



Family Home Visitors: Increasing Minority Women's Access to Health Services

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Abstract

The article describes how service access barriers (language, trust) were addressed at different levels (organization, service provider, community) by involving Family Home Visitors to support Nurse Practitioners in providing pre- and postnatal services to linguistic minority women in Ontario. The investigators undertook a secondary analysis of 18 semi-structured interviews with health unit informants, Nurse Practitioners, program users, and community leaders, including Family Home Visitors. Health units facilitated collaboration between two programs aimed at serving mothers with young children, resulting in both programs using Family Home Visitors. They enhanced minority women's trust in Nurse Practitioner services by providing interpretation, outreach and support. Family Home Visitors increased Nurse Practitioners' community knowledge and insights of the family situation. The findings contribute to our understanding of strategies to overcome language and trust barriers and improve access to programs for isolated women from linguistic minority backgrounds. Family Home Visitors' role has the potential for being expanded and deserves more system support.

Keywords

Family home visitor; Health services accessibility; Home-based family services; Language and medicine; Language barrier; Linguistic minorities – Medical care; Maternal health services; Minority women – Medical care; Postpartum depression; Pre- and postnatal services; Prenatal care; Trust

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ABSTRACT

The article describes how service access barriers (language, trust) were addressed at different levels (organization, service provider, community) by involving Family Home Visitors to support Nurse Practitioners in providing pre- and postnatal services to linguistic minority women in Ontario. The investigators undertook a secondary analysis of 18 semi-structured interviews with health unit informants, Nurse Practitioners, program users, and community leaders, including Family Home Visitors. Health units facilitated collaboration between two programs aimed at serving mothers with young children, resulting in both programs using Family Home Visitors. They enhanced minority women’s trust in Nurse Practitioner services by providing interpretation, outreach and support. Family Home Visitors increased Nurse Practitioners’ community knowledge and insights of the family situation. The findings contribute to our understanding of strategies to overcome language and trust barriers and improve access to programs for isolated women from linguistic minority backgrounds. Family Home Visitors’ role has the potential for being expanded and deserves more system support.

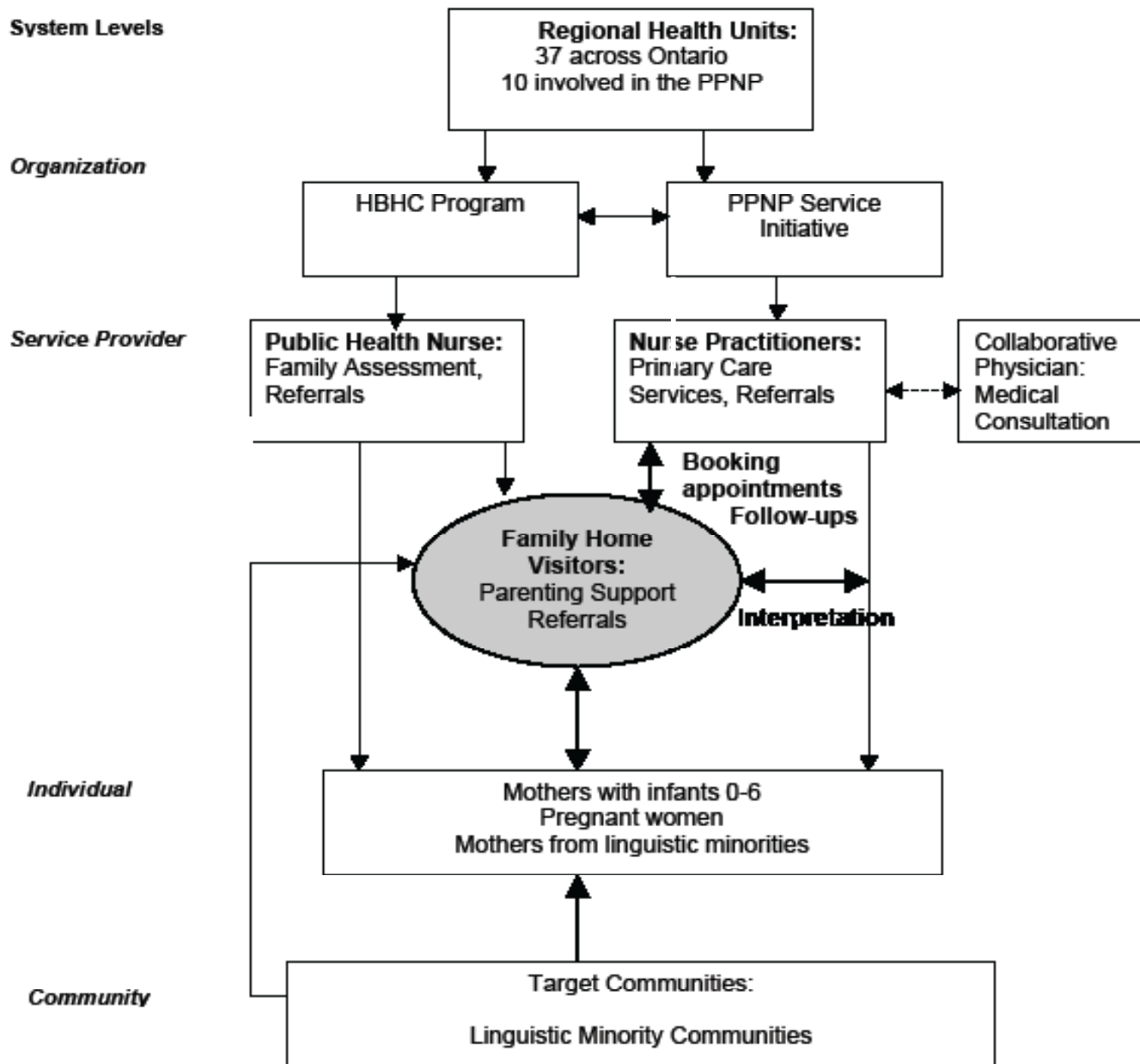
Key Words: language barrier; family home visitor; trust; postpartum depression; pre- and postnatal services

INTRODUCTION

The focus of this article is to describe how collaboration between two public health programs in Ontario, the Prenatal and Postnatal Nurse Practitioner Services Initiative (PPNP) and the Healthy Babies Healthy Children Program (HBHC), led to a unique way of addressing barriers to pre- and postnatal care among linguistic minority women. Specifically, barriers related to language and women’s mistrust of the health system were addressed through the involvement of family home visitors as a bridge for communication, outreach and support between the health practitioners and linguistic minority women.

The PPNP is a pilot program that provides primary care nurse practitioner services for pre- and postnatal care in ten Ontario community sites determined to have a shortage of family doctors. The Healthy Babies Healthy Children (HBHC) program serves families with children between 0-6 years of age who are at risk for physical, cognitive, communicative and psychosocial developmental delays (Ministry of Health and Long-Term Care, 2001). Families considered at risk receive visits from Public Health Nurses, who frequently involve a Family Home Visitor to take over some of the support functions (see Figure 1).

Figure 1. Prenatal and Postnatal Nurse Practitioner Service Initiative (PPNP) and Healthy Babies Healthy Children (HBHC)



In 2004, the Government of Ontario undertook an interim evaluation of the five-year PPNP pilot. The detailed method and findings of this evaluation are reported elsewhere (Estable, MacLean, Meyer, Peterson & Engdasaw, 2005; Snelling et al., 2005). One evaluation research question was whether the PPNP reduced barriers and facilitated access to health services for mothers and their children. In this article, we report the findings from a secondary analysis of the qualitative interview data. The interest for this secondary analysis arose from the emerging theme of the Family Home Visitor role in reducing the barriers related to language and trust, at three different system levels: organization, service provider and community.

Access to Pre- and Postnatal Care

Intervention in the pre- and postnatal period can significantly contribute to improved health outcomes (World Health Organization, 2006). For example, home visiting programs that focus on pre- and postnatal care improve maternal and child health, especially when targeted to high-risk populations (Hiatt et al., 1999; Ryan et al., 2006; Wade & Fordham, 2005; Wager et al., 2004). One important objective of the Canadian health care system is to provide universal access to health services including the most vulnerable sectors of the population such as recent immigrants and linguistic minorities (Health Canada, 2005). Health policy makers and health care providers are especially challenged to provide appropriate and accessible support to immigrant and linguistic minority women in the pre- and postnatal period (Bowen, 2001a). Zerkowitz et al. (2004) emphasize how migration itself may place pregnant immigrant women at higher risk for depression. Others report differences between Canadian-born and immigrant mothers in their perceptions and understanding of the type of information and support they receive (Loiselle et al., 2001).

Conceptualizing Barriers to Access

Ricketts and Goldsmith (2005) describe a battle of frameworks in research on health services access, recognizing that access itself can also be seen as a policy goal and a political symbol. Within these frameworks, many authors and program planners use the concept of barriers when describing unequal access to services (Engdasaw et al., 2003; Sword, 1999). Language is one of the most frequently mentioned barriers across all frameworks (Bowen, 2001b; DesMeules et al., 2004; Wager et al., 2004; Wu, Penning, & Schimmele, 2005).

Barriers only afflict certain segments of populations, usually the socio-economically vulnerable (Andersen et al., 1983; Beach et al., 2006; Gelberg, Andersen & Leake, 2000), and only when the need arises to communicate with a health care provider. Scheppers et al. (2006) define this concept as potential barriers, which can occur at three levels: Barriers at the system level include structural factors, organizational factors, and policy; at the service provider level, they are related to gender, skills, training, attitudes, practices; individual level barriers include demographic characteristics such as gender, ethnicity, income, and language. Scheppers et al. (2006) recognize that an ethnic minority person's decision to use health services, though an individual choice, is frequently framed in the social context though cultural, social and family ties. In our view this social context is best described by adding another level: community. Barriers at each level need to be identified and overcome to facilitate service access. For example, a community's cultural norms might act as a barrier to accessing professional health services, but can become a facilitator if community members become involved in program development, resulting in improved service responsiveness to the unique community norms and needs.

Family Home Visitors and Service Barriers

Family Home Visitors are part of the health system, especially in programs that support childbearing women in Canada (Jack, DiCenso & Lohfeld, 2005; Wade & Fordham, 2005), the U.S. (Gomby, 2000; McFarlane, 1996; Olds et al, 2002), Australia, and the U.K. (Drennan & Joseph, 2005; Houston & Cowley, 2003). Family Home Visitors generally are paraprofessionals or lay workers, also described as natural helpers (Barnes & Fairbanks, 1997), home visitors (Gomby, 2000; Hiatt, Sampson & Baird, 1997), paraprofessional aids (Van Tuijl, Leseman & Rispens, 2001), paraprofessional advocates (Grant, Ernst, Pagalilauan & Streissguth, 2003), lay health promoters (Meyer, Torres, Cermeño, MacLean & Monzón, 2003), lay health advisors (Eng, Parker & Harlan, 1997), or volunteer mothers (McFarlane, 1996). They are recruited from the community or target population; receive training; are supervised through an agency and usually complement the work of trained health professionals, such as Public Health Nurses or Nurse Practitioners. Frequently these workers are women who work on a voluntary basis or receive a small honorarium. In Ontario, Family Home Visitors are fully funded to work within the HBHC program. Family Home Visitors' most frequent activities include delivering information on healthy child development, providing emotional support, assessing family needs and providing referrals to community resources (Ryan et al., 2006). Studies confirm that home visiting programs are effective in increasing healthy child development (Ryan et al., 2006) and decreasing postpartum depression (Dennis & Hodnett, 2007). Fewer studies have examined how effective lay family visitors are compared to public health nurses to deliver the core program components (Woodgate, Heaman, Chalmers & Brown, 2007). We also did not find any studies that compared the types of services and challenges faced by family visitors serving minority linguistic clients versus those assisting majority linguistic clients.

METHODS

Given the iterative nature of qualitative research it is sometimes difficult to determine when data warrant secondary analysis. According to Heaton (1998), the work reported in this paper can be classified as an additional sub-set analysis. We selected a sub-set of the sample from the original study that merited a more extensive analysis. In the following section, we briefly summarize the methodology used for the primary evaluation, followed by a description of our decisions to explore the data related to the role of Family Home Visitors, the methods used to select the sample for secondary analysis and the analysis of this sub-set of data. The University of Ottawa's Research Ethics Board approved the research procedures.

Primary Evaluation Sampling

Study participants included health unit staff from all ten PPNP pilot sites across Ontario (26 participants). At four of these sites participants also included program users (n=18), and community leaders (n=12). Community leaders were defined as leaders of community groups who are members of the target population (e.g., an ethnic minority, religious group), or service providers who work closely with members of the target population. At the sites which targeted linguistic minority women, criteria for community leaders also included language and cultural background.

Data collection

Semi-structured interviews were conducted with all participants. The authors were involved in the design of data collection tools, and conducted all interviews with program users and community leaders. We all had extensive interview experience with women from a range of socio economic and ethnic backgrounds. All interviews with program users and community leaders were carried out in

person at a place that was comfortable for the interviewee: Health units, early years centres, and in six instances, at the participant's home. Children were present with mothers during many interviews. Some of the health unit informants were interviewed over the phone. Four interviews with mothers required the use of an interpreter.

Data analysis

Forty-eight interviews were audio taped and transcribed verbatim. The interviewer took field notes for the remaining three interviews, because participants did not want to be audio-taped. All identifiers were removed from the transcripts. All fifty-one transcribed interviews were content analyzed for the primary analysis. The data were read first for simple content summaries, and secondly for new and emerging themes. A codebook with detailed definitions was developed and all interviews were coded using QSR N6 (QSR International Pty, 1991-2000) qualitative data analysis software. Results of the primary analysis are reported elsewhere (Estable et al., 2005).

Secondary Analysis of Data

The role of Family Home Visitors was not a central focus of the initial PPNP evaluation. For example, the interview schedule did not include specific probes to explore their role, nor did we initially target Family Home Visitors to participate in the study. At two sites, however, Family Home Visitors assisted the interviewers with data collection by translating and accompanying an interviewer to mothers' rural homes. Health units had hired these Family Home Visitors because of their prior voluntary work within their communities. It became evident to the researchers that Family Home Visitors had intimate knowledge of their communities' language and culture, meeting the study eligibility criteria for community leaders. Based on these observations, two interviews were conducted with Family Home Visitors.

A review of the evaluation data revealed that four of the ten PPNP sites had identified linguistic minorities and/or new immigrants (Mennonite, Amish, Arabic and Chinese women) as their target population and involved Family Home Visitors as interpreters (see Figure 2). Data collected from two of these sites included interviews with mothers and community leaders.

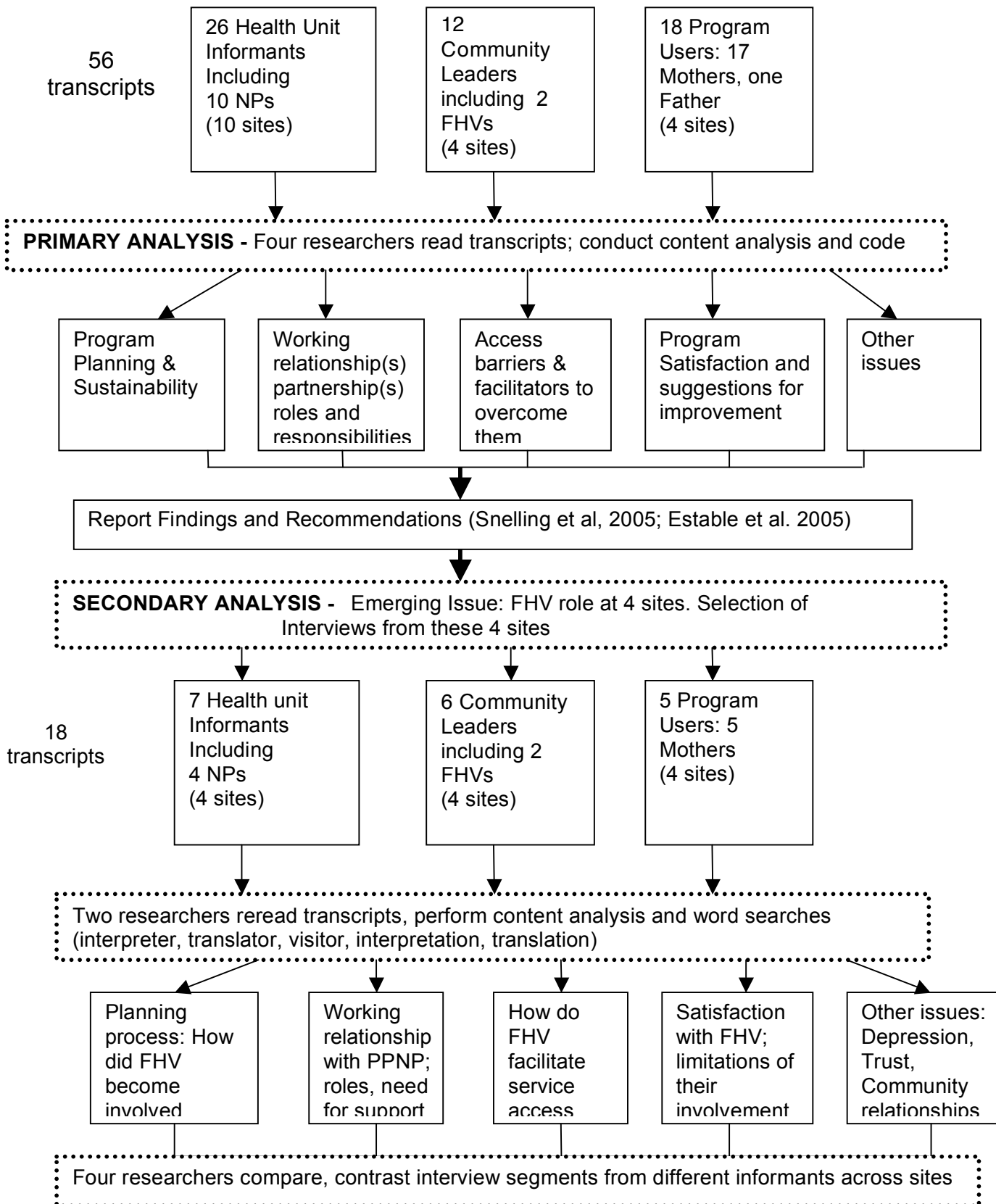
Sampling for secondary analysis

Eighteen interview transcripts from these four sites were included in this secondary analysis. These interviews had been conducted with six community leaders including two Family Home Visitors; five mothers; four Nurse Practitioners; and three Program Managers. We were limited to two interviews from Family Home Visitors, because the importance of their role only became apparent during the primary data analysis. We had not targeted them for initial interviews.

Secondary data analysis

Two authors re-read the interviews to identify comments about Family Home Visitors' relationships with Nurse Practitioners and mothers; the planning process that had led to Family Home Visitor's involvement; and other emerging themes. Interviews were read a minimum of three times. We used many of the main codes and category schemes from the primary study, and added new intersections and specific word searches. The four authors used a similar approach to the primary data analysis. We examined concepts underlying the themes relevant to Family Home Visitors, compared, contrasted, and checked for confirmation and disconfirmation. Themes explored in detail were: Family Home Visitor role, support function, trust, community knowledge, and depression. Word searches of the terms 'visitor', 'interpreter', 'interpretation', 'translation', and 'translator' were conducted. Data uncovered in these searches were submitted to the same process as the other coded data, and combined with the other data to enrich, confirm, and disconfirm findings. Key decisions are summarized in a decision-making map in Figure 2.

Figure 2 - Interview Analysis Process and Decision-making Map



RESULTS

In the following we apply an adaptation of Scheppers et al.'s (2006) framework, examining the barriers of language and trust at three system levels: organization, service provider and community as illustrated in Table 1 below.

Table 1. Themes: Addressing barriers to access among ethno-linguistic minority women

Theme	Level	Findings	Service Delivery Impact
Addressing the Language Barrier	Health Care System: Collaboration between Family Home Visitors Program and Prenatal and Postnatal Nurse Practitioner Service Initiative	<ul style="list-style-type: none"> • Agreement at public health unit level to involve Family Home Visitors (FHV) as interpreters • Close working relationships between programs • Link institutionalized in some sites via FHV and Prenatal Postnatal Nurse Practitioners (NPs) working, integrated into each other's programs and client bases. • Community leaders aware, and supportive of, need to provide professional interpretation rather than family members for health services 	FHV assumed additional responsibilities: <ul style="list-style-type: none"> • Linked mother and nurse practitioner • Conducted follow-ups, provided health promotion education • Translated health materials • Gave emotional support • Booked appointments • Became advocates for mothers
	Service Provider: Nurse Practitioner collaboration with Family Home Visitors	<ul style="list-style-type: none"> • NPs involved FHV proactively via scheduling arrangements • FHV better than other interpretation options since they were already familiar with the program, with the public health system, with health terminology, and could discuss/interpret sensitive matters without family members or males present. 	
Addressing the Trust Barrier	Community: FHV's community location and knowledge	<ul style="list-style-type: none"> • FHV understood, explained, reduced reluctance to seek help outside community due to customs of self-reliance, or fear of not being accepted 	<ul style="list-style-type: none"> • FHV encouraged women to seek medical care and prenatal care; • More awareness, assessment, and intervention on depression in community for both FHV and NP • Distress and insomnia for FHV who did not have mental health training or formal places to debrief, and who added hours and efforts to support these mothers outside of their FHV hours or mandates
	Service Provider: FHV facilitate trust building between NPs and mothers	<ul style="list-style-type: none"> • FHV were well-respected community members; knowledgeable about community health practices, community needs and community resources, used word-of-mouth communications • FHV involved in uncovering depression via asking depression-related questions for NPs and exploring client feelings for accurate interpretation • FHV connected these isolated mothers to social networks 	

Addressing the Language Barrier

Our data indicated that language as a barrier for receiving pre- and postnatal services was addressed at the organization and service provider level.

Organizational level: Health units' program collaboration through involvement of Family Home Visitors with the PPNP. Although the provincial level initiative included targeting minority linguistic groups for PPNP services, there was no requirement to ensure that Nurse Practitioners were able to communicate with the target population. At a regional level, four health units chose to address language as a barrier at the program planning stage or early during program implementation, by collaborating with HBHC programs to involve multilingual Family Home Visitors as interpreters.

The three sites that initially planned for Family Home Visitor involvement had targeted Low German-speaking Mennonite and Amish families. Mennonite Low German is a distinct German dialect. Many of the Mennonite families had recently immigrated from Mexico where they had lived in relative isolation and had preserved their language and customs over generations. The fourth site was reaching out to new immigrants from several linguistic minority backgrounds, including Low German. At this site, an Arabic Family Home Visitor and a Low German-speaking Family Home Visitor worked occasionally with the Nurse Practitioner. Prior to hiring the Low German-speaking Family Home Visitor, one of the Low German-speaking community leaders occasionally interpreted for the Nurse Practitioner. Although the need to serve Low German Mennonite families had been identified, the requirement for interpretation only emerged once the Nurse Practitioner began to serve this population.

Collaborative service delivery at the organizational level was facilitated by health units' partnerships or close working relationships with the newly established PPNP. Many health unit informants emphasized that their HBHC program and the PPNP essentially served the same population: families with young children under the age of six. Program integration variations included: HBHC referrals to the Nurse Practitioner; mutual referrals; a shared client base; the Nurse Practitioner actually providing HBHC services; and the Nurse Practitioner being physically situated in the same centre as this program. One health unit manager described how the link between the two programs was institutionalized through the position of the Family Home Visitor who was working for both programs.

I'd say HBHC it's really integrated with, because of the linkage with the Family Visitors and too just the nature of the two populations that each program serves, the Healthy Babies Healthy Children, the Nurse Practitioners: the Low German speaking people. You know, there's both. Really high risk kind of is a common thread between the two programs... with Healthy Babies, because of the nature of the work; very highly integrated I would think, compared to other projects. (Program Manger)

Community leaders were aware of the importance of addressing the language barrier at an organizational level. Several emphasized the need to provide professional interpretation rather than using family members. Health units should budget for interpretation at the program planning stage in programs directed at multilingual populations. Community leaders referred to the interpretation cost. Their comments indicated that they were aware that the potential barrier (Scheppers et al., 2006) of language was exacerbated when combined with the potential barrier of income: poor people or poor organizations who cannot afford to pay for interpreters find it harder to overcome the language barrier.

We do work with a translator, and we try to, you know, when we schedule appointments to schedule one with a translator. But it is not automatic for us because we have to pay for that, whereas the translator is funded by the health unit and is part of her job is to work with the Nurse Practitioner, to be there available in the clinic. (Community Leader)

Service provider level: Nurse Practitioner collaboration with Family Home Visitors. Nurse Practitioners lacked the language skills to provide services to the minority population that they were required to serve. To address this deficit, Nurse Practitioners involved Family Home Visitors in a proactive way to facilitate communication with their clients. At all four sites the Nurse Practitioner had arranged a schedule with the Family Home Visitor to be available at a predetermined time during the week. During that time, preference was given to seeing mothers and children from the specific linguistic background. The site which served more than one language group had varied arrangements with different Family Home Visitors. The Low German-speaking Family Home Visitor was available at very specific times, whereas the Arabic-speaking Family Home Visitor was asked to assist as needed. In addition to office visits Family Home Visitors also interpreted during home visits and over the telephone. Nurse Practitioners emphasized the additional benefit of Family Home Visitors interpreting for them: they knew the PPNP well, and were able to explain all components to mothers in simple terms in their own language.

It's nice to have someone who knows the program interpret the information, because quite often what happens is, when a family member translates, they will say, "This person says don't use this, but we know better," or they won't interpret word for word. And so that makes it kind of difficult. And someone who does know the program, has kind of already thought about what it is that we do and so it is already there. They already know what they are going to say. (Nurse Practitioner)

Other benefits included increased comfort levels of both mothers and Nurse Practitioners because they felt understood and were able to discuss sensitive issues without the presence of a family member or male interpreters.

Otherwise you have to rely on the husband - the husband usually speaks better English and sometimes you may not always get the full story. I also have Arabic families where the wife does not speak well and I also have some Chinese families that don't speak well and a lot of times you do have to rely on the partner but you always kind of worry, you know, about the translation, um, did they get the point across? [...] Did they actually tell me what she said? Like, and, you know, sometimes some women are very quiet when they're there and I always worry and you can't screen for any kind of abuse when the partner's there so, um, when the partner's not there if they speak Low German I can talk about that with the moms and, uh, so far I have not had disclosure on an abuse. (Nurse Practitioner)

Nurse Practitioners acknowledged the importance of having interpreters available who could explain concepts and words that might not exist in another language. Nurse Practitioners at Low German sites were unable to rely on written information to reinforce their messages. Material in Low German was not available, because Mennonite Low German is a predominantly spoken language (Hall & Kulig, 2004). In addition, literacy rates especially among women in these communities tend to be low (Farabaksh & Lauzon, 2008). Family Home Visitors at these sites verbally translated English written material, such as pamphlets on different health issues. In these situations, mothers were relying almost exclusively on this verbal information.

What I am finding is that I am bringing out information, mostly written in English, translating it verbally, and then still leaving it there so that hopefully they can practice what I have read to them, and then get some information out of it on their own when I am not there. But most of the time they just go by what I said during the visit. (Family Home Visitor)

Changing the service delivery practice to overcome the language barrier. Family Home Visitors assumed a number of additional responsibilities to assist the Nurse Practitioner in her work: They served as a link between the Nurse Practitioner and the mothers, conducted follow-ups, provided health promotion education, translated information materials, gave emotional support, and booked

appointments. Family Home Visitors became the bridge which women used to make appointments with health professionals when they could not do it themselves, either because they did not speak enough English or because they did not have access to a telephone. At several sites, the Family Home Visitor made all the bookings for the Nurse Practitioner, including arranging home visits. If the Family Home Visitor knew what home visits the Nurse Practitioner had already scheduled, she arranged for other mothers nearby to receive a visit in the same day. Family Home Visitors were seen as more accessible than other health service providers, because they were members of the community and mothers knew how to contact them in an emergency, as one mother explained through an interpreter:

And once, their youngest child was sick and she didn't know what to do. And so through a Family Home Visitor, they made an appointment for him and [NP name] did help them [...] And she has really appreciated her already. (Interpreter translates for mother)

Family Home Visitors were very familiar with the living conditions of their clients - beyond what an interpreter usually would know, because they visited families on a regular basis as part of their regular work within HBHC program. One Nurse Practitioner described the Family Home Visitors as "almost another pair of eyes" able to provide a more detailed account about the home situations of their clients. A program manager explained this important aspect of the Family Home Visitor's work:

We have our Arabic Family Visitor goes out and sees them almost on a weekly basis to reinforce and if she's seeing something in the home then she will get back to [NP name] and so it's that teamwork, and I know [NP name] has been very interested by how they present in the clinic is one way and how they present to the Healthy Babies Nurse or Family Visitor. They say, "well, yes, but there's this going on," and it's often quite different than how they present because they're putting on their good face and presenting themselves as best they can often when they're coming to see the Nurse Practitioner. (Program Manger).

Family Home Visitors also took on an advocacy role for mothers, by encouraging them to discuss other needs with the Nurse Practitioner. For example, one Family Home Visitor reported the absence of almost any furniture in the home of a recently arrived newcomer family. Having learned to make do, the mother would not have thought to ask the Nurse Practitioner or program staff for assistance.

One Family Home Visitor reported that her role frequently involved following-up with women after their visit with the Nurse Practitioner. The Nurse Practitioner often asked the Family Home Visitor to give a mother a call, to check on her or her children's well-being or to find out how a medication had worked. The Nurse Practitioner was unable to conduct such follow-up calls without the assistance of the bilingual Family Home Visitor.

And quite often, the Nurse Practitioner, I don't know whether it is because she's such a kind hearted person, she will sometimes call me and say: "Would you please call this client and ask her how she is doing today." So often I do a telephone call for her, just to see how things are going, to see how the meds are working. (Family Home Visitor)

Another unexpected function carried out by Family Home Visitors was reinforcement of health messages. Given their knowledge of the conversations that mothers had with Nurse Practitioners, they were able to check with mothers whether or not they had followed the advice that they had received from the Nurse Practitioner; and if not, what had kept women from doing so.

Addressing Lack of Trust as a Barrier to Service Access

Our analysis revealed that language as a barrier to service access was closely linked with mothers' lack of trust in the health service delivery system, including Nurse Practitioners. Without being able to communicate in the same language, it is more difficult to establish trust, however, we found

additional factors that contributed to the development of trust operating at the community and service provider level.

Community level: Family Home Visitors' community location and knowledge. Family Home Visitors who were working with Mennonite and/or Amish populations explained the reluctance of many community members to access any type of service outside their community. This reluctance was partly due to the community's philosophy of self-reliance and resistance to any government interference, indicating a lack of trust in public institutions. Some community members preferred to not register for the free health care services available to all residing in Canada. In addition, many newcomers did not know about the type of care available in Canada. One Family Home Visitor explained how lack of service knowledge combined with lack of trust in services provided by non-community members essentially became an access barrier in itself.

I think it goes back to the trust. You know, for some of them it's something that's totally foreign to them. ... A lot of the women don't go for prenatal care at all, in Mexico, at all. And here they hold off as long as they can. Yes, it's just they are not used to it. They are not used to being taken care of themselves. (Family Home Visitor)

Family Home Visitors identified another barrier that interfered with trust building: community members' fear of not being accepted, including the health care practices and medications that they were used to from other countries.

Well, obviously the language barrier is certainly there. And also [pause] they don't feel that they are worthy of the health care because they are realizing that they won't be able to speak and being afraid of the health care that they are used to in Mexico and the things that they... like the pills that they have taken and stuff like that. They are afraid that they won't be approved, that it won't be accepted and that their lifestyles will not be accepted as well. So that is the barrier, certainly fear. It kind of summarizes all of it. (Family Home Visitor)

Service provider level: Family Home Visitors facilitate trust building between Nurse Practitioners and mothers. Nurse Practitioners looked to Family Home Visitors to help overcome a trust deficit with their target population. Family Home Visitors were well-respected members of their community. Many had a history of volunteer involvement with the community and the service sector prior to becoming a Family Home Visitor. They were knowledgeable about their communities' immigration history and patterns, economic situation, general living conditions, internal divisions, family norms, and health practices. This knowledge improved service access on two levels: They were able to facilitate the establishment of trust between the Nurse Practitioner and mothers, and they knew about community resources that the Nurse Practitioner might not have been aware of. For example, some resources were only accessible to community members, such as special assistance programs for different types of newcomers; or social events that could help break women's isolation. Family Home Visitors also provided the Nurse Practitioner with knowledge that only members from a specific community would be privy to, such as health practices that might be common within the community, but unknown outside of it. They offered insights about women's reluctance to follow through with advice given by health professionals; and ways to overcome mothers' hesitation to seek help for health problems in the first place.

Family Home Visitors raised another issue, perhaps common to many women in all communities: women's reluctance to make their own health a priority. Family Home Visitors emphasized how their position as community members had made it possible to develop trusting relationships with women from many families. As a result, they were able to encourage women to seek medical help earlier, before problems escalated to a crisis. In particular, for the PPNP, Family Home Visitors encouraged women to obtain prenatal care earlier in their pregnancies. Prior to the

PPNP, most women would wait to find a midwife or a doctor until their seventh month. Now, many of them declared their pregnancy and sought prenatal care earlier. As a result, Nurse Practitioners were able to provide early prenatal care, including nutritional advice and vitamin use, a key outcome of the PPNP intervention. Family Home Visitors were also aware that word-of-mouth was an important mechanism for communication about the program. Positive comments from women who used the services spread to others and built trust. As one Family Home Visitor described:

I think ...there's definitely, with certain families... there still is the barrier. You just can't pass that. But with certain families, more and more they are coming to you with problems where they wouldn't have before and they are coming for earlier care for prenatal care. I think it's time. You just have to be available to them. (Family Home Visitor)

Implications of Overcoming Language and Trust Barriers: Supporting Mothers with Depression

In their regular roles, Family Home Visitors likely would not have been privy to certain aspects of women's lives, which they learned as a consequence of becoming the communication link between the Nurse Practitioner and mothers. Interpreting during the Nurse Practitioners' assessments of mother's health, including emotional health and diagnosis of depression, provided Family Home Visitors with an even deeper insight into the psychological well being of some of the mothers. Being intimately involved with families in their homes caused the Family Home Visitors some deep emotional concerns for the well being of the mothers and their children.

It [depression] is very common and it comes out when the Nurse Practitioner asks about it. However, in common circles, I don't think it is spoken about. But when a professional asks then it comes out and the women are very likely to discuss it. But only in a setting where they know it won't leak through. (Family Home Visitor)

One Family Home Visitor described how providing accurate interpretation required her to explore the mothers' feelings, to make sure the Nurse Practitioner understood what the mother was going through. This process caused the Family Home Visitor to identify on a deeper level with mothers' emotionally difficult situations. She found this deeper understanding brought both positive and negative emotions: she was pleased to be able to understand and convey women's situations better; but she also experienced distress, and had difficulties sleeping.

At first it was difficult. I found that I couldn't sleep at night because, especially where there is postpartum depression, knowing that a mom is out there crying and lonely and sad and that the children are watching their mom cry, that was very difficult at first. Because I was interpreting this through the Nurse Practitioner, I found that very difficult. We are supposed to be a fly on the wall, but to use the same words as them and to make sure that the Nurse Practitioner understands how these moms are feeling, you can't separate yourself from that. So, I did find that difficult at first. But at the same time, I found myself really understanding a lot of the things that these moms are going through too. For me it is so easy because I am so involved in the community. I know where to get help and these moms don't. It was a real awakening to see what these people are really going through. (Family Home Visitor)

It is unlikely that Nurse Practitioners would have been able to assess and help mothers suffering from depression without the assistance of Family Home Visitors who were able to bridge language and trust gaps to break some women's isolation.

And I'm trying to build myself up with some medicaments [medication] also, to help depression and things. My memory is bad, it's real bad. But I try to just live one day at a time, and try to make my husband and children the most important thing of my life. Yes, the most important thing, is what I would say. (Mother)

Nurse Practitioners worked with the Family Home Visitors on ways to assist mothers to overcome depression, either by encouraging mothers to get out of the house and socialize more, and/or through providing access to anti-depressant medication. Family Home Visitors recognized that some communities were quite fragmented. Although they shared a language and an ethnic identity, many newcomers lived quite isolated from other newcomer families. It was challenging to connect women with each other to break their isolation, escape their loneliness and hopefully also their depression. Without knowledge of the networks and divisions within the community, the Nurse Practitioners might not have been able to facilitate the process of helping to increase social contact among mothers with small children living in similar situations. One Family Home Visitor explained how she was building social networks among the women she visited on a regular basis.

In one of the apartment buildings, there are eight units, and of the eight, seven of them were Low German families that lived there. And even though they came, some of them came from the same villages in Mexico, they don't socialize here at all. They didn't even know who lived two doors down or whatever, and they don't visit and they don't, you know. (Family Home Visitor)

Family Home Visitors were aware of the additional burden that they carried as a consequence of this part of their role. They made special efforts to provide care and support to other mothers, beyond and outside the hours for which they were being paid. This involved considerable planning about what else they could do, as Family Home Visitors and as community members, to help the families in distress.

I do keep track of how many clients I interpret for and how many times, but what they don't see is the personal interaction, the day to day, they don't see the tears, especially when it comes to depression and solving some of that. They see the numbers, and the numbers don't reflect the time that you spend into it, and the effort. (Family Home Visitor)

Women trusted the Family Home Visitors' expertise, which permitted them to address more sensitive issues with mothers.

I do find that, even though I am an interpreter and I know all about their community, and I am from the community, they see me as a professional even though I am just a Family Home Visitor and so they are willing to talk about depression and birth control and stuff like that. (Family Home Visitor)

DISCUSSION

Language differences and similarities between service providers and clients are frequently used to explain differential access to health services, and are used as an indicator of system equity for minority linguistic groups (Engdasaw et al., 2003; Pitkin Derosé & Baker, 2000; Schillinger & Chen, 2004). The findings from this study contribute to our understanding of strategies to overcome language and trust barriers and improve access to programs for women from linguistic minority backgrounds.

Our findings indicate that language barriers were addressed at a regional system level (health units) as a result of collaboration between the HBHC and PPNP. The program reduced the language barriers because it was linked with an established service that had bilingual employees. Some health units had planned to use the Family Home Visitors as interpreters, while others reallocated some Family Home Visitor hours to the PPNP once they realized the need for this service. The provincial ministry (MOHLTC, 1999) did not require the health units' proposals for PPNP funding to include a budget for interpretation when targeting minority populations, nor did they allocate funds for this function. Without designated funding, having to locate, make arrangements, and pay for interpreters

might be a barrier to serving linguistic minorities (Diciccio-Bloom & Cohen, 2003; Maltby, 1999; Nailon, 2006).

Based on these findings, the role of Family Home Visitors went beyond interpreting: they played a critical role in ensuring Nurse Practitioners access to the target population, and by establishing trust with the community over time, which was facilitated by their position as community members. We propose that the mothers in this study would not have discussed sensitive issues with an interpreter or the Nurse Practitioner without the establishment of a trusting relationship that was facilitated by the Family Home Visitors. Campbell, Kulig, Hall, Babcock and Wall (2004) confirm this reluctance of recently immigrated Mennonite women to engage with health professionals. The importance of establishing interpersonal relationships in the context of nurses conducting home visits has been well documented (Jack, DiCenso & Lohfeld, 2005; Mitcheson & Cowley, 2003; Roggman, Boyce, Cook & Jump, 2001; Sharp, Ispa, Thornburg & Lane, 2003; Wade & Fordham, 2005; Zust & Moline, 2003).

Collaboration at the service provider level between Nurse Practitioner and Family Home Visitors resulted in a reduction of access barriers related to language and lack of trust. In addition, mutual learning occurred: Nurse Practitioners gained community knowledge, whereas Family Home Visitors increased their health knowledge and their assessment skills for detecting health problems including depression. Furthermore, they enhanced each others' roles: the Nurse Practitioner was seen as a more trusted, compassionate person, and the Family Home Visitor was viewed as more of a professional.

Zelkowitz et al. (2004) report that 42% of pregnant immigrant women present depressive symptoms, compared to only 12% in the general population. Immigrant women with depressive symptoms are more likely to lack social support systems compared to immigrant women who do not show these symptoms, and assessment of support systems is recommended for new immigrant mothers to prevent or address postpartum depression (Posmontier and Horowitz, 2004). A systematic review of the benefits of home visits found improved postnatal depression detection and treatment as a result of family visiting programs (Elkan et al., 2000). These visits included the services of both nurses and Family Home Visitors. Family Home Visitors who can communicate with new immigrant mothers in their own language could play a crucial role in preventing some women from developing postpartum depression, or helping them to overcome this illness more quickly, by linking them to appropriate services (Campbell et al., 2004; Murray, Woolgar, Murray & Cooper, 2003). One important finding from our study, that supports this earlier evidence, was the supportive role that Family Home Visitors played for linguistically isolated depressed women. In our study, the Family Home Visitors who provided interpretation for the Nurse Practitioners became familiar with intimate details about the mothers' mental health.

Coping with mental health issues, such as depression, requires the care of a health professional. Family Home Visitors from minority communities might benefit from additional training, agency support, and resources to respond to the health needs of their clientele. We are not suggesting that Family Home Visitors practice beyond their supportive listening role, but rather that their role in a collaborative team, such as the PPNP and HBHC initiative, be fully recognized and supported. Clear definition of professional boundaries and knowledge of when to refer are key ingredients to ensure the well-being of mothers and protect paraprofessional Family Home Visitors from attempting to provide services that they are not trained for. In addition, Family Home Visitors require a structured mechanism for discussion of emotionally stressful knowledge, as happens in most counseling supervisions. Co-workers such as Nurse Practitioners or Public Health Nurses could serve that role. Health care organizations working across programs need to establish reporting and supervision systems to avoid potential difficulties.

Strengths and Limitations

Secondary analysis of qualitative interview data poses methodological challenges. Medjedovic and Witzel (2005) review some of the opportunities and constraints in secondary analysis of qualitative interview data, and propose that codes and category schemes from the primary study can be adequate for the performance of secondary analysis under certain conditions. We chose to use many of the main codes and category schemes from the primary study, but also added new intersections and specific word searches.

In reviewing some of the key questions about secondary analysis of qualitative data, Van den Berg (2005) raises concerns about whether it is possible to analyze qualitative data without in depth knowledge of the research and social context in which the data were produced. Heaton (1998) also identified a series of methodological and ethical issues, which need to be considered in secondary analysis of qualitative data, and which "are more problematic if the secondary analyst was not part of the original research team" (p.4). In our study, the primary and the secondary analyses were performed by the same researchers, ensuring that the research and social contexts were fully understood, and that the inter-subjectivity of qualitative interviewing was not lost to the secondary analysis process.

Weed (2005) identifies additional problems in the secondary analysis of primary qualitative data, including issues of validity and reliability. To ensure integrity and quality of qualitative research using secondary analyses, the author recommends an open and transparent procedure that leaves a clear audit trail of decisions and interpretations to ensure trustworthiness. As well as the annotated interview transcripts, coding frameworks, coded data and printed node summaries, we kept detailed notes of meetings and correspondence in which interpretations for the data were suggested, discussed, and confirmed among all authors.

CONCLUSION

This article highlights the role of Family Home Visitors and their contributions in facilitating access to health services for minority women. Although health unit staff, including Nurse Practitioners, appreciated these important contributions, the true role of Family Home Visitors needs to be formally recognized and supported by the health system. Family Home Visitors working with minority women would benefit from supports such as funding, training, and peer support.

Without the Family Home Visitors, the Nurse Practitioners in this study might not have been able to provide services to isolated minority women who are not fluent in English: the population targeted by this program. The collaboration between the two health unit programs benefited the women who otherwise would have been less likely to receive pre- or postnatal health services.

Future primary research is needed to build upon these preliminary findings. For example, qualitative studies exploring the full range of functions and services that Family Home Visitors provide are warranted. These investigations should include exploration of how Family Home Visitors assist mothers from the perspective of mothers and of other service providers. Studies are also recommended that compare maternal health outcomes (e.g., depression) between linguistic minority women who receive services through a Family Home Visitor and those who do not.

Family Home Visitors aided the program evaluation in a truly collaborative fashion. Although we were involved in the PPNP evaluation, we only became aware of Family Home Visitor's role in the program because we wanted to speak with women who were not fluent in English. The Family Home Visitors helped us to contact women, arranged interviews, and provided translation. Without

this assistance from the Family Home Visitors, the evaluation of the program's impact on the target population would not have been possible.

The collaborative role of Family Home Visitors with Nurse Practitioners can go well beyond cultural interpretation. Depression was identified as a health issue in the communities studied. The role of Family Home Visitors in providing support to clients from linguistic minorities suffering from depression seems particularly promising.

REFERENCES

- Andersen, R. M., McCutcheon, A., Aday, L. A., Chiu, G. Y., & Bell, R. (1983). Exploring dimensions of access to medical care. *Health Services Research, 18*(1), 49-74.
- Barnes, M. D., & Fairbanks, J. (1997). Problem-based strategies promoting community transformation: Implication for the community health worker model. *Family & Community Health, 20*, 54-65.
- Beach, M. C., Gary, T. L., Price, E. G., Robinson, K. A., Gozu, A., Palacio, A., Smarth, C., Jenkes, M. W., Feuersein, C. J., Bass, E. B., Powe, N. R., & Cooper, L. A. (2006). Improving health care quality for racial/ethnic minorities: A systematic review of the best evidence regarding provider and organization interventions. *BioMed Central Public Health, 6*(104), 1-11. Retrieved: Sept 12, 2006 from: <http://www.biomedcentral.com/1471-2458/6/104>.
- Bowen, S. (2001a). Language barriers in access to health care. Prepared for Health Canada. Retrieved April 6, 2006, from http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2001-lang-acces/index_e.html.
- Bowen, S. (2001b). Access to health services for underserved populations in Canada. In: "Certain circumstances". Issues in equity and responsiveness in access to health care in Canada. A collection of papers and reports prepared for Health Canada. Retrieved April 6, 2006, from http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2001-certain-equit-acces/part1-tc-tm_e.html.
- Campbell, R., Kulig, J.C., Hall, B.L, Babcock, R. & Wall, M. (2004). Childbearing practices in Kanadier Mennonite women: Cross-cultural nursing has focused on understanding the knowledge, beliefs and practices of unique cultural groups and incorporating this information into the delivery of nursing practice. *The Canadian Nurse, 100*(8), 34-41.
- Dennis, C. L., & Hodnett, E. (2007). Psychosocial and psychological interventions for treating postpartum depression. *Cochrane Database Systematic Reviews, 4*, CD006116.
- DesMeules, M., Gold, J., Kazanjian, A., Manuel, D., Payne, J., Vissandee, B., McDermott, S., & Mao, Y. (2004). New approaches to immigrant health assessment. *Canadian Journal of Public Health, 95*(3), 122-126.
- Dicicco-Bloom, B., & Cohen, D. (2003). Home care nurses: A study of the occurrence of culturally competent care. *Journal of Transcultural Nursing, 14*(1), 25-31.
- Drennan, V. M., & Joseph, J. (2005). Health visiting and refugee families: Issues in professional practice. *Journal of Advanced Nursing, 49*(2), 155-163.
- Elkan, R., Kendrick, D., Hewitt, M., Robinson, J. J. A., Tolley, K., Blair, M., Dewey, M., Williams, D. & Brummel, K. (2000). The effectiveness of domiciliary health visiting: a systematic review of international studies and a selective review of the British literature. *Health Technology Assessment 4*(13), 1-339.
- Eng, E., Parker, E., & Harlan, C. (1997). Health advisor intervention strategies: A continuum from natural helping to paraprofessional helping. *Health Education & Behavior, 24*(4), 413-417.
- Engdasaw, A., Estable, A., MacLean, L., Tomcik, K., Meyer, M., & Gupta, M. (2003). Equal access indicators for Ontario's mandatory core programming requirements. Ontario Public Health Association and the Community Health Research Unit.

- Estable, A., MacLean, L., Meyer, M., Peterson, W., & Engdasaw, A. (2005). Assessing access in nurse practitioner-provided prenatal and postnatal care: perspectives of clients and community leaders. Final Report. Submitted to: Early Years Program Branch, Policy Development and Program Design Division, Ontario Ministry of Children and Youth Services.
- Farabakhsh, R., & Lauzon, A. (2008). Exploring the impact of participatory health literacy programs: A case study of old colony rural Mennonite women immigrants in South-Western Ontario. In J. Groen & S. Guo (Eds.), *Online proceedings of the Canadian Association for the Study of Adult Education (CASAE) 27th National Conference: Thinking Beyond Borders: Global Ideas, Global Values* (pp. 87-93). Vancouver, BC: Univ of British Columbia, 2008. Retrieved March 23, 2009, from <http://www.oise.utoronto.ca/casae/cnf2008/onlineproceedings-2008/cas2008-farabakhsh.pdf>.
- Gelberg, L., Andersen, R. M., & Leake, B. D. (2000). The behavioural model for vulnerable populations: Application to medical care use and outcomes for homeless people. *Health Services Research*, 34(6), 1273-1302.
- Gomby, D.S. (2000). Promise and limitations of home visitation. *Journal of the American Medical Association*, 284, 1430-1431.
- Grant, T., Ernst, C. C., Pagalilauan, G., & Streissguth, A. (2003). Postprogram follow-up effects of paraprofessional intervention with high-risk women who abused alcohol and drugs during pregnancy. *Journal of Community Psychology*, 31(3), 211-222.
- Hall, B. L., & Kulig, J. C. (2004). Kanadier Mennonites: A case study examining research challenges among religious groups. *Qualitative Health Research*, 14(3), 359-368.
- Health Canada (2005). Canada Health Act – Overview. Retrieved April 5, 2006, from http://www.hc-sc.gc.ca/hcs-sss/medi-assur/overview-apercu/index_e.html.
- HBHC (2002). Healthy Babies Healthy Children Program Update. Toronto ON: Queen's Printer of Ontario. Retrieved April 4, 2006, from http://www.health.gov.on.ca/english/providers/pub/child/hbabies/hbabies_update.html.
- Heaton, J. (1998). Secondary analysis of qualitative data. *Social Research Update*, 22, 1-6.
- Hiatt, S. W., Sampson, D., & Baird, D. (1997). Paraprofessional home visitation: Conceptual and pragmatic considerations. *Journal of Community Psychology*, 25(1), 77-93.
- Hiatt, S., Michalek, P., & Younge, P. (1999). Characteristics of volunteers and families in a neonatal home visitation project: The Kempe community caring program. *Child Abuse & Neglect*, 24(1), 85-97.
- Houston, A. M., & Cowley, S. (2003). Health needs assessment in the health visiting service and the impact on the ethnic community. *International Journal of Nursing Studies*, 40, 85-94.
- Jack, S. M., DiCenso, A., & Lohfeld, L. (2005). A theory of maternal engagement with public health nurses and family visitors. *Journal of Advanced Nursing*, 49(2), 182-190.
- Loiselle, C. G., Semnic, S. E., Côté, B., Lapointe, M., & Gendron, R. (2001). Impressions of breastfeeding information and support among first-time mothers within a multiethnic community. *Canadian Journal of Nursing Research*, 33(3), 31-46.
- Maltby, H. J. (1999). Interpreters: A double-edged sword in nursing practice. *Journal of Transcultural Nursing*, 10(3), 248-254.
- McFarlane, J. (1996). De madres a madres: An access model for primary care. *American Journal of Public Health*, 86(6), 879-880.
- Medjedovic, I., & Witzel, A. (2005). Sekundäranalyse qualitativer Interviews. Verwendung von Kodierungen der Primärstudie am Beispiel einer Untersuchung des Arbeitsprozesswissens junger Facharbeiter. [Secondary analysis of interviews: Using codes and theoretical concepts from the primary study]. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research [On-line Journal]*, 6(1), Art. 46. Retrieved on September 12, 2006 from: <http://www.qualitative-research.net/fqs-texte/1-05/05-1-46-d.htm>.

- Meyer, M. C., Torres, S., Cermeño, N., MacLean, L., & Monzón, R. (2003). Immigrant women implementing participatory research in health promotion. *Western Journal of Nursing Research*, 25(7), 815-834.
- Mitcheson, J., & Cowley, S. (2003). Empowerment or control? An analysis of the extent to which client participation is enabled during health visitor/client interactions using a structured health needs assessment tool. *International Journal of Nursing Studies*, 40, 413-426.
- MOHLTC - Ministry of Health and Longterm Care. (1999). Prenatal and Postnatal Nurse Practitioner Services Initiative. Retrieved February 12, 2006, from <http://www.phb.ca/documents/extended%20nursepractitioner%20attachment4.1%20mar12.2002.doc>.
- MOHLTC - Ministry of Health and Longterm Care (2001). Implementation guidelines for the Healthy Babies Healthy Children program, phase II. Retrieved April 6, 2006, from http://www.health.gov.on.ca/english/providers/pub/child/hbabies/implem_phase2.html.
- Murray, L., Woolgar, M., Murray, J., & Cooper, P. (2003). Self-exclusion from health care in women at high risk for postpartum depression. *Journal of Public Health Medicine*, 25(3), 131-137.
- Nailon, R. E. (2006). Nurses' concerns and practices with using interpreters in the care of Latino patients in the emergency department. *Journal of Transcultural Nursing*, 17(2), 119-128.
- Olds, D. L., Robinson J., O'Brien, R., Luckey, D. W., Pettitt, L. M., Henderson, C. R., Ng, R. K., Sheff, K. L., Korfmacher, J., Hiatt, S., & Talmi, A. (2002). Home visiting by paraprofessionals and by nurses: A randomized, controlled trial. *Pediatrics*, 110(3), 486-496.
- Pitkin Derosé, K., & Baker, W. (2000). Limited English proficiency and Latinos' use of physician services. *Medical Care Research and Review*, 57(1), 76-91.
- Posmontier, B., & Horowitz, J. A. (2004). Postpartum practices and depression prevalences: Technocentric and ethnokinship cultural perspectives. *Journal of Transcultural Nursing*, 15(1), 34-43.
- Ricketts, T. C., & Goldsmith, L. J. (2005). Access in health services research: The battle of the frameworks. *Nursing Outlook*, 53(6), 274-280.
- Roggman, L., Boyce, L., Cook, G., & Jump, V. (2001). Inside home visits: A collaborative look at process and quality. *Early Childhood Research Quarterly*, 16, 53-71.
- Ryan, B., Lero, D., Robinson, R., Forsyth, A., Eaton, F., Smith, D., & Smith, J. (2006). Healthy Babies Healthy Children. Follow-on evaluation. Consolidated report. Toronto ON: Ministry of Children and Youth Services.
- Scheppers, E., Van Dongen, E., Dekker, J., Geertzen, J., & Dekker, J. (2006). Potential barriers to the use of health services among ethnic minorities: A review. *Family Practice, An International Journal*, 23(3), 325-348.
- Schillinger, D., & Chen, A. H. (2004). Literacy and language disentangling measures of access, utilization, and quality. *Journal of General Internal Medicine*, 19, 289-290.
- Sharp, E., Ispa, J., Thornburg, K., & Lane, V. (2003). Relations among mother and home visitor personality, relationship quality, and amount of time spent in home visits. *Journal of Community Psychology*, 31(6), 591-606.
- Snelling, S., Ehrlich, A., Grafton, D., Michel, I., MacLean, L., & McFarland, V. (2005). Evaluation of the Prenatal and Postnatal Nurse Practitioner Services Initiative: Interim Report. Sudbury ON: Public Health Research, Education and Development Program.
- Sword, W. (1999). A socio-ecological approach to understanding barriers to prenatal care for women of low income. *Journal of Advanced Nursing*, 29(5), 1170-1177.
- Van den Berg, H. (2005). Reanalyzing qualitative interviews from different angles: The risk of decontextualization and other problems of sharing qualitative data [48 paragraphs]. *Forum Qualitative Sozialforschung/ Forum: Qualitative Social Research [On-line Journal]*, 6(1), Art. 30.

- Available at: <http://www.qualitative-research.net/fqs-texte/1-05/05-1-30-e.htm>.
- VanTuijl, C., Leseman, P. P. M., & Rispen, J. (2001). Efficacy of an intensive home-based educational intervention programme for 4- to 6-year-old ethnic minority children in the Netherlands. *International Journal of Behavioral Development*, 25 (2), 148-159.
- Wade, K., & Fordham, J. (2005). Voices from the Field – Prenatal and postnatal home visiting. In R. E. Tremblay, R. G. Barr, & R. D. Peters (Eds.), *Encyclopaedia on Early Childhood Development* [Online]. Montreal, QC: Centre of Excellence for early Childhood Development; 1-6. Retrieved April 6, 2006, from <http://www.excellence-earlychildhood.ca/documents/wade-fordhamang.pdf>.
- Wager, K. A., Lee, F. A., Bradford, W. D., Jones, W., & Kilpatrick, A. O. (2004). Qualitative evaluation of South Carolina's postpartum/infant home visit program. *Public Health Nursing*, 21(6), 541-546.
- Weed, M. (2005). "Meta interpretation": A method for the interpretive synthesis of qualitative research. Research [53 paragraphs]. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research* [On-line Journal], 6(1), Art. 37. Available at: <http://www.qualitative-research.net/fqs-texte/1-05/05-1-37-e.htm> [Date of Access: Sept. 12, 2006].
- Woodgate, R., Heaman, M., Chalmers, K., & Brown, J. (2007). Issues related to delivering an early childhood home-visiting program. *The American Journal of Maternal Child Nursing*, 32(2), 95-101.
- World Health Organization (2006). *Pregnancy, Childbirth, Postpartum and Newborn Care: A Guide for Essential Practice* (Rev.ed.). Geneva: Department of Reproductive Health and Research, Family and Community Health, World Health Organization.
- Wu, Z., Penning M. J., & Shimmele, C. M. (2005). Immigrant status and unmet health care needs. *Canadian Journal of Public Health*, 96(5), 369-373.
- Zelkowitz, P., Schinazi, J., Katofsky, L., Saucier, J. F., Valenzuela, M., Westreich, R., & Dayan, J. (2004). Factors associated with depression in pregnant immigrant women. *Transcultural Psychiatry*, 41(4), 445-464.
- Zust, B. L., & Moline, K. (2003). Identifying underserved ethnic populations within a community: The first step in eliminating health care disparities among racial and ethnic minorities. *Journal of Transcultural Nursing*

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