Community Health Workers Addressing Health Inequities in Canada: The Multicultural Health Brokers Model

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Presentation foci

- A Multicultural Health Broker (MCHB) model:
  - a complex multifaceted approach to addressing the social determinants of health affecting immigrant & refugee women & their families in Edmonton, AB, Canada
- Challenges facing minoritized immigrant & refugee families:
  - a layered explication of the persistence of barriers & gaps over 20 years
- Challenges of integration of the MCHB model into health & social service systems:
  - an examination of systemic exclusions

Data sources

– The lived experience of MCHBs and three convergent studies

Yvonne Chiu

1993-present: Emergence & expansion of Multicultural Health Brokers in response to community-identified issues

Lucenia Ortiz

2003: Doctoral research: a participatory study resulting in a grounded theory – *Multicultural health brokering: Bridging cultures to achieve equity of access to health*

Ruth Wolfe

2010: Doctoral research: a qualitative critical ethnography – *Working in the gap: A critical examination of the race / culture divide in human services from the vantage point of the Middle Woman*

Sara Torres

2008-present: Doctoral research: a qualitative case study focusing on understanding how Multicultural Health Brokers (MCHBs) address health equity for immigrant & refugee communities in Edmonton, Canada

History

- 1993: *Ad hoc* emergence of community-based support women

  "*We don't get the services or the communication or the information that we really need to be a successful people in this country.*" *(Research participant in Wolfe, 2010)*
- 1998: Formation of the Multicultural Health Brokers Cooperative (8 brokers)
  - A pivotal & strategic decision *not* to "join" the formal health care system in the interests of maintaining autonomy & the capacity to advocate
- 2010: Persistent need
  - 40 brokers in 18 communities working across four sectors

MCHB mandate & principles

- To support immigrant & refugee individuals & families in attaining optimum health through relevant health education, community development & advocacy support

- Based on principles of democratic governance, direct responsiveness & accountability, & equity & social justice

Who are the MCHBs?

- 40 workers who are members of 18 local communities: Arabic-speaking, Chinese, Eritrea, Ethiopia, Eastern Yugoslavia, Filipino, French-speaking African, Karen, Korean, Kurdish, Iraqi, Iranian, Romanian, Somali, South Asian, Spanish-speaking, Sudanese, Vietnamese communities
- Minoritized (im)migrants, primarily women
- Grassroots, community-based, not professionals

2008-2010 MCHB statistics

- Support to over 2000 families
  - one-to-one or group pre/post-natal education, labour & delivery support - 1560 families
  - early parenting & early childhood development support - 545 families
  - intense home visitation for children from birth to six years old - 50 families
  - support to families with children with disabilities - 110 families
  - collaborative child welfare intervention - 150 families

Source: Coop reports, 2009, 2010

Community context

- Edmonton, Alberta
  - Population: 1,034,945 (GMA)
  - Immigrant population (landed): 18% (GMA)
  - Refugee population: Not available

Source: http://www.edmonton.ca/city_government/municipal-census.aspx

Framework for Canadian health care system

Embedded in the Canada Health Act (1984)

- Five principles:
  - public administration
  - comprehensiveness
  - universality
  - portability
  - Accessibility

- Tax supported for (medically necessary) hospital & medical care (no fee for service to the patient)
  - Exceptions: partial coverage for home care, long-term care, dental care, physiotherapy, and pharmaceuticals (White &Nanan 2009)

Why are brokers needed?

- Q: Why do we need MCHBs if Canada has universal access to health care?
- Generally, marginalized communities are not all served by mainstream health and social services

Why are brokers needed? (cont'd)

[Support from the Heart: AV Clips 1 & 2: Perinatal health / Education]

More specifically,

- Marginalized communities lack knowledge about what services & supports are available & how systems work

- Intermediaries are needed to bridge differences between pre-migration & main stream concepts, practices and systems

- Often immigrants and refugees are unable to use available services or to use them effectively (owing to language, gender, etc)

Why are brokers needed? (cont'd)

Immigrants and refugees are vulnerable to:

- Fear, distrust & lack of confidence (avoidance of main stream services)
- Negative experiences with human service interfaces (refusal to access)
- "No (wo)man's land" (gaps between services & sectors, non-existence of needed services & resources)

Source: Wolfe, 2010

Broader contexts

- Normative assumptions underlying immigration & settlement policy
  - Rapid transition
  - Assimilation

Source: Wolfe, 2010

Broader contexts (cont'd)

- Discrimination
  - Not *universal,* but *routine*

"We know, whatever you do, in this country, the race is an issue. It is a given." (Research participant in Wolfe, 2010)

- Systemic racism
  - Absolutely one-way

"The [systems] are set up for the people who are born and grow up in Canada. The system is not set up for the people who came from a different country who have not a very strong language quality." (Research participant in Wolfe, 2010)

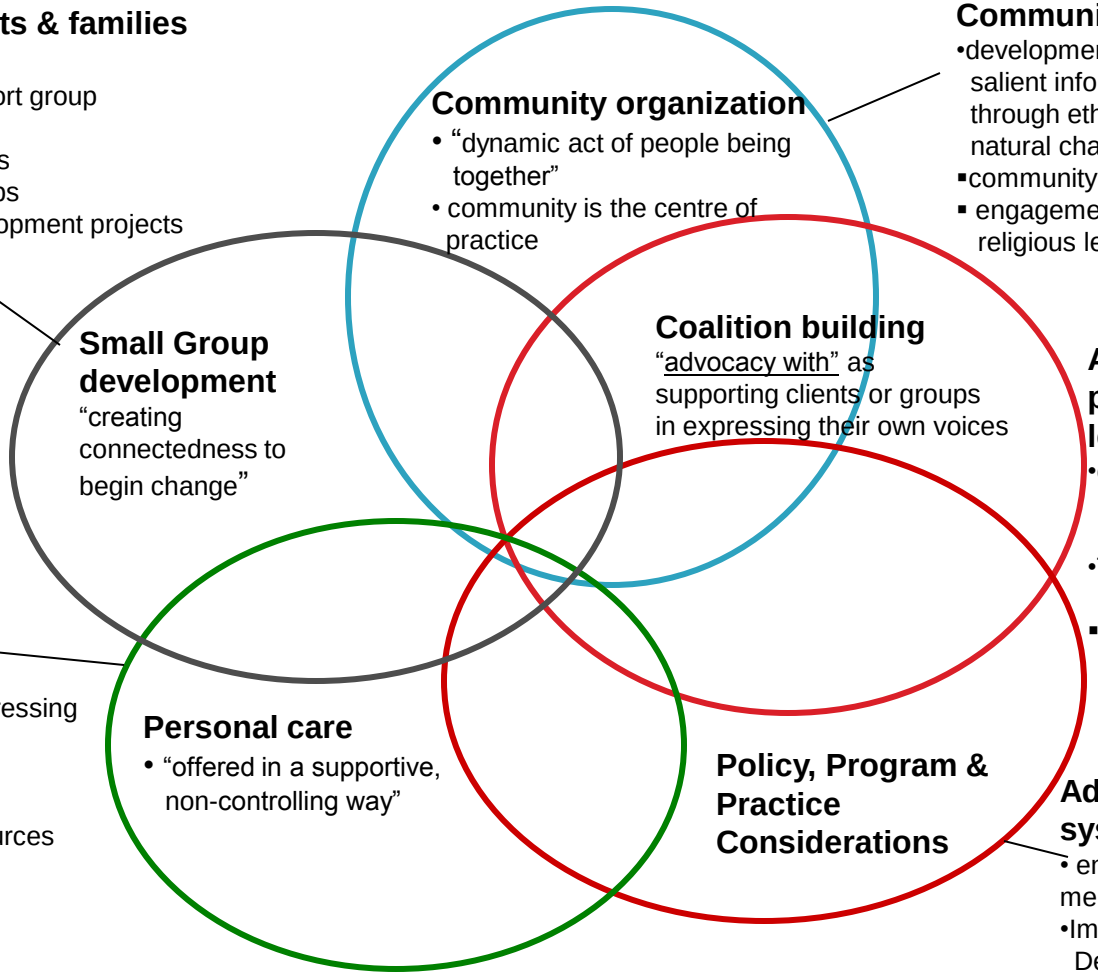
How are MCHBs achieving health equity for immigrant and refuge women?

- They help health services providers understand the pre-migration and migration experiences of immigrant –refugee clients and how these affect their health experience and health outcomes
- They respond proactively to changes in migration patterns and provincial health policies
- They lobby policy-makers and health and social services agencies for changes in the system that reflect the needs of immigrant and refugee communities
- They empower individuals and communities to utilize preventive health programs and take action for their health and well being

Key elements in addressing the social determinants of health include helping immigrants and refugees with:

- **Income/Social Status** (child tax credit, maternity leave benefits, subsidized housing)
- **Social Support Networks** (parenting groups, coalition building)
- **Education & Literacy** (ESL classes, system navigation, advocacy)
- **Employment/Working Conditions** (immigration paperwork)
- **Personal Health Practices & Coping Skills** (balancing cultures)
- **Healthy Child Development** (children's services, child protection)
- **Health Services** (remove barriers to perinatal & other health services)
- **Gender** (prevention of violence against women)
- **Culture** (pre-migration- cultural competency)

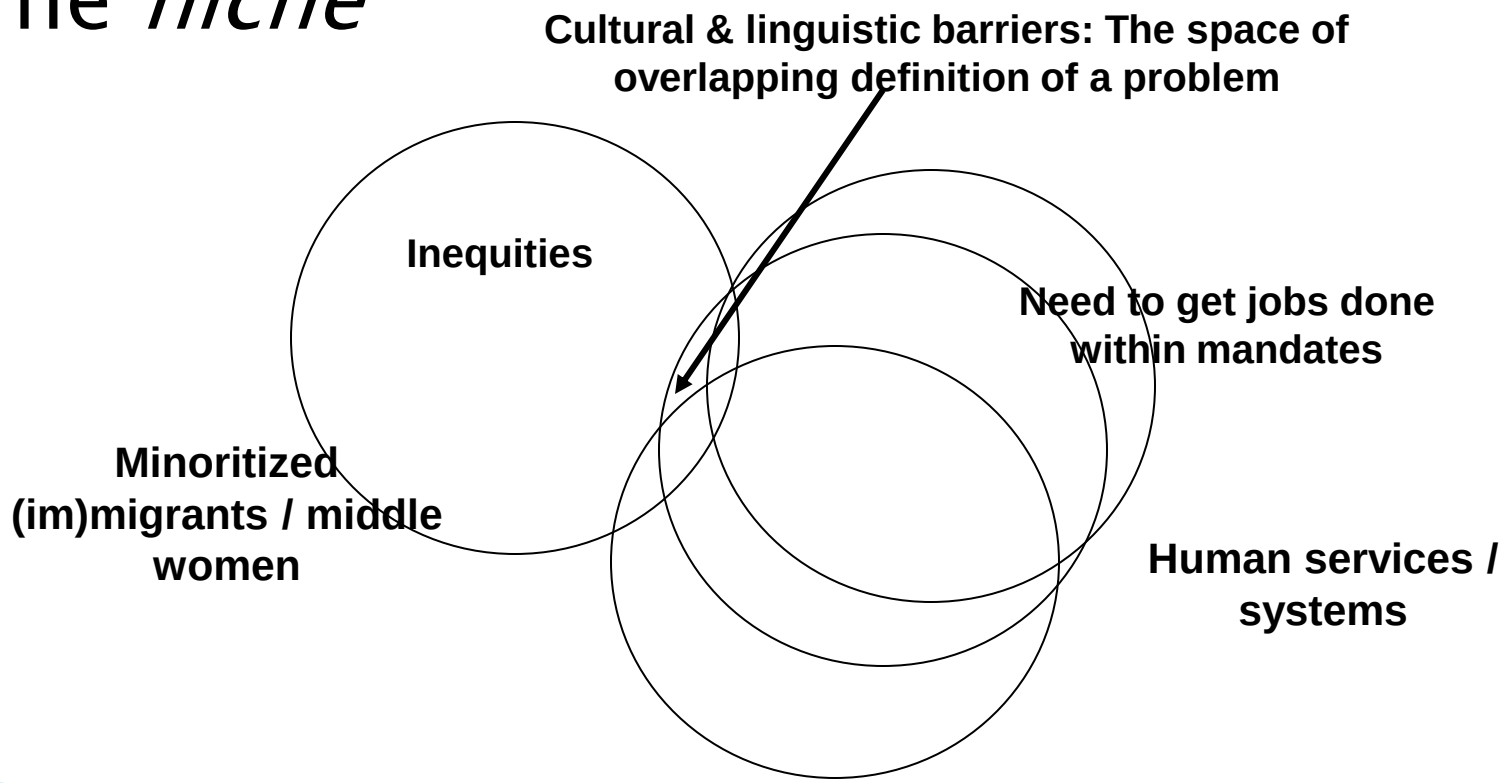
Dimensions of the multicultural health brokering practice



•Labonte, R. *Issues in health Promotion series #3. Health promotion and empowerment: Practice frameworks.* Toronto: Centre for Health Promotion, University of Toronto & ParticipACTION,1993.

Why is it a persistent challenge?
[Yvonne Chiu audio clip]

The *niche*



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Thank You!

And

Questions?