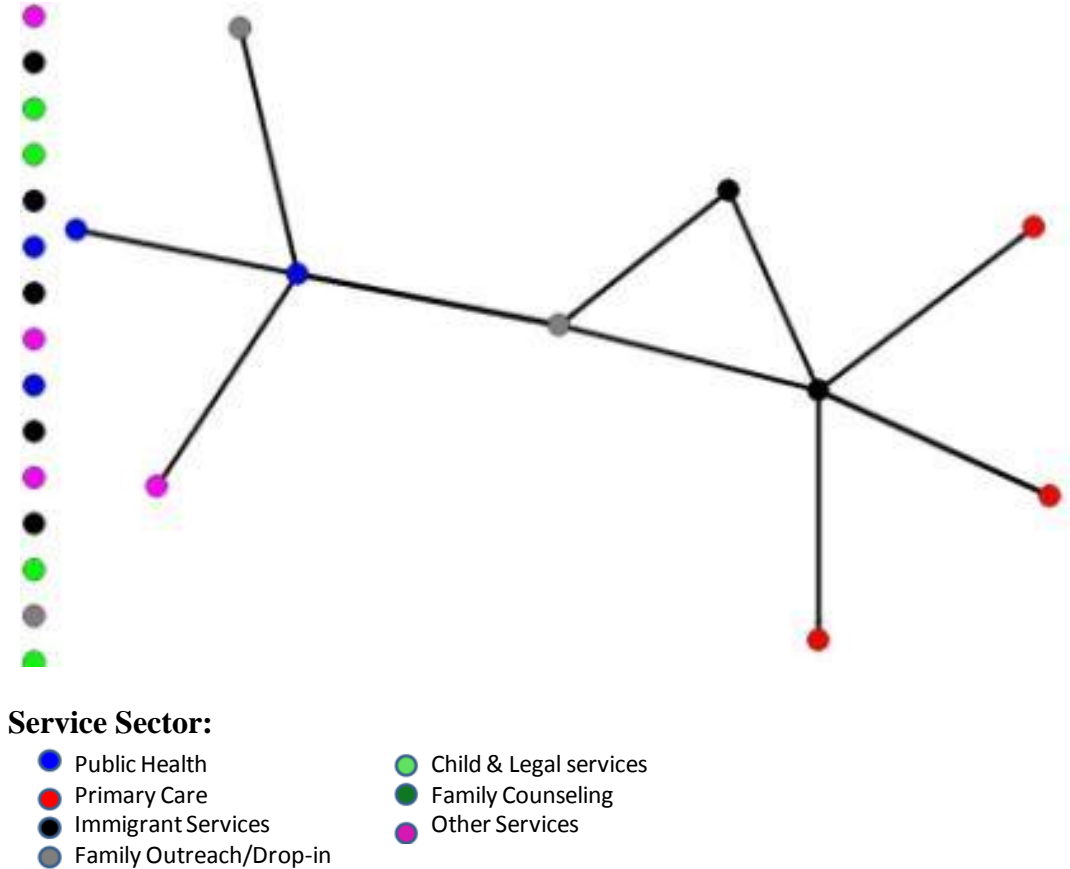
- | | |
|---------------------------|--------------------------|
| ● Public Health | ● Child & Legal services |
| ● Primary Care | ● Family Counseling |
| ● Immigrant Services | ● Other Services |
| ● Family Outreach/Drop-in | |

To identify the strongest organizational linkages for dealing with immigrant family concerns, organizations involved with at least one other organization in 3 or more types of PHC concerns were selected. This created the ‘backbone’ network map illustrated in Figure 14. In this map of strongly tied organizations, public health and immigrant services have the greatest number of strong connections to other partners;

however, each connects strongly to a separate set of organizations. The drop-in centre in the middle, although it has fewer direct connections compared to others in this map, plays a particularly powerful role for immigrant families with young children. This centre represents a bridge (Valente & Fujimoto 2010) between other prominent members and their associated linkages, bringing the network together on multiple issues faced by immigrant families:

We get asked a lot informally like, ‘where can I go about this’, or ‘my doctor says this’ or ‘I’m concerned about my son or my daughter not doing this or doing this’. So just being that first point of informal contact ...
 (Outreach/drop-in worker 010)

Figure 14: Organizations with 3 or more Ties (PHC need connections) to One Another



The co-location of services within family drop-in centres was identified as one of the primary mechanisms through which PH was able to link with other partners in the delivery of child and family programs to immigrants and their young children. Other co-located services included immigrant services providing ESL classes, while nurse practitioners provided wellness clinics for young mothers.

The Purpose behind Brokerage

Three distinct purposes attached to brokerage emerged from the key informant interviews; 1) brokerage on behalf of clients, connecting services to meet the needs of families with young children directly, 2) brokerage for the purpose of building partnerships around issues related to immigrant needs, and, 3) brokerage for the purpose of building systems competencies. The last two purposes can be combined under a single construct - building capacities.

All three of the brokerage functions were carried out by settlement service org 21. Org21 was described as a hub for information concerning immigrant needs, as a source of referral for immigrant families, and as a partner in the delivery of services to high need families, particularly newly arriving refugees. “I have to take my hat off to [org21]. I mean they’re really the framework that helps get families directed whether it’s towards us, whether it’s toward [other organizations]” (CHC physician 30). A settlement worker described how staff time was committed by the organization toward network building: “And it wasn’t until this position was created that I had technically hours in my job description to spend time going to those types of meetings” (Settlement worker 017).

Org21 also took time to promote competencies in other partnering organizations through workshops or presentations, or by attending joint sessions with families, using these as teachable moments for other providers. Another settlement worker further explained: “So that motivates me. Motivates me to go and dig more and look for people that can be allies in this system and that maybe are interested in [a] conversation with us and that are interested maybe in changing” (Settlement worker 011). An annual immigrant health fair, originally initiated by org21, presents an example of an effective mechanism for developing systems competencies through the engagement of multiple partners.

So luckily we were able to start up a little committee to plan the Health Fair which ended up to be an ongoing network and it kept growing. ... We have people from public health, from the children’s hospital, from parent resource centre, from other immigrant serving agencies... (Settlement Worker 017)

Others within the services network (e.g. outreach and drop-in centres) also promoted capacities in their partnering agencies, but these were less strategic as organizational objectives, and more about supporting families during interactions with other less culturally skilled service providers.

Most organizations stood out as brokers primarily for their pragmatism in making things happen for their clients. One example involved a family drop-in centre:

this public housing area has become particularly attractive for newcomer clients... this particular organization is doing a great job in providing internal services to the clients as well as connecting them to the larger community... (Settlement worker 011)

A CHC nurse described a situation where an immigrant mother and newborn had an inaccessible family doctor. Public health supported them with a referral to the CHC:

So [public health] contacted us – can you take up this responsibility? So we say ... if the patient agrees to change family physicians.... So obviously they did and we followed up with the baby and the patient. (CHC Nurse 031)

Discussion

In this case study, settlement service org21 was represented in all network relationships considered, sharing the role of network broker with different organizations at different times. This organization was also unique in its strategic capacity building function within the network. PH and PC services had strong links to this organization, with opportunities for tapping into the knowledge, experiences and client base of this resource. This, however, was still limiting in terms of client access since most of this settlement service's activities were focused around the needs of refugees. This limitation points to the need for different kinds of brokers and services to address gaps as individual services are often restricted by their mandates, specializations and/or resource capacities. As examples, PH's associations with family physicians and post-natal discharge programs, and another settlement service's association with schools, each provided opportunities for linking immigrant families to needed services. As an accelerator for making connections, family drop-in centres also provided a venue for providers from different organizations to come together in the delivery of services to the local neighbourhood. Different providers had different things to offer in this case, and together created the resources which defined the capacity of the provider community.

This case study took into account an inter-sectoral and determinants of health perspective, and what has been encouraged to be optimal PHC practice at the local level

(Van Olmen *et al.* 2010, WHO 2008). The SNA techniques used in this study helped to illustrate relationships among service organizations and to identify brokers within the network. The qualitative data helped to describe the organizational relationships as witnessed by key informants, corroborated information portrayed in the network maps, and then furthered our understanding concerning what brokers do in supporting the activities of the network overall.

Limitations: Personal biases may have been introduced into the selection of organizations for this study by the local providers involved in this process, but the researcher did vet these choices against documented program descriptions, and later with those interviewed or surveyed. Non-participants (asterisked organizations in Table 10) were more often organizations without a stated mandate to work with immigrants or with the health concerns of young families in the study neighbourhood; their opinions may have offered different insights into the workings of the network overall. No information was available to demonstrate how non-participants related to one another. Despite a response rate of 78% (a participation rate of 68% when 31 is the denominator) the researcher was able to accommodate missing data by using directional measures of betweenness centrality, a technique supported empirically (Costenbader & Valente 2003) Immigrant families did not participate in the study. Our understanding of the family experiences in this study was limited to the interpretation of providers. The role of organizations as brokers in supporting access to services may have been inflated, that is, how families relied on their own informal networks was not considered.

Literature describing how organizations within service delivery systems coordinate their activities in support of immigrant communities was found to be scarce. The work of Whitaker *et al.* (2007) was instrumental in the conceptualization of the current research, providing a description of a network model that promoted cultural competency and collaboration among agencies delivering services to Latino women exposed to intimate partner violence in two U.S. communities. A qualitative review of their initiative demonstrated an improved system for addressing client needs and promoting access to services using bicultural network coordinators. In another example, a county public health department in Washington State was instrumental in establishing a collaborative network of 26 agencies tasked to collectively develop systemic cultural competencies and capacities tailored for 6 different marginalized groups including selected ethnic minorities. A qualitative evaluation again showed improved systems capacities and expanded collaborative initiatives (Garza *et al.* 2009).

The social network methods in this study were used in previous research involving other types of services delivery systems that addressed chronic diseases such as HIV/AIDS, mental health and diabetes (Kwait *et al.* 2001, Provan *et al.* 2002, Provan *et al.* 2005, Rivard & Morrissey 2003, Tausig 1987). Eisenberg & Swanson (1996) demonstrated the brokerage role played by NGO's for maternal-child services in four different communities. No studies were found applying these methods to services networks for immigrant families. More research is needed in other kinds of settings to determine if the findings of this case study apply within different context. Highlighted

findings and their application to policy, practice and future research is provided in Table 11.

Table 11: Key Findings and their Application to Policy, Practice and Future Research.

Case Study Findings	<i>Policy Application</i>	<i>Practice Application</i>	<i>Research Application</i>
Brokers were depended on for many of the network interactions, helping to sustain this PHC system for recent immigrant families.	Funding for NGO’s identified as brokers needs stability. Time given to providers for networking is needed to build competencies and capacities.	Increased cultural competency among all providers may reduce dependencies on broker agencies. Training and skills to work within systems with multiple partners is essential.	Similar research is needed in other settings to demonstrate application beyond the context of this case, and within different types of communities.
Different types of immigrant family needs involved different network participants. Fragmentation was highest for the GI Illness network.	Navigating the system may be difficult when different providers are involved in different concerns. Again, support for central broker organizations may be needed to make the appropriate connections.	Cultural competencies and collaborations for enabling access may need to be strengthened within specialized service networks as well.	More research is needed on targeted issues faced by immigrant families, the services involved, and how these services collectively respond.
Legal services played an important role in the settlement experiences of recent immigrant families; one legal service acted as a prominent broker on concerns faced by families.	This finding supports a health in all policies framework, linking the mandates for different kinds of community agencies to health outcomes for immigrant families.	PHC providers need to be aware of other services supporting the needs of recent immigrants, and create innovative partnerships for meeting family needs holistically.	It is important to continue to consider the inclusion of non-health funded agencies in PHC services research. Methods for improving their participation need to be developed.

In summary, brokers within this service delivery system for immigrants differed under various circumstances, offering different types of advantages to the network and the families served. The study concerned how services in a relatively inexperienced setting compared to a larger urban centres, adapted to new immigrant arrivals. Service brokers in this sense were the forerunners for enabling systemic adaptation – through client advocacy and building systems competencies. Still, there could be more: “we have a lot of work to do ... we haven’t made the connections and we haven’t done the asking and the sensing that we needed to do and we’re only beginning to do that in the last couple of years. So we’ve got a long road ahead of us” (PHN 014).

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CHAPTER 4

COMPETENCE TRUST AS FUNDAMENTAL TO A CULTURALLY COMPETENT PRIMARY HEALTH CARE SYSTEM FOR IMMIGRANT FAMILIES

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*COMPETENCE TRUST AS FUNDAMENTAL TO A CULTURALLY COMPETENT
PRIMARY HEALTH CARE SYSTEM FOR IMMIGRANT FAMILIES*

Abstract

Recent immigrant families to Canada with young children will face several challenges during the settlement process. For service providers working with recent immigrant families, responsibilities go beyond their own organization's capacities, and toward a reliance on others within their services network, and with whom they share clients, to also demonstrate an ability to address the unique health needs of this client base. This case study explores how trust in the cultural competencies of other organizations can impact the functioning of a primary health care system in its responsiveness to a changing Canadian population. Methods from social network analysis and qualitative inquiry are used to describe the case, based within a mid-sized urban centre in Atlantic Canada.

Introduction

Recent arrivals to Canada may encounter a variety of challenges during the settlement process (Hyman, 2001; Simich, Beiser, Stewart & Mwakarimba, 2005). Those with young children have the added responsibility of ensuring their children's well-being, and for this reason they are more likely to seek out services that can help to address their needs as a family (Karwowska, Nijssen-Jordon, Johnson & Davis, 2002; Lipson, Weinstein, Gladstone & Sarnoff, 2003). Individual services may have limitations in what they can offer to newcomers. However, if service providers working with recent immigrant families are well networked providers would more likely be able to access

additional resources on behalf of their families, particularly if others in their network offer something different and needed.

Within a determinants of health framework, the tasks of PHC require inter-sectoral collaborations (Pan American Health Organization, 2007). Others have identified collaboration among service providers as a prerequisite for ensuring a culturally competent services system that enables the sharing of resources and competencies when working with ethnic minorities (Whitaker, Baker, Pratt, Reed, Suri et al., 2007). This concept is consistent with the work of Cross, Bazron, Dennis & Isaacs (1989), who define *cultural competence* as a set of “congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enables the system or professionals to work effectively in cross-cultural situations”.

Several researchers have identified trust among organizations as one of several indicators and facilitators of inter-organizational collaboration (D’Amour, Ferrada-Videla, San Martin-Rodriguez, & Beaulieu, 2005; D’Amour, Goulet, Labadie, San-Martin-Rodríguez & Pineault, 2008; Ivery, 2007; Martin-Misener, Valaitis et al, 2008; Ryan-Nicholls & Haggarty, 2007; Shi & Collins, 2007; Walker, Smith & Adam, 2009). The concept of trust between organizations is somewhat elusive, being highly conditional on several factors that influence the formation and quality of relationships. These can include socio-political influences (D’Amour et al., 2005), but also attributes of the partnering agencies themselves that manifest in the trustworthiness of each partner: their credibility, reliability and integrity (Seppänen, Blomqvist & Sundqvist, 2007). Trust itself is evolutionary and reciprocal with feedback loops responding to the relationship as

much as to the influences that form the relationship in the first place (Mayer, Davis & Schoorman, 1995; Sengir, Trotter, Briody, Kulkarni, et al., 2004). Trust among service providers operating to support new arrivals to Canada requires a different kind of attention. Trustworthiness is particularly important when working with diverse populations. It is therefore also important to understand the role of trust within a culturally competent system that is both collaborative and prepared for diversity.

Purpose

The case study to be described addresses the research question “How do the perceived cultural competencies of different community-based organizations affect the delivery of PHC services for young children of recent immigrants?” Propositions relating to this question were as follows:

- The cultural competency of organizations has an important influence on the relationships formed among organizations.
- Organizations will report greater trust in competent partners and interact more with those trusted.
- Connections to culturally competent organizations increase the reach of PHC services in meeting the needs of immigrant children.

The case consisted of a group of community based services available to recent immigrant families with young children living in a neighbourhood of a mid-sized urban centre in Atlantic Canada⁸. In the context of this study, the cultural competency of a service organization refers to its ability and preparedness to work with the unique health

⁸ Recent immigrants refer to immigrants who arrived in Canada within the last five years. Young children are children newborn to 6 years of age born within or outside Canada.

related needs of recent immigrant families with young children. For purposes of comparison and measurability, a construct of *competence trust* was adopted. *Competence trust* as used in the trust literature is defined as a belief in the other's ability to do the job or complete a task (Black, 2007; Norman, 2002; Wakabayashi, 2003). In this study, *competence trust* referred to a belief in the other's cultural competencies when working with recent immigrant families.

Methods

Organizations selected for inclusion in the case study either provided services to recent immigrants and/or to families with young children living in a neighbourhood with a proportionately high concentration of immigrant residents relative to the rest of the municipality (Statistics Canada, 2007). An on-line social network survey and key informant interviews were the two methods used for data collection.

Social Network Survey

Sample Selection

Twenty-seven organizations were selected to complete the survey. The organizations were chosen starting with a list of organizations attending an immigrant health fair in 2009. Other organizations were added to the list after reviewing a municipal resource manual. The list was then further refined through consultations with the local health board and a settlement services agency. A lead staff member from both agencies was asked to indicate which of the organizations listed provided services to immigrants and/ or young families living in the study community. The researcher finalized the list after a review of each organization's description in the resource manual,

or on the organization's website. The director or lead manager of each of the 27 organizations was asked to identify representatives who could respond to the survey on their organization's behalf.

Data Collection and Analysis

The survey instrument was first developed with reference to other network surveys described in the community organizational research literature (Kwait, Valente, & Celentano, 2001; Provan, Veazie, Staten & Teufel-Shone, 2005). Initial versions were reviewed by four colleagues in epidemiology for face validity of the measurement constructs, and tested with undergraduate nursing students for clarity and readability of the questions and layout. A public health manager and community health board member from the study neighbourhood offered comment concerning user acceptability and relevance. Colleagues assisted in testing the revised on-line version over repeated trials to ensure functionality and data reliability in the reports generated.

The survey consisted of two domains – the first section asked respondents descriptive, categorical questions about their organization. Respondents were also asked to rank their organization's cultural competency by responding to a series of five cultural competency attribute questions followed by an overall question concerning their preparedness in working with recent immigrant families. Questions are presented in Table 12. Questions were derived from the literature (Davis-Murdoch, 2005; National Center for Cultural Competence, 2006) and vetted by a regional consultant in cultural competency.

Table 12: Network Survey Questions on Organizational Cultural Competency Attributes

C5. These last few questions ask about your organization’s / program’s preparedness in working with recent immigrants.

On a scale of 1 to 4, please indicate how each of the following statements best describes your agency and/or practice:	1 don’t agree	2 somewhat agree	3 mostly agree	4 definitely agree
a) Staff and practitioners are aware of the ethnic diversity within the communities you serve, and of differences that may exist in the health risks and beliefs of different ethnic groups.	1	2	3	4
b) Programs and services have been adapted to respond to the needs and issues of recent immigrants within your service area.	1	2	3	4
c) Resources have been allocated to provide appropriate language and/or outreach services for recent immigrants.	1	2	3	4
d) Staff are provided opportunities for training in empathic listening and communication skills that work across cultures.	1	2	3	4
e) Staff and practitioners are accepting, respectful and responsive in their interactions with recent immigrants.	1	2	3	4

C6. Overall, how well prepared is your agency / program for dealing with the unique needs of recent immigrants and their families?

1-not very prepared 2-somewhat prepared 3-mostly prepared 4-very prepared

The second section included a list of 31 organizations and ‘service groups’. In addition to the 27 organizations selected to complete the survey, four groups of service providers or ‘service groups’- family doctors, day cares, walk-in clinics, and cultural associations -were included to create the final list of 31, i.e.27 individual and four service groups . Service sectors represented on the list included public health programs, primary care services, immigrant services, family out-reach and drop-ins, child and legal services, family counselling, and an ‘other’ category that included housing, food banks, cultural associations, and public libraries.

Respondents were asked about the frequency of their and their co-workers' contact with each listed organization or group, and about ways of working with these others on behalf of recent immigrant families with young children (i.e. referral to, referral from, information sharing and resource sharing). Other questions asked about relationships with organizations when addressing selected PHC issues (e.g. child growth and development, nutrition, diarrheal illness). To create a measure for *competence trust* toward other organizations, respondents were asked "to what degree do you and your co-workers trust each organization's ability to address the unique needs of recent immigrant families with young children?", with the response options 'not at all', 'somewhat', 'mostly', 'absolutely' and 'unsure'. A response of 'absolutely' and a combined response of 'mostly or absolutely' were the two measures of *competence trust* used in comparisons with other relationship variables.

Jaccard's similarity coefficient⁹ (Dunn & Everitt, 1982) was calculated to determine associations between *competence trust* and frequency of contact among network members. This was also used to determine associations between *competence trust* and different ways of working together, (i.e. referral to, referral from, share information and share resources). The Quadratic assignment procedures (QAP) correlation function of UCINET was used to generate the coefficient values. This function calculates measures of association between two matrices of relationship data. QAPs are used to calculate standard errors to test for the significance of association

⁹ Jaccard's coefficient applies to binary data indicating the presence/absence of a condition (Dunn & Everitt, 1982).

(Hanneman & Riddle, 2005). For comparisons in this study, each matrix data set represented yes (1) or no (0) responses to one of the relationship questions.

The social network analysis (SNA) methods used in this study were largely descriptive using sociograms (network maps) to display relationship connections among the organizations (network members) listed in the survey (Wasserman & Faust, 1994). As well, measures of *centrality* were calculated for network members, and then displayed in the sociograms, using relative node size to indicate organizations of prominence (high centrality) within the network depending on the question (Scott, 2006). More specifically, *in-degree centrality* was determined for each organization based on the number of times the organization was a recipient of exchanges with other organizations (e.g. referred to, mostly and/or absolutely trusted by), or to what degree the organization was central on different PHC issues (i.e. growth & development, nutrition, diarrheal illness). All social network analyses were conducted using UCINET (Borgatti & Everett, 2002) and NetDraw (Borgatti, 2002) applications.

Organizations were given a *total self-assessment* score of cultural competency equal to the sum of the five competency attribute questions in Table 12. Organizations also had an *overall rating* based on responses to the question “Overall, how well prepared is your agency/program for dealing with the unique needs and disparities experienced by recent immigrants and their families?” An *attributed score of competence trust* for each organization was calculated based on the number of times an organization was trusted mostly or absolutely in its preparedness to meet the needs of recent immigrant families by other survey respondents. Organizations placed in the upper quartile on one or both of

the self-assessment scores and on one or both of the *competence trust* scores were accepted as competent – this was an arbitrary cut-off to explore attributes of perceived culturally competent organizations in this network.

Key Informant Interviews

Sample Selection

Key informants were selected for interviews as recommended by researchers familiar with local services, and by the first set of informants interviewed. Selection was purposeful to ensure the inclusion of different professions such as nurses, doctors, social workers and settlement workers. The aim was also to include providers working within public health, primary care, settlement services and non-government organizations. Organization leads either participated themselves as informants or nominated one or two designates.

Data Collection and Analysis

One-on-one interviews were conducted with key informants. Interviews lasted between 45 and 90 minutes, following a process of descriptive qualitative inquiry (Sandelowski, 2000). Informants were asked about things that influenced their relationships with organizations when addressing the needs of young immigrant families. In particular, respondents were asked how families' experiences with other organizations influenced the respondent's relationship with these organizations. Interviews were tape-recorded. Transcriptions were imported into NVivo8 (QSR International Pty Ltd. 2009). A process of constant comparative analysis was applied to identify key themes (Crabtree

& Miller, 1999) that were related to relationship influences, cultural competency, trust and access to services.

Triangulation of Results

The network survey results were compared with key informant responses on constructs such as familiarity among service providers, and associations between working relationships and *competence trust* in partners. Key informants provided context to help explain organizations' high competency scores from the survey, both attributed by other organizations (a sum of *competence trust*) and self-assessed competency (i.e. based on total self-assessment scores and overall self-rating). Negative and positive experiences/perception toward another organization (e.g. how another organization had treated a respondent's clients) were examined to determine their impact on organizational relationships. Relationship influences were identified and explored in the qualitative data, applying organizational theory (Ivery, 2007) in a process of deductive / inductive coding to inform data categorization. Influential factors affecting working relationships as derived from the qualitative data were coded under the broad pre-defined theoretical categories of internal factors (staff, funding), environmental factors (political, economic), and organizational forms (goals, boundaries, activities) (Ivery, 2007).

Results

Context of the Case

The neighbourhood served by the organizations included in this case study consisted of two bordering city planning zones. Based on the 2006 Canadian Census, the

proportion of the residents represented by immigrants in this community was high compared to the rest of the municipality: 15.3% for zone A and 8.9% for zone B, compared to 7.4% for the municipality (Statistics Canada, 2007). Zone A was the more affluent of the two planning zones based on observation in the field and other 2006 Census data. A community assessment report created by the local planning board for Zone B described residents as ethnically diverse and of mixed economic status.

Twenty-one of the 27 selected organizations (78%) participated in the SNA survey (excluding the generic ‘service groups’), with participation from all service sectors. One-on-one interviews (12 in person and 2 by phone) were conducted with 14 key informants. Those interviewed represented a hospital based outreach program; two family drop-in centres, two public health programs, a community health centre, one family practice, two settlement services, a social work program with community liaison, and an interpreter service. Interviewees consisted of 4 nurses, 4 social workers, 3 settlement workers, 2 physicians, and an interpreter dispatch coordinator.

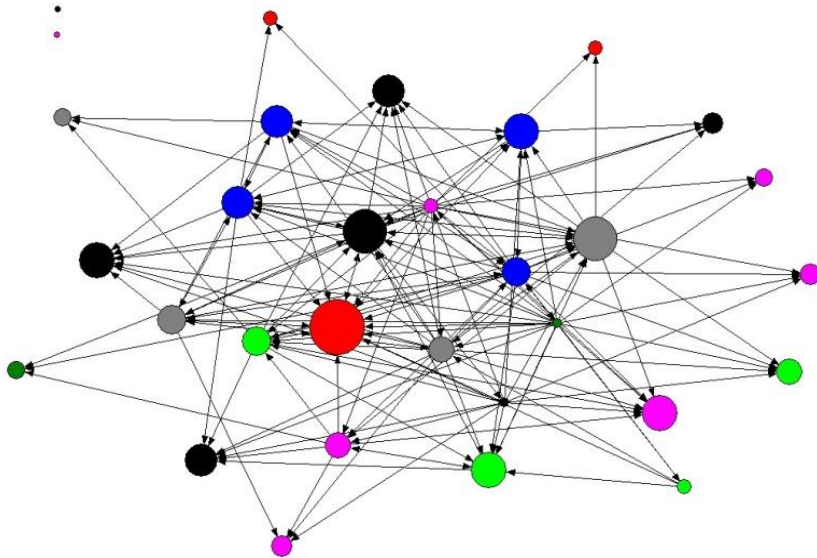
Factors Influencing the Formation of Working Relationships

Competence Trust

The following network map (Figure 15) displays relationships where respondents answered ‘absolutely’ to the *competence trust* question. How participants responded toward others is indicated by the lines and direction of the arrows. Prominent members in this network (high in-degree centrality), are identified by the size of each node. One primary care service in particular stood out as highly trusted within the network of

services. Greater *competence trust* was also attributed to various immigrant services, and a drop-in centre.

Figure 15: *Competence Trust* Network: ‘Absolute Trust’ toward other organizations in their ability to address the needs of recent immigrant families with young children



Service Sector:

- | | |
|---------------------------|--------------------------|
| ● Public Health | ● Child & Legal services |
| ● Primary Care | ● Family Counseling |
| ● Immigrant Services | ● Other Services |
| ● Family Outreach/Drop-in | |

Node size = relative in-degree centrality.

The statistical correlation between ‘regular contact’ (defined as ‘in contact more than once a month’), and ‘*competence trust*’, was significant, (Jaccard Coefficient= 0.301, $p= 0.031$, for trust ‘absolutely’; Jaccard Coefficient= 0.357, $p= 0.024$, for trust ‘mostly or absolutely’). *Competence trust* when measured as trust ‘mostly or absolutely’ was also significantly associated with ‘referral to’, referral from’, ‘share resources’ and ‘share information’, but was only significant for ‘share resources’ when *competence trust* was

restricted to trust ‘absolutely’ (Table 13) . Demonstratively, *competence trust* (measured as ‘mostly trusted’ or better) was associated with organizations interacting and working together.

Table 13: Correlations between Trust and Types of Interaction among Organizations.

Networks Compared	Trust Mostly or Absolutely		Trust Absolutely	
	Jaccard Coefficient	P value	Jaccard Coefficient	P value
Trust and Referral To	0.510	0.005	0.305	0.166
Trust and Share Information	0.462	0.045	0.264	0.394
Trust and Share Resources	0.281	0.007	0.261	0.009
Trust and Referral From	0.430	0.001	0.300	0.052

Note: Jaccard’s similarity coefficient applies to binary data indicating presence or absence of a relationship.

Socio-Political Influences

Internal factors (staff, funding). Organizations with staff committed to partnership development tended to be more involved with other organizations and committees. Others felt their clinical commitments were all consuming, with no spare time to dedicate to networking. “being on committees is a big time commitment” (ID019). Work for no pay, and limited time were acknowledged as reasons for lack of network participation by physicians working in fee-for-service practices. Some providers found it easier to access the skills within their own organization rather than having to look for resources outside. Services with staff or translators who could speak the language of

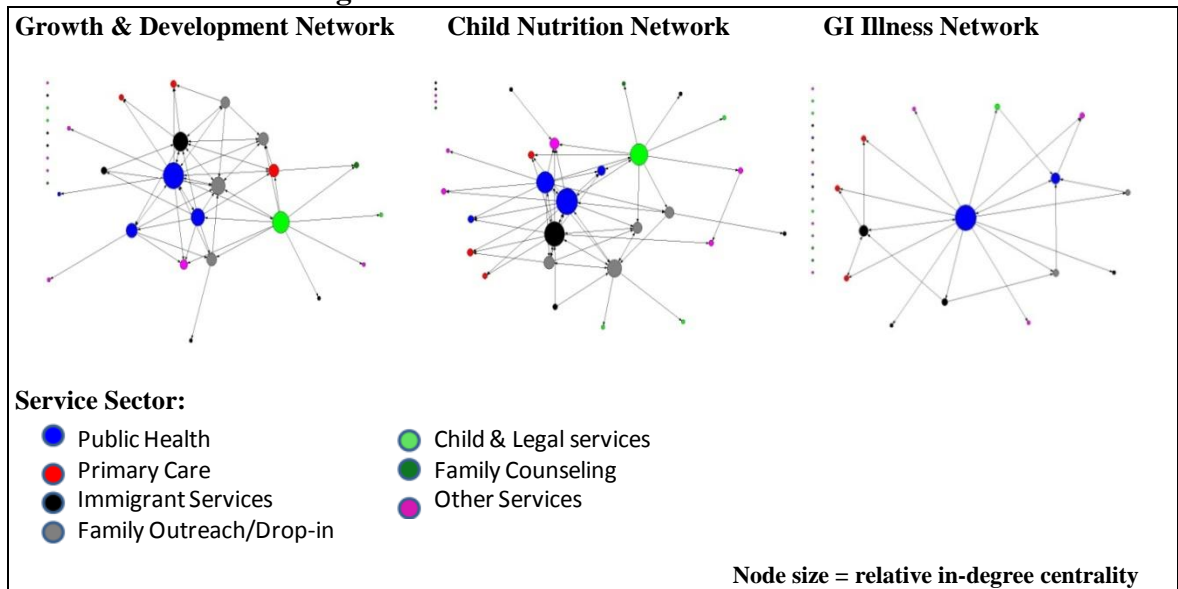
immigrant families were sought out by others needing these skills to assist them in working with families.

Environmental factors (political, economic). Key informants acknowledged the importance of political support for their programs. At the time of data gathering, the provincial government was promoting policies for supportive services to encourage the retention of immigrants as part of their labour force strategy. Various provincial and regional programs were attending joint planning and networking events as a consequence to learn more about immigrants and their needs: “They were there because they were on diversity committees in their workplace and they wanted to bring back knowledge” (ID017).

Historically, limited funds outside of mainstream services meant that non-government organizations (NGO’s) dedicated to immigrant needs were finding themselves in competition with one another. “Well we all get funding from [the same source] so we have to protect our niche, our information, our ideas” (ID019). Extra effort was needed to sustain relationships under these circumstances. At least one program was planning to expand its scope to draw more funding from a dwindling pool. This had a cautionary impact on relationships, though ultimately there was still interest among providers to work together. “Well what I see is a lot of people have worked really hard to overcome that and to work together” (ID012). Their shared interests in immigrant families was pushing them past this economic constraint into joint planning, the primary example being the participation of several agencies in planning an annual multi-cultural health fair.

Organizational Factors (goals, boundaries, activities). As illustrated in Figure 16, survey responses indicated that a different network of working relationships existed depending on the issues being addressed. Prominent members changed (in-degree centrality) as did the number of organizations involved with each issue. For example, public health played a prominent role in the gastro-intestinal (GI) illness network. For both the growth and development and nutrition networks, influence within the network was much more distributed among members.

Figure 16: Working with other organizations concerning different needs of young children of recent immigrants.



Qualitative results were consistent in supporting the view that different partners were drawn together depending on the health issue faced by immigrant families.

Partnerships formed were, however, limited by organizational mandates:

I feel I do have to be careful to focus and refocus continually on our agreement [with funder], which says this is what I'm hired to do and this is my role and this is what I can manage. (ID019)

In other situations, formal relationships among services facilitated co-location and other forms of working together.

We have a contract with [the public health authority] for a home visitor. So, we have one of those home visitors based in our center and public health is also represented on our board of directors; a public health nutritionist and a public health nurse. (ID010)

Family Experiences Influencing Competence Trust and the Quality of Relationships

The impact family experiences had on relationships between providers can be described as ‘strengthening’ in response to positive and helpful family experiences, ‘cautioning’ in response to culturally (or otherwise) insensitive experiences, and ‘damaging’ when experiences appeared to threaten families.

Strengthening - Response to Helpfulness

Key informants considered their client’s experiences with other organizations as the litmus test concerning their approval of an organization and willingness to engage in future interactions. Positive experiences that were both instrumentally helpful but also broached with sensitivity toward families – i.e., being involved ‘in the families’ lives, family focused, strength based approaches, having the time, and being open and adaptable - were key elements of obtaining approval, and often with a renewed commitment toward the relationship:

they are actually one of our greatest resources when it comes to families with expectant mothers ... [It] seems that they have really done a lot of soul searching, ... so that we are really able to connect with them... (ID011)

Cautioning – Response to Insensitivity

Providers were cautioned by the culturally insensitive experiences reported to them by families, when relating to organizations involved in these experiences. Insensitivities such as a lack of culturally appropriate resources, not giving the family enough time, or being directive rather than supportive, were most often referenced. Concerns were raised in the context of inequitable access to programs normally offered to the general population: “they feel like an outsider going to a mainstream services. They don’t feel comfortable or understood. ... and then they don’t come back” (ID017). Using older children as translators in sensitive situations repeatedly incensed informants who qualified this as disrespectful behaviour on the part of providers. “There are lots of reasons, lots of cultural reasons ... why it is absolutely inappropriate to have a family member interpret” (ID018).

Cautionary responses from providers ranged from: delayed future contact or avoidance, engagement only out of necessity (‘there’s no one else’), or withdrawal from the relationship entirely. “If it really became inappropriate or was not something that we felt was respectful of the clients that we work with, we probably wouldn’t continue” (ID010). Tolerance for insensitive behaviour of other providers did, however, vary with willingness by some to see the potential for growth in the other. “You know, we all make mistakes, whether it’s on our side or the client side or whatever, and if the system’s too rigid and doesn’t allow for any of us to make mistakes, I mean, it’s going to fall apart” (ID030).

Damaging – Response to families under threat

The most difficult forms of relationships experienced among providers were those perceived to be threatening for families. Issues around child protection or immigrant status gave authoritative agencies power to significantly disrupt the lives of these families, if deemed necessary. Provider perceptions of cultural competency in the authoritative partners were coloured by the perceived impact any conflict with authority had on families. In some circumstances, providers felt the family's trust toward them, not just the partnering agency in authority, was being placed in jeopardy. Providers were sometimes pushed into situations of 'damage control' trying to minimize as much as possible the fallout on their relationship with the family, while recognizing the legitimacies of some of the concerns being addressed by the authority. Providers were left with the challenge of regaining the confidence of clients, having lost their clients' trust through association:

and then if things don't go according to family's needs and expectations ...then there can be a lot of that mistrust and, 'why are you with me if you're not able to bring me my children back... what are you doing in my home? Have you done anything?' And sometimes, I wonder the same.
(ID011)

In this example, access to services for families was no longer so much about relationships between organizations, as much as it was about loss of trust toward those willing to help. In these situations, mediation by providers to help families also involved educating other providers to improve their cultural understanding and sensitivities. If the provider was open to learning, relationships between providers were strengthened.

I work with ... lawyers on both sides... There's a frustration level that I sense sometimes at their own lack of being able to communicate, right?

It's new for a lot of people and some people have very strong feelings and emotions. But I feel most people I work with are very grateful and relieved that there's somebody there willing to do that mediation piece. (ID012)

At times, providers also needed to work toward recovering relationships with their colleagues:

[Some] workers only comply with the rules and do not have enough flexibility. And everybody has different styles of work and I appreciate that. Any negative experience that I've had only encourages me more to go back to the organization, go back to staff, go back to management. (ID011)

Trusted Providers Enabling Family Access to Services

Many barriers were identified by key informants, limiting the ability of families to access needed services from community partners. These included lack of transportation, language and cultural barriers, difficulties in finding child care, and fear of service providers perceived as representing a judgmental authority. As indicated in the interviews, trust in a service organization, and the willingness of families to utilize services, often arose from family experiences and/or attributes of the organization that made the organization both welcoming and physically accessible. Accessibility included the location of services within the community, access to interpreters, being family focused, and having staff of different cultures.

Four organizations were identified as exemplars of cultural competency, all four being placed in the top quartile of a self-assessment cultural competency score and an attributed *competence trust* score. From key informant interviews, attributes of commitment, responsiveness, adaptability, and openness were highlighted characteristics

shared among the four organizations. The commitment of time to work with the complex needs of immigrant families and allow for the development of trust was thought essential: “if you have the time you can listen and you can pick up on the questions people have. You can more easily pick up on the cultural differences. And, you can build a trust” (ID017). As well, being adaptable and hands on was important: “Do you want to drive over or we can call and make an appointment. We don’t mess around. We’re practical” (ID019). Being linguistically and culturally accessible was also important: “we’ve had some families that have come into our centre just because they have seen lots of woman dressed in traditional Muslim dress. So, they sort of think this is a place that’s comfortable for me” (ID010). Finally, offering or enabling access to a diversity of services added value in meeting family needs: “So we help our clients register their children to school. We help them access health care, whether it’s primary health care through family doctors or whether it’s sometimes helping them even by [accompanying them], going to the children’s hospital” (ID011).

Discussion

In this study, we have focused primarily on agency interactions, while acknowledging the impact of more contextual influences on the formation of these relationships. Funding and political support, for example, had a lot to do with the on-going survival of an organization, driving organizations toward or away from each other. On the other hand, and perhaps ironically, an agency’s enthusiasm for interacting with other organizations was often an outcome of perceived cultural competencies (*competence trust*) in these others.

Applying constructs from organizational theory and organizational ecology to this analysis (Freeman & Audia, 2006; Hurley & Kaluzny, 1987; Ivery, 2007) revealed that different factors - internal, environmental and organizational– played a role in the formation of relationships among service providers in this case study. These factors created opportunities for gaining familiarity with one another’s competencies, and in some cases, opportunities for developing relationships that were either trusting due to positive experiences, or else cautionary, leading to avoidance. In situations where providers witnessed families in conflict with authorities, a secondary outcome – the perceived loss of a family’s trust in organizations working with the authorities – meant a loss of access to these resources when families withdrew from what had been a helpful relationship. This finding adds support to the remark “anyone who enjoys his or her collaborative relationship with an ‘outsider’ can become suspect” (Smith, 1998 citing Mintzberg et al., 1996, p. 134).

As a premise of organizational theory, adaptation and change is often resisted by the inertia of the dominant organizational structures (Hurley & Kaluzny, 1987). Not surprisingly, of the four organizations recognized for their cultural competence, three were NGO’s, organizations with the least financial stability; the fourth organization represented an inter-disciplinary, community-based model of primary care that differed from the traditional family practice model. Encouragingly, during the time of this study, new champions promoting the adoption of culturally competent practices and policies were emerging within conventional organizations, while others were already in place.

Settlement services, for example, continued to be recognized as leaders in the advancement of cultural competencies within the services network.

Limitations: The lack of participation in the survey of all selected organizations may have missed relationships of interest for this study although core service sectors were represented. Organizations included in the study were selected based on the biased perceptions of those consulted; however, pre-existing resources (the health fair participation list, and the community resource manual) created opportunities to challenge these biases. The researchers were unable to recruit multiple participants from each organization and therefore results are potentially biased by the opinions of the organizational representatives. The results are based on the opinions of providers, not the immigrant families; however, relationships among provider organizations were the focus of this paper. A survey response rate of 78% (21 of 27 selected organizations) also introduced a response bias into the results. (The participant rate was 68% when using 31 as the denominator for the network. This includes the four ‘service groups’.) On the other hand, assuming reasonable network representation among respondents, directed measures of centrality (in-degree centrality) as used in this study, have been empirically demonstrated to remain stable with only half the network membership participating (Costenbader & Valente, 2003).

In summary, revisiting the propositions presented in this paper, the cultural competencies of organizations in working with immigrant families as perceived by providers indeed impacted the ‘quality’ of relationships among providers. Other socio-political factors (e.g. shared mandates, supportive funding) tended to drive relationship

formation and organizational interactions. Trust in competent partners was evident.

Competence trust – trust in the other’s cultural competence made partnerships with these other organizations desirable. Providers saw value in partnering with culturally competent organizations in order to access and provide services to recent immigrant families with young children, but also as a means of acquiring and developing their own competencies. Culturally competent providers saw sharing and working with other organizations as a strategy for developing competencies within the services system overall, therefore improving access to services for recent immigrant families and their young children.

Although different factors influence the formation of relationships among service providers working with recent immigrant families, these engagements still require a level of trust, in this case *competence trust*, in order for relationships to be truly collaborative (Provan et al, 2005; Seppänen et al., 2007). Cultural competency in an organization engendered trust and desirability. A willingness to learn and develop competencies also encouraged the sharing of knowledge and skills among agencies. To aspire toward a truly culturally competent system in which knowledge, resources and responsibilities are distributed, shared and made accessible trust and good will among partnering organizations could very well make all the difference.

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CHAPTER 5

REFLECTIONS AND CONCLUSIONS:

HOW COMMUNITY SERVICES COLLECTIVELY ADDRESS THE PRIMARY
HEALTH CARE NEEDS OF RECENT IMMIGRANT CHILDREN: ADAPTING
SYSTEMS AND *COMPETENCE TRUST*

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Preamble

Canada, by different degrees within different regions, continues to experience a growing diversity in population through immigration. Our ability as nurses and other providers to adapt to the challenges created by this changing ethno-cultural makeup may reflect our learnings and exposures, both personally and professionally. For communities still at the beginning phases of this transition, embracing the messages coming from those with a strong voice on the issues faced by new arrivals may be a first step toward greater competency and accessibility for community-based health care systems. These messages may indeed be about our own societal survival as we see in the changing faces of our communities, the means by which to sustain Canada's collective prosperity and wellbeing. We need to see ourselves in this.

At the beginning of this dissertation, I offered three anecdotes of personal life experience that have helped to shape my values and outlook as an adult and health professional. My intention was to inform the reader of some of my pre-existing assumptions that were likely to be introduced into this research. But it was also my intention to create a place of grounding for myself, a reminder of who I am, as I pursued this area of inquiry, an area that I believe has profound implications for our health care systems as much as for nursing practice. I have experienced the oppression of those in

positions of power. I have been in positions of power. And I, as a nurse, have seen doors not quite open for reaching those in the most vulnerable of positions. As a young community nurse, I could feel the potential in the nurse-client relationship, saw the hope, but did not know then what to do with it in order to make a sustainable difference for the families I saw in struggle.

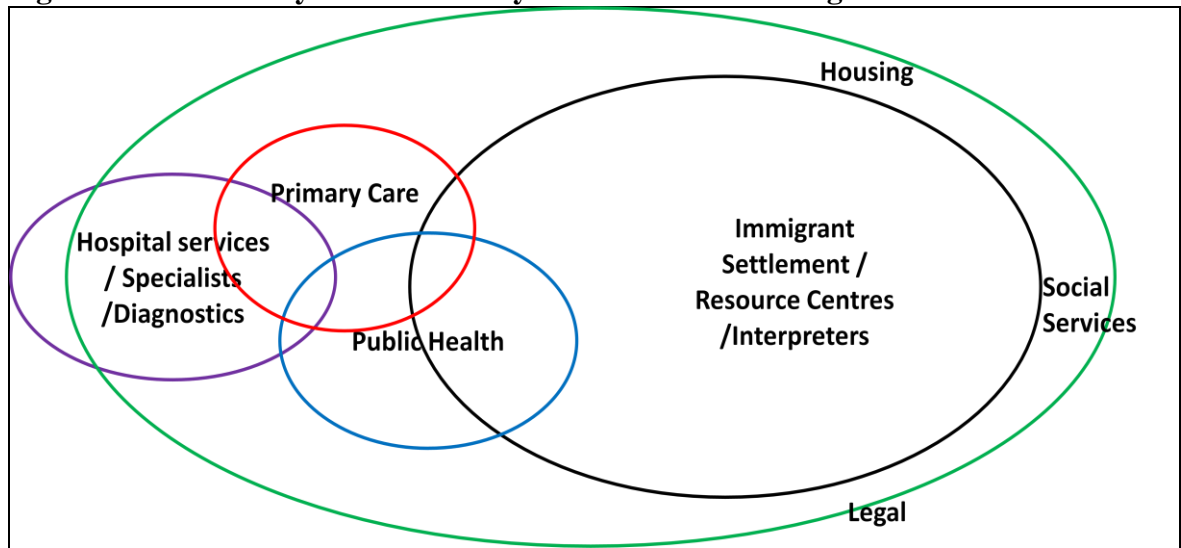
As stated at the beginning of this dissertation, the purpose of this research was to contribute to our knowledge of how best to meet the PHC needs of recent immigrants. In doing so this study has taken into account constructs of cultural competency and trust from an ecological, systems perspective. As discussed, recent immigrant families with young children can be in a vulnerable state on arrival, lacking many of the things we take for granted but which are the most basic of requirements for living in our society. The services system may indeed be called upon to help families in this transition period. How the system works as a whole – not any one professional or organization – needs to be considered, recognizing that needs for this population can be complex, and solutions multi-faceted. With this in mind, nurses need to reframe their role to include the sharing of responsibilities through collaboration with different kinds of providers. Nurses need the knowledge and skills on how to do this, to work within PHC systems while being aware of and developing their own culture competencies in working with diversity.

The Case Re-described

Figure 17 presents a conceptual model for this study of a PHC service system for recent immigrants. It demonstrates the engagement of different types of service groups and sectors as happened in this case. Community health institutions - public health and

primary care - are included in the model but are situated off from the centre, though still in prominent positions. From a determinants of health perspective (WHO, 2008), family health needs may require other forms of support. Organizations with a focused mandate and skill set to address the interests and wellbeing of immigrants and their families during their period of settlement may play a more pivotal role at this stage than those with a wider scope that serves the general population (e.g. primary care services). Agencies in this study that satisfied this focused condition were immigrant settlement services and family drop-in centres located within the neighbourhood where new immigrant families lived. These organizations thus appear more centrally within the model. As an inclusive, adaptive model, PHC responsibilities at the local level are in reality systemic, conditional and shared.

Figure 17: A Primary Health Care System for Recent Immigrant Families



This study demonstrated evidence of a relatively cohesive group of community-based services. Identifiable brokers helped to move the system toward improved access for recent immigrant families. Familiarity through regular contact was examined as part

of the development of relationships but was not enough to explain what followed. Fragmentation occurred depending on the topic of concern, even though the overall familiarity of network members with one another was evident. As a refinement of our understanding of trust and its influence over relationships, trust, *competence trust* more specifically, did play a role in the quality of relationships among providers. In particular, respondents were drawn toward organizations with demonstrated competencies in ‘attracting’ and working with new immigrant families. Conversely, organizations avoided one another when philosophies and approaches differed, or when conflicts existed around the treatment of families.

Many other kinds of relationship influences were also identified within the case study. For example, competition among NGO’s over limited resources was one factor that threatened working relationships. Mandates as well as external socio-political drivers influenced the formation of partnerships and how exchanges occurred within the network. The content and form of work exchanged among services in this network were important to understand, since patterns of interaction as well as the brokers involved in these exchanges did shift and change under different conditions.

In summary, for community-based services involved with recent immigrant families, a variety of conditions created different kinds of influences over different kinds of working relationships, with some being more positive than others. This was also predictable under existing organizational theory addressing inter-organizational collaboration (D’Amour, Ferrada-Videla, San Martin Rodriguez & Beaulieu, 2005). Something to augment organizational theory, however, is still needed in order to better

understand the complexity of a service system where cultural competency should intuitively, and did observably, play a significant role. To that end, the following discourse will revisit theory in light of this case study to see where cultural competency best fits, and then attempt to push theory a bit further toward one that supports a cultural competent services system in progress.

Theory Revisited

Interpreting Cultural Competency and Access

In this study, those at the frontline of service delivery valued positive relationships among providers for enabling access to needed services by recent immigrant families. Good, effective relationships were characterized by the cultural competencies of partnering organizations. Variability among agencies in their cultural competencies when working with recent immigrant families was evident both through self-report, and as perceived by other services. As a system, competencies were demonstratively shared among member organizations, though perhaps not consistently, with brokers often acting as model agencies to promote culturally competent practices (Ivery, 2007).

Cultural competency and its meaning were not explored in all aspects just, simply, whether the reporting organization or other organizations were prepared to address the unique needs of recent immigrant families. As a paradox needing further accounting and based on this condition of cultural competence, the community health centre (CHC) had the highest competency as attributed by others (*competence trust*). Almost everyone interviewed recognized this service for its ability to work with recent immigrants, and pointed toward the CHC as a model service, even though immigrants were not the main

focus of this agency, nor was the CHC that well connected with many of the organizations serving the neighbourhood of interest. What this service had was a long-standing reputation for working with diversity. As reported by key informants, this CHC had existed for years within a high needs community, serving different marginalized groups. Its transference of competencies toward working with immigrants, particularly refugees, was seen as a natural consequence: “Our community has had a number of groups that are marginalized and disadvantaged. ... that’s one of the reasons why I think we felt a strong kinship with the refugees that we have been taking” (CHC respondent). So, again, when thinking about cultural competencies as suggested in the literature, competencies often transcend working with any one group – the fundamentals of cultural competency can be thought of as an ability to adapt to the needs of diverse groups (Baines, 2007; Greatrex-White, 2008; Chrisman, 2007; Isaacs, 2010; Suh, 2004).

Specific knowledge and skills among professionals when working with recent immigrants may be needed (e.g. language supports or cultural knowledge) but core attributes that enable adaptability to difference are essential. For the Canadian Nurses Association (2010), “the underlying values for cultural competence are, inclusivity, respect, valuing differences, equity and commitment” (pg.1). Within a culturally competent framework developing relationships of trust are important and can be accomplished by interacting with clients and co-workers with openness, understanding, and a willingness to hear different perceptions (Davis-Murdoch, 2005).

For an organization to be competent, it was evident from this case that overall adaptability also needs to be considered – adaptability with respect to supportive policies,

funding, training, opportunities for exchange and engagement, and so forth (Chrisman, 2007; Davis-Murdoch, 2005). Additionally, and as also proposed and explored here, for a system of services to be culturally competent, *competence trust* can be the enabling factor that brings together the collective competencies of all partners into a process of exchange and interaction that is dynamic, adaptive and responsive to the needs of immigrant families.

In an ideal, culturally competent system there is an assumption that attributes of cultural competency that are adaptive to the needs of immigrant families would be characteristic of all agencies (Cross, Bazron, Dennis, & Isaacs, 1989). All agencies therefore could theoretically be welcoming points of access into the system for families. In this case study there was a relatively cohesive network of interacting service organizations, but with dependencies on a subset of members (the brokers) to enable the flow of ‘work’ on behalf of the immigrant families. These dependencies imply a services network still maturing in its ability to address the unique needs of this population. Measures of *competence trust*, and self-assessed competence varied among agencies, hence supporting this view. For families to have access to services, *competence trust* among organizations mattered – with lack of trust, work flow within the system was constrained and the nature of interactions was less open, with more avoidance behaviour.

Beyond Organizational Theory

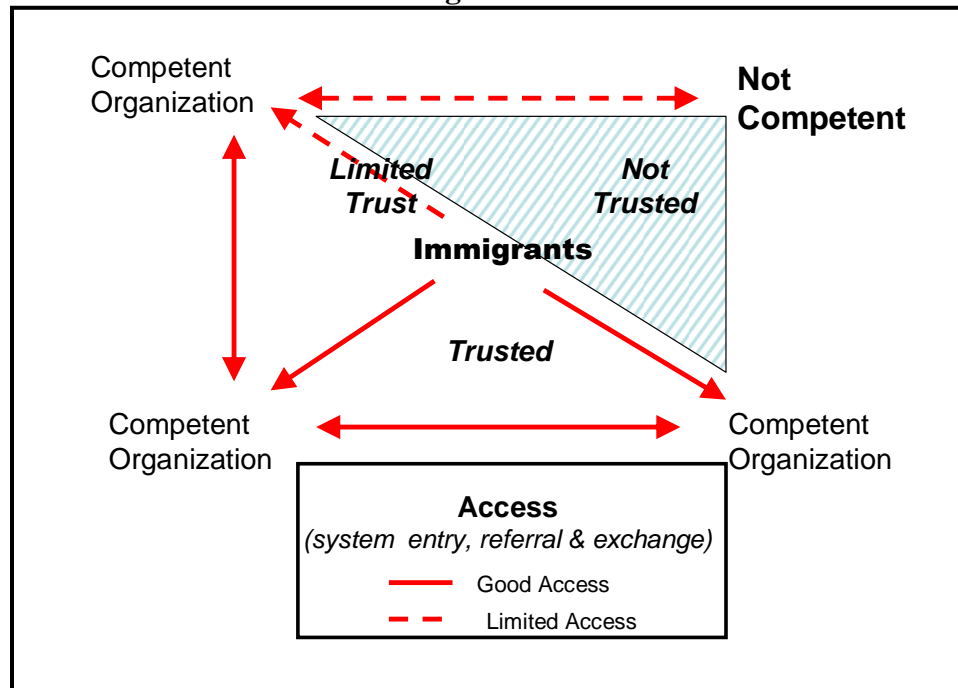
Using Yin’s framework, this case study began with a set of theoretical propositions situated under two primary research questions: “How do community based services work with one another in order to address the PHC needs of young children of

recent immigrants?”, and “How do the perceived cultural competencies of the different community organizations affect the delivery of PHC services for young children of recent immigrants?” The propositions themselves were challenged in this dissertation by theory derived from organizational ecology which speaks to states of inertia and resistance to change within dominant institutions, and to inter-organizational relationships that are competing or cooperative depending on perceived risks and benefits (Hannan, Polos & Carrol, 2007; Ivery, 2007). As part of a client oriented culture, professional relations that support client interests are of value to service providers (Walker, Smith & Adam, 2008). As seen in this case study, partnerships with agencies were perceived as either risky or beneficial depending on whether or not these partnerships were considered supportive of families. Socio-political influences, also captured within organizational theory, were eventually identified as drivers toward relationships, that is, conditions that encouraged interactions among organizations. However, the quality of relationships among providers needed other explanation once relationships were formed.

Figure 18 is the model of trust and competency originally proposed as a starting framework for understanding working relationships among service providers. It focuses on the proximal condition of trust within relationships (between providers, but also between clients and providers) with an attempt to demonstrate how client access is affected. The prediction of this model, that non-culturally competent organizations would not be trusted and therefore access for families through referral and exchange would be lost, only worked at the extreme, that is, when situations were perceived as threatening

for families. Again, this framework does not tell us the whole story as many organizations continued to work together despite their misgivings.

Figure 18: How Services Access for Immigrants could be influenced by *Competence Trust among Service Providers**



**Competence Trust* is one's belief in the other's competence, a form of trust. In the diagram, trust refers to *Competence Trust*. Competent refers to culturally competent.

Table 14 provides a summary of related findings from Chapter 4 on *competence trust*, based on the perceptions of the providers who participated in the study. The table references the different types of experiences families had with provider organizations as perceived by providers (helpful, unhelpful and threatening), how these perceptions influenced relationships among partnering organizations (strengthening, cautioning, damaging), and then ultimately how this could impact family access to services (increased, reduced, lost).

Table 14: The Impact of Perceived Family Experiences on Provider Relationships and Family Access

DRIVERS toward Engaging other providers	Perceived Family EXPERIENCE	Impact on Provider Relationships	Provider RESPONSE	OUTCOME for Families
Internal <i>(staff, funding)</i> Environmental <i>(political, economic)</i> Organizational <i>(goals, boundaries, activities)</i>	Helpful	Strengthening/ Sustaining	Engage Further	Increased Access
	<i>-flexible, welcoming and responsive</i>	<i>-trust and confident in the partner's competency</i>	<i>-more referral exchange, resource sharing</i>	<i>-families have a growing network of services to access</i>
	Unhelpful	Cautioning	Avoidance	Reduced Access
	<i>-insensitive, unreliable, racist</i>	<i>-reduced trust</i>	<i>-engage minimally or only as necessary (e.g. mandated).</i>	<i>-opportunities to benefit from the others' services lost</i>
	Threatening	Damaging	Fight or Flight	Uncertain or Lost Access
	<i>-family in conflict with authority</i>	<i>-Conflicting values -supporting the family while acknowledging a problem</i>	<i>-work toward resolution; -damage control - Distancing</i>	<i>-family stops coming</i>

Table 15 uses a similar typology – helpful, unhelpful and threatening – to illustrate the kinds of direct experiences providers had with other organizations and then, how these could also affect client access. Constructs are drawn from the direct experiences of providers with the cultural competencies of other organizations (as derived from key informant statements not addressed in this dissertation thus far), but also from the direct influences of competition as reported by participants and predicted by organizational theory.

Table 15: The Impact of Provider Experiences on Provider Relationships and Family Access

DRIVERS toward Engaging other providers	Provider EXPERIENCE	Impact on Provider Relationships	Provider RESPONSE	OUTCOME for Families
Internal <i>(staff, funding)</i> Environmental <i>(political, economic)</i> Organizational <i>(goals, boundaries, activities)</i>	Helpful	Strengthening/ Sustaining	Engage Further	Increased Access
	-able to provide needed information and resources -available & willing to learn	-developing trust and confidence in partner's competency & reliability	-more referral exchange, resource sharing -seek opportunities to educate	-families have a growing network of services to access growing in competency
	Unhelpful	Cautioning	Avoidance	Reduced Access
	-unreliable, uninformed, perceived not to be committed -conflicting values	-reduced trust; lost confidence	-engage minimally or only as necessary	-opportunities to benefit from the others' services lost
	Threatening	Damaging	Fight or Flight	Uncertain or Lost Access
-competition for funding -niche building -lack of coordination	-niche protection -reduced communication & sharing of ideas	-distancing -acknowledge the threat -seek resolution in support of families	-confusion for families; loss of continuity when funding is unstable.	

The model as applied in both tables 14 and 15, introduces the concepts of threat and conflict, the consequences of which are likely to be negative for families without a skilled approach toward resolution. The threat may be toward the integrity of the family if immigrant status or parenting concerns are the issue. Loss of trust among providers in this case may or may not have anything to do with cultural competencies in the partnering organizations. However, the outcome for the family (or provider) is still experienced as negative, and therefore access to services for families is at risk.

As suggested, other influential factors may have preceded *competence trust* as drivers toward relationship formation among providers. Further, the ingredients of systems competency would need to include more than just culturally competent partners

who can be trusted. As derived from this case study and other reports (Cross et al, 1989; Davis-Murdoch, 2005; Whitaker, Baker, Pratt, Reed, Suri.et al., 2007), a culturally competent system would also include systemic access to linguistic resources, equitable funding, and political support that then becomes expressed in mandates, training agendas and program priorities. When these things are made available, the professionals themselves are enabled to do their jobs in a competent manner, sharing and exchanging the competencies of the entire network. Moreover, trust becomes part of a feedback loop supporting client access to services within a working system. Trust is both influential and responsive to systemic cultural competency.

The last statement goes beyond organizational theory, having a skewed emphasis on trust and competency. Forbes & McCartney (2010) have argued that systems theory, from which organizational theory is derived, is limited in explaining relationships within a services model. Social capital theory may have an advantage: “Systems approaches are useful in contrasting separate services... but may tend towards normative accounts that focus on organizational goals and activities and under-specify the relational realities experienced by staff. They thus fail to uncover important perspectives in the interstices between and amongst different ... services systems” (Forbes & McCartney, 2010, pg. 324).

Social capital, simply stated, consists of relationships and their qualities. Social capital can be defined as “a collective asset in the form of shared norms, values, beliefs, trust, networks, social relations, and institutions that facilitate cooperation and collective action for mutual benefits” (Bhandari & Yasunobu, 2009, pg. 480). Elements of social

capital can be grouped under three broad categories: social networks (of families, friends, communities, and associations), norms of reciprocity (shared norms, values, and behaviours), and trust (in other people and institutions) (Halpern, 2005). Trust among organizations is thought of as part of the process of social capital exchange that occurs within networks, and that can be sanctioned by the norms of those involved in order to operationalize the everyday aspects of network interactions. From this perspective, trust, as well as shared norms and values are *proximal* constructs, that is, in the moment of exchange and within the relationship. The socio-political-environmental influences identified under organizational theory are arguably *distal* to the relationship, though influencing its formation and sustainability. Both proximal and distal influences may need to be aligned in order for relationships and network exchanges to occur that are adaptive to changing needs, the needs of arriving immigrants for example. If not aligned, resources, skills, mandates and policies are not likely to reflect what individuals and organizations are most willing to work toward collaboratively with one another.

As an analogy, Walker et al. (2009) demonstrated a greater dependency by managers within a primary care network on formal relationships as a condition of trust, compared to front line service providers who were more directly involved with clients and co-workers from different agencies. In the latter case, front-line providers developed trust with colleagues through informal relationships. Managers saw working relationships from the view of organizational accountability, while service providers were in the midst of the relationships themselves, operating within professional frameworks with accountability toward clients in the forefront. Although the current case study did

not separate out the viewpoints of managers from direct service providers; distal, organizational drivers of which management is often responsive to; and proximal, relationship experiences in the delivery of services were evident and influential in the operations of the network.

Norms and Values Matter

Shared norms and values (i.e. shared philosophies) were acknowledged by interview participants as reasons for partnering with other service agencies. Cultural competency could be considered a valued attribute in this case; this shared value engendered a form of trust that supported the interactions occurring within the network. And, in social capital theory terms, the brokers in this case study may indeed have provided the synergy for realizing the social capital of the organizations involved - the *bonding* within organizations, the *bridging* across organizations and the *linking* across service sectors and other stakeholders (Halpern, 2005).

Relationships Tied to Investments

Despite the respondents' caution in discussing negative aspects of relationships, some common themes did arise. When things became tense in the interactions between providers and families, relationships among providers were, as predicted, challenged. However, most relationships still carried on. Some, who were most often members of broker organizations, spoke out and even reinvested in the relationship with other providers with much more intensity in order to educate the other. Why?

In social capital terms, relationships among service providers are investments, with a likely desire among all parties to preserve the advantages gained through these

relationships (Forbes & McCartney, 2010; Gulati & Higgins, 2003). In this case, those most invested in the issues faced by immigrants had potentially much more to gain through their actions in trying to promote the cultural competencies of others. Some were even willing at the extreme to end relationships if their interests in families were somehow compromised. However, for others, challenging other agencies or severing ties could conceivably have resulted in losses of other kinds - access to needed skill sets and resources for example. In the words of one service provider, “There’s no one else”.

All of this illustrates that when we see a relatively cohesive group (e.g. relationships around general health concerns) we should be cautioned not to simply stop there if we want to understand relationships. What relationships really mean and how well they are working requires another perspective. Social capital theory (Forbes & McCartney, 2010) can aid as a reference point for understanding the proximal dynamics of relationships, augmenting explanations offered by organizational ecology.

Contributions to Nursing Practice

Although not a focus of this dissertation, nurses as staff of both PC and PH agencies were involved as participants in this case study and thus warrant comment. Attributes and behaviours that engender trust –compassionate, competent and ethical care; promoting health and well-being; promoting and respecting informed decision making; preserving dignity; maintaining privacy and confidentiality; promoting justice; and being accountable – are expectations of nurses under the ethics and values of Canada’s nursing profession (Canadian Nurses Association, 2008). Descriptions of cultural competence in nursing practice extend this list to include attributes of openness,

adaptability and responsiveness within different cross-cultural situations (Davidson, Meleis, Daly, & Douglas, 2003; Isaacs, 2010), values of inclusivity, respect, equity and commitment (Canadian Nurses Association, 2010), and selected cultural skills and knowledge when working with specific cultural groups (Leininger, 2006).

However, as members of health care teams and of systems, the ability of nurses to actualize these attributes and behaviours still requires opportunity (Kooker, Shoultz, & Codier, 2007). As stated by many during case interviews, opportunities were not always there. For some, more time was needed to really understand the needs of families, while supportive mechanisms (e.g. interpreters and other linguistic supports) needed to be more available to enable nurses to perform within a culturally competent practice framework.

The growth points still needed to actualize a culturally competent system will continue to require change agents. In this case study, nurses working in PC and PH, functioned as brokers, connecting families to other services to help meet their needs. Brokerage by nurses as described by study participants happened most often in connecting families to other PC or PH services, but also to the drop-in centres where families could receive other supports. But nurses also have the potential for other forms of brokerage, that is, brokers of change or change agents, to improve systemic cultural competencies. This implies a leadership role that goes beyond the modeling of best practices in cultural competence as individual practitioners.

Change agents actively engage in moving organizations and systems forward in their adaptation to a changing environment (Foster-Fishman, Nowell & Yang, 2007). Nurses as change agents or champions in innovation (Ploeg, Skelly, Rowan, Edwards,

Davies, Grinspun et al., 2010), are located at all levels of the health care system. The positioning of change agents provides a critical opportunity to effect needed change in primary health care. In doing so, nurses need to apply advanced (and even basic) skills in persuasion and influence, knowledge brokerage, along with tacit and formal knowledge of organizational and group behaviour (Balogun, Gleadle, Hailey & Willmottz, 2005; Bhatnagar, Budhwar, Srivastava, & Saini, 2010). But most importantly, nurses need to demonstrate persistence and commitment toward a vision of what will be rather than what is (Ferlie & Bennett, 1992).

Community health nursing has a long history already embedded in systems thinking (Hall & Weaver, 1977). New graduates with current knowledge in systems frameworks (Bellack, Morijikian, Barger, Strachota, Fitzmaurice, et al., 2001) along with existing nursing leaders seasoned through organizational-cultural experiences, need to embrace their values as a caring profession and work across boundaries to create an environment of systemic cultural competence. This also means having the knowledge, skills and an awareness of self in working with diversity (Davidson et al., 2003).

Notably, the promotion of competencies and capacities to work with new populations is not one profession's job, and certainly not one person's. Motivation by nurses to promote cultural competence within their employing organization will likely instil organizational attributes that support competencies. Only through the further infusion of competencies within global practices – trans-disciplinary and inter-sectoral – will cultural competency be operationalized, normalized and sustained. In institutions such as public health and other settings where nurses work, there will likely always be

competing agendas for how time is spent and prioritized. What are not competing are the principals and practices of a caring profession, and within which all other agendas can be framed.

Study Limitations

In assembling the services to be considered for this case study, not all saw themselves as necessarily part of a PHC network for immigrant families, particularly organizations without health or immigration as part of their core mandate. This may explain some of the difficulties in recruitment. This does, however, introduce a selection bias, with the viewpoints as well as the relationships between non-participants absent in the results. The role of many non-health funded institutions in this services network is therefore under-represented. Under-representativeness holds true also for private practice family physicians given their lack of participation in the survey, despite initial attempts to recruit family doctors with the help of the local family practice association. The association supported the research by mailing an invitation to participate to their membership – approximately 400 physicians. One physician responded but was subsequently unavailable for contact. Family doctors were identified as a group on the organization list created for the survey, but family practitioners themselves did not respond.

Study design may have also influenced recruitment - two arms of recruitment were needed to address the two different data collection methods. This was likely confusing for some potential respondents, but also made it difficult to manage the process. Had, for example, the qualitative component been embedded within the SNA

study (or the reverse), only one recruitment protocol and consent process would have been required.

Participants in this study had a great deal to say about their own work and how they were meeting the needs of immigrant families. They talked freely about the needs of families generally, the barriers families faced, and, the problems with which they were able to help families. However, commenting on their interactions with other organizations seemed more difficult. Judgments or opinions about their experiences with other organizations in addressing the needs of immigrant families were most often stated cautiously and in generalities. This could be a consequence of not being able to guarantee anonymity for responding organizations, particularly within such a small service community. The most difficult experiences and their impact may not have been shared by some with insight lost as a consequence.

Immigrants themselves were not engaged in this research. The questions and purpose of this study – to understand relationships among providers – did not call for their involvement, though in retrospect, knowing their opinions concerning different providers could have helped to validate the respondents' own perceptions about other organizations and their cultural competencies. Questions about barriers to service access would also have been more credible coming from the families themselves. The choice in selecting service providers as the source of information, however, was both strategic and appropriate, given the focus of this study. Further, as an outsider to the community, the researcher would have needed more experience and time with the community in order to gain the trust and participation of a vulnerable group - an ethics consideration, as much as

a practical one (e.g. the costs of translation and transportation). Encouragingly, most of those involved in the study also provided direct service and could, through their experienced eyes, credibly speak to the barriers faced by families in an informed manner. More importantly to the research questions, respondents could speak to their own ‘perceptions’ of the families’ experiences, and how these perceptions impacted their relationships with other providers.

Descriptions of nurses working with recent immigrants as offered by key informants ranged from, “they don’t seem to be committed” to “they are the backbone when it comes to servicing this population”. Given the design of this study, however, with organizations as the units of analyses, how nurses were viewed within this case was most likely fixed within the opinions directed toward the employing institutions and not the profession. The differences in the opinions concerning nurses came from key informants with different contextual experiences in working with nurses, that is, differences in places where nurses worked such as public health, hospitals, and primary care, and then differences based on subject matter such as infectious diseases, growth and development, clinic interventions, and so forth.

Future Research

As a future research agenda, theoretical models that address the process of becoming a culturally competent service system needs further development. Models are needed that account for a balance between organizational stability (legitimized funding, goals and objectives) and relevancy (adaptability to changing needs) (Granovetter, 1985; Hannan, Polos & Carrol, 2007). As a starting point for theory development, trust among

organizations should also be considered given its prominence within social capital and trust theory as a requirement for effective and efficient organizational systems that are likely to be dynamic and responsive to change (Covey & Merrill, 2006).

Improved methods are needed for setting case boundaries under a PHC framework that is inclusive of different service sectors. Definitions are also needed about what constitutes an organization, particularly when comparability across studies is desirable. In this case, theory justified inclusion, but there were trade-offs. Practical decisions in methods and analyses needed to be applied in some instances in order to accommodate non-participants, for example, using directional versus symmetrical measures of centrality as described in chapter 2. Private practice physician opinion was not represented in the results of the SNA survey. Physician participation in research continues to be a problem for many researchers (Hummers-Pradier, Scheidt-Nave, Martin, Heinemann, Kochen & Himmel, 2008); creative ways for motivating and rewarding physicians for their participation need to be identified. As part of a solution, methods are also needed for effectively communicating the importance of participation with those who do not intuitively identify with the study boundaries and its purpose.

In the policy arena, this case study demonstrated the pivotal role played by NGO's as broker organizations enabling recent immigrant families to connect with public health, primary care and other supportive services. A loss of these organizations, settlement services in particular, would most likely have a significant impact on the functioning of this local network in the provision of services for immigrant families. Other organizations were still developing their cultural competencies, with dependencies of the NGO's for

reaching this population. The precarious nature of network dependencies on NGO's is evidenced by the recent cuts to settlement service programs that occurred in many parts of Canada in late 2010 (Citizenship and Immigration Canada, 2010). Ontario was particularly affected (CBCNews, 2010). Because of the contextual nature of case study, the transferability of the findings from this case are limited given vast differences in the immigrant experience, for example, for large urban centres such as Toronto compared to Maritime communities. Similar research is needed to investigate the policy implications of cutbacks to settlement services within different types of communities, given what we know about the value of settlement services from this case.

Finally, studies designed to address the role of nurses as change agents for promoting systemic cultural competencies could add to our understanding of how nurses are best able to perform in these capacities. Studies are also needed to identify the barriers (e.g. learning needs, and systemic barriers) faced by nurses in assuming these leadership roles. In line with this is the need to further investigate how best to incorporate into nursing curricula, education that encourages a trans-disciplinary/inter-sectoral lens for dealing with complex system issues, using current examples (Hodges, 2011). More specifically, demonstrations are needed of how adaptive systems thinking taught within curricula can also prepare nurses to understand, acquire and promote cultural competencies within our institutions that are adaptive and responsive to a changing population dynamic now being experienced across Canada (Edwards, 2011; Ogilvie, 2011).

Conclusions

Organizational ecology was used in this case study as a starting point for understanding how organizational systems work in response to the PHC needs of recent immigrant families with young children. This theory provided a list of questions for identifying and examining influential factors on the dynamics of organizational interactions in relation to the needs of this client group. In this case, different socio-political influences were at play, bringing to light the need for adaptation and new alliances. Agencies charged with the responsibilities of immigrant settlement were most often the brokers who acted to ensure family's needs were being met, particularly given the barriers faced by families within an under-resourced services system collectively inexperienced in meeting immigrant needs. Variability in cultural competencies was evident; those organizations with greater knowledge and specialization in immigration had the added role of brokering for the advancement of cultural competency in others.

Trust, according to theorists in social capital and trust theory, provides the lubricant (even the glue) for ensuring the effectiveness and efficiency of the system and its members (Mayer, Davis & Schoorman, 1995; World Bank, 2011). Unlike the socio-political (often macro-level and distal) factors identified through organizational theory, trust in the other's competencies, a micro level and proximal experience, appeared in this case study to affect the quality of how different organizations worked together and the desirability of these relationships. Distal socio-political influences were ultimately considered to be the drivers toward relationship formation.

Recognizing the importance of trust for ensuring network operational effectiveness as supported here and in the literature (Covey & Merrill, 2006; Nugent & Abolafia, 2006; Provan et al., 2005), it was important to also understand how trust was created in this service community, particularly trust in each other's cultural competencies when addressing the needs of recent immigrants. Outside of the competitive/adaptive nature of organizational systems as understood within organizational theory, the constructs of trust, norms and values offered by social capital theory, operating at the organizational as much as the interpersonal level (Forbes & McCartney, 2010), may better help to explain how experience with others' competencies affected the quality of relationships. For example, positive and negative experiences in relation to how clients were treated as perceived by providers had an important influence on trust among providers. Those organizations trusted for their cultural competence were much more desirable as partnering organizations by providers who also valued their relationships with immigrant families.

The mandates and goals of an organization as well as competition for scarce resources had their selective influences on relationships. Ultimately, organizations worked together as needed, but with a willingness to participate more with one another when values, goals and other influences (e.g. policy) were most congruent. Competition did exist as predicted by organizational ecology with the greatest implications for the least stable organizations – the NGO's. However, competing organizations were still willing to try and overcome this in order to support a common value and interest – the

wellbeing of families, along with a recognized need to learn and share more with each other.

Existing models for understanding these observations are not sufficient. Social capital theory demonstrates how things work with or without trust; organizational theory demonstrates push and pull factors in response to change. Models that truly identify the 'how' of effective adaptation to change are still needed; in this case study, the need for change was introduced by newcomers to Canada. Ultimately, a shift in values and norms may also be needed to accommodate change; these shifts would further need to be legitimized through change in organizational interests, mandates and goals (Haman, Polos & Carrol, 2007). This is risky (Covey & Merrill, 2006) and, chances are, resource demanding requiring reinvestment. Perceptively, decision makers will need to be selective about what organizational forms survive (organization ecology), and taking risks will require trust (social capital) in order to be open to something other than hard and fast rules. The trick will be in finding the balance between stability (i.e. old mandates and goals) and relevancy (i.e. new requirements) in a changing environment.

In this case study, *competence trust*, the recognition of cultural competencies in others, and brokerage, supported a movement toward greater cultural competence in the services system overall. Organizations under different kinds of mandated constraints were listening to each other and wanting to adapt. The aspirations of cultural competency in nursing practice are legitimized when this occurs: whether nurses now find themselves supported in the tailored work that they do with new families arriving in Canada, or else

encouraged to participate themselves as change agents in the development of systemic cultural competencies.

The Radical

Change agents, agents of mercy

Nightingale glow caring across boundaries

The myth of culture replaced by acculture

The metaphysical radical

Rubs against the grain making lines that counter balance

The inertia that resists is not the point

The point of change remains a state of beginning

What forms will be the radical

The radical becomes formation

The agent pivots observing seeing feeling then moving

Creating the counter balance

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APPENDICES

Appendix A: Alma-Ata Declarations of 1978

Primary health care:

1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
2. addresses the main health problems in the community, providing **promotive, preventive, curative and rehabilitative services** accordingly;
3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; *promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases*; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. *involves, in addition to the health sector, all related sectors and aspects of national and community development*, in particular agriculture, animal husbandry, **food, industry, education, housing**, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

5. *requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources;*
and to this end develops through appropriate education the ability of communities to participate;
6. *should be sustained by integrated, functional and mutually supportive referral systems,* leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
7. *relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed,* suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

http://www.euro.who.int/AboutWHO/Policy/20010827_1

Appendix B: Selected Demographics for Clayton Park and Fairview Communities

Clayton Park:

Population: Based on the 2006 Census of Population, Clayton Park has a population of 30,911 which is 42.4% higher than in 1996. In 2006, 18.2% of the population of Clayton Park was under the age of 20 and 15.4% was 65 years or older.

Income: In 2006, the median income for individuals in Clayton Park was \$30,666 a year, compared with the provincial median of \$24,030, and the Canadian median of \$26,917. Families in Clayton Park had a median income of \$68,928, compared with the provincial median of \$55,412 and the Canadian median of \$63,866.

Immigrants: In Clayton Park, there were 4,652 immigrants which is 15.3% of the population.

Compared to the rest of Canada, Nova Scotia has a relatively low immigrant population. In 2006, there were 45,190 immigrants which is 5.0% of the population compared to 19.8% immigrants for Canada.

Families: In 2006, for Clayton Park, total census families increased 36.4% to 8,324. Married families increased by 26.0% while common law families increased 100.4% and lone-parent families increased 33.2%. Lone female parent families were 14.0% of all families while lone male parents were 2.1% of all families.

Fairview:

Population: Based on the 2006 Census of Population, Fairview has a population of 14,478 which is 3.1% lower than in 1996. In 2006, 17.1% of the population of Fairview was under the age of 20 and 15.7% was 65 years or older.

Income: In 2006, the median income for individuals in Fairview was \$24,832 a year, compared with the provincial median of \$24,030, and the Canadian median of \$26,917. Families in Fairview had a median income of \$53,145, compared with the provincial median of \$55,412 and the Canadian median of \$63,866.

Immigrants: In Fairview, there were 1,274 immigrants which is 8.9% of the population. Compared to the rest of Canada, Nova Scotia has a relatively low immigrant population. In 2006, there were 45,190 immigrants which is 5.0% of the population compared to 19.8% immigrants for Canada.

Families: In 2006, for Fairview, total census families decreased 6.2% to 3,799. Married families declined by 13.7% while common law families increased 19.3% and lone-parent families increased 0.6%. Lone female parent families were 18.4% of all families while lone male parents were 3.9% of all families.

Source:

Government of Nova Scotia (2009). "Community Counts". Retrieved February 27, 2009

From <http://www.gov.ns.ca/finance/communitycounts/default.asp>.

Appendix C:

SNA Glossary of Terms

Term	Description
Actors & Nodes	Actors represented by nodes in a network map, are distinct members of a network. They may be individuals (e.g. clients, community residents), or collective units (e.g. groups, organizations).
Boundary Spanners	Boundary spanners are actors who connect groups in a network which are otherwise distantly connected if at all.
Brokerage	The ability to create bridges across dissimilar groups or individuals, and therefore control the flow of information and other types of exchange. This is what <i>boundary spanners</i> do.
Centrality	<i>Betweenness Centrality:</i> The number of times an actor is found along the shortest pathway between all other actors in a network. Actors with high betweenness centrality are identified as network brokers, facilitating the flow of exchange among network members. Directed betweenness centrality applies when the flow of exchange is one way. <i>Degree Centrality:</i> The sum of all other actors who are directly connected to the actor of interest. Many connections or <i>ties</i> , increase degree centrality. High degree centrality indicates a position of influence within the network.
Cut-Point	An actor within a network that, if removed, will disconnect other actors from the network. This is also a broker role.
Density	A network level measure that demonstrates the overall level of connectedness among actors (organizations) in the network. Density is calculated by dividing the total number of ties that actually exist in a network by the total number of possible ties, giving a proportional score ranging from 0 to 1.
Path	The series of ties (number of graph lines) connecting two actors in a network.
Structural Hole	A structural hole is a relationship of non-redundancy between two actors with structural dissimilarity. The relationship provides network benefits that are additive rather than overlapping.
Ties	A tie is the relationship between two actors in a network. A <i>weak tie</i> is often associated with a <i>structural hole</i> and may mean only one form of relationship with another actor or network subgroup. A <i>strong tie</i> may mean many different types of connections (additively, a multiplex relationship) found within close working units or families.

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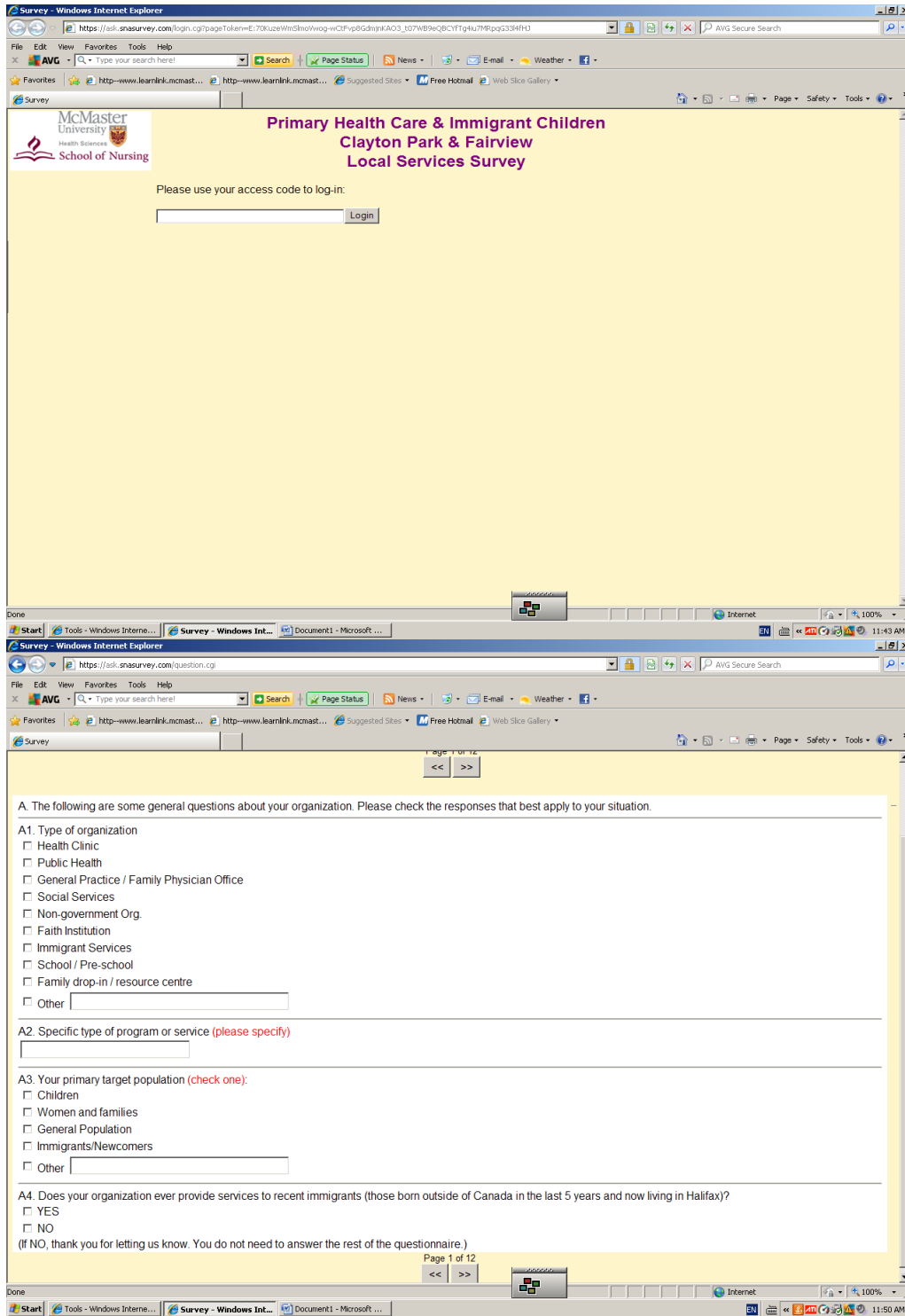
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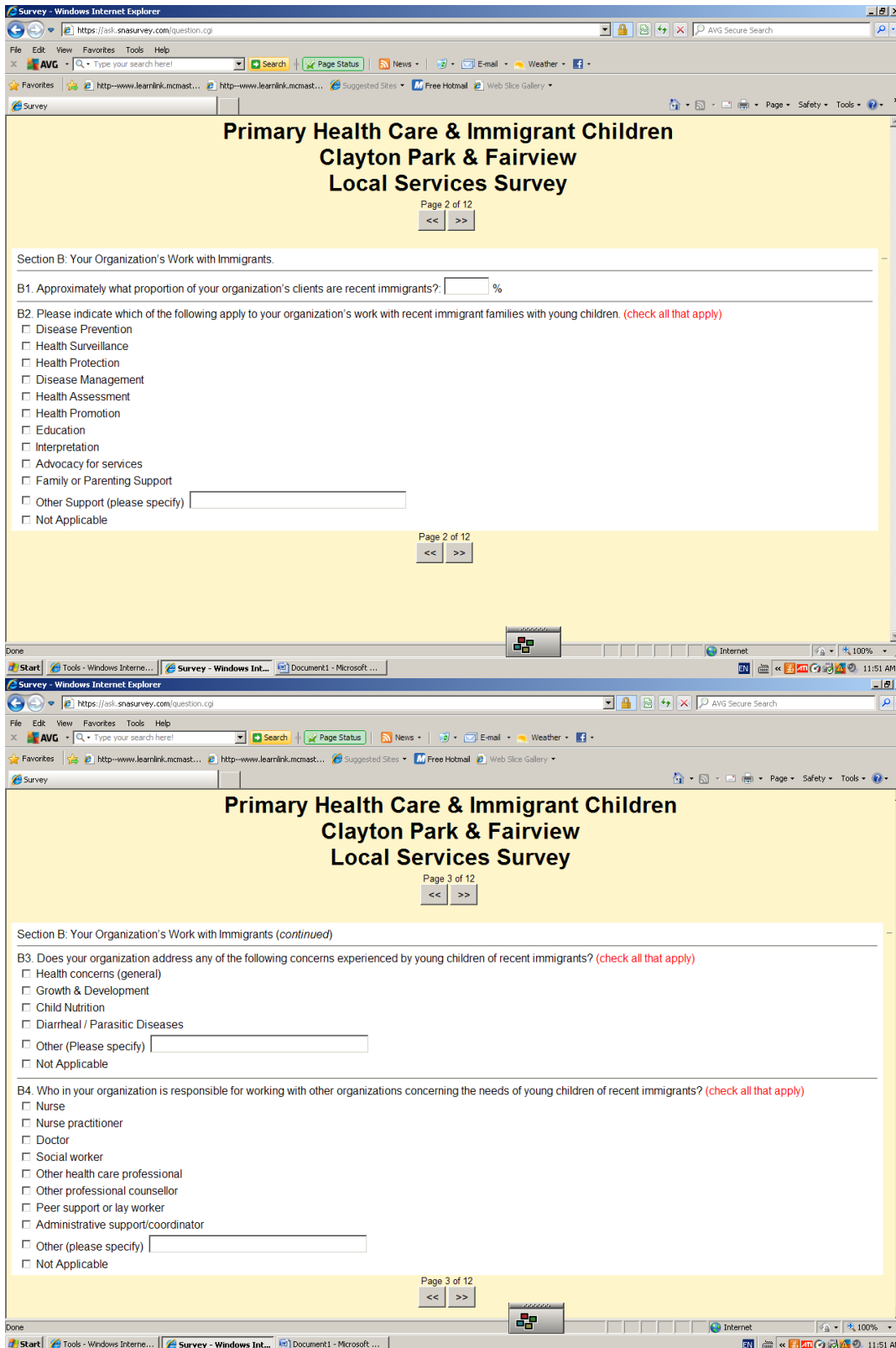
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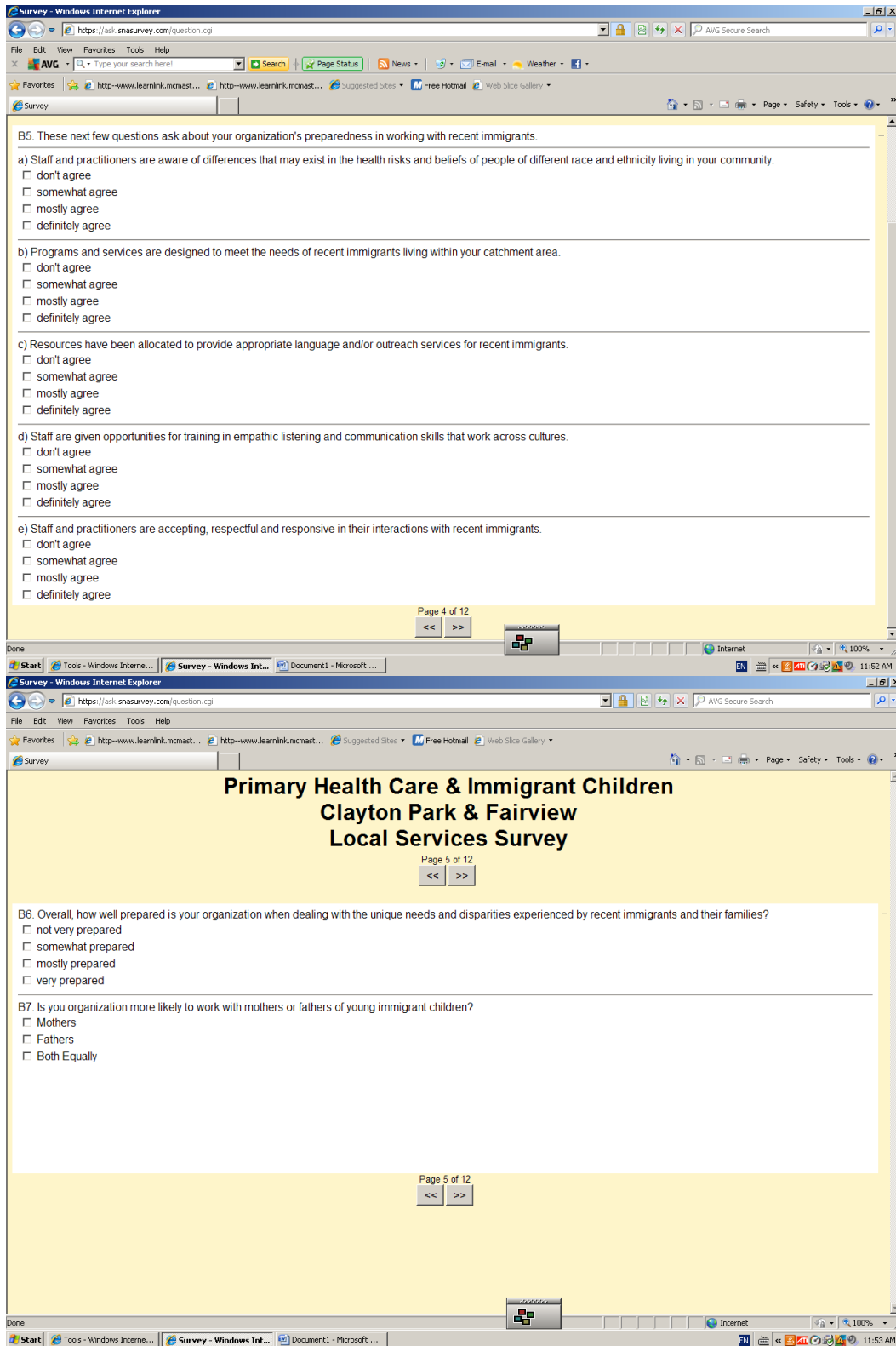
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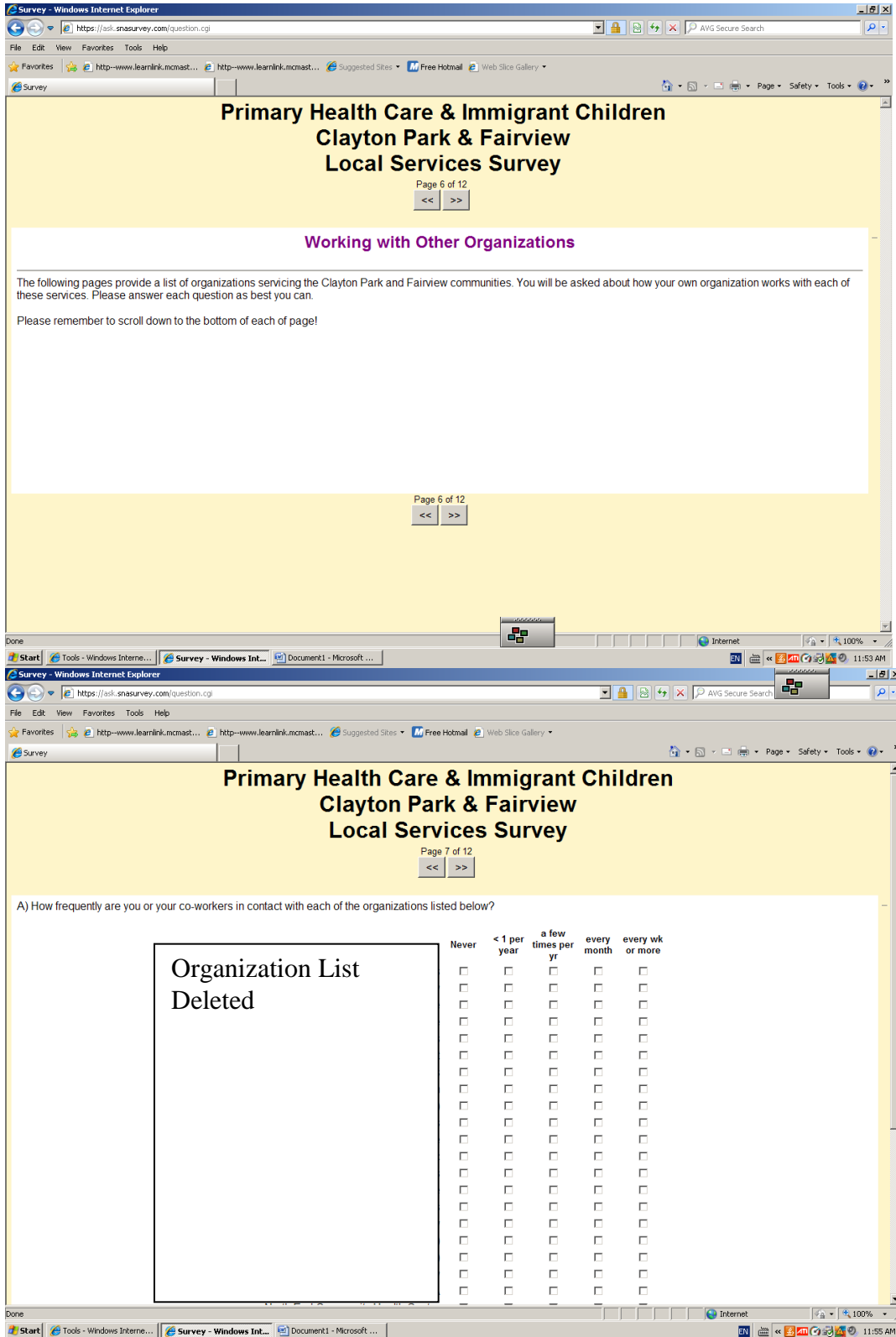
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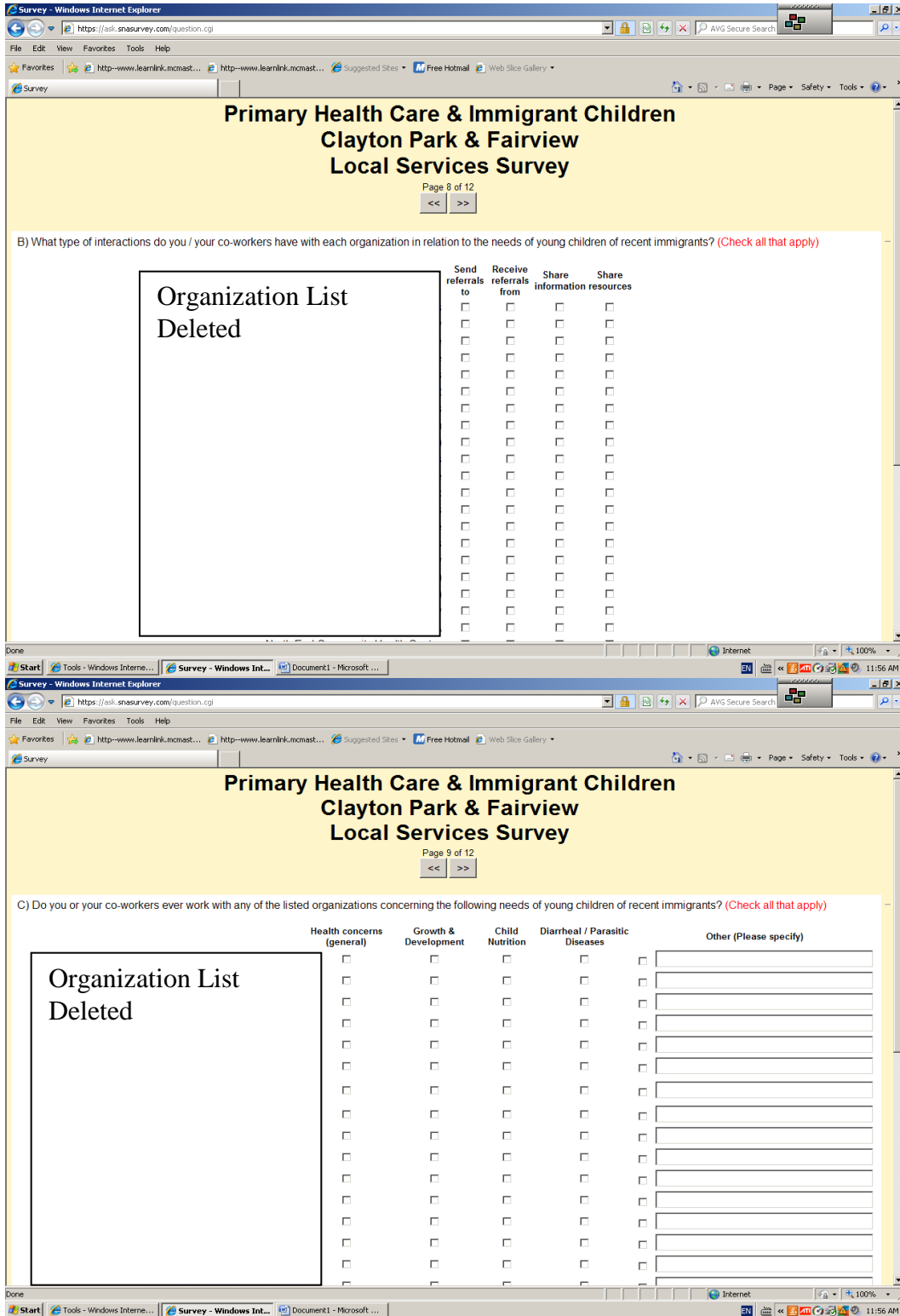
Appendix D: Website Screenshots of SNA On-line Survey

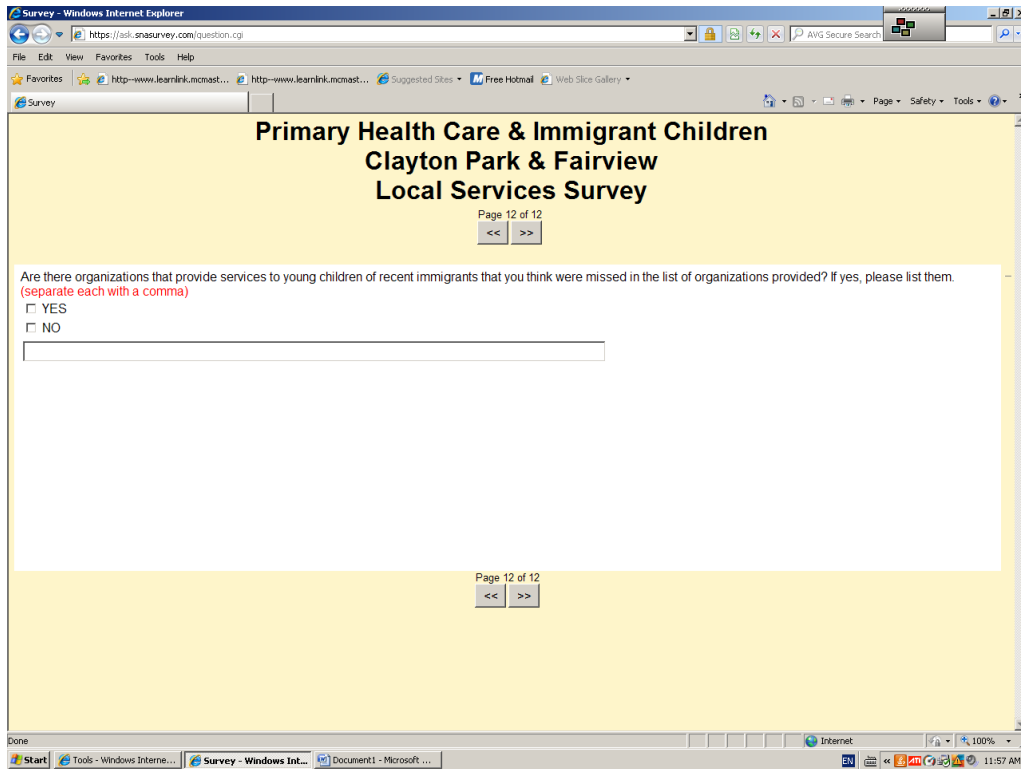












Appendix E: Tables of Example Coding Schemes

Coding Scheme: Family Experience and Trust among Providers			
Family Experience Helpful			
Type	Name	Sources	References
Tree Node	History of mutual success	11	19
Tree Node	always done good work	5	10
Tree Node	ALL_Practical & Hands on	9	12
Tree Node	ALL_Supportive	7	12
Tree Node	taking the time	6	8
Tree Node	Creative_Adaptable	2	3
Family Experience Unhelpful			
Type	Name	Sources	References
Tree Node	ALL_Lack of equitable access to services	6	10
Tree Node	other provider fails the family	4	6
Tree Node	wearry of unfamiliar services	3	5
Tree Node	ALL_Perceived discrimination in partners	1	5
Tree Node	Insensitivity_misused	3	3
Tree Node	perceived rights abused_unfair treatment	2	4
Tree Node	not for everyone	1	1
Family Experience Threatening			
Type	Name	Sources	References
Tree Node	Threatening _ decreased family trust	6	14
Tree Node	Child protection and child rearing contested	4	9
Tree Node	Immigrant Screening and threatened Status	2	2
Tree Node	Cultural discord and family conflict	1	1
Impact on Provider Relationships			
Type	Name	Sources	References
Tree Node	ALL_Strengthening_Sustaining	10	26
Tree Node	ALL_Cautioning	6	15
Tree Node	ALL_Conflicting or damaging	4	7
Provider Response			
Type	Name	Sources	References
Tree Node	ALL_Engage Further	7	17
Tree Node	Fight or Fight	6	12
Tree Node	Promote competence	5	11
Tree Node	Avoidance	4	6
Family Outcome			
Type	Name	Sources	References
Tree Node	ALL_Increase Access	9	20
Tree Node	ALL_Reduced Access	9	39
Tree Node	ALL_Uncertain_lost access	10	32

Coding Scheme: Other Relationship Influences/Drivers			
SOCIO-POLITICAL Environment			
Type	Name	Sources	References
Tree Node	ALL_resource gains_social capital	11	41
Tree Node	ALL_Accessibility	11	39
Tree Node	ALL_Formal requirements	12	25
Tree Node	Co-locating services	11	28
Tree Node	ALL_Family attributes	6	18
Tree Node	ALL_competition	6	17
Tree Node	ALL_leadership and coordination	3	11
Tree Node	Supportive funding	5	8
Tree Node	political recognition	4	8
COMPATIBILITY			
Type	Name	Sources	References
Tree Node	Special needs different connections	7	21
Tree Node	Network different for Infectious Diseases	4	13

Coding Scheme: Brokerage			
THE CONNECTORS			
attributes of connecting organizations			
Type	Name	Sources	References
Tree Node	resourcefulness	6	9
Tree Node	Location in the community	5	7
Tree Node	Well connected & knowledgeable	6	6
Tree Node	Connected to language resources	5	5
Tree Node	Models of cultural competence	5	6
Tree Node	Role expectation	3	5
Tree Node	Leadership	2	3
Tree Node	Optimistic	2	2
What brokers do			
Type	Name	Sources	References
Tree Node	Triage and Advocacy	10	41
Tree Node	Build systems competencies	6	18
Tree Node	build connections	6	16

Appendix F: Interview Protocol

Procedures	Specifics
Prior to Interview	
1. Identify interviewees and essential background information about them.	Interviewees as key informants are nominated by research supporters local to Halifax. (See sample selection). Purposeful sampling will be applied in order to ensure diversity among the participants interviewed (type of organization, type of profession). An introduction and study information sheet will be sent by e-mail to the program or department head of those nominated.
2. Arrange date and time of interview, explain aims of project.	Interviewee contact information will be obtained at the time of nomination. Contacts will be made personally by the investigator by phone or e-mail, with a brief introduction to the study. E-mail addresses will be verified at that time in order to forward information concerning the study. Interviewees will be told how or through whom their contact information was obtained.
3. Send interview questions ahead of interview along with participant information sheet. Obtain consent to participate.	Information will be sent by e-mail. The interviewee will be encouraged to prepare their own questions in advance should they have any concerning the research. They will be asked to acknowledge receiving the questions and information sheet and to indicate their agreement to participate through their e-mail response. The interviewee will also be asked to sign the consent section of the information sheet, and to return this by fax. The information sheet will include contact details for the interviewer.
4. Request permission for taping interview.	Interviews will be conducted in person or by phone at the time agreed upon. Prior to the beginning of the interview, the researcher will ask permission to record the dialogue. The interviewee will be informed that a transcript of the interview is available for their review if requested. The investigator will discuss confidentiality and security of all data to be collected.
5. Check tape recorder, spare batteries and tapes.	Test the equipment.
During Interview	
1. At interview, provide background information to the project	Briefly review the goal and intention of the study. (Refer to Interview Guide introduction).

2. Conduct the interview.	<p>The investigator will conduct an in-depth interview lasting about one hour. With the interviewee's permission, the investigator will start recording (verify that the recording works). The Interview Guide will be used to guide discussion. Notes will be maintained during the interview, jotting down key phrases, and quotes.</p> <p><i>Note:</i> The investigator may change the discussion line based on the responses heard. Probes may be asked to engage the participant to discuss issues not mentioned or only slightly disclosed earlier.</p>
3. At the end of interview review next steps.	<p>The Investigator will explain what is planned with the audio-taping, and how information will be secured. The investigator will also assure the interviewee that transcripts will be provided for review if requested. The interviewee will be encouraged to contact the investigator at any time to learn more; they can request that their interview be withdrawn from the study. Investigator contact information will be provided; interviewees will be thanked for their time.</p>
4. Request permissions to follow up issues by telephone/face to face/e-mail	<p>Interviewees will be asked if they can be contacted in the future for clarification or should additional questions arise in the course of the study.</p>
After Interview	
1. Ensure ID coding on all interview documents; prepare for appropriate storage and transcription.	<p><i>Using Codes and securing all data:</i> Create a unique ID Code for the interview. All documents of each interview will be identified with this interview code and dated: i.e. consent form, Interview Guide with notes; the micro-cassette; memos. Micro-cassettes and other data will be placed away safely, and consent forms and other documents with identifying information stored in a separate file; there after the participants will be referred to by their code.</p>
2. Write up contextual interview / memoing notes.	<p>Memoing will be conducted immediately following the interview. Memos will consist of:</p> <ul style="list-style-type: none"> • Summaries of memorable things the interviewee said at different moments. • Methodological difficulties or successes • Personal emotional experience. • New questions or hunches that may need to be explored further.
3. Send tapes to be transcribed	<p>Once the audio-tapes have been transcribed, transcripts will also be labelled with ID codes and placed in a secure and locked cabinet.</p>
4. Write letter of thanks to interviewee.	
5. Check and edit transcript	<p>Verify that speakers are appropriately identified; check against tape recording where transcripts are unclear.</p>

6. Follow-up with interviewee	Send transcript to interviewee and ask to confirm/or request deletions as needed. Request any additional information at this point. Arrange to follow up with telephone/face to face meeting where necessary.
7. Prepare for analysis using Nvivo 8.	Save transcript and notes as WORD files ready to enter into Nvivo 8 database.

Modified protocol template based on protocol developed by *Changing Faces*, Retrieved February 21, 2009 from <http://www.lancs.ac.uk/fss/projects/edres/changingfaces/protocol/practical.htm> 2009-02-22

Appendix G: SNA Survey Protocol

Procedure	Specifics
Pre-Survey	
1. Sample Identification / Organization list	A list of organizations for inclusion in the study will be identified through consultation with key informants. (SEE Sample Selection Strategy)
2. Contact CEO's of organizations for permission to engage staff participation.	A letter will be sent to the CEO of each organization introducing the study. The letter will request their organization's participation, and permission to contact staff. Those who do not respond within 5 days will be actively pursued by e-mail and phone follow-up. Appointments will be made with CEO's as needed to discuss the research and to encourage participation. The need for further REB assessment pending each organization's requirements will also be determined at this time. (<i>REB approval will have already been received from McMaster, PHAC, and Capital Health, Nova Scotia</i>).
3. Obtain contact information of potential respondents nominated by CEO (names, phone #s, addresses, e-mails)	A list will be created with contact information for all nominated participants. This will be maintained in a secure, locked environment.
4. Contact individuals by e-mail with introduction and invitation to participate/ obtain consent	Participant information Sheet (B) will be e-mailed to all nominated individuals.
5. Follow-up procedures for recruitment	Non-respondents to the invitation e-mail will be contacted by phone within 10 days to discuss the research and determine their decision concerning participation. If in agreement, the survey will be conducted by phone at an agreed upon time.
Survey Administration	
6. Survey completed on-line (option 1)	Following consent, respondents will be sent an introductory letter (content attached), with instructions on how to connect to the on-line survey website.
7. Survey completed by phone (option 2)	With consent, the survey will be conducted by phone at the time of the first phone call, or else at a designated time agreed to by the participant.
8. Monitor returned questionnaires and check for completion	Check returned questionnaires against the list of potential respondents. Review entries for completion. Date all questionnaires. Check that no one respondent has completed more than one survey (e.g. respondent completed both a phone survey and on-line survey).

<p>9. Follow-up procedures for incomplete surveys.</p>	<p>a) Contact non-respondents by e-mail 5 days after the introductory letter in order to encourage completion. Resend e-mail reminder a second time 5 days later. Call respondent 5 days later if no response yet received (i.e. completed survey or declined participation).</p>
<p>Post Survey</p>	
<p>10. Send thank you letter.</p>	<p>Send thank you letter by e-mail. Ask for permission to contact in future should new questions arise related to this study. Ensure respondent has contact information for any future questions. Offer to send a summary of report once the survey is completed.</p>
<p>11. Prepare data for analysis using UCINET</p>	<p>Obtain secured/encrypted data from snaSurvey.com. Conduct data quality checks and ready for entry into UCINET for local analysis.</p>

Appendix H: McMaster Health Sciences Ethics Approval



RESEARCH ETHICS BOARD



REB Office, 1057 Main St. W., Hamilton, ON L8S 1B7
Telephone: 905-521-2100, Ext. 42013
Fax: 905-577-8378

Research Ethics Board Membership

Jack Holland MD FRCP FRCP(C)
Chair

Suzette Salama PhD
Vice-Chair/Ethics Representative

Mary Bedek CCHRA (C)
Privacy Officer

Morris Blajchman MD FRCP(C)
Hematology

Julie Carruthers MLT
Research, Transfusion Medicine

Adriana Carvalho MD, MSc, PhD
Psychiatry

David Clark MD PhD FRCP(C)
Medicine

Jean Crowe MHS
Rehabilitation Science

Lynn Donohue BA(Hons)
Community Representative

Farough Farrokhyar Mphil, PhD, Fdoc
Surgery

Sylvia Fung BSP LLB
Pharmacy/Legal

Melanie Griffiths FRCR (UK)
Diagnostic Imaging

Cindy James BScN
Gastroenterology

David Jewell M S.W, MHSC
Geriatrics

Graham Jones BSc, MSc, PhD, MD, FRCP, FCCP
Peter Kavrak PhD
Laboratory Medicine

Rosanne Kent RN BA MHS(M)
Cardiology

Carolyn Kezel RN
Pediatrics

Grigoris Leontiadis MD PhD,
Gastroenterology

Steve Lloyd MD Family Medicine

Cheyl Main MD FRCP, Medical
Microbiology and Infectious Diseases

Shelly McLean MBA
Community Representative

Madhu Natarajan MD, FRCP, FACC
Cardiology

Ariana Gic Perry BA, LL.B, LL.M
Candidate Community

Kesava Reddy MB BS FRCS FACS
Neurosurgery

Susan Rivers RN MSc(T)
Geriatrics

Gita Sobhi BSc Phm
Pharmacy

Brian Timmons PhD
Pediatrics

Marie Townsend BA(Hons), MBA
Administration

Graham Turpie MD FRCP
Medicine

Andrew Worsler MD
Emergency Medicine

Jim Wright BSc MD
Radiation Oncology

Ed Younglai PhD
Obstetrics/Gynecology

The HHS/HSB REB operates in compliance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans; the Health Canada / RCI Good Clinical Practice Consolidated Guidelines (GCP); and the applicable laws and regulations of Ontario. The membership of this REB also complies with the membership requirements for REBs as defined in Canada's Food and Drug Regulations (Division 5: Drugs for Clinical Trials Involving Humans Subjects).

June 16, 2009

PROJECT NUMBER: 09-168

PROJECT TITLE: How community services work together to Address the primary health care needs of Recent immigrant children.

PRINCIPAL INVESTIGATOR: Dr. Ruta Valaitis

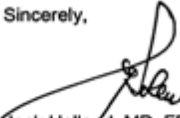
This will acknowledge receipt of your letter dated April 27, 2009 and your recent e-mail which enclosed copies of the revised documents which incorporated some additional revisions made by IWK for the above-named study. Many of these issues were raised by the Research Ethics Board at their meeting held on April 21, 2009. Based on this additional information, we wish to advise your study has been given *final* approval from the full REB. The study protocol, version 1.0 dated March 30, 2009, including the Participant Information Sheet (A): Interview version 4.1 dated June 15, 2009 and (B), version 4.0 dated June 6, 2009 April 27, 2009, along with the Letter to Head of Organization, version 2.0 dated April 27, 2009, the Interview Guide, SNA Survey Introductory Letter and SNA Survey Questionnaire, all version 1.0 dated March 30, 2009 was found to be acceptable on both ethical and scientific grounds. **Please note** attached you will find the Information Sheet/Consent Form with the REB approval affixed; all consent forms used in this study must be copies of the attached materials.

We are pleased to issue final approval for the above-named study for a period of 12 months from the date of the REB meeting on April 21, 2009. Continuation beyond that date will require further review and renewal of REB approval. Any changes or amendments to the protocol or information sheet must be approved by the Research Ethics Board.


The Hamilton Health Sciences/McMaster Health Sciences Research Ethics Board operates in compliance with and is constituted in accordance with the requirements of: The Tri-Council Policy Statement on Ethical Conduct of Research Involving Humans; The International Conference on Harmonization of Good Clinical Practices; Part C Division 5 of the Food and Drug Regulations of Health Canada; and the provisions of the Ontario Personal Health Information Protection Act 2004 and its applicable Regulations.


PLEASE QUOTE THE ABOVE-REFERENCE PROJECT NUMBER ON ALL FUTURE CORRESPONDENCE

Sincerely,


Jack Holland, MD, FRCP, FRCP (C)
Chair, Research Ethics Board

Appendix I: Interview Information Sheet A





Faculty of Health Sciences
School of Nursing

1200 Main Street West
Hamilton, Ontario, Canada
L8N 3Z5

Phone 905.525.9140
Fax 905.524.5220
<http://www.fhs.mcmaster.ca/nursing>

PARTICIPANT INFORMATION SHEET (A): Interview

Title of Study: How community based services work together to address the primary health care needs of recent immigrant children

Principal Investigator: Sandy Isaacs, MSc. RN. PhD Student, School of Nursing, McMaster University
Thesis Supervisor: Dr. Ruta Valaitis, PhD, RN, School of Nursing, McMaster University.

Sponsor: The Dorothy C. Hall Chair in Primary Health Care Nursing, McMaster University & the Public Health Agency of Canada

You are being invited to participate in a research study conducted by the School of Nursing, McMaster University because of your professional experience and knowledge of community based services in Halifax. You were selected with help from others in Halifax who are also familiar with services in your area. Your name was provided by your director. This is a PhD research project conducted under the supervision of Dr. Ruta Valaitis with McMaster University.

Participation will involve an open discussion with Sandy Isaacs by telephone or in person. In order to decide whether or not you want to be a part of this research study, you should understand what is involved and the potential risks and benefits. This form gives detailed information about the research study. Once you understand the study, you will be asked to sign this form if you wish to participate. Please take your time to make your decision. Feel free to discuss this with others.

The PhD student and lead investigator for this study, Sandy Isaacs, is also employed by the Public Health Agency of Canada. Compensation to cover the other costs of the study is being received from the Dorothy C. Hall Chair in Primary Health Care Nursing, School of Nursing, McMaster University.


WHY IS THIS RESEARCH BEING DONE?

Immigrants often need help in settling into a new location. This includes connecting them to the health and social services they need. Many recent immigrants from different parts of the world may face barriers when seeking help for their health concerns. There is still a lot we don't know about how community based services work together to help recent immigrants with their primary health care needs. The principal investigator, as part of her PhD studies, hopes to address this knowledge gap by gathering information that could be useful to community based services in the Halifax area and elsewhere.

CDHA-RS/2010-009

1 of 4

Participant Initials: _____

 School of Nursing

Version 4.1 date: 15 June 2009

WHAT IS THE PURPOSE OF THIS STUDY?

This study is intended to help improve our understanding of how communities can best meet the primary health care needs of recent immigrants. Our focus is on community based services for young immigrant children between 0 and 6 years of age living in the communities of Fairview and Clayton Park.

WHAT WILL MY RESPONSIBILITIES BE IF I TAKE PART IN THE STUDY?

If you volunteer to participate in this study, we will ask you to do the following things:

We hope to interview you by phone or in person sometime in the next two weeks. The interview will take approximately one hour of your time. The time of the interview will be scheduled to suit your needs. If in person, the interview will occur in a location of your choice.

The interview is intended to be an open discussion. The interview questions will be based on the attached interview guide. The discussion will be audio-taped to make sure all of your ideas are captured correctly. If you would like, you will be provided with a written transcript of the conversation. You can then make corrections or ask for deletions if you feel this is needed. All of the discussion will be kept strictly confidential and the recordings kept under the control of the researcher.

All personal information about you will be removed from the results of this study; your contact information will be maintained in a separate, locked environment. You will be asked about community based services within Halifax and how these work together to address the primary health care needs of young children of recent immigrants. You will not be asked for any identifying information concerning clients or patients.

This is intended to be a one-time interview. You will be asked at the end of the interview for permission to be contacted at a later time if new questions come up in the course of the study.

At the end of the interview, you may be asked to help identify other organizations for this study. You might also be asked to review a survey questionnaire to help improve this form.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

Even though your name and that of your organization will not appear in any reports, it may still be possible for local reviewers to recognize organizations offering specialized services. Your supervisor may still be able to recognize your responses since he/she would have agreed to your participation, and there are very few participants per organization. You can decide not to participate in all or part of the interview if you feel sharing your opinions could create problems for you at work, or for your organization. You will also have an opportunity to review the transcripts of your interview and request deletions if you so wish.

Your director or program head may be consulted on how your organization is represented based on a summary of the information collected from you and your co-workers. With this in mind, he/she will be asked for permission to proceed before this summary is released in any reports.

CDHA-RS/2010-009

2 of 4

Participant Initials: _____

Version 4.1 date: 15 June 2009

HOW MANY PEOPLE WILL BE IN THIS STUDY?

10 to 12 people working within community service organizations in Halifax will be interviewed individually. As a separate part of this research, approximate 30 organizations will be asked to participate in an on-line survey.

WHAT ARE THE POSSIBLE BENEFITS FOR ME AND/OR FOR SOCIETY?

There is no anticipated direct benefit to you from your participation in this study. Your participation may help to inform local services on how the primary health care needs of children of recent immigrants are being addressed within Halifax. New knowledge from this research could help to improve primary health care services for recent immigrants within Canada.

IF I DO NOT WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?

It is important for you to know that you can choose not to take part in the study. You can withdraw at any time. Choosing not to participate in this study will in no way affect your standing as an employee.

WHAT INFORMATION WILL BE KEPT PRIVATE?

Your data will not be shared with anyone except with your consent or as required by law. All personal information such as your name, address, phone number, and employer name, will be removed from the data and will be replaced with a number. A list linking the number with your name will be kept in a secure place, separate from your file. The data (e.g. audio-tapes, notes and paper transcripts), with identifying information removed, will be securely stored in a locked research office at the researcher's place of employment. Electronic copies of the data will be stored on a secure server. The raw data for this research study will be retained for 10 years.

For the purposes of ensuring the proper monitoring of the research study, it is possible that a member of the Faculty of Health Sciences McMaster University Research Ethics Board may consult your research data. However, no records which identify you by name or initials will be allowed to leave the secured office in which data are stored. By signing this consent form, you authorize such access.

If the results of the study are published, your name will not be used and no information that discloses your identity will be released or published without your specific consent to the disclosure.

CAN PARTICIPATION IN THE STUDY END EARLY?

If you volunteer to be in this study, you may withdraw at any time. For example, you can withdraw during the interview itself, even after giving your consent. You have the option of removing your data from the study. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

Appendix J: SNA Survey Information Sheet B



Faculty of Health Sciences
School of Nursing

1200 Main Street West
Hamilton, Ontario, Canada
L8N 3Z5

Phone 905.525.9140
Fax 905.524.5226
<http://www.fhs.mcmaster.ca/nursing>



PARTICIPANT INFORMATION SHEET (B): On-line Survey

Title of Study: How community based services work together to address the primary health care needs of recent immigrant children.

Principal Investigator: Sandy Isaacs, MSc. RN. PhD Student, School of Nursing, McMaster University

Thesis Supervisor: Dr. Ruta Valaitis, PhD, RN, School of Nursing, McMaster University.

Sponsor: The Dorothy C. Hall Chair in Primary Health Care Nursing, McMaster University & the Public Health Agency of Canada

You are being invited to participate in a research study conducted by the School of Nursing, McMaster University because of your professional experience and knowledge of community based services in Halifax. You were selected with help from others in Halifax who are also familiar with services in your area. Your name was provided by your director. This is a PhD research project conducted under the supervision of Dr. Ruta Valaitis with McMaster University.

Your participation will involve completing a short on-line survey. In order to decide whether or not you want to be a part of this research study, you should understand what is involved and the potential risks and benefits. This form gives detailed information about the research study. Once you understand the study, you will be asked to sign this form if you wish to participate. Please take your time to make your decision. Feel free to discuss this with others.

The PhD student and lead investigator for this study, Sandy Isaacs, is also employed by the Public Health Agency of Canada. Compensation to cover the other costs of the study is being received from the Dorothy C. Hall Chair in Primary Health Care Nursing, School of Nursing, McMaster University.

WHY IS THIS RESEARCH BEING DONE?

Immigrants often need help in settling into a new location. This includes connecting them to the health and social services they need. Many recent immigrants from different parts of the world may face barriers when seeking help for their health concerns. There is still a lot we don't know about how community based services work together to help recent immigrants with their primary health care needs. The principal investigator, as part of her PhD studies, hopes to address this knowledge gap by gathering information that could be useful to community based services in the Halifax area and elsewhere.

CDHA-RS/2010-009

1 of 4

Participant Initials: _____

Version 4.0 date: 06 June 2009



WHAT IS THE PURPOSE OF THIS STUDY?

This study is intended to help improve our understanding of how communities can best meet the primary health care needs of recent immigrants. Our focus is on community based services for young immigrant children between 0 and 6 years of age living in the communities of Fairview and Clayton Park.

WHAT WILL MY RESPONSIBILITIES BE IF I TAKE PART IN THE STUDY?

If you volunteer to participate in this study, we will ask you to do the following things:

We are requesting your participation in an on-line survey. The survey will take approximately 20 minutes of your time. The survey will ask you questions about your organization's work relationships with other organizations and services in the Halifax region. We are interested in the relationships that help services to address the primary health care needs of young immigrant children. All questions are very short, and most ask you to check off your response. In order to participate, we will need your e-mail address. You will then receive information by e-mail about how to connect to the survey website and how to complete the form. A reminder e-mail may follow within two weeks if the on-line survey has not been completed. Some of you may require assistance in completing the form. If you require such assistance you may contact the researcher directly to complete the survey by phone rather than doing so on-line. You will be encouraged to contact the researcher at anytime for assistance, or to answer any of your questions concerning the survey.

All personal information about you will be removed from the results of this study; your contact information will be maintained in a separate, locked environment. You will not be asked for any identifying information concerning clients or patients.

This is intended to be a one-time survey. You will be asked at the end of the survey for permission to be contacted at a later time if new questions come up in the course of the study.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

Even though your name and that of your organization will not appear in any reports, it may still be possible for local reviewers to recognize organizations offering specialized services. Your supervisor may still be able to recognize your responses since he/she would have agreed to your participation, and there are very few participants per organization. You can decide not to participate in all or part of the survey if you feel your answers could create problems for you at work, or for your organization.

Your director or program head may be consulted on how your organization is represented based on a summary of the information collected from you and your co-workers. With this in mind, he/she will be asked for permission to proceed before this summary is released in any reports.

HOW MANY PEOPLE WILL BE IN THIS STUDY?

Approximately 30 organizations are being asked to participate in this on-line survey. As a separate part of this research, 10 to 12 people working within community service organizations in Halifax will be interviewed individually.

CDHA-RS/2010-009

2 of 4

Participant Initials: _____

Version 4.1 date: 15 June 2009

WHAT ARE THE POSSIBLE BENEFITS FOR ME AND/OR FOR SOCIETY?

There is no anticipated direct benefit to you from your participation in this study. Your participation may help to inform local services on how the primary health care needs of children of recent immigrants are being addressed within Halifax. New knowledge from this research could help to improve primary health care services for recent immigrants within Canada.

IF I DO NOT WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?

It is important for you to know that you can choose not to take part in the study. You can withdraw at any time. Choosing not to participate in this study will in no way affect your standing as an employee.

WHAT INFORMATION WILL BE KEPT PRIVATE?

Your data will not be shared with anyone except with your consent or as required by law. All personal information such as your name, address, phone number, and employer name, will be removed from the data and will be replaced with a number. A list linking the number with your name will be kept in a secure place, separate from your file. The data with identifying information removed will be securely stored in a locked research office at the researcher's place of employment. Electronic copies of the data will be stored on a secure server. The raw data for this research study will be retained for 10 years. Information collected on the website may be monitored by a U.S. agency.

For the purposes of ensuring the proper monitoring of the research study, it is possible that a member of the Faculty of Health Sciences McMaster University Research Ethics Board may consult your research data. However, no records which identify you by name or initials will be allowed to leave the secured office in which data are stored. By signing this consent form, you authorize such access.

If the results of the study are published, your name will not be used and no information that discloses your identity will be released or published without your specific consent to the disclosure.

CAN PARTICIPATION IN THE STUDY END EARLY?

If you volunteer to be in this study, you may withdraw at any time. For example, you do not have to complete the survey form, even after giving your consent. You have the option of removing your data from the study. You can decide not to answer some of questions and still remain in the study.

WILL I BE PAID TO PARTICIPATE IN THIS STUDY?

There is no reimbursement from the researcher for your time spent participating in this study. All participants are being offered copies of a summary report of the research findings following completion of the study.

WILL THERE BE ANY COSTS?

Your participation in this research project will not involve any additional costs to you.

IF I HAVE ANY QUESTIONS OR PROBLEMS, WHOM CAN I CALL?

If you have any questions about the research now or later, please contact Sandy Isaacs by e-mail at isaacssm@mcmaster.ca, or by phone at 519-826-2212.

If you have any questions regarding your rights as a research participant, you may contact the Office of the Chair of the Hamilton Health Sciences/Faculty of Health Sciences Research Ethics Board at 905-521-2100, ext. 42013. The office can also be reached by e-mail: klimeko@mcmaster.ca.

CONSENT

I have read the information presented in this information sheet about a study being conducted by Ms. Sandy Isaacs and Dr. Ruta Valaitis of McMaster University. I have the opportunity to ask questions about my involvement in this study, and to receive any additional details I want to know about the study. I understand that I may withdraw from the study at any time, if I choose to do so. Research results will be sent to me at the end of the study.

I agree to participate in the on-line survey. I have been given a copy of this form.
Yes No Yes No

Name of Participant

E-mail Address / Wk. Phone Number

Mailing Address

Date: ____/____/____
yyyy/mm/dd

Signature



**Please fax this final page with signature to:
Sandy Isaacs 519-826-2244
OR E-mail your response to: isaacssm@mcmaster.ca**

Thank you!

CDHA-RS/2010-009

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Participant Initials: _____

Version 4.1 date: 15 June 2009

Appendix K: Letter to Head of Organization

S. Isaacs_PHC and Immigrant Children

version:2.0 date: 27 April 2009

Letter to Head of Organization

Your organization is being invited to participate in a research study conducted by the School of Nursing, McMaster University. The primary investigator, Sandy Isaacs, is a PhD student under the supervision of Dr. Ruta Valaitis. We are hoping you will be able to help us by permitting some of your staff to participate in an on-line survey. Staff participation in this study needs to be voluntary.

We are including organizations in the Halifax area that offer services to recent immigrant families or to young children living in the communities of Clayton Park and Fairview. Your organization (practice) was suggested to us by the Capital District Health Authority or the Metro Immigrant Settlement Association (MISA). The researchers are interested in learning how local community services work together to help young children of recent immigrants with their health needs. By young children we mean children from 0 to 6 years of age. Their immigrant parents would have arrived in Canada within the past 5 years. More information about the study is available in the attached information sheet.

We are hoping for all organizations receiving this letter to allow selected staff some time to complete the on-line survey. We are only surveying staff specifically identified by the head or designate of each organization. Selected staff should be knowledgeable about their organization's relationships with other agencies in addressing the health needs of recent immigrants and their children.

Once you have read the attached information sheet, and if you are willing to allow staff to participate, could you please forward to us the names and e-mail addresses of those you feel would be most able to respond on behalf of your organization. Three or more names would be welcomed. We encourage you to share the attached information with the staff you select prior to forwarding their names and e-mails to us. We will also ask each staff member to sign a consent form before collecting any information.

If you have any questions, or would like to speak to the investigator before making your decision, please feel free to contact Sandy Isaacs at 519-826-2212, or e-mail her at isaacsstm@mcmaster.ca. Please note that some organizations may also be asked to allow staff to participate in one-on-one interviews. These organizations will receive a separate request to permit interview participation.

Names and e-mails of selected staff for the survey can be listed on this page and returned to Sandy Isaacs at the same e-mail address or by faxing to: **519-826-2212**.

Nominated Staff for Online Survey Participation:

<Selected staff should be knowledgeable about their organization's relationships with other agencies in addressing the health needs of recent immigrants and their children.>



1

S. Isaacs_ PHC and Immigrant Children

version:2.0 date: 27 April 2009

Name	E-mail Address
_____	_____
_____	_____
_____	_____

Please send this page to Sandy Isaacs:
isaacsm@mcmaster.ca
Or Fax: 1-519-826-2244



Appendix L: Study Summary for Stakeholder Information

**How community services work together to address the primary health care needs of
young immigrant children**

Background:

New immigrants today arrive in Nova Scotia (N.S) from many different parts of the world. In 2006 over 65% of immigrants to N.S. were from Asia, the Middle East, Africa and the Pacific regionⁱ. Between 2002 and 2006, 65% or 5,288 immigrants to N.S. settled in Halifax. Many recent immigrants to Canada and North America often face barriers when seeking assistance for themselves and their families in order to meet their health needs. These barriers can include language and cultural differences, but also misunderstanding, mistrust or perceived personal risk when involving official agencies or other forms of authority^{ii,iii,iv}. Where people settle can also have an impact. Immigrants to large urban centers with well established immigrant populations are believed to have greater access to community supports compared to immigrants settling in other locations^v. More information is still needed to understand how recent immigrants to mid-size urban centers are best able to obtain the services they need.

Like many other parents, recent immigrants are more likely to seek professional help for their children rather than for themselves despite the barriers they may face^{vi,vii,viii}. How services work together in order to meet the needs of these children could say a lot about the way in which communities adapt to the needs of new arrivals. Recent immigrant families can, for example, have very unique needs^{ix} requiring different types of

knowledge and creative approaches from nurses, other health care providers and their partnering agencies.

About the Study:

This study is about local community services and how they work together to address the primary health care needs of young children born to recent immigrants. By young children we mean children between 0 and 6 years of age. By recent immigrants, we mean people who have moved to Canada during the past 5 years. The study is focusing on organizations that offer services to recent immigrants or to young children living in the Halifax communities of Clayton Park and Fairview. These communities were selected because of their proximity to one another, the number of immigrants living in the area, and the diversity of community residents relative to the rest of Halifax.

The study questions being asked are:

- How do community services within Halifax work with one another in order to address the primary health care needs of young children of recent immigrants living in the communities of Fairview and Clayton Park?
- How does the cultural competency (the ability to work effectively in cross-cultural situations) of the different community organizations affect access to primary health care services for young children of recent immigrants?
- How are nurses helping to sustain and/or promote a collaborative services network for immigrant children living in the communities of Fairview and Clayton Park?

This case study involves one-on-one interviews and an on-line survey. Sixty minute one-on-one interviews will be conducted with 10 to 12 health / community service providers (e.g. nurses, social workers, doctors, out-reach workers etc.) The on-line survey will be conducted with selected staff from approximately 30 organizations in the Halifax region. The heads of each organization will be asked for permission before approaching their staff to volunteer for an interview and/or a survey.

There is still a lot we don't know about how local community services work together to help recent immigrants and their children. The principal investigator, as part of her PhD studies, hopes to address this knowledge gap by gathering information that could be useful to community services in the Halifax area, and possibly elsewhere in Canada.

Confidentiality:

All information collected for this study will be stored in a secured location, and the names of participants separated from their responses. Public reports about this study will not include names of either individuals or organizations. Information will be summarized and quotes disguised to prevent others from identifying individuals. It is sometimes possible in closely connected communities, for some local reviewers to recognize organizations that provide specialized services even with their names removed. This will be discussed with the heads of these organizations to ensure they are comfortable with the information provided by their organization before any reports are released.

The Investigators:

This study is being conducted by the School of Nursing McMaster, University. The PhD student and lead investigator for this study, Sandy Isaacs, is also employed by the Public Health Agency of Canada. The research is under the supervision of Dr. Ruta Valaitis. Compensation to cover the other costs of the study is being received from the Dorothy C. Hall Chair in Primary Health Care Nursing, School of Nursing, McMaster University.

Any questions concerning this study can be addressed to:

Sandy Isaacs by calling 1-519-826-2212, or e-mailing: isaacssm@mcmaster.ca

ⁱ Nova Scotia Office of Immigration, (2007). *Nova Scotia immigration trends: Nova Scotia immigration information fact sheet, 2006*. Retrieved Nov. 18, 2008 from <http://www.novascotiaimmigration.com/en-page1119.aspx>.

ⁱⁱ Hilfinger-Messias, 2002 Hilfinger-Messias, D.K. (2002). Transnational health resources, practices, and perspectives: Brazilian immigrant women's narratives. *Journal of Immigrant Health, 4* (4), 183-200.

ⁱⁱⁱ Ma, 2000 Ma, G.X. (2000). Barriers to the use of health services by Chinese Americans. *Journal of Allied Health, 29*(2), 64-70.

^{iv} Xu, Sun, Zhang 7 Xu, 2001 Xu, Y., Sun, J., Zhang, J., & Xu, Z. (2001). Health-seeking behaviors and barriers to health care of South East Asian immigrants: Implications for the home health nurse. *Home Health Care Management & Practice, 14*(1), 22-30.

^v Pitkin Derose, K., Escarce, J. & Lurie, N. (2007). Immigrants and Health Care: Sources of Vulnerability *Health Affairs, 26* (5) 1258.

^{vi} Binns, Lanier, Pace, Galliher, Ganiats, Grey, et al., 2007 Binns, H. J., Lanier, D., Pace, W. D., Galliher, J. M., Ganiats, T. G., Grey, M., et al. (2007). Describing primary care encounters: The primary care network survey and the national ambulatory medical care survey. *Annals of Family Medicine, 5*(1), 39-47.

^{vii} Truman & Reutter, 2002 Truman, C. D., & Reutter, L. (2002). Care-giving and care-seeking behaviours of parents who take their children to an emergency department for non-urgent care. *Canadian Journal of Public Health, 93*(1), 41-46.

^{viii} Lipson, Weinstein, Gladstone & Sarnoff, 2003 Lipson, J.G., Weinstein, H.M., Gladstone, E.A., & Sarnoff, R.H. (2003). Bosnian and Soviet refugees' experiences with health care. *Western Journal of Nursing, 25*(7), 854-871.

^{ix} Hyman, 2001 Hyman, I. (2001). *Immigration and health*. Working paper 01-05. Health Canada. ISBN 0-662-31343-7. Minister of Public Works and Government Services, Canada. Retrieved August 28, 2008, from <http://www.hc-sc.gc.ca/sr-sr/pubs/hpr-rpms/wp-dt/2001-0105-immigration/index-eng.php>.