**REVISITING A COMMUNITY HEALTH CENTRE MOVEMENT**

**REVISITING A COMMUNITY HEALTH CENTRE MOVEMENT**

By

PHIL HOBBS, BSW

A Thesis

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AUTHOR: Phil Hobbs, BSW. (McMaster University)

SUPERVISOR: Dr. Stephanie Baker Collins

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**ABSTRACT**

This thesis explores the role and functionality of the Hamilton Urban Core Community Health Centre (HUCCHC) within the context of advocacy and activism to understand how this institution can contribute a pathway for social change in public health. This qualitative case study uses an interpretive lens to analyze primary health care at the HUCCHC, and how it is being used to improve the social determinants of health (SDH). The study investigated participants’ understandings of how the HUCCHC demonstrates that a community health centre can be a catalyst for social change. Moreover, this research project asked what sorts of conditions or circumstances are necessary to foster an environment conducive for community organizing for social change. This study employed field observation and interview techniques to gather data.

Findings suggest that building equitable relationships based on dignity and respect, and community engagement were the foundational aspects necessary to provide the conditions conducive for community organizing. However, the outcomes from these relations put the HUCCHC at risk of becoming marginalized. Findings further suggest that equitable relationships and community engagement also provided a foundation for social action. The HUCCHC demonstrated that it is a catalyst for social change by embracing a primary health care model that also fosters a social action approach to health care.

**ACKNOWLEDGEMENTS**

Dedicated to:

*KATHI HILL*

It is been expressed a thousand times, and without question, I would not have been able to complete this journey without you. Over the past five years every time I looked over my shoulder, I found you by my side. “*You’ve never left my side, even when I fell behind*”. Your patience, understanding, guidance, support, and encouragement have given me the strength to move forward; when I had little to give. Although we know this has been a long and arduous journey; today is a good day, and we have waited a long time for this moment. I’m waking up to a new world, and I’m so glad you’re here. “*Thank you for the life you’ve given me…thank you”*. I love you.

In memory of:

*JOHN CONNOLLY*

It is with sincere appreciation that I express your contributions to my journey. You were the first mate on my ship as I sailed away from a past life towards the shoreline of this new world. I’m here, and I wish you were too. Your legacy will always be reflected in my work; and each time I feel this to be true, I will be able to recall the times we spent together with fondness. You have impacted my life, and from this, I will be able to share this gift with others.

**My Thesis: The Last Piece of this Academic Journey**

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# CHAPTER I - INTRODUCTION

## RATIONALE

My overarching and key area of interest in social work is improving the social determinants of health (education, housing, food security, income, equality etc.). In particular, I am interested in education, and education as a means of social change. When I refer to education I refer to *formal* (universities), and *informal* (grassroots) methods of transferring, or generating knowledge, which is a powerful tool for social change. Furthermore, I have an interest in community organizing for social change. In this case, I am interested in exploring the role and functionality of community health centres (CHCs), within the context of advocacy and activism, to understand how these institutions can contribute a pathway for social change.

Keeping with the philosophy of the School of Social Work at McMaster University (McMaster University, n.d.), I understand that social work, and social workers, have a unique role to play in helping to create strong communities. Under a universal health care system that Canadians should be proud of, the voices of the disadvantaged and marginalized, and other groups that have accessibility issues for health care, need to be heard, responded to, and respected. Social work has a role to play towards improving our health. Creating opportunities, and providing safe places for community organizing, is empowering, and is healthy for communities. Social workers have abilities that can be utilized to promote good health, they understand and respect diversity, and are able to critically think, and challenge authority(s) regarding policy decision making. Social workers can move beyond program design and delivery into policy development. Social work can move towards improving the social determinants of health (SDH) by understanding them as the ‘structural’ determinants of health. Social workers can educate citizens on the structural and systemic issues that prevent people from achieving optimum health. In summary, social work can make connections between policy and public health.

The ‘medical model’ is clearly not designed to meet the needs of health promotion through advocacy and activism, and fails to address the SDH. Community organizing for social change is not part of the medical model’s mandate for health care. This model has strengths in other areas, such as treating illness and injury. However, these are mostly based on ‘downstream’ thinking – treatment after illness has occurred. It is evidently clear, humane, and cost effective to *prevent* illness, rather than treat it – or at worst, not to cause it.

## UPSTREAM THINKING

 Upstream thinking is an alternative way of thinking that matches my philosophy of health care. ‘*Upstream’* is a non-profit organization, and an ideology. It is a social movement created by Dr. Ryan Meili ([www.thinkupstream.net](http://www.thinkupstream.net)). Excerpts about this movement are as follows:

* *Upstream is a movement to create a healthy society through evidence-based, people-centred ideas. Upstream seeks to reframe public discourse around addressing the social determinants of health in order to build a healthier society.*
* *Upstream thinking means investing wisely for future success rather than spending all of our time and resources responding to and perpetuating failure.*
* *Upstream works with a growing body of evidence on these social determinants of health and uses that knowledge to guide recommendations for change.*
* *By sharing stories through a variety of media, Upstream seeks to creatively engage citizens, sparking within them a personal stake in the social determinants of health and a demand for upstream alternatives to the status quo.*
* *Upstream uses this evidence and storytelling to foster a vibrant network of organizations and individuals who share this vision.*
* *By demonstrating that a better way is possible, we can help create the conditions for wiser decisions and a healthier Canada.*

(Meili, n.d.)

This philosophy is the framework, reason, and motivation behind creating and writing this thesis.

## COMMUNITY HEALTH CENTRES

Community Health Centres are places where prevention, the social determinants of health (SDH), and advocacy come together to improve the health and wellbeing of a community.

**History**

 Premier Tommy Douglas of Saskatchewan has been credited with pioneering Medicare in Canada (Rachlis, 2005). In Tommy Douglas’s original version of Medicare, he conceived of it as having two stages: first, medical care to treat illness; and second, a system based on prevention (Dutt & Raza, 2007; Rachlis, 2005). The second stage embodies one of the fundamental principles behind a Community Health Centre (CHC), and is its historical starting point. At the time Tommy Douglas described his version of medicare, he asserted that if medicare did not address the second stage, “costs would rise and medicare would lose political support” (Rachlis, 2005, p. A13). The building of the network of CHCs has been in response to the need to prevent illness, and to curb the rising costs of health care.

The Canadian Association of Community Health Centres (CACHC) state the first CHC was established in Winnipeg Manitoba in 1926. The CACHC adds that throughout history the development of CHCs have taken on many forms across the provinces and territories in Canada (CACHC, n.d.). They are designated as CLSC’s (Quebec), Co-Operative Health Centres (Saskatchewan), and Ontario’s mixed network of AHAC’s (Aboriginal Health Access Centres), CFHT’s (Community Family Health Team), NPLC’s (Nurse Practitioner Led Clinics), and CHCs. Since then this network has grown to over 700 sites nationwide, supporting nearly 3 million Canadians.

In 1962 the first CHC in Ontario opened in Sault Ste. Marie. Further expansion and growth occurred in the mid-1970’s (AOHC, 2010). During this period, Dr. John E. F. Hastings provided his report on the Community Health Centre Project (herein referred to as the Hastings report).

The Hastings Report was seminal in the development of CHCs in Canada.

In this report, Dr. Hastings tabled three principle recommendations:

1. *The development by the provinces, in mutual agreement with public and professional groups, of a significant number of community health centres, as described in this Report, as non-profit corporate bodies in a fully integrated health services system.*
2. *The immediate and purposeful re-organization and integration of all health services into a health services system to ensure basic health service standards for all Canadians and to assure a more economic and effective use of all health care resources.*
3. *The immediate initiation by provincial governments of dialogue with the health professions and new and existing health services bodies to plan, budget, implement, coordinate and evaluate this system; the facilitation and support of these activities by federal government through consultation services, funding, and country-wide evaluation.*

(Hastings, 1972, p. 362)

Dr. Hastings also provided eleven other committee recommendations. Although all of these recommendations were never fully realized, the Hastings Report did set the standard in the development of CHCs. Moreover, Dr. Hastings identified what a CHC is, why they were needed, the implications, and outlined a new model of a health services system (Hastings, 1972).

The Association of Ontario Health Centres (AOHC) state that, in the beginning, the Ministry of Health considered CHCs as experimental pilot projects (AOHC, 2010). Then, in 1977, the provincial government decided to freeze funding to CHCs. The following year Dr. Michael Rachlis of the South Riverdale CHC invited Dr. Hastings to address the founding Convention of Community Health Centres of Ontario (AOHC, 2010), generating interest and pressure on the provincial government. It was not until 1982 that the Minister of Health, Larry Grossman, announced that CHCs were no longer experimental projects:

*Community health centres will also no longer be considered an experiment. We will no longer view them as human service organizations (H.S.O.’s) that have not fully matured. The C.H.C. is a distinct, different and important element in the health services system and it will receive stable and ongoing funding in the same manner as the other established elements within the system* (Grossman, 1982).

One month after this speech, the AOHC was officially incorporated. Following the announcement by Larry Grossman, CHCs began to flourish; moving from twelve CHCs in 1985 to thirty-one by 1990 (AOHC, 2010). In 1994, the provincial government froze funding again; citing that CHCs needed to collect and submit data that demonstrates their purpose and effectiveness as a provincial program. From this an Evaluation Framework for the CHC program was developed (AOHC, 2010), and in 1999 the funding freeze was lifted.

 The turn of the century lead to another growth surge for CHCs. In 2004, the AOHC adopted recommendations from the AOHC ‘Renewal Action Plan’ to become a more focused policy and advocacy organization (AOHC, 2010). The following year the Minister of Health announced a 60% CHC expansion over three years that included twenty-one new CHCs and eighteen new satellite CHCs. In 2009 the AOHC adopted a CHC Model of Care, which focuses on five service areas: primary care, illness prevention, health promotion, community capacity building, and service integration. The primary focus of this thesis - in relation to the CHC Model of Care - is community capacity building through advocacy and activism; to understand how a CHC can provide a pathway for social change.

 Recently, CHCs have embraced social media to augment community engagement (CACHC, n.d.). “Health 2.0 for CHCs” is designed to provide a venue for knowledge exchange and networking with tools like blogs, Twitter, and Facebook. The CACHC claims that these tools are used to enable health and community service organizations to better connect with the individuals and communities they serve. It is also claimed that they help to bridge the gap between community partners, volunteers, decision-makers, news-media and others. Furthermore, they better equip health providers, researchers and the full range of staff at CHCs to access and share pertinent information and evidence to improve the overall functioning of CHCs (CACHC, n.d.).

**What is a CHC?**

CHCs are located throughout the world, including across Canada, with each country defining a CHC in their own way. The Hastings Report defines a CHC as “an organization and service concept, [and] a financial and administrative integration of resources” (Hastings, 1972, pp. 362-363).Furthermore, “it promotes personal and community responsibility” (Hastings, 1972, pp. 362-363)*.* The report also states that the services are to help individuals, families, and communities deal with the “many-sided problems of living” (Hastings, 1972, p. 362). The report also acknowledges that high quality health care is not enough. At a CHC, care must be taken to ensure that there is an environment that people understand and accept; that it is completely accessible by community members; and that it assures services for particular groups such as the poor, marginalized, young and old, and people from a range of cultural backgrounds.

What a CHC *does*, or is intended to *do*, is part of the framework from which this thesis is built. Based on the previous discussion, a CHC is built on what Tommy Douglas called the ‘second stage’ of medicare (CACHC, n.d.; Dutt & Raza, 2007; Rachlis, 2005) – a system based on prevention. Although the idea of prevention is not explicitly expressed in the Hastings Report, there are underpinning notions of this concept when discussing citizen involvement; community needs; social, political, and organizational issues; education and knowledge transfer; the importance of Boards; and effective public participation (Hastings, 1972). I feel that a health care model that moves towards prevention - therefore addressing the social determinants of health (SDH) – can be a birthplace, and provide the necessary environment, to foster community organizing for social change.

**Why do we need CHCs?**

From the beginning, evidence suggests that the primary impetus behind the formation CHCs have been financial concerns: to reduce health care cost (Hastings, 1972; Rachlis, 2005). However, the principles behind primary health care have also been a pillar in the development of CHCs. Primary health care is based on equality in a universal health care system that moves beyond the medical model of health care to include other areas of concern such as access to social services, environmental issues, broader social and economic issues, and lifestyle choices (Dutt & Raza, 2007) – all which are elements of the SDH. Therefore, CHCs are needed to reduce health care costs by helping to prevent illness, and additionally, to adhere to a true universal health care system that is accessible to all Canadians alike. CHCs are also important centres for communities to organize for social change by providing a venue for community groups to organize and challenge the root causes of illness.

## THE HAMILTON URBAN CORE COMMUNITY HEALTH CENTRE

The Hamilton Urban Core Community Health Centre (HUCCHC) was founded in 1996, and is located in the inner core of Hamilton Ontario. The HUCCHC is a non-profit organization serving individuals and communities to shape a better and healthier city. The HUCCHC is community governed, and provides multidisciplinary interprofessional health care framed by the social determinants of health (SDH).

**History**

In a meeting with Denise Brooks (Brooks, 2015) designed to gather information about the HUCCHC, she described the history of the HUCCHC as follows. The HUCCHC was born as a result of community action. Various representatives from organizations and concerned citizens lobbied for approximately 10 years prior to the birth of the HUCCHC. An application was filed on behalf of this community that identified the various needs and why, and how this CHC should come to existence. Once approval was granted, the HUCCHC was born. At this point in time Wesley Urban Ministries was the lead contact, and manager of the first funds that were granted. The HUCCHC was built as a people-centred health care facility. The roots of the HUCCHC set the tone of the organization it has become.

The HUCCHC occupies the old Hamilton bus terminal. At the time this location was selected, it was ideal. It was an abandoned building that was not a historical site, and it was located in the inner core of the city close to many necessary resources.

From 1996 to 1998 the HUCCHC was run by an executive director that began selecting out for a ‘better’ population (more well). This was met by an adverse reaction from the community partners that had lobbied for this CHC – it was seen as not serving the intended community. In 1998, Denise Brooks became the new executive director.

In 1998 there were only 215 clients. During this time there was an influx of Roma refugees in Toronto – mostly from the Czech Republic and Hungary – and Toronto needed help to accommodate them. When Denise took over the HUCCHC she described the doors as being ‘closed’. Responding to Toronto’s need for help, the HUCCHC ‘opened’ its doors to the Roma refugees. Over the next few months this lead to substantial growth at the HUCCHC, which was now reporting over 1000 clients. This response set the tone for the operation of the HUCCHC.

Under this philosophy and framework, the HUCCHC used community engagement to solve problems. In the early days the HUCCHC had lots of break-ins. Denise considered ways to address this problem by inviting some of the folks that frequented the HUCCHC in for pizza. She discussed how the HUCCHC was there for the people – for them – and that stealing hurt everyone and that she needed their help. The local group provided some advice on how to prevent theft; from this consultation, the climate changed from stealing to helping. Engaging the community proved to be an effective way to solve problems. This approach has also been successful in working with the community on many other issues. When the people of the community feel respected, they have responded by engaging with health care. Currently the HUCCHC serves over 7000 clients – and they have increased their services without increasing their physical space.

**Mission, Vision, Values, and Beliefs** (HUCCHC, n.d.)

The HUCCHC’s Mission Statement reads as follows:

*The Hamilton Urban Core Community Health Centre is committed to providing our community with the highest level of primary health care, education and advocacy, especially with those individuals in our community who face barriers to improving their health and well-being.*

Excerpts from their Vision Statement include:

* *We believe that peace, shelter, food, income, a stable eco-system, sustainable resources, social justice and equity are fundamental conditions to the health and well-being of individuals and communities.*
* *We recognize that a healthy community can only be achieved through collective action.*
* [The HUCCHC] *is a centre where people have equitable access to health and well-being, as it is free of systemic barriers.*
* [The HUCCHC] *a healthy community in which there is collective responsibility to take care of one another and the environment.*
* *[It is] an agent of change which influences and challenges social, economic and political structures and policies to achieve access, equity and equality in primary health care.*

Excerpts of their Values and Beliefs include:

* *All people have a right to be treated with dignity and respect.*
* *Primary health care and services must be accessible, available and appropriate, and be directed towards addressing the specific issues of people who experience barriers to access.*
* *All forms of oppression including racism, sexism, ableism, heterosexism, ageism, classism and economic oppression impact on the health and well-being of individuals and communities.*
* *People essentially have an understanding of their own health and health needs, and have the right to informed choice.*
* *Focusing on the most disadvantaged will benefit everyone in the community and society.*

The HUCCHC focus includes terms such as: respect, dignity, education, advocacy, peace, accessibility, community, and equality. They include phrases such as: primary health care, collective action, agent of change, challenging structures, systemic barriers, commitments to social justice, and addressing the SDH. All of these terms and phrases embody the ways of treating people, goals for services, improving health and wellbeing, removing barriers, and ways to address the systemic conditions that impact the SDH. Through diligent research I will discover what features the HUCCHC fosters that provides an environment conducive for community organizing for social change.

## PURPOSE

The purpose of this research is to explore the role and function of a community health centre (CHC), within the context of social action, to understand how this institution is being used as a pathway for social change. Moreover, I want to explore how a CHC addresses the social determinants of health (SDH). The particular CHC I chose is the Hamilton Urban Core Community Health Centre (HUCCHC). I want to develop an understanding of what conditions or circumstances are necessary at the HUCCHC for people to collectively organize for social change. Moreover, I want to explore what participants have found within the HUCCHC that has been meaningful or supportive to organize for social change.

Upon the completion of this thesis, I hope to acquire knowledge that can be shared, and used, by the HUCCHC, and community members, to ultimately contribute to improving the SDH. I want to provide an interpretive analysis that represents a reflective look, at this moment in time, on how the HUCCHC demonstrates it is acting as a catalyst for social change.

## ABOUT THE THESIS

**Assumptions**

In writing this thesis I have made a few assumptions; they are as follows. First, I am assuming that the development of CHCs represent a social movement that was/is geared toward a health care model based on prevention. Moreover, CHCs are active bodies that seek to improve the SDH by providing an alternative framework to the medical model, which is insufficient to tackle the complex issues of the determinants of health. Second, I am assuming that social action/activism takes place at the HUCCHC. Community organizing for social action takes place in many spheres; and when it comes to the SDH, it is assumed that the HUCCHC would be a logical place to organize in the urban Hamilton area.

This chapter has first discussed: my rationale; community health centres, the HUCCHC, and the purpose of this thesis. This discussion laid the framework behind why CHCs exist, what their intended mission/values are, how they go about accomplishing this mission, and why I am interested. In terms of the outline of my thesis, Chapter I represents the pieces of my “intellectual puzzle” (Mason, Finding a focus and knowing where you stand, 2002). These pieces shape my ontological and epistemological perspectives that have been encapsulated in my research, and in my writing. Chapter II is my literature review, and it serves two purposes. First, I provide a critical analysis on the ‘contextual pieces’ of my thesis (the social determinants of health and social movements). Second, I provide ‘theoretical reviews’ of social capital theory and community organizing theory. Chapter III discusses my methodology. In this section I will provide the methodological details of my exploratory, qualitative research case study, and will outline the interpretive approach I will use. Furthermore, I will discuss how I will gather data, and how I will analysis it. In Chapter IV I will present my Findings. These Findings are broken into two parts. First, I will discuss the participants understanding of the foundational aspects the HUCCHC uses to build rapport, and the concerns about standing with the marginalized. Second, I discuss how the participants described their social action approach to health care. Chapter V is dedicated to provide a discussion on my *Findings* with the intention of answering my research questions. Finally, Chapter VI is the conclusion; which reflects an overview of my thesis, discusses the limitations of my study, and provides some implications for social work. The final sections list my references, and appendices.

**Research Question**

The research question I will be exploring is: How does the HUCCHC demonstrate that a community health centre can be a catalyst for social change? Moreover, what sorts of conditions and/or circumstances are necessary to foster an environment for the HUCCHC to act as a center for community organizing for social change?

# CHAPTER II - LITERATURE REVIEW

This literature review will be broken into two sections: *contextual pieces* and a *theoretical review*. The *contextual pieces* section is comprised of the social determinants of health (SDH) and social movements. This section of the literature review sets the context from which I will answer my research question(s). My primary interest is social change, and this anchors my research question(s). Within the context of this thesis a conceptual view of the SDH and social movements is warranted to understand: how the social change desired is improving the SDH; and how the HUCCHC is part of a social movement.

The *theoretical review* section is comprised of a discussion of social capital theory and community organizing theory. With respect to my research question I will examine what characteristics are necessary to foster community organizing for social change. In order to do this, I need to explore the values, attributes, or qualities - from this point forward referred to as the ‘*features’* - that others say foster an environment conducive for a social movement to form or emerge. Therefore, I performed some preliminary research for literature on any theoretical constructs associated with social change, activism, and advocacy, as they relate to the SDH. From this, two broad theories emerged: social capital theory and community organizing theory. My reviews are not considered exhaustive; they are intended to provide a critical analysis of these theories to find the *features* others say are necessary for communities to organize for social change. These terms or phrases will provide a reference point when analyzing data.

## THE SOCIAL DETERMINANTS OF HEALTH

The World Health Organization (WHO) defines ‘health’ as, “a state of complete physical, mental and social well-being” (Irwin & Scali, 2007, pp. 235-236). The social determinants of health (SDH) are the social factors – or living conditions - that shape the health of a population (Mikkonen & Raphael, 2010); and the approach assumes, “that where we live, grow, work, and play determine not only life opportunities, but also determine risk of illness and individual actions taken to prevent or treat illness” (Amaro, 2014, p. 6). Shaped by the distribution of resources and power (Amaro, 2014), the social determinants of health are: peace, education, shelter, food, income, a stable eco-system, sustainable resources, social justice, and equity (World Health Organization, 1986).

Since 1948 it has been the WHO that has been the catalyst for global improvements to the SDH. Irwin & Scali (2007) reported that during the 1950’s the world realized major drug research improvements that produced an array of new antibiotics, vaccines, and other medicines. Unfortunately, because of Cold War Politics, many countries (lead by the USA) – and including the WHO - favoured these new health technologies, and were reluctant to emphasize a social model of health (Irwin & Scali, 2007). New health technologies favoured the privileged – the people who could gain access to them - while leaving the most serious health challenges experienced by the poor unaddressed. During the 1960’s and early 1970’s it was clear that the dominant health care models (i.e. medical models) were not meeting the needs of most populations. In response, a number of countries joined forces to pioneer what became known as community-based health programmes (Irwin & Scali, 2007) – the birth of CHCs. “In Central America, South Africa, and the Philippines, loose alliances of community-based health programmes gradually grew into social movements linking health, social justice, and human rights agendas” (Irwin & Scali, 2007, p. 238).

**Primary Health Care**

Following this resurgence, in 1978 the WHO laid-down another milestone in modern public health at the Alma-Ata conference in Kazakhstan as they introduced the Primary Health Care (PHC) model as a means for social change. The PHC model was seen as a fundamental *level of care* within a health system, and also as a *philosophy* of health work as part of the overall social and economic development of the community (Irwin & Scali, 2007) – the SDH. PHC moves beyond the traditional medical model of health care to focus on equality and policy, in areas such as accessibility, life-choices, and the environment in which people live (Canada, 2012; Irwin & Scali, 2007). Furthermore, it has emphasis on prevention and health promotion (Canada, 2012). Since the Alma-Ata conference, the PHC model had limited success, and faced its biggest challenge in the 1980’s with the rise and dominance of neoliberalism.

Under neoliberalism, the primary goal of policy is to reduce the states involvement in key areas – including health care, assuming that free-markets promote the common good. Furthermore, under a neoliberal ideology, individual blame is justified by the state by no longer being responsible for what is considered to be ‘lifestyle choices’. Since the late 1980’s and into the 1990’s (the birth of neoliberalism), the WHO witnessed a waning of its authority (Irwin & Scali, 2007).

At the turn of the century the SDH gained some new momentum in countries such as Sweden, Australia, Canada, New Zealand, and Western Europe. Notably, Sweden provided the most comprehensive model of national policy action on the SDH. Under Sweden’s policy, objectives are formulated in terms of the determinants of health, such as people’s degree of social and political participation, economic security, and opportunities for decent work (Irwin & Scali, 2007). “The goal of the strategy is the creation of societal conditions that ensure good health, on equal terms, for the entire population” (Irwin & Scali, 2007, p. 250). Sweden’s approach seems to be a model which CHCs can use to effectively make change to the SDH. Sweden demonstrates that “effective national policymaking on the SDH is possible when certain enabling *conditions* (emphasis added) are fulfilled” (Irwin & Scali, 2007, p. 250).

The SDH are human rights issues that reflect the relationship between people’s social position, their living conditions, and their health outcomes (Irwin & Scali, 2007).

*Recent efforts based on the role of place and health are revisiting the important roles of social capital, collective efficacy, community organizing, and empowerment of community residents as agents of change for improving community conditions that impact health.*

(Amaro, 2014, p. 6)

**The SDH – A Canadian Context**

Bringing the SDH into the Canadian context, Dr. Dennis Raphael provides a list of fourteen elements considered to be these determinants (Mikkonen & Raphael, 2010, p. 9). They are:

*Aboriginal Status Disability
Early Life Education
Employment and Working Conditions Food insecurity*

*Health Services Gender
Housing Income / Income Distribution Race Social Exclusion
Social Safety Net Unemployment / Job Security*

It is considered that these social determinants of health have a stronger effect on Canadian health than other associated behaviors such as: “diet, physical activity, and even tobacco and excessive alcohol use” (Mikkonen & Raphael, 2010, p. 9). This thesis takes into account both the WHO, and Dr. Raphael’s list of the SDH.

**Health Promotion Strategies**

Gore & Kothari (2013) provide an interesting analogy on health promotion strategies to address the SDH. They differentiate between two initiatives: *environment-based* and *structural-based*. Environment-based initiatives are defined as, “those that are meant to improve healthy living by influencing the immediate environment in which people spend their time, such as schools, workplaces and community spaces” (Gore & Kothari, 2013, p. e52). The concept of changing factors in the proximal environment to impact health outcomes is similar to the concept defined by the WHO as ‘intermediary determinants’.

Structural-based initiatives are defined as, “those that directly acknowledge the impact of various structures (e.g. social, political, economic) that create inequalities and attempt to address them directly in order to improve healthy living” (Gore & Kothari, 2013, p. e52). These structural-based initiatives address the SDH, which the WHO identifies as the ‘structural determinants’ of health. These initiatives conceptually embrace an *upstream* way of thinking. These initiatives challenge the structural mechanisms that create social stratifications, which result in *preventable* unhealthy living conditions. In summary, it has been suggested that both the intermediary (programs and services) and structural determinants (policy and public opinion) need to be addressed concurrently in order to effectively improve overall health and wellbeing.

## SOCIAL MOVEMENTS

**What is a Social Movement?**

McCarthy and Zald (2009) define a *social movement* as, “a set of opinions and beliefs in a population which represents preferences for changing some elements of the social structure and/or reward distribution of a society” (p. 196). Smith (2014) provides a similar definition offered by Manual Castells: “purposive collective actions whose outcome, in victory as in defeat, transforms the values and institutions of society” (p. xix). This definition introduces us to an important concept of collective action and the transformation of society. These terms have parallels found in the community organizing literature to gathering/bringing people together for the purpose of social change.

Shragge (2013) claims that social movements have a life cycle; they rise into prominence and then decline. Ultimately, some organizations that are put into action replace activists with professionals to develop community programs and services. Under this model Shragge (2013) suggests these organizations tend to represent those they serve rather than mobilizing them. However, as new movements emerge or campaigns are launched, community-based organizations can provide a place to organize, a place to carry out political education, and a place of support and nourishment (Shragge, 2013).

More specifically, and in relation to the HUCCHC, McCarthy and Zald (2009) provide a definition of a *social movement organization* as, “a complex, or formal, organization which identifies its goals with the preferences of a social movement or a countermovement and attempts to implement those goals” (McCarthy & Zald, 2009, p. 197). The formalization of social movements into organizations sets a new context on how they will operate.

**Health Social Movements**

Similar to the definitions of social movements/organizations, Orsini (2014) defines health social movements as, “collective challenges to medical policy and politics, belief systems, research and practice that include an array of formal and informal organizations, supporters, networks of cooperation and media” (Orsini, 2014, p. 335). Orsini (2014) asks, “whether health is emerging as a ‘master frame’ around which an array of movements is organizing or whether health might constitute yet another way to frame underlying questions of injustice” (p. 333).

Orsini (2014) goes on to illustrate three separate social movements (HIV/AIDS, Environmental Illness, and Asthma), which present new challenges not normally addressed by many traditional social movements from the past. First, these social movements simultaneously critique and engage with science, and challenge our common understanding of expert knowledge. Second, these movements reflect on, and attempt to, reframe already existing grievances (racial and gender oppression, and class inequalities) that have energized social movements for decades. They do this through the lens of health. The third new challenge relates to the ability to engage in forms of contentious politics. In other words, social movement actors whose health is compromised may have limited ability to participate by reason of their own physical health – example: attending an HIV/AIDS demonstration out in the blazing hot sun (Orsini, 2014). Through the definition of health social movements, and the three challenges that they address, we can gain more perspective on what the HUCCHC represents, and why it may act as it does.

**An Urban Health Social Movement**

Shragge (2013), provides an excellent example of a CHC that represents a social movement organization. He describes the Pointe St. Charles Community Clinic, which is one of several community health care clinics that were built in working class neighborhoods in Montreal. This particular clinic was established in 1968. Emerging from social movements, these service organizations embody the values and orientation of a social action approach to health care. A social action approach works beyond the local to challenge the legitimacy of existing power relations. This clinic had a wider vision of health care than the traditional medical-illness model: “they believed that ill health was connected to poverty and the related housing, working, and general living conditions” (Shragge, 2013, p. 37). This philosophy is rooted in an ‘Upstream’ (Meili, n.d.) way of thinking. This clinic’s approach to health care, “moved from the diagnosis and cure of individual illness to a social analysis with social change as the cure. In addition, they challenged the monopoly of professionals over the definition and delivery of health care” (Shragge, 2013, p. 37). Shragge (2013) concludes that although the clinic has become more bureaucratic with its growth and increasingly large mandate of providing a wide range of health care programs and social services, it has still managed to support and lead a variety of community action projects and social struggles.

**Implications for My Study of the HUCCHC**

In my thesis I will be examining how the participants of the study feel that the HUCCHC’s approach to health care takes on the dimensions of a social movement. In other words, what is the relationship between the HUCCHC and a social movement? Comparably, does the HUCCHC represent the essence of a social movement organization? In my study of the HUCCHC, I will be looking for any *features* participants reveal that may identify it as a social movement.

The HUCCHC presents itself as an organization whose goal is to, “shape a better [and] healthier city for the client communities served and represented by the Centre” (HUCCHC, n.d.). Modeling the HUCCHC as a social movement organization may help to provide theory and an understanding on *why* it demonstrates it is a catalyst for social change. Furthermore, the HUCCHC seems to have followed in the footsteps of the Pointe St. Charles Community Clinic: being built as a local organization that can provide a range of democratically controlled health and social services (Shragge, 2013). Therefore, it appears that, in part, the HUCCHC has adopted a social action approach to health care.

## SOCIAL CAPITAL THEORY

This section of the literature review will critically analyze social capital theory in a way that contributes to my research project. I will attempt to decipher what ‘*features’* of social capital make this a viable construct to foster community organizing for social change.

**What is Social Capital?**

Although the idea of social capital has been around since the 19th century, Pierre Bourdieu seems to be the first to dedicate an entire work to this concept (Macinko & Starfield, 2001). He conceptualized social capital as ‘the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition” (Carpiano, 2006, p. 167). In this sense, social capital can be used to obtain resources that may not have been readily available without a connection to a group. Carpiano (2006) states that the amount of social capital that a group possesses depends on two factors: the size of the group that can be mobilized, and the types of capital it possesses. Moreover, Bourdieu’s theory forces us to consider not only the existence of community social networks, but also the potential or actual resources possessed by the network, and the ability to draw on these resources when required to achieve a collective goal. Both Bourdieu and Putnam emphasize the importance of *social networks* as either a resource, or something that is inherent within social capital.

In recent times Robert Putnam has been the most influential social capital theorist within community development and public health (Carpiano, 2006). Putnam’s definition of social capital “refers to features of social organization, such as trust, norms, and networks, that can improve the efficiency of society by facilitating coordinated actions” (Macinko, 2001, p. 390). However, Carpiano points out that later in Putnam’s work, he uses a different definition:

*Social capital refers to the norms and networks of civil society that lubricate cooperative action among both citizens and their institutions. Without adequate supplies of social capital – that is, without civic engagement, healthy community institutions, norms of mutual reciprocity, and trust – social institutions falter.*

(Carpiano, 2006, p. 167)

Despite the modification of the definition, four features emerge: *social networks*, *norms, reciprocity*, and *trust* (Carpiano, 2006). These features are consistent across all the literature reviewed.

**Assuming the Benefits of Social Capital**

Social capital is a concept that is historically connected with the social sciences (Rostila, 2011). Although social capital has its limitations, concerns, and controversy, there is a general consensus that having social capital is, in one way or another, beneficial to an individual, group, or community (Baum, 2007; Carpiano, 2006; Eriksson, Dahlgren, & Emmelin, 2009; Hawkins & Maurer, 2011; Hunter, Neiger, & West, 2011; Pearce & Smith , 2003; Wakefield, Elliott, & Cole, 2007). Most of these authors have gone on to explain ‘how’ social capital contributes to health and wellbeing and here are illustrations and examples by authors that indicate that the features of social capital can foster community organizing for social change in relation to improving health and wellbeing. For example, Rostila (2011) claims that social capital in societies could play an important role in uniting people to ensure that budget cuts do not affect local and public services such as health services. Eriksson concludes that, “social capital is believed to improve the capacity of communities to work together for solving collective health problems” (Eriksson, 2009, p. 318). Further to this, Pearce (2003) remarks “it is plausible that social capital could be associated with health at the community level” (p. 125).

However, scholars lack consensus around the definition of social capital, how it is constituted, and how it is conceptualized. It has been stated that the concept of social capital may be considered as one of the most criticized concepts in the social- and health- related sciences due to conceptual disagreements (Rostila, 2011). The conceptual disagreements related to social capital and health will be covered next.

**Linking Social Capital and the Social Determinants of Health**

Amid all the conceptual disagreements there has been a significant amount of literature that links social capital and health. Eriksson (2009) contends that social capital has become an attractive concept within health research because of its emphasis on the social determinants of health. Additionally, Carpiano (2006) and Rostila (2011) assert that combining elements from various social capital theorists can provide effective models for social change. Arguing the effectiveness of social capital in tackling health concerns, Baum (2007) emphasizes that governments (politician and policy makers) and civil society (community action) play an equal and important role in addressing issues of health inequality. Furthermore, societies with high levels of social capital are more likely to be committed to, and be effective in, taking action on the social determinants of health than those with low levels of social capital (Baum, 2007).

Conversely, there have been arguments made about effectiveness of social capital in relation to health inequalities. Pearce & Smith (2003) ask, can social capital be an effective tool to challenge the various forms of inequality faced by communities? In answering this question they caution the readers. First, in trying to increase social capital one could inadvertently get into ‘victim blaming’, and producing interventions that are ineffective, and in some cases, outright harmful. The second caution is that if you increase social capital in one area you are, or may be, taking it away from another. Finally, the vagueness of the concept of social capital it makes it widely acceptable but open to widely varying interpretations, and offers very little in the way of interventions (Pearce & Smith , 2003). However, and in relation to the topic of this thesis, both Baum (2007) and Pearce & Smith (2003) would claim that the HUCCHC would need to have high levels of social capital in order to be effective for the local community to organize for social change.

**Bonding and Bridging**

Another consistent aspect of social capital in the literature is found in Putnam’s two forms of social capital: Bonding and Bridging social capital. Consideration of these two forms of social capital frames the prevalent features of social capital. *Bonding* social capital is inward looking, and “refers to cooperative and trusting relations between members of a network who see themselves as similar in terms of their shared social identity and is good for underpinning specific reciprocity and mobilizing solidarity” (Rostila, 2011, p. 112); but this form tends to reinforce exclusive identities and homogenous groups. Alternatively, *Bridging* social capital is outward looking, and is characterized by the respect and shared feelings between people who understand that they are dissimilar in some socio-demographic sense. It is “probably more valuable for the creation of collective resources, as they facilitate cooperation between dissimilar people in a given social structure” (Rostila, 2011, pp. 112-113).

**A Collective Conceptualization**

Another way to take up or to frame social capital is to group the definitions by the two notions of the concept – the individual or collective nature (Macinko & Starfield, 2001; Rostila, 2011). An important claim that Macinko makes is that social capital cannot accrue to an individual unless he or she interacts with others (Macinko, 2001). From this claim the question emerges: once social capital is produced, where does it reside? Some authors claim that social capital is a collective good of social structures rather than of individual actors within social structures (Rostila, 2011).

The collective notion of social capital theory contains some fundamental differences versus the individual notion. “Collective approaches to social capital emphasize that the concept refers to a feature of larger social structures or organizations rather than to individuals within the structure” (Rostila, 2011, p. 113). This develops Putnam’s claim that social capital is created through active participation of citizens in organizations and groups. Therefore, social capital is accrued through the collective actions of a group, organization, or community, and resides within this same group (Carpiano, 2006; Eriksson, Dahlgren, & Emmelin, 2009; Macinko & Starfield, 2001; Rostila, 2011). Rostila (2011) states that under the collective notion, all forms of non-exclusive social resources are generated by coordinated action in a social structure in order to pursue shared objectives. Macinko & Starfield (2001) suggest that both Putnam’s and Bourdieu’s social capital theory is collective. Finally, “in the process of exporting social capital from sociology to the health-related disciplines, the concept came to be strongly influenced by collective definitions” (Rostila, 2011, p. 114).

**Alternative Models**

Combining elements of different theories has proven to be advantageous for several authors, including Carpiano (2006), Rostila (2011), and Eriksson, Dahlgren, & Emmelin (2009). For example: Eriksson et al. (2009) claimed that using only Putnam’s theory was not enough as an analytical framework to design community health interventions aimed at building new or mobilizing existing social capital – additional models were required. Thus, bringing in alternative models that blend different theories was not only a pragmatic decision, it also reintroduced new terms.

Carpiano (2006) introduces us to a new conceptual model of how social capital can influence health. Arguing the use of new definitions, he conceptualized a resourced-based model that could be applied to health research that has four components: *Structural Antecedents*, *Social Cohesion,* *Social Capital*, and *Outcomes* *of Social Capital*. Carpiano relates Putnam’s terms of networks, trust, and reciprocity, as ‘social cohesion’, and this term is associated with social capital. He defines social cohesion as the patterns of social interaction and values that lead to social capital. Carpiano conceptualized this as “the degree of trust, familiarity, values, and neighborhood network ties shared among residents – factors that are influenced by area socioeconomic conditions and serve as the basis from which social capital can be formed” (p. 170).

Rostila (2011) presents another resource-based definition of social capital for health research that attempts to bridge the two notions of the individual and collective. The definition derived from this model claims that, “it comprises social resources that evolve in accessible social networks or social structures characterized by mutual trust” (p. 109). Furthermore, Rostila asserts that the use of a resource-based theory of social capital in health research captures the original core concept: *social resources*. Rostila provides a model (p. 117) that demonstrates that social capital has two dimensions: Social Networks - a structural dimension; and Social Trust – a cognitive dimension. These are said to constitute preconditions for social capital. Within social networks there are formal and informal social contacts. Rostila (2011) defines formal contacts as social relations created in voluntary associations (schools, work, clubs), and informal contacts as the cooperative and trusting relations between members of a network. Fundamental to this model are social resources. Rostila describes this as “the capital that is embedded in social networks and social structures and possibly further providing both individual and collective returns” (p. 118).

The alternative models provided by Carpiano (2006) and Rostila (2011) introduce (or reintroduce) us to new terms, phrases, or models that are valuable additions to some features that may be necessary to foster an environment conducive for social change. They both explore a resource-based theory of social capital that claims to rationalize why each model is important in contributing to better health outcomes by addressing the determinants of health.

**What has been Discovered?**

It is within the discussions, definitions, concepts, and models of social capital theory that I start to find some *features* (the values, attributes, qualities, or requirements), that are essential to foster an environment conducive for community organizing for social change. Although these terms have some overlap, and can be mutually reinforcing, these features can be explored independently. These features are:

* ***Social Networks:*** The connections and effective bonds formed between individuals as a result of their social interactions (Macinko & Starfield, 2001; Wakefield, Elliott, & Cole, 2007). They can be formal - membership in organized groups, or informal - with neighbours and friends (Wakefield, Elliott, & Cole, 2007). They can also be seen as parallel with the notion of Marx’s ‘bounded solidarity’, which is “the idea that adverse circumstances help otherwise unrelated people band together to improve their lot” (Macinko & Starfield, 2001, p. 397).
* ***Civic Engagement*:** Canadian citizens that have the opportunity and desire to get involved within the local community. Using Putnam’s definition of civic engagement, Macinko & Starfield (2001) described this feature as having “high levels of newspaper readership, voter turnout, and membership in choral societies, soccer clubs, and other groups among their citizenry” (p. 391).
* ***Reciprocity***: “Citizens act as equals with the same rights and obligations for all. Horizontal relations of reciprocity and cooperation are common” (Eriksson, Dahlgren, & Emmelin, 2009, p. 322). Also seen as ‘*norms of reciprocity*’; which is the normality of exchange of nontangible goods (such as favours), and can been seen as the reciprocal trust that is built within social networks (Carpiano, 2006; Eriksson, Dahlgren, & Emmelin, 2009; Macinko & Starfield, 2001; Rostila, 2011; Wakefield, Elliott, & Cole, 2007).
* ***Trust*:** “Involves a belief in the ability and desire of others to meet their obligations” (Wakefield, Elliott, & Cole, 2007, p. 430). Forms of trust can be civic or interpersonal; or can be seen as trust in others or government. Moreover, cooperation is achieved on the basis of an expected *reciprocity* (Eriksson, Dahlgren, & Emmelin, 2009). For localized *networks* to function together to produce collective effects, there must be a generalized trust amongst members (Macinko & Starfield, 2001).
* ***Norms*:** Can be seen as the norms of reciprocity, norms of behaviour, group norms, and norms of observance. “Norms are inculcated and sustained through socialization, modeling, and sanctions” (Wakefield, Elliott, & Cole, 2007, p. 430). The regulation and use of common property (i.e. a CHC or other public space), is an example of this.
* ***Structural Antecedents*:** Are the precursors that lead to social cohesion (below) and therefore social capital. They are the structural characteristics of a neighborhood and surrounding area (i.e. inter-neighborhood socioeconomic conditions), “that have implications for type and strength of social ties and resources available within the neighborhood itself” (Carpiano, 2006, p. 168).
* ***Social cohesion*:** Carpiano (2006) defines social cohesion as “patterns of social interaction and values (such as network formation and ties, familiarity, and mutual trust) that lead to social capital, and which serve as intermediaries between structural antecedents and social capital, but are necessary foundations for establishing social capital within neighborhoods” (p. 168).
* ***Social Resources*:** Community member’s accessibility to resources that is determined on level of the factors such as *trust*, *network* ties, and *reciprocity* (Rostila, 2011).

**Social Capital Criticisms, Controversy, and Limitations**

As noted earlier, social capital has its share of criticisms and controversy, and therefore some important caveats should be noted. Carpiano (2006) points us to one of social capital’s most notable criticisms: inadequate attention to potentially negative aspects of social capital and power issues. Several authors (Baum, 2007; Macinko & Starfield, 2001; Pearce & Smith , 2003; Rostila, 2011) state that social capital can contribute to negative externalities. Rostila (2011) claims that one property of social networks is often referred to as ‘closure’. He confirms two potential negative impacts: exclusion from a group’s resources can have detrimental health consequences – for example, marginalized people joining elite groups holding greater resources. And closed networks can also facilitate submission to norms, behaviors and attitudes (intended or not) that are detrimental to people outside of the group – for example: a ‘neighbourhood watch’ committee designed for the ‘safety’ of a neighbourhood. Therefore, it is possible to produce exclusionary social capital that can have negative health impacts.

**Summary**

Despite the criticisms and controversy, most authors agree that there is merit in the features of social capital, but they are conflicted on its application, and draw attention to its limitations. It stands to reason that the features discovered (social networks, reciprocity, norms, civic participation, trust, social cohesion, and social resources) are all good and desirable features. However, depending on what *form* (bonding or bridging) is used in the application of social capital, in the specific research study; or, what conceptualization (individual or collective) or notion of social capital is ascribed to; will produce varying results in research studies. This section of the literature review was not designed to evaluate social capital theory in its entirety (including effectiveness), but to identify and select the viable *features* necessary under this construct that are responsible to foster community organizing for social change.

## COMMUNITY ORGANIZING THEORY

Two books will be reviewed in detail regarding community organizing theory. They are: *Pragmatics of Community Organization* by Bill Lee (Lee, 2011), and *Activism and Social Change* by Eric Shragge (Shragge, 2013). Bill Lee provides a practical guide to community organization; while Eric Shragge answers his core question, “what does community organizing contribute to the process of social change?” (Shragge, 2013, p. 2). I will analyze the literature with the intent on extracting conditions and/or circumstances conducive for community organizing. I will do this by organizing this review into two sections: *definitions*, and *the role* of a community organizer. I will close the discussion with an example of a negative circumstance – *frustration* - that can initiate community organizing.

These books provided an ample list of features that would be necessary to foster an environment for community organizing for social change. There are a wide variety of community organizing models and approaches discussed, compared, or contrasted in each of the two books. I will not attempt to provide any value assessment between these models when deciphering the features found within them – each have their own merit. In doing so, I recognize that some of terms may be taken out of context due to the different values and beliefs that underpinned each book. However, extracting features from these various models does meet the intent of this literature review. Furthermore, I recognize that there is a ‘thin line’ between ‘community organizing’ and a ‘social movement’ – the later which I have used to describe the HUCCHC. Thus, many of the terms, phrases, ideologies, descriptions, and discussions about both of these concepts overlap, and at times, become one and the same.

**Definitions**

It was meaningful to examine definitions by both authors in order to uncover various terms or phrases that would represent the necessary features required for communities to organize for social change. Bill Lee defines ‘community’ as a complex notion, but when simply put, it is a group of people (Lee, 2011). Boothroyd, cited in Lee (2011), states that, “in sum, the essence of community is free cooperation in groups large enough to have variety, resilience, and capacity for complex work, but small enough for members to feel needed, recognized, efficacious, creative and unique” (Lee, 2011, pp. 47-48). Furthermore, “a community is not static. It has a history. People leave or join it” (Lee, 2011, p. 76). In summary, a community was defined as a group of people that are interconnected, and whose connections satisfy an individual’s social fulfillment; and that these features (the group, their interconnectedness, and social fulfillment) are subject to change over the course of time.

Lee commented that ‘community organization’ (organizing) is, “the purposeful bringing together of people and structuring their effort to achieve some alteration or development in the life of a group” (Lee, 2011, p. 2). Later Lee advances a definition of community organization by stating that:

*Community organization is a social intervention which seeks to maximize the ability of oppressed or disadvantaged people to take action and influence their environments; by facilitating a growing understanding of their social, political and economic environments and of themselves as citizens. The aim is to develop power to: acquire resources; change inadequate institutions and laws; or build new ones, more responsive to their needs and those of all human beings.*

(Lee, 2011, pp. 100-101)

Eric Shragge uses a different definition to describe community organizing:

*Community organizing is a search for social power and an effort to combat perceived helplessness through learning that what appears personal is often political. Community organizing creates a capacity for democracy and for sustained social change. It can make society more adaptable and governments more accountable…Community organizing means bringing people together to combat shared problems and to increase their say about decisions that affect their lives.*

(Shragge, 2013, p. 3)

Lee (2011) presents a community organization model that sees community work as a means of addressing the goals of empowerment and social justice while having some specific objectives that are relevant to my thesis: *citizen involvement, sense of community,* and *social learning* (Lee, 2011, pp. 86-87)*.*

Based on the definitions and organizational model provided above, I have selected a few key words/phrases to discuss. It is understood that these terms/phrases are not mutually exclusive, but are reinforcing, intersectional, and complexly woven features that foster an environment conducive for social change. These features are: *bringing people together, empowerment, power, learning, and democracy.*

***Bringing people together***

The phrase ‘bringing people together’ (or variations of this) can be found in the definitions of community and community organizing. The ability, or the opportunity, for people to gather, unite, or bond must take place in order for community members to organize for social change – the assembly of groups is a catalyst for social change. When speaking about community organizing Lee (2011) claims, “the organizing endeavor can be seen as the process of bringing people together to share their experiences, create a vision, and develop means to act and to attain that vision” (Lee, 2011, p. 59). Therefore, a feeling of interconnectedness, belonging, and empowerment can be achieved when groups are formed.

*As human beings we strive to render ourselves and our environment understandable, predictable and manageable. When we think about it, that is why groups of people first came together to form primitive communities; individuals would perish but the groups offered physical protection, the opportunity to share difficult tasks and the possibility of social interaction.*

(Lee, 2011, p. 42)

It is important for the members to have a positive sense of themselves as a distinct group (Lee, 2011), therefore, to have a sense of community. In order to foster an environment conducive for organizing for social change, a sense of themselves and their community is essential.People feeling separated from society experience loneliness and feelings of confusion and impotence, and alienation is disempowering (Lee, 2011). Thus, in order to feel powerful we must also experience some connection to others (Lee, 2011)**.** Furthermore, “an organized people can share information (on the problems they face), resources, or their own skills. They can divide tasks that need to be done to achieve their objectives, in an efficient manner” (Lee, 2011, p. 91).

However, when discussing the importance of the notion of bringing people together, other key terms emerge: opportunity and equality. Just because you may be able to bring people together, it doesn’t mean they can successfully accomplish anything. The HUCCHC opening its doors to the community does not guarantee any progressive social action that leads to the improvement of the health and wellbeing for anyone. The formation of groups can only represent an opportunity – nothing more. But, ‘opportunity’ is the most important part. The reference to opportunity is a common thread amid the various features throughout this section of the literature review, which no doubt represents a feature that the HUCCHC must have to provide the right conditions for social change.

Examining equity, Lee (2011) asserts, “we cannot argue too strongly for the building of consensus, and for the fostering of networks of support within the community” (p. 81). However, the fostering of networks within a community has limitations. Lee (2011) claims that in striving to overcome a ‘social wrong’, or in building a ‘social right’ participants and organizers will become stressed. Therefore, the establishment of positive human relationships – which is a major aspect of a sense of community – will alleviate the negative effects of stress. Emphasis was made that, in bringing people together, these groups must engage in a constructive, respectful, and a positive manner in order to remain as a cohesive and functioning group.

***Empowerment***

In relation to community organization, Lee (2011) suggests that empowerment means, “that we feel we have an ability to influence (not totally control) our environment so that we can have our needs met” (p. 38). This feeling is mediated by three factors:

*Instrumental – dealing with concrete issues and needs, such as levels of employment; or access to nutrition, or to social, educational, or health services.*

*Personal – relating to our emotional and relational life, such as the ability to communicate or be mobile, or to have access to friendship or support networks. These factors concern the ability to communicate or understand, or the access we have to communication and understanding.*

*Structural – concerning the social political, or economic institutions and their support or constraint [on] peoples’ lives. Issues such as racism, sexism, or ableism would be found here. The degree to which people suffer from these oppressions profoundly affects their quality of life.*

(Lee, 2011, p. 38)

The instrumental, personal, and structural aspects of empowerment play a pivotal role in a person’s wellbeing. A person’s wellbeing is the most essential concern of the HUCCHC.

Recognizing empowerment as process and an outcome, Sadan (1997) identified several ideological approaches to provide a framework of ideas for the discussion of empowerment. In order for her to develop empowerment into a theory she had to sort out and accept meanings. From the meanings she provided, I found ‘individual empowerment’ to be most relevant to my thesis:

*Empowerment is an interactive process which occurs between the individual and his [or her] environment, in the course of which the sense of the self as worthless changes into an acceptance of the self as an assertive citizen with socio-political ability.*

(Sadan, 1997, p. 75)

Furthermore,

*The process of empowerment is an active process. Its form is determined by the circumstances and the events, but its essence is human activity in the direction of change from a passive state to an active one”.*

(Sadan, 1997, pp. 75-76)

Both of these definitions of empowerment have strong associations with citizenship, and social action. They speak of a transformation process that occurs in the individual that is realized through a collective process. Both reflect what are necessary outcomes of community organizing for social change.

The feminist assertion that the ‘personal is political’ is helpful to my study because feminists asserted that issues such as sexism and racism were public issues that are embedded into the framework of policies which perpetuate systemic oppression. Furthermore, the feminist movement moves beyond class analysis to make a significant contribution towards shaping the vision and processes of community organizing (Shragge, 2013). The goal of organizing is;

*the elimination of permanent power hierarchies between all people that can prevent them from realizing human potential. The goal of feminist organizing is the elimination of sexism, racism, and other forms of oppression through the process of empowerment.*

(Shragge, 2013, p. 11)

Feminism provides a broader understanding of what constitutes the struggle for social justice, and is a comprehensive approach to social change (Shragge, 2013). This is attached to the assertion that ‘the personal is political’. Shragge (2013) states that collective action can reshape not only our lives, but also the world around us. Collective action moves beyond seeing individuals struggling in isolation to survive to being part of a collective shared interest and vision. This can be a transformative an empowering experience. Therefore, changing society can be seen as a way of changing oneself (Shragge, 2013).

***Power***

In regards to community, Lee (2011) quotes Hustedde & Ganowicz: “power is about who controls or has access to resources…if community development is about building capacity, then concerns about power are pivotal” (p. 60). Access to power is an essential goal of social action. Therefore, being able to provide the opportunity, space, or dedicating time towards building capacity would be valuable in community organizing for change. Thus, understanding where power resides is paramount – and power resides in numbers. Lee (2011) contends that, “a key element of power is having a large number of people on our side, and that large numbers of people are essential for a change process. Shragge (2013) adds that, “social power is gained through collective action” (p. 3). With concerns about power being pivotal, so is collective action, and so is access to resources.

There are several forms of social resources, and funding is one of them. Both Lee (2011) and Shragge (2013) make a strong connection between money and power. Regarding funding, both authors agree that in most cases an organizations survival is based on money. With this, comes an inheritance. Lee (Lee, 2011) suggests that models of organization tend to come from the corporate sector. “It is not surprising that we tend to use the bureaucratic model despite the fact that it is both undemocratic and sometimes downright oppressive” (Lee, 2011, p. 69). Ample funding is a double-edged sword. Funding can help organizations achieve success; but dependency on funding agents can corrupt even the most well-intentioned organizations. “Funding agencies, government or private, tend to demand the creation of familiar corporate structures before funding is granted. To access funding, the community conforms in order to satisfy the ‘accountability’ requirements of the funder” (Lee, 2011, pp. 69-70). It is suggested that there is a contentious relationship between power/money/funding, and the social good.

***Learning***

There is a strong and multifaceted connection between knowledge, learning, and power. “Learning is a participatory process that teaches about how power operates and what can be done to advance one’s interests, is essential in all processes of organizing” (Shragge, 2013, p. 4). Is his book, Shragge discusses an aspect of learning as the movement from the personal to the political. He states that, “organizing is an opportunity for political education” (Shragge, 2013, p. 9).

Lee (2011) links learning to power. “To develop an active and healthy community we must have the opportunities, and means, to learn. Social Learning is linked with the development of power. Knowledge is one of the five elements of power” (Lee, 2011, p. 92). Social learning has three facets: *skills*, *system knowledge*, and *structural analysis*. Skills refer to improving self-esteem by acquiring new skills – by learning how to do something new. System knowledge addresses the ability to use the complex system of regulations, laws, and public organizations. Structural analysis is a crucial aspect of recognizing and utilizing a person’s experience. It is about gaining a new and useful analyses of themselves, their community, the larger society, and/or problems with which they face (Lee, 2011). Shragge (2013) adds that, “teaching individuals a variety of skills builds on their capacities. Connecting people and building relationships allows individuals to share their talents through linkages with existing community resources” (p. 110). In all cases, learning, teaching, or knowledge, continues to prevail as one of the most predominant features necessary to foster an environment conducive for social change.

***Democracy***

Shragge (2013) states that there are four traditions within the wider community movement that can act to promote a social change agenda within community development organizations: democracy, education, alliance-building, and mobilization. These traditions help us to sustain a vision of why people organize. This vision is shaped by values of social justice and equality (Shragge, 2013). Education (learning), alliance-building (interconnectedness), and mobilization (action), for the most part, have previously been covered. Democracy, understood in its widest sense, is a process of people gaining control of aspects of their own lives through the organizations in which they have a voice (Shragge, 2013). In order for citizens to have success at promoting a social change agenda, people must learn to shape their lives, and create responses (Shragge, 2013). “Creating a ‘democratic space’ in which those without power can have a voice is a starting point in creating social change” (Shragge, 2013, p. 131).

Citizen involvement is the spirit of democracy – and is related to health. “[An] active citizenship is crucial to the health of any society” (Lee, 2011, p. 88). Lee (2011) references Saul Alinsky who states that the very essence of citizenship is our active involvement the life of our communities. Moreover,

*citizens have both the right and the responsibility to act. To be able to act, however, people must see themselves as citizens; with rights and abilities to express opinions, and to acquire the resources they need. The link to empowerment is obvious: for a group of people to feel positive about their ability to influence their lives, they must actually take action.*

(Lee, 2011, p. 89)

In order to foster an environment for the HUCCHC to act as a centre for community organizing, it must be able to fundamentally get people to see themselves as citizens – and citizenship has rights and privileges that need to be recognized to contribute to good health.

**The Notion Of Role**

As described by Lee (2011), the notion of *role* provides some insight in response to ‘fostering an environment’. The five ‘Roles’ of a community organizer are: *initiator* (catalyst/agitator), *encourager/supporter, popular educator, planner* (strategist/advisor)*,* and *mediator* (Lee, 2011, p. 107).

* ***Initiator:***When people have endured long-term oppression, or a sudden crisis resulting in either illness or death, community members may be ‘stuck’ and looking for assistance. A community organizer will often get things started – be the people who ask the first question or get the first meeting called. The community organizer’s function is to create “a climate of introspection and self-assessment for the…community, and facilitating communication, stimulating awareness of problems, and encouraging belief in the possibility of change” (Lee, 2011, pp. 107-108).
* ***Encourager:***Providing adequate support for people to recognize they have a voice, and it shall be heard, is essential in community work. A community organizer “will need to be able to encourage people to believe in themselves, their abilities, and their ability to learn” (Lee, 2011, p. 108). Lee adds, “this has obvious connections with the catalyst role but is broader” (Lee, 2011, p. 108).
* ***Popular Educator:***Much of the role of a popular educator (learning) has been previously covered. Further to this, Lee (2011) explains that it is the community worker’s responsibility to value marginalized and oppressed people’s experiences as valuable knowledge. It is to assist people to examine these experiences so that they can identify where the roots of the problems lie, the things they know already, and what they need to know to come together and/or confront oppressive systems and processes (Lee, 2011).
* ***Planner:***Planning strategies suited towards group member’s abilities optimizes people’s confidence to increase their say. “Strategy or planning requires a set of activities: research, issue identification, and prioritizing” (Lee, 2011, p. 109). Importantly, the community worker must be mindful to assist members develop the skills required in order for them to accomplish these activities on their own. “Initially the community worker may have to take the ‘lead’ in planning and strategizing, but in a collaborative manner in which people are able to learn to do it for themselves” (Lee, 2011, p. 110). Successful planning leaves citizens with the confidence and self-esteem necessary to move their social movement forward.
* ***Mediator:***Increasing your say starts at ‘home’. Lee (2011) acknowledges that in communities rife with turmoil and conflict – as many oppressed communities are – it may be necessary for the community worker to act as a go between in order to get various members of the community to communicate more clearly and fairly with one another. This should also include getting people to see, at best, their common humanity, or at least their common interests (Lee, 2011).

**Circumstances (Frustration)**

In closing I would like to draw attention to one of the negative *circumstances* that may be responsible for inciting people to seek the HUCCHC as a place to organize for social change: *frustration*. Lee (2011) cites Maier and Ellen (1961) relating the theory of frustration to when people act, not to deal with the actual objective conditions, but to relieve the anxiety associated with the frustrated condition. They suggest that,

*if people find themselves in situations where their ability or opportunity to influence the course of their lives is sufficiently severed, and if this lasts a sufficient length of time, that eventually a ‘frustration threshold’ will be crossed and the inner tension of the person will become the dominant cause of behaviour.*

(Lee, 2011, p. 41)

Frustration with one’s physical health and wellbeing can be the impetus to spark change – and this can take place in profound ways. A person who is frustrated will ‘act’ to relieve the anxiety associated with this condition on whatever or whoever is available (Lee, 2011). If we imagine ourselves as passive, powerless, and a victim, “we become preoccupied, not with creation, but with survival – or simply with the relieving of stress and anxiety” (Lee, 2011, p. 45).

**What has been Discovered?**

It is within the discussions, definitions, and concepts that I start to find some features within community organizing theory that are essential in fostering community organizing for social change. Similar to social capital theory, these terms have some overlap, and can they be mutually reinforcing. These features are: *bringing people together, empowerment, understanding and working with power relations, learning/teaching* (popular educator)*, providing a democratic environment, being an initiator* (catalyst/agitator), an *encourager/supporter,* a *planner* (strategist/advisor)*,* and/or a *mediator.* It is reasonable to assume that the features discovered are desirable features. This section of the literature review was not designed to evaluate community organizing theory in its entirety, but to identify and select the viable *features* necessary under this construct that are responsible to foster community organizing for social change.

# CHAPTER III – METHODOLOGY

*It seems if we are to ‘know’ something, anything, we must of course study it, think about it, and analyze it, but more importantly we must experience it.* (Amster, 1999, p. 130)

In review, the research questions I will be exploring are: How does the HUCCHC demonstrate that a community health centre can be a catalyst for social change? Moreover, what sorts of conditions and/or circumstances are necessary to foster an environment for the HUCCHC to act as a center for community organizing for social change? In this case the social change desired refers to improving the SDH, in the local community, by the HUCCHC. To determine ‘what sorts of *conditions* or *circumstances* are necessary’, I will be examining what characteristics participants feel are necessary to foster community organizing for social change within the HUCCHC. In order to do this, I need to explore the values, attributes, or qualities (the *features*) that foster an environment conducive for social change to occur.

## WHY QUALITATIVE RESEARCH?

This research study is qualitative in nature. I choose this approach because; “through qualitative research we can explore a wide array of dimensions of the social world, including the texture and weave of everyday life, the understandings, experiences and imaginings of our research participants, the ways that social processes, institutions, discourses or relationships work, and the significance of the meanings that they generate” (Mason, 2002, p. 1). I will be doing all of this by using a methodology that “celebrate[s] richness, depth, nuance, context, multi-dimensionality and complexity” (Mason, 2002, p. 1). In keeping an “internal consistency” (Carter & Little, 2007), and for the purposes of this research project; the interview process is the best way to understand the depth of knowledge of each participant, the nuances of community organizing, and the complexities of the HUCCHC acting as an agent for social change. This qualitative case study is of an organization, and I need to explore contextual pieces of how this organization functions, and how this social reality is interpreted. Human communication through the dialogue of an interview is the preferred method of data collection. In this case alternative methods (i.e. surveys) will not produce the desired results.

**MY THEORETICAL PERSPECTIVE:**

## AN INTERPRETIVE FRAMEWORK

This thesis will be written using an interpretive approach. A good report will give the reader a feel for another’s social reality. It will be a *thick,* and *rich,* description of the “meanings, values, interpretive schemes, and rules of living used by people in their daily lives” (Neuman, 1997, p. 71). Moreover, it will “resemble a map that outlines a social world or a tourist guidebook that describes local customs and informal norms” (Neuman, 1997, p. 71).

It is important to say a few words about my research framework. There are two core principles I will discuss. First, in conducting this research study, I don’t believe I hold on to any absolute *truth*. Amster quotes Diesing, “since there are many perspectives there can be many true interpretations…[I]n hermeneutics truth is irrelevant, and all interpretations are equally valid” (Amster, 1999, p. 132). Thus, a truth can only be found from the perspective of the participants. In this case, it is found in the identity and culture of the HUCCHC, at the time the research was conducted; and I recognize this will change over time. Second, I have my predispositions, hang-ups, and agendas. Amster asserts that, “it might be said that a researcher without a bias is either dishonest, disinterested, or dead” (Amster, 1999, p. 122). Throughout my *Findings* and *Discussion* section I will be honest and transparent about the lens I am using and therefore honor the expectations of a good, reflexive, interpretive research study. My intent is to provide a report that helps to understand how the realization of progressive social action at the HUCCHC is interpreted, experienced, produced and/or constituted. Thus, in order to get the data I require I will use an interpretive approach in conducting and reviewing interviews to collect the data.

It is from the interviews (supplemented with observational field notes), that I want to learn “what is meaningful or relevant to the people being studied” (Kreuger & Neuman, 2006, p. 78) - what fosters group organizing. I will do this by getting to know the particular setting and see it from the point of view of the people within it (Blaikie, 2010b; Kreuger & Neuman, 2006), by acquiring an in-depth understanding of how participants attach meaning in their relationship with the HUCCHC. Furthermore, an interpretive approach recognizes that social reality is fluid and subject to different socially created meanings at different times (Blaikie, 2010b; Kreuger & Neuman, 2006). The nature of this approach is reflected by the changing, evolving, and varied use of the HUCCHC, which has been influenced by changing politics, governance, and social discourse at various times throughout its history. I recognize that I will only be taking a ‘snapshot’ of the current social conditions in the present time. Furthermore, an interpretive approach is not value free (Kreuger & Neuman, 2006). I will be reflecting on, reexamining, and analyzing my personal points of view along the way; I will become a “passionate participant” (Kreuger & Neuman, 2006, p. 82).

An interpretive approach is the most pragmatic way to answer my research question(s). I want to conduct this part of the research using an interpretive approach because I feel that sharing the feelings and interpretations of the participants will allow me to develop ideas on what circumstances and conditions are necessary for group organizing. I will study what is unique about the HUCCHC that fosters group organizing, and what unique meaning systems exist within this environment. Kreuger & Neuman (2006) state that the fundamental nature of social reality is not waiting to be discovered, instead it is “largely what people perceive it to be” (p.78). Thus, I need to understand the perceptions of the participants with respect to their relationship with the HUCCHC. “Ordinary people are engaged in a process of creating flexible systems of meaning through social interaction” (Kreuger & Neuman, 2006, p. 79). This statement aligns with the questions I have about what system of meaning has been created through the participant’s social interaction with the HUCCHC. ‘Social interaction’ is particularly important here because this is where the evidence is to answer my research question(s). The interpretive approach is intended to give the reader a feel for another’s social reality (Kreuger & Neuman, 2006). It is this social reality that I wish to explore. Finally, good evidence cannot be isolated from the context in which it occurs or the meanings assigned to it by the participants involved. Any explanation that is derived from this evidence will be considered as good and true when it makes sense to those being studied, and if the reader can deeply enter into the participants reality (Kreuger & Neuman, 2006). This is the goal I expect to achieve when analyzing and reporting my findings in the data.

## DATA GATHERING

**Case Study**

A case study design will be used as my research strategy. Case studies are “the preferred strategy when “how” or “why” questions are being posed, when the investigator has little control over events, and when the focus is on a contemporary phenomenon within some real-life context” (Yin, 1994, p. 1). These conditions reflect my research project, and my questions. Furthermore, case studies are used to study (but are not limited to) people, events, policies, communities, agencies, institutions, and organizations. My research project studies an organization. Finally, case studies are an excellent strategy for ‘exploring’ phenomenon (Yin, 1994), or in my case, characteristics. Yin’s (1994) book, *Case Study Research: Design and Methods*, will be used in methodologically guiding my research project.

**Recruitment**

The recruitment process began by gaining permission from Denise Brooks (executive director of the HUCCHC) to conduct this study at the HUCCHC. During this process it was discussed that Denise Brooks would send out a preapproved email script to potential participants (Appendix A-1 and A-2). The McMaster University Research Ethics Board (MREB) approved the email scripts. Furthermore, a letter was signed by Denise Brooks stating that she would be responsible for recruiting all participants on my behalf. There were no exclusionary requirements; all staff members and various community partners would receive the email script with instructions to reply directly to myself – therefore all participants would remain anonymous. All participants who replied received a return email that: initiated the participant to select a place, date, and time, that was convenient for them to participate in an interview; and had an attachment of the *Letter of Information and Consent* (Appendix B-1 and B-2) explaining the purpose, procedures, risks, benefits, confidentiality, and the participant withdraw information about this study. Prior to beginning each interview, this document was signed by the participant. Each interview was semi-structured and guided by the questions in Appendix C-1 and C-2. I conducted six *key informant*, and two *program participant* (*community partner*) interviews over a span of four days.

**The Participants**

Since there were no exclusionary factors, it was a generous mix of people; each providing their unique perspective, each having their distinct characteristics, each bringing their own experiences into the conversation. Interviews provided a thickness and richness in understanding the HUCCHC. These participants delivered a combination of thoughts and feelings that helped me to produce an understanding, or provide a reason, to ‘why’ social change may take place at the HUCCHC.

Six participants were employed by the HUCCHC. They occupy various positions within the centre, and had worked there from as little as two, to as many as eighteen years – since the HUCCHC was born. The staff I interviewed was culturally diverse, and they had all arrived at the HUCCHC in many different ways. Some staff had the experience of landing in Canada as a newcomer, while others arrived at the HUCCHC with cultural linkages to the community. Two participants were community partners to the HUCCHC. These participants provided an ‘outside’ perspective to the role of the Urban Core in the community, or shared the discourse of the milieu in Hamilton.

**Interpretive Questions**

The interpretive questions I asked the participants were designed around the two groups I sampled: *key informants* (people employed by the HUCCHC), and *community partners* (people that represent outside organizations that have a relationship with the HUCCHC – in the MREB application referred to as *program participants*). It is assumed by using an interpretive approach that people may or may not experience social or physical reality in the same way (Kreuger & Neuman, 2006), and likely there will be differences between and within the two sample groups based on individual perspectives and experiences.

**Sampling**

The implications for my data analysis start with generating the qualitative data – determining the sample with the anticipation that they hold the knowledge that I seek. The strategic sampling that was employed was purposive sampling. Mason (2002) describes this as ‘theoretical sampling’; which is concerned with constructing a sample or group which is meaningful theoretically and empirically, “because it builds in certain characteristics or criteria which help to develop and test your theory or your argument” (p.124). In my research project the participants hold knowledge that is complex, nuanced, situated and contextual. The majority (six of the eight interviews) of my participants work for the HUCCHC.

**Interviewing**

I used the most popular and commonly recognized methods of data collection (Mason, 2002): qualitative interviewing. It was an in-depth, semi-structured interview that was designed to provide a candid conversation about the relevant features of the HUCCHC. I chose to use qualitative interviewing because my ontological position suggests that, “people’s knowledge, views, understandings, interpretations, experiences, and interactions are meaningful properties of the social reality which [my] research questions are designed to explore” (Mason, 2002, p. 63). Furthermore, I have an epistemological position “which allows that a legitimate or meaningful way to generate data on these ontological properties is to talk interactively with people, to ask them questions, to listen to them, to gain access to their accounts and articulation, or to analyze their use of language and construction of discourse” (Mason, 2002, pp. 63-64).

Interviews were recorded using a SONY – ICD-PX333**©** portable audio recording device. For backup, I used a *Blue Microphones – Snowball ice***©** microphone to audio record into a preexisting recording program on my computer. Interviews started after the *Letter of Information and Consent* (Appendix B1 & B2) was reviewed and signed. A complete guide for my interview questions is provided in Appendix C1 & C2. A few sample questions are listed below:

* Your personal opinions and views on activism and advocacy work.
* Do you feel that you participate in, or have any experience with, any advocacy/activism activities at The Urban Core? – Tell me about them.

Most interviews concluded with the following two questions:

* What would the City of Hamilton be like without the HUCCHC?
* Is there something important we forgot to discuss?

## DATA ANALYSIS

**Grounded theory**

 Charmaz (2012) states that “grounded theory is a method for studying processes; it is also a method in process” (p.2). I analyzed the data using a grounded theory process. I am considering that in answering my research questions I may provide a ‘mid-range theory’ on what conditions and/or circumstances are required to foster community organizing within the HUCCHC – and possibly why I surmise this happens.

Charmaz (2012) describes grounded theory as “a systematic method of analyzing and collecting data to develop middle-range theories” (p. 2). It is a method that begins with, but does not end with, inductive inquiry. Furthermore, it is a comparative, iterative, and interactive method (Charmaz, 2012). Major grounded theory strategies include theoretical sampling, coding, and memo-writing. Theoretical sampling means, “sampling for development of a theoretical category, not sampling for population representation” (Charmaz, 2012, p. 3) – in essence, theoretical sampling *is* an abductive strategy (follows this discussion). With respect to data analysis, the task is to code for processes, actions, and meanings in the data. Charmaz (2012) explains that, “it breaks the data up into their components or properties and defines the actions that shape or support these data” (p. 5). Memo writing is the intermediate step between coding and writing the first draft (Charmaz, 2012). This aspect fits well with my interpretive approach for this research project as a tool to answer the ‘why’ questions.

**Abductive Research Strategy**

I found that using an ‘abductive’ research strategy would work best for my research project. Blaikie (2010b) states that an abductive research strategy can answer both the ‘what’ and the ‘why’ questions. “However, it answers ‘why’ question[s] by producing understanding rather than an explanation, by providing reasons rather than causes” (p.89). Providing an understanding, or reasons, of why community groups organize with the HUCCHC is the premise of my research project. In order to access any social world it requires understanding the accounts that people can give of their own actions, and the actions of others. “These accounts contain the concepts that participants use to structure their world, and the ‘theories’ they use to account for what goes on” (Blaikie, 2010b, p. 90). Using an interpretive approach works well with this strategy. The questions I will ask of my data will be designed to evoke a narrative on *what* conditions or circumstances are necessary in order for the HUCCHC to act as a centre for community organizing for social change, and *why* this happened. In summary, an abductive strategy involves “developing descriptions and constructing theory that is grounded in everyday activities, and/or in the language and meanings of social actors” (Blaikie, 2010b, p. 92).

# CHAPTER IV – FINDINGS

Buried in the Hamilton urban core resides the weathered structure of the HUCCHC. Part 1 of this chapter realizes how the equitable relationships provided by the employees of the HUCCHC have built rapport with a marginalized population in need of resources; and where the HUCCHC stands on issues framed by the SDH. Part 2 considers the social action approach to health care that has become possible because of the strength of the relationships established in Part 1.

## PART 1: STANDING WITH THE MARGINALIZED

**Observations Of Health Care In A Public Space**

As I approached the HUCCHC for the first time I was taken back by its unusual appearance. The building was obviously old, but it was something more than that. Maybe it was because this health centre was originally designed as a bus terminal. Outside there was a large canopy that covered an area where buses used to stop. This now resembled a bird’s wing that stretched out from the main building offices to provide protection against the elements. On this hot and sunny day, it provided shade for some of the homeless population that had congregated underneath. The inside of the building only provided minimal relief from the elements. Closed windows trapped in the inadequate coolness of a faulty air-conditioning system. Upstairs was hotter than the main floor. Downstairs the shower facilities had flooded, and were out of order – and had been for some time.

During my tour of the facilities, it was apparent that the offices had reached their capacity, and were now over-crowded. Generally, people’s work area was not much larger than a cubicle in a washroom. There was no space for books and office supplies as they infringed on each other’s work area. Also, many areas designated for counseling lacked any privacy whatsoever. It was clear that some clients had to be content to reveal their intimate details, in a most vulnerable state, amidst all staff within earshot. Considering the space constraints, finding space for my interviews represented a challenge as well. All staff selected a particular meeting room/lunch room to participate in the interviews. This small and congested sauna provided minimal interruptions – as long as you stuck a paper note on the door that there was a meeting in progress. At the HUCCHC, there was little relief from the stifling temperature and overcrowded conditions.

This is a ‘health’ centre - and it is in poor health. Overall, I found the conditions to be less than adequate to serve between 7000 – 10,000 of the most vulnerable population in Hamilton. I cannot imagine the state of this health centre is indicative of all Community Health Centre’s across Ontario. Would the doctors and nurses at my local hospital accept these conditions as ‘satisfactory’ to provide health care services? I wondered what circumstances have happened in order for these conditions to exist. I sought to understand how the HUCCHC, under these conditions, could act as a centre for social change. Moreover, how do they demonstrate they are improving the SDH?

In contrast to the dismal environmental and structural conditions of the HUCCHC were the messages and atmosphere that saturated the space within the centre. Pictures, posters, articles, brochures, and statements, were abundantly displayed throughout the main floor, and lined the upstairs corridor. They provided information, messages, guidance, hope, values, beliefs, and an understanding of why the HUCCHC exists. The information provided a scope of the programs and services available at the centre, and how to connect to these services. In the upstairs corridor, the messages were presented in meaningful images that focused on education, employment, and inclusion; all of which symbolized the determinants of health. Also, posters addressed the many variations of what health equity is. ‘Staff only’ areas included a ‘Statement of Staff Rights’. What was exceptional about these rights was how they reflected similar rights that were recognized for their clients – a powerful statement of equity that is embedded in the soul of the HUCCHC. On the main floor the doors were covered with paper hearts and light bulbs. The hearts were a ‘thank you’ written by various clients of the centre stating how they felt about the HUCCHC. Written on the paper light bulbs were ‘bright ideas’ that clients had for the centre. The posters, pictures, and memoirs added a personal testimony to what the HUCCHC was made of, and why it exists.

I feel that this is an important place to comment on the topic of how people who use the HUCCHC are addressed by the staff. Many terms were used such as *clients*, *people*, and *folks*. It must be noted that there was never a time in the interviews (or otherwise) when I felt as though there was any hierarchal relationship of power between that of the ‘expert’ staff, and that of a person being served. All terms were used in a respectful way. In order to be consistent throughout this thesis, I will use the term ‘client’; as I find using any other term (i.e. people) may become confusing. *Client*, to me, means a person who is not employed by the HUCCHC, who utilizes there programs, services, or facilities in any way.

**Using Equity As A Catalyst For Social Change**

Participants I spoke with described the foundational features of their work with clients. The main process at issue was establishing rapport, which included establishing equitable relations. These equitable relations were built by engaging, consulting, and listening to clients. Furthermore, it was about understanding clients’ needs. The outcome of these relations was a mutual sense of trustworthiness between employees of the HUCCHC, and clients. Drawing from my interviews, the following section discusses each of these processes. I show how the rapport created by HUCCHC staff with clients and community members facilitated the HUCCHCs social change activity.

***Recognizing Health Equity***

 The HUCCHC recognized the importance of equity in achieving optimum health. According to some of the posters displayed in the upstairs corridors of the HUCCHC, health equity is:

* *An acknowledgment that all people have a right to health.*
* *The result of responsible effective social policies that improve the conditions in which people live, work, and play.*
* *A recognition that racism, social isolation, and all other forms of oppression are fundamental social determinants of health.*

I found these statements of health equity to represent more than just slogans posted on a wall, but representing some of the fundamental ways in which the HUCCHC is constructed, and organizes itself as a health centre. The following explores what participants described as some of the primary ways in which this takes place.

***Engaging, Consulting, and Listening***

Engaging, consulting, and listening to clients are hallmark features that the HUCCHC demonstrates in building rapport that fosters sustainable relationships. In social work, it is common knowledge that building rapport with a client is essential before any meaningful change or benefit can take place. Engaging, consulting, and listening were some of the most prominent features discussed by all participants.

When engaging the community, it is important to consider community members as the ‘experts’ of their situation and experience. Asking members of the community what they need, what they want to do, or what they see, is the starting point to create a framework for social action. Also, it is important to realize where workers are coming from:

*Because we can have perceived ideas or we can have biases based on our history, based on our education, based on our knowledge, that will impact how we interact with the community. We have to recognize the community for what they bring into the table, into the conversation, right, and that is why it is so important to engage. If you try to engage community from a point of view, as I said, that they are not, eventually you are setting them up for failure.*

This statement exemplifies the participants understanding of the important principles behind community engagement, and introduces us to the concept of conducting relationships in a respectful and equitable manner.

Showing respect and treating people with dignity was stated as one of the core values of the HUCCHC: “All people have a right to be treated with dignity and respect” (HUCCHC, n.d.)*.* Demonstrating respect would involve certain actions – actions such as engaging, consulting, and listening. Employees of the HUCCHC provided a variety of examples of how they treat the community, the clients, in an equitable manner. Additionally, the Urban Core demonstrated respect through actions of consultation.

* *We consulted with the community, we said ok, the LHIN’s asking a question, we want you guys to know that you also have an opinion on things.*
* *They decided this* [having more space] *is an important thing, and so when we said, when we asked them, what should we do?*
* *We held, with about 25 different multi-cultural communities here, a few sessions to say: tell us what you want us to be.*
* *However, when we sit down, because we invited the community to basically sit down, we share the meal and we talked.*
* *So, we are doing [things]different in many ways. So what ways? I do believe, first of all, we are the people sitting down with them and really listening… What would you like to do? How would you like to do it?*

The HUCCHC has constructed many creative ways to find out what the clients want from their centre. The invention of a game called ‘Coreopoly’ was one of the creative ways to find out where money should be spent at the HUCCHC. Clients were given a budget of one thousand dollars in Coreopoly money and asked where they thought it should be spent. From this creative form of expression emerged the realization that clients want a larger health centre. This lead to the birth of a campaign called *Committed to the Core*. In essence, this was a community driven, HUCCHC lead, campaign for social change. This was designed to improve a determinant of health – their community health centre.

***Establishing Trust***

It has been said that trust is earned. At the HUCCHC, trust was described as being earned through the longevity of equitable relationships. Participants marked this as especially true with newcomers to the country. One participant described clients having a lack of trust for schools and other institutions back home. Employees said that being here was different:

*And that they could trust an institution…So sometimes they are not very trusting, still, of other institutions…And I mean it’s happened over a lifetime. It will take time before there is ever that 100 percent trust and security.*

Based on the stories of participants and my own observations, the HUCCHC has fulfilled a commitment to building trusting relationships. They have been able to overcome preexisting impressions that institutions are in some way immoral or corrupt:

*Because most of our clients are not involved* [in politics]*, and they don’t believe in politics anymore. I see from my own perspective, of being a newcomer, and when I was here first. I came from a country that, we don’t believe in politics, we don’t trust police.*

 Newcomers to the HUCCHC need a safe place to ‘land’. They need a helping hand, genuineness, and a place they can feel safe. Providing safety can be a prerequisite to building social trust. It was mentioned on several occasions about how the HUCCHC provides a safe place to gather.

*I think that a lot of our clients see this as a safe place with zero judgment.*

Before communities can organize for social change, they need to secure a safe place of contact to establish trusting relationships.

 If trust is a prerequisite for social capital, and social capital can lead to better health; it stands to reason that building genuine trusting relationships fosters an environment conducive for community organizing for social change. Building social trust is a fundamental dimension, and a prerequisite of gaining social capital (Carpiano, 2006; Rostila, 2011). Forms of trust can be civic or interpersonal; or can be seen as trust in others or government. *Social cohesion* (Carpiano, 2006) – the collective terms of networks, trust, and reciprocity - are the patterns of social interaction and values that lead to social capital. The many conversations I had informed me that there was a healthy level of social cohesion between the HUCCHC and their clients. Convincing clients of trustworthiness is essential to communities.

*Like many communities, trust, is a big thing, you know, trust. And they have to see, trust, that you really want to help that.*

***Grounding Health Care In Client Needs***

There needs to be a place to start: at the HUCCHC the starting point is clients’ needs. The HUCCHC is in contact with the most difficult population to care for in the Hamilton area; people that have been marginalized, alienated, and oppressed. They were described as people who are homeless, or experiencing poverty; newcomers to Canada - where language is a barrier; or people with addictions or mental health issues. Identifying the immediate concerns of this population, what are their priorities, or what are their needs, are of the upmost concern for the HUCCHC. The staff appears to have been built around the ability to understand these requirements.

*We are not out there for statistics. We are out there for services. I think that is what people should see about the Urban Core, is we are out there because of the clients. When we say clients centre, we really mean client centered.*

Being client centred is also about timing.

[We] *make sure that the programs we deliver today are the correct to the clients’ needs*…*The population shifts and changes all of the time. Even as such, we cannot expect that the needs will stay the same.*

Furthermore, an employee of the HUCCHC informed me on the values and beliefs that are required to work with the population they serve. He stressed the importance of having this client centred approach to health care.

*This is one of the values. We are reminded, and new staff is reminded, the existing staff is already familiar with our approach,* [which] *is how client centered oriented we are*. *Everything revolves around the clients.*

The HUCCHC may be a person’s first point of contact, and the success of where they go from there can be established early on. One participant spoke about working with newcomers that are taking their first steps in trying to integrate into Canadian society.

*I’ve seen the struggles with access to health care, although, the first sort of theme is not usually the health care component. Many people when they come would like to gain access to work and so on. So they put health care on the back burner.*

Later into the conversation this person discussed how he pondered some logical pathways towards health care.

*I thought there is a logical process to move into primary health care, to support them with health promotion activities and so on.*

Employees of the HUCCHC were passionate about receiving acknowledgement for their efforts in client service. The HUCCHC has committed to this form of health care. The good news is that, outside of the organization, other participants were recognizing their efforts.

*What seems to be a dominant part of it* [the HUCCHC] *is really focusing on serving their clientele, and coming up with creative and innovative ways to meet their needs.*

These circumstances seem to contribute to the conditions necessary to build sustainable relationships. First points of contact, or first impressions, are very powerful in human affairs. Addressing client needs was a resounding feature necessary in providing primary health care. Participants described each client as being unique, and each client requiring their distinctive pathway towards health and wellbeing.

**Summary**

 Amid all that has been mentioned about engaging, consulting, listening, trust, and a client centered approach to health care: notions of equity stand out as one core principle necessary to act as a catalyst for social change.

## PART 2: SOCIAL ACTION

I previously discussed how participants discussed equity in terms of ‘fair-mindedness’ amongst the people concerned, while respecting each other’s identity. Now I will discuss how employees of the HUCCHC moved beyond that with clients; and their subsequent social action approach to health care. This approach was described as being about pooling resources, from both sides, in order to make social change. It was about knowing what is right and just, and pursuing that goal as a collective group. It was about an organic decision-making process representing a true democracy. It was about decentralizing power, appreciating peoples creative energy, solidarity, respect, and building trust. It was asserted that these conditions and circumstances are about health and wellbeing.

**Pursuing Social Justice**

Pursuing the goal of social justice resonates with social movement and community organizing theory. I will start this section off by reiterating a quote from the *Literature Review* chapter that speaks to the conditions at the HUCCHC:

*As human beings we strive to render ourselves and our environment understandable, predictable and manageable. When we think about it, that is why groups of people first came together to form primitive communities; individuals would perish but the groups offered physical protection, the opportunity to share difficult tasks and the possibility of social interaction.*

(Lee, 2011, p. 42)

The quote above mirrors stories told by participants about the Roma refugees. The story about the immigration of the Roma people in the mid-1990’s was reiterated, at least in part, by each participant, inside and outside of the organization during my interviews. The historical framework of the HUCCHC was built on the way it succeeded with the Roma refugees. The importance of the Roma refugees set the precedence in terms of the model of health care that the HUCCHC is today. The Roma population was at high risk of perishing as people were brought together as newcomers in a foreign country facing significant barriers. The HUCCHC offered safety, shared difficult tasks, and provided the necessary social interaction in order for people to survive, and thrive.

*So they had asked us to help them to meet, to be able to talk about what was going on. What were the issues? How they could be addressed? And maybe, how they could be together to support one another.*

The initial gathering of people would eventually lead to the United Roma Association of Hamilton (URAH). Participants noted that the URAH now host their own website, and manage their own affairs – and they give back.

*They are very much giving back. So when there was activism around poverty, they got on-mass on buses and went to protest in Queens Park. They did things like that, and that is their journey. And that’s one of the groups that have made such a journey from here.*

Today the HUCCHC maintains a strong alliance with the URAH.

**Bringing People Together**

In my investigation of ‘bringing people together’, two ideas emerged from this theme. The question of ‘why’ differentiates these two ideas. The first idea involves the concept bringing together for the purpose of being invigorated and finding enjoyment in healthy social interaction – being in good company. The second idea evolves when groups of people find their ability or opportunity to influence the course of their lives hindered, and therefore their health is jeopardized - campaigning. The following provides clarity around what I found out regarding these two ideas.

***In Good Company***

I had unexpected responses when inquiring about ‘social action’. When asking questions such as: have you participated in any social action, or what was the most memorable social action; participants suggested that bringing people together for the pleasure of social activities (i.e. soccer) represented a social action. Some participants discussed how social engagement was a key to a healthier society.

There was one participant who was adamant about the importance of bringing people together for social interaction, to provide an opportunity to escape from social isolation, and to unite with people who are, or have been, in a similar situation, either in Canada, or back at home. The most memorable social action for him was organizing people around soccer.

*Or soccer. We are doing so much. For example, and now automatically are coming the young. And soccer is not just about soccer, believe me. It’s absolutely not. I believe it is the best settlement program you can imagine.*

He goes on to discuss how soccer extends beyond what transpires on the field; but how this brings out communities from different nationalities, and their families, that develop friendships, which provides a social connectedness like no other program. It is a place you learn to speak English, or you make a connection for a job. It is about belonging and wellbeing.

*We are reducing social isolation. You are giving them connection. You are giving them sense to balance somebody. So soccer, it’s one of the best and the biggest one* [social action]*.*

Two other social actions that were predominant in the conversations were the annual HUCCHC *Barbeque*, and the *Health* *Street Fair*.

*We have a lot of events here, like, Health Street fairs and BBQs. And its not just a BBQ, we have things set up and we have people from other organizations, or the fire department come over and teach the kids about smoke detectors. Just getting everybody together. The Health Street Fair we have about twenty community partners come and set up their tables and its all health information in different languages. And it’s just to show everybody what’s out there.*

Participants stated that the Barbeques and Street Fairs move beyond feeding people or providing health information. They provided the opportunity for social engagement, education, and a sense of belonging. But most importantly, it brought joy into people’s hearts that are normally suffering from some form of social isolation and/or oppression. Soccer, a barbeque, or a street fair, provided, if only for a little while, escape from what is currently, or has been, a tumultuous lived experience.

*After a couple of months* [the people] *forget everything, and realize that we are all human beings. Who cares. I’m looking if you are positive or negative. That’s the most important thing.*

***Campaigning***

Campaigning is an integral part of what the HUCCHC defines as a process of health care. The HUCCHC’s vision statement asserts that, “we recognize that a healthy community can only be achieved through collective action” (HUCCHC, n.d.)*.* As new movements emerge or campaigns are launched, community-based organizations can provide a place to organize, a place to carry out political education, and a place of support and nourishment (Shragge, 2013). Many participants recognized the importance of initiating or supporting campaigns early on.

*When you start the process, the building process, from the ground up, when you recognize the assets and recognize the leaders, and empower the community, right, focus on community development and capacity building, you are investing in long term. Because, one day you want to be able for the community to say you know what, from this point on, we will take it, we will take it from here.*

As has been suggested regarding the development stage of campaigning, along with an equitable relationship, there needs to be an ability to support those who need it, and a reciprocal relationship of learning. The people at the HUCCHC were able to communicate how they go about achieving this:

*I would have to say that the Urban Core tries to give a voice to people who need help with that. Their opinions matter, their thoughts matter, quite often the client input - where surveys are conducted a lot of the time - on what clients think we need to do, or how can we do something better? What would they like to see?*

A participant discussed what he has learnt from clients:

*Yah…more from the point of view of people. When I talk with them I never suspected that the people that I talked to, I never suspected for them, to be, “yes, I will speak up, I will stand up”. That was a good learning experience.*

From this statement the participant went on to discuss how people can sometimes have preconceived notions of others, and this may lead to people being perceived as ‘not interested’. Later in the conversation, the topic turned to peoples ‘abilities’. He explained that most of the time in the environment at the HUCCHC, the community (whether they are clients, staff, or visitors of the HUCCHC), see clients as being down, and experiencing difficulties. However, once people get involved and start talking to clients experiencing these hardships, they see they have a lot of abilities. Moreover, the clients experiencing difficulties are able to come forward with good ideas on ‘what to’ and ‘how to’ do things.

Most often the reference to initiating communication with people has the notion of crossing a barrier. Opening a line of communication, opening a conversation, or giving people a voice, fosters an environment for community organizing. Speaking directly with people uncovers valuable information. Employees of the HUCCHC can find out what people want, and then demonstrate that they have the ability to help people achieve these objectives – perhaps through empowering, or maybe through campaigning.

* *People want their stories heard. They are given that forum here.*
* *Well I think here clients find acceptance by the staff members, and they are given many avenues to express whatever views.*

Moving beyond the HUCCHC’s connection with clients to initiate collective campaigns is the importance of connecting with other health campaigns/movements geared towards social change/improvement. The HUCCHC demonstrates its commitment to this endeavor:

*I think we are being perceived as sort of experts of working with marginalized population. We try to be the leaders and come up with different ways and initiatives to raise the awareness to influence change, and to involve people, and give the power to people, to be part of it, right? Because I don’t think we are in any position to be able to create change from our own perspective. We need to be part of it, the people need to own…they need to be connected to it. As such, that’s why we are connected to grassroots organizations, we support their initiatives. And then, the organizations are always invited to our initiatives, and be part of it, and so on. So it is a fluid relationship.*

The participants indicated that the HUCCHC recognizes other movements as they emerge, and supports campaigns as they are launched. They also assert that more activism geared around population health is required in the Hamilton area.

* *Well we definitely lack it* [activism]*. We definitely need more of it in this city. We try to do the best we can but there is just not enough of us.*
* *Well I think I’m for it* [activism]*. I think it’s necessary there are a lot of people who, for whatever reason, need somebody else’s voice to help them be heard.*

Campaigning can be an effective tool to promote health care. Health care comes in many different forms. One form is educating people on political choices. The HUCCHC hosted a forum that invited officials running for office to speak with the electorate. The HUCCHC invited them before the election, and then extended an invitation for the successor to return and be held accountable to the promises they made. This powerful orchestration of political education may have had meaningful results. One community partner suggested:

*I think it did influence who I voted for.*

**Educating Clients to Initiate Social Change**

When I refer to education I refer to *formal* (universities), and *informal* (grassroots) methods of transferring, or generating knowledge, which is a powerful tool for social change. With respect to the HUCCHC, when I refer to education I am referring to the informal education that takes place. It is about inquiring, researching, and investigating details about the socio-political world in which the community lives. It is about understanding the terms and conditions, and the rules of engagement, that people face on a daily basis, in order to establish how to make progressive change. This can happen in the subtlest ways, and it is more than information sharing; it is about the acquisition of power. When a person learns information that is valuable to a group, and shares it with the group, the group becomes more knowledgeable: and knowledge is power. When speaking of community organization, Lee (2011, pp. 100-101) states:

*The aim is to develop power to: acquire resources; change inadequate institutions and laws; or build new ones, more responsive to their needs and those of all human beings.*

Edging into many conversations were comments about how staff at the HUCCHC find their way out into the community to understand what is going on. Many times this involves attending a variety of committee meetings (municipal, social service, and HUCCHC) – sometimes after normal business hours. The dedication in understanding community matters was important to the staff. There was a commitment in doing research to get the facts, and to share this with others. This enabled staff to approach clients of the centre with pertinent information on matters that could directly or indirectly impact their lives. This affords clients (if they choose), the opportunity to organize, engage, and react, to matters (such as policy/law/legislative change) early in the process.

*Like one of the things that I do is, keep information about resources. How resources are; like housing and financial. Any changes on social assistance that are coming up, or difficulties. But, I think most of all, what we do is we try to be involved in committees. What’s going on in the city? What’s going on with the politicians, what is the platform of all of the politicians. What can we see in change, and then kind of educate people about it.*

Further into the conversation, the participant discussed the importance of rallies, and voting. He spoke of encouraging people to exercise their rights, and most importantly, not to be afraid to do so. An educated electorate can be a very power means for social change.

*Knowing exactly what’s going on. You hear things, but if you are not informed, then you are not able to provide anybody with anything that can be kind of a good prospective for what they should be doing.*

At times this also involved a collaborative effort. Sometimes this was about standing behind or with another organization. In answering a question about the role of the HUCCHC in relation to an issue that may be taken up, for example, by an anti-poverty group, one participant stated:

*We will take it on. We will participate. We bring the issue up. But, I don’t, I haven’t seen the Centre going forward to say yes, we are representing this; we are going to take it on. It’s more that we do research. We take on the information, and we share with people that can do more then what we can do.*

Forming, joining, and participating in coalitions was indicated as standard practice at the HUCCHC. Sharing knowledge is an important element in community organizing, and necessary in advocating for social change.

**Being At The Margins**

The HUCCHC demonstrates it is a catalyst for social change by the way it shows a commitment to improving health and wellbeing (for both clients and themselves), through action-based strategies committed to social justice. These strategies ‘lead by example’. However, the participants shared that the HUCCHC had now become vulnerable to being marginalized by other organizations – and treated accordingly.

*So, lots go along with the status quo, and people who don’t, groups who don’t, organizations who don’t, businesses who don’t, are marginalized and considered difficult, othered, challenging, renegade, you know, those sorts of things. And it’s always a fight from the margins in order to make and effect some change.*

When it comes to CHCs, and in relation to the status quo, it seems as though the HUCCHC is on the outside looking in.

*I’ve learned that if you’re working and supporting and involving and representing marginalized people, that you are marginalized as an organization. There is no difference between you and they. And the assumption is that because of that is, you need less.*

It also seems that ‘needing less’ and ‘receiving less’ had become one and the same.

Participants reasoned that by supporting, involving, and/or representing marginalized people, employees of the HUCCHC could find themselves at the margins of conversation.

*That when you commit to working with people that are marginalized, you as an agency, and you as a person working with the people, become marginalized around many of the mainstream tables.*

This statement reflects some of what it means to be marginalized, and to be isolated, excluded, and silenced. Furthermore, employees are deprived of time – the time to share their story. This is how one participant framed it:

*I think though, one of the challenges I think that we experience; if you are busy ‘doing’, you don’t really get opportunities for the ‘telling’.*

Communication, both written and oral, is essential in creating an understanding by the community of what the HUCCHC is trying to achieve.

The attempts by the HUCCHC to achieve healthy outcomes through a social action approach to health care are not received well by all. Lobbying or activism is seen to have boundaries, or rules of engagement, and is not considered (by all) to be something that constitutes ‘health care’. Current models of health care (i.e. the medical model, or the charitable model) maintain the status quo. Many people feel that it is imperative to stand by this system – that it is a successfully functioning model. Funding flows through these models – and it is made clear in policies from funding agents about the tolerance for lobbying and activism. Although one community partner has a strong relationship with the HUCCHC and has always stood by its side, the participant cautioned about being at ‘arms length’ when it comes to lobbying and activism, and would personally rather see their organization refrain from these activities.

* *For us, one thing we always are mindful of, is: read the fine print in your funding contract because governments are stipulating the lobbying the activism.*
* *I know in some of our funding contracts, it’s really out there in black and white, and the feds are really big about that. Thou shall not… and others to. So, I don’t think I would see us being the catalyst for that type of work.*

Without question there are risks with speaking out, or in this case, being associated with people speaking out.

*I’ve spoken to organizations that, again this is according to them, they feel that they’ve been black listed, because they’ve been vocal about certain things.*

But this opens a question: are the risks associated with ‘not’ speaking out are greater than risks of remaining silent? What if it costs people their lives? Maybe it is about the audience you are speaking to, or the ‘way’ you speak out.

*I think your audience becomes really important, and how you deliver your message becomes really important, and I think if you can marry the two with a good balance, I think it’s good.*

For executive directors of organizations involved (in some capacity), with health care, this advocacy chill must present difficult choices in creating a sustainable balance in health care.

*Sometimes what you’re trying to do is in the best interest of those that you are serving, but you can inadvertently also harm them if you end up losing funding.*

Losing funding can pose as a real and ominous threat for any organization. It also would not be hard to imagine that ‘restricting’ funding can be used as a pervasive measure to ‘adjust’ the activities or direction of an organization – without ‘rocking the boat’.

Challenging ideas around social action, one participant summarized it by saying that it depends on your social location:

*Social action is different for everyone. It depends on your location. So, some people are privileged to have social action, and they can go about it, and everybody accepts that as the right thing to do, and what a wonderful thing to do, and aren’t they lovely. But, there are others who are not as sanitized in their social action, or are not looked upon the same way, so it’s quite different.*

I think looking at social action or activism in only ‘one’ dimension limits an understanding of why it is more important for some versus others – or at least why it is different. The staff at the HUCCHC seem to think so.

**Needing Resources**

Employees were not shy to announce their most desperate plea: what the HUCCHC requires most is more resources. This is not an uncommon request from anyone involved in social services; and a claim made by every person I spoke with employed by the HUCCHC. What we need is, “*more funding*”. It was indicated that funding was required in two main areas: building capital, and human services. Building capital was described as more space – for employees, and for clients – by renovating the existing building, or by operating from a new facility. Space was required for employees to perform their job, and give space for community organizing programs such as workgroups. More human resources were required to ease the pressure off employees that are already stretched thin on time. Participants had great concern that they were not able to offer the comprehensive range of programs and services necessary to provide complete health care services for their clients. Participants asserted that clients felt the same way about needing more space:

* *Our biggest problem is we need a bigger place.*
* *Number one was always: we need to meet, we need a space to meet.*

Both a larger space, and more human resources, were asserted as necessary to provide relief to employees of the HUCCHC, and to properly serve their clients’ needs. These resources should represent an equitable share of the funds available. Ensuring that the HUCCHC had a necessary share of the resources available would demonstrate, to the participants, that funders have dignity and respect for the staff and clients of this centre. However, when comparing against other CHCs, most participants felt jilted.

*What is the difference between us? We provide the same services. Their location is beautiful, and new, and we are still dealing with issues like today; where we cook in our offices, or we freeze! There is no control of the temperature. That makes it really hard sometimes, to see how resources can be so unbalanced in the same level of services, because we provide the same level of services.*

Employees that came from other organizations remarked that other organizations fared much better with the more generous resources they were given.

*And that was a great experience also, because the other agencies that I worked for; everything was provided. They had a great budget.*

It is not that people were dissatisfied with the HUCCHC, but how obvious it was that others had more to work with. Participants indicated that being committed to working for the HUCCHC was an acceptance of sacrifice when it came to funding/budgets – but it was a sacrifice they were willing to make.

The texture in the voices of participants suggested an injustice was at play in the system. It was expressed that they struggled to understand the reasoning behind why this injustice exists. To understand or rationalize ‘why’ other people, outside of the centre, did not see things the way they staff at the HUCCHC experienced them on a day-to-day basis.

* *I’ve also learned that the agenda of policy makers and decision makers etc., is never anywhere in the same field as the people who are experiencing the injustice or the inequity*.

The separation between the policy and decision makers, and the front lines of health care, left many staff members baffled by their incomprehensive understanding of what was going on at the HUCCHC.

One participant outside of the HUCCHC empathized with their funding concerns, but viewed their funding issues in a different way. It was more of a focus on the overall allocation of resources at the HUCCHC. They indicated that the HUCCHC had too much duplication with other programs available throughout Hamilton, therefore funding was misallocated. It was suggested that some resources should be allocated differently, and a better utilization of existing services and programs could be adopted; and other organizations were there to help. This was not to suggest that the HUCCHC has abundant resources, but suggestions on better management of the funds they do have.

*Use your resources wisely. We all have to that, and there seems to be a lot of duplication.*

There were also connections made about the Hamilton community, in the form of partnerships – relationship building.

*But, I think, the bigger issue is the lack of partnership. You know, how do you reduce your duplication without talking, you have to talk…Ok, if I give up this, can you pick it up? Because it’s not just me, there’s other players in the city.*

In summary, resources continue to be a struggle for the HUCCHC. People who work there feel jilted out of something they feel they deserve – something that is obviously required. Staff felt as though they had become marginalized in an unjust system. Others, outside the HUCCHC, felt as though a better allocation of resources would help them tremendously.

**Understanding Relationships and Connections**

The role that relationships play in social change was summarized in a memorable and heartfelt story told by one of the participants. The story started with describing how a senior manager from the City of Hamilton came over to talk about how the HUCCHC was attempting to get the City to move on some issue. And the first thing the manager said was:

*So who are your people? And I was like: I got people? What do you mean who are my people? I had no idea what she meant when she said who are your people.*

The confusion was that the participant thought the City manager might be talking about the client population. In fact, it was something quite different:

*But she was saying, who am I connected to? Who do I have that is influential enough that would make it worth her while to be speaking with me, and to listen to what I have to say.*

The recognition of this power differential spoke volumes. It now provided a conceptual understanding of where the boundaries are.

*One of the things that it taught me is that it’s still the same game. That no matter what else, that for sure, who gives you blessing, and who you are connected to, will determine how much change you are able to make, in that sort of realm. And I am not a connected person. So that means you have a harder fight.*

Contrary to this perspective, one of the community partners of the HUCCHC believed that knowing people, making connections, or finding the ‘right’ audience was not an anomaly. In fact, it was considered a necessity. It was suggested that the resource problems that the HUCCHC was experiencing came down to developing the right relationships; in a respectful manner.

*I think a lot of it comes down to relationships…I think the important thing is, even if you’re doing advocacy work, or any type of work, the most important piece becomes the relationship.*

Furthermore, speaking to the ‘right’ audience was imperative to access resources.

*I think that, in my opinion, that, perhaps maybe the audience isn’t always the right audience. So that becomes an issue. So, if again, [regarding] social justice, you need to have the ear of the right people to make a difference.*

**Realizing Health At The HUCCHC**

There was no shortage of pride when describing the character, actions, abilities, values, beliefs, or framework of the HUCCHC, when describing what it takes for clients to realize good health.

* *One of the things we are saying is that health care should be accessible to everybody. Like, a strong here thing here is to remove barriers that people have.*
* *We’re definitely trying to change the quality of living of the clients.*
* *I guess about equality, so, the model for community health centres is: everyone matters. And I really think the Urban Core, and the staff here, tries to; every person, even if they are part of a larger group, it’s, they’re trying to help every single person.*

Personal commitments by the staff regarding equality, accessibility, removing barriers, making change, everyone matters, and improving a person’s overall health and wellbeing, are concepts that mirror the HUCCHCs mission, vision, values, and beliefs. Moving towards this model of health care requires cooperation and collaboration amongst staff. They all had praise for each other.

* *I would say the majority of staff members respect each other.*
* *So there is a lot of collaboration, I guess this is the word I would use.*
* *The staff is diverse, and I’ve found that, and I’ve been here a long time, the staff members are respectful to each other.*

I feel that I am not naïve enough to believe that the environment at the HUCCHC is all roses and butterflies. However, there has to be a successful learning in favour of cooperative and collaborative relationships, in order to improve the health of their clients.

From the outside there are similar perceptions to those of internal staff. These perceptions capture an essence that the HUCCHC wants to change *something*. Most predominantly, outside participants recognize a movement toward human dignity. These participants realize that, how others perceive the HUCCHC, is demonstrated in the way they treat people. While some participants recognized that others had limitations on what is considered ‘treating’ people with dignity, others did not.

* *I do think they have a defined agenda. They’ve got things they want to change.*
* *But generally, it* [what the HUCCHC emotes] *really seems to be a universal sense of human dignity. But it really seems to be a core value of the organization, as a whole. I see their staff interact with people that are hard to interact with.*

A community partner was in awe about how the HUCCHC handled, or did not handle, the setting up of tents on the HUCCHCs property. The participant suggested that - much to some of local community members’ dismay - the HUCCHC did not respond to a homeless population setting up tents/shelter on their property by evicting them. Instead, they were treated quite differently.

*I keep coming back to those tents, they speak so loudly! There just seems to be this driving sense that every person deserves to be treated with dignity and respect. And they get that there.*

During the interview process, participants recalled various stories about how many employees of the HUCCHC engaged, consulted, and listened to this homeless population, and how they were concerned about their health, or what they could do to help them.

**Being Courageous by Creating a Standard Of Service**

In order for the HUCCHC to take on issues of social justice and equity, to provide conditions of dignity and respect that foster an environment conducive for social change, and for them to survive; the HUCCHC must be as courageous as their clients.

*We recently launched the Community Truth Hearings on poverty and equity, and we are being recognized for taking the initiative to do it. I think it takes a tremendous amount of courage, as an organization, to be part of a social movement like this.*

The most profound report about courage came from a participant not employed by the HUCCHC. Their unique insight opened my eyes to some of the core features the Urban Core demonstrates it has as catalyst for social change. In referring to the fluctuating homeless population that used the premises of the HUCCHC to camp out, he described this as a counter-cultural statement in providing dignity and respect to this homeless population.

*I think that when they do that, and they’re counter-cultural like that, it provides a dignity; but also it’s a strong social statement. You go there and you think, these people are living on their property, and you GET, right away, even before you walk in the door, that this is a place they are welcome. Period, end of sentence. And if you not comfortable with it - tough. It is such a statement on their behalf. I’m always in awe that they do it.*

This participant asserted that it is an incredibly important thing they do. He said that homelessness is as much about a loss of dignity as anything else; and that being unwelcome, or chased off of property, including public property, subjects this population to unnecessary stress that negatively impacts individuals immediately, and in the long term. His story described a citywide movement to displace the homeless, and the implications around their worth and their value. He spoke to the fact that the HUCCHC is one place where they are treated as people. It was recognized by the community that staff from the Urban Core regularly engaged with their guests. From my perspective, I also see this as a strong statement of trust, and to some degree, safety.

*I think it’s kind of counter-cultural and counter-intuitive, and yet 100% in line with who they seem to be.*

Listening to participants, I felt that ‘going against the grain’ required a tremendous amount of courage; and it keeps others who oppose those actions off-balance. Outsiders were unsure of a new perspective that puts values and beliefs on human dignity above all else.

 Further into the conversation he described how the HUCCHC was on the cutting-edge of many things. For him, this not only included engaging the homeless population, but the efforts to communicate with clients in multiple languages, and their prompt response to provide relief in extreme temperatures (as compared to the City of Hamilton). He did not see other agencies performing in the same way.

Overall, the admiration was clear. The operation of the HUCCHC was in line with his values and beliefs, and he was respectful of how a human service organization should function.

*Coming into the field new, watching them, that’s a constant reminder on how to run my organization; and what I need to do…It calls us to a standard of service.*

## SUMMARY

The *Findings* chapter presented a narrative that was broken into two parts. The first part discussed what I had discovered and observed about the physical structure of the HUCCHC, and the people that worked within it. Furthermore, I explored what participants said about equity and building rapport with a marginalized population – and how this framed health care at that facility. The second part was about what they are ‘doing’ about it – the action piece of the narrative. This section builds on what was discovered in the first part by considering the social action approach to health care that the HUCCHC uses; and how this had become possible because of the foundation described in Part I of this chapter.

# CHAPTER V – DISCUSSION

The HUCCHC was born into a neglected structure that in its early days as a bus terminal, served at least three purposes: send people to a new destination (work, vacation, or reunite family - both locally and regionally); accept, greet, or connect people arriving from various destinations; or provide a common and recognizable meeting place for people located in the urban core. All of this formed a social identity unique to its location in the Hamilton area. The building has evolved since then, and it is no longer a bus terminal. However, its current identity as the HUCCHC remains in line with the buildings original purposes - to provide a place for people to connect - while adding many of its own purposes.

## UNPACKING PRIMARY HEALTH CARE AT THE HUCCHC

What emerged from the *Findings* was the concept of how ‘primary health care’ is constituted at the HUCCHC. The HUCCHC demonstrates that it moves beyond the traditional health care system - which is based on delivering services designed to diagnose and treat individual illness - to augment a *level of care* based on prevention, health promotion, and “a social analysis with social change as the cure” (Shragge, 2013, p. 37). Furthermore, it was discovered that when ‘health care’ is framed by the SDH, ‘prevention’ must be included as part of the equation to improve health in the individual, and the community at large. Preventing illness, on a structural scale, moves beyond treating illness, and employs ‘Upstream’ thinking. This way of thinking makes connections between policy and public health. Changes to policies that improve health are not usually *given* away – they are claimed through various forms of social action. Therefore, it is through social action that social change can occur. In relation to the particular *level of care* that has been adopted by the HUCCHC; social action for social change represents one way of how improved health and wellbeing is achieved.

In review, my research questions are: How does the HUCCHC demonstrate that a community health centre can be a catalyst for social change? Moreover, what sorts of conditions and/or circumstances are necessary to foster an environment for the HUCCHC to act as a center for community organizing for social change?

Based on what emerged from the *Findings* (how primary health care is constituted at the HUCCHC), and to help answer my research questions, I must consider what primary health care looks like to the HUCCHC. When participants were answering my interview questions, it struck me that they may in fact be describing what primary health care looks like to them. The participants descriptions included some elements such as: the character of the HUCCHC, the pursuit of social justice, the collective actions that occurred, the clients participation in deciding their health care, bringing people together (community organizing), and educating clients on prevailing health problems; all built on the client centred framework of the HUCCHC. Employees asserted their commitment to: dignity, respect, equity, accessibility, inclusion, removing barriers, and making structural change, when discussing improvements to a person’s overall health and wellbeing; and the courage it takes to do so. Notably, these concepts also mirror many elements of the HUCCHCs mission, vision, values, and beliefs. They are also consistent with the social determinants of health (SDH). In summary, it is reasonable to assume that health care will look different when it is framed by the SDH, and organized under a primary health care model.

How the HUCCHC is perceived in providing health care is part of their social identity. Understanding this identity is my pathway for discovering how the HUCCHC embodies a primary health care model – which, in-turn, answers my research questions. Thus, the *Findings* indicate that HUCCHC could epitomize: a social movement that fosters an environment for community organizing for social change; the mark of a courageous struggle that provides a social action approach to health care; or another way to frame social injustice through the lens of health. The *Findings* ultimately suggest that it was a combination of all of the above.

**The conditions and circumstances: A social movement that fosters an environment for community organizing for social change.**

Participants provided several ideas about what features the HUCCHC employs that fosters an environment conducive for community organizing for social change. Themes of equitable relationships, bringing people together, and a client-centred model of health care, represent a standard of service that fosters community organizing. Participants were passionate about establishing equitable relationships that showed dignity and respect for their clients. They taught me that bringing people together to experience fun and pleasure *was* a social action. Moreover, this social connectedness was paramount in creating a healthier community, and providing the opportunity for social change in their clients’ lives. They also described a client-centred model of health care that moved the HUCCHC towards goals and objectives formed by participation of the people that it impacts. This model realizes the clients’ investment in their future. This outlined the start of what conditions foster an environment conducive for social change.

Furthermore, concepts based in social capital theory proved to be effective in describing the conditions (features) necessary to foster social change as well. Many participants outlined the importance of social networks. There were a wide range of social networks described, but none were described with more emphasis than the networks that were developed at soccer, the HUCCHC Barbeques, or the Street Fairs. These social networks reflected the idea of bounded solidarity (Macinko & Starfield, 2001): of generally unrelated people banding together to improve their lot. Reciprocity amongst community members was also identified as a condition to foster community organizing. People sharing sometimes nothing more than their story, builds trust and safety. Based on what I discovered in the Findings, I would suggest that the strongest condition described by participants was trust. Trust in the HUCCHC was essential in creating the conditions necessary to foster and environment for community organizing.

Community organizing theory also played an important role to help me identify circumstances that help to foster community organizing for social change – particularly the notion of role. Being an initiator, the HUCCHC stimulated an awareness of the problems, and encouraged the belief in the possibility of change. Being an encourager they provided support for the people who attended community meetings. An example of this would be the Community Truth Hearings. The HUCCHC provided not only the space to conduct these hearings, but the opportunity and support for people to recognize that they have a voice, and to understand that what they have to say is important. Being a popular educator was demonstrated on several occasions such as: trips to Queen’s Park, and during local election periods by having the candidates present their platform to the urban core community. This moved beyond what politicians say, towards creating an understanding of where the problems lie, and what people can do to confront the oppressive systems and processes that affect peoples lives – and therefore health.

**Demonstrating a courageous struggle to provide a social action approach to health care.**

Despite the precarious environment, the HUCCHC has formed an identity based on a social action approach to health care. The HUCCHC demonstrates leadership, commitment, collective action, client-centered services, community engagement, and courage. All of these elements have the intended purpose to improve the health and wellbeing of people located within the urban core of Hamilton. The HUCCHC respects Tommy Douglas’s ‘second stage’ of Medicare (Rachlis, 2005), which focuses on preventing illness. They do this in a manner that emphasizes citizen involvement in the spirit of democracy. “[An] active citizenship is crucial to the health of any society” (Lee, 2011, p. 88). It is a social action approach to health care that moves beyond the local community to challenge the legitimacy of power relations (Shragge, 2013).

 I understand that not every organization wants to be a catalyst for change, or thinks they cannot perform this work directly. However, if it is not organizations like the HUCCHC who should be lobbying for changes to improve community health; then who should? Who will take responsibility for helping people organize for improvements to overall health and wellbeing? Who will help those with the smallest of resources gain control of their lives?

Feeling isolated as an organization, and excluded from conversations at the tables of change, one participant expressed their frustration of being marginalized as a CHC. Weary from the constant battles faced by CHCs, this participant needed to know they were not alone. They needed to know that what employees of the HUCCHC experience on a day to day basis has helped to shape their approach to health care; and this approach sees them standing by their clients’ side. Regarding the search for likeminded CHCs that support a social action approach to health care, the participant stated: “*where you at?”*

Participants’ testimonies claim that the HUCCHC demonstrates they have the courage to create a standard of service that looks *Upstream* into causes of people’s health and wellbeing. So, are tackling social justice and equality issues improving health? For most of the participants the answer is: yes. Issuing a powerful counter-cultural statement that offers dignity and respect to a homeless population in poor health is a perfect example of how the HUCCHC acts as a catalyst for social change. Making everyone matter balances-out the playing field in primary health care. Opting not to ascribe with the status quo is a statement of courage; one that moves toward improving the SDH. This innovative perspective on primary health care requires upstream thinking, it must be cutting edge, and must put human dignity above all else.

**Framing a Health Social Movement: Another way to frame social injustice through the lens of health.**

Another perspective is that some participants of the HUCCHC may be framing their organization as a health social movement. I want to guide the conversation back to, and expand on, what has already been discovered about health social movements. In the chapter “*Health Social Movements: The Next Wave in Contentious Politics*?”, Orsini (2014) provides some insight into answering some ‘why’ questions that emerged from the interviews. Orsini asks, “whether health is emerging as a ‘master frame’ around which an array of movements is organizing OR [emphasis added] whether health might constitute yet another way to frame underlying questions of injustice” (Orsini, 2014, p. 333). Moreover, Orsini contends that these movements throw up many challenges not normally addressed by traditional movements; one of them is:

*They reflect, albeit in news ways, some of the traditional political cleavages that have animated the social movement landscape for decades, namely, gender and racial oppression and class inequalities. To varying degrees, these movements work to reconstruct or reimagine already existing grievances with respect to, for instance, racial oppression or gender oppression through the lens of health* (Orsini, 2014, pp. 333-334)*.*

Understanding the HUCCHC through this lens opens up a new possibility on how the HUCCHC may represent a health social movement, and/or the circumstances that foster an environment conducive for community organizing for social change.

Previously I have argued that if social change is required to improve health and wellbeing, then the HUCCHC is a catalyst for this change. In order to understand how the HUCCHC demonstrates they are a catalyst for social change, is important to establish its frame of reference - by the way it was constituted by participants as being: ‘at the margins’.

So what does this mean - being at the margins? My findings suggest that the face of being marginalized shows the weathered lines of a lifetime of struggle. It holds experience, wisdom, and a truth, in a social reality grounded in a different point of view. Themes of equitable relationships, bringing people together, campaigning for social justice, a client-centred health model, political education, and defining what primary health care looks like, have brought the HUCCHC close to the population they serve – maybe to the point of taking on this marginalized identity.

The importance of identity could help in interpreting how the HUCCHC could be framed as a health social movement. Adopting an identity that characterizes being marginalized helps to appreciate the social actions that the HUCCHC takes to promote health and wellbeing for both themselves, and their clients. It demonstrates how the HUCCHC is a catalyst for social change by challenging the constraints that hinder their progress (the required funding necessary to improve a facility in poor health) – in a similar way that their clients challenge constraints. Many times throughout the interview process participants commented on how the oppressive nature of the clients’ environment detrimentally affected their health. Given that there may be a parallel between the HUCCHC and their clients – with respect to being marginalized – there becomes a logical assumption that they are both fighting a similar battle on different terrains. In relation to the HUCCHC and their clients being similar, both find themselves at considerable risk being at the margins. For the HUCCHC, as with their clients, being marginalized was part of their lived experience.

## SUMMARY

So what does this all mean? How does the HUCCHC demonstrate that it can be a catalyst for social change? Moreover, what sorts of conditions and/or circumstances are necessary to foster an environment for the HUCCHC to act as a center for community organizing for social change? Additionally, and given that the HUCCHC adheres to primary health care services, what does this tell us about what primary health care looks like when it is framed by the SDH? And why is it important to understand this in order to answer my research questions?

The *features* (values, attributes, or qualities necessary to foster an environment conducive for community organizing) that emerged were reflective of what was found in the literature reviewed. What was remarkable was the conviction with which participants spoke as they described these features. Their stories were honest and sincere, and were notably enticing. They added a depth and breadth into my discussion that was appreciated. This service organization communicated that they embody the values and orientation of primary health care.

Being marginalized was visually found in the structure where the HUCCHC resides, in the seamless narrative of the staff that spoke with me, and in their description of the relationships of the charitable hands that feed them. They demonstrate that they are a catalyst for social change setting a standard for service that starts with giving all their clients the dignity and respect they deserve. They challenge the status quo on what optimum health should look like, and speak out when they know things are unjust. They do this because they have an identity, and the courage to pursue what is just, even when confronted with the many faces of resistance.

The HUCCHC embodies the principles behind what the World Health Organization described as primary health care, which has been one of the foundational aspects behind the development of CHCs. Additionally, it marks a courageous battle for health care from the margins. Furthermore, it is designed and constituted as a social movement that provides a social action approach to health care. Conceivably, it is an old soul that struggles to find its way amid the modernity of a medical model of health care. Or finally, maybe the HUCCHC has found another way to frame social justice through the lens of health.

# CHAPTER VI – CONCLUSION

## OVERVIEW

Throughout this thesis I attempted to describe how the HUCCHC demonstrates it is a catalyst for social change; moreover, what sort of conditions or circumstances were necessary to foster an environment conducive for social organizing for social change. I first provided the framework from which I was going to tell this story. I provided the lens of ‘upstream’ thinking that inspired me to write this thesis. I discussed what a CHCs role is in primary health care, and the details about the HUCCHC that fulfilled these principles.

My literature review provided some conceptual ideas about the SDH, and social movements. It was important to create the link between the SDH and ‘upstream’ thinking because it appeared as though this is how the HUCCHC framed their approach to primary health care. Looking at social movements was central to my understanding of the HUCCHC. I uncovered that, in many ways, the HUCCHC represented the characteristics of a social movement. The literature review also provided two theoretical reviews on social capital and community organizing theory. It was important to gain comprehensive knowledge of what other authors claim to be important in providing the conditions and/or circumstances necessary to foster an environment favorable for social change. With these theoretical reviews, I was able to establish a reference point for the analyzing the data.

Using an interpretive approach enabled me to tell the story of the HUCCHC from the participant’s perspective. It described a ‘truth’ from their perspective. I tried to be honest and transparent about the results that I found. The Findings described how participants saw social action at the HUCCHC being interpreted, experienced, produced and/or constituted. I have learned and then shared, what is meaningful or relevant to participants in this study.

Perhaps the most important contribution of this research is to provide an opportunity for stories to be told. One participant framed it in this way: “*one of the challenges I think that we experience, if you are busy doing, you don’t really get opportunities for the telling*”. Telling versus doing. The HUCCHC has been starved of the time it takes to tell their story. Perhaps my role was to become a storyteller – to create and share part of the legacy of the HUCCHC by identifying how they constitute primary health care.

All of above was undertaken to answer my research questions (how does the HUCCHC demonstrate it is a catalyst for social change, and what sorts of conditions or circumstances foster an environment conducive for community organizing). All conclusions drawn from the data represented my interpretations of how participants answered my research questions. My research questions were posed for the purpose of studying the role and functionality of the HUCCHC, within the context of social action, to understand how this institution is being used as a pathway for social change. Additionally, I explored how the HUCCHC addresses the SDH. The objective was to provide a report that may contribute in helping them achieve their goals for improving the SDH.

## LIMITATIONS

The limitations of this research study are inherent by its different design aspects. First, it is a case study, and cannot be considered as representative of any other CHC. Furthermore, the HUCCHC is located in the urban core of a large city, which serves particular populations. Again, this is not representative of other CHCs that are located in more rural areas who serve different populations.

Another limitation involves sampling. The majority of the participants represented employees of the HUCCHC. It is reasonable to assume that they may refrain from discrediting the HUCCHC in any way, and therefore may withhold their comments on certain aspects or events that have/are taking place. During the writing of the Findings I struggled with whether to include the two perspectives from outside of the HUCCHC. On one hand, they provide an alternative perspective to what is going on at the HUCCHC; on the other hand, I wanted to make sure I honored the collective voices of the people I interviewed, to capture what it was they saw. This also brought up the limitations that I did not include participants who are clients of the centre. They would have added another perspective to the Findings.

A further limitation is that, by the research design, it is my interpretation of the participants’ points of view. I attempted to let the findings speak for themselves. I amalgamated the collective voices that described how they constituted primary health care with an attempt to give the reader a feel of another’s social reality. However, I do bring in my own stance as a social activist; and this stance, as well as my epistemology and ontology are embedded throughout this thesis.

Additional limitations could arise if there are attempts to draw causal explanations from these findings. It was not my intention to prove any hypothesis, or test, or measure any criteria against another’s theories or explanations. The sole purpose of this study was to discern themes that emerged from my experiences, and report them in a way that honored the lenses of the participants.

## IMPLICATIONS FOR SOCIAL WORK

***How should social work be done differently in a CHC setting?***

Let me begin with social workers who seek to be employed at a CHC. Before a social worker considers employment at a CHC, a few things should be contemplated. First, one should understand the organization. This necessitates the examining the mission, values, beliefs, or vision. I feel that it would be imperative for a social workers philosophy to be in line with the overall philosophy of the CHC and the executive director. For example: a CHCs philosophy should be framed around the SDH. A social worker should have a comprehensive understanding of what this means.

Keeping in line with the Introduction of this thesis, and respecting the School of Social Work at McMaster University, social work, and social workers, have a unique role to play in helping to create strong communities (McMaster University, n.d.). Strong communities are developed when everyone is involved, and nobody is left behind; which matches the philosophy behind the Ontario’s Community Health Centres’ slogan that ‘Every One Matters’. Community development is essential in promoting good health and wellbeing; community organization makes this a success. Therefore, I feel it would be essential for a social worker to have a comprehensive understanding of community organizing, social movements, and the SDH, to understand what primary health care looks like.

Social workers need to make connections between policy and public health. They must provide the opportunity to organize in a safe place. The goal is to provide a setting that empowers people, and therefore influences people’s ability to control their environment – and to gain confidence in doing so. Social workers should appreciate that community organizing skills would benefit the clients of a CHC. Furthermore, understanding social movement theory helps to find ways to challenge elements of the social structure that can influence policy, and therefore health. Embracing ‘Upstream’ thinking moves health issues into the policy realm. Social workers should recognize that the SDH are also the ‘structural’ determinants of health, and these can be challenged.

Finally, social workers are increasingly working in ‘professional’ health care institutions. In many cases these environments perpetuate power imbalances, and they are resistant to change or conflict. Social workers should realize that the environment at a CHC might be quite different that other health care institutions. As previously stated, the ‘medical model’ is clearly not designed to meet the needs of health promotion through advocacy and activism, and fails to address the social determinants of health. However, social workers employed in these mainstream setting can help to establish supportive working relations with CHCs. Forming helpful and respectful partnerships in the community fosters an environment where people can learn from, and support one another. Community partnerships can be mutually beneficial when they are geared toward improving community health and wellbeing.

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# APPENDIX A-1

**EMAIL RECRUITMENT SCRIPT – KEY INFORMANT**

Phil Hobbs, BSW

Masters Candidate in Social Work

A Study of the Hamilton Urban Core Community Health Centre and its Role in Social Change

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

E-mail Subject line:McMaster University Research Study – The Urban Core

I am inviting you to participate in a research interview that will take 30 – 60 minutes to complete at a location of your choosing. As part of graduate program in Social Work at McMaster University, I am carrying out a study that explores the role and functionality of the Hamilton Urban Core Community Health Centre (The Urban Core), with respect to advocacy and activism, to understand how this institution is being used as a pathway for social change. I’m interested in discovering what conditions or circumstances are necessary in order to have The Urban Core act as a centre for social change.

Your opinions, views, and perspectives as a staff person are valued for this research project, whether you have directly engaged in any advocacy/activism work or not. Your involvement is voluntary, and there is no obligation to participate. If you choose to participate, please do not hit reply to this email, but please reply to the email address indicated below in order to respect your privacy.

The risks in this study are minimal. However, since this is a case study, and all key informants will come from The Urban Core, there are social risks. You may worry about how others will react to what you say, and since your group (community) is small, others may be able to identify you on the basis of references you make. Prior to the start of the interview I will discuss with you the steps we will be taking to minimize this risk.

You can stop being in this study any time during the interview, and afterwards up to June 1, 2015. I have attached a copy of a letter of information about the study that gives you full details. This study has been reviewed and cleared by the McMaster Research Ethics Board. If you any have concerns or questions about your rights as a participant or about the way the study is being conducted you can contact:

The McMaster Research Ethics Board Secretariat

Telephone: (905) 525-9140 ext. 23142

c/o Research Office for Administration, Development and Support (ROADS)

E-mail: ethicsoffice@mcmaster.ca

**PLEASE REPLY DIRECTLY TO PHIL HOBBS** **hobbspp@mcmaster.ca** **IF YOU ARE INTERESTED IN PARTICIPATING IN THIS STUDY.**

We would like to thank you in advance for your time and consideration. After a week, we will send you a one-time follow-up reminder.

Phil Hobbs BSW,

Masters Candidate in Social Work

Department of Social Work

McMaster University, Hamilton Ontario

hobbspp@mcmaster.ca

# APPENDIX A-2

**EMAIL RECRUITMENT SCRIPT – PROGRAM PARTICIPANT**

Phil Hobbs, BSW

Masters Candidate in Social Work

A Study of the Hamilton Urban Core Community Health Centre and its Role in Social Change

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E-mail Subject line:McMaster University Research Study – The Urban Core

I am inviting you to participate in a research interview that will take 30 – 60 minutes to complete at a location of your choosing. As part of graduate program in Social Work at McMaster University, I am carrying out a study that explores the role and functionality of the Hamilton Urban Core Community Health Centre (The Urban Core), with respect to advocacy and activism, to understand how this institution is being used as a pathway for social change. I’m interested in discovering what conditions or circumstances are necessary in order to have The Urban Core act as a centre for social change.

The Urban Core provided me with a list of many people that may be interested in participating in this study. It was indicated that you are a person that has had some experience in working with the Urban Core in the capacity of community organizing for social change. Your opinions, views, and perspectives are valued for this research project. However, your involvement is voluntary, and you have no obligation to participate. If you choose to participate, and to respect your privacy, I will not be disclosing who has replied to this email to anyone at anytime. Furthermore, if you choose not to participate, this will not affect your relationship/services with The Urban Core in any way.

The risks in this study are minimal. However, there are psychological and social risks. Although this study is not intended to explore the nature of any social problem that was being addressed by your organization or group, you may inadvertently touch on a few points during the interview that may make you feel uncomfortable. Also, you may worry about how others will react to what you say, and since your group (community) is small, others may be able to identify you on the basis of references you make. Prior to the start of the interview I will discuss with you the steps we will be taking to minimize this risk.

You can stop being in this study any time during the interview, and afterwards up to June 1, 2015. I have attached a copy of a letter of information about the study that gives you full details. This study has been reviewed and cleared by the McMaster Research Ethics Board. If you any have concerns or questions about your rights as a participant or about the way the study is being conducted you can contact:

The McMaster Research Ethics Board Secretariat

Telephone: (905) 525-9140 ext. 23142

c/o Research Office for Administration, Development and Support (ROADS)

E-mail: ethicsoffice@mcmaster.ca

**PLEASE REPLY TO ME (below) DIRECTLY IF YOU ARE INTERESTED IN PARTICIPATING IN THIS STUDY.**

We would like to thank you in advance for your time and consideration. After a week, we will send you a one-time follow-up reminder.

Phil Hobbs BSW,

Masters Candidate in Social Work

Department of Social Work

McMaster University, Hamilton Ontario

hobbspp@mcmaster.ca

# APPENDIX B-1

**LETTER OF INFORMATION / CONSENT**

**Key Informant**

**A Study about:**

**The Hamilton Urban Core Community Health Centre and its Role in Social Change**

**Principal Investigator: Student Investigator:**

Dr. Stephanie Baker Collins Phil Hobbs

School of Social Work School of Social Work

McMaster University McMaster University

Hamilton, Ontario, Canada Hamilton, Ontario, Canada

(905) 525-9140 ext. 23779E-mail: hobbspp@mcmaster.ca

E-mail: sbcollins@mcmaster.ca

**Purpose of the Study:**

You are invited to take part in a study on the Hamilton Urban Core Community Health Centre’s (HUCCHC) role in providing public space as an avenue for community organized groups to organize for social change. I am doing this research for my thesis.

The purpose of this research project is to explore the role and functionality of the HUCCHC, with respect to advocacy and activism, to understand how this institution is being used as a pathway for social change. I’m interested in discovering what conditions or circumstances are necessary in order to have the HUCCHC act as a centre for social change.

**Procedures involved in the Research:**

My aim will be to undertake several different methods of collecting information. One method is key informant interviews. The interview is expected to last approximately 30 to 60 minutes. With your permission, this interview will be audio-recorded. I will have a notebook during the time of the interview that will primarily be used as a reference to help recall and guide my questions. Measures will be taken to respect your privacy, and to secure the information collected – see Confidentiality below. This interview can take place wherever you will be most comfortable, but should be in a place that is, or should be, free from distraction.

I will be asking you questions about (but is not limited to):

* Your work at The Urban Core.
* Your personal opinions and views on activism and advocacy work.
* Do you feel that you participate in, or have any experience with, any advocacy/activism activities at The Urban Core? – Tell me about them.
* Describe the nature of what is happening – the conditions or circumstances - at The Urban Core that fosters **staff members** to organize for social change. To what extent does this take place?
* Describe the nature of what is happening – the conditions or circumstances - at The Urban Core that fosters **community groups** to organize for social change. To what extent does this take place?
* How and why are groups formed? Who forms groups? What elements do you feel make some groups more successful or meaningful than others?
* How can success stories be replicated in the future?

**Are there any risks to doing this study?**

It is not likely that there will be any harms or discomforts from/associated with conducting this interview. However, since this is a case study, and all key informants will come from HUCCHC, there are social risks.

Social Risk: You may worry about how others will react to what you say, and since your group (community) is small, others may be able to identify you on the basis of references you make. I describe below (Confidentiality) the steps I am taking to protect your privacy.

To minimize risk, you do not need to answer questions that you do not want to answer, or that make you feel uncomfortable.

**Are there any benefits to doing this study?**

The research will not benefit you directly – but you can contribute your voice towards meaningful social change. I hope that what is learned as a result of this study will help to better understand what role a CHC can play in the formation of social action groups. I also hope to identify the pathways that make this feasible. In this case, my research is exploratory and is not intended to have a direct impact on the local community, or society in general, but it can contribute towards the knowledge of how community groups can impact the social determinants of health.

**Confidentiality**

In order for your identity to remain as anonymous as possible, I will not be asking any personal information (name, age, job title etc.).Every effort will be made to protect your confidentiality and privacy. I will not use your name or any information that would allow you to be identified.

However, we are often identifiable through the stories we tell (Social Risk). Please keep this in mind in deciding what to tell me. Your participation in the study will remain private and confidential between us. Please keep in mind that the results of the study (in whole or in part) will be made available to the HUCCHC upon their request. The time, date and location of the interview will remain confidential. A pseudonym will be used to reference you anywhere in my written report.

The Information I collect will be stored on a ‘memory stick’ that will be protected by a password. Once the study has been completed, the data will be destroyed. This will take place by the August 31, 2015.

**Participation and Withdrawal:**

Your participation in this study is voluntary. It is your choice to be part of the study or not. If you decide to be part of the study, you can stop (withdraw), from the interview for whatever reason, even after signing the consent form, or part way through the study, or up until June 1, 2015. If you decide to withdraw, there will be no consequences to you. In cases of withdrawal, any data you have provided will be destroyed unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study.

**Information about the Study Results:**

I expect to have this study completed by no later than *September 30, 2015.* After completion, if you would like a summary of the results, please let me know how you would like me to send it to you

**Questions about the Study:**

If you have questions or need more information about the study itself, please contact me at:

*Phil Hobbs*

*hobbspp@mcmaster.ca*

This study has been reviewed by the McMaster University Research Ethics Board and received ethics clearance. If you have concerns or questions about your rights as a participant or about the way the study is conducted, please contact:

 McMaster Research Ethics Secretariat

 Telephone: (905) 525-9140 ext. 23142

C/o Research Office for Administrative Development and Support

 E-mail: ethicsoffice@mcmaster.ca

**CONSENT**

* I have read the information presented in the information letter about a study being conducted by Phil Hobbs of McMaster University.
* I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.
* I understand that if I agree to participate in this study, I may withdraw from the study at any time or up until approximately ***June 1, 2015.***
* I have been given a copy of this form.
* I agree to participate in the study.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Participant (Printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I agree that the interview can be audio recorded.

… Yes.

… No.

2. …Yes, I would like to receive a summary of the study’s results.

Please send them to me at this email address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Or to this mailing address:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

… No, I do not want to receive a summary of the study’s results.

# APPENDIX B-2

**LETTER OF INFORMATION / CONSENT**

**Program Participant**

**A Study about:**

**The Hamilton Urban Core Community Health Centre and its Role in Social Change**

**Principal Investigator: Student Investigator:**

Dr. Stephanie Baker Collins Phil Hobbs

School of Social Work School of Social Work

McMaster University McMaster University

Hamilton, Ontario, Canada Hamilton, Ontario, Canada

(905) 525-9140 ext. 23779E-mail: hobbspp@mcmaster.ca

E-mail: sbcollins@mcmaster.ca

**Purpose of the Study:**

You are invited to take part in a study on the Hamilton Urban Core Community Health Centre’s (HUCCHC) role in providing public space as an avenue for community organized groups to organize for social change. I am doing this research for my thesis.

The purpose of this research project is to explore the role and functionality of the HUCCHC, with respect to advocacy and activism, to understand how this institution is being used as a pathway for social change. I’m interested in discovering what conditions or circumstances are necessary in order to have the HUCCHC act as a centre for social change.

**Procedures involved in the Research:**

My aim will be to undertake several different methods of collecting information. One method is an interview. The interview is expected to last approximately 30 -60 minutes. With your permission, this interview will be audio-recorded. I will have a notebook during the time of the interview that will primarily be used as a reference to help recall and guide my questions. Measures will be taken to respect your privacy, and to secure the information collected – see Confidentiality below. This interview can take place wherever you will be most comfortable, but should be in a place that is, or should be, free from distraction.

I will be asking you questions about (but is not limited to):

* Initially I will invite conversations that discover the nature of what your community group/organization was/is, and generally what was/is the cause that pulled you towards The Urban Core as an ally for social change?
* Your opinions, values, views, beliefs of advocacy and activism. What do you feel were some of the common values and beliefs of other members involved?
* What role did The Urban Core play for you? What are the important attributes associated to The Urban Core that contributed to having a successful or meaningful experience? What impact(s) do you think this had on your community group?
* What help, if any, did The Urban Core have in forming your community group? What elements supported your journey? What has your relationship been with The Urban Core since completion?
* Describe the nature of what is happening – the conditions or circumstances - at The Urban Core that you see fosters community groups to organize for social change.
* How can success stories be replicated in the future?

**Are there any risks to doing this study?**

It is not likely that there will be any harms or discomforts from/associated with conducting this interview. However, there are minimal social and psychological risks.

Social Risk: You may worry about how others will react to what you say, and since your group (community) is small, others may be able to identify you on the basis of references you make. I describe below (Confidentiality) the steps I am taking to protect your privacy.

Psychological Risk: Although this study is not intended to explore the nature of any social problem that was being addressed by any community organized group, you may inadvertently touch on a few points during the interview that may make you feel uncomfortable.

To minimize risk, you do not need to answer questions that you do not want to answer, or that make you feel uncomfortable. Immediately following the interview we can address or resolve any uncomfortable feelings you may have, and decide how this can be resolved to your satisfaction.

**Are there any benefits to doing this study?**

The research will not benefit you directly – but you can contribute your voice towards meaningful social change. I hope that what is learned as a result of this study will help to better understand what role a CHC can play in the formation of social action groups. I also hope to identify the pathways that make this feasible. In this case, my research is exploratory and is not intended to have a direct impact on the local community, or society in general, but it can contribute towards the knowledge of how community groups can impact the social determinants of health.

**Confidentiality**

In order for your identity to remain as anonymous as possible, I will not be asking any personal information (name, age, job title etc.).Every effort will be made to protect your confidentiality and privacy. I will not use your name or any information that would allow you to be identified.

However, we are often identifiable through the stories we tell (Social Risk). Please keep this in mind in deciding what to tell me. Your participation in the study will remain private and confidential between us. Please keep in mind that the results of the study (in whole or in part) will be made available to the HUCCHC upon their request. The time, date and location of the interview will remain confidential. A pseudonym will be used to reference you anywhere in my written report.

The Information I collect will be stored on a ‘memory stick’ that will be protected by a password. Once the study has been completed, the data will be destroyed. This will take place by the August 31, 2015.

**Participation and Withdrawal:**

Your participation in this study is voluntary. It is your choice to be part of the study or not. If you decide to be part of the study, you can stop (withdraw), from the interview for whatever reason, even after signing the consent form, or part way through the study, or up until June 1, 2015. If you decide to withdraw, there will be no consequences to you. In cases of withdrawal, any data you have provided will be destroyed unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study.

**Information about the Study Results:**

I expect to have this study completed by no later than *September 30, 2015.* After completion, if you would like a summary of the results, please let me know how you would like me to send it to you.

**Questions about the Study:**

If you have questions or need more information about the study itself, please contact me at:

*Phil Hobbs*

*hobbspp@mcmaster.ca*

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**CONSENT**

* I have read the information presented in the information letter about a study being conducted by Phil Hobbs of McMaster University.
* I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.
* I understand that if I agree to participate in this study, I may withdraw from the study at any time or up until approximately ***June 1, 2015.***
* I have been given a copy of this form.
* I agree to participate in the study.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Participant (Printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I agree that the interview can be audio recorded.

… Yes.

… No.

2. …Yes, I would like to receive a summary of the study’s results.

Please send them to me at this email address:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Or to this mailing address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

… No, I do not want to receive a summary of the study’s results.

# APPENDIX C-1

**INTERVIEW GUIDE – KEY INFORMANT**

**Information about these interview questions**:

This gives you an idea what I would like to learn about community organizations organizing for social change. Interviews will be one-to-one and will be open-ended (not just “yes or no” answers). Because of this, the exact wording may change a little. Sometimes I will use other short questions to make sure I understand what you told me or if I need more information when we are talking such as: “*So, you are saying that …?*), to get more information (“*Please tell me more?”),* or to learn what you think or feel about something (“*Why do you think that is…?”).*

**Questions** (but is not limited to):

* Your work at The Urban Core.
* Your personal opinions and views on activism and advocacy work.
* Do you feel that you participate in, or have any experience with, any advocacy/activism activities at The Urban Core? – Tell me about them.
* Describe the nature of what is happening – the conditions or circumstances - at The Urban Core **that fosters** **staff members** to organize for social change. To what extent does this take place?
* Describe the nature of what is happening – the conditions or circumstances - at The Urban Core **that fosters** **community groups** to organize for social change. To what extent does this take place?
* How and why are groups formed? Who forms groups? What elements do you feel make some groups more successful or meaningful than others?
* How can success stories be replicated in the future?

Is there something important we forgot? Is there anything else you think I need to know about the HUCCHC that relates to advocacy, activism, or community organizing?

**END**

# APPENDIX C-2

**INTERVIEW GUIDE – PROGRAM PARTICIPANT**

**Information about these interview questions**:

This gives you an idea what I would like to learn about community organizations organizing for social change. Interviews will be one-to-one and will be open-ended (not just “yes or no” answers). Because of this, the exact wording may change a little. Sometimes I will use other short questions to make sure I understand what you told me or if I need more information when we are talking such as: “*So, you are saying that …?*), to get more information (“*Please tell me more?”),* or to learn what you think or feel about something (“*Why do you think that is…?”).*

**Questions** (but is not limited to):

* Initially I will invite conversations that discover the nature of what your community group/organization was/is, and generally what was/is the cause that pulled you towards The Urban Core as an ally for social change?
* Your opinions, values, views, beliefs of advocacy and activism. What do you feel were some of the common values and beliefs of other members involved?
* What role did The Urban Core play for you? What are the important attributes associated to The Urban Core that contributed to having a successful or meaningful experience? What impact(s) do you think this had on your community group?
* What help, if any, did The Urban Core have in forming your community group? What elements supported your journey? What has your relationship been with The Urban Core since completion?
* Describe the nature of what is happening – the conditions or circumstances - at The Urban Core that you see fosters community groups to organize for social change.
* How can success stories be replicated in the future?

Is there something important we forgot? Is there anything else you think I need to know about your relationship with The Urban Core, that relates to advocacy, activism, or community organizing?

**END**