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Community Health Workers in Canada

Innovative Approaches to Health Promotion Outreach and Community Development Among Immigrant and Refugee Populations

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Abstract: This article provides results from an empirical case study that showcases a community health worker practice targeting immigrants and refugees in Canada. The study focuses on the Multicultural Health Brokers practice, which offers an innovative approach to health promotion outreach and community development addressing broad social determinants of health. This article offers new evidence of both the role of community health worker interventions in Canada and community health workers as an invisible health and human services workforce. It also discusses the Multicultural Health Brokers contribution both to the "new public health" vision in Canada and to a practice that fosters feminist urban citizenship. **Key words:** *Canada, community development, community health workers, health human services workforce, health promotion, health care system, immigrants, Multicultural Health Brokers, public health, refugees*

DESPITE the universality of Canada's health care system, populations experiencing marginalization require community-based models that reorient services to provide health promotion outreach to these communities. The community health worker (CHW) model is seeing a resurgence in the North and South worlds in the 21st century to reorient these services (Lewin et al., 2005; Nemcek & Sabatier, 2003). In Canada and other countries, many CHW interventions originate in

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primary care and public health settings as well as community-based organizations. Canada, however, lags behind other countries in documenting these interventions and lags even further in recognizing CHWs as part of health and human services workforce.

This article discusses CHWs' roles as part of Canada's health and human services workforce and showcases a particular Canadian community-based CHW intervention as one effective model that warrants greater integration with, and/or recognition by, the formal health system. The case is the Multicultural Health Brokers Co-op (MCHB Co-op), an independently run health worker cooperative that supports at-risk immigrant and refugee women and their families seeking perinatal health and other social services in Edmonton, Alberta. The MCHB Co-op undertakes its outreach through Multicultural Health Brokers (Health Brokers) who form the core of its workers. Health Brokers do not just concentrate on a single health problem (eg, pregnant women at risk of having low-birth-weight infants) but also support actions related to social determinants of health, such as lack of housing, food insecurity, and isolation. They also undertake community development initiatives to maximize the long-term possibilities for positive outcomes for the health and well-being of women and their families. They assert that they are building a different practice and vision to address the perinatal health and other social needs of immigrants and refugees and that they also contribute to the adaptation, settlement, and integration of these populations into Canadian society. But is their practice different from other CHWs in the health system? The article answers this question by illustrating the MCHB Co-op and the Health Brokers innovative approach in health promotion outreach that addresses broad social determinants of health; fosters intersectoral, cross-governmental collaboration; and builds community capacities. The article is structured as follows:

- First, the authors provide an overview of Canada's health care context—in particular, the role of CHW models (independent and integrated) within the health system.
- Second, the authors illustrate 4 aspects of the work of the MCHB Co-op: (*a*) articulating, reflecting on, and monitoring the Health Brokers practice; (*b*) enhancing the capacity of the organization; (*c*) developing a market niche; and (*d*) seeking intersectoral, cross-governmental collaboration.
- Third, the authors theorize that the MCHB Co-op and Health Brokers contribute to the "new public health" vision of Canada while building a different type of practice that contributes to feminist urban citizenship.
- Finally, the authors argue for more formal recognition and inclusion of CHWs in the health and human services workforce.

THE CONTEXT

The term "community health worker" or "CHW" is not commonly used in Canada, where CHWs are variously known as lay health workers, community health representatives, family home visitors, Multicultural Health Brokers, community health advisors, diabetes prevention workers, women's health educators, patient navigators, and peer health providers, among others. This article uses the term "CHW" to refer to staff engaged in generic community outreach programs and "Health Brokers" to refer to CHWs engaged in our case study. Community health workers, regardless of how they are named, share characteristics of being:

> ... front-line health workers who are members of the communities they serve. They understand the issues faced by these communities in accessing health and social services and how these systems work; additionally, they offer linguistically- and culturally-appropriate assistance to these communities. (Torres et al., 2013, p. 3)

Within Canada's universal health care system, CHWs play an important role both in providing health promotion outreach to communities experiencing marginalization and in linking members of these communities to formal health care services. Canada's health care system is governed by the 1984 *Health Act*'s

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principles of public administration, universality, accessibility, portability, comprehensiveness, and accountability (Romanow, 2002). These principles lay the foundations of an almost universal health system that all populations, including immigrants and refugees, can access regardless of their ethnicity, gender, ability, sexual orientation, geographic location, citizenship, or socioeconomic status. The 10 provincial governments and 3 territories of Canada are responsible for the administration, organization, and delivery of health services to their residents. In Alberta, where the MCHB Co-op and Health Brokers operate, health is governed by the Minister of Alberta Health and Wellness and administered by a single health board (Alberta Health Services [AHS]),* which oversees the operations of 5 health zones across the province. One of these, the "Alberta Health Service Edmonton Zone Public Health," subcontracts the MCHB Co-op and Health Brokers to deliver a Perinatal Health Outreach program for at-risk immigrant and refugee women in the city.

Canada receives an average of 252 000 immigrants and refugees per year (Chagnon, 2013). In Edmonton, the 2001 census indicates that there were 165 200 immigrants living in its Census Metropolitan Area, and of those, 65 200 were recent immigrants. Immigrants living in Edmonton represent 7% of its total population (Citizenship and Immigration Canada, 2005). Although our health care systems purports to be universal, immigrants and refugee communities experience health inequities as well as preventable health inequalities in their settlement adaptation and integration into Canadian society (Spitzer, 2004). Canadian CHWs, such as Health Brokers, play an active role in addressing these gaps.

There is a dearth of academic and gray literature on CHW program interventions, both worldwide and specific to Canada, although the model has been used in Canada since 1962 with community health representatives working with aboriginal communities on Reserves (National Indian & Inuit Community Health Representatives Organization, 2000). Other CHWs include the perinatal outreach workers funded under the auspices of the Canada Perinatal Nutrition Program, which serves close to 50 000 women in more than 2000 communities per year (Public Health Agency of Canada, 2011).

The role of CHWs within Canada's health care system falls on a continuum from independent to integrated models (Torres, 2013). Community health workers in integrated models are those operating within health care settings, such as hospitals, community health centers, and public health units. Those who are independent of the institutional health care system operate through community-based organizations. Those who are integrated within the institutional system occupy full-time or part-time salaried permanent positions. Their wages and benefits are better than those working in the independent model and are more closely aligned with the wages of other workers within the formal system. The home visitors working in Ontario's Healthy Baby Healthy Children Program (Jack et al., 2002) are an example of CHWs in an integrated model. Generally, the programming of integrated models responds to a single discrete intervention. For example, these CHWs provide information on chronic and infectious disease prevention and management. The scope of CHW activities in integrated models is often limited to these tasks, and workers must confine themselves to these roles (Torres, 2010). Community health workers who are independent of the institutional health care system, on the contrary, are freer to develop their own programming and, if they have the capacity, to expand their roles to respond to other needs identified by their communities. Under this model, CHWs can be paid or volunteer for their respective organizations, but their funding is often less stable because the size of the contract received by the organizations delivering programs is negotiated with, but ultimately determined by, funders (Torres, 2013; Torres et al., 2013).

*As of writing this article (June 17, 2013), the administration of the AHS has been restructured. The "single health board" as described herein has been dismantled and replaced by an "official administrator."

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While there are no data on the size or distribution of the CHW workforce in Canada (Torres, 2013), the number of CHW workforce in other countries is considerable. For example, Brazil has a workforce of 257 265 CHWs (Johnson et al., 2013), Iran employs 31 000 CHWs (Javanparast et al., 2011), and there are an estimated 121 000 CHWs in the United States (Health Resources and Services Administration, 2007). In addition, CHW studies in these countries indicate that tension exists between those CHW roles that focus on monitoring and supporting interventions for communicable and noncommunicable chronic disorders (Rodrigues Fausto et al., 2011) and those that are concerned more with serving as agents for community development and change (Rosenthal et al., 2011).

Rodrigues Fausto et al. (2011) argue that as a result of the insertion of CHWs into Brazil's institutional health care system, CHWs are increasingly molded to fulfill a technical role linked to monitoring and supporting communicable and noncommunicable chronic disorders rather than being freer to fulfill a political role (Rodrigues Fausto et al., 2011). The same trend was found in Iran, where technomedical roles of CHWs take precedence over sociopolitical aspects of their work. According to Javanparast et al. (2011), the job descriptions of CHWs (called *behvarz* in Farsi) reveal an increasingly comprehensive approach to primary health care. However, "the long list of basic health care tasks may, in practice, leave little time for behvarz to serve as agents for community development and change" (Javanparast et al., 2011, p. 11). The US literature also indicates the need for research studies to document and discuss the balance in CHW roles between community action, advocacy, and direct patient role interventions (Rosenthal et al., 2011) to achieve particular outcomes (Community Resources LLC, 2007). Wiggins and Borbon (1998, p. 45) suggest that "CHWs' role as agents of social change is, in fact, their most important role ... and that 'the true value-added' in the CHW model comes when [CHWs] are allowed and encouraged to play this role" (as cited in Rosenthal et al., 2011, p. 256).

Beyond the aforementioned selected countries where systematic research evaluating the characteristics of CHW programs and outcomes associated with CHW interventions has been conducted (Lewin et al., 2010; Viswanathan et al., 2009), Canada lags behind in such research; specifically, it lacks studies profiling the CHW workforce at the federal and provincial levels. In the United States, on the contrary, 2 major national studies (Health Resources and Services Administration, 2007; Rosenthal et al., 1998) describe the CHW workforce on a national level. Also, US CHWs also obtained a Standard Occupational Category in 2010—SOC #21-1094 Community Health Worker—recognizing their work as a distinct occupation (Balcázar et al., 2011; Federal Register, 2009). In President Obama's 2010 *Patient Protection and Affordable Care Act*, the role of CHWs in achieving the goal of improving health outcomes and containing costs was recognized (Martinez et al., 2011). Despite an ongoing need for CHW training, meaningful compensation, and respect for their work, the CHW workforce in the United States has moved from not being accorded recognition in the past to being seen as an important contributor within the current health care system reform (Balcázar et al., 2011; Rosenthal et al., 2011).

Compared with the United States where local and state-level CHW associations frequently engage in advocacy, Canadian CHWs lack a common voice. Torres (2013) found that, to date, CHWs in Canada are unrecognized and unregulated public health workers. Consequently they lack: an organizing or umbrella body (local, regional, provincial, or national); a single definition for their work; data on composition and competencies; a registry of workers; a national occupational classification; a single curriculum, standardized training, or agreed common competencies; and a common nomenclature (Torres, 2013). In the sections that follow, the authors describe the MCHB Co-op and Health Broker CHW model that uses an innovative approach to addressing health equity for immigrants and refugees experiencing marginalization. This model has the potential to raise the profile

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of CHWs as a workforce in the Canadian context.

METHODS

This article is the result of a case study investigation that featured the MCHB Co-op, the Health Brokers practice, and 2 MCHB Co-op programs that were regarded as embedded mini-cases: the Perinatal Outreach and Support (funded by the AHS) and Health for Two (funded by the Canada Prenatal Nutrition Program and the AHS). The case study was conducted over an 18-month period (May 2009-November 2010), followed by data validation sessions, ending in June 2012, to corroborate findings with the study participants. The study triangulated multiple research strategies and data sources: (*a*) participant and direct observation (n = 87 entries); (*b*) in-depth interviews with Health Brokers, mentors, immigrant and refugee mothers using perinatal services, health care professionals from the AHS, and outsiders to the MCHB Co-op, who knew about the work of Health Brokers (n = 44); (*c*) document review and analysis of policy and other documents; and (*d*) review and analysis of the MCHB Co-op client caseload database (n = 3442). In addition, data also included field notes of both descriptive and analytical reflections taken throughout the on-site research. Both hand coding and the qualitative analysis software QSR Nvivo8 were used in coding and data management of qualitative data. Descriptive analysis was conducted for the MCHB Co-op client caseload database. All aspects of the study received ethics approval from the University of Ottawa Research Ethics Board and the University of Alberta Health Ethics Board.

FINDINGS

The study was designed to better comprehend the modus operandi of the MCHB Co-op model in order to understand its functioning and programming and the Health Brokers practice in health promotion outreach to immigrant and refugee communities. The work of the MCHB Co-op and Health Brokers is best captured in 4 elements of their holistic work: (*a*) articulating, reflecting on, and monitoring the Health Brokers practice; (*b*) enhancing the capacity of the organization; (*c*) developing a market niche; and (*d*) seeking intersectoral, cross-governmental collaboration.

The first element is how the Health Brokers practice is articulated and monitored. The MCHB Co-op and Health Brokers provide service delivery and community capacity building through at least 9 programs to more than 2300 immigrant and refugee families (Tables 1 and 2). They guide the practice by their own multicultural cultural brokering theory (Ortiz, 2003) and a health promotion empowerment approach they adopted from Labonté (1993). Ortiz's (2003) theory has 4 stages: initiation; building connectedness; brokering support; and achieving equity of access to health (MCHB Co-op, Aylmer Health Co-op, & BC Multicultural Health Services Society, 2008). Labonté's (1993) approach includes 5 dimensions or strategies: one-on-one support; small group development; community organization and community mobilization; advocacy; and policy and practice (advocacy at the system level) (Labonté, 1993). The MCHB Co-op also hires mentors to support all aspects of Health Brokers' work. The 5 mentors interviewed for this study have university-level education, ranging from bachelor's to master's and PhD programs. Mentors support Health Brokers to grasp what it is to be Health Brokers, to develop their skills, to be attentive in their relationship with their clients, to learn about their personal growth, to take subject-specific training, and to strengthen the capacity of the organization (Torres, 2013). Mentors monitor Health Brokers' interactions with clients through their workers' caseload database, the centralized referrals system, and ethics protocols. Mentors and Health Brokers are an effective team because the latter have in-depth knowledge of the communities and the former have a similar understanding of the health and social services systems. Their work is complementary and they trust and challenge each other to fulfill the organization's mandate to improve the lives of immigrant and refugee women and their

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Table 1. Service Delivery Interventions for Pregnant Women and Children Zero to 6 Years Old: Multiyear Projects Funded

No.	Program	Description	Population/ Communities	Government-Level Funding, With Yearly Renewal
1	Perinatal Outreach and Support	Prenatal, postnatal, and early parenting support to families from pregnancy to 2 mo after delivery	10% of the births among immigrant and refugee women	Alberta Health Services (provincial government) Funding: $317 502.56 Running since 1997
2	Health for Two	Prenatal and postnatal support Supplies milk coupons and vitamins to pregnant mothers who are at risk of having low-birth-weight or preterm infants	10% of pregnant /new mothers immigrant and refugee women	Public Health Agency of Canada, Perinatal Nutrition Program (federal government) In coordination with the Alberta Health Services Funding: in-kind Running since 1997
3	Culturally Responsive Home Visitation Program	Intense home visitation support to families with children 0- to 6-y old From pregnancy to 2 mo after delivery	45 families experiencing complex situations at any one time	Children Services (provincial government) Funding: $224 148.00 Running since 2002
4	The Multicultural Family Connection	Early parenting and early childhood development support for families with children 0- to 6-y old	All immigrant and refugee families needing support	Children Services (provincial government) Funding: $216 360.00 Running since 2004
5	Intervention Support and Childcare Services	System navigation on childcare services and culturally affirming practices with the daycare sector	Refugee and immigrant families dealing with welfare authorities because of family violence involving children or child neglect	Children Services (provincial government) Funding: $384 480.00 Running since 2008
6	Multicultural Family Support for Children with Disabilities	Support to families with a high incidence of children with disabilities Other families might be included	Communities from Afghan, Kurdish, Chinese, Vietnamese, and Sudanese backgrounds	Children Services (provincial government) Funding: $131 280.00 Running since 2007

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Table 2. Community Capacity-Building Interventions Targeting Youth and Seniors: Multiyear Projects Funded

No.	Program	Description	Population/ Communities	Government-Level Funding, With Yearly Renewal[a]
1	Multicultural Senior Outreach Program	Culturally and linguistically relevant support to seniors	Immigrant and refugee seniors experiencing isolation	City of Edmonton and nongovernmental Senior's organization Funding: $39 640.00 Running since 2007
2	Multicultural Youth Mentorship and Leadership	Youth programming in the areas of recreation, arts, and heritage language	Cambodian, Kurdish, French-speaking African, and Spanish-speaking communities	Alberta Youth Strategies (provincial government) Funding: $50 000.00 Running since 2006
3	Immigrant and Refugee Youth Mental project	Supports leadership and mental health care Youth-directed programming in recreation, arts, and mentoring	Azerbaijani, Eritrean, and Ethiopian, Somali, Sudanese Kurdish, Iraqi, Colombian, Afghani, and Karen communities	Alberta Health and Wellness (provincial government) Funding is $300 000.00 Running since 2009

[a]This is a pilot project.

families; this collaboration is reinforced by their shared theoretical approaches.

The second element is the creation of the health worker cooperative. The MCHB Co-op's articles of incorporation indicate that it supports immigrant and refugee individuals and families to attain optimum health through health education, community development, and advocacy (MCHB Co-op, 2004). The MCHB Co-op finances its operations to blend what Ortiz (2003) refers to as an "entrepreneurial" [business] objective of providing employment to its members, while addressing the social objective of achieving equity of access for the community. In 2012, the MCHB Co-op had 54 members and workers (nonmembers), who carried out its programs, the vast majority of whom were Health Brokers. Of the 54 members and workers, 5 were male Health Brokers. Some participants have explained that the MCHB Co-op has attempted to recruit more male Health Brokers, but in the words of one participant, "it has been hard to recruit and retain them." The predominance of women Health Brokers in the MCHB Co-op can be explained by 3 factors. These are as follows: the MCHB Co-op was created to work on perinatal health outreach; in some cultures, women are not allowed or might not be willing to talk about health or other issues with male workers; and the majority of the programming the MCHB Co-op and Health Brokers offer is often viewed as traditionally female occupations. Of the 15 Health Brokers interviewed for the case study, 1 was a man. All the Health Brokers came from ethnically diverse backgrounds and had immigrated to Canada between 2 and 35 years earlier. Almost three-fourths had post–secondary education. Just 13% had completed high school, with the rest having a college diploma or some college or university courses.

The study participants felt strongly that they needed to have an independent

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organization in order to implement a holistic pre- and postnatal program grounded in the needs of immigrant and refugee women and their families and not be limited by the local health system's guidelines (AHS Edmonton zone). One participant stated:

> . . . if [we] became part of the system and we are absorbed into the system, it will be hard for us individually to try and review where the system is not working . . . . And some [Health Brokers] were worried that their holistic practice could be affected . . . .

The MCHB Co-op became an official entity in 1998 after several years of conversations among the Health Brokers and organizational experts to determine the best structure for their work. Since then, the MCHB Co-op has sought support from professional consultants in cooperative development to gain expertise in organizational issues, including business plans, hone practice skills and competencies, as well as foster internal leadership and managerial skills (Ortiz, 2003).

The MCHB Co-op and Health Brokers adopted the principles and values of the cooperative movement, as established by the International Co-operative Alliance. These include self-help, self-responsibility, democracy, equality, equity, and solidarity (International Co-operative Alliance, 2005-2011). The MCHB Co-op embraces these principles in policy documents, that is, by referencing them in its bylaws (MCHB Co-op, 2005) and listing them in its policy handbook (MCHB Co-op, 2009). Since the creation of the MCHB Co-op, Health Brokers have been conscious that they need to put in additional hours to ensure that they learn about the functioning of the organization and adhere to their collective decision-making process.

The third element of the work of the MCHB Co-op and Health Brokers is their market niche, that is, culturally and linguistically appropriate programming for immigrants and refugees in their area. Identifying and sustaining a market niche are crucial to the success of any cooperative. As a workers' cooperative, the niche they fill offers goods and services that enable outreach to marginalized populations, and in particular, culturally competent and linguistically appropriate programs delivered by Health Brokers. They provide services in their first language to immigrant and refugee families from at least 18 different cultural backgrounds and collectively are able to speak 29 languages. The MCHB Co-op and Health Brokers were proud of the niche they had created because of their approach to removing barriers to accessing health and social services faced by immigrants and refugees. One health care professional from the AHS stated that because the Health Broker model was culturally and linguistically appropriate, it had been successful in making a "paradigm shift" within some parts of the health system. According to this health care professional, because of this shift, most health service providers in the city now understood the need to look at "culture" when serving immigrants and refugees. This participant stated:

> . . . I think the Health Brokers have really done, and maybe they don't realize it—but they've done a pretty remarkable job at encouraging a paradigm shift in Edmonton and area, of really coming from a—you know this isn't just about translating a resource, it's about understanding the cultural framework.

The MCHB Co-op and Health Brokers niche is reflected in the funding they received to implement the 9 programs described in Tables 1 and 2. Just over one-third of Health Brokers' interventions target families with young children. As one mentor explained:

> . . . the target in these programs is the child who is under the age of six . . . , but the primary client is, the mother . . . . So we work with the mother, we work with the child to ensure . . . at the end of the day to ensure the well-being of the child . . . .

The fourth element of the work of the MCHB Co-op and Health Brokers is their approach to foster intersectoral, cross-governmental collaboration to create, implement, and evaluate all their programs. The MCHB Co-op and Health Brokers believe that the issues experienced by immigrant and refugee women and their families should not be confined to silos; instead, multiple

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systems ought to be involved to address the problems that interact to create situations of vulnerability for these populations. According to participants, in the early 2000s, 2 factors changed the scope of Health Brokers' work; a high influx of international refugees and internal displacement of immigrants and refugees from other parts of Canada looking for jobs in Alberta's booming economy. These factors have dramatically changed the scope of demands for all health and social services, placing pressure on Health Brokers' services and support for newly arrived communities. When Health Brokers undertook health promotion activities focusing on perinatal health, they met with families struggling with inadequate income, poor housing, mental health care issues, or family problems, including intergenerational conflict and family violence. Health Brokers learnt that they had to help women deal with these problems before mothers were able to turn their full attention to perinatal health or other health issues. Indeed, this was the main reason Health Brokers sought to work under an independent health worker organization. The government health unit was interested only in funding the prenatal work done by Health Brokers and not the work they did in other areas, including family violence, connecting women to community groups, and finding housing or childcare.

The MCHB Co-op and Health Brokers strive to blend service delivery and community capacity-building programs that address the social determinants of health. The *Perinatal Outreach and Support* program is the main entry point for referring clients to the MCHB Co-op or Health Brokers. Families, however, might be referred to Health Brokers because the children are experiencing abuse or neglect. In this case, families are enrolled in the *Intervention Support and Childcare Services* program because they may require specialized services and intensive support. Pregnant women or mothers with newborns may be in crisis owing to a combination of factors: they live in low socioeconomic conditions; they are experiencing spousal violence; and their infants and older children are also victims of that violence. In cases such as these, Health Brokers negotiate, simultaneously, between multiple systems, including health, child intervention, immigration, and social services to address the needs of these families.

The MCHB Co-op and Health Brokers have been successful in obtaining intersectoral, multiyear/cross-governmental project funding to support immigrant and refugee women and their families. For example, MCHB Co-op's overall revenue for the 2008-2009 fiscal year reached $2.1 million. In addition, most of the projects highlighted in Tables 1 and 2 had been renewed yearly for several years. Participants stated that part of their success lay in their knowledge and understanding of the different communities and of the health and social services systems, as well as their commitment to guide their practice based on the needs of the communities.

Notwithstanding the successes, some challenges are worth highlighting: First, while the MCHB Co-op can offer service delivery and community capacity-building programs to families, increasing services has implications for the Health Brokers caseload. In essence, Health Brokers are required to manage more cases of families in crises; resultantly, their stress levels increase; furthermore, they must keep themselves updated on additional subject-related matters and available health and social services resources. Second, they must undertake increased lobbying on behalf of clients within a potentially larger number of mainstream institutions. Third, new projects raise challenges for mentors because the number of Health Brokers hired, communities served, and languages spoken increases. As a result, mentors have to identify more support systems for Health Brokers and their clients as well as monitor mechanisms to foster high-quality work. Finally, funders tend to favor service delivery over community development, which means that community development programs, if financed at all, receive substantially less funding and that a great deal of work in this area takes place on Health Brokers' own time.

Indeed, some participants were concerned about the lack of funding to sustain all aspects of Health Brokers' work, which resulted

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in the MCHB Co-op's inability to offer full-time work and better wages and benefits to all Health Brokers. According to some participants, the lack of financial support for work that addresses the social determinants of health causes the MCHB Co-op and Health Brokers to disregard work overload concerns. The majority of Health Brokers work part-time or are contract employees. A standard per hour rate for Health Brokers was set up by the membership when the MCHB Co-op was officially registered in 1998. This hourly rate, however, has not changed in accordance with inflation. Health Brokers feel that when their "unpaid" or volunteer work is counted in, they have lost even more ground in their hourly rate. Most Health Brokers working part-time hours have to take on other jobs to make ends meet.

Despite the challenges, Health Brokers and mentors believe that, in the long term, they are helping communities become successful in settling and living permanently in Canada. One Health Broker described how she had helped a mother first with perinatal information and support and then with enrollment in "English as a Second Language" classes. After the mother completed English classes, the Health Broker helped her enroll in an early childhood education program, which led her to find a full-time childcare job. Afterward, the mother learned how to drive a car; later on, she purchased a car. Now this mother continues to work full-time in her childcare job and is actively volunteering as a Health Broker, helping other mothers to improve their situations.

DISCUSSION

The MCHB Co-op and Health Brokers CHW model is like no other CHW model found to date in Canada. Findings from this case study suggest that Health Brokers are building a different practice and vision to address the perinatal health and other social needs of immigrants and refugees. The strength of the MCHB Co-op and Health Brokers independent CHW model is that it allows for creativity and flexibility in both the conceptual frameworks used to guide the Health Brokers practice and their ability to grow and expand their programming. The study revealed that the MCHB Co-op and Health Brokers are constantly changing because they adapt their programming to do what is best for immigrant and refugee families. This is something that Health Brokers would be unable to do if their practice were integrated in the institutional health care system. Health care professionals interviewed also acknowledged that the independent nature of the Health Brokers model allows more flexible response to the emerging needs of the communities served.

The Health Brokers practice differs from other CHW models, which focus on a single intervention, because their practice features the 4 parallel elements described earlier. This means that while Health Brokers and mentors learn and develop new skills, they enhance the internal capacity of the organization. They also create new programs and negotiate between several systems (eg, health, child intervention, immigration, social services) and multiple communities (eg, Ethiopians, Mexicans, Pakistani, Chinese), use multiple strategies (eg, one-on-one work, group work, communities work, and coalition building), and target many social determinant of health (eg, access to health services, housing, child abuse or neglect, and isolation). Other literature on the role of CHWs shows that they maintain and or gain the trust of the communities precisely by helping them with issues that extend beyond health care or the health system's mandates. Henderson and Kendall (2011) argue that that failing to address these broader issues would alienate CHWs from their communities and limit their opportunity to address more specific health concerns.

The Health Brokers practice is also complex because as an independent health worker cooperative, the funds their organization receives are not enough to cover all the work hours of Health Brokers or deliver all of the programs needed by the communities. The MCHB Co-op and Health Brokers are aware that volunteer work is necessary to fulfill obligations to members, communities, and funders. Indeed, studies of worker cooperatives

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point out that in addition to financing, considerable commitment of all members to sweat equity is crucial to establishing and maintaining cooperatives successfully (Hough et al., 2010).

Although some Health Brokers seemed to be completely satisfied with the level of volunteer commitment needed, others were overwhelmed by it because of difficulty balancing work and family life. For one mentor, the number of hours Health Brokers put into volunteer work is exploitation. This is where Health Brokers are torn between wanting normal workweeks and maintaining their commitment to the MCHB Co-op and their communities. They make themselves available to help clients beyond their stipulated hours, even when that implies working evenings or weekends. Forrest et al. (2011) also identify this extra work as a problem faced by CHWs in other parts of the world. In their study of indigenous Māori people in New Zealand, the authors found that "CHWs referred to time as a gap in service because people's issues didn't occur between 9 to 5 and felt after-hours support and care were needed" (Forrest et al., 2011, p. 25). The main problem here is that CHWs are often not compensated for the extra work (Henderson & Kendall, 2011).

THEORETICAL CONCEPTUALIZATIONS

The MCHB Co-op and Health Brokers did not exist in 1986 when the Ottawa Charter for Health Promotion (Last, 2007; O'Neill et al., 2012) was developed. Health Brokers did not attend the 2005 discussions for the Bangkok Charter (Andermann, 2013), but they certainly adhere to the principles and values of these charters. The MCHB Co-op and Health Brokers health promotion approach among immigrants and refugee communities includes targeting the underlying determinants of health, seeking social justice, and addressing health equity, embodying the tenets of the influential 1986 Ottawa Charter for Health Promotion (Last, 2007; O'Neill et al., 2012). By doing this, the work of the MCHB Co-op and Health Brokers contributes to the "new public health" (Rootman & O'Neill, 2012; White et al., 2013), by promoting the health of immigrants and refugee communities by targeting the social determinants of health and seeking partnerships and involvement of various sectors of government and civil society. The MCHB Co-op and Health Brokers' approach discussed earlier is demonstrative of their innovative outreach strategies to communities experiencing vulnerability and marginalization (Andermann, 2013). These workers are contributing to an understanding of health from the community perspective, from the ground up (White, et al., 2013).

Feminist Urban Citizenship

The work of the MCHB Co-op and Health Brokers also contributes to what has been theorized as feminist urban citizenship (Andrew, 2008). Feminist urban citizenship is presented here as a process in which immigrant and refugee women and their families, regardless of whether they have obtained political Canadian citizenship, are nevertheless involved in shaping the sociopolitical realities for their health and well-being. Andrew (2008) notes, "Women, particularly immigrant women, experience the urban reality in an especially intense fashion, as it is they who are largely responsible for knitting together public and private, family and school, neighbourhood and community" (p. 243). In their daily work, the MCHB Co-op and the Health Brokers practice in Edmonton are working together to decrease the burden that immigrant and refugee women experience in settling in and feeling welcome in the city.

In the public sphere, the MCHB Co-op and Health Brokers educate immigrant and refugee women and families on their rights as patients, program users, and citizens. As patients, they teach families that they have the right to ask their physicians for information; as program users, they teach families that they have the right to seek services and obtain these from health and social services systems; and as citizens, families learn that they have the right to make their voices known to policy makers, such as city officials and members of the legislature. As citizens,

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they also teach families to use different strategies to make their voices heard. In the private sphere, the MCHB Co-op and Health Brokers negotiate with families to address some cultural practices that perpetuate patriarchal oppressive relations brought from their cultural backgrounds into the new city. For example, in some cultures, women are not allowed to leave their home without the permission of the husband. In cases such as this, Health Brokers negotiate with the husband so that women are able to attend group activities where they can network with other women from their communities and learn about life in Canada. The violence prevention program to protect children from abuse or child neglect is another example in which Health Brokers negotiate between the private and public spheres to improve the health and well-being of children, women, and families.

CONCLUSION

The authors illustrated in this article that the MCHB Co-op and Health Brokers are building a new community of practice to address the perinatal health and other social needs of immigrants and refugees in Edmonton. The MCHB Co-op and Health Brokers offer an innovative CHW model because they articulate, reflect on, and monitor their practice; operate and sustain an independent organization; develop and maintain a market niche of culturally competent and linguistically appropriate programming; and seek intersectoral, cross-governmental collaboration to develop programs that address the social determinants of health. In addition, Health Brokers engage immigrant and refugee communities and help new arrivals to become successful in settling and living permanently in Canada. Owing to all these newly documented successes, the authors argue that the MCHB Co-op and Health Brokers contribute to the new public health and feminist urban citizenship. The MCHB Co-op and the Health Brokers practice are like no other CHW model found to date in Canada.

Despite their significant contributions in support of vulnerable populations, Health Brokers and other CHWs remain largely invisible, uncounted, and are not recognized by the wider Canadian community or health care systems. The road ahead for this workforce in Canada is not without its challenges. Further research is needed to analyze and evaluate the characteristics of CHW programs and outcomes associated with such interventions, including the effectiveness of the Health Brokers practice. In addition, major local-, provincial-, and federal-level studies are necessary to profile the Canadian CHW workforce. The voices of CHWs need to be at the forefront of these research and policy development initiatives. Ultimately, the onus will also be on the CHWs themselves to organize their community of practice as a coherent workforce. In conclusion, we can learn a great deal from the MCHB Co-op and Health Brokers practice case study. This applied research is also important and highly relevant to health care providers and other professionals, including policy makers, researchers, and academics seeking to reorient health promotion policies and community development initiatives to populations facing marginalization. The Health Brokers practice represents a social laboratory for learning about interventions and innovative approaches that target health equity for marginalized populations in Canada. Public recognition and investment in Health Brokers' programs and services for new arrivals in Canada are not only an investment in the health care system but also a positive investment to help ensure the health and well-being of our future citizens.

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