A CRITICAL EXPLORATION OF
VOLUNTARY SECTOR SOCIAL POLICY ADVOCACY WITH
MARGINALIZED COMMUNITIES USING A POPULATION HEALTH LENS
AND SOCIAL JUSTICE

A Thesis
Submitted to the Faculty of Graduate Studies and Research
In Partial Fulfillment of the Requirements
for the Degree of
Doctor of Philosophy
in Canadian Plains Studies
University of Regina

by
Gloria Christina DeSantis
Regina, Saskatchewan
December 2008

Copyright 2008: Gloria C. DeSantis
ABSTRACT

There appears to be little data on the social policy advocacy work of the voluntary social service sector, also known as community-based organizations (CBOs), in Canada and their role in helping to create healthier communities. Research on this topic is timely in light of the following: shifting expectations of social service CBOs over the past few decades; questions about CBO-government relations; a growing importance of measuring the outcomes/impacts of the social service CBO sector; a need to alter free market ideology and introduce the counterweight of social justice principles to reduce health inequities; a growing interest in holistic policy development; growing awareness that social policies have health implications; and the Canadian welfare state is under transformation.

My purpose was twofold: to explore the evolving nature of policy advocacy work undertaken by social service CBOs in Saskatchewan using a population health lens, and to examine the perceived outcomes/impacts of these processes on marginalized groups of people, CBOs, governments and communities using this lens. Using a critical inquiry methodology, qualitative data were collected through a multi-method approach. A case study design was adopted. An examination of the case study context comprised data collected through telephone interviews with 39 voluntary social service agencies from 18 communities throughout Saskatchewan, through government annual reports spanning 60 years and through observations of the political context. The case study included an examination of documents from a policy advocacy coalition, personal interviews with 17
individuals involved with the coalition, and observations of the coalition. Follow-up focus groups were conducted with these 17 interviewees.

There were a number of findings. There has been growth in the number and diversity of social service CBOs over the past 30 years, government funding cuts and Canada Revenue Agency rules negatively affected CBOs, CBOs perceive policy advocacy is interconnected with other advocacy types, a sense of fear and vulnerability affect some advocacy participants, and of the 39 social service CBOs, 35 said they believed they contribute to people’s health/well-being through their daily work with the social determinants of health (e.g., poverty). A number of different types of advocacy processes were found to exist and some included marginalized people while others did not; CBOs’ choices about including people appeared to depend on a number of conditions (e.g., perception of participation barriers, sense of vulnerability). Interviewees described a variety of perceived outcomes/impacts of advocacy processes (e.g., learning, behaviour change, social connectedness, emotional reactions) in different spheres. The advocacy processes and their impacts were multiple, fluid and not totally predictable. A conceptualization of policy advocacy processes and population health was formulated as were implications and suggested actions for moving toward the creation of healthier communities through enhanced engagement in social policy making.
ACKNOWLEDGEMENTS

Over the past five years while working on this study, I have had the pleasure of working with many people to whom I must say “thank you!” Thank you to Dr. Andrew Stubbs, my plain language editor, for his work on my interview tools. Thank you to my colleagues on the front lines who assisted me with my pre-test work: Linda Terry, Morteza Jafapour, Bill Davidson, Els Scheeper, Susan Tremaine, Lynn Randall, Suzanne Brown, Theresa Savaria, and Diane Delaney. Thank you to Knox Metropolitan Church, especially Joan, for arranging meeting space to do interviews and conduct focus groups. Thank you to Saskatchewan Corporations Branch and the federal Charities Directorate for creating two customized datasets for my use.

Thank you to the 56 people who participated in this study. Listening to their insight and wisdom gives me great hope for the future of advocacy work and social change!

Thank you to my mentors/supervisors Dr. James Mulvale and Dr. Bonnie Jeffery, who challenged me every step of the way. Thank you also to my committee members Dr. Larena Hoeber, Dr. Polo Diaz and Dr. David Gauthier for their insightful comments and suggestions over the years.

Thank you to two special friends: my dear friend and hockey team mate Ev Rieder who constantly reminded me about balance when there was none; and my dear childhood friend Dana Woito who is my soul sister and my rock.

Thank you to my Mom and Dad, for inspiring me early in life to care about my community, to get involved, and to always strive to be the best I can be. Thank you to my children – Ali, Stefan and Aidan – for their patience over the years and for their understanding when I acted disoriented, which was frequently (for no obvious reason to them). And thank you to my life-partner, Joe Piwowar, who lived this experience himself. He took over many of my mothering duties and always seemed to know what to say to keep me going. “Just keep putting one foot after the other”, he said many times … even after I broke my leg!

Happily, it’s over. Now it’s time to head outside and play some serious road hockey!
# TABLE OF CONTENTS

ABSTRACT ........................................................................................................................................... i  
ACKNOWLEDGEMENTS .................................................................................................................... iii  
TABLE OF CONTENTS ........................................................................................................................ iv  
LIST OF TABLES .................................................................................................................................. viii  
LIST OF FIGURES ............................................................................................................................... ix  

## 1. INTRODUCTION

1.1 Overview, main purpose, objectives and key research questions ................................................. 2  
1.2 Rationale for this study .................................................................................................................. 3  
1.3 The social service CBO sector, social policy advocacy and coalitions ........................................ 8  
1.4 Health, population health and social justice .................................................................................. 14  
1.5 Critical inquiry .............................................................................................................................. 17  
1.6 Overview of the dissertation ........................................................................................................ 19  

## 2. CONCEPTUAL FRAMEWORK

2.1 Critical inquiry ............................................................................................................................... 20  
2.1.1 Power, control and knowledge-making .................................................................................... 21  
2.1.2 Inequality, exclusion and silence ............................................................................................ 22  
2.1.3 Multiplicity and fluidity ........................................................................................................... 27  
2.1.4 Action for change ...................................................................................................................... 27  
2.2 The Canadian welfare state, social justice, and CBOs ................................................................. 28  
2.2.1 The Canadian welfare state as context for CBOs .................................................................... 28  
2.2.2 Social justice within the world of CBOs .................................................................................. 31  
2.2.3 CBOs and CBO-government relations ................................................................................... 33  
2.3 CBO social policy advocacy as civic participation ...................................................................... 37  
2.3.1 Advocacy volunteers ................................................................................................................. 38  
2.3.2 Social policy making ............................................................................................................... 40  
2.3.3 What is social policy advocacy? ............................................................................................... 42  
2.3.4 What is the purpose of advocacy? ............................................................................................ 44  
2.3.5 Who does social policy advocacy? ........................................................................................... 45  
2.3.6 How is policy advocacy done? ............................................................................................... 46  
2.3.7 Advocacy chill – contradictions about the voice of CBOs ....................................................... 47  
2.3.8 In summary .............................................................................................................................. 49  
2.4 Population health lens .................................................................................................................. 50  
2.4.1 Defining population health ..................................................................................................... 50  
2.4.2 Population health, inequities and advocacy .......................................................................... 52  
2.4.3 Determinants of health .......................................................................................................... 54  
2.4.4 Processes-of-change ................................................................................................................ 61  
2.4.5 Health status .......................................................................................................................... 63  
2.4.6 Summary of key population health elements ......................................................................... 64  
2.5 Outcomes and impact measurement ............................................................................................ 65  
2.6 Summary ....................................................................................................................................... 70
6.2 Advocacy process based on the Coalition case study ........................................... 184
   6.2.1 Coalition advocacy process ........................................................................... 184
   6.2.2 Perceived participation barriers noted by Coalition participants ............... 191
   6.2.3 Opportunities to enhance participation noted by Coalition members ........ 194
6.3 Conditions that appear to affect advocacy ......................................................... 196
6.4 Discussion ............................................................................................................. 198
   6.4.1 Advocacy types, strategies and volunteers .................................................... 198
   6.4.2 Participation and exclusion ........................................................................... 199
   6.4.3 Conditions are multiple and fluid ................................................................. 201
   6.4.4 Experiences of an advocacy process ............................................................. 202
   6.4.5. Power-over and power-with-others ......................................................... 204
7. OUTCOMES/IMPACTS OF ADVOCACY PROCESSES............................................ 206
   7.1 Outcomes/impacts using a population health lens ........................................... 208
       7.1.1 Outcomes/impacts on advocacy volunteers ............................................. 210
       7.1.2 Outcomes/impacts on CBOs .................................................................. 218
       7.1.3 Outcomes/impacts on governments ......................................................... 221
       7.1.4 Outcomes/impacts on communities ....................................................... 224
       7.1.5 Summary, missing elements, emergent pieces ......................................... 225
   7.2 Observations of the Coalition over one year ..................................................... 228
   7.3 Focus group findings ......................................................................................... 232
   7.4 A glimpse of 39 CBOs perceptions of outcomes/impacts ................................ 236
   7.5 Discussion ......................................................................................................... 238
       7.5.1 Learning outcomes/impacts ...................................................................... 239
       7.5.2 Emotional reactions ................................................................................... 240
       7.5.3 Advocacy volunteers’ sense of power and control ..................................... 240
       7.5.4 Social connectedness outcomes/impacts.................................................. 241
       7.5.5 Behaviour outcomes/impacts ................................................................... 242
       7.5.6 Closing thoughts ....................................................................................... 243
8. CONCLUSIONS ........................................................................................................... 245
   8.1 Conceptualization of CBO advocacy and population health ............................. 245
   8.2 Main themes, implications and suggestions for action ....................................... 249
       8.2.1 Advocacy volunteers and advocacy work .................................................. 249
       8.2.2 Social service CBOs play roles in creating health/well-being ..................... 251
       8.2.3 Advocacy processes: power to include or exclude .................................... 253
       8.2.4 Advocacy changes individuals and communities: health/well-being links ... 259
       8.2.5 Multiplicity, fluidity and some unpredictability ......................................... 262
       8.2.6 Rules, money, fear and silence … but not always ....................................... 265
       8.2.7 Structural and political determinants of health/well-being .......................... 267
   8.3 Limitations and further research ....................................................................... 272
   8.4 Lingering questions ............................................................................................. 274
   8.5. Concluding comment ....................................................................................... 275
REFERENCES.............................................................................................................. 277
APPENDICES .................................................................................................................. 299
Appendix A - Social policy advocacy and social movements .................................. 300
Appendix B – Research Ethics Board approval for phases 1 and 2 ....................... 303
Appendix C – Research Ethics Board approval for phase 3 ................................. 304
Appendix D – Introductory letter for Phase 1 Telephone Interviews .................... 305
Appendix E - Consent form and information package: phase 1 phone interviews .... 307
Appendix F – Introductory letter for phase 2 personal interviews ......................... 314
Appendix G - Consent form and information package: phase 2 interviews .......... 316
Appendix H - List of Saskatchewan CBO policy advocacy documents .............. 326
Appendix I - Macro-context observations list ......................................................... 338
Appendix J - Summary observations of Coalition’s meetings ............................... 340
LIST OF TABLES

Table 3.1: Overview of the study................................................................. 73
Table 3.2: Research questions and methods of data collection .................... 83
Table 3.3: Research questions and methods of analysis............................... 99
Table 4.1: Profile of the 39 CBOs interviewed............................................ 118
Table 4.2: Profile of the 17 Coalition interviewees ...................................... 122
Table 4.3: Summary profile of focus group participants in phase 3................. 125
Table 5.1: Overview of phase 1 research questions, methods and analysis ...... 126
Table 5.2: Government annual reports mission, issues and departments by year 134
Table 5.3: Government annual reports containing collaboration with CBOs by year .... 135
Table 5.4: Government annual reports containing “health/well-being” .......... 138
Table 5.5: Description of CBO-government relations.................................... 144
Table 5.6: Trends influencing CBO advocacy work .................................... 154
Table 5.7: CBOs’ descriptions of government-CBO relations over time ........ 156
Table 5.8: CBO descriptions of the involvement of marginalized people over time .... 158
Table 6.1: Overview of chapter 6 data collection and analyses..................... 171
Table 6.2: Examples of policy, program and research advocacy initiatives....... 174
Table 6.3: CBO advocacy strategies and involvement of marginalized groups ..... 180
Table 6.4: Perceived participation barriers noted by 39 CBOs ....................... 182
Table 6.5: Opportunities pursued to enhance participation noted by 39 CBOs.... 183
Table 6.6: Participation barriers noted by Coalition participants .................... 193
Table 6.7: Opportunities pursued to enhance participation noted by the Coalition...... 195
Table 6.8: Some conditions affecting advocacy types, strategies and volunteers .... 197
Table 7.1: Overview of chapter 7 data collection and analyses..................... 207
Table 7.2: Summary of outcomes/impacts of Coalition’s work in four spheres .... 227
Table 7.3: Perceived outcomes/impacts on volunteers noted by 39 CBOs .......... 237
LIST OF FIGURES

Figure 2.1: A conceptualization of population health.......................... 52
Figure 2.2: Outcomes/impacts model .................................................. 68
Figure 3.1: Research design - outcomes/impacts and population health models .......... 81
Figure 4.1: Map showing the spatial distribution of the 39 CBOs in Saskatchewan..... 117
Figure 5.1: Macro-context organizations, flows and influences.......................... 146
Figure 6.1: Typology of social policy advocacy described by 39 CBOs............... 176
Figure 6.2: Coalition’s advocacy story ..................................................... 186
Figure 6.3: Outcomes/impacts model with a focus on the process component........ 203
Figure 8.1: Conceptualization of CBO policy advocacy and population health........... 246
1. INTRODUCTION

For 17 years I worked and volunteered in the voluntary, social service sector – also known as community-based organizations (CBOs) (see section 1.3) - doing community-based research with people who were marginalized (e.g., people who lived in poverty, people who had physical or psychiatric disabilities, First Nations peoples, people who came to Canada as refugees or immigrants, and women who were assaulted by their partners). All of these people lived in extremely negative social conditions. We came together and collectively identified and defined their issues, completed research together, defined solutions, and acted on those defined solutions. Much of this work was done in collaboration with other CBOs and sometimes with governments and funders. Regardless of who was involved, the end product was always the creation of material to advocate for policy or program changes directed at governments. These usually took the form of research reports containing recommendations for change and implementation strategies.

Over time I became aware of the following: community-based social policy advocacy was necessary in order to create healthier communities; marginalized groups of people who struggle everyday to survive needed to be included in advocacy work; and that many government policy making processes did not engage communities. At one point I became involved in a local healthy communities movement. I began to understand the “social conditions” with which I had been working for many years were the same as the “social determinants of health” with which many health sector people were working. I learned much about marginalized communities and their disproportionate share of
illnesses. Consequently, marginalized communities, social justice, social policy advocacy processes, social service CBOs, and health became central to my doctoral research.

1.1 Overview, main purpose, objectives and key research questions

This study is about social service CBOs working in collaboration with marginalized populations to advocate for and assist in the movement toward healthier communities through public policy participation. I adopted a critical inquiry theoretical perspective for which the foci are the forces of social injustice and power relationships (Crotty 2003). Social justice is central to the social policy advocacy processes advanced by many CBOs (Boucher, Fougeyrollas, and Gaucher 2003; Institute for Media and Society 2002; Maxwell 2006) as well as to reducing population health inequities (Beauchamp 2003; Hofrichter 2003a; Levy and Sidel 2006a). Social justice comprises four dimensions: equitable distribution of material resources (e.g., income) and nonmaterial social goods (e.g., rights, opportunities, power) (Fraser 2003; Hofrichter 2003a; Mullaly 1997); recognition and respect for the dignity of all people (Cohen, de la Vega, and Watson 2001); enhanced participatory opportunities (Fraser 2003; Mullaly 1997); and the development of people’s capacities and human potential (Gindin 2002).

My purpose was twofold: to explore the evolving nature of policy advocacy work undertaken by social service CBOs in Saskatchewan using a population health lens, and to examine the perceived outcomes/impacts of these processes on marginalized groups of people, CBOs, governments and communities using this lens. My study comprised the following three objectives and six research questions:
Objective A: to undertake a contextual analysis that includes an examination and description of the policy advocacy function of social service CBOs within social policy making contexts in Saskatchewan.

Question #1: How is the CBO social policy advocacy function presented in documentary material over time in Saskatchewan?

Question #2: How do social service CBOs in Saskatchewan understand and incorporate marginalized people into policy advocacy processes?

Question #3: Using a population health lens, what did CBOs perceive were outcomes/impacts of these advocacy processes on marginalized people and communities?

Objective B: to identify and describe the processes and outcomes/impacts of a social policy advocacy case study using a population health lens.

Question #4: What were the experiences and perceptions of marginalized people, CBO staff and government regarding a local social policy advocacy coalition process?

Question #5: Using a population health lens, what were these interviewees’ perceptions of the outcomes/impacts of this local coalition?

Objective C: to conceptualize the links between social policy advocacy processes and population health.

Question #6: Based on the answers to the above five questions how can the links between CBO policy advocacy processes and population health be conceptualized?

I will now explain the rationale for my focus and these particular research questions.

1.2 Rationale for this study

First, there appears to be little empirical data on the advocacy role of the social service CBO sector in Canada (Brock and Banting 2001b; Harvie 2002; Legowski and Albert 1999), except for a study conducted on advocacy (i.e., inform, educate, influence,
lobby) in 2000, which was modified to “teaching, educating or mentoring” in the follow-up research in 2004 (Hall, McKeown, and Roberts 2001; Hall et al. 2006). “Surprisingly little empirical data are available on how the voluntary sector participates in public processes or how its advocacy activities vary” (Harvie 2002, p. 5). In Canada, most of the studies done on advocacy have focused on the legal issues of charitable lobbying activities (see for example Phillips, Chapman, and Stevens 2001). Thus an explanation of the historical development of advocacy is warranted.

Second, over the past 30 years there have been many changes in the expectations placed on social service CBOs. Changes which have taken place in local, provincial and federal governments have led to shifting expectations of CBOs (Antony and Samuelson 1998; Jetté, Lévesque, and Vaillancourt 2001; Lightman 2003; Mulvale 2001; Rice and Prince 2003; Vaillancourt and Tremblay 2002). There have been shifts in expectations from the private sector, especially regarding financial accountability (Browne 1996; O'Sullivan and Sorensen 1988). There have also been shifts in expectations from citizens in that they expect CBOs to fill gaps where governments will not nor cannot (Brock and Banting 2001a) and citizens have declining confidence in governments (Salamon and Anheir 1996). Finally, there are world-wide trends that have also had an impact on the CBO sector including globalization and technological changes (Jackson and Sanger 2003; Tremblay et al. 2002). These shifting expectations have meant the sector has had to redefine itself over time.

1 These scholars offer descriptions about shifts in ideology, a shift from a charity model to self reliance and capacity building models, social and health program restructuring and funding cuts, downloading, and deficit reduction – to name but a few.
Third, and related to expectations, are concerns about CBO-government relations. When CBOs and their program participants want to change government social policies, they must interact with governments, however, “advocacy and funding are two of the most controversial areas of government and voluntary sector relations” (Brock and Banting 2001a, p. 10). In some communities, certain CBOs are powerless and dependent on governments, whereas in other communities and other CBOs, the relationship is one of interdependence and mutuality (Boudreau 2006). Coston’s (1998) CBO-government relationship typology ranges from repression and rivalry to collaboration and includes three main dimensions: the degree of government resistance or acceptance, the distribution of power in the relationship, and the degree of formality. Rice and Prince (2003) emphasize that although we often discuss government-CBO partnerships, these conversations tend to ignore power inequalities. Advocacy coalitions are vehicles within which we can examine the relations among CBOs, governments and marginalized citizens. These coalitions constitute what Nozick (1992) refers to as “power-with-others” and occurs when people act together on a common purpose, or engage in a common struggle (see also Jansson 1999, p. 267-272).

Fourth, there is growing importance for measuring the impacts of the social service CBO sector in general given the expectations of foundations, donors, board members, and governments (Flynn and Hodgkinson 2001a). The CBO sector appears ready to engage in research but there are methodological challenges "because there is no clear path in the extant literature on how to measure organizational outcomes or impacts" (ibid., p. 6-7). However, McCarthy and Castelli (2001) offer prescriptions on how to conduct comparative studies of advocacy organizations in the United States. In
Saskatchewan, I did not find any analyses of the policy advocacy role of social service organizations.²

Fifth, there is a need to alter the prevailing free market ideology, neo-liberalism, and introduce the counterweight of social justice principles in order to reduce health inequities among different populations in society (see section 2.4.2). Free market ideology emphasizes the following elements: individuals are responsible for their own health and do not have collective community obligations; there is a sense of powerlessness to confront premature death; voluntary behaviour and free choice mean that some people will make unhealthy choices (e.g., smoking); there is a tendency to blame-the-victim for her/his disability or premature death; and there is over-investment and over-confidence in curative medical services (Beauchamp 2003, p. 269-70). Social justice emphasizes the following perspectives: society is responsible for helping to create healthy populations; collective action should be encouraged; many social and political structures cause premature death; unhealthy choices (e.g., smoking) are connected to larger societal structures; and powerful people and institutions create an unfair distribution of illnesses for which medical services are not the solution (ibid., p. 272-75).

Sixth, there appears to be a growing interest in holistic policy development including the integration of health, social, economic and environmental issues.³ For instance, there is greater awareness that many social welfare policies have health implications (Kawachi and Kennedy 1999; Raphael 2003, 2004; Savarese and Morton 2005; Vaillancourt et al. 2003). Some common examples of social welfare policies which

---

² I found many examples of advocacy reports produced by CBOs though. These are presented in chapter 5.
³ This observation is based on my previous work with CBOs and governments.
have health implications are income assistance for people who are unemployed, subsidized housing, child protection and immigrant/refugee integration into Canadian society. Raphael (2003) argues convincingly that increasing poverty – a social issue which is tightly tied to both health and economic policies - threatens Canadians’ health as shown through cardiovascular disease data. Over the past 20 years, holistic approaches have been found in cross-government department initiatives (e.g., regional intersectoral committees in the Saskatchewan provincial government) (Regina Qu'Appelle Health Region - Mental Health and Addiction Services 2007), across communities (e.g., healthy communities initiatives, safe city initiatives) (refer to section 2.4.3) and across university campuses (e.g., sustainable campus movements). Beauchamp (2003) and Cook (2006) explain that health policy should permeate all government departments. This present research ties together social service CBOs and population health.

Finally, the current restructuring and shifting of responsibilities in the Canadian welfare state and interest in new models make topics of health, social services, advocacy processes, and marginalized communities relevant today. The current welfare state debates about whether the government, voluntary, private or family sectors should deliver certain services have intensified over the past twenty years with arguments for and against the privatization of some health care and social services, and pressure put on families – primarily women – to deliver services (Antony and Samuelson 1998; Brock and Banting 2001b; Browne 1996; Jetté, Lévesque, and Vaillancourt 2001; Lightman 2003; Mulvale 2001; O'Sullivan and Sorensen 1988; Rice and Prince 2003; Vaillancourt and Tremblay 2002). There appears to be no more consensus today than there was 60
years ago about who should deliver which services to whom (Canadian Welfare Council 1938; O'Sullivan and Sorensen 1988; Thériault, Gill, and Kly 2002).

In summary, research on the social policy advocacy role of CBOs in collaboration with marginalized communities and the implications for health/well-being is timely. The reasons are compelling and numerous: there are few empirical data on the advocacy work of the social service CBO sector; there have been shifting expectations of social service CBOs over the past few decades; there are questions about CBO-government relations which can be examined through advocacy coalitions; there is growing importance of measuring the outcomes/impacts of the social service CBO sector; there is a need to alter free market ideology and introduce the counterweight of social justice principles to reduce health inequities; there appears to be a growing interest in holistic policy development; social policies have health implications; and the Canadian welfare state is under transformation thus exploring new welfare state models is appropriate. I will now describe three of the major concepts of my research, the social service CBO sector, social policy advocacy, and advocacy coalitions.

1.3 The social service CBO sector, social policy advocacy and coalitions

There are diverse labels for the CBO sector: voluntary sector, charities, philanthropic organizations, nonprofit sector, nongovernmental organizations, solidarity organizations, social economy, third sector, co-operatives, and community economic
development organizations.\textsuperscript{4} The current label commonly used by practitioners and researchers in Saskatchewan is “community-based organization” (CBO), so I adopted this label for my study. I focused exclusively on social service CBOs in my study; social service CBOs are defined below.

Definitions of the CBO sector are diverse. Since my research is based in Canada and focuses on CBOs and governments, the following definition is adopted because it was created by a government-CBO partnership and contains key elements found in other definitions (see for example Febbraro, Hall, and Parmegiani 1999; Hall and Banting 2000):

“This sector consists of organizations that exist to serve a public benefit, are self governing, do not distribute profits to members, and depend to a meaningful degree on volunteers. Membership or involvement in these organizations is not compulsory, and they are independent of, and institutionally distinct from the formal structures of government and the private sector. Although many voluntary sector organizations rely on paid staff to carry out their work, all depend on volunteers, at least on their boards of directors” (Government of Canada 2002, p. 13).

There is a diversity of CBO types in Canada. Using Salamon and Anheier’s (1997) ground-breaking classification system, the International Classification of Nonprofit Organizations (ICNPO), which was recommended for adoption in Canada (Sharpe 2001), Hall et al. (2004, p. 19) produced Cornerstones of Community. In doing so, they

\textsuperscript{4} Each of these has different definitions and characteristics. They can each be traced to a country of origin and an academic discipline, which is beyond the scope of the current work. For more detail refer to Salamon and Anheier (1996) about their pioneering research in 13 countries initiated in 1990. Nonetheless, a short note about “registered charities” is essential. In Canada “registered charities” are governed by the Income Tax Act which is administered by the Canada Revenue Agency. There are definitions and strict guidelines for these registered agencies regarding permissible advocacy activities. For those who work against the guidelines, their charitable number is revoked, they lose tax exemption status, they lose the right to issue tax receipts for donations, and they lose the prestige associated with being registered with the federal government. This will be explained further in chapter 2.
discovered there were 161,000 registered organizations across Canada in 2003 and of these, 7963 were in Saskatchewan.\(^5\) Of this total in Saskatchewan, 8.6\% or 685 organizations were classified as “social services”. Of the remaining categories and their approximate numbers for Saskatchewan, 2080 were religion, 1920 were sports and recreation, 810 were arts and culture, 640 were fundraising and voluntarism promotion, 420 were business/professional/unions, 335 were health organizations, 335 were education organizations and the remaining numbers were development and housing, environment, and law/advocacy/politics.\(^6\) In the same 2004 report, Saskatchewan ranked second nationally in the number of organizations per capita.

The ICNPO classification defines “social services” as those CBOs which provide services to a target population(s). This definition includes child welfare and day care, youth welfare and services (e.g., YWCA, YMCA), family services (e.g., family violence shelters, single parent agencies), services for the handicapped (e.g., group homes, specialized transportation services), services for the elderly (e.g., homemakers services, meal programs), self help and personal development, disaster/emergency prevention and control, temporary shelters, refugee assistance, income support and maintenance, and material assistance (e.g., food banks). The following three ICNPO categories have also been included in my research because these categories are aimed toward marginalized

\(^5\) Please note these are organizations that are registered with the Canada Revenue Agency and/or Saskatchewan Justice, Corporations Branch. There are additional organizations that are not registered with either level of government.

\(^6\) Febrero et al. (1999) describe in their literature review, at least a dozen voluntary sector classification systems used around the world. Some of these are: Social Economy Classification, National Survey of Giving and Volunteering, Revenue Canada Classification, National Taxonomy of Exempt Entities in the United States, North American Industrial Classification System, UK Charity Commission Classification System, International Standard Industrial Classification, and the International Classification of Nonprofit Organizations (ICNPO).
groups: “development and housing” (e.g., neighbourhood associations, nonprofit housing corporations, sheltered workshops, job training); “mental health”; and “law/advocacy/politics” (e.g., offender reintegration). For brevity in my dissertation, I refer to these four ICNPO categories as “social services”.

CBOs are also diverse in their functions. In general, the social service CBO sector acts as a “social seismograph” leading the way in identifying new social problems (Hall and Banting 2000, p. 3). Legowski and Albert (1999) offer an overview of one societal domain and five organizational activity domains, or functions, provided by the voluntary health sector, although the same applies to the voluntary social service sector. In the societal domain, these CBOs assist in the development of social capital and community cohesion (see also Jenson 1998). In the organizational domain, CBOs offer the following five components: care/treatment as well as health promotion/disease prevention services, research, fundraising, regulating practitioners active in the field, and engaging in advocacy work. It is with this last function that this dissertation is concerned.?

After reviewing literature on social policy advocacy (refer to chapter 2), I chose Ezell’s (2001) definition because it fits the type of policy advocacy with which I am familiar and on which I wanted to focus this research. "Advocacy consists of those purposive efforts to change specific existing or proposed policies or practices on behalf of or with a specific client or group of clients" (ibid., p. 23). I adopted and modified this definition for my research (see italic changes inserted): \textit{policy advocacy consists of those purposive efforts of CBOs to change specific existing or proposed government...}

\footnote{7 It is noteworthy that some of these functions are not mutually exclusive; an organization can be engaged in research and advocacy simultaneously.}
policies in collaboration with groups of marginalized people and CBOs. I made these modifications because my research focuses specifically on government social policy advocacy and not the variety of advocacy types that exist,\(^8\) CBOs play a central role in engaging people in processes - especially marginalized people who are not necessarily their “clients” - and it is collaborative in that CBOs and marginalized people work together. Throughout this dissertation, the term advocacy is used in this way.

Advocacy may be conducted by a single CBO or by a group of CBOs and individuals. A vast literature exists on groups of CBOs, unions, professional associations, and marginalized people (i.e., advocacy volunteers) who come together to make social change; for example, there are coalitions, networks, partnerships, action groups, associations and councils (see for example, Carroll 1997; Stienstra and Wight-Felske 2003).\(^9\) I chose the term coalition because the local case study in which I was interested, adopted this label. A coalition forms when “organizations agree to act in concert on particular issues of common interest, but maintain a clear identity; they give up the right to act independently on this particular issue” (Lee 1999, p. viii). Coalitions usually comprise a group of individuals and/or organization representatives (Dobson 2003), that often begin with impetus from a perceived threat (Bleyer 1997) (e.g., a new government policy that has predicted negative effects on a neighbourhood), build power through their members (Dobson 2003), form around a shared specific issue and change objective (Ezell 2001), and disband once their desired change has been accomplished (Ezell 2001). The

\(^8\) For example, individual advocacy, direct service advocacy, and legal advocacy (Ezell 2001; Jansson 1999; Neufeldt 2003; Sheldrick 2004).

\(^9\) In my community-based experiences, governments have also been known to join these groups.
local advocacy coalition I chose as a case study fits this description. My case study coalition began meeting in 1999 and achieved a partial policy victory in 2005. There were approximately 25 members from CBOs, marginalized communities and the provincial government at the outset, but by 2005 there were approximately 12 active members. The Coalition’s goal was to convince the municipal and provincial governments to adopt an affordability policy for a public service. This coalition is described more fully in chapters 3 and 4.

It is worth pausing to ask explicitly, why is it necessary for CBOs and coalitions to engage in social policy advocacy work? To begin, in their simplest form, social policies are about choices made by governments (Graham, Swift, and Delaney 2003; Wharf and McKenzie 1998). “Social policies are guiding principles for ways of life, motivated by basic and perceived human needs … Social policies tend to, but need not be, codified in formal legal instruments” (Gil 1992, p. 24) such as government acts, regulations or by-laws.10 Social policies often focus on disadvantaged populations like those alluded to in the ICNPO list above. They are influenced by different ideologies, and they deal with societal issues including “social justice, social equality, human rights … progressive distribution of wealth, full employment, … criminal justice and mutual aid” (Mullaly 1993 as cited in Graham, Swift, and Delaney 2003, p. 13).

There is much literature about government policy making, especially regarding current theories, trends, influences and challenges (Orsini and Smith 2007b). There are also different critical perspectives on policy analyses (see for example Fischer and

---

10 Some theorists note the somewhat artificial separation between social policies, economic policies and health policies (Gil 1992; Lightman 2003).
Forester 1993; Hajer and Wagenaar 2003; Yanow 1999). There are different types of policy making including incremental, rational, mixed scanning and social justice models (Graham, Swift, and Delaney 2003). These different models illustrate that policy making has evolved into a highly technical exercise, usually driven by experts and politicians; it is their values and world views which shape policy content (Graham, Swift, and Delaney 2003; Wharf and McKenzie 1998) although some theorists would argue this is no longer the case today with weakened nation states (Hajer 2003). Often the community and CBOs are left working from the outside in. Hence, the evolution of a policy advocacy function by CBOs is not surprising. In fact, CBOs have been doing advocacy work for decades (Canadian Welfare Council 1938) and it is recognized that CBOs have a long history of being “instrumental in the development of most of the public services we rely on today” (e.g., schools, hospitals) (Voluntary Sector Initiative 2001, p. 2). Wharf and McKenzie (1998, p. 36) conclude that each social policy making model “may be adapted to be more inclusive … however, none insist on inclusiveness”. Graham, Swift and Delaney (2003) are more blunt: “there are very few built-in structures in Canada to ensure that citizens, both those directly affected by policy or those with an interest in policy, have the opportunity to be heard” (p. 185).

1.4 Health, population health and social justice

One could explore social policy advocacy through a variety of avenues, however, I chose health and population health. There are a number of discourses surrounding the concept of health which set the stage for a discussion about population health. Reid (2004b) explains there are three dominant discourses of health: biomedical, individual
responsibility, and social determinants (see also Orsini 2007). Reid states that nineteenth century biomedical discourse focused on human biology and genetics and their role in causing diseases. She further explains that the discourse, centred on individual responsibility (also known as behavioural), infers that ill health is a result of bad choices, lack of will power, weakness, lack of education, and personal failure. Basically, this discourse shames and blames these “inferior” people (ibid., p. 15). Interestingly, Reid asserts that this discourse coincides with the current discourse on poverty which comprises two key dimensions: poor people are flawed through biology, psychology, or through their upbringing but they have free will to make choices (e.g., they can choose welfare or a job). Reid (2004) goes on to explain that social determinants of health discourse focuses on sociological, structural and systemic factors that influence people’s health. Within this discourse, it is asserted that people do not have a choice about whether they stay healthy; illness happens as a result of people’s economic, social and political living conditions. Orsini (2007) would likely disagree with this point; he asserts the recent move toward population health includes a shadow paradigm of individual “responsibilization”.

The social determinants of health discourse is a key component of population health. Population health is:

“… measured by health status indicators and influenced by social, economic, and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services. As an approach, population health focuses on the interrelated conditions and factors that influence the health of populations over the life course, identifies systemic variations in their patterns of occurrence, and applies the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations” (FPTAC Federal 1999) (FPTAC).
I chose population health with its emphasis on social determinants of health as my lens because of my community-based experiences with social conditions (e.g., poverty, discrimination, violence) which are essentially the same as social determinants of health. In general, the social determinants of health include, but are not limited to, food insecurity, low income, social exclusion, job insecurity, powerlessness, poor quality housing, and unsafe neighbourhoods (Berkman and Kawachi 2000; Evans, Barer, and Marmor 1994; Kawachi and Berkman 2003; Marmot and Wilkinson 2006; Raphael 2004). Research results about the social determinants of health show, in general, that the following groups of people have poorer health than others: people living in poverty, racial and ethnic minorities, women, elderly people, people with disabilities, refugees, people who have been incarcerated, lesbians and gays, and transgender/transsexual individuals (Coburn, D'Arcy, and Torrance 1998; Levy and Sidel 2006b). “The social and economic structure of society” can be labelled the “ultimate determinants”, or causes, of morbidity and mortality in a society (Reid 2004, p. 3).

Research on the social determinants of health show that different groups – like those listed above and those who receive social services through CBOs in the ICNPO list – differ in their health statuses. These groups are oppressed, or marginalized, in our current society. “The margin is the context in which those who suffer injustice, inequality and exploitation live their lives” (Kirby and McKenna 1989, p. 33). Jenson (2000) states that marginalization refers to groups of people who may be marginalized economically, politically, and socially. Mullaly (1997) using the term oppression, concurs. He adds that oppression is not accidental, is systematically applied and is continuous. Mullaly describes five forms of oppression: marginalization, exploitation, powerlessness, cultural
imperialism, and violence.11 Within this context, marginalization refers to specific groups – Aboriginal peoples, people of certain racial groups, young and old, people who have physical or mental disabilities, unskilled workers, and many single mothers – who are not accommodated in the labour market and also excluded from participating fully in society which in turn leads to material deprivation. Mullaly’s description of marginalization fits with social service CBO work and consequently is the term I adopted.

Social justice is a response to marginalization and oppression. In the health literature, the goal of social justice is to reduce health inequities (Hofrichter 2003b; Levy and Sidel 2006b; Reid 2004b). A social justice tool for reducing health inequities is human rights. In general, human rights agreements are intended to protect all people from social, economic, religious and political mistreatment and make governments responsible for enacting such protections (Gruskin and Braveman 2006; Kly and Thériault 2001). Health is a human rights concern and a right of citizenship supported by a number of international covenants (Reid 2004). An historic goal of public health has been the minimization of death and disability that affects marginalized groups of people more than others (Beauchamp 2003).

1.5 Critical inquiry

I adopted critical inquiry for my research on CBO social policy advocacy because it encompasses the following key elements which are also relevant to social justice:

1 Mullaly (1997) explains exploitation refers to dominant groups who maintain power over the labour of others, powerlessness refers to the social division of labour but is more complex than the Marxist model, cultural imperialism occurs when a dominant group makes its experiences and culture the norm, and violence occurs in the form of harassment, intimidation, assault and/or instilling fear in subordinate groups.
perspectives and the need for social change. Crotty (2003) states, “critical inquiry keeps the spotlight on power relationships within society so as to expose the forces of hegemony and injustice” (p. 157). Crotty acknowledges injustice and oppression exist, but believes they should not. As a result, critical research seeks to make change.

Given critical researchers’ acknowledgement about hegemony, injustice and oppression, it is not surprising they reject the apparent ‘neutrality’ of traditional academic research endeavours. Carroll (2004) offers three reasons why one should be critical rather than neutral in the social sciences. First, critical inquirers believe that knowledge is bound by the structures and processes of domination. Second, critical inquirers know “that our social world – including our knowledge of that world – is not simply the result of a natural process, but is an historical construction” (p. 2). Third, Carroll emphasizes that because people have produced injustice in the past, it can therefore be reconfigured in the future; human agency and change are important features. Critical social researchers often regard their work as a step toward “political action that can redress the injustices found in the field site” (Kincheloe and McLaren 2005, p. 305) and they have “an emancipatory interest in knowledge” (Alvesson and Sköldberg 2000, p. 110).

My expectation was that my study would generate new and emancipatory knowledge. However, the ways in which knowledge is created and named requires careful attention. Natural inquiry (Lincoln and Guba 1985), feminist theories (Tanesini 1999) and decolonization theories (Smith 2004) posit there are different ways of knowing

12 Critical researchers believe that all research has some ideological base. Lincoln and Guba (1985, p. 175) offer the following example: “the technocratic androcentrism that pervades the university is no more ideologically neutral than is my socialist feminism”.

18
that usually reflect different perspectives held by different people. Kirby and McKenna (1989, p. 26) explain that knowledge is socially constructed and based in social interactions. Different labels and explanations for the same event exist across different groups of people.  

1.6 Overview of the dissertation

This dissertation contains eight chapters. Chapter 2 provides the conceptual framework I adopted which was based on five bodies of literature: critical inquiry, CBOs and their advocacy policy advocacy function, social justice and marginalization, health and population health specifically, and impact/outcomes theory. Chapter 3 describes the methodology that I used. Chapter 4 contains a description of the 56 study participants. Since critical inquiry and case study methodology require deep contextual analysis, chapter 5 contains my empirical findings about the historical political context of my study. Chapter 6 includes primary data about social service CBOs’ perception of their roles in creating health and well-being, and how advocacy is operationalized by Saskatchewan CBOs. Chapter 7 offers primary data about the perceived impacts of a Coalition’s advocacy work on marginalized members, CBO members, governments and the larger community. Chapter 8 contains conclusions, implications, suggestions for action and thoughts about future research.

13 For example, Smith (2004, p. 88) recounted a process of colonization wherein Indigenous peoples described a four-step process including contact and invasion, genocide and destruction, resistance and survival, and recovery. A Western perspective described the process as initial discovery and contact, population decline, assimilation, and reinvention as hybrid culture.

14 I cannot name the Coalition because I must maintain interviewee anonymity.
2. CONCEPTUAL FRAMEWORK

Critical inquiry is a theoretical orientation that “keeps the spotlight on power relationships within society so as to expose the forces of hegemony and injustice” (Crotty 2003, p. 157). It is a useful concept with which to explore the involvement of social service CBOs and marginalized communities in social policy advocacy processes because advocacy occurs when a group of people believe an injustice exists. Social justice is central to the social policy advocacy processes advanced by many CBOs (Boucher, Fougeyrollas, and Gaucher 2003; Institute for Media and Society 2002; Maxwell 2006) as well as to reducing population health inequities (Beauchamp 2003).

In general, social service CBOs play mitigating roles in oppressive situations through the delivery of social services (e.g., food, clothing, shelter) as well as by engaging marginalized people in social policy advocacy for change. These organizations tend to work where unhealthy social conditions (i.e., social determinants of health like poverty) are prevalent (Browne 1996; Hall and Banting 2000; Shragge and Fontan 2000). Using a population health lens, one can delineate social determinants of health (e.g., poverty, exclusion) and processes of change, which can result in different outcomes for different marginalized populations (Hancock, Labonte, and Edwards 2000).

I examined five bodies of literature to inform my research. First, I will explain the main features of critical inquiry and show why it is an appropriate theoretical perspective for my study. Second, I will explore the Canadian welfare state and social justice. Third, I will present literature about policy advocacy as a form of civic participation. Fourth, I
will explore population health including social determinants, governance and health status. I end with an explanation of outcomes and impacts measurement.

2.1 Critical inquiry

There are many different forms and types of critical inquiry, just as there are many different forms of positivisms, feminisms, and ethnographies (Carroll 2004; Crotty 2003; Kincheloe and McLaren 2005). Political movements of the 1960s and 1970s played an important role in the evolution of critical inquiry (e.g., critique of capitalism, feminist and anti-racist critiques of domination, revolt against (neo)colonialism) (Carroll 2004) (see also Curry-Stevens 2006). “Habermas endorses the new social movements as social forces that are expressive of moral concerns about the public good …” (Farganis 2004, p. 18). These movements resulted in greater awareness of knowledge-making and power in social research, which in turn led to social scientists’ interest in creating more empowering strategies (Carroll 2004, p. 8).

The Institute for Social Research at the University of Frankfurt, “The Frankfurt School”, was established around 1930 and is widely accepted as the origin of the critical inquiry tradition (Eriksen and Weigård 2003). The Frankfurt School espoused there are no neutral descriptions, but rather social theories either “reveal illegitimate power relations or … obscure suppressive conditions” (ibid., p. 5); those involved with the School wanted to uncover hidden power relations in society.

---

15 Kincheloe and McLaren (2005) cite four emergent schools of critical inquiry which stemmed from the original Frankfurt School in Germany: a Neo-Marxist tradition (e.g., Horkheimer, Adorno, Marcuse), the genealogical writing of Foucault, practices of poststructural deconstruction (e.g., Derrida), and postmodernists (e.g., Derrida, Foucault, Lyotard).
What follows is a general overview of the key features of critical inquiry that are also central to my research involving social service CBOs, marginalized communities, and government policy makers. These features are power/control and knowledge making, inequality and exclusion, multiplicity and fluidity, and action for change.

2.1.1 Power, control and knowledge-making

Power has and probably always will be contested (Lukes 2005) and since power is not the primary focus of my research, I will simply provide an overview of power including some definitions and some links to hegemony, discourse, control, and knowledge-making as they relate to my research. In his analysis of theories of inequality by various writers (e.g., Marx, Weber, Durkheim, Dahrendorf, Giddens), Grabb (2007) explains that power can be a positive as well as a negative force in society (see also Gordon 1980) and that power is central to social inequality. Foucault conceptualizes a typology of forms of power that move us beyond a simple duality of power and domination; rather, he views government as a place where power is “an open, strategic and reversible set of relations” while domination is the “fixing and blocking of these relations into permanent, hierarchical distributions” (Dean 2006, p. 46). Grabb (2007, p. 211) defines power as “a differential capacity to command resources, which gives rise to structured, asymmetric relations of domination and subordination among social actors”. Grabb explains there are three means of power generation including control of resources, control of people and control of ideas (i.e., knowledge). Power as described by Grabb is a salient variable in the relations between governments, CBOs and marginalized people engaged in advocacy processes.
Fraser (1997) suggests that hegemony is a useful term because it pulls together power, inequality and discourse (p. 154). She cites Gramsci’s theory of hegemony and the idea that dominant groups have the power to construct “self-evident descriptions of social reality” which then become common sense (ibid., p. 153). Foucault believes power operates through discourses (Gordon 1980, p. 110-16)\(^{16}\) and power shapes consciousness (Kincheloe and McLaren 2005). Hegemonic ideology creates a discourse and is about how the “media, political, educational and other socio-cultural productions coercively manipulate citizens to adopt oppressive meanings” (Kincheloe and McLaren 2005, p. 310). The social norms and conventions created by dominant groups that facilitate the making of hegemonic ideology and discourse generate “a permanent disposition, a durable way of standing, speaking, walking and thereby of feeling and thinking” in dominated people (Bourdieu 1990, p. 70; see also Lukes 2005, p. 139-144). Wilkinson states the link between lack of liberty “and the problems of low social status, subordination and lack of control which are so damaging to health are clear.” (Wilkinson 2006, p. 354). Indeed, as I will elucidate in section 2.4 on population health, power and control are relevant determinants of health.

In Freire’s community work teaching people to read and write, he encouraged people to explore words and their power, which in turn awakened their consciousness of injustices (i.e., “conscientization”) (Crotty 2003, p. 148). Thus, critical inquiry is not only concerned with the oppressive aspects of power but also “focuses on the productive

---

\(^{16}\) Discourse can be defined as “a system of meaning that provides a way of interpreting or understanding a set of objects in the world … Discourses are organized, maintained and resisted by talk and action” (Carroll 2004, p. 273).
aspects of power – its ability to … engage marginalized people” in rethinking their role (Kincheloe and McLaren 2005, p. 309). CBO advocacy work incorporates both oppressive and productive aspects of power. 17

Power can be examined in terms of their use. Nozick (1992) describes three uses of power in her book about building sustainable communities: a) power-within is about people’s self-awareness and “power to act for oneself” (p. 101); b) power-with-others occurs when people act together on a common purpose, or engage in a common struggle (see also Jansson 1999, p. 267-272); and c) power-over-others is coercive and entrenched in society’s “structures of hierarchy and domination” and typically enacted by governments (Nozick 1992, p. 101). Building communities is a process which requires power-within and power-with-others (Nozick 1992, p. 99) (see also Kretzmann and McKnight 1993; McKnight 1995). Many community building processes adopt advocacy approaches which incorporate these different spheres of power.

Finally, power is reflected in who creates, and what counts as, knowledge. The production of knowledge is a social practice; “conditions and social relations inherent in knowledge production influence its content” (Sayer 1992, p. 6). Tanesini (1999) bluntly

17 The term empowerment often surfaces in discussions about power, power sharing and marginalized communities taking control of their lives. Empowerment is a complex and contested concept with opposing ideological foundations (e.g., neo-conservative ideologues believe empowerment is about people picking themselves up and fixing their own problems while more leftist ideologues believe empowerment is about emancipation (Cruikshank 1999). The concept of empowerment is often adopted and used uncritically (ibid.). Arai (1996) describes five characteristics of empowerment: a) an individual’s change in capacity to utilize power and control, b) multidimensional elements including psychological, social economic and political, c) multiple levels including the individual, group and/or community, d) a holistic quality, in that there are interactions between the dimensions and the levels, e) a process of change that occurs when individuals, groups or communities “mobilize themselves toward increased citizen power” (p. 28). This dissertation was not intended to focus on empowerment but rather to break down and examine more closely the elements which are related to empowerment (i.e., change processes, individual and community levels, social and political dimensions).
states that knowledge is connected to political interests. Foucault believes that knowledge is power (Farganis 2004) (this is similar to Grabb’s point about power generation) and that the exercise of power legitimates what is truth, what is real (Gordon 1980). Those who control research (e.g., universities, governments), control knowledge making (Guba and Lincoln 2005); the media also exerts control on knowledge-making and knowledge dissemination. Those who work with marginalized communities are aware of the necessity for these communities to take control and make change based on their experiential knowledge (ibid.).

2.1.2 Inequality, exclusion and silence

Central to critical inquiry are notions of inequality, exclusion and the silencing of people’s voices, which is oppression (Kincheloe and McLaren 2005) and an outcome of hegemony. In his analysis of theories of inequality (refer back section 2.1.1), Grabb (2007) concludes that power is central to social inequality. The three major means of power generation are the control of resources, the control of people and the control of ideas. These correspond with three main “structures of domination”: economic structure, political structure and ideological structure (ibid., p. 205-17). The means of power and the structures of domination form the horizontal axis in Grabb’s schema. The vertical axis comprises the bases for social inequality (e.g., exclusion, exploitation) and includes class-related bases (e.g., income, occupation) as well as nonclass bases (e.g., sex/gender, race/ethnicity, age). These bases of inequality create exclusion and voicelessness but they are also the “rallying points for collective action” (ibid., p. 216). Letting those who are traditionally silenced speak for themselves is essential to critical inquiry (Guba and
Lincoln 2005, p. 209); advocacy is about giving voice to those who are traditionally silenced in various contexts.

Exclusion is a multi-dimensional concept (Jenson 2000). Exclusion broadly defined is “the structures and the dynamic processes of inequality among groups in society which, over time structure access to critical resources … and reproduce a complex of unequal outcomes” (Galabuzi 2004, p. 236). Labonte (2004) too defines “disadvantage as an outcome of social processes, rather than as a group trait” (p. 257) and that we must pay attention to structures and practices that exclude people (ibid., p. 253). These perspectives on exclusion encourage us to see beyond economic hardship to understand the process of marginalization and how people end up being excluded from community life generally (Shaw, Dorling, and Smith 2006).

Freire describes a “culture of silence”, a condition of oppression wherein people do not have a voice. Worse yet, they are unaware they do not have a voice, and therefore cannot exercise their right to participate (Crotty 2003, p. 154). As well, oppressors control others to behave in certain ways by instilling fear and doubt in them such that they accept what is forced on them (Graham, Swift, and Delaney 2003). However, Reid (2004b) cautions us about “societal determinism” wherein the social and economic underpinnings of society create passive people (p. 6) (see also Alvesson and Sköldberg 2000). Thus, in conducting critical inquiry, we must be careful not to focus too much on the negative features of society but be open to the non-repressive features too. In my research, I understand that advocacy offers the opportunity to explore both.
2.1.3 Multiplicity and fluidity

Critical inquiry encourages us to be aware of multiplicity and fluidity. Critical inquirers recognize there are a multiplicity of people and perspectives within communities. “Oppression has many faces and focusing on only one at the expense of others (e.g., class oppression versus racism) often elides the interconnections among them” (Kincheloe and McLaren 2005, p. 304). Mulvale (2001) promotes the term, “multiple axes of inequality” (p. 141-73) and Tanesini (1999) states “systems of oppression are deeply related” (p. 153). Critical inquiry requires awareness of these interconnections. In my community work I recognized examples of these interconnections and people’s different experiences of the same phenomenon; for example, poor people describe different experiences of living in poverty.

Similarly, research in the field of critical inquiry is fluid and dynamic, not static. “The relationship between concept and object and between signifier and signified is never stable or fixed” and is influenced by social relations (Kinchemoe and McLaren 2005, p. 304). The interactions between critical inquirers and marginalized communities are always unpredictable and complex (ibid.). Even power varies in degree and changes over time depending on the context and the actors (Cohen, de la Vega, and Watson 2001, p. 11).

2.1.4 Action for change

Action for change is another salient feature of critical inquiry. As already explained, critical inquiry acknowledges that negative forces of power exist which oppress people and maintain their exclusion, but this should not be so. Critical inquiry
seeks to name, define and create action to change oppressive situations (Carroll 2004).

Social policy advocacy is action directed to change oppressive situations.

Critical inquiry is defined by its search for “emancipatory knowledge - knowledge in the context of action and a search for freedom” (Crotty, p. 159). In Freire’s community work with poor people, “reflection and action upon the world in order to transform it” was central (Crotty, p. 151). This is known as “praxis” and leads to conscientization (Freire 2003). Friere’s key point, however, is that “the great humanistic and historical task of the oppressed: to liberate themselves and their oppressors as well” (p. 44). Thus, change is about both the oppressed and the oppressors.

2.2 The Canadian welfare state, social justice, and CBOs

2.2.1 The Canadian welfare state as context for CBOs

The welfare state is the environment within which social service CBOs operate in Canada, and thus requires an explanation. In the welfare state in Canada, social services (refer to section 1.3) are delivered through dynamic interactions between four sectors: a) the state, also known as the government or public sector; b) the voluntary sector, also known as CBOs; c) the for-profit or private sector; and d) the informal sector comprising family, friends and neighbours (Thériault and Salhani, 2001; Orr, 1999). 18 This section offers historical and ideological descriptions of this welfare state and its changing nature.

In general, the Canadian welfare state, often referred to as the Keynesian Welfare State (KWS), evolved rapidly after World War II as part of the development of

---

18 Esping-Andersen (1998, p. 135) and Bakker and Scott (1997, p. 305) refer to only three sectors – market, family and state - when theorizing about the welfare state and its services.
capitalism; this was also known as the liberal model (Esping-Andersen 1998, p.141), post-war Keynesian model (Bakker and Scott 1997) or welfare pluralism model (Browne 1996). The KWS is a collection of political and economic strategies designed to resolve problems of harmonizing wealth production and distribution; it is tolerated in Canada but not warmly embraced (Bakker and Scott 1997, p. 285-6).

Between 1940 to 1970, the Canadian welfare state was characterized by a blend of publicly funded programs, delivered primarily by governments and CBOs. Programs and services were based on universalist principles, the state played a central care taking role, volunteers were active in program delivery through CBOs, and the private sector played a minor role in the provision of health or social services (Bakker and Scott 1997; Browne 1996). The era was characterized by an activist state (Burke, Mooers, and Shields 2000) and an institutional ideology (Scott 1992) wherein governments were expected to fund and encourage the development of services like health, education, housing, and recreation as well as provide money to supplement people’s low incomes (Bakker and Scott 1997, p. 285-6; see also Teeple 2000, p. 15).

There is a consensus in the literature reviewed that significant changes have been taking place since the early 1970s. These changes have been referred to as a paradigm shift, a transition, changing federal government philosophy, and restructuring of the welfare state in Canada (Antony and Samuelson 1998; Bakker and Scott 1997; Brock and Banting 2001b; Browne 1996; McQuaig 1999; Mulvale 2001; Orr 1999b; Rice and Prince 2003; Scott 1992; Teeple 2000; Vaillancourt and Tremblay 2002). Most recently

---

19 Teeple (2000, p. 3) explains that labels should be used cautiously because many have become blurred over time and there is not a consensus about the use of these labels and their key elements.
with this welfare state restructuring, there is an interest in new models – for example, a
solidarity model (Vaillancourt et al. 2002) and a new social architecture model (Jenson
2004; Scott 2005).

Today, the welfare state in Canada has moved closer to a corporatist regime
(Esping-Andersen, 1998), also known as a post-liberal Keynesian welfare state (Bakker
and Scott 1997), neo-conservative (Teeple 2000) or neo-liberal (Curry-Stevens 2006).20
Curry-Stevens describes a long list of social policy losses (e.g., government withdrawal
from social housing) associated with the transition in Canada to neo-liberalism over the
past 15 years (p. 115). This type of welfare state adopts a “shrinking state” approach
(Burke, Mooers, and Shields 2000)21 and a residualist ideology (Scott 1992) and is
characterized by minimal government service provision, promotion of self-reliance, CBO
sector and private sector delivery of many social services, promotion of the informal
sector (e.g., family and friends) to meet personal needs, reduction in citizen engagement
by governments, and programs which are targeted and selective, not universal (Bakker
and Scott 1997; Broad and Antony 1999; Brooks 2001; Browne 1996; Teeple 2000).

The restructuring of the Canadian welfare state may not be wholly negative,
however (Tremblay et al. 2002). In fact, it may provide an opportunity for us to work to
avoid the neo-liberal model and instead to create a “solidarity-based model involving a
new and clearly defined partnership between the state” and the CBO sector (ibid., p. 20).
Vaillancourt and Tremblay (2002) explain the neo-liberal model has not necessarily taken

20 Neo-liberalism and neo-conservativism are different (Broad and Antony 1999, p. 10; Mulvale 2001, p.
224)
21 Burke, Mooers and Shields (2000) describe the pre-1970 era as one of “limited inclusion” while the post-
1970s era as one of “aggressive exclusion” (p. 13).
hold in certain provinces; Québec may be an emerging example wherein the CBO sector is asserting itself and influencing social policies (Vaillancourt et al. 2002).

2.2.2 Social justice within the world of CBOs

Social justice and critical inquiry may be conceived as two sides of the same coin: critical inquiry focuses on power relationships and seeks to expose forces of injustice (refer back to Crotty 2003) while social justice is a response to injustice, marginalization and powerlessness.

I have already explained in the introductory chapter who are marginalized people22 and that marginalization is also a process.23 “Overlapping patterns of oppression based on class, race, ethnicity, gender, age” (Reid 2004b, p. 23), ability and sexual orientation are common in our society. When a number of these characteristics occur simultaneously (e.g., women who have disabilities, First Nations people who live on low incomes), it can be labelled the multiple axes of inequality (Mulvale 2001, p. 141-73). Marginalization takes place primarily in social and psychological spaces, but it can also take place in physical space (e.g., a neighbourhood). People who are marginalized are usually “silent” (Crotty 2003), invisible in society (e.g., people who are homeless) and stereotyped, in that when they are seen they are described negatively (Reid 2004b). CBOs are a vehicle to advance social justice and reduce marginalization (Kobayashi 2000; Maxwell 2006).

22 Other terms found in the literature include oppressed, excluded, vulnerable, disadvantaged, subordinated and disempowered.
23 For example, colonization was a process of marginalization wherein First Nations peoples were denied the same rights as others and stripped of their culture and language through government policy (Smith 2004).
Social justice can include four components. First, social justice can focus on reducing marginalization through redistribution of material resources (e.g., income) and nonmaterial social goods (e.g., rights, opportunities, power) (Fraser 2003; Hofrichter 2003a; Mullaly 1997). Second, social justice can focus on encouraging recognition and respect for the dignity of all people (Cohen, de la Vega, and Watson 2001). Redistribution is about different income groups and class inequality while recognition is about culture and social status hierarchies (Fraser 2003). Redistribution is necessary because capitalism with its focus on free markets, private ownership and individualism is naturally antagonistic to social justice with its emphasis on equal opportunity, rights and access to resources (Gindin 2002). Recognition aims to “revalue unjustly devalued identities” (Fraser, p. 12).

A third component of social justice is the political element in which participatory obstacles can exist independent of redistribution and recognition to systematically marginalize people from decision-making processes (Fraser, p. 67-68). In order to remove political obstacles (i.e., exclusion), one needs to enhance democratization and participatory opportunities (ibid., p. 73) (see also Mullaly 1997). Hofrichter (2003) points out that "democracy has always depended on the willingness of ordinary people to participate, with or without the support of legal authorities, in social movements” (p. 13).²⁴

Gindin (2002) suggests that redistribution, recognition and participation are not enough. He states that humans create social life and that we have “the dynamic capacity

²⁴ These social justice authors only tangentially venture into the philosophical world of John Rawls’ social contract and John Stuart Mills’ utilitarianism (for these and others see Solomon and Murphy 2000).
to change ourselves” (p. 12). Thus, conceptions of social justice should shift to include “capacities, development and potentials” (p. 12); he insists the focus should be on what we can become, not that we should have “fairer access …. to compensate us for what we are not” (p. 12). Therefore, social justice can include four dimensions: equitable distribution, recognition, participation, and capacity development. Social justice is a central theme in social policy advocacy work advanced by many CBOs (Boucher, Fougeyrollas, and Gaucher 2003; Institute for Media and Society 2002; Maxwell 2006).

2.2.3 CBOs and CBO-government relations

When CBOs and their program participants want to change government social policies, they must interact with governments (Brock and Banting 2001a). “Advocacy and funding are two of the most controversial areas of government and voluntary sector relations” (Brock and Banting 2001a, p. 10). Let us briefly examine the CBO sector before exploring CBO-government relations.

As already noted, most social service CBOs work with the most marginalized groups in our society. They deliver social services (e.g., provide groceries and meals, offer family counselling, provide literacy training), advocate for enhanced social policies and programs, build networks of engaged people, seek out innovative solutions to community problems and enhance democracy (e.g., support freedom of expression) (Banting 2000; Brock 2002a; Brock and Banting 2001b; Browne 1996; Goldenberg 2004; Hirshhorn 1997; Institute for Media and Society n.d; Jenson 1998, 2001; Knapp, Robertson, and Thomason 1990; Maxwell 2001; Quarter 1992; Shragge and Fontan 2000). The CBO sector plays a role in society “which is perceived to be unique, in many
respects, from that of governments or corporations, and is central to community engagement and to the building of social capital” (Hamdad and Joyal 2007, p. 6) (see also Knapp, Robertson, and Thomason 1990; Rice and Prince 2003; Salamon and Anheir 1996). In a public opinion poll conducted in Canada regarding CBOs, 79% of those surveyed thought charities understood community needs better than do governments, 72% thought charities met community needs better than governments do, and 87% agreed these organizations improve our quality of life (Muttart Foundation 2004).

Hall and Banting (2000) describe the International Classification of Nonprofit Organizations (ICNPO) which focuses on structural-operational elements of these organizations (Salamon and Anheir 1996). Statistics Canada recently adopted the ICNPO for its national research on the nonprofit sector (Hamdad and Joyal 2007) and volunteers (Hall et al. 2006). Using ICNPO, CBOs must fit the following five criteria in order to be included in the nonprofit sector:

“Organized. The organization must be institutionalized to some extent. The key concept is not that the organization be legally recognized but that it has some institutional reality (e.g., some degree of internal structure) …

Private/independent. The organization must be institutionally separate from government. It must be ‘non-governmental’ in the sense of being structurally separate from the instrumentalties of government …

Nonprofit-distributing. The organization must not return any profits generated to the owners or directors.

Self-governing. The organization must be equipped to control their own activities (i.e., have their own internal democratic processes) and not be so tightly controlled by government or private business that they … function as part of these institutions.

Voluntary. The organization must have a significant degree of voluntary participation, either in the conduct of its activities (program volunteers) or the management of its affairs (voluntary members of the board of directors) …” (Hall and Banting 2000, p. 7).

With these criteria, co-operatives, mutuals, and self-help groups would be excluded (Dreessen 2000; Quarter 1992; Quarter et al. 2001).
The CBO sector, by definition, lies outside government. Two key criteria from ICNPO are central for my research: that organizations must be independent from government and self-governing in order to control their own activities and to resist government interference.

It is generally acknowledged the CBO sector is not a unified sector with clearly defined boundaries (Quarter 1992; Quarter et al. 2001; Tremblay et al. 2002). Hall et al. (2004) provide “the first national portrait of the many thousands” of CBOs in Canada (p. 7). Hall et al. found the voluntary sector in Canada reported a total revenue of $112 billion from 161,000 organizations. In Sharpe’s (2001) analysis of registered charities, there was a 26% increase in the number between 1991 and 1999. Thus, the CBO sector in Canada is significant in economic impact, scope and size.

Different CBOs have different types of relationships with governments (Brock 2002b; Brock and Banting 2001b). In some communities, certain CBOs are powerless and dependent on governments, whereas in other communities and other CBOs, the relationship is one of interdependence and mutuality (Boudreau 2006). A typology comprising eight relationship types (i.e., repression, rivalry, competition, contracting, third-party government, co-operation, complementarity, and collaboration) placed along a continuum is illustrative of this (Coston 1998). In addition, three relationship dimensions are included: the degree of government resistance or acceptance, the distribution of power in the relationship, and the degree of formality. Rice and Prince (2003) emphasize that although we often discuss government-CBO partnerships, these conversations tend to ignore power inequalities. The CBO sector is a government tool as long as the focus is on
“social integration rather than social change” and there is no confrontation (Shragge and Fontan 2000, p. 6).

Over the past 30 years, a number of government-initiated changes have influenced CBO advocacy behaviour. The trend toward a reduction in the number of operating grants, the increase in the number of contracts or fee-for-service arrangements, funding cuts to certain CBO programs, and the downloading of government services to CBOs have all greatly affected CBOs (Banting 2000; Brock and Banting 2001b; Brooks 2001; Browne 1996; Hall et al. 2005; Rice and Prince 2003; Vaillancourt and Tremblay 2002). Teeple (2000, p. 113) refers to these changes as “the planned reduction and privatization” of welfare state services which are expected to save the government money. In essence though, it will simply shift the cost of services “from taxpayers to those who make charitable donations” to CBOs (Brooks 2001, p. 186). These changes affect the type of advocacy which CBOs formulate because CBOs who compete against each other for funding do not readily co-operate on advocacy campaigns (Browne 1996; Luther and Prempeh 2003).

These government trends can tie CBOs’ programs and services to government priorities. Most contracts are “almost universally tied to direct services, to the exclusion of community development” (Hudson 1999, p. 221) and advocacy with marginalized groups (Brooks 2001; Browne 1996). As CBOs become more heavily state-funded to deliver social programs, there will be an accompanying decrease in CBO facilitated “citizenship-building activities of informal learning, organization and advocacy” (Shragge, Graefe, and Fontan 2001, p. 21), the CBO sector will become more closely aligned with state priorities (Hudson 1999; Vogel 1991), governments will control what
CBOs do (Scott 2003), CBOs will not criticize government policies (McFarlane and Roach 1999c; Vogel 1991), and CBO risk-taking behaviour and innovation will subside (Browne 1996). For Brooks (2001), CBOs are a form of social organization in which civic engagement (i.e., providing space for citizens to come together to participate in policy processes) could be seriously compromised. Together these impacts have led to what is known as “advocacy chill” (Scott 2003, p. 5) (see also Harvie 2002).

Interestingly, Knapp, Robertson, and Thomason (1990) cite studies in which governments influence CBO advocacy, but also allude to studies which show no effect.

In the late 1990s in Canada, there was a recognition that CBO-government relations required attention. As a result, the Voluntary Sector Initiative (VSI) was formed. The VSI was a five-year, $94 million, federal government-CBO sector initiative intended to enhance quality of life by improving services offered through CBOs (Brock 2002a). The focus was on relationship building between the federal government and CBOs, capacity building for CBOs, conducting a national survey of giving and volunteering, and making revisions to regulatory measures. Two major documents were released, both of which acknowledged that advocacy and policy participation were “inherent to debate and change in a democratic society” (Voluntary Sector Initiative 2001, p. 8; Voluntary Sector Initiative 2002).

2.3 CBO social policy advocacy as civic participation

The focus of this doctoral research is on the social policy advocacy function of social service CBOs in Canada generally and Saskatchewan specifically. “The history of advocacy parallels the development of democratic societies” (Rektor 2002, p. 3). Social
Policy advocacy is a form of civic participation. Civic participation - also known as citizen involvement and engagement (Phillips and Orsini 2002) as well as citizen action and civicness (Hancock, Labonte, and Edwards 2000) – refers to individuals who “are actively engaged in social and political action such as lobbying” directed at governments (ibid., p.53). Panitch (1993) and Abelson et al. (2003) state there is an increasing interest in democratizing public policy processes through engaging an informed citizenry given the current non-participatory nature of governments in Canada.

There are a number of benefits of civic participation. Dobson (2003) lists these: CBOs and citizens offer experiential knowledge that can help solve local problems; the greater the diversity of people involved in informing policies, the greater the likelihood of more effective solutions; advocacy is a form of public participation that helps to reduce exclusion for marginalized groups; citizen involvement in policy development improves policy legitimacy; and advocacy can enhance democracy and increase social capital because people come together to work on common goals.

### 2.3.1 Advocacy volunteers

An “associational revolution” is taking place in the social space between the private sector and the government sector that is attracting “new attention and new energy” in 32 countries (Salamon, Sokolowski, and List 2003, p. 3). There has been an increase since the mid-1980s in the number of groups forming and those indicating interest in policy reviews (Rice and Prince 2003; see also Sharpe 2001). In research undertaken on CBOs in the United States between 1955 and 1985, the evolution of social service-based CBOs into hybrid organizations which marry service provision and
political action showed the emergence of advocacy volunteers as well as activist staff (Minkoff 2002).

“Charitable giving, volunteering, helping others directly … are all important ways that Canadians become engaged in their communities … and express their caring and compassion for others” (Hall et al. 2006, p. 57). At the time of Hall’s study, Saskatchewan had the highest rate of volunteering at 54%, compared to all provinces and territories (ibid., p. 31). However, there are no published reports containing data about policy advocacy volunteers within each of the fifteen ICNPO organization types.26 Advocacy volunteers are different from service delivery volunteers; advocacy volunteers work to change the conditions, the structural causes, of social problems in communities (Merrill 2005). When we talk about volunteers generally, our language usually reflects “virtues of selflessness, altruism, service to others, compassion” which in turn leads to an image of volunteers as “warm, kind, compassionate people” (Merrill 2005, p. 1). However, those volunteers who are involved in structural change activities are labelled differently - threatening, aggressive, and fanatical are common terms (ibid.). These are volunteers who perceive the existence of oppressive and unjust structures and work to change them – often without the understanding of the dominant culture, thus they are negatively labelled. Nonetheless, Nunn (2002) explains that social capital can be formed through the creation of networking opportunities and learning that takes place when volunteers engage in civic and political participation.

26 Hall et al. (2006), in the Canadian Survey of Giving, Volunteering and Participation, explain volunteers are active in “law, advocacy, and politics” organizations, but questions remain about volunteers’ advocacy work in other fields (e.g., social services, health, housing).
2.3.2 Social policy making

There are different ways in which CBOs connect with governments at different steps in the policy making process. Generally, the policy making process comprises the following steps: initiation of policy agenda and identification of values and issues; policy research, options assessment and drafting; policy adoption; policy implementation; and policy impact evaluation (Foster and Broad 2002; Gil 1992; Graham, Swift, and Delaney 2003; Phillips and Orsini 2002). Advocacy can take place at any step along the way. However, many policy making processes do not seem to incorporate the plurality of identities, experiences, and histories that constitute current society (Jenson 2001). As well, even if CBOs get involved, mainstream discourse prevails. For example, McKeen (2004) describes the failure of Canadian feminist CBOs and movements to counter the dominant family-oriented and “liberal-individualist constructions” within the national poverty policy making context. Social policy making has become a highly technical exercise driven by experts and politicians with few, if any, requirements for full citizen and CBO participation (Curry-Stevens 2006; Gil 1992; Graham, Swift, and Delaney 2003; Laforest and Orsini 2005; Wharf and McKenzie 1998).

It is instructive to examine Arnstein’s (1969) classic ladder which shows the different ways people participate in policy making and how each of these ways reflects a different degree of power and control in the process. Starting at the bottom, where people have the least power, and moving to the top where people have the most power, some of those rungs are: manipulation, such as rubberstamp advisory committees; consultations, usually in the form of public hearings; partnerships wherein decision-making is shared;
and delegated power in which citizens have the majority of seats on a committee. Boyce et al. (2001) differentiate between policy advocacy, which occurs from the outside (i.e., outside government walls) and policy participation, which occurs from the inside, while Phillips and Orsini (2002) explain that in policy making processes, uninvited involvement by CBOs and citizens “is usually referred to as advocacy” (p. 3). Stienstra (2003) puts it succinctly: governments consult, CBOs advocate.

The public policy world where all of this unfolds is in a state of flux as is the policy making process itself (Orsini and Smith 2007a). The changing context of policy making demands a reconsideration of traditional approaches to policy analysis (Hajer 2003). Some of these changes relate to a shift toward geographic based policies and policy making, a rethinking of governance and participation, and an undervaluing of scientific expertise (ibid.). Orsini and Smith’s book, Critical Policy Studies, presents four current and major themes: shifts in political economy theory; citizens, diversity and participation; incorporating new knowledges and discourses into policy; and “risky subjects” like national security (2007b). The different critical perspectives on policy analyses (see for example Fischer 2003; Fischer and Forester 1993; Hajer and Wagenaar 2003; Yanow 1999) lead us to see shifts in democratic governance and the need for more deliberative, participatory policy making approaches and access to local knowledge (Fischer 2003; Hajer and Wagenaar 2003). These shifts have implications for and provide a useful backdrop to CBO facilitated policy advocacy work.

27 Canada West Foundation (1997) completed research on a variety of forms of government consultation, evaluated their effectiveness and suggested a new model, deliberative democracy, be adopted.
2.3.3 What is social policy advocacy?

Advocacy and activism are terms used differently in a variety of countries; there is a range of activities captured by these two terms and the lines between them are not always clear (Hick and McNutt 2002a). In North America, Hick and McNutt explain that “advocacy is often used as a broad concept to include social action and lobbying” (p. 7). As well, advocacy and social movements have been used as synonyms, but the terms are not interchangeable. Burstein (1999) explains that advocacy may be conceived as a subset of social movements (refer to Appendix A for a comparison of these two concepts).

Advocacy can be both a process and a product. The process of advocacy can be defined as “…the act of speaking or of disseminating information intended to influence individual behaviour or opinion, corporate conduct, or public policy and law” (Rektor 2002, p. 1; see also Harvie 2002). Advocacy means “speaking up for yourself or for an individual, family or community in a situation that is viewed as undesirable, unfair and changeable” (Wight-Felske 2003, p. 324) (see also Neufeldt 2003).

The definition of advocacy as a product focuses on a general goal of improving people’s lives. Based on Harvie’s (2002) interviews with CBOs, there are at least two views of what advocacy accomplishes: “enabling those who need help to find their own voice” and it is a way of giving power to citizens who are powerless in their relationship with the state (ibid., p. 3). Advocacy is about "…achieving positive changes in government programs and policies through … coalitions, networking and lobbying" (Ad Hoc Committee to Realistically Change Welfare Rates 1990).

Cohen, de la Vega, and Watson (2001) state that advocacy has many different meanings and that in theory, advocacy has no bounds. Yet in reality, many people’s
voices and their issues are excluded from policy decisions. They see advocacy and social justice as integrally linked:

“Advocacy is the pursuit of influencing outcomes – including public-policy and resource allocation decisions within political, economic and social systems and institutions – that directly affect people’s lives. Advocacy consists of organized efforts and actions based on the reality of ‘what is’. These organized actions seek to highlight critical issues that have been ignored … to influence public attitudes, and to enact … laws and public policies so that visions of ‘what should be’ in a just, decent society become a reality. Human rights – political, economic, and social – are an overarching framework … Advocacy has purposeful results: to enable social justice advocates to gain access and voice in the decision making of relevant institutions; to change the power relationships between these institutions and the people affected by their decisions … and to result in a clear improvement in people’s lives” (p. 8)

Ezell (2001) offers a similar description: "Advocacy consists of those purposive efforts to change specific existing or proposed policies or practices on behalf of or with a specific client or group of clients" (p. 23). In general, change focuses on the status quo although sometimes change focuses on trying to defeat new government programs that are predicted to have a negative impact on groups of people. These efforts are purposive in that there is a planned, action strategy with specific goals and outcomes articulated. The targets for change include both policies and practices. These can be either proposed or already existing. As noted in chapter 1, I adopted and modified Ezell’s definition for my research: **policy advocacy consists of those purposive efforts of CBOs to change specific existing or proposed government policies in collaboration with groups of marginalized people.**

Using Ezell’s description as a foundation, I will now examine the purpose of advocacy, who advocates, and how it is done. I will then examine material about government legal restrictions on advocacy which silence CBOs.
2.3.4 What is the purpose of advocacy?

Four types of advocacy can be delineated based on purpose. These types are systems/policy, program, legal and ideological advocacy. None of these are mutually exclusive though; advocacy work weaves in and out of these four types depending on the situation. The first type of advocacy, systems/policy/legislative advocacy occurs when CBOs, “researchers, economists, and consultants from think-tanks and universities try to influence bureaucrats and decision makers within the system” (Cohen et al., 2001, p. 9) (see also Boland, Bartron, and McNutt 2002; Jansson 1999; McCarthy and Castelli 2001).28 However, marginalized individuals like those with disabilities may also be involved (Neufeldt 2003). Second, programmatic or direct service advocacy is an attempt to make CBOs and government agencies more accessible or to encourage them to deliver new or enhanced services (Jansson 1999; McCarthy and Castelli 2001). Third, legal advocacy occurs through the courts and usually pertains to people’s rights (Sheldrick 2004). Canada has a Charter of Rights and Freedoms under which people have the right to advocate for legal protection and change where there is disadvantage (e.g., disability, visible minority) (Moran 2001). Fourth, ideological advocacy occurs when groups of people push to have their beliefs and values made dominant; it is also known as community advocacy wherein the community is educated about an issue (e.g., through the media). These changed community attitudes can become public support for the advocates (Cohen et al 2001; Ezell 2001).

28 McCarthy and Castelli (2001) also describe political campaign activity which refers to organizations’ participation in election campaigns in the United States. This is not included here because registered CBO charities are not permitted to do this kind of advocacy in Canada.
One final observation is necessary. Shragge and Fontan (2000) note that much advocacy work focuses on the status quo and not transformative or structural social change. Browne (1996) believes this is a problem and offers this insight:

“Social movements and voluntary organizations form a dense social fabric which provides invaluable resources for democratic life… a thriving civic society may constitute a deep fund of social capital … But if the voluntary sector and social movements produce social capital on the margins of a world ruled entirely by market forces … then all their efforts may not amount to more than love in a cold world, palliative measures for those most hurt or least able to cope” (p. 82).

2.3.5 Who does social policy advocacy?

Advocacy seeks to help “relatively powerless groups, such as women, children, poor people ... and people with disabilities” (Jansson 1999, p. 10). There are at least four categories of “who” advocates for these powerless groups. The first category is self advocacy – people who speak on their own behalf (Ezell 2001; Phillips 2003). Second, individual or case advocacy exists wherein a person speaks on behalf of someone who cannot (e.g., parents who speak on behalf of their disabled children) (Neufeldt 2003). Third, mass advocacy takes place when large groups of people, usually not a homogenous groups, create public actions (Ezell 2001). This may take the form of interest-group or grassroots advocacy which occurs when individuals and CBOs collectively identify specific issues and connect with decision makers (Cohen et al. 2001; McCarthy and Castelli 2001); coalitions are an example of groups of CBOs and individuals (Dobson 2003) who “agree to act in concert on particular issues of common interest, but maintain a clear identity … they give up the right to act independently on this particular issue” (Lee 1999, p. viii). This is also known as the power of collective voice to present common issues (Neufeldt 2003). Fourth, professional advocacy includes
lawyers, professors and specially educated people who work with people with
disabilities, for example (Neufeldt 2003). In closing, advocacy usually involves dialogue
among three groups – those who are directly negatively affected by a policy or
government action, organizers/advocates, and governments (Tilly 1999). Many CBOs
create the place and space for excluded people to talk about social policies (Jenson 1998,
p. 22-25).

2.3.6 How is policy advocacy done?

Policy advocacy is about process and participation. Advocacy is a complex and
difficult process to explain (Rektor 2002). The Voluntary Sector Initiative Advocacy
Working Group views advocacy as a circle with “different activities coming in and out of
play at various times in the process” (ibid., p. 1). In the literature explored, there appear
to be six key advocacy strategies with many activities in each. None of these strategies
are mutually exclusive, and they change over time (Watters 2003).

First, direct contact with policy-makers, politicians and government staff is a
strategy to convince governments through meetings, conversations, and all-candidates
gatherings that a change is needed (Dobson 2003). This is often done by a CBO or a
coalition of CBOs and marginalized individuals working together (D'Aubin 2003; see
also Peters 2003); it may also include less face-to-face contact and instead involve letter
writing and phone campaigns (Peters 2003) as well as e-advocacy using list-serves and
e-petitions (Hick and McNutt 2002b; McNutt 1999). Second, groups might adopt a media
advocacy strategy to generate public awareness and educate people about an issue
(Dobson 2003). Third, confrontation strategies may be adopted (Dobson 2003) including
citizen investigations and direct action which usually includes large groups of people involved in creating a public display of support or opposition (e.g., boycotts of private businesses, public demonstrations in front of parliament buildings) (Cohen et al. 2001; McCarthy and Castelli 2001; Peters 2003). Fourth, research strategies may be adopted and research results delivered to policy makers (D’Aubin 2003). Fifth, many groups adopt monitoring strategies. Brooks (2001) suggests that “overseeing, monitoring and evaluating government and other powerful institutions in society” is a key feature of CBOs’ advocacy function (p. 202; see also D’Aubin 2003). This strategy seeks to locate where the main change barriers are and tailor advocacy activities to move them (Fox 2001). Finally, some groups adopt legal strategies through the courts (D’Aubin 2003; McCarthy and Castelli 2001). In closing, advocacy work looks different in different countries and what has been included here reflects practice in Canada (Enns 2003).

2.3.7 Advocacy chill – contradictions about the voice of CBOs

Advocacy is perceived differently by different people. The social service CBO sector perceives advocacy as an activity which must succeed, is legitimate, deals with real-life issues, is genuine and analytic, is the only way to make change with/for people living on the margins of society, is positive and “charitable”, and expresses visions and hopes for a better society (Harvie 2002). The public appears to view advocacy positively too. In a public opinion survey conducted in Edmonton, 95% agreed that charities should speak out on issues relating to the environment, health care and poverty; between the years 2000 and 2004, there was an increase from 25% to 33% who agreed that it is acceptable for charities to use blockades or other forms of non-violent activities as forms
of advocacy (Muttart Foundation 2004). However, many governments perceive advocacy as an activity that must be controlled; they believe that it is one-sided and is not genuinely analytical. In the eyes of government officials, advocacy is negative, controversial and threatening (Institute for Media and Society 2003; Rektor 2002).

In Canada the main law governing registered charitable CBOs, the Income Tax Act through the Canada Revenue Agency (CRA), specifies what kinds of advocacy activities are permitted (Phillips, Chapman, and Stevens 2001) (see also Randon and Randon 1994 regarding international research on the legal treatment of CBO advocacy). Canada’s charity laws are based on a 400-year old Elizabethan England model of charity (Bridge 2000). This model is based on the notion that people who have more resources should share with others who do not (Rektor 2002). This charity model accepts the status quo (ibid.). An advocacy model on the other hand, “looks critically at our society and identifies areas where changes” can be made (ibid., p. 4). Thus, advocacy does not fit with the 400-year old charity model, which is the basis for Canadian welfare law.

In general, charitable education is permitted but political advocacy is not. “Education must not amount to promotion of a particular point of view or political orientation, or to persuasion, indoctrination or propaganda” (Bridge 2000, p. 1), no more than 10% of a charity’s resources can be devoted to advocacy activities (i.e., “the 10% rule”) and these activities must be non-partisan (Bridge 2002). To make this situation worse, there appear to be inequities in the system. CRA treats different groups differently.

29 Not all social service CBOs are registered with the federal government as charities.
(e.g., research institutes are treated more leniently than are grassroots organizations) (Broder 2002) and so do the courts (Phillips 2001a).

A contradiction has surfaced. Although one arm of the federal government - federal tax laws - forbids charities to embark on certain advocacy activities, another arm of the federal government welcomes dialogue with CBOs. The Voluntary Sector Initiative (VSI) (section 2.2.3) states "dialogue between the Government of Canada and the voluntary sector will take place at the various stages of the public policy process" in order to exchange knowledge and create the best possible policies (Voluntary Sector Initiative 2002, p. 8) (see also Government of Canada 2006). Thus policy dialogue is encouraged. Yet despite the many years of CBO-government collaborative work, there is still no clarity of “advocacy” in the Income Tax Act (Hall et al. 2005).

2.3.8 In summary

Some key observations about this advocacy literature are apparent. First, social justice is an integral element of most CBOs’ policy advocacy work. Second, advocacy as collective action is a form of civic participation with a focus on changing an unjust policy or program in order to enhance quality of life for marginalized people. Third, by definition, policy advocacy occurs when CBOs and/or marginalized individuals confront those with power and place their demands before them. Fourth, advocacy work entails speaking up and using one’s voice. Fifth, there is typically a multiplicity of people and voices involved in advocacy work. Sixth, there are contradictions within governments themselves about how much CBOs should be permitted to advocate in Canada. Finally, the definition of advocacy for the purposes of my study is - policy advocacy consists of
those purposive efforts of CBOs to change specific existing or proposed government policies in collaboration with groups of marginalized people (Ezell 2001).

2.4 Population health lens

A lens is a transparent device that focuses light rays on an object. A population health lens is the device I chose to explore my object of study, social service CBO advocacy. I chose population health for a number of reasons. First, it includes a process component (i.e., governance) and my research focuses on advocacy processes. Second, population health comprises a broad definition beyond disease; this fits with social service CBOs’ work on social determinants of health. Third, population health identifies health status inequities across groups, thus my interest in social justice could be pursued.

2.4.1 Defining population health

Before defining population health, let us define health. Health is broadly defined as:

“a state of complete physical, social and mental well-being and not merely the absence of disease or infirmity … Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical abilities” (World Health Organization 1998, p. 11).

I adopted the term “health/well-being” for my research30 because it is broad in scope and I wanted my study participants to be mindful of this; I did not want them thinking solely

---

30 Hancock et al. (2000) note there is not a consensus about well-being. Hancock et al. use a narrow approach to well-being (e.g., happiness, satisfaction), whereas the Canadian Policy Research Networks’ The Well-Being Diamond is broad in that well-being and welfare appear to be used as synonyms. The Canadian Index of Well-being is even broader and includes seven domains (e.g., living standards, healthy populations, environment, civic engagement) (http://www.atkinsonfoundation.ca/ciw/). Within Aboriginal cultures, well-being is broader and incorporates a holistic construct, which is “historically and culturally mediated (Adelson 2000, p. 3). There are also institutes that focus on specific aspects of well-being, like economic well-being (see the Centre for the Study of Living Standards, http://www.csls.ca/iwb.asp). And there are innumerable others which adopt “well-being” as a broad concept without a clear definition (Personal Aspects of Poverty Group 1995; Peters 1995; Townson 1999).
about foot care clinics and hospitals. This broad definition and the term health/well-being are appropriate because they encourage us to think about a broad range of social conditions, or social determinants of health like poverty, which affect people’s health.

Population health is situated in the realm of communities and societies (Institute of Medicine of the National Academies 2003). There is no definitive history or clear starting point for this population health concept (Szreter 2003). There are many definitions and descriptions of population health and these differ from health promotion and public health (Hamilton and Bhatti 2002; Hayes and Dunn 1998; Kindig and Stoddart 2003). Population health is “more than traditional public health” in that it encompasses determinants of health and their inequities (Young 2005, p. 5). For my purpose, the health of populations is:

“… influenced by social, economic, and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services. As an approach, population health focuses on the interrelated conditions and factors that influence the health of populations over the life course, identifies systemic variations in their patterns of occurrence, and applies the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations” (FPTAC Federal 1999, p. 7).

Hancock et al. (2000) focus on and operationalize similar components in their population health indicators work. In general, their model posits there are a variety of health determinants that manifest themselves across different spheres (e.g., individual, community, state) (see also Labonte et al. 2002), which interact over time and space through many different processes of change. This can result in a variety of health outcomes (e.g., positive and negative health status). Figure 2.1 offers a visual representation of their population health model. Each component of this model -
determinants of health, processes-of-change, and health status - will be examined further. Before doing so, a glance at population health inequities is necessary given my interest in social justice.

Figure 2.1: A conceptualization of population health

2.4.2 Population health, inequities and advocacy

A consideration of health inequities brings social justice to the fore (Hofrichter 2003b; Levy and Sidel 2006b; Reid 2004b). The health of the public is essentially a social justice issue because there are preventable deaths and disabilities (Beauchamp 2003). In explaining health inequities, Levy and Sidel (2006) offer two ways of defining social injustice. First, it is “the denial or violation of economic, sociocultural, political,
civil, or human rights of specific populations … based on the perception of their inferiority by those with more power” (ibid., p. 6). Health inequities must be reduced because health is “a fundamental right of citizenship” (Reid 2004b, p. 3). International human rights agreements make governments responsible for removing obstacles and creating conditions for people to achieve their rights – even if this means that governments grant special attention to marginalized groups (Gruskin and Braveman 2006; Kly and Thériault 2001). Second, Levy and Sidel (2006a) use the Institute of Medicine’s definition of public health, “it is what we as a society do collectively to assure conditions in which people can be healthy”, which reflects a social justice orientation (p. 6). This definition focuses on the policies and programs which positively affect people’s health. Levy and Sidel summarize the work of others and operationalize equity in health as the lack of systemic disparities in the social determinants of health and health status among groups who have different advantages or vulnerabilities. Hancock et al. (2000, p. 67) note that “inequalities in health are not fixed and inevitable, or at least most of them are not”; many inequalities are a consequence of societal structures.

Advocacy is essential for reducing health inequities. Advocacy for health is “a combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or program” (as cited in World Health Organization 1998, p. 5). Social justice can be promoted through healthy public policies and programs, but the turnover of state health
directors every few years, the large scale of federal bureaucracy, and government silos combine to make amelioration of health inequities difficult (Plough 2006).31

2.4.3 Determinants of health

On the left side of Figure 2.1, population health determinants32 are numerous. Quite simply, determinants of health are those many elements that influence people’s health including those that fall into the following categories: sustainable ecosystems, environmental viability, liveable built environments, community conviviality (e.g., social support networks), social equity (e.g., inclusion, access to power), and prosperity (e.g., employment) (Hancock et al. 2000). A similar list was found in The Federal Provincial Territorial Advisory Committee on Health (1999) description in section 2.4.1 (see also Evans, Barer, and Marmor 1994; Heymann et al. 2006; Kawachi and Berkman 2003; Kindig and Stoddart 2003). Some researchers also cite examples of public policies which contribute to ill health (Neysmith, Bezanson, and O'Connell 2005; Raphael 2004). Lynch and Kaplan (1999) further explain that the “distributional aspects of the economy” are determinants (p. 203), while Reid (2004b, p. 3) states the “ultimate determinants” are the social and economic structures of society. Within the population health model, health care services play a relatively minor role in creating healthy populations when compared to these other factors (Evans and Stoddart 2003; Keleher 2007a; Lalonde 1974; Lawrence

---

31 Advocacy to reduce health inequities is evident in three health paradigms: population health (Hayes and Dunn 1998), health promotion (Hamilton and Bhatti 2002) and healthy communities/cities (Butterworth and Duhl 2007; Raphael and Curry-Stevens 2004) (see also O'Hara 2006 regarding “Inclusive Cities Canada”).

32 Determinants of health may also be known as the “social/ecological model”; this “model describes how social, physical and genetic factors influence health status” (Plough, 2006, p. 419).
Population health determinants can be located in a series of contexts, environments or spheres from the micro to the macro scale (Labonte et al. 2002). In Figure 2.1, the micro sphere is the individual and the macro spheres include market/state and the ecosystem. The spheres have reciprocal effects on each other (ibid.). For example, an unhealthy ecosystem has detrimental effects on the health of individuals.

What specifically are “social determinants of health”? The following have been labelled “social determinants” of health: social gradient, socio-economic status, social connectedness and inclusion, race and ethnicity, working conditions, housing, power and control, discrimination, perception of place in a social hierarchy, and neighbourhood (Berkman and Kawachi 2000; Institute of Medicine of the National Academies 2003; Kawachi and Berkman 2003; Marmot and Wilkinson 2006; Raphael 2004). Social service CBOs work with these determinants of health on a daily basis (refer back to sections 1.3 and 2.2). Using the Hancock et al. (2000) model, I focused on their categories of health determinants labelled equity and conviviality. In particular I was interested in the following five determinants: socio-economic status, social exclusion and discrimination, perception of one’s place in a social hierarchy, power and control, and social connectedness. I chose these because they are directly linked to social justice as well as participation.

First, a social determinant of health which has received much attention over the past few decades is socio-economic status (SES). SES falls in the “social equity” category in the population health model in Figure 2.1. SES is a complex variable that can
be measured through education level, occupational position, or income level, to name a few components. There are a variety of factors related to SES including material wealth, family background, race and ethnicity, and social networks. The simplest way to describe the effect socio-economic status has on health is to say that people with lower incomes have poorer health status as reflected in mortality and morbidity data (Evans 1994; Evans and Stoddart 1994; Hayes and Glouberman 1999; Institute of Medicine of the National Academies 2003). However, there are innumerable and complex issues associated with this general conclusion (e.g., prevalence of certain illnesses over others, differences across countries, and differences among ethnic and age groups) (Evans, Barer, and Marmor 1994; Hancock, Labonte, and Edwards 2000; Marmot and Wilkinson 2006). SES is connected to health through many different pathways (e.g., housing conditions, air quality, diet and nutrition). Adler (2001) and Lynch and Kaplan (1999) state that multiple socio-economic factors travel through multiple pathways to influence health while Hertzman, Frank and Evans (1994) label these multiple pathways “sources of heterogeneity”. Many of these pathways and relationships are not yet fully understood (Institute of Medicine, 2003, p. 60) and it is hard to draw firm conclusions (Evans and Stoddart 2003; Lynch and Kaplan 2000).

Second, exclusion and discrimination are related to SES, race and religion and also found under “social equity” in the population health model in Figure 2.1. Exclusion has been labelled a determinant in *The Toronto Charter for a Healthy Canada* (Raphael 2004, p. 361). Further, it has been labelled a determinant of welfare and well-being (Mitchell and Shillington 2005). “Social exclusion is an expression of unequal relations of power among groups in society which then determine unequal access to … resources”
(Galabuzi 2004, p. 238). Social exclusion and discrimination inhibit people’s access to the necessities of life (e.g., food, shelter, health care) as well as negatively affects people’s mental and social well-being (Hancock, Labonte, and Edwards 2000; Peters 2003). Guildford (2000) defines social exclusion as an economic issue (i.e., lack of income). Galabuzi (2004) explores exclusion as a form of discrimination (e.g., racism) that is found in housing, employment, policing, and justice systems. Discrimination mediates “the experience of inequality into powerlessness, hopelessness, and despair” which have emotional and physical impacts (ibid., p. 247). The opposite, social inclusion, can have a positive impact on people’s mental health and social well-being (Berkman and Glass 2000; Hancock, Labonte, and Edwards 2000). Labonte (2004) cautions us about focusing on the groups who are excluded and instead encourages attention on “the socio-economic rules and political powers that create excluded groups” (p. 262).

Third, we can also explore people’s perceptions of, and the social meanings they attach to, their locations in social hierarchies; this is found under the component, “social equity” in population health model shown in Figure 2.1. The material conditions of life (e.g., poverty) affect health but the social meanings we attach to our place in society, our perception of our location in a social hierarchy or social gradient, and the connected psychological circumstances, have greater influences on health status (Brunner and Marmot 2006; Ferrie et al. 2004; Hancock, Labonte, and Edwards 2000; Hayes and Dunn 1998; Hayes and Glouberman 1999; Reid 2004b; Wilkinson 2006) (see also Hawe and Shiell 2000 who describe a gradient). However, there is not a consensus about this link between health and social hierarchy perception (Lynch 2003). Wilkinson (2001)
hypothesizes that “more inequality and a steeper social hierarchy may change social relationships as a stronger emphasis on vertical relationships drives out more egalitarian horizontal ones” (p. 41). These social hierarchies reflect degrees of power-powerlessness in that people who live in poverty are more powerless and less healthy than those who are not (Reid 2004b). It is this concept of power to which we turn next.

A fourth social determinant of health, also found under the “social equity” component in Figure 2.1, is power and control. Power is more appropriately labelled a psychosocial determinant of health because it is not an individual attribute but rather a relational attribute; it is simultaneously “a social, political, economic, and cultural phenomenon” in societies (McCubbin 2001) (see also Labonte 1990). Basically, health/well-being is a result of the way societies are structured around power and powerlessness (McCubbin 2001). “A sense of power and the ability to influence and control one’s living and working conditions … is an important aspect of health” (Hancock et al. p. 49) (see also “control” in the Whitehall studies described by Wilkinson 2006). Power and control can help individuals to achieve wellness (Prilleltensky, Nelson, and Peirson 2001). Based on his research on stress, Lerner (1991) coins the term, “surplus powerlessness”, which denotes self blame and immobilization. Surplus powerlessness “keeps us from making the changes that we actually could make” in our lives (p. 3). As a result, anger which should be directed at a highly problematic social order is instead directed inward and results in poor health (ibid., p. 3).33 Since a lack of power in various spheres (i.e., individual and community) is a risk factor for poor health, 

33 Smail (2001) warns about the risks inherent in a fully psychological analysis of powerlessness. It leads to victim-blaming and lack of consideration of underlying structural factors which cause stress.
empowering marginalized people is an essential tool for health creation (Reid 2004b, p. 4). Empowerment is a process of gaining power and more control over one’s life (Segal, Silverman, and Temkin 1995). However, empowerment is a contested concept which on one hand is about individuals securing power and control over their own lives but on the other hand is about the invisible grasp of government authority on people (see Cruikshank 1999).

Fifth, a large body of evidence has accumulated over the last two decades that consistently points to the importance of the social environment, social connectedness or social well-being for health which is found under “community conviviality” in Figure 2.1 (Berkman 1999; Brunner and Marmot 2006; Corin 1994; House, Landis, and Umberson 1999; Kawachi and Berkman 2000; Kawachi, Kennedy, and Glass 1999; Kawachi et al. 1999). I examine two here, social support networks and social capital, which are labelled differently by different theorists but are similar in nature. Social networks of family and friends are very important to health status (Hayes and Glouberman 1999). In an analysis of the 2003 Canadian General Social Survey, Cycle 17, the size of respondents’ familial, friendship and organization networks had a positive impact on self-reported health (Bouchard, Roy, and van Kemenade 2006). Evidence was found that shows that support and assistance received with daily activities through these networks was positively related to health (ibid.). Hayes and Glouberman (1999) go on to explain that the quality and depth of these relationships help to buffer stress and provide emotional support. Additionally, social capital is also linked to health (Crampton 1997; Kawachi and Berkman 2000; Kawachi, Kennedy, and Glass 1999; Putnam 2001; Veenstra 2001; Woolcock 2000). Social capital refers to the elements of social structures including bonds
and relationships among individuals and groups in a community that are based on interpersonal trust, norms of reciprocity and mutual aid which are also resources for collective action (isuma 2001; Kawachi and Berkman 2000; van Kemenade 2002).

Kawachi and Berkman (2000) reviewed literature which showed higher social capital is linked to higher political participation (e.g., higher voter turnout) and “individuals living in states with low social capital were at increased risk of poor self-rated health” (p. 184). Once again however, there are multiple pathways and some contradictions among these social determinants which make conclusions and policy recommendations difficult (Berkman 1999; Evans and Stoddart 2003; Hawe and Shiell 2000; House, Landis, and Umberson 1999; Kawachi and Berkman 2000; Kawachi, Kennedy, and Glass 1999; Olivier 2003).

Before leaving this section on determinants, it is worth briefly describing a determinant which has not yet been mentioned in this chapter: political determinants of health. A variety of elements factor into a discussion about political determinants: ideology of neo-liberalism, free markets and global competition, private sector’s need to reduce the size and role of government, and the creation of deficit mania have influenced political parties and the content of social policy in Canada (Langille 2004) (see also Rachlis 2004; Raphael and Curry-Stevens 2004). 34 Data collected between 1945 and 1980 from OECD countries show that countries with “political traditions more committed to redistributive policies and full employment policies … were generally more successful

______________

34 To this list I would add the political problems associated with jurisdictional boundaries between different levels of government which beg questions about who is responsible for what, and who should pay for what (e.g., Canadian Health and Social Transfer, Social Union Framework Agreement ).
in improving the health of populations” (Navarro and Shi 2003, p. 195). Thus, one reasonable way to increase health/well-being is to expand social programs that address these determinants, but in Canada just the opposite has occurred (Forget 2002).

2.4.4 Processes-of-change

In the middle of Figure 2.1, Hancock et al. (2000) explain that the various determinants of health in communities are affected by many different processes - both formal (e.g., those created by governments) and informal (e.g., those created by residents living in communities). The two key features for Hancock et al. are governance and education. My primary interest is the dimension labelled governance because this is where advocacy occurs. SPHERU (Labonte et al. 2002) describes governance in the context of population health as “the role of democratic and participatory forms of government in creating health promoting conditions” (p. 5). Government and governance differ. “Whereas governing through a paradigm of government is centred on control, governance involves collaboration and co-ordination, both across sectors and across policy areas … The advantage of traditional government is the ability to deliver uniform programs unilaterally to a broad segment of an eligible population; in contrast, governance recognizes difference and the value of flexibility. …” (Phillips 2001b, p. 183).

Hancock et al. (2000) describe governance “as the sum of all the ways .... in which we participate in running our communities and our society” (ibid., p. 51) (see also Jenson 2001). Hancock et al. explain participation benefits communities as well as individuals and that citizen apathy does not exist in communities where there is a high
level of citizen action, advocacy and public demonstrations. They also state the key elements of governance include volunteerism/associational life, human rights, voter behaviour, perception of political leaders and citizen action/civicness. A good example of governance occurred when a collection of 1500 groups and organizations from across Québec “launched an ambitious process of collective action and public deliberation” in order to convince the Québec government to adopt Bill 112 to reduce poverty and social exclusion. These groups ultimately succeeded (Noël 2002, p. 3).

My primary interest is in Hancock et al.’s elements of voluntarism and citizen action/civicness because these are central to CBO-facilitated social policy advocacy. Voluntarism is citizen engagement and is important for community health (Hancock et al.). Citizen action and civicness are about “individuals actively engaged in social and political action such as lobbying and advocacy …” (ibid., 53). Thus citizen action, citizen engagement, and public participation are terms with similar meanings. We are reminded that Arnstein (1969) connects participation and power: “citizen participation is a categorical term for citizen power” (p. 216) (refer back to section 2.3.2). Thus, if one could maximize people’s participation, then one could maximize people’s sense of power and control which in turn should have a positive impact on health (see also Gauvin et al. 2006, Primer on Public Involvement prepared for the Health Council of Canada; McCubbin and Dalgard 2002).

---

35 Voluntarism is a broad concept that usually includes a variety of activities including donating money and volunteering one’s time. Volunteering is not as broad and usually refers to doing work without remuneration for another individual or organization.
Labonte and Edwards (1995) explain if we truly believe in equity, then we should opt for “citizen control with professional advice only” within these processes (p. 19). The participation of marginalized people in public meetings and community action enhance their capacity to act on things important in their lives and thus has positive impacts on their health (ibid.). Two-way interactions in these public processes, which happen further up Arnstein’s ladder, seem important; the nature of positive two-way interactions may foster social capital and empowerment (Abelson et al. 2003). Empowerment involves a change in an individual’s capacity and ability to utilize power; empowerment cannot be given to an individual or community, but rather, it is about change that occurs through self-mobilization (Arai 1996).

2.4.5 Health status

Referring back to the right side of Figure 2.1, Hancock et al. (2000) explain the population health model allows us to use a broad concept of health and measure positive and negative health status as well as health disparities. Positive health status includes a good quality of life; this is a super-ordinate construct encompassing positive sense of well-being (e.g., life satisfaction, happiness)\(^{36}\) and positive self-reported health (e.g., mental and physical health). Negative health status includes mental health disability rates (e.g., stress/anxiety), morbidity and disability measures (e.g., low birth weight), mortality measures (e.g., suicide, lung cancer) and low functional health assessments. Hancock et al. readily note negative health is better understood and there is more agreement on

\(^{36}\) Although Hancock et al (2000) note there is not a consensus about this construct.
indicators than positive health concepts. For more information on health disparities, refer back to health inequities as described in section 2.4.2.

A brief note of clarification is required before going further. The Hancock et al. model does not distinguish between “lived experiences” and “felt experiences”, however, a number of studies have pointed to the need to examine both types of experiences. Qualitative research typically measures people’s lived experiences but felt experiences, emotions, are important too because they influence health/well-being (Gallo and Matthews 2003; McIntyre, Officer, and Robinson 2003; Robinson, McIntyre, and Officer 2005). Lived experiences refer to the meanings as well as ways of seeing and interpreting the world whereas felt experiences refer to emotional responses which are reflections of people’s inner feelings (ibid.). In my research I was not only interested in the lived experiences of study participants, but felt experiences too.

2.4.6 Summary of key population health elements

Population health as proposed by Hancock et al. (2000) utilizing a determinants-processes-health status model is useful for research because it delineates key components. This summary provides an overview of the central features of my research: the three main components of population health and their elements. First, there are many determinants of health. Some of the social determinants of health which correlate with poor health status and which are of particular interest to me include low socio-economic status, social exclusion due to poverty or disability, perception of one’s place in a social hierarchy, a lack of power and control in one’s life, and a lack of social networks and social relationships of trust and mutual aid. Many of the causal mechanisms and pathways that
help explain poorer health status resulting from these determinants are inconclusive.

Second, change processes within the area of governance include the participation of marginalized people in social policy work; the very act of participation can have positive outcomes/impacts for individuals. As well, community participation might foster social capital which is a community level health outcome. Third, one can examine positive and negative health status as well as health disparities. The model can be used to examine different spheres from the individual through to the community and broader society.

Given these three main components and their elements, how might we operationalize a research project to gather empirical data on CBO-facilitated processes-of-change, advocacy, with marginalized communities and how might we measure the outcomes/impacts of these processes? Answers to these questions are offered in the two remaining sections and in chapter 3.

2.5 Outcomes and impact measurement

How can one measure the outcomes and impacts that may be triggered by CBO-facilitated policy advocacy processes on individuals, communities and governments? In order to answer this question, I briefly explored the bodies of literature pertaining to the evaluation of social service CBOs (e.g., Laraia, Dodds, and Eng 2003), measuring social movement impacts (see Appendix A which compares social movements and advocacy) (e.g., Giugni, McAdam, and Tilly 1999; Klandermans and Staggenborg 2002) and social accounting in the CBO sector (e.g., Quarter, Mook, and Richmond 2003). Despite these bodies of literature, there are measurement challenges which prohibit researchers from
arriving at firm conclusions about impacts (Day and Devlin 1997; Dreessen 2000; Dreessen 2001; Sharpe 2001).

There appears to be no theoretical framework for CBO advocacy measurement and there are few studies on the outcomes and impacts of advocacy processes (Flynn and Hodgkinson 2001b). There are challenges to measuring social policy advocacy processes because these processes are non-linear and fluid, there is a diversity of people involved, there are many external forces, the time frame to make change is usually long, and they take place in a community setting, therefore, boundaries are difficult to delineate (Guthrie et al. 2005; Harvie 2002). It is suggested that perhaps measurement should be “less about precision and more about increasing understanding and knowledge …” (Mayne 1999, p. 5). Using social movements\(^{37}\) as the focus, Tilly (1999) offers a description of this measurement challenge: “there is no way to trace outcomes of complex social processes without having robust descriptions and explanations of their operations" (Tilly 1999, p. 256) and a map of the dynamic process over time (Giugni 1999). The same can be said about public policy advocacy work because people are affected by “an infinite array of experiences” (Greenway 2001, p. 217; Tilly 1999). We can never really know which strategy or tool caused a government to respond in a certain way (Cohen et al. 2001). Measuring outcomes and impacts "demands assessment over long periods of time" and one needs to study several fronts including the community level (Flynn and Hodgkinson

\(^{37}\) I use both social policy advocacy and social movement literature here because of their similarities. There are also bodies of literature that are related to policy advocacy including community organizing (Lee 1999; Wharf and Clague 1997). However, I was specifically interested in social policy advocacy \textit{per se}. 


66
2001, p. 14). One apparently successful measurement example is the longitudinal research undertaken by the Canadian Ethnocultural Council (CEC).

“It is impossible to measure precisely the CEC effect upon national public policy. But this analysis shows a clear trend over the past decade, as the CEC has moved from being on the winning side on many of its issues during the late 1980s when multiculturalism and human rights were high on the public policy agenda, to the losing side as the end of the millennium approaches” (Kobayashi 2000, p. 252).

A series of steps can be taken in an attempt to get closer to theories about the outcomes and impacts of a process (Guthrie et al. 2005; Mayne 1999; Tilly 1999): acknowledge the contribution problem, formulate hypothesized causal chains, create a logic model and theory of the change process, define benchmarks and indicators, identify instances where a causal chain is operating in the data, and test alternative explanations for the observed effects. It is important not to miss "side effects" because these affect individuals' lives too but are not directly linked to the original intervention goals (Land 2001). Giugni (1999) encourages us to look beyond the advocacy initiative or movement and gather data about the larger context which includes political structures.

Given my community-based research experiences with CBOs, including United Ways, I was interested in using a program outcome measurement model formulated for United Way of America and used by CBOs (Hatry et al. 1996). It has also been adopted by a number of scholars (e.g., Flynn and Hodgkinson 2001; Legowski and Albert 1999). Figure 2.2 presents this inputs-activities-outputs-outcomes model (Hatry et al. 1996).
Figure 2.2: Outcomes/impacts model

Inputs include the monetary, material, and human resources put into programs. Activities are the processes undertaken using these inputs in order to arrive at outputs and outcomes. "Outputs are direct products of program activities, usually measured in terms of the volume of work accomplished (e.g., number of classes or counselling sessions)" (ibid., p. 1). "Outcomes ... are the benefits or changes derived from the program" or activity for individuals or populations; outcomes indicate what has changed (ibid., p.2). Different levels of outcomes may be measured as indicators of change: initial outcomes (e.g., changes in knowledge, attitudes or skills), intermediate outcomes (e.g., changes in behaviour that result from new knowledge, attitudes or skills), and longer-term outcomes.
(e.g., meaningful changes for participants in their status, for example, moving out of poverty) (Greenway 2001; Hatry et al. 1996; Legowski and Albert 1999).38

Flynn and Hodgkinson (2001) move beyond outcomes which tell us what happened and further explain that impacts tell us why a phenomenon or change occurred. Impacts are more difficult to measure because we must first analyze and understand the causal relationships between inputs, outputs, outcomes and underlying phenomena. There is no agreement in the literature about the definition and use of the terms outcome and impact (Amenta and Young 1999; Greenway 2001), and during my pre-test, respondents seemed confused about my differentiated use of these terms. Given CBOs and other groups use outcomes and impacts interchangeably, I adopted this approach for my research and I placed them together in Figure 2.2.

The final component of the outcomes/impacts model is the historical political context. Scholars have noted this context can affect outcomes/impacts (Giugni 1999). Outside influences, seemingly boundless communities, political structures and the synergistic effects of many elements of people’s lives all influence outcomes/impacts (Cohen et al. 2001; Greenway 2001; Guthrie et al. 2005; and Tilly 1999).

38 We can also examine different levels of outcomes/impacts on policies which in turn affect people’s lives. Amenta and Young (1999) define three levels of policy outcome/impact: minor outcome/impact at the lowest level that includes winning a specific state policy decision; at the medium level is new legislation with longer term impact; at the highest level with the greatest impact occurs when a group secures "continuing leverage over political processes" and structural reforms (ibid., p. 31-32). This includes change in the power relations between advocates and governments as well as the acceptance of advocates as legitimate voices for the groups they represent (ibid.).
2.6 Summary

The goal of this chapter was to lay out the main features of my study. I began with an explanation of the features of critical inquiry as they relate to my research on the social policy advocacy work of social service CBOs (i.e., power/control and knowledge-making, inequality and exclusion, multiplicity and fluidity, and action for change). Second, an exploration of the Canadian welfare state was undertaken because this is the context – environment - within which CBOs undertake social policy advocacy. Central to this discussion of the welfare state was my interest in a social justice ideology and the nature of CBO-government relations. Third, social policy advocacy was examined in depth including an exploration of social policy advocacy as a form of civic engagement. CBO-facilitated social policy advocacy in Canada is plagued by benefits and risks. Fourth, broad definitions of health/well-being and population health were presented. Population health, as well as its three main components - health determinants, processes-of-change and health status - was explored with the goal of adopting it as a lens to examine people’s experiences and perceptions of advocacy processes. Of particular importance are socio-economic status, exclusion and discrimination, perception of social hierarchy, power and control, and social connections (i.e., social networks and social capital) as determinants and how these may be affected by participation in advocacy processes. The final section explored outcome/impact literature and concluded that measuring these kinds of processes and their outcomes/impacts can be done, but not without challenges.

There is one final explanation required - the merging of the population health model in Figure 2.1 and the outcomes/impacts model in Figure 2.2. These two models
can be used in concert as a way to operationalize my study. One model delineates the structure while the other model delineates the content, or key elements (see Goertzen, Hampton, and Jeffery 2003 as an example of this approach). First, the outcome/impact analysis model in Figure 2.2 (i.e., inputs, processes, outputs, outcomes/impacts) provides the overarching structure. Second, the population health elements from Figure 2.1 comprise the specific content to be explored (i.e., social networks and social capital, exclusion, social hierarchy, power and control) within that model. Figure 3.1 in Chapter 3 shows the population health model merged with the outcomes/impacts model which is the conceptualization of my study. In sum, my study is about CBOs as vehicles for the policy participation of marginalized people and the effects of this participation, both positive and negative, on individual participants, CBOs, governments and communities (i.e., different spheres).
3. METHODOLOGY

3.1 Overview

Crotty (2003) encourages us “to devise for ourselves a research process that helps us more than any other to answer our research question” (p. 216). This is what I did. I considered qualitative research designs and theoretical perspectives, many methods of data collection and many methods of data analysis. I chose several methods which I thought would guide me to answers to my research questions.

As already indicated, I adopted critical inquiry as the theoretical orientation for my multi-method study. I used a qualitative case study research design which included field notes (i.e., methodological and analytic), documents, observations, interviews and focus groups. The methods of analysis included deconstruction, content analysis, open coding and categorizing of interview data, and theme development. This study was conducted in three phases for which ethics approval was granted from the University Research Ethics Board (refer to Appendices B and C). Phase 1 focused on the context, phase 2 focused on a case study and phase 3 focused on summarizing and conceptualizing. Table 3.1 provides an overview of my study. Each of these components will be explained in this chapter, but first I must explain critical inquiry as a research methodology.
Table 3.1: Overview of the study

<table>
<thead>
<tr>
<th>Research question for each phase</th>
<th>Methods of data collection</th>
<th>Methods of data analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 1 - context</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Question #1</strong></td>
<td>- Observations</td>
<td>- Content analysis</td>
</tr>
<tr>
<td>How is the CBO social policy advocacy function presented in documentary material over the past 60 years in Saskatchewan?</td>
<td>- Documents (government reports, CBO reports)</td>
<td>- Content analysis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Phase 2 – Coalition case study</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Question #4</strong></td>
<td>- Documents (e.g., meeting minutes)</td>
<td>- Content analysis</td>
</tr>
<tr>
<td>What were the experiences and perceptions of marginalized people, CBO staff and government regarding a local social policy advocacy coalition process?</td>
<td>- Personal interviews</td>
<td>- Coding, categorizing &amp; theme development</td>
</tr>
<tr>
<td><strong>Question #5</strong></td>
<td>- Observations</td>
<td>- Content analysis</td>
</tr>
<tr>
<td>Using a population health lens, what were these interviewees’ perceptions of the outcomes/impacts of this local coalition?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Phase 3 – context and case study</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Question #6</strong></td>
<td>- Focus groups and all of the above</td>
<td>- Coding, categorizing of focus group data as well as the above</td>
</tr>
<tr>
<td>Based on the answers to the above five questions how can the links between CBO policy advocacy processes and population health be conceptualized?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In conjunction with these seven data collection methods, I also created two sets of field notes, which were used to track my research and thinking over time: methodological field notes and analytic field notes.

3.2 Critical inquiry as a research methodology

Researchers who adopt a critical inquiry perspective know “that our social world – including our knowledge of that world – is not simply given, or the result of a natural process, but is an historical construction” (Carroll 2004, p. 2) (see also Alvesson and Sköldberg 2000). We construct meanings over time as we interact with others and interpret what is going on around us (Crotty 2003, p. 43). “Different people may
construct meaning in different ways, even in relation to the same phenomena” (ibid., p. 9). This fits with my experience working in communities wherein, for example, poor people do not all share the same meanings about living in poverty. The interaction and constant interplay over time mean that people’s interpretations of their world – the people in it and the events that affect them – are not fixed and finite and that meanings change over time (Crotty 2003; Kincheloe and McLaren 2005).

The following summary assumptions are common among critical researchers:

“… that all thought is fundamentally mediated by power relations that are socially and historically constituted; that facts can never be isolated from the domain of values or removed from some form of ideological inscription; … that language is central to the formation of subjectivity (conscious and unconscious awareness); that certain groups in any society and particular societies are privileged over others … the oppression that characterizes contemporary societies is most forcefully reproduced when subordinates accept their social status as natural, necessary or inevitable; that oppression has many faces and that focusing on only one at the expense of others (e.g., class oppression versus racism) often elides the interconnections among them; and finally, that mainstream research practices are generally, although, most often unwittingly, implicated in the reproduction of systems of class, race, and gender oppression” (Kincheloe and McLaren 2005, p. 304).

Given critical inquiry, I knew I needed to be sceptical about the data I collected (Alvesson and Sköldberg 2000) and maintain a critical edge (Carroll 2004). I adopted two overlapping mindsets in order to remain critical in my research. First, I took on an oppositional role and investigated “status quo arrangements that enforce and protect power” and domination (Carroll 2004, p. 3). Second, I took on a subversive role to “disturb the ordinary, taken-for-granted assumptions” (Carroll 2004, p. 3) and looked for alternatives (Alvesson and Sköldberg 2000, p. 138).
3.3 Research design – qualitative case study

My purpose was twofold: to explore the evolving nature of policy advocacy work undertaken by social service CBOs in Saskatchewan using a population health lens, and to examine the perceived outcomes/impacts of these processes on marginalized groups of people, CBOs, governments and communities using this lens. This study examined people’s experiences and perceptions of social policy advocacy processes generally, as described by a group of social service CBOs, and specifically, as described by participants involved in a local advocacy coalition. I set out to describe and understand social policy advocacy as a form of civic participation grounded in social justice. And I was aware that “process-sensitive scholars watch the world flow by like a river in which the exact contents of the water are never the same” (Kincheloe and McLaren 2005, p. 319).

3.3.1 Qualitative research

I chose a qualitative, multi-method research approach because I believe research is value-laden, not value-free (Carroll 2004), meanings are not fixed and finite (Crotty 2003), and knowledge is socially constructed (Carroll 2004; Crotty 2003; Kirby and McKenna 2004). There are several qualitative research characteristics that require brief introductions because they set the stage for my study. First, Lincoln and Guba (1985) recommend research take place in communities not artificial environments because “realities are whole [and] cannot be understood in isolation from their contexts” (p. 39), in particular, realities are constructed, multiple, and holistic. Communities can be defined in multiple ways – physical, political, social psychological, historical, linguistic,
economic, cultural and spiritual; communities of interest also exist (Smith 2004, p. 126). My research was conducted in community settings where participants naturally live and interact daily. These settings included people’s homes, CBO offices, government offices and a downtown church where Coalition meetings took place.

Second, qualitative research studies rarely have emergent designs which have pre-determined directions or steps to follow. Rather, they are often quite open-ended (Campbell and Gregor 2002; Lincoln and Guba 1985; Lofland and Lofland 1995, p. 5). Criticalists wish to avoid research blueprints that constrain exploration (Kincheloe and McLaren 2005). For example, I had not intended to participate in local Coalition meetings because it had stopped meeting after its policy victory. However, I soon discovered the Coalition had resumed regular monthly meetings and I was invited to participate. Thus, observations of the Coalition and their context became an addition to my plan as my research unfolded.

Third, the location or situatedness of the researcher affects the entire research process from conception to conclusion because the researcher is the measuring instrument (Lincoln and Guba 1985; Tanesini 1999). “What knowledge we are able to observe and reveal is directly related to our vantage point, to where we stand in the world” (Kirby and McKenna 2004, p.71). 39 The ways in which I decide to explore my topic and how I interact with people within the research setting require careful thought (Campbell and Gregor 2002, p. 15). In my letters of invitation to potential participants, I

39 Decolonization theory refers to this as the insider/outsider problem (Smith, 2004).
explained that I was an advocacy practitioner and a CBO worker with the hope potential participants would be more open and trusting.

Fourth, qualitative researchers choose purposive, non-representative sampling methods because these approaches allow for an increased range for multiple realities (Lincoln and Guba 1985). For example, I was interested in sampling a diversity of CBOs from around the province. Thus, I sought CBOs in small, medium and large communities, from the northern and southern areas of the province and different size CBOs.

Fifth, inductive analysis from the data is a characteristic of qualitative research (Danermark et al. 2002; Lincoln and Guba 1985). I was interested in working with people’s experiences and perceptions of advocacy, not from theories already written. I was also interested in understanding their perspective on how well, if at all, they understood advocacy was linked to their health/well-being as well as to their larger community. Thus, it was their reality and constructions that I sought to reconstruct (Lincoln and Guba 1985).

Finally, the data analysis and conclusions are holistic (Danermark et al. 2002), are negotiated with study participants, and have tentative application to other contexts (Lincoln and Guba 1985). Instead of the traditional requirements of data validity and reliability, Lincoln and Guba (1985, p. 289-330) explain the requirements to ensure data are “trustworthy” and to refer to specific data handling procedures to ensure results are credible, transferable, dependable, and confirmable (see section 3.6). In my research, I invited participants to engage in further discussions with me about their transcripts.
3.3.2 Case study

I chose a case study design because I wanted to “investigate a contemporary phenomenon within its real-life context … when the boundaries between the phenomenon and context are not clearly evident” (Yin 2003, p. 13). The phenomenon is a local Coalition and its policy advocacy work. However, the Coalition’s advocacy work does not unfold in a vacuum; its behaviour and its work are highly influenced by what goes on in the political context (e.g., city council decisions).

More specifically I chose to do an “embedded case study design” using a “typical case” which has a revelatory function wherein the “contextual conditions” require careful attention (ibid., p. 39-46). The phenomenon of interest - the case study - is the Coalition, and represents one unit of analysis, but there are also numerous sub-units including members of the Coalition, the individuals who had to deal with the Coalition (e.g., city staff) and government committees (ibid., p. 42).40 Case studies are known for their special interest in the context, within which phenomena are located because this context – also known as the setting – influences them (Creswell 1998; Marshall and Rossman 2006; Reid 2004a; Yin 2003). There is an awareness within the community health field about the significant role of the setting, environment, or “complex social context” and the impact it has on phenomena and people’s behaviour (Keleher, MacDougall, and Murphy 2007; Kunitz 2007; Poland, Frohlich, and Cargo forthcoming). In light of this, I decided

40 Yin (2003) explains that an embedded case study includes more than one unit of analysis. “For instance, even though a case study might be about a single … hospital, the analysis might include outcomes about the clinical services and staff employed by the hospital” (ibid., p. 42).
to use multiple methods to collect data, which allowed me to develop a deep description of the context within which advocacy unfolds as well as a deep description of the case.

The first phase of my study focused on the context of advocacy. Campbell and Gregor (2002) explain there are two sites or settings: “the local setting where life is lived and experienced by actual people and the extra- or trans-local that is outside the boundaries of one’s everyday experiences” (p. 29). They further explain that people’s experiential knowledge may not be insightful because their lives may be organized in extra-local sites where power is actually held, but without their explicit awareness. Phase 1 was a broad scan of the trans-local site or macro context – the environment within which CBO advocacy unfolds – and was intended to gather descriptive, historical data about the political context of CBO-led policy advocacy work in Saskatchewan and Canada.

The second phase of my research, an in-depth case study, is based on an “issue advocacy campaign” (McCarthy and Castelli 2001). It is within this phase that Campbell and Gregor’s (2002) “local context” is captured. This phase was intended to gather deep descriptions of people’s experiences and perceptions of a local policy advocacy effort including perceptions about outcomes/impacts. The Coalition was the policy advocacy initiative chosen for this research. This Coalition was chosen for three reasons: it occurred recently (i.e., 1999 to 2005) and I therefore did not have to contend with participants’ memory recall, it appeared to exist on a workable scale (i.e., approximately 25 people were involved), and there was local access to potential study participants so my financial costs were low.
In the third phase of research I implemented a focus group method to critique and verify the data summary and begin to conceptualize links between advocacy and population health.

Figure 3.1 provides an overview of my case study. In general, the outcome/impact analysis model described in chapter 2 (i.e., inputs, processes, outputs, outcomes/impacts) provides the overarching structure for the case study (Flynn and Hodgkinson 2001a; Hatry et al. 1996). The population health concepts from chapter 2 are the specific content to be explored (e.g., social networks, power) (see Goertzen, Hampton, and Jeffery 2003 as an example of structure and content). The components in which I was most interested were the “processes” and “outcomes/impacts” from the literature and are highlighted with shaded boxes. I was aware these elements might be modified once I began my research.
**Figure 3.1: Research design - outcomes/impacts and population health models**

**3.4 Sampling and data collection**

**3.4.1 Overview**

The collection of seven methods shown in Table 3.2 was chosen in an effort to immerse myself in advocacy (Marshall and Rossman 2006). Doing qualitative research requires the researcher to become actively involved so that she can experience that which
she is studying fully and intimately (Lofland and Lofland 1995). This section includes the
details about each method and how I used these methods in my three-phase study. In phase
1, I collected data through macro-context observations, documents, and telephone
interviews. In phase 2, I focused on the Coalition as the case study and collected
documents, personal interview data, and observational data. In phase 3, I conducted focus
groups.

Field notes are common in qualitative research initiatives. I created two “process”
files – also known as field notes - in order to track the details of my research process
(Kirby and McKenna 1989). One file contained methodological field notes that related to
my decisions about the evolving research process, including selection criteria and coding,
and the other file contained analytic field notes wherein I wrote about each interview and
drew conceptual pictures and diagrams (Strauss and Corbin 1998), including my evolving
assumptions, questions, analyses, interpretations and emerging results. I reviewed these
notes periodically in order to check my assumptions, key decisions, and shifting
interpretations.
Table 3.2: Research questions and methods of data collection

<table>
<thead>
<tr>
<th>Research question for each phase</th>
<th>Methods of data collection</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 1 - context</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Question #1</strong></td>
<td>Observations</td>
</tr>
<tr>
<td>How is the CBO social policy advocacy function presented in documentary material over the past 60 years in Saskatchewan?</td>
<td>Documents (government reports, CBO reports)</td>
</tr>
<tr>
<td><strong>Question #2</strong></td>
<td></td>
</tr>
<tr>
<td>How do social service CBOs in Saskatchewan understand and incorporate marginalized people into policy advocacy processes?</td>
<td>Phone interviews</td>
</tr>
<tr>
<td><strong>Question #3</strong></td>
<td></td>
</tr>
<tr>
<td>Using a population health lens, what did CBOs perceive were outcomes/impacts of these advocacy processes on marginalized people and communities?</td>
<td></td>
</tr>
<tr>
<td><strong>Phase 2 – Coalition case study</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Question #4</strong></td>
<td></td>
</tr>
<tr>
<td>What were the experiences and perceptions of marginalized people, CBO staff and government regarding a local social policy advocacy coalition process?</td>
<td>Documents (e.g., meeting minutes)</td>
</tr>
<tr>
<td><strong>Question #5</strong></td>
<td></td>
</tr>
<tr>
<td>Using a population health lens, what were these interviewees’ perceptions of the outcomes/impacts of this local coalition?</td>
<td>Personal interviews, Observations</td>
</tr>
<tr>
<td><strong>Phase 3 – context and case study</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Question #6</strong></td>
<td></td>
</tr>
<tr>
<td>Based on the answers to the above five questions how can the links between CBO policy advocacy processes and population health be conceptualized?</td>
<td>Focus groups and all of the above</td>
</tr>
</tbody>
</table>

3.4.2 Phase 1 – Macro-context (observations, documents, phone interviews)

Phase 1 focused on research required to develop a deep description of the context within which CBO advocacy unfolds. An understanding of the environment or context within which CBO advocacy is undertaken is essential for understanding the results of the case study because case studies do not exist in isolation (section 3.3). The key research questions answered in phase 1 were:

**Question #1:** How is the CBO social policy advocacy function presented in documentary material over the past 60 years in Saskatchewan?

**Question #2:** How do social service CBOs in Saskatchewan understand and incorporate marginalized people into policy advocacy processes?
Question #3: Using a population health lens, what did CBOs perceive were outcomes/impacts of these advocacy processes on marginalized people and communities?

Observations of macro-context

Conducting observations in the field requires the observer to be open to see what is going on, but one also needs to be clear about what is relevant (Campbell and Gregor 2002, p. 72). I kept general observational notes that can be described as the big picture context, which I labelled ‘macro-context_observational notes’. I observed political and government events that occurred at the provincial and national levels which I thought might affect local CBO advocacy work. Contrary to many observational methods texts, there were no physical settings or surroundings to observe, but there was a virtual social service community that transcended municipal and provincial boundaries (Hick and Reich 2002). Angrosino (2005, p. 742) states “no technological revolution has been more challenging to the traditions of observational research than the rise of the Internet and … salience of the virtual community”.

The unit of analysis was the “social world”, which refers to a sprawling, shapeless entity with a large unspecified population with “vague boundaries that can be crossed simply by choosing to stay abreast of events in that world through” the media (Lofland and Lofland 1995, p. 112). For my purpose, I labelled this the ‘virtual voluntary sector social service world’. I started observations and taking notes in September 2003 and my last entry was made in January 2008. There were 35 pages of point-form notes.
Through e-lists and websites, I observed events and related reactions including social policy changes at both provincial and federal government levels\textsuperscript{41}, federal government advocacy rule changes\textsuperscript{42}, governments making decisions that directly affect CBOs,\textsuperscript{43} and reactions from individuals and CBOs to these events (e.g., email messages with counter-analyses, calls to action). I also attended conferences regarding social and health policy making, connected with national nonprofit research and advocacy institutes like think tanks (e.g., Canadian Centre for Policy Alternatives), connected with large CBOs that were known to have a strong advocacy base (e.g., Community Social Planning Council of Toronto), and wrote about my reflections of the past 17 years when I worked on policy advocacy initiatives. I also sought out provincial and local coalitions and networks and requested to be put on their e-lists and subsequently collected their publicly released material (Methodology notes June 5, 2006). Hick and McNutt (2002a) explain that e-advocacy at this macro-level has been increasing over the past 10 years.

\textit{Documents in macro-context}

The search for and analysis of documents produced over 60 years was intended to provide an historical description of the evolution of CBO advocacy, CBO-government relations and central concepts such as health/well-being. I searched for government annual reports and CBO documents. The search for and analysis of the contents of

\textsuperscript{41} For example, a social policy which could negatively affect marginalized populations (e.g., a cut in the amount of money people receive on their welfare cheques) could result in some CBOs advocating in reaction.

\textsuperscript{42} For example, as provincial elections were called in a number of provinces, the Canada Revenue Agency issued an “advisory on partisan political activities” on October 4, 2007, reminding registered CBOs about their advocacy limitations (Macro-context observational notes Oct. 2007). This would have had different impacts on different CBOs depending on their size, who funds them, etc.

\textsuperscript{43} For example, during the summer of 2006, the federal government cut the budget for Status of Women, which had funded women’s CBOs across Canada. The funding cut was directed at advocacy related activities going on in women’s CBOs (Macro-context observational notes Aug. 2006).
written documents such as government reports, allowed me to look at phenomena within
an historical context in order to better understand how and why the present came to look
the way it does (Berg 2004). I did not simply collect a list of events and facts about the
past but rather I sought “to understand both literal and latent meanings … within their
historical time frames. Definitions and connotations for terms change over time” (ibid., p.
236). Therefore, looking into the past with the aid of these documents helped me to
investigate social change (Peräkylä 2005) (see also Phillips and Hardy 2002; Titscher et
al. 2005). As well, Smith (1991) explains “how our political discourses and texts organize
relations among us” (p. 211); she emphasizes that power and ruling relations are
mediated through texts (see also Campbell and Gregor 2002; DeVault and McCoy 2004).

The Saskatchewan Ministry of Social Services created the annual reports which I
analyzed. This Ministry works in the “areas of income support, child and family services,
supports for persons with disabilities and affordable housing” (Saskatchewan 2007) and
is considered an institution. An institution is identified as “a complex of relations forming
part of the ruling apparatus, organized around a distinctive function” (Smith 1991, p.
160). An example is the government’s welfare system. Smith is not simply referring to a
government bureaucracy, but rather the entire collection of discourses and relations that
constitute its ruling apparatus. The Saskatchewan Ministry of Social Services was the
government department that worked most closely with CBOs in the 1940s and continues
to do so today. This source constitutes the most comprehensive and standardized
collection of documents from which to examine advocacy context, CBO-government
relations, and the evolution of advocacy from a government’s perspective.
The unit of analysis was individual documents. The first annual report from the Province of Saskatchewan Department of Social Welfare – which is what it was called at that time - was dated 1944-45. Annual reports for every fifth year beginning in 1944-45 were selected because this allowed me to capture enough detail of the evolution of this government while also spanning the ruling years of different political parties and their influence on CBOs. The data I collected from each annual report were government mission/mandate/objectives, issues of the day as indicated by departmental divisions, collaborative government-CBO committees, funding for various CBO functions, and descriptions of advocacy and its proxies (e.g., lobbying) as well as health/well-being.

I also completed keyword electronic searches for CBO documents at the University of Regina, University of Saskatchewan and the Saskatchewan Legislature Library. The keywords I used in the advanced searches were CBOs and similar concepts (e.g., nonprofit agencies), advocacy and similar concepts (e.g., activism), social services, and Saskatchewan. For each of the 32 CBO documents I found, I noted the following features: social service area (e.g., housing, mental health), date published, marginalized group(s) involved, government policies targeted, advocacy strategies employed, and type of description, if any, about government-CBO relations.

**Telephone interviews with CBOs in macro-context**

I conducted telephone interviews with social service sector CBOs from communities across Saskatchewan. These CBOs were chosen from two government datasets for the year 2003, the most recent and complete year: the registered charities dataset maintained by the Canada Revenue Agency and the registered nonprofit corporations dataset maintained by Saskatchewan Justice, Corporations Branch. The
federal dataset contained 5,015 organizations registered as charities in Saskatchewan by the end of December 31, 2003. The provincial dataset contained 6,252 organizations registered as nonprofits in Saskatchewan by the end of December 31, 2003. One cannot simply sum these two numbers to arrive at a total number of CBOs for Saskatchewan because some of these CBOs were registered as charities and nonprofits simultaneously. These two datasets were merged into one data file and sorted into an alphabetical list by reserve/city/town in order to create a file from which social service CBOs could be sampled.

A purposive sample of 95 CBOs was drawn in order to ensure CBOs from the northern and southern areas of the province, from large and small communities, from large and small CBOs, and CBOs that serve a variety of marginalized populations (refer to Labonte and Edwards 1995 who implemented a similar method) (see Appendix D for the introductory letter). The goal was to create a description of a diversity of policy advocacy initiatives being undertaken by social service CBOs in Saskatchewan (Methodology notes October 10, 2004); this added depth to my context. Thirty-nine CBOs agreed to participate in a phone interview. These interviews were done by telephone because it was the most cost-effective method of accessing respondents across an entire province. The key criterion for participation was that they had at least five years of community-based social policy advocacy experience with marginalized groups of people.

A semi-structured telephone interview tool guided data collection. The unit of analysis was the CBO. Participants were sent a detailed package by mail in advance of the interview (see Appendix E for consent form and information package). They were
asked to prepare for the interview by consulting board members and other staff regarding answers to the interview questions. This reinforced my interest in a CBO perspective rather than the individual’s perspective. The population health and outcome/impact models served as the basis to develop the semi-structured interview questions.

Each interview began with general questions about whether participants believed their CBO contributed to the health/well-being of marginalized populations. They were also asked to describe their general approach to advocacy involving their program participants (see Appendix E). The second part of the interview dealt with the inputs/resources that each CBO used to do this policy advocacy work in collaboration with marginalized groups of people. The third section contained questions about the strategies used by each CBO to involve marginalized people in advocacy work including barriers and opportunities to their participation. The fourth section focused on questions relating to perceived outcomes/impacts of their policy advocacy work. Participants were asked about the changes, both positive and negative, they saw occur in the marginalized groups of people who participated in policy advocacy campaigns (i.e., changes in values and attitudes, felt/emotional reactions, learning, social networks and relationships, inclusion/exclusion and discrimination, power and control, perception of place in social hierarchy, behaviour, and status/condition) (Berkman and Glass 2000; Flynn and Hodgkinson 2001a; Hancock, Labonte, and Edwards 2000; Hatry et al. 1996; McCarthy and Castelli 2001). This section also included questions on the perceived impacts on their CBO, their community, and the governments involved. The fifth and final section included questions about trends in CBO advocacy and whether they thought advocacy
was a necessary CBO function today.\textsuperscript{44} The 39 interviews took an average 65 minutes each to complete. The telephone interviews were semi-structured, in that I asked participants predetermined questions, but I also gave them the opportunity to expand on issues they deemed important.

Interviews were audio-recorded and then transcribed into computer text verbatim; audio-recording the interviews freed me to better facilitate the interview and take notes about items that I wanted to revisit with respondents (Lofland and Lofland 1995). Transcripts of each interview were sent to each respondent for verification. In my Analytic Notes after each interview, I wrote my reflections about the interview, as suggested by Lofland and Lofland (1995, p.87). After completing all the interviews, I analyzed the data.

3.4.3 Phase 2 - Case study (documents, interviews, observations)

Documents pertaining to the Coalition, interviews with Coalition participants and observations of the Coalition were the main features of the case study. I chose to work with an “issue advocacy campaign” wherein individuals and organizations involved with an issue are identified and invited to participate in the research (McCarthy and Castelli 2001). This approach was appropriate because it allows for a "direct focus upon the interacting process of advocacy", enhanced mapping of all organizations involved, and the opportunity to analyze both the co-operative and conflictual elements of advocacy work (ibid., p. 118). The questions addressed in this phase were:

\textsuperscript{44} A plain language writer edited this interview tool before it was finalized and sent to the 39 CBOs.
Question #4: What were the experiences and perceptions of marginalized people, CBO staff and government regarding a local social policy advocacy coalition process?

Question #5: Using a population health lens, what were these interviewees’ perceptions of the outcomes/impacts of this local coalition?

Documents of the case study Coalition

My first goal was to understand the Coalition’s life cycle. To achieve this, I collected various documents that, when taken together, tell the story of the Coalition. The documents included Coalition minutes, city advisory committee minutes, city council minutes, student research papers written for a University of Regina course on the Coalition’s topic, and newspaper articles about the work of the Coalition. The earliest documents dated back to March 2001. The Coalition had actually started meeting before March 2001, as will be shown in the data collected during the interviews. Unfortunately, because of staff changes and office moves, minutes of meetings that were held in 1999-2000 could not be found. Documents from a variety of sources were deemed important because they assisted in creating a complete Coalition story, albeit from a diversity of perspectives (Yin, 2003).

In order to find these documents, I contacted people who I knew had been active Coalition members given my summer 2004 exploratory research and I asked to borrow their Coalition files. I made photocopies of all these documents and put them in chronological order. I then used these documents to re-create the Coalition’s story (Guthrie et al. 2005; Mayne 1999; Tilly 1999). Given my critical inquiry perspective, I decided to elevate the advocacy volunteers’ and CBOs’ voices above the voice of the

45 The Coalition had actually started meeting before March 2001, as will be shown in the data collected during the interviews. Unfortunately, because of staff changes and office moves, minutes of meetings that were held in 1999-2000 could not be found.
governments because often their voices are suppressed (Kirby and McKenna 1989). In light of this, I wrote the Coalition story from their perspective.

**Personal interviews with case study Coalition participants**

Personal interviews were conducted with people who were Coalition members or those who had to work with the Coalition at some point during the process. The unit of analysis was the individual. Tilly (1999) recommends involving three key groups in Coalition research: marginalized people (defined here as low income and/or disabled who are the beneficiaries of a proposed policy change), CBO staff as advocates and government staff as power holders.46 These three groups were found in the Coalition.

Some scholars recommend a three-interview approach (Seidman 1998):

“The first interview establishes the context of the participants’ experience. The second allows participants to reconstruct the details of their present day experience within the context in which it occurs. And the third encourages the participants to reflect on the meaning their experience holds for them” (ibid., p. 11).

I adopted Seidman’s three key areas (i.e., participant life history context, reconstruction of a current day event/experience, and participants’ reflections on these experiences), but collapsed data collection into one interview instead of three due to concerns about participant attrition.

Invitations that explained my research were mailed to the 25 people whose names I found in Coalition meeting minutes and city advisory committee minutes and reports (see Appendix F). The key criterion for Coalition members to participate in the research

---

46 Given my experience with this kind of research, these three groups are not necessarily mutually exclusive in practice although they may be presented as distinct groups in theory. This was indeed the case with the Coalition (e.g., a union representative was an employee of the government, but also an advocate).
was that they had attended 75% of the Coalition meetings during 2002, 2003, and 2004 (i.e., the period during which the one-year pilot project was accepted by the government). For government representatives, the key criterion was they worked directly with this policy issue and the Coalition during that time period. In total, 17 people agreed to participate in a personal interview. Those who agreed to participate were sent introductory material in advance and asked to prepare for the interview by reading the interview questions (see Appendix G). The nature of this interview required people to form thoughtful responses using their memory of past events. I used the Accessibility Guidelines (Waterloo Region Social Services Department 2006) to create documents for one individual in my sample who was visually impaired.

Again, data collection was guided by a semi-structured interview tool (refer to Appendix G).47 I conducted the interviews in people’s homes, in a meeting room in a church downtown which was a gathering place for the Coalition, in CBO offices, and in government offices. This personal interview tool was similar to the CBO phone interview tool: it was based on the outcome/impact model with a focus on population health elements. It began with participants’ focused life history. “Focused” refers to a person reconstructing her/his life events that centre on past advocacy efforts in their families and communities (Seidman 1998). The second part of the interview included an in-depth exploration of participants’ experiences with the Coalition. The areas covered were inputs/resources, processes and strategies including barriers to and opportunities for participation, outputs and accomplishments, outcomes/impacts and general comments.

47 A pre-test had been done with six people who had been involved in coalitions in another province with whom I had had working relationships. A plain language writer edited this interview tool.
Participants’ self-reports of experiences and perceptions were central. One of the last questions focused on perceived outcomes/impacts of the policy advocacy process. Participants were asked about changes, both positive and negative, they saw occur in Coalition members as well as those who had to deal with the Coalition (i.e., changes in values and attitudes, felt/emotional reactions, learning, social networks and relationships, inclusion/exclusion and discrimination, power and control, perception of place in social hierarchy, behaviour, and status/condition) (Berkman and Glass 2000; Flynn and Hodgkinson 2001a; Hancock, Labonte, and Edwards 2000; Hatry et al. 1996; McCarthy and Castelli 2001).

The 17 interviews took an average 100 minutes each to complete. The interviews were semi-structured, in that I asked the predefined set of questions and participants responded but I gave them the latitude to expand on issues they deemed important. Interviews were audio-recorded and then transcribed into computer text verbatim. A transcripts of each interview was mailed or emailed to the appropriate respondent for verification prior to analysis. Once again, after each interview I wrote my reflections in my Analytic Notes.

Observations of case study Coalition

Observations of the Coalition had not been part of the original research design approved by my doctoral committee because it appeared the Coalition had disbanded in early 2005 after City Council adopted the Coalition’s recommendation and approved a policy change. I soon discovered at another community meeting that I attended that the Coalition had not disbanded, but simply taken a break. It met in July 2006 and I was invited by the Chairperson to attend their meetings. I started attending their monthly
meetings in October 2006. This is an example of “emergent design”, or the addition of another method to a research design after a study has begun (Danermark et al. 2002; Lincoln and Guba 1985). The unit of analysis was the group of people who comprised the Coalition. This Coalition is considered a “group” as defined by Lofland and Lofland (1995, p. 107); “a dozen or so people who interact with some regularity over an extended period of time and who conceive of themselves as a social entity”.

In general, I was interested in people’s experiences and interactions in an advocacy process. There were five main areas of data collection: a) The settings within which advocacy meetings took place (i.e., a CBO space, a government space, a public library meeting room, a church, and what these settings looked like in terms of colour, size, décor, and furniture); b) The people who attended (i.e., from CBOs, the community or governments); c) What happened at these advocacy meetings (e.g., accepted rules of order, behaviour during meetings, relationships among the participants because I was interested in power, and the content/nature of the advocacy conversations); d) What was happening outside the Coalition’s meetings which might affect what took place at their meetings (i.e., what municipal government was working on at the time); e) The physical artifacts used during the meeting (e.g., a laptop to take minutes) as well as those created by the participants after the meetings (e.g., meeting minutes, research reports). I recorded this information as well as my reflections, impressions and feelings about what I saw (i.e. the atmosphere of the meetings including the emotional atmosphere) (Lofland and Lofland, 1995). The first entry in my observational notes was made October 2006 and the last entry was done in September 2007; a total of 20 pages were written.
3.4.4 Phase 3 - Focus groups with Coalition participants

The third phase of my study focused on the following research question:

Question #6: Based on the answers to the above five questions how can the links between CBO policy advocacy processes and population health be conceptualized?

Focus groups were implemented as a component of the Coalition case study. Focus groups, usually containing less than 12 people, serve three primary but overlapping functions including pedagogy, politics and qualitative research (Kamberelis and Dimitriadis 2005). My interest was qualitative research. Focus groups have the following strengths which interviews do not: “promoting among participants synergy that often leads to the unearthing of information … [and] facilitate the exploration of collective memories and shared stocks of knowledge that might seem trivial” (ibid., p. 903). The central feature of focus groups “is their explicit use of group interaction to produce data and insights” (Morgan 1997, p. 2).

Those people who were interviewed in phase 2 of my research were invited to participate in a focus group. This provided a feedback loop for respondents to verify the contents of the data summary (Lincoln and Guba 1985) and to spur memories and opinions based on what others discussed (Lofland and Lofland 1995). The focus groups also offered participants the opportunity to further reflect on their experiences because there was likely a “heightened awareness of the research topic” following the interviews (Morgan 1997, p. 69). Finally, the groups provided an opportunity for participants to conceptualize the links between CBO advocacy processes and population health.
The unit of analysis was the group. I had planned to have three focus groups: advocacy volunteers, CBO staff, and government representatives who were interviewed in phase 2. Some literature shows these three groups can have very different perspectives (Krueger 1994, p. 77; Morgan 1997, p. 67). There is also an implied hierarchy of “authority” or power (Morgan 1997, p. 37) wherein governments are perceived to have the most power and marginalized people have the least. This hierarchy may affect how people behave and their perception of their right to speak (Freire 2003). For these reasons, I attempted to organize three separate focus groups. However, I was only able to organize two groups; one for the advocacy volunteers and one for the CBO staff. I was not able to organize a government focus group because there was a high refusal rate due to a number of factors (e.g., a provincial election call, one participant moved, and another participant left the government to work in a CBO).

I produced a six-page data summary report for each group titled, Preliminary Summary of Findings. These reports were sent to the participants, who were then asked to think about the following five questions before the focus group meeting: 1) Is there anything that is not clear in the Summary?; 2) do you think there is anything important missing from the Summary?; 3) do you think there is information contained in the Summary that you believe should not be there because it’s wrong or misleading?; 4) given this study is about health/well-being, can you explain the connections between your involvement in the Coalition and your health/well-being?; and 5) I would like to take us beyond individuals like yourselves and ask a question about the broader community - what role, if any, do coalitions like the Coalition play in helping to create healthier communities?
Both of the focus groups were held in a meeting room at a church in the downtown area. It was a familiar place to the participants because they had many meetings there (Morgan 1997) and it was accessible. The meetings began with question #1, yet participants immediately raised issues that had nothing to do with the list of five questions (Methodology Notes Sept. 29, 2007). I had to facilitate the meeting in such a way that these other issues were legitimized, but at the same time draw the conversation back to the purpose of the meeting. Both of the focus groups were audio-recorded. After each focus group I wrote my reflections in my Analytic Notes. I created transcripts of each focus group and sent them to the respective participants for verification.

3.5 Data analyses

3.5.1 Overview

In this section on data analyses, I describe the analytic tools that I used for each of the seven data collection methods as well as my methodological field notes and analytic field notes. Table 3.3 offers an overview. As I collected data throughout these three phases, I regularly went back to check what I had written earlier in these field notes. “The act of interpretation underlies the entire research process … [it] is not something which occurs only at one specific point” (Kirby and McKenna 2004, p.69). This was a constant iterative process of working in the present, while reflecting on my past thinking and assumptions, revising codes and categories, and putting these aside and then looking at them again (Kirby and McKenna 1989).
Table 3.3: Research questions and methods of analysis

<table>
<thead>
<tr>
<th>Research question for each phase</th>
<th>Methods of data analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 1 - context</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Question #1</strong></td>
<td>- Content analysis of</td>
</tr>
<tr>
<td>How is the CBO social policy</td>
<td>observations and</td>
</tr>
<tr>
<td>advocacy function presented in</td>
<td>documents</td>
</tr>
<tr>
<td>documentary material over the</td>
<td></td>
</tr>
<tr>
<td>past 60 years in Saskatchewan?</td>
<td></td>
</tr>
<tr>
<td><strong>Question #2</strong></td>
<td>- Coding, categorizing</td>
</tr>
<tr>
<td>How do social service CBOs in</td>
<td>and theme development of</td>
</tr>
<tr>
<td>Saskatchewan understand and</td>
<td>interviews</td>
</tr>
<tr>
<td>incorporate marginalized people</td>
<td></td>
</tr>
<tr>
<td>into policy advocacy processes?</td>
<td></td>
</tr>
<tr>
<td><strong>Question #3</strong></td>
<td></td>
</tr>
<tr>
<td>Using a population health lens,</td>
<td></td>
</tr>
<tr>
<td>what did CBOs perceive were</td>
<td></td>
</tr>
<tr>
<td>outcomes/impacts of these</td>
<td></td>
</tr>
<tr>
<td>advocacy processes on</td>
<td></td>
</tr>
<tr>
<td>marginalized people and</td>
<td></td>
</tr>
<tr>
<td>communities?</td>
<td></td>
</tr>
<tr>
<td><strong>Phase 2 – Coalition case study</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Question #4</strong></td>
<td>- Content analysis of</td>
</tr>
<tr>
<td>What were the experiences and</td>
<td>documents &amp;</td>
</tr>
<tr>
<td>perceptions of marginalized</td>
<td>observations</td>
</tr>
<tr>
<td>people, CBO staff and government</td>
<td>- Coding, categorizing</td>
</tr>
<tr>
<td>regarding a local social policy</td>
<td>and theme development of</td>
</tr>
<tr>
<td>advocacy coalition process?</td>
<td>interviews</td>
</tr>
<tr>
<td><strong>Question #5</strong></td>
<td></td>
</tr>
<tr>
<td>Using a population health lens,</td>
<td></td>
</tr>
<tr>
<td>what were these interviewees’</td>
<td></td>
</tr>
<tr>
<td>perceptions of the outcomes/</td>
<td></td>
</tr>
<tr>
<td>impacts of this local coalition?</td>
<td></td>
</tr>
<tr>
<td>**Phase 3 – context and case</td>
<td></td>
</tr>
<tr>
<td>study**</td>
<td></td>
</tr>
<tr>
<td><strong>Question #6</strong></td>
<td>- Coding, categorizing</td>
</tr>
<tr>
<td>Based on the answers to the</td>
<td>of focus group data as</td>
</tr>
<tr>
<td>above five questions how can the</td>
<td>well as the above</td>
</tr>
<tr>
<td>links between CBO policy</td>
<td></td>
</tr>
<tr>
<td>advocacy processes and</td>
<td></td>
</tr>
<tr>
<td>population health be</td>
<td></td>
</tr>
<tr>
<td>conceptualized?</td>
<td></td>
</tr>
</tbody>
</table>

I used qualitative research, computer-based, software called Atlas-ti Version 5.2.9 (2007) for five of the seven types of data because they were electronic texts. The data that had to be analyzed manually were the government annual reports and the documents collected for the Coalition case study (e.g., meeting minutes, city council reports). Atlas-ti is considered to be “a concept database, not an analysis program … tools to support analysis … a support to bring order to the growing list of codes” (Woolf July 2007, p. 2). Since most of the data were electronic and accessible through Atlas-ti, I could easily search approximately 1400 pages of text within seconds for key words, codes, and various themes.
I completed both within-method data analysis for each of the seven methods as well as between methods data analysis. Within-method analysis was done first. Within-method data analysis refers to the processing of data collected from a sample using the same method. For each of the seven methods I applied specific analytic techniques. I used the language of the sources themselves (i.e., an interviewee, a government official in a press release) for initial code categories, but I had to be careful when I moved across the seven methods because different people use different language (Titscher et al. 2005). I constantly had to check back into the primary documents through Atlas-ti and re-read paragraphs from which the data were taken; this was a process of “constant cross-comparisons and matchings” (Kirby and McKenna 1989, p. 148). Also, some of the data were re-coded as a result of my evolving thinking (Analytic Notes Sept. 2006 to Sept. 2007). Each of these analytic processes are described in detail below.

Once the data were coded and themes were developed for each of the seven methods, I conducted between-methods analysis. Between-methods data analysis is also known as “triangulation” of data sources or cross-methods analysis (Creswell 1998; Marshall and Rossman 2006; Yin 2003). Between methods analysis is an analytic process of looking for convergent and divergent themes in the data (Lincoln and Guba 1985). Convergent themes share characteristics. Divergent themes are uncommon or contradictory; they are also known as “satellites” (Kirby and McKenna 1989) or “residual cases” (Lofland and Lofland 1995). In my data analysis I accounted for these divergent themes by saving and labelling them as such along with all the themes so they would not get lost.
Throughout my study – not just during the data analysis phase - I was reflective. Deconstruction is a specific tool to aid reflection during analysis. It encourages one to “turn things upside down, and make hitherto oppressed side the dominating one … [as well as] undermine the difference between two opposites …” and then go on to construct something new (Alvesson and Sköldberg 2000, p. 154). Deconstruction destabilizes and creates openings for transforming concepts (Carroll 2004, p. 227). Using deconstruction encouraged me to expose underlying meanings and preconceptions in my collected data (Denzin 2004).

3.5.2 Phase 1 – Analysis of context (observations, documents, interviews)

Observations of macro-context

I used content analysis (Titscher et al. 2005) as the analytic tool on my macro-context observational notes which were linked to Atlas-ti. Titscher et al. (2005) suggest that certain analytical procedures which may be carried out independently or in combination. The two procedures that I adopted were a) the summary which preserves the essential content but reduces its size and b) an explication which explains and clarifies the material. These procedures were applied to the document that I created based on electronic textual material I collected from governments, conferences, seminars, national institutes and large CBOs. I was interested in the following elements: CBO-government relations, the current political atmosphere surrounding advocacy, CBO reactions to government document releases, and possible implications for health/well-being. I labelled this document an “observational document” in Atlas-ti.
Documents in macro-context

I analyzed two sets of texts in order to trace the historical evolution (Titscher et al. 2005) of CBOs, CBO advocacy, and CBO-government relations. Together these two sources also provided me the opportunity to get a general sense of evolving discourse (Phillips and Hardy, 2002) before analysing present day interview data. In my attempt to trace this evolution, I examined a 60-year span. The first source I analyzed was provincial government annual reports. The second source of texts was CBO advocacy reports, dated back to 1938. This was the earliest document I found during my keyword library search.

First, I analyzed 13 provincial Ministry of Social Services annual reports. I completed content analysis by analysing annual reports from every fifth year (beginning with the first one published in 1944-45 and ending with the one published in 2005). For each annual report I read and noted government missions/mandates/objectives, issues of the day as indicated by departmental divisions, which collaborative government-CBO committees existed, funding for CBO functions, and how advocacy and its proxies (e.g., lobbying) as well as health/well-being were described. I also used deconstruction to see beyond the immediate message offered by the collection of words (Alvesson and Sköldberg 2000; Denzin 2004). I looked for assumptions upon which the texts appeared to rest while remaining sensitive to the time period (Peräkylä 2005). I also looked for implicit intentions of the writers, and for invisible descriptions about the relationship between the government and CBOs. These government documents do not simply describe the government; they also help to expose the government’s perspective on CBOs, marginalized populations and society in general.
Second, I searched for CBO-produced reports; the oldest document I found in this library search was 1938. I applied content analysis, namely summarization and explication, to these reports (Titscher et al. 2005). I read each CBO document that I found and noted the following features: social service area, date published, marginalized group(s) involved, government policies targeted, advocacy strategies employed, and any coverage of government-CBO relations. In addition to these explicit elements, I also reflected on and noted unwritten preconceptions and assumptions upon which the text appeared to stand; this goes beyond line-by-line data analysis (Peräkylä 2005; Titscher et al. 2005). Deconstruction aids this deeper examination (Alvesson and Sköldberg 2000; Denzin 2004).

**Telephone interviews with CBOs in macro-context**

I used coding and categorizing tools from grounded theory to analyze, through Atlas-ti, the verbatim textual data collected through telephone interviews (Strauss and Corbin 1998). I was interested in both cognitive and emotional data found in each individual’s transcript (Lofland and Lofland 1995, p. 113-18). Cognitive refers to the meanings which people attach to concepts; meanings can include “norms, understandings, interpretations, definitions of a situation, typifications, ideology, beliefs …” (ibid.). Some of these may go unarticulated by interviewees so I probed further in the interviews. Therefore, when I was analysing the data I had to be aware and think carefully about what I was re-reading and coding because meanings are fragile, often owned by those in privileged positions, and constantly changing (ibid.) (see also Grabb 2007; Kincheloe and McLaren 2005).
Emotional aspects refer to people’s feeling responses to their world. Emotions are inner experiences that are publicly observable (Robinson and McIntyre 2007). A number of studies have pointed to the need to not only examine people’s “lived” experiences, but their “felt” experiences as well because emotions have been shown to have an impact on health/well-being (Gallo and Matthews 2003; McIntyre, Officer, and Robinson 2003; Robinson and McIntyre 2007).

I had approximately 800 pages of transcripts from the 39 CBOs which were linked to Atlas-ti. Atlas-ti was used to attach codes to pieces of text, to create categories (i.e., “families) and to store memos. Atlas-ti also permitted multiple coding and categorizing of the same sentences and paragraphs, which is essential to qualitative analysis (Kirby and McKenna 1989). This software also permitted me to move data without untying them from their original sources and to retrieve quotations quickly by clicking on codes.

My first step in data coding was to do “open coding” (Strauss and Corbin 1998, p. 101-121). Open coding is an “analytic process through which concepts are identified and their properties and dimensions are discovered in the data” (ibid., p. 101); basically, this was a micro-analytic process of breaking down large chunks of text into meaningful smaller units. This involved reading each transcript from beginning to end. I then went back to the beginning of the transcript and did line-by-line second order coding, which means that I read the sentences and attached a label, or code, that best represented that sentence; in most cases, I adopted words used by the interviewees themselves (Strauss and Corbin 1998) (Analytic Notes April 19, 2007). It was common to have one sentence with two or three codes attached to it. I also completed paragraph-by-paragraph coding.
because, taken as a whole, paragraphs can contain additional meanings. Once I completed
this second order coding, I organized these codes into meaningful, larger groups of data
and chose labels that best represented the collection of second order codes; these became
first order codes. I adopted a constant comparative method of coding during this process
(Kirby and McKenna 1989; Strauss and Corbin 1998). Basically, I re-read and re-coded
data segments a number of times before I felt comfortable. This is known as the
“dynamic relationship between data”, and between data and categories (Kirby and
McKenna 1989, p. 128).

There was one section of the interviews, outcomes/impacts, for which I did not do
inductive analysis. Rather, I adopted categories from the literature (e.g., learning, social
networks, power and control). Listing these in the interview tool was deemed necessary
because during the pre-test, the respondents asked me for clarification. As well, by listing
the categories I kept respondents focused on a broad definition of health.

My second step was to do “axial coding” (Strauss and Corbin 1998). Axial coding
is the process of “systematically developing and relating categories” (Strauss and Corbin
1998, p. 142). Essentially, this process included searching for connections between the
open codes and reassembling data into new formulations (Lincoln and Guba 1985); in
one instance I developed a typology based on data categories (Lofland and Lofland
1995). The search for and development of categories led to broader and more meaningful
categories. For example, I asked the 39 CBO interviewees about barriers they faced in
their attempts to participate in advocacy work. From their data, I gleaned 182 second
order codes which were systematically divided into 22 first order codes. These 22 first
order codes were analyzed into seven main categories including: lack of practical
supports; disabilities; culture and language barriers; psychological barriers (e.g., fear); survival barriers; lack of awareness and skills; and structural barriers imposed by governments and CBOs. To report these data, I relied on Strauss’ (1987) extensiveness criterion to order categories in tables (i.e., the category most frequently found was placed first in the table). Extensiveness refers to pervasiveness across respondent transcripts, not within each transcript. During this phase of the analysis, I returned regularly to my macro-context observational notes, my document analysis work, and my analytic notes to remind myself of emerging patterns (i.e., method triangulation).

3.5.3 Phase 2 – Analysis of case study (documents, interviews, observations)

Documents of case study Coalition

I used content analysis (Titscher et al. 2005) on the Coalition documents. Once again, the two analytic procedures that I adopted were a) summarization, which preserves the essential content but reduces its size and b) explication which explains and clarifies the material. More specifically, I adopted Lofland and Lofland’s (1995, p. 134) “tracing back” technique to create a summary; this technique helped me to re-create the sequence of events and processes that makes up the Coalition’s story. Yin (2003) refers to this approach as a type of chronological “time-series analysis” (p. 125). I searched for both the manifest and latent meanings in the text in an attempt to uncover hidden meanings, especially those regarding positive and negative elements of advocacy (Berg 2004). These procedures were applied to the Coalition’s meeting minutes, their reports, city hall

48 In fact, Yin (2003) states this may not simply be a descriptive analysis but causal events can actually be measured if one has enough patterned data temporally sequenced (p. 125).
reports, and newspaper articles. I completed this analysis manually because there were no electronic copies. I had approximately 135 pages of city hall documents, approximately 145 pages created by the Coalition, and 20 newspaper articles.

**Personal interviews with case study Coalition participants**

Once again, I used the analytic tools of coding and categorization from grounded theory and analyzed the verbatim textual data collected through personal interviews and linked to Atlas-ti (Strauss and Corbin 1998). Again, as per section 3.5.2 regarding the telephone interviews, I analyzed these personal interview transcripts with an interest in both cognitive and emotional elements. I had approximately 400 pages of transcript text from the 17 Coalition case study respondents. I completed open and axial coding on these interviews as well; this was inductive work except for one section of the interview about outcomes/impacts for which I relied on health literature. Again, I used the extensiveness criterion across interviewees (Strauss 1987).

**Observations of case study Coalition**

These were electronic notes that I created after every Coalition meeting that I attended; they too were linked to Atlas-ti. These notes included observations of actual Coalition meetings as well as minutes sent out by email and e-messages that were considered part of the Coalition’s process. I did content analysis on the material products generated by the Coalition (e.g., meeting minutes) as well as on those documents that were generated by others but which impacted the Coalition, for example, city hall reports (Titscher et al. 2005). The two procedures that I adopted were a) summarization, which preserves the essential content but reduces its size and b) explication, which explains and clarifies the material (ibid.). I also critically examined my observational notes about
meetings, the people who attended, interactions within the meetings, and events taking place outside the meetings (especially important were city council activities). I had 30 pages of observational notes.

### 3.5.4 Phase 3 – Analysis of focus groups

The unit of analysis was the group - more specifically, the interactions among the group members as well as the content of the advocacy conversations. “Neither the individual nor the group constitutes a separable ‘unit of analysis’… [I needed to] seek a balance that acknowledges the interplay between these two” (Morgan 1997, p. 61). The two focus groups (i.e., volunteers and CBOs) were asked the same five questions. The ensuing 38 pages of transcripts contained the content of what was collectively discussed. I also included notes about the interactions and dynamics within the group immediately after each focus group (Krueger 1994).

I used open and axial coding from grounded theory as the analytic tools on the data collected through the focus groups and linked to Atlas-ti (Strauss and Corbin 1998). I was interested in understanding each group’s responses, but I was also interested in comparing the answers between the two groups (Morgan 1997). I was particularly interested in a) whether each individual participant mentioned certain codes (i.e., Krueger’s extensiveness) and how similar the words were, b) how much energy and enthusiasm the code/topic generated (i.e., Krueger’s intensity), and c) how similar or different the two groups’ discussions were of the central topics of advocacy impacts on the health/well-being of individuals and communities. I completed a descriptive summary and interpretive analysis for meanings from the transcripts (Krueger 1994). As with the
other qualitative data in my study, I struggled with, coded and kept the unusual cases because even the “absence of patterns in the data can be a meaningful discovery” (Krueger 1994, p. 137).

3.5.5 Development of themes

Yin (2003) cautions “embedded case study” researchers against analysing the sub-units and forgetting to return to the case study. Before beginning work on theme development, I re-read the results from the three methods regarding the Coalition case study. This helped me put the case study back into the centre of my analytic process.

I developed themes by searching for connections between categories. I set out to describe and understand advocacy as a form of civic engagement from a variety of perspectives. In order to develop themes, I relied on criteria developed by (Strauss 1987, p. 36) regarding the choice of themes as one moves from codes to categories to themes. 49 I used the following criteria to judge whether a category should become a theme:

- It is central - all other major categories can be related to it somehow.
- It occurs frequently - within all or almost all cases, codes point to this concept. This refers to extensiveness across transcripts and not the number of times a code is found within each transcript.
- It relates easily to other codes and categories – the data are not forced.
- It explains maximum variation - the central category is able to explain the data and all its variations, including contradictory codes and categories.

3.6 Data trustworthiness

“Given that objectivity cannot be established and that there is only interpretation” (Reid 2004b, p. 80), qualitative researchers must be able to show there is some “truth” to

49 I included four of their points here; I omitted two additional points because they related to theory-building which I am not doing.
the results of a study. Lofland and Lofland (1995) state that for all data collected, questions regarding their truth are legitimate. Thus, I should be concerned about the accuracy of my perception of the data and analysis as well as the study participants’ perceptions.

Lincoln and Guba (1985) state there are four criteria for establishing the trustworthiness of the data and the results. First, one must establish credibility. “The reconstructions that have been arrived at via the inquiry are credible to the constructors of the original multiple realities” (ibid. p. 296). In order to establish credibility, I compared findings from the multiple methods, matched patterns and addressed rival explanations (Yin 2003). I listened to a diversity of viewpoints and checked my interpretations with participants. I also sent all 56 transcripts to the interviewees for them to verify. Finally, I spent one year volunteering with the Coalition in order to experience their advocacy process.

Second, I must show transferability or applicability to other sites. Lincoln and Guba (1985) state it is my “responsibility to provide the data base that makes transferability judgements possible on the part of potential appliers” (p. 316). I accomplished this through a deep description of the historical political context. I arrived at this description through systematic observations, document analysis and interviews with CBOs from around the province. I also created a detailed description of the Coalition as an example of an advocacy process.

Third, I must show dependability - that “the findings of an inquiry would be repeated if the inquiry was replicated with the same subjects in the same context” (Lincoln and Guba 1985). I maintained detailed methodology field notes from the
beginning of my research; these, combined with this methods chapter, could be used by another researcher to replicate my study.

Finally, Lincoln and Guba (1985) state the results must be confirmable, that is, they must be grounded in the data and not the researcher’s biases, interests, or perspectives (p. 290). Since this type of qualitative research relies so heavily on the researcher’s interpretation, there is a need to check this. I believe that my multiple methods approach, detailed methodology notes, analytic notes, the Atlas-ti software program, observational notes and documents form an “audit trail” (ibid., p. 319). These can be traced to see where data substantiate results.

3.7 Reflections and limitations

In this section, I offer some reflections about my data collection and data analysis work. First, as I reflected on my data collection, my methodology field notes and my analytics notes, I realized one of the significant challenges I faced was convincing people to focus on “social policy” advocacy during the interviews. CBOs readily told me about their research advocacy, program advocacy and funding advocacy when answering my social policy advocacy questions. It is now apparent to me these various forms of advocacy are but points on a continuum of advocacy (Analytic Notes May & June 2006).

Secondly, a similar issue occurred with the advocacy volunteers. They struggled to stay focused on advocacy processes. Instead, they constantly wanted to tell me about their specific policy issues (Analytic Notes Dec 2006 & January 2007).

Third, regarding the phone interviews with CBOs around the province, I discovered that crises in participants’ environments affected their interview. For example,
a murder in an interviewee’s neighbourhood association catchment area meant I had to wait for a month while he dealt with the police investigation and organized a public meeting. This interviewee would have been changed by this crisis and interviews with him before and after such a crisis would likely reveal different results. The next time I do this type of research, I will add an explicit question about recent events in both their micro and macro contexts which they believe affected their thinking about advocacy and its impacts.

3.8 Knowledge-making: my identity, trust, and power

I was the measuring instrument in this research project, thus I was acutely aware of both my interpretive role and my knowledge-making role. Those who control research also control knowledge making (Guba and Lincoln 2005). I described briefly in the introduction to this dissertation who I am and how I arrived at this research focus. These life experiences influenced my choice of research design and were the filters through which I interpreted the data. I agree with Crotty’s (2003, p. 8) point that “there is no objective truth waiting for us to discover it … meaning comes into existence … out of our engagement with … our world”. It is from this understanding, that I generated knowledge.

I was acutely aware of how I might be perceived by the study participants. The notable and visible features of my identity that may have influenced the 17 participants were: I am a white, middle age, middle class, able-bodied, female student. Some of these features were irrelevant to the 39 CBOs because we connected by phone. There were also
many invisible features about myself that I did not disclose to participants (i.e., life experience growing up in poverty, feminist values).

These filters affected my views of society generally and my data in particular. Given these personal filters, I attempted to be reflective over the course of my research. As I have already noted I kept both methodological and analytic field notes and referred to them regularly in order to check my assumptions with the unfolding analysis. For example, at the outset of my research, I had assumed people with disabilities would not be very active in carrying out the advocacy tasks and activities, however, I discovered they were as active as others in the Coalition (Analytic notes Jan. 2007). Other avenues for reflection that I pursued included engaging interviewees in conversations about the research results during the focus groups as well as having conversations with interviewees about their transcripts. These avenues gave me the opportunity to probe deeper into certain areas.

I was aware that I was an “outsider” to the Coalition. Therefore, I had to think strategically about gaining entry and trust (Yin 2003). Since I was involved in other Coalitions in the same community I was known by some participants. I worked through these people and was invited to Coalition meetings; this is what Lofland and Lofland (1995) refer to as using your connections to gain entry. Once inside I explained that like them, I was involved in advocacy. I think that knowing I shared a similar perspective
made them more comfortable, promoted trust and encouraged individuals to speak freely (Methodology Notes Sept. 2006) (Creswell 1998).50

Finally, I was aware and struggled from the beginning with the notion of power. I knew I controlled this research process, but I did not feel comfortable. It was important to me to create openings to share power during the process. There were three key openings. First, I mailed out the interview package which contained full information about the research agenda, how I found them, and the list of interview questions. Second, I completed interview transcripts and sent these back to them and asked for verification; they were in control of their transcripts. Third, in the focus groups, I encouraged people to explain their perspectives and noted everyone had a legitimate voice, which ultimately would lead to the creation of credible knowledge.

50 Similarly, when I began the phone and personal interviews, I explained that I had been involved in CBO advocacy work for 17 years. Reiterating anonymity and confidentiality at the outset of the interviews also helped further develop positive rapport (Creswell 1998).
4. SAMPLE DESCRIPTION

This chapter presents a description of my interview samples. A total of 39 CBOs from around the province of Saskatchewan were interviewed in phase 1 and 17 individuals involved in an advocacy coalition were interviewed in phase 2. The phase 2 participants were subsequently invited to participate in phase 3.

4.1 Phase 1 – Description of CBOs that were interviewed

My goal to sample for diversity around the province appears to have been met. Figure 4.1 is a map of Saskatchewan and shows the spatial distribution of the 39 participating CBOs. The different-sized dots represent a different number of CBOs sampled from each community. CBOs from 18 different communities comprise the study sample.

Table 4.1 provides a description of the 39 CBOs that were interviewed. Six diverse characteristics are highlighted. First, geographic location was important. Of these 39 CBOs, 29 were located south of Prince Albert and 10 were located in or north of Prince Albert. Second, the size of the community within which these CBOs were located was salient: 18 of the CBOs were from large cities, 12 were from medium size communities and nine were from small communities. Third, diversity in the size of the

51 Ninety-five CBOs from around the province had been invited to participate and 39 agreed to participate. Of the 56 who did not participate, 29 did not reply to my phone calls, 21 refused to participate because they were either too busy to commit the time or they felt it was best to not talk about their advocacy work, 2 had disconnected phone numbers and 4 said they would participate but I gave up trying to schedule them after nine attempts.

52 One CBO wrote a three-page letter to me indicating why they believed they did not fit the criteria and definition of advocacy, were too busy, and declined to participate. Upon reading the letter, I thought they fit the criteria to participate and phoned to explain this to them. I invited them to reconsider, but after a few weeks they refused. I then asked if I could use their letter in my research as a transcript and they agreed.
agency (based on number of employees) was also an important feature: four were very small agencies, six were small agencies, 13 were medium size agencies and 16 were large agencies. Fourth, type of CBO was critical. I used the International Classification of Nonprofit Organizations (ICNPO) (Hall et al. 2004) and found that there were 22 CBOs whose primary designation was “social services”, six were labelled “mental health services”, six were labelled “development and housing”, and six were labelled “advocacy and law”. Fifth, there was a diversity of people interviewed including 23 executive directors/managers, seven front line staff, four board presidents, and five CBOs who requested group interviews (four groups had two people, while one group had four people). Finally, the sex breakdown consisted of 26 males and 21 females.

The marginalized groups of people served by these 39 CBOs include the following: adults/teens with cognitive disabilities, adults/teens with physical disabilities, adults with psychiatric/mental health disabilities, individuals and families living in poverty, low income seniors, single parent families, people on Community Service Orders, some First Nations and Métis peoples, young offenders, women and men released from corrections facilities, female victims of domestic or stranger violence, people who are homeless/transient, people living in subsidized housing, immigrants and refugees, and people living in high risk neighbourhoods (e.g., high crime rate). It is common for CBOs

53 In my study I use the term “social service CBO” to encompass all of these designations. The CBOs in my study included: food banks, women’s shelters, neighbourhood associations, multi-service centers, immigrant serving agencies, Indian Friendship Centres, nonprofit housing, associations for community living, community mental health groups, and low income advocacy groups.

54 These latter two features were beyond my control. CBOs themselves chose who I would interview from their agency.
to serve more than one of these groups simultaneously (e.g., a women’s shelter may have to deal with anti-violence policies as well as provincial social assistance policies).

Figure 4.1: Map showing the spatial distribution of the 39 CBOs in Saskatchewan
Table 4.1: Profile of the 39 CBOs interviewed

<table>
<thead>
<tr>
<th>Characteristic</th>
<th># of CBOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location in Saskatchewan</td>
<td></td>
</tr>
<tr>
<td>Northern area - Prince Albert and northward</td>
<td>10</td>
</tr>
<tr>
<td>South of Prince Albert</td>
<td>29</td>
</tr>
<tr>
<td>Size of community*</td>
<td></td>
</tr>
<tr>
<td>Small (less than 6,999 people)</td>
<td>9</td>
</tr>
<tr>
<td>Medium (more than 7,000 people but less than 40,000)</td>
<td>12</td>
</tr>
<tr>
<td>Large (more than 180,000)</td>
<td>18</td>
</tr>
<tr>
<td>Size of agency □</td>
<td></td>
</tr>
<tr>
<td>Very small = $30,000 annual revenue, typically no staff, all volunteers</td>
<td>4</td>
</tr>
<tr>
<td>Small = $30,000 to $99,999 annual revenue, typically 1-4 FTE staff</td>
<td>6</td>
</tr>
<tr>
<td>Medium = $100,000 to $499,999 annual revenue, typically 5-9 FTE staff</td>
<td>13</td>
</tr>
<tr>
<td>Large = $500,000 + annual revenue, typically 10 or more FTE staff</td>
<td>16</td>
</tr>
<tr>
<td>Primary area of activity (from ICNPO) ◊</td>
<td></td>
</tr>
<tr>
<td>Social services</td>
<td>22</td>
</tr>
<tr>
<td>Mental health services</td>
<td>6</td>
</tr>
<tr>
<td>Development &amp; housing (e.g., neighbourhood groups)</td>
<td>6</td>
</tr>
<tr>
<td>Law and advocacy</td>
<td>5</td>
</tr>
<tr>
<td>Person interviewed (respondents)</td>
<td></td>
</tr>
<tr>
<td>Executive Director/Managers</td>
<td>23</td>
</tr>
<tr>
<td>Front line staff</td>
<td>7</td>
</tr>
<tr>
<td>Board Presidents</td>
<td>4</td>
</tr>
<tr>
<td>Small group interviews (four groups had 2 people each, 1 group had 4 people) †</td>
<td>5</td>
</tr>
<tr>
<td>Sex of respondents (total of 47, not 39, because small groups interviewed)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>21</td>
</tr>
<tr>
<td>Male</td>
<td>26</td>
</tr>
</tbody>
</table>

Notes: These 39 CBOs are numbered from CBO1-1 through to CBO1-39; CBO1 refers to phase 1 of the study and the second number refers to each CBO numbered consecutively.
* There are no communities in Saskatchewan with populations between 40,000 and 180,000.
□ I created these categories based on Hall et al. (2004).
◊ ICNPO, the International Classification of Nonprofit Organizations, focuses on the primary area of agency activity; some major research initiatives in Canada have adopted this classification system instead of the Canada Revenue Agency system (see for example, Hall et al., 2004). The ICNPO classification system is recommended by the United Nations because it is more detailed and aids international comparative research.
† The 5 CBOs that requested more than one person be involved in the interview believed they would better represent their CBO with more than one voice involved in the interview. Since the CBO was the unit of analysis, I agreed to their request.

There is further diversity in this sample of 39. I had drawn a clear distinction between CBO staff and their program participants (i.e., “clients”) at the outset of my project. However, there were some confusing moments when, during the interviews in
phase 1, I asked CBO participants who were either staff or a volunteer board member about policy advocacy and who was at the advocacy tables (or not), what content was covered (or not) and from what perspective, and whether marginalized people were invited to meetings. Some of them replied they themselves had been – or were currently – marginalized so they were speaking from personal experience. Thus, although I had drawn a sample of CBO staff and volunteers, 13 of the 39 had been “clients” themselves and said they brought those experiences with them to their policy advocacy work (Analytic Notes March 17, 2006).

This sample of 39 is a section of a pie, a pie for which we do not know the exact contents (Methodology Notes June 20, 2006). There are additional CBOs that may have added more diversity to my results. Some of the additional CBO types that are missing from my sample include fundraising agencies such as United Ways, faith-based social justice groups, recreation-oriented CBOs, child care CBOs, literacy CBOs, service clubs (e.g., Kiwanis Clubs), and international development agencies (e.g., Canadian International Development Agency). All of these CBOs have been known to advocate depending on the agency, the community and the people involved.55 The type of advocacy and the degree to which they engage marginalized individuals is not known due to the paucity of policy advocacy research in Canada (Brock and Banting 2001b; Harvie 2002; Legowski and Albert 1999).

55 This is based on my community-based work and volunteer experiences over a 17 year period.
4.2 Phase 2 – Description of Coalition case study participants

The advocacy Coalition which was my case study began meeting in 1999 with the involvement of a few CBOs and a provincial government representative. Within two years there were 25 active members. They began their advocacy work with a focus on a municipal policy but within a year, the provincial government had been drawn into the process. By 2005 the Coalition had won a partial policy victory which was solidified when the municipal and provincial governments signed a cost-sharing agreement.

This social policy advocacy coalition set out to change what Amenta and Young (1999) labelled minor outcome/impact at the lowest level, which focuses on winning a specific public policy decision. The Coalition made no attempt to make change at the medium level, which would have focused on legislative change, nor at the highest level, which would have included structural change (ibid). Table 4.2 provides a profile of the 17 people who were interviewed. The 17 people were classified using Tilly’s (1999) three main categories as follows: six were advocacy volunteers (i.e., people living on low incomes and/or had disabilities who volunteered their time with the Coalition); six were government representatives; and five were CBO staff. In summary, across the three main groups, there were nine females and eight males, four were older than 60 years while 12 were between the ages of 30 and 59 years and one was under 30 years, four indicated they lived on a low income while 13 said they did not, five participants said they had a disability while 12 said they did not, and finally, 14 said they had lived in the community

56 Based on coalition meeting minutes, I had generated a list of 25 people that had been involved with the coalition in 2002, 2003 and 2004 and 17 agreed to participate. Reasons for non-participation included: they thought they were not that involved with the Coalition, did not return my phone calls, refused without offering reasons, withdrew because of illness, and one had died.
for 11 years or longer while the remaining three had lived in the community 10 years or less. For each of these characteristics, there was almost equal distribution across Tilly’s (1999) three main groups except for low income and disability in which larger number of participants were from the advocacy volunteer group. This advocacy Coalition undertook its work in a “large community” (i.e., population greater than 180,000).
## Table 4.2: Profile of the 17 Coalition interviewees

<table>
<thead>
<tr>
<th>COALITION INTERVIEWEES</th>
<th>DESCRIPTION (material extracted from profile form completed by interviewees)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advocacy volunteers</strong></td>
<td></td>
</tr>
<tr>
<td>Vol-40</td>
<td>Female; 71 yrs. +; no response to ethnicity; undergraduate degree in philosophy and English; roles include partner/spouse, parent, volunteer and environmental activist; no disabilities although “everyone has some sort of disability”; not low income; aging impacts health; lived in the community 3-5 yrs; to get around town use bicycle, walk or take the bus, volunteer in 6 additional groups &amp; CBOs</td>
</tr>
<tr>
<td>Vol-41</td>
<td>Female; 60-70 yrs.; Scandinavian-Nigerian; master’s degree in biology; roles include parent and volunteer; yes has disability; yes low income; impacts on health include “joints are slowly disintegrating and due to osteoporosis had a spinal fracture of femur and heart is starting to misbehave”; lived in the community 11 yrs.+; to get around town use the bus, volunteer in 5 additional groups and CBOs</td>
</tr>
<tr>
<td>Vol-42</td>
<td>Male; 50-59 yrs; undergraduate degree in Science and Certificate in Community Development; roles include part-time employee and volunteer; no disabilities; yes low income; impacts on health include riding bicycle/walking, working with nature and reduced stress from not following society as it demands more; lived in the community 11 yrs.+; to get around town use his bicycle, volunteer in 7 additional groups &amp; CBOs</td>
</tr>
<tr>
<td>Vol-43</td>
<td>Male; 30-39 yrs; Caucasian; less than grade 11; roles include volunteering at 3 CBOs; many disabilities including visual and muscular; yes low income; impacts on health include muscles and aches which can change in a day; lived in the community 11 yrs.+; get around town by paratransit or motorized scooter, volunteer in 4 additional groups &amp; CBOs</td>
</tr>
<tr>
<td>Vol-44</td>
<td>Male; 50-59 yrs; Caucasian; completed grade 12; roles include volunteering; no disabilities; yes low income; impacts on health include floor hockey, singing &amp; music &amp; “lots of volunteer commitments”; lived in the community 11 yrs+; get around town by bus, volunteer in 6 additional groups &amp; CBOs</td>
</tr>
<tr>
<td>Vol-45</td>
<td>Female; 50-59 yrs; no response to ethnicity; completed grade 12 and some university; roles include volunteer, mother and wife; yes disability; not low income; impacts on health include success in community achievements, renewed involvement in community, networked with good people who’ve had positive impact; lived in the community 11 yrs+; get around city with own accessible van or paratransit, volunteer in 10 additional groups &amp; CBOs</td>
</tr>
<tr>
<td><strong>Government representatives</strong></td>
<td></td>
</tr>
<tr>
<td>Gov-46 (staff)</td>
<td>Female; 60-70 yrs; no response to ethnicity; completed undergraduate university degree (Social Work focus on youth); roles include full-time employee, partner/spouse, parent; no disabilities; not low income; impacts on health include regular exercise, personally deal with stressful situations ASAP, moved to condo so less responsibility; lived just outside the community for 11 years+; get around town with her own car</td>
</tr>
</tbody>
</table>
| Gov-47 (staff)         | Female; 60-70 yrs.; “I am a white woman, yet feel connected to people globally”; completed Master’s in sociology and B.A. in Community Development; roles include partner/spouse, volunteer, artist part time; no disabilities; not low income (“but if I were without my partner, I’d say yes to low income”); impacts on health include “I left a stressful job and retired, I
have time to walk/be outdoors/go to the gym, I feel better than ever even though my body is older”; lived in the community for 6-10 yrs; use public transit to get around town.

Gov-48 (elected)  
Male; 50-59 yrs; Canadian ethnicity; completed undergraduate university (economics); roles include government decision maker/elected official; no disabilities; not low income; impacts on health - no response; lived in the community for 11 yrs+; use car or walk to get around town.

Gov-49 (staff)  
Male; 30-39 yrs; ethnicity - no response; completed Master’s degree (MBA); roles include full time employee; no disabilities; not low income; impacts on health - no response; lived in the community for 11 yrs+; get around town using personal car

Gov-50 (elected)  
Male; 40-49 yrs; ethnicity – Caucasian; completed grade 12, completed some university; roles included full-time employee, partner/spouse, volunteer, student, small business owner; yes has disability; not low income; impacts on health “5 years ago I didn’t realize the effects of being a smoker. I have been able to quit but my lungs have been damaged”; lived in the community 11 yrs+; to get around town use private vehicle

Gov-51 (staff)  
Female; 50-59 yrs; ethnicity - Canadian (mother English, father Ukrainian); completed undergraduate university, environmental studies & urban planning; roles include full-time employee and volunteer; no disabilities; not low income; impacts on health - getting older, more knowledge of nutrition, depression; lived in the community for 11 yrs+; to get around uses car or bus

CBO staff

CBO2-52  
Male: 20-29 years; ethnicity – Caucasian; completed undergraduate university, social work generalist practice and structural practice; roles include full-time employee, partner/spouse, volunteer; no disabilities; not low income; impacts on health - a living income, meaningful work, diet; lived in the community for 6-10 years; to get around town he uses his own car

CBO2-53  
Female; 50-59 yrs.; ethnicity - British/Icelandic; completed undergraduate university degree, sociology/political science; roles included part-time employee, partner/spouse, caregiver for elderly parents, parent, volunteer; yes disability - AVM on brain and suffered a stroke; not low income; impacts on health - accidental medically induced stroke during surgery, seizure disorder from scar tissue, anxiety following seizure disorder; lived in the community 11 yrs+; to get around town she uses her own car

CBO2-54  
Male; 40-49 yrs.; ethnicity - Lebanese descent, Irish parents, adopted, spent much time in First Nations context; completed master’s degree, B.A. sociology and Master’s in Theological Studies; roles include FT employee, partner/spouse, parent, advocate; no disabilities, not low income; lived in community for 11 yrs+; to get around he uses his car, walks, or use transit

CBO2-55  
Female; 30-39; ethnicity – Canadian; completed undergraduate university degree, business; roles include PT employee, partner/spouse, parent, volunteer, student; no disabilities; not low income; impacts on health – exercise; lived in community 11 yrs+; to get around she uses her own vehicle

CBO2-56  
Female; 30-39 yrs; ethnicity - First Nations; completed undergraduate degree, B. Ed Cross Cultural (First Nations & Metis); roles include full-time employee, partner/spouse, parent; no disabilities; not low income; impacts on health - getting a degree, less alcohol consumption, walking 3-5 times per week; lived in the community for 11 yrs+; to get around town she uses her own vehicle

Note: As explained earlier CBO1 refers to CBOs interviewed in phase 1 while CBO2 refers to interviews that took place in phase 2. The 56 participants were numbered from 1 to 56 and then additional identifiers (i.e., CBO1, CBO2, Vol, and Gov) were added as a prefix to make reporting results in the ensuing chapters easier to follow.
Just as in my phase 1 sample, I discovered each category was not necessarily homogeneous. For example, “government” is not a homogenous category. I already knew there were politicians and staff at local, provincial, and federal government levels as well as Band Councils, but soon I saw there were front-line staff and senior staff and there were government staff who worked in community settings (e.g., community health clinics, public health nurses with psychiatry specializations) as well as those who only worked in offices. They also had different roles and values – some actually worked against each other on community issues within the same department (Analytic Notes January 27, 2007).

As I worked through these 17 interviews, I began to realize I had an “ethical hangover: a persistent sense of guilt or unease” about my research (Lofland and Lofland 1995, p. 28). I wanted to properly represent the perspectives of my study participants. At one point in the data collection process I felt compelled to stop using the term “marginalized groups” (which is the label I adopted from the literature at the outset of my research) and instead use “advocacy volunteers” (Analytic Notes February 27, 2007). This new label seemed to better represent this group of people; it is more active and less negative.

4.3 Phase 3 – Description of focus group participants

I described in the methods chapter that my goal was to organize three focus groups to discuss data results. The three focus groups were to include the following groups of people who were interviewed in phase 2: advocacy volunteers, CBO staff, and
government representatives. I was able to organize a focus group for the advocacy volunteers and a group for the CBOs, but not the government representatives because of a high refusal rate (refer back to section 3.4.4.). Five of the six advocacy volunteers participated in one focus group and three of the five CBO staff participated in another. Table 4.3 provides a summary of their characteristics. In general, both women and men participated, the majority of participants in both groups were aged 30 to 59 years, the majority of the advocacy volunteers lived on low incomes, disabilities were present in both groups, and the majority from both groups were long-term community residents.

Table 4.3: Summary profile of focus group participants in phase 3

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Advocacy volunteers</th>
<th>CBO staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Male</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60+ years</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>30-59 years</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Younger than 29 years</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Low income?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>Disability?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Length of time in the community</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 to 2 years</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3 to 5 years</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6 to 10 years</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>11 years or more</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>
5. CBO SOCIAL POLICY ADVOCACY CONTEXT

This chapter contains both data results and discussion for phase 1 which focused on research required to develop a deep description of the historical political context within which CBO advocacy unfolds. An understanding of the environment or context within which CBO advocacy was undertaken is essential in order to understand the results of the case study because case studies do not exist in isolation (refer to section 3.3, especially Yin [2003]). This chapter presents data collected from four key sources: Saskatchewan government annual reports, Saskatchewan CBO documents, macro-context observations (national scale), and interviews with 39 Saskatchewan CBOs. These data answer question #1, how is the CBO social policy advocacy function presented in documentary material over the past 60 years in Saskatchewan, and question #2, how do social service CBOs in Saskatchewan understand and incorporate marginalized people into policy advocacy processes? Table 5.1 provides an overview.

Table 5.1: Overview of phase 1 research questions, methods and analysis

<table>
<thead>
<tr>
<th>Research questions</th>
<th>Methods of data collection</th>
<th>Methods of data analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 1 - context</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Question #1 (sections 5.1 and 5.2)</strong> How is the CBO social policy advocacy function presented in documentary material over the past 60 years in Saskatchewan?</td>
<td>- Documents (government annual reports, CBO reports)</td>
<td>- Content analysis</td>
</tr>
<tr>
<td><strong>Question #2 (section 5.3)</strong> How do social service CBOs in Saskatchewan understand and incorporate marginalized people into policy advocacy processes?</td>
<td>- Observations (national, macro-context)</td>
<td>- Content analysis</td>
</tr>
<tr>
<td></td>
<td>- Phone interviews</td>
<td>- Coding, categorizing, themes</td>
</tr>
</tbody>
</table>
5.1 Saskatchewan government and CBO documents

As explained in chapter 3, the larger context or environment within which advocacy unfolds is important to fully understand case studies. Question #1, which guided this part of my research was, “How is the CBO social policy advocacy function presented in documentary material over the past 60 years in Saskatchewan?” I was interested in texts dealt with social services CBOs, social policy advocacy, marginalized populations and government-CBO relations. This section provides data collected from Saskatchewan Ministry of Social Services annual reports, and CBO reports, which taken together provide a snapshot of the environment within which CBO advocacy unfolds. I used content analysis, the results of which are presented in sections 5.1.2 and 5.1.3. The two content analysis procedures I adopted were summarization, which preserves the essential content but reduces its size and explication, which explains and clarifies the material (Titscher et al. 2005). Before presenting the results of my analysis in these two sections, I offer a glance of some Saskatchewan history that relates to CBOs in section 5.1.1.57 Throughout section 5.1, I adopted the language of the time when presenting data (e.g., “mentally retarded” in 1976, “battered women” in 1989).

5.1.1 A glance at Saskatchewan history

“The Saskatchewan identity – or ethos – was shaped by people’s accommodation to a stark frontier environment … the vastness of the country …” (Archer 1980, p. 348). Saskatchewan’s sparse, rural population “required state led action to ensure basic

57 I understand that social policy making and the role of CBOs are affected by elements beyond the province; the federal government and the Social Union Framework Agreement are but one example (Marchildon and Cotter 2001).
infrastructure was available” (Rasmussen 2001, p. 96) including social security, health and education services (Lipset 1950) because the private sector was not interested in providing services especially in remote, northern areas (Meinhard and Foster 2002). The prairie climate also influenced people’s behaviour. The drought and the Depression of the 1930s was a catalyst for government involvement in the delivery of health and social programs (Canadian Welfare Council 1938; Dusel 1990).

The first few decades of the 20th century saw the evolution of a powerful, organized, agrarian movement in Saskatchewan due to the perceived exploitation by eastern Canadian businesses (Lipset 1950). During this time, politicians and government staff regularly attended meetings of various farmer movements (e.g., Grain Growers), and from these meetings created public policy (Brown, Roberts, and Warnock 1999). Many of these pioneers had experience with socialism, co-operatives and activism in their European birth countries (Lipset 1950). In those days, the care of the sick and elderly was the responsibility of families, particularly women; churches also provided informal health and social services to those in need (Dusel 1990). Early social movements and volunteer organisations played activist roles in the development of health and social services (Fairbairn 1997). Women played activist roles through volunteer-led farmer groups (e.g., Women Grain Growers Association) which supported the evolution of the CBO sector through early Homemakers Clubs and Women’s Institutes (Saskatchewan Women's
Institute 1988). Some examples include travelling libraries, health clinics, and clothing exchanges (Saskatchewan Women's Institute 1988; see also Taylor 1997).\(^{58}\)

Saskatchewan Premier Tommy Douglas formed the first democratic socialist government in Canada in 1944 (Scott, 1992). Premier Douglas belonged to the Co-operative Commonwealth Federation (CCF), the predecessor to the New Democratic Party (NDP). The CCF is credited with encouraging a positive role for the provincial government in building a more secure future, reducing social inequities, and encouraging innovation (e.g., a social assistance plan in 1955, Medicare in 1962) (Marchildon and Cotter 2001). The CCF began with a democratic socialist orientation\(^{59}\) and focused on public and co-operative ownership; over time they discovered there was not enough money to implement their ideas, so they approached sectors outside government (Larmour 1985).

One of those sectors was the CBO sector, which was already in existence when the CCF took office. For example, Family Service Regina – known as the Bureau of Public Welfare in 1913 – was active in child welfare and the reduction of juvenile delinquency and modified its services over time to serve unmet needs in the community (Pitsula 2001b). Family Service Regina was “firmly rooted in the community … and

\(^{58}\) They advocated within a context of “patriarchal ideologies of male superiority” (Rollings-Magnusson 1999, p. 171).

\(^{59}\) The CCF’s socialist orientation helps explain the early social policy environment and government relations with the CBO sector. *The Regina Manifesto*, published in 1933, was a key socialist document for the CCF: “the principle regulating production, distribution and exchange will be the supplying of human needs and not the making of profits” and an aim is to replace the capitalist system (Lewis and Scott 1943, p. 163). The CCF/NDP may have planned to create a socialist province but Saskatchewan never reached the ideal (Lipset 1950). The CCF/NDP has been credited with many radical reforms but there are some examples where radical social change never occurred; for example, there were rich farmers and poor farmers (ibid., p. 226). This is known as “the degree to which Saskatchewan is socialist” (Praud and McQuarrie 2001, p. 149).
maintained an interest in “social advocacy” (ibid., p. 207). Similarly the Canadian Mental Health Association advocated for the evolution of mental health services away from large, government-run institutions to community settings especially in the 1960s and 1970s (Dickinson 1989).

Between 1971 and 1982 the New Democratic Party held political office. Premier Blakeney “favoured community control of many social services” and preferred the CBO sector as delivery agents (O’Sullivan and Sorensen 1988, p. 78). During this time, provincial government spending on the CBO sector increased by 25% as did the number of funded CBOs (ibid., p. 80). The Federation of Saskatchewan Indians doubled its budget and went “from a lobby group to a program delivery organisation” (Pitsula 2001, p. 359). The government encouraged CBO-operated child care centres that were selective (i.e., for low income families) and not based on the principle of universality (Martin 1995). Some concerned groups (e.g., women, disabled) organized and demanded basic reforms in certain policies which ultimately “… contributed to the demise of the NDP in the 1982 election” (Harding 1995, p. 11).

After 1982 and throughout the 1980s, the Conservatives held office and had a propensity to focus on the ‘deserving poor’ and shift away from comprehensiveness and universality (O’Sullivan and Sorensen 1988). Social programs were gutted, poverty moved from being a societal responsibility to an individual’s responsibility, and the Saskatchewan Coalition for Social Justice comprising representatives from more than 80 organizations became a strong non-parliamentary opposition to fight these government decisions (Brown, Roberts and Warnock, 1999). With the reduction in social programs came a rise in demand for food bank CBOs; “food banks … represent an old-fashioned
charity, which has stepped in to fill the role that had been filled by the state in the post-war period” (O'Sullivan and Sorensen 1988, p. 85). Increased demands for other social service CBOs followed (Warnock 2003). In 1983 a review of the welfare system was completed, driven by the crisis in increased caseloads and the severity of people’s issues (Adams 1983). In one section, a potential role for CBOs was stated:

“There are a number of very capable nongovernmental agencies … for single parent clients … Unfortunately the potential contribution of these nongovernmental agencies has neither been fully achieved nor well recognized. … It is suggested that nongovernmental social service agencies be encouraged and expanded to assume responsibility for all essential services to single parents except financial …” (ibid., p. 57) (my underline added).

However, it appears a consensus was never reached on the division of responsibility for human services: “government and nongovernment agencies … have played roles of varying importance in various fields of service delivery depending on the particular issue and on time and place” (O’Sullivan and Sorensen, p. 79). The residual welfare model has been adopted by the major political parties in different policy areas over time (ibid.).

During the 1990s and early 2000s, the NDP returned to office in Saskatchewan and continued interest in the CBO sector. One government report explicitly stated that a government department had “devolved responsibility and authority to provincial organizations that work with a range of community based institutions and agencies” (Saskatchewan 2000, p. 2). For example, the government had entered into agreements with Aboriginal organizations regarding the delivery of child and family services (Orr

---

60 Public attitudes as reflected in newspaper coverage between 1970-90 toward welfare recipients were more sympathetic in the 1970s, but by the end of the 1980s, these attitudes had hardened (Wardhaugh 2007).
Other provincial government documents detail histories of government-CBOs having worked together and increasing human service integration (Saskatchewan 1996; Saskatchewan 2002).

In summary, the nature of the CBO sector over the past 60 years has been influenced by governments and communities. Voluntary responses to community needs and dialogues with governments were evident from the early days when Saskatchewan first became a province. In 1944, when the CCF took office, principles of democratic socialism and programs that adopted these principles prevailed. Interest in CBOs as social service delivery agents began in the 1960s and increased into the 1970s and 1980s while the NDP and Conservatives, respectively, were in office. Some scholars contend the Conservatives only funded CBOs that served “deserving groups”. As well, some scholars state there has never been clarity about the division of responsibility between governments and CBOs regarding social services.

5.1.2 Saskatchewan Ministry of Social Services annual reports

This section presents textual data extracted and analyzed from 13 Government of Saskatchewan Social Service annual reports beginning in 1944-45 (the first year of publication) and finishing in 2004-05; every fifth year was selected for analysis. The main areas examined include: government mission/mandate/objectives, issues of the day as indicated by departmental divisions, collaborative government-CBO committees, funding for CBO functions, and how advocacy and its proxies (e.g., lobbying) as well as

---

61 This is noteworthy because Aboriginal peoples were noticeably absent from the early literature on CBOs. Pitsula (2001a) explained that until the end of World War II, “Indians and Non-Indians were two solitudes” largely because many Indians lived on reserves and secondly, federal government policies, “were based on repression of indigenous culture” (p. 352).
health/well-being were described. In addition to these explicit elements I also reflected on and noted implicit elements (i.e., unwritten) and assumptions upon which the text appeared to stand (refer to sections 3.4.2 and 3.5.2). I use the term “Department” to refer to this Ministry throughout this section because it has been a department since 1944.
First, Table 5.2 shows government mission/mandate, and issues of the day.

**Table 5.2: Government annual reports mission, issues and departments by year**

<table>
<thead>
<tr>
<th>Report year</th>
<th>Provincial government mission, issues, organizational divisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1944-45</td>
<td>In 1944-45 when the Department of Social Welfare was first formed its key issues appeared to be child welfare and “juvenile delinquency”, “deserted wives”, residential care for “the infirm”, income assistance, and municipalities granting financial aid to people in need (Saskatchewan 1946). These issues were reflected in the organizational chart and the Acts. Children’s Aid Societies were the only CBOs described. There was no mission statement.</td>
</tr>
<tr>
<td>1949-50</td>
<td>A “nursing home and housing” for the elderly division was created as was a corrections division (Saskatchewan 1951). “Rehabilitation” was added to the title of the Department and the Social Welfare Act and there was an emphasis on child welfare and abuse prevention. There was no mission statement.</td>
</tr>
<tr>
<td>1954-55</td>
<td>The Department stated it is “to help clients use the resources of the community and the resources within themselves to cope with the problems they face” (Saskatchewan 1956, p. 9). At that time the following were in place: Bureau on Alcoholism, a Housing Act, regional offices, “rehabilitation of the disabled” and co-operative development projects for Métis communities.</td>
</tr>
<tr>
<td>1959-60</td>
<td>Similar issues persisted. In addition, the Department was concerned about the aged and need for appropriate accommodation so they encouraged charitable organizations to build facilities. For the first time, the statement of expenses included a breakdown of grants to homes for “aged, needy, infirm and blind persons” (Saskatchewan 1961, p. 69).</td>
</tr>
<tr>
<td>1964-65</td>
<td>Housing, care for the aged and child welfare – especially in “Indian and Métis communities” - continued to dominate the report (Saskatchewan n.d-h, p. 10 and 19).</td>
</tr>
<tr>
<td>1969-70</td>
<td>Community involvement in child welfare issues and policies emerged in the form of “regional advisory boards” comprising “local citizens” and parent associations (Saskatchewan n.d-i, p. 8).</td>
</tr>
<tr>
<td>1974-75</td>
<td>There was a Community Living Division for people with disabilities and “expansion of community-based non-custodial type programs” within the Corrections Division (Saskatchewan n.d-g, p. 27) as well as community services for the aged.</td>
</tr>
<tr>
<td>1979-80</td>
<td>A written objective of the Community Services Division was to “develop and support community-based agencies which supplement and complement the Department’s objectives” (Saskatchewan n.d-f, p. 10).</td>
</tr>
<tr>
<td>1984-85 and 1989-90</td>
<td>The Department included “non-government organizations”(NGOs) as a part of its organizational structure as well as two pages of NGO description in each annual report (Saskatchewan n.d-b, n.d-c); “improved communication between the Department and non-government providers of social services was a priority” (Saskatchewan n.d-b, p. 3).</td>
</tr>
<tr>
<td>1994-95</td>
<td>NGOs were not on the organizational chart but community development was a common term throughout the document. The Department “facilitates and leads community development activities and works with stakeholders through partnerships” (Saskatchewan n.d-d, p. 4); “work within the Department and … community-based organizations to … contribute to … human service integration” and to expand the range of services (ibid., p. 6).</td>
</tr>
<tr>
<td>1999-2000</td>
<td>A community development division was shown on the organizational chart and appeared to be a theme throughout the document, but no CBOs were noted on the chart. However, CBOs were described in each of the six regional reports offering services to a variety of populations (Saskatchewan n.d-e).</td>
</tr>
<tr>
<td>2004-05</td>
<td>Both community development and CBOs disappeared from the organizational chart and only appeared four times in the report while “inclusion” appeared many times throughout the document (e.g., economic inclusion, inclusive communities) (Saskatchewan n.d-a).</td>
</tr>
</tbody>
</table>
Second, I searched for collaborative government-CBO committees in order to examine the nature of government-CBO relations. Table 5.3 contains these data.

Table 5.3: Government annual reports containing collaboration with CBOs by year

<table>
<thead>
<tr>
<th>Report year</th>
<th>Government-CBO collaboration/committees</th>
</tr>
</thead>
<tbody>
<tr>
<td>1949-50</td>
<td>Collaboration was first seen in the 1949-50 annual report within the child welfare area when the Department described the development of the advisory committee in Prince Albert; “we have long wished to have the help of citizen groups” and there was an indication that “many agencies … contribute” (Saskatchewan 1951, p. 14).</td>
</tr>
<tr>
<td>1954-55 and 1959-60</td>
<td>There was nothing written about committees but the Department noted the cooperation of other governments and “private welfare agencies … is deeply appreciated” (Saskatchewan 1956, 13).</td>
</tr>
<tr>
<td>1964-65</td>
<td>It appeared “cooperation with agencies” continued in the area of child protection (Saskatchewan n.d-h, p. 17).</td>
</tr>
<tr>
<td>1969-70</td>
<td>It appeared “cooperation with agencies” continued in the area of child protection (Saskatchewan n.d-h, p. 17).</td>
</tr>
<tr>
<td>1974-75</td>
<td>It was noted that “the membership of the [Advisory] Board represents a cross section of the provincial community including two persons form anti-poverty organizations” (Saskatchewan n.d-g, p. 12). In the planning of special care facilities for the elderly, “the Branch cooperates with churches, charitable organizations and municipalities” (ibid., p. 22).</td>
</tr>
<tr>
<td>1979-80</td>
<td>The report contained one reference to a government-CBO committee: the Regulations Review Committee for seniors homes “included representatives of the Saskatchewan Association of Special Care Homes, individual home administrators and health care professionals” (Saskatchewan n.d-f, p. 10).</td>
</tr>
<tr>
<td>1984-85</td>
<td>It was noted “Our system … is characterized by an ever-stronger partnership between the provincial government and hundreds of nongovernmental organizations and agencies” with explicit reference to “working jointly with native organizations” (Saskatchewan n.d-b, p. 1 and p. 8).</td>
</tr>
<tr>
<td>1989-90</td>
<td>“In partnership with the Saskatchewan Foster Parents Association, the Division developed program proposals and policies …” and local and provincial co-ordination was facilitated through the Saskatchewan Human Services Association (Saskatchewan n.d-c, p. 3).</td>
</tr>
<tr>
<td>1994-95</td>
<td>“Partnerships” appeared to be important because the following statement was placed on the same page as the organizational chart: the Department “facilitates and leads community development activities and works with stakeholders through partnerships and public involvement” (Saskatchewan n.d-d, p. 4). The Action Plan for Children and the Assistant Deputy Minister’s Forum on Human Services were cited as examples which were multi-government and multi-CBO oriented.</td>
</tr>
<tr>
<td>1999-2000</td>
<td>Community partnerships language persisted (Saskatchewan n.d-e); there was a northern Community Reference Panel, Regional Intersectoral Committees comprising primarily provincial departments but included CBOs in some communities, and a partnership between the Department, the Saskatchewan Association of Rehabilitation Centres and the Association for Community Living regarding disability policies and services.</td>
</tr>
<tr>
<td>2004-05</td>
<td>Four instances of “CBO” were found and the clearest indication of collaboration or partnership was the following: “the Department has agreements with 18 First Nations providing authority to First Nations Child and Family Service Agencies to deliver” services (p. 6).</td>
</tr>
</tbody>
</table>
Third, I examined the evolution of Department funding for CBO functions \textsuperscript{62} over time. There was no funding indicated for CBOs in 1944-45. In 1949-50, there was one grant to a CBO acknowledged; it was for $11,000 for the Disabled Civilians Workshop that manufactured garments (Saskatchewan 1951). In 1954-55 the Department provided grants to the Disabled Civilians Workshop, the Society for Crippled Children and Adults, and a number of residential care facilities for the aged (Saskatchewan 1956).

By 1959-60 the Department had taken over the functions once provided by the Saskatoon Children’s Aid Society, but increased maintenance and capital grants for “aged, needy, infirm and blind persons” organizations and churches as shown through two full pages of grant lists; 56 organizations received maintenance grants (Saskatchewan 1961, p. 69). Further expansion of funding for service delivery and facilities ensued into 1964-65 with the addition of a Métis training program at Lac La Ronge, Salvation Armies, group foster homes, seniors facilities, John Howard Society for parole supervision, and 4H Clubs to integrate children with disabilities (Saskatchewan n.d-h).\textsuperscript{63} This trend continued in the 1969-70 document and “added emphasis was placed on encouraging communities to develop services for the aged … and disabled …” (Saskatchewan n.d-i, p. 53).

In 1974-75 and 1979-80, the Department acknowledged a network of community-based programs including correctional programs (i.e., through band councils, town councils, and friendship centres), child care centres, special care homes for seniors, 

---

\textsuperscript{62} The purpose of my study was not to compare the actual amount of funding over time, but rather the number and type of CBOs and their functions that appeared in these annual reports.

\textsuperscript{63} It is noteworthy that for some groups, people with disabilities in particular, referrals are two-way between the Department and CBOs (Saskatchewan n.d-h, p. 32).
activity centres for seniors, home care, youth treatment residences, employment supports, and “assistance to mentally handicapped persons” (Saskatchewan n.d-f, p. 10; Saskatchewan n.d-g). Expansion continued into 1984-85 with the addition of funding to women’s crisis CBOs, teen parent services, and alternatives-to-custody programs (Saskatchewan n.d-b). It is here that I first saw “fee-for-service agreements” differentiated from “grants”. The 1989-90 report contained lists of CBOs providing government funded services (Saskatchewan n.d-c), but there appeared to be a shift in tone:

“The management of grants administered to all non-government organizations which are mandated, supplementary, or complementary to the Department’s services, has been consolidated into the Contract Services Branch. This Branch ensures fiscal accountability and sound internal management in these organizations” (ibid., p. 14).

In 1994-95 regional highlights included the “continued establishment of Indian Child and Family Services agencies” (Saskatchewan n.d-d, p. 31) and “contracting” with CBOs. In the 1999-2000 annual report, each regional sub-section contained information on the number of CBOs that received “grants” and the total amount, however, in the Community Living Division there was also a note about the need to review and streamline “CBO service agreements” (Saskatchewan n.d-e, p. 39). Finally, in 2004-05, the explicit explanation of CBOs’ role in the social welfare system was very different than in previous years; the report’s emphasis was on performance and financial results (Saskatchewan n.d-a). The Department had operating agreements with 450 housing organizations (e.g., CBOs, governments, co-operatives, private landlords) and 18 First Nations Child & Family Service Agencies, but no numbers were provided for the employment or community living divisions.
Fourth, how is advocacy as well as health/well-being described over time in these annual reports? Over the 60 year period, “advocacy” appeared twice; once in reference to the Children’s Advocate Office which was created in 1994-95 and once again in 1999-2000 when “grants totalling $1.25 million were made to several provincial organizations to provide advocacy and specialized resource services on behalf of people with disabilities” (Saskatchewan n.d-e, p. 38).

Over the 60 year study period, “health/well-being” was found a number of times in the reports. The first few citations place well-being within a societal context and focus on the importance of interdependency while the latter citations appear to be more narrowly focused on individuals and economic factors. Table 5.4 presents these data.

**Table 5.4: Government annual reports containing “health/well-being”**

<table>
<thead>
<tr>
<th>Report year</th>
<th>Health/well-being occurrences</th>
</tr>
</thead>
<tbody>
<tr>
<td>1954-55</td>
<td>“A healthy society is dependent on the well-being of those who make up that society” (Saskatchewan 1956, p. 14);</td>
</tr>
<tr>
<td>1969-70</td>
<td>A principle under Public Assistance was stated: “The public assistance program is founded on a belief in the integrity and dignity of the individual and on the recognition that members of society are dependent upon one another and that the welfare of all is dependent upon the well-being of each” (Saskatchewan n.d-i, p. 16);</td>
</tr>
<tr>
<td>1974-75</td>
<td>Under Community Services for Aged: “the programs are designed to enable aged persons to continue independent living … by helping to prevent or delay disabling conditions and by promoting physical, mental and social well-being” (Saskatchewan n.d-g, p. 23);</td>
</tr>
<tr>
<td>1984-85</td>
<td>The mission of the Department was “to promote human growth and development and, thereby, the well-being of the people of Saskatchewan” (Saskatchewan n.d-b, p. 1);</td>
</tr>
<tr>
<td>1994-95 and 1999-2000</td>
<td>Well-being was found on just about every page, except for the Community Living Division. The following quote was found on the same page with the 1994-95 organizational chart: “Saskatchewan Social Services works with communities to advance the well-being of children, families and individuals” (Saskatchewan n.d-d, p. 4);</td>
</tr>
<tr>
<td>1999-2000</td>
<td>In the Income Security section, an objective was “to support communities to develop services which contribute to the social and economic well-being of low-income children, families and individuals” (Saskatchewan n.d-e, p. 26);</td>
</tr>
<tr>
<td>2004-05</td>
<td>Well-being was found in the following: “typically, employment is people’s main source of income and the main route for improved well-being … stable employment can contribute to the health and well-being of individuals and their families … and to the well-being of communities and the overall economy” (Saskatchewan n.d-a, p. 9).</td>
</tr>
</tbody>
</table>
In closing, several summary statements can be made about these 13 annual reports published by the Ministry of Social Services (today’s title) between 1944 and 2005. With regard to finding CBO “advocacy” in the annual reports, I only found one policy advocacy example and it was in the 1999-2000 annual report when a $1.25 million grant was made to several provincial disability organizations to do advocacy and provide specialized services. With regard to the Department’s mission/mandate/organizational divisions and issues of the day, one CBO (e.g., Children’s Aid Societies) was described in the 1944-45 report, the number and types of CBOs increased over the ensuing 25 years, and, by 1979-80 a Departmental objective was to support CBOs to provide services that supplement and complement the work of the Department. In the 1980s and 1990s, CBOs were part of the Department’s organizational chart or explicitly included in each regional section. By 2004-05 the CBO label only appeared four times in the annual report. Thus, based on these annual reports, government interactions with CBOs grew over the 60 year period except for 2004-05. With regard to collaborative committees and partnerships between the Department and CBOs, before 1969 there was “co-operation” with agencies but little stated about committees until the 1969-70 report which explained Department-initiated community advisory boards that expanded in the ensuing 30 years into joint review committees, and ever-stronger partnerships through multi-government and multi-CBO committees – except for 2004-05. With regard to Department funding for various CBO functions, operating and capital grants were common before 1979, and contracts and fee-for-service agreements were common in 1979-80 and 1984-85. With regard to finding “health/well-being”, the first citation was in 1954-55 with periodic use over the years until 1994-95 and 1999-2000 when it was used heavily throughout the
annual reports. Let us now shift our focus away from a government perspective and explore CBO perspectives.

5.1.3 Saskatchewan CBO documents

This section provides the analysis of the pre-2003 CBO documents found during a search of the two Saskatchewan university libraries and the Legislature Library. I searched for documents that were written by and/or specifically about Saskatchewan CBOs. The first set of key words entered into the electronic catalogue search was Saskatchewan, CBO and advocacy. This search resulted in no documents at any of the three libraries, thus I tried a number of subsequent searches using additional key words (see section 3.4.2). In the end, I had a list of 32 documents - the earliest was published in 1938 - for which policy advocacy, social service CBOs and Saskatchewan were focal. I read each document and noted social service area, population group, focal policy/issue the CBO(s) wanted to have changed, the advocacy strategy noted (if any), and a general description/tone of government-CBO relations. Each of these 32 documents is summarized in Appendix H. In addition to content analysis for literal meanings, I also examined latent meanings and assumptions in the texts (Alvesson and Sköldberg 2000; Denzin 2004; Peräkylä 2005).

As a collection, the 32 documents covered a range of social service areas and population groups, but none were explicitly labelled “policy advocacy” documents, yet

---

64 I recognize this collection of 32 CBO documents is but a snapshot, not an exhaustive search, of what has been written over time because based on my community work, many CBOs do not send their reports to libraries.

65 Actually there were 34 documents but in two instances, additional reports were written using the same data so I placed them together as one and included the additional references.
the intent of these documents was to advocate for certain policy choices. The following is a topical summary of the 32 documents: social welfare and health services for those affected by the Depression in the 1930s; governments and CBOs working together; description of small town CBOs work; affordable housing for seniors and families; housing and care for people with disability needs; elder care; personal social services\textsuperscript{66} for a variety of marginalized groups; community-based services for the “mentally retarded”; income security and employment for people with disabilities; housing and mental health; unmet needs of off-reserve Indian and Métis; the nature of psychiatric services; “battered women’s” services; gaps in human services generally and the role of CBOs; provincial welfare policies; the evolving relationship between governments and CBOs; well-being of children 0-14 years; comparison of provincial welfare models; community economic development; non-medical homecare services for the elderly; and human rights and community mental health services.

Second, these documents also dealt with a variety of issues and public policies to be changed. The following is a summary of issues: who is responsible for planning, development and delivery of human services; where are current gaps and unmet needs for which groups of people; income security; ideology/values (e.g., universality, de-institutionalization, primacy of community, human rights); shifting demographics (e.g., increase in Aboriginal population, rural de-population); housing continuum and care needs of people with disabilities; government spending trends on personal social services

\textsuperscript{66} Personal social services are “those services distinct from income maintenance, health, housing, educational, employment and correctional services which complement, supplement or are in place of services rendered by families or friends on an individual basis and which are provided on a professional and voluntary basis, under governmental and nongovernmental auspices.” (Riches and Kramer 1979, p. 8).
for a variety of groups (i.e. increase in spending on those who are deserving such as the elderly); the nature of community-based services and co-ordination; quasi-non-government-organizations (QUANGOs); shifts in type and level of government funding to CBOs as well as an increasing reliance on volunteers to replace staff; paradoxes regarding governments downloading services to communities; sense of powerlessness to change things and fear of reprisal; grassroots participation; increase in complexity of people’s problems brought to CBOs; racism against First Nations peoples; the variable nature of CBO-government relations; rehabilitation for people with disabilities; employment supports; mental health; intimate partner violence against women; northern and remote communities service delivery; and cultural sensitivity.

Third, I searched for social policy advocacy strategies. Explicit coverage of advocacy strategies was rare in these documents; most of the documents tended to list recommendations for change, but no advocacy strategies. One older document indicated “petitions and delegations … and other attempts to influence the public or government are … uncommon” (Laskin 1961, p.32). There were six documents in which I found explicit reference to advocacy and calls to action, but again, no specific strategies. The following were some examples: local consumer and advocacy groups should be involved in government regional planning committees (Sanche and Bates 1976); it is difficult to suggest a strategy against government downloading on to CBOs because how does one argue against “community control over services” (Riches and Maslany 1983, p. 49); co-ordinated lobbying and advocacy may be necessary to make policy makers aware of needed changes (Community Needs Partnership 1989); CBOs are an advocacy vehicle for people on welfare to use to confront government workers (Ad Hoc Committee to
Realistically Change Welfare Rates 1990); and Saskatchewan has a long tradition of progressive social action, mutual aid and co-operation from which to draw upon (Thériault, Gill, and Kly 2002).

In the remaining majority of documents where there was a clear indication of the need to make changes, but no explicit note about advocacy, there were what I would label, polite suggestions about how we should implement these recommendations including: governments and CBOs should participate equally “to build a well balanced program” (Canadian Welfare Council 1938, p. 69); for the many unmet needs a collaborative effort is needed (Saskatchewan Senior Citizens Provincial Council 1988, p.2); the continued development of this housing system “has and is still being enhanced at all levels of government and within the voluntary sector” (Saskatchewan Co-ordinating Council on Social Planning 1977, p. 44); solving these issues should be a collective effort between governments and CBOs (Canadian Red Cross Society 1990); and the need to work toward a more balanced relationship between governments and CBOs (McFarlane and Roach 1999a, 1999c).

Fourth, I examined these texts for an indication of CBO-government relations. It was here that I had to re-read the documents looking for descriptions, tone and assumptions regarding the nature of CBO-government relations. Table 5.5 highlights examples from the five main categories of findings across the 32 documents.
Table 5.5: Description of CBO-government relations

<table>
<thead>
<tr>
<th>a) Type of relationship preferred with government</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective delivery of social services depends on good relationships and common objectives (Canadian Welfare Council 1938); balanced relationships including two-way communication as well as recognition and respect for differences (McFarlane and Roach 1999a; Roach 2000); process of mutual learning (Gill and Thériault 2002); sharing of responsibilities is necessary (Haire 1975; Hayward and Kennedy 2002); and governments and CBOs aspire to build healthy partnerships (Council on Social Development Regina Inc. 1993). Some of the documents indicate there are reciprocal referral relationships and information sharing already taking place (Thériault and Salhani 2001).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>b) Negative feelings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tension and antagonism (Dickinson 1989), conflict (Beaudry 2001), difficulties “conducting needs assessments in a politically, economically and socially sensitive area” (Canadian Red Cross Society 1990), feeling de-valued and looked down on by society and government (Ad Hoc Committee to Realistically Change Welfare Rates 1990), a feeling of powerlessness for CBOs (Manning 1994), and sense of impatience – because the government announced deinstitutionalization policies but the funding did not follow (Crocus Co-operative, Saskatoon Mental Health Association, and Saskatoon Housing Coalition 1987).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>c) Policy choices should be based on shared values and rights</th>
</tr>
</thead>
<tbody>
<tr>
<td>The relationship should be based on a consensus of community values not funding (Riches 1976), and when governments do not ensure essential services (e.g., mental health services) are available, they violate human rights (Kly and Thériault 2001).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>d) Government funding and influence</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBOs receive funding from governments through contract renewals, a direct offer to fund a new service, or through tendering processes (McFarlane and Roach 1999c); “the overall government-nonprofit working relationship is determined by the tone set during these negotiations, the length of time the contract has been in place, and the nature of the personal interaction among government personnel and nonprofit staff” (ibid., p. 12). CBOs “deliver services on behalf of the state, some fill gaps left by the state and some respond to emerging social needs” and these differences result in different relationships (ibid., p. 3). Governments’ subtly influence CBO decision-making through funding (Council on Social Development Regina Inc. 1993; Dickinson 1989; Kly and Thériault 2001) and joining CBO boards of directors (Riches and Maslany 1983). “This is a relationship of power and control” (Manning 1994, p. 116).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>e) Expect government leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is important for the government to be a leader regarding legislation (Community Needs Partnership 1989; Riches and Maslany 1983), a lack of political will is not appropriate (Saskatoon Social Planning Council 1995), and the provincial government should have leadership at provincial and local levels (Saskatchewan Co-ordinating Council on Social Planning 1977).</td>
</tr>
</tbody>
</table>

In summary, the CBO policy advocacy function was not explicitly labelled as such in this body of literature, but social policy advocacy exists in Saskatchewan as shown through these 32 documents. These documents were created as advocacy tools to make change. Six of these documents had explicit calls to action while the remainder
offered polite recommendations directed at governments, including requests for greater collaboration. A diversity of issues and population groups were described in these documents. Questions about who is responsible for what social services, gaps in social services and unmet needs, and increased reliance on volunteers because of staff cuts were prevalent. Government-CBO relations were also described including type of relationship preferred, negative feelings about the relationships, importance of values and rights, shift in type of funding, and government leadership expectations.

5.2 Observations of the macro-context

Moving beyond Saskatchewan, what does the larger environment within which CBO advocacy happens, look like? The material covered in this section came from qualitative data I collected between September 2003 and January 2008. I monitored websites and received material (e.g., press releases, updates, summaries, announcements) through e-communication from the 10 national CBOs, the federal government, the provincial government, and local CBOs and networks/coalitions (see Appendix I for a list) and applied content analysis. In most instances, after receiving an e-communication, I searched for reactions and clarification on websites and newspapers as well as watched local coalitions. All of this material was stored in an e-file labelled “macro-context observational notes” and in general, tells a story about what was going on in the virtual voluntary sector social service world during my study period (Angrosino 2005; Hick and McNutt 2002b). The schematics illustrated in Figure 5.1 reflect the complexity of the real world observed. Figure 5.1 provides an overview of this material; the details are in Appendix I.
There are four central nodes, drawn as boxes, in this macro-context shown in Figure 5.1: the federal government, the provincial government, national level CBOs and networks, and local CBOs and networks/coalitions. This macro-context is best
characterized as social justice-oriented because all of the national CBOs involved were doing work on social equity issues regarding marginalized groups.

During my data collection period, I monitored two government-CBO sector initiatives; refer to the two cloud-like shapes in Figure 5.1. I was aware the Federal government’s Voluntary Sector Initiative (VSI) had concluded its work, but components of the VSI still existed (e.g., Voluntary Sector Forum) and were still being discussed among CBOs. Secondly, the Saskatchewan Premier’s Voluntary Sector Initiative (VSI) was still active; it began in 2002 and was intended to create a better environment for CBOs and the provincial government to work together. During my study period, the Premier’s VSI held a series of meetings with local CBOs in Saskatchewan. These meetings were intended to provide forums to further the dialogue between the provincial government and CBOs regarding the needs of these two sectors as well as develop communication mechanisms. 67

Another central feature of Figure 5.1 is the dynamic flows based on e-communications among these central nodes as indicated by the white arrows. In general, the e-communications I received from national and local CBOs were either about specific social policies or about policy making processes. These policies and processes were intended to influence government to change because they clearly defined a problem and they made recommendations for change (see Appendix G for a list of these policies and processes). These CBOs sent material, based on their research, to governments in an

attempt to influence policy. For example, the Voluntary Sector Forum sent a pre-budget submission in 2003 to the Federal Standing Committee on Finance but it also sent it to CBOs for them to use as a basis for their own advocacy.

As well, there were additional flows in Figure 5.1, as shown by the dark arrows, from the federal government to national and local CBOs; these were about rules and funding. Let us examine the thick dark arrows, rules, first. The Canada Revenue Agency (CRA) established an e-list to which they encouraged all CBOs to subscribe to so they could receive regular newsletters regarding CRA rules based on the *Income Tax Act* (Macro-context observation notes Sept. 22, 2004). The CRA e-newsletter offered updates from the Charities Directorate including travelling seminars regarding the annual Charities Return Form, rules and regulations, sanctions, and partisan political activities. One core issue was about how social policy advocacy is perceived and treated by the CRA. In general and as noted in chapter 2, section 2.3.7, charitable education was permitted but political advocacy was not. “Education must not amount to promotion of a particular point of view or political orientation, or to persuasion, indoctrination or propaganda” (Bridge 2000, p. 1), and no more than 10% of the charity’s resources was allowed to be devoted to advocacy activities (i.e., “the 10% rule”). In 2007 during provincial elections there was heightened awareness and concern among CBOs about the CRA (Macro-context Observational Notes Jan. – Nov. 2007); for example, I was invited to a large Regina CBO board meeting (i.e., with revenue in excess of one million dollars) to explain advocacy and its risks and benefits (Macro-context Observational Notes Jan.

---

The CRA circulated an *Advisory on Partisan Political Activities* on October 4, 2007 which stated

“During election campaigns, the CRA steps up monitoring of activities of registered charities and will take appropriate measures if a registered charity undertakes partisan political activities. Partisan political activities are those that involve direct or indirect support of, or opposition to, any political party or candidate for public office. Registered charities are prohibited from partisan political activity, because supporting or opposing a political party or candidate for public office is not a charitable purpose at law.”

I subsequently discovered in communication with some CBOs and coalitions that this *Advisory* led to more questions regarding what activities were permitted during elections and which were not; because of this lack of clarity some CBOs stated they would not participate in public debates or discussions because of fear of sanctions by CRA (Macro-context observational notes, Nov. 5, 2007).

A second critical observation in Figure 5.1 was about funding as shown by arrows originating from the federal government. Stepping back to the summer of 2006, with the new Conservative federal government, an announcement was made to cut $1 billion from a variety of CBO programs – shown as an explosion in Figure 5.1. Some examples of these funding cuts included: Status of Women Canada advocacy programs; the Court Challenges Program which advocated for pension benefits for same-sex spouses; and Community Access Program which provided computers and internet access in communities without such resources.69 This announcement resulted in a multi-faceted reaction including newspaper articles written by CBOs, press releases spread through

---

CBO e-networks and labour unions, the formation of coalitions, and calls to confront the federal government to rescind these cuts (e.g., an on-line protest against the elimination of the Court Challenges Program was launched, a petition was launched by a literacy CBO). One national CBO, Imagine Canada, noted the impact of these cuts in a press release: “The federal government has significantly restricted the ability of organizations to play a role in public policy by terminating a number of advisory mechanisms and cutting funding for advocacy activities …” (Imagine Canada n. d). Finally, the Institute for Media, Policy and Civil Society (IMPACS) – an advocacy CBO - circulated an email message on March 21, 2007 that indicated they were closing their organization after 10 years of operation due to the lack of core funding and “ripple effects of cut-backs to federal grants announced last summer”.

In summary, watching activities unfold in this macro-environment over my study period gave me a glimpse into the inside of this virtual, voluntary sector social service world. In general, CBOs communicate with governments regarding social policy content and about creating better policy making processes. Despite the VSI’s goals regarding working better together, CBOs continue to be concerned about federal CRA rules and funding cuts. We now turn our attention to what CBOs around the province of Saskatchewan have to say about advocacy.

---

5.3 Phone interviews with Saskatchewan CBOs

The focus of this section is on answering research question #2: how do social service CBOs in Saskatchewan understand and incorporate marginalized people into policy advocacy processes? In keeping with the nature of this chapter which is about trends and context, I focused primarily on the questions from the phone interviews with the 39 CBOs which asked respondents about their advocacy environment and trends they have seen over the years in social policy advocacy work and descriptive data about advocacy generally. I did line by line coding and paragraph coding of the transcripts and then category development as explained in section 3.5.2 (Strauss and Corbin 1998). I begin with general descriptive data about advocacy, then examine CBO-defined trends and then conclude with CBO perceptions of health/well-being. Chapter 6 goes into greater depth about advocacy – this section is but an introduction.

The definition of policy advocacy I adopted for my research was - **policy advocacy consists of those purposive efforts of CBOs to change specific existing or proposed government policies in collaboration with groups of marginalized people** (Ezell 2001). This was the definition the 39 CBO respondents were given at the beginning of the study and referred to periodically during the phone interviews. The first major finding was that although I asked CBO participants to tell me about their policy advocacy, they also told me about their program and funding advocacy, their research-based advocacy and their one-on-one advocacy with their clients71 (details of these data are presented in chapter 6). What is noteworthy here is that 29 of the 39 CBOs drew clear

---

71 I use the term “clients” because the CBO interviewees used that term.
links between these different types of advocacy, thus in practice these types of advocacy appeared to exist on a continuum. For example,

“When we talk about public policy advocacy … and I was looking at your definition here … in our pamphlet about our agency, we basically identify that we provide advocacy … and we have defined that as part of our mandate …. to improve services for persons with mental illness or … through increased funding and changes to legislation and policies … and that is a very broadly defined concept. We do that only in partnership with our funders and other community based organizations and other government organizations. We get involved with other people to try and advocate for improved services and increased funding. Then we, on a day-to-day basis, are involved in advocacy for our residents in our programs that are a little more specific to what their needs might be” (CBO1-22).72

In general, these CBOs’ advocacy work was informed by their daily one-on-one work with clients; “we don’t officially have a policy advocate … things just come out of our service delivery and I think that we kind of use that to rationalize our lobbying efforts or our advocacy for our people” (CBO1-10). CBOs said they knew what policy advocacy needed to happen because of their day-to-day front-line work with people in need (CBO1-24, CBO1-28, CBO1-37, CBO1-39). For some CBOs there also seemed to be the need to defer to clients’ opinions about how far to go with advocacy. For example,

“We were going to lobby for something bigger … but I wasn’t going to make any waves as long as she [a client] was still kind of beholden to those folks [at Social Services] because again our concern is what’s best for her and if she didn’t want to pursue anything there was absolutely no question that we weren’t going to get involved … if the client’s moved on and you’ve got your hands full … we do constantly worry about what’s good for the client and whether, you know, what’s good for the rest of the world, a political issue is, you know, worth fighting about. Yeah, sometimes we do defer to the client’s needs and wishes at that point and let the big stuff slide” (CBO1-37).

72 CBO1 refers to CBOs interviewed in phase 1. For example, CBO1-22 refers to CBO #22 in phase 1.
Second, the CBOs discussed advocacy in terms of visibility and scale. One group of CBOs stated they do advocacy but they do not talk about it, and they stated their advocacy is simply about them “voicing their opinion” and working behind the scenes (CBO1-7) or they are funded solely to do one-on-one advocacy (CBO1-26). Another group of CBOs was more visible as they stated they “crack open that door a bit” (CBO1-14), their work is small scale (CBO1-37), or they take a low profile (CBO1-18). Yet another group of CBOs said their advocacy work was large scale, formal and visible. This included large CBOs and CBOs that operated on a province-wide basis and that also received either federal or provincial government funding to do policy advocacy targeted at another level of government (CBO1-21 and CBO1-35). It also included CBOs that have joined province-wide networks/coalitions that did not receive government funding, but were quite visibly active in working to change government policies – and seemed to have no fear of government reactions (CBO1-35 and CBO1-19).

Third, CBOs told me about trends that directly affected the type and amount of CBO advocacy work. Some of these trends may appear contradictory, but may be explained by a closer examination of the different governments, policy issues, CBOs and their approaches, staff involved, urban versus rural, and time periods (CBO1-2 explained many of these differences in his policy advocacy work over the past 20 years). There were four key trends that influenced CBO advocacy work as shown in the examples cited in Table 5.6; the first item was a more recent trend while the other three were situated in a longer time horizon. These trends are: growth in CBOs working co-operatively recently; changes in the type of government funding over past few decades; competition among CBOs reduced advocacy; and fear and vulnerability that stem from rules.
The categories that appeared in the greatest number of CBOs are presented first in the table using Strauss’ (1987) extensiveness criterion; this refers to frequency across CBO cases, not within CBO cases.

### Table 5.6: Trends influencing CBO advocacy work

#### a) Growth in CBOs working together and speaking out over the past few years (stated by 21 CBOs)

There is more working together among CBOs (CBO1-18), more multi-agency coalitions (CBO1-29) and partnerships (CBO1-31), more readiness to act because of our networks are in place (CBO1-14), more capacity building is taking place especially on reserves today (CBO1-8), “cross-pollination” and closer working relationships are happening (CBO1-3, CBO1-19), more commitment to fight to make change (CBO1-20), “the more difficult the time, the more vocal we are” (CBO1-31), less fear in speaking out (CBO1-34), and as CBOs “we’re becoming braver … more apt to voice our opinion than we used to be” (CBO1-16).

#### b) Changes in the type of government funding over the past few decades (stated by 19 CBOs)

More project funding is tied to specific projects means less money and time to do advocacy (CBO1-28), “if you were doing any advocacy work they weren’t going to fund you” because they didn’t want to be criticized (CBO1-30), “the largest group of marginalized populations are First Nations” and they have a problem with resources (CBO1-26), and no funding to support policy advocacy efforts (CBO1-2). Some agencies have had increases in government funding but their funding agreement also requires them to not engage in advocacy work (CBO1-18). One CBO stated it does not receive government money so it is free to speak (CBO1-24).

#### c) Competition among CBOs reduced advocacy over the past few decades (stated by 13 CBOs)

Some CBOs indicated that the competition for funding wasn’t as bad as it used to be (e.g., CBO1-14 and CBO1-16), however it does still exist today with governments “request for proposals” process (CBO1-14) which has pitted CBOs against each other and reduced co-operation (CBO1-25), and we’ve lost the collective environment we had in the 1970s as “agencies are played off against each other” (CBO1-26).

#### d) Fear and vulnerability that stem from rules over the past few decades73 (stated by 12 CBOs)

“Lots of times at these tables we talk about how we cannot be seen as “advocating” because we’re all charities and we have to follow the 10% rule for charities. So we always live in fear that … you know, don’t say too much” (CBO1-27), “but in terms of our agency having people come in and encourage people to talk about TEA, no we don’t do that. …. a lot of agencies are not supposed to be doing that either … there is that fear that funding will be cut” (CBO1-26), and governments dictate what “CBOs can, should, must do and the kind of restrictions they place on you about advocacy … I think we’re in a particularly vulnerable time” (CBO1-19).

Fourth, CBOs described a number of issues related to trends in the political atmosphere and government-CBO relations. The dominant issue was that not much had

---

73 Nine of the 39 CBOs explicitly noted government rules like CRA and that these influence CBO choices and behaviour.
changed in the political atmosphere across political parties over the past few decades as shown by the following: “today we are no longer under Premier Grant Devine, but it sure as hell feels like we are” (CBO1-26), when the government is not responsive we see community action … “we’ve waited for them [NDP] to do the right thing by poor people … they’re angry and frustrated” (CBO1-24), and “you’ve got to be vigilant and speak out no matter what government it is” (CBO1-19). Secondly, some CBOs thought governments had become more watchful of CBOs today especially given the Canada Revenue Agency 10% rule: “over the last 5 years … government has become more concerned about agencies speaking out” yet back in the 1970s the government funded advocacy (CBO1-26). Finally, one “residual case” (Lofland and Lofland 1995) pertains specifically to disability groups and their advocacy. The advocacy work undertaken by physical and cognitive disability CBOs in the 1970s has persisted to today through the assistance of a province-wide advocacy association representing 70 CBOs (CBO1-14).

In terms of government-CBO relations trends, six categories of answers emerged. These categories are not mutually exclusive because different CBOs move in and out of different types of advocacy with different governments as already explained. These government-CBO relation trends included: some CBOs said they were positively received by governments; government resistance to CBO participation affected relations; government functions, rules, attitudes and perceptions affected relations; government resistance to CBOs proposed solutions affected relations; governments-CBOs as “partners” trend is more recent; and government advisory committee problems. Table 5.7 presents examples of these data. The categories which appeared across the greatest
number of CBOs, extensiveness, are presented first in the table; the remaining categories are presented in descending order.

Table 5.7: CBOs’ descriptions of government-CBO relations over time

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a) CBOs positively received by governments trend (stated by 15 CBOs)</strong></td>
<td>Governments are now coming to us (CBO1-31) and are more willing to listen (CBO1-16), the government actually asked for CBO’s assistance (CBO1-19), some government departments are more in touch than others (CBO1-2), when the government finalized the policy document “90% of our suggestions were incorporated” (CBO1-2), the government is encouraging us (CBO1-31), the government learned that [we] “are a great resource” (CBO1-5), and “governments are beginning to finally recognize the value and the contribution of nonprofits” (CBO1-4).</td>
</tr>
<tr>
<td><strong>b) Government resistance to CBO participation affects relations (stated by 15 CBOs)</strong></td>
<td>“I’m so … stunned at how entrenched the levels of bureaucracy are against genuine participation from the residents” (CBO1-20), “the government claims it wants community input but they don’t really” (CBO1-26), “they have never offered to come out” and meet with the tenants (CBO1-7), “guess if it’s your job to develop a policy paper … I think maybe they feel it’s their job and they should have the knowledge, they should be able to do this without the input of these peons” (CBO1-2), “one of the biggest problems that’s happened with nonprofits is that we have been seen by government as … primarily, service deliverers and they have forgotten … the value of CBO’s with … grassroots input into policy” (CBO1-19) and the government did not like our inter-agency group and tried to dismantle it (CBO1-2).</td>
</tr>
<tr>
<td><strong>c) Government functions, rules, attitudes and perceptions affect relations (stated by 14 CBOs)</strong></td>
<td>The government “hears about issues … but they’re juggling priorities just like we are everyday … but it’s more about what politically is going to work” (CBO1-27), “one of the things that really worries me is the level of government intrusion through regulation and … so called accountability … there’s a pretty fine line between accountability and control” (CBO1-19), “it’s part of our funding agreement … that we can’t advocate” (CBO1-18), “we're all charities and we have to follow the 10% rule for charities” (CBO1-27), “so we’re limited to 10% of our overall activities, no more than 10% to be devoted to public advocacy” (CBO1-28), “they're very sympathetic and they really try to work hard for us but they have their rules … they’re very inflexible” (CBO1-17), and the government was surprised when the CBO did not rubber-stamp the draft policy report but instead re-wrote it (CBO1-2).</td>
</tr>
<tr>
<td><strong>d) Government resistance to CBO solutions affect relations (stated by 9 CBOs)</strong></td>
<td>“They’ve already, through a different process, made up their minds they’re not going this way” and basically ignored CBOs and residents (CBO1-20), “the policy writers … didn’t appreciate our input” (CBO1-2), and the city sees our advocacy work as negative (CBO1-6).</td>
</tr>
<tr>
<td><strong>e) Governments-CBOs as “partners” trend is more recent (stated by 8 CBOs)</strong></td>
<td>“As we’re recognized more and more as partners it increases our power and so it becomes more of a two-way street where … it gives us some voice with government … and so it’s if we’re going to do this, this and this for you … then we need you to pay attention to some of the issues that we have and it’s not just in terms of budgets but it’s in terms of the whole ability to advocate for change (CBO1-4), and it is good to have conversations and a relationship with government staff (CBO1-1).</td>
</tr>
<tr>
<td><strong>f) Government advisory committee problems (stated by 6 CBOs)</strong></td>
<td>These committees (e.g., the disability advisory committee of the provincial government) have either “collapsed because we just weren’t satisfied with it and so out of that came a CBO driven provincial network about 12 years ago and it has really taken off” [CBO1-19]), or these advisory committees are perceived negatively by the CBOs that were interviewed (e.g., “typical advisory thing that you couldn’t really speak out” [CBO1-19]) or the advisory group lacked the diversity necessary to create the best policies and programs (e.g., it lacked diverse First Nations spiritual perspectives [CBO1-2]).</td>
</tr>
</tbody>
</table>
Before leaving this section I must draw attention to a “residual case” (Lofland and Lofland 1995). It was only in a few instances that I heard CBOs explain that governments prefer to hear clients’ perspectives through CBOs and not meet directly with clients (see for example CBO1-5). It was not clear what might be the government’s motivation, but one suggestion was that

“You know, they’re [government] always looking for a cohesive kind of consensualized kind of group that they can listen to and they have told us that off and on … just hearing a unified voice on any particular issue … I think that it’s actually grown over the years so that they do value that. I mean they may not like what we have to say quite often but maybe that’s where you actually make progress” (CBO1-19).

It is important to flag this item because if marginalized people are not being engaged by governments and/or CBOs to participate in policy discussions yet they are the focus of these policies, this is exclusion and from a critical inquiry perspective requires action.

Fifth, there were trends cited regarding the involvement of marginalized people in advocacy as well. As already noted, depending on the agency, the issue and the time frame, some of these may appear to be contradictory. Before examining these data, some CBOs cautioned me about identifying and labelling people as marginalized – people do not generally come to advocacy meetings and indicate they have a certain history (e.g., women who were victims of domestic violence, [CBO1-21], low income Aboriginal people involved in the Commission [CBO1-2]) while others do (CBO1-25). There were three categories identified regarding marginalized groups participation: positive trends in marginalized people’s participation over time; negative government attitudes (e.g., racism); and real and perceived threats if people speak out. These are presented in Table 5.8 using the extensiveness criterion to order the categories (Strauss 1987).
Table 5.8: CBO descriptions of the involvement of marginalized people over time

<table>
<thead>
<tr>
<th>a) Positive trends in participation (stated by 11 CBOs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>There has been an increase in victims going public with their stories (CBO1-4), there has been an increase in First Nations peoples wanting and having a say (CBO1-8), many disability groups are represented by a province-wide advocacy association funded by the government (CBO1-35), some marginalized individuals will speak publicly but “it depends on the issues … and whether or not they’re really mad” (CBO1-23), and the involvement of these people makes initiatives more credible (CBO1-10).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>b) Negative government attitudes (stated by 9 CBOs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The government appears to have become more apathetic toward us and the groups we work with (CBO1-6), the government has become more “desensitized to … you know the needs of particular marginalized people” (CBO1-19), stigmatization has grown (CBO1-38), there has been no reduction in racism (CBO1-18), and many different types of marginalized people still do not or can not use their voice to make change (CBO1-26).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>c) Real and perceived threats by governments if individuals speak out (stated by 9 CBOs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I’ve seen those people who have not backed off and have gotten cut off” after they ignored a welfare worker’s threat (CBO1-24), an individual became ill after being told to stop advocating “or we’ll find a way to … cut off your cheque” (CBO1-28), marginalized people are “reluctant to mess around with the big guys” (CBO1-37), some marginalized people fear reprisal from their government social worker so they do not speak out (CBO1-26), and quietly but directly a CBO interviewee said he had been told to “back down” (CBO1-28).</td>
</tr>
</tbody>
</table>

Finally, do these 39 CBOs perceive they have a role to play in creating health/well-being? Health/well-being was broadly defined and “is not just about the absence of disease, but rather, about feeling well, having energy, having a sense of purpose in life, having good social relationships, feeling connected to one’s community, and having a sense of control over one’s life and living conditions” (from phone interview glossary of terms, adapted from the World Health Organization [1998] and Hancock, Labonte and Edwards [2000]). Of the 39 social service CBOs, 35 (90%) said yes they believed they contribute to people’s health/well-being. Taken together, the 35 CBOs explained what services they provided and how these contributed to health/well-being using this broad definition. Some examples cited were: recreation programs, food provision, cooking skills, housing and shelter provision, education and skills development, employment, encouraging social relationships and inclusion, creating a
family atmosphere at their CBOs, getting people involved, and promoting independence. One area that was missing from the original definition for the interview was noted by First Nations CBOs and it was a spiritual dimension to health/well-being (CBO1-2 and CBO1-8). They pointed out that well-being encompasses four directions and is a holistic concept – physical, mental, spiritual, and emotional. Finally, the 39 CBOs were asked if advocacy was a necessary function of CBOs in this current era in order to enhance the health/well-being of individuals and communities. Their collective answer was clear – 34 (87%) of them said yes.

In summary, CBOs saw policy advocacy as interconnected with program advocacy, funding advocacy, research advocacy and one-on-one advocacy. Advocacy was perceived as simply voicing an opinion in a small group through to a much larger scale including province-wide advocacy involving 70 CBOs. There was a sense the political atmosphere had not changed much over the past 30 years and that CBOs need to be ready to speak out regardless of the government in office. A number of government-CBO relations were described including partnerships, CBOs positively received by governments, government resistance to CBO solutions and participation, and government rules and attitudes. Influences on CBO advocacy included type and amount of funding, competition among CBOs, and growth recently in CBOs working together. Trends regarding the involvement of marginalized populations included positive involvement stories, negative trends in which governments seemed apathetic and desensitized to problems, and people were threatened by governments if they spoke out. Finally, the majority of social service CBOs said they believe they contribute to health/well-being.
5.4 Discussion

I set out to answer two main research questions in this chapter. As a result of the data analysis, the following five main areas comprise this section: growth and diversity of CBOs over time, social policy advocacy trends, marginalized people’s participation, CBOs’ role in health/well-being, and government-CBO relations over time.

5.4.1 Trends in growth and diversity of CBOs

Over the 60 year period that I examined Saskatchewan literature including government annual reports, CBO documents and some general history, there was growth in the number and diversity of social service CBOs; this is mirrored in Canada-wide data (Hall and Banting 2000 showed a 3% increase per year; Sharpe 2001 showed a 26% increase between 1991 and 1999). Child welfare, disability and seniors CBOs were the first noted in government annual reports in the 1940s and 1950s (section 5.1.2). In the 1960s, CBOs serving the elderly were clearly in existence, in fact, they were “encouraged” and funded by the provincial government (section 5.1.2). The 1970s and 1980s showed growing numbers and diversity of CBOs which resulted from increasing support from the provincial government in terms of funding and including CBOs as part of government organizational charts in annual reports (section 5.1.2, 5.1.3, and 5.3). In the 1970s, the government annual reports indicated CBOs supplement and complement the objectives of the Department, however, the 1980s revealed more selective funding of CBOs. Those CBOs who worked with “deserving” groups received more funding (O'Sullivan and Sorensen 1988) (sections 5.1.1, 5.1.3 and 5.3); for example, the elderly were more deserving than those with mental illnesses or those on social assistance.
1990s saw the provincial government explicitly state it devolved responsibility to CBOs and encouraged more social service integration in communities (section 5.1.1 and section 5.1.2); during this time, “community development” became a prevalent term in the government annual reports. This situation reflects the adoption of the residual welfare state model in Saskatchewan (O'Sullivan and Sorensen 1988; Riches 1976; Scott 1992).

5.4.2 Trends in social policy advocacy

How was advocacy presented and treated over time in the Saskatchewan literature and 39 CBO interviews? Three major findings are explained here. First, advocacy is not an explicitly used label in two Saskatchewan sources (i.e., sections 5.1.1 and 5.1.2), yet we know advocacy has been occurring based on the CBO documents analyzed (section 5.1.3) and the interview results of the 39 CBOs (section 5.3). Second, “social policy advocacy” as a finite concept with clear defining lines does not exist for the CBOs interviewed. Third, there has been a reduction in advocacy over the past 30 years according to the CBOs interviewed, but they also stated over the most recent past few years CBOs are working more collaboratively. Let us examine each of these.

First, the term “advocacy” as per the definition I adopted for my research, is not explicitly labelled in the Saskatchewan literature, yet we know CBOs are doing advocacy given the 39 phone interviews and 32 CBO documents analyzed. The only two instances in which advocacy was found in the government annual reports was once in the 1994-95 description of the Children’s Advocate Office and then again in 1999-2000 when $1.25 million was given to “provincial organizations to provide advocacy … on behalf of
people with disabilities” (Saskatchewan n.d-e, p. 38). It is noteworthy that the 1949-50 provincial government annual report indicates funding was provided to the Disabled Civilians Workshop and 50 years later the provincial government provided funding for advocacy for the same population group. Thus, disability groups appear to be received positively by the provincial government.\textsuperscript{74}

Second, “social policy advocacy” as a finite concept with clean lines and boundaries is not reflected in these results. The blurring together of policy advocacy, program advocacy, research advocacy, funding advocacy and one-on-one advocacy was common. Depending on the issue area, CBOs begin with one type of advocacy and move around the other types as needed (see section 5.3). The one common element appears to be that they all result from CBOs’ daily social service delivery work. This is supported by the CBO documents that I analyzed which showed that CBOs provided a diversity of services and that experience with service provision can lead to the creation of advocacy tools like the documents that identify and describe problems and recommend policy and program changes to governments (see section 5.1.3). Furthermore advocacy appears to differ across CBOs, social policy areas, population groups, governments, and rural/urban areas, but these data do not permit this depth of analysis (see section 5.3).\textsuperscript{75}

There were some trends that affected social policy advocacy, including government funding arrangements, fear and vulnerability, competition among CBOs, recent growth in

\textsuperscript{74} Based on the annual reports analyzed, no other CBOs doing policy advocacy with marginalized groups received funds.

\textsuperscript{75} Some of the CBO interview data indicated that different levels of government fund CBOs to track and advocate for policy change directed at other levels of government (sections 5.1.1 and 5.3) (e.g., a provincial CBO is funded by a federal government department to identify, define and encourage change in provincial government social policies [CBO1-26]).
CBOs working together and the dynamic nature of government-CBO relations (see section 5.4.5 for more information regarding the last item).

Third, between 1970 and approximately 2000, there appeared to be a decrease in social policy advocacy as indicated in data from some of the interviewed CBOs. Through these data, it appeared that advocacy was accepted and even funded in some cases in the 1970s (section 5.3), but the environment changed over time such that CBOs did very little advocacy in the late 1990s (ibid). This change in environment appears to have coincided with an increase in fee-for-service contracts with governments (section 5.1.2) and increased enforcement of CRA rules by the federal government - known as “advocacy chill” (section 5.3) (Bridge 2002; Harvie 2002). Slightly more than half (i.e., 21/39 CBOs, 53%) of the interviewed CBOs stated they believe there has been an increase in CBOs speaking out and working together over the past few years.76

5.4.3 Trends in marginalized people’s participation in advocacy work

Given my interest in critical inquiry, marginalized communities, voice, and silence, I asked the CBOs about the involvement of the people they work with in their policy advocacy initiatives. Data from the 39 interviewed CBOs caution us about the identification of people as marginalized. For example, some CBO staff have had life experiences with marginality and bring these to their advocacy work, but this is not often publicly stated. As well, some CBO volunteers who join policy advocacy initiatives do not always identify themselves as having a certain history, while some do. Thus, when

__________________________

76 This was a semi-structured question. Interviewees were not explicitly asked about increases in advocacy.
studying collective policy advocacy processes, without these disclosures, we must be cautious about stating who has been excluded.

In general, three main areas regarding marginalized groups participation were found (see section 5.3). First, some positive trends were cited in more people speaking publicly about their issues and participating in advocacy initiatives. Second, there were some negative trends cited in that governments appeared more apathetic about certain groups and that stigmatization had grown and racism/discrimination persisted. Third, some interviewees stated people felt threatened by government staff, which led to stress, illness, and decisions not to speak publicly about their issues and advocate for change.

Before leaving this section, it is worth reiterating the point about a “residual case” (Lofland and Lofland 1995) regarding some CBOs’ explanation that governments prefer to hear clients’ perspectives through CBOs and not meet directly with clients (see for example CBO1-5). If marginalized people are not being engaged by governments and/or CBOs, then this is social exclusion (Fraser 2003; Grabb 2007; Hancock, Labonte, and Edwards 2000) and from a critical inquiry perspective requires action (Carroll 2004).

5.4.4 Social service CBOs role in health/well-being

As I have already indicated, I was interested in social service CBOs’ contributions to “health/well-being” (section 5.3). Of the 39 social service CBOs, 34 (87%) stated that in this current era, advocacy is necessary in order to enhance the health/well-being of individuals and communities while 35 (90%) said they believe their organization
contributes to the health/well-being of the program participants. All of these 35 CBOs talked about health/well-being from the broad definition I provided them, although a few had the tendency to talk about traditional medical issues (e.g., immunization, foot care). As well, two of the First Nations CBOs explained that I had missed the spiritual dimension in my definition and then went on to talk about a holistic perspective on health/well-being.

From a population health perspective, the finding that 90% of the social service CBOs interviewed said they contribute to people’s health/well-being is significant. These CBOs described a diversity of services directed at ameliorating negative social conditions, also known as the social determinants of health, with diverse groups of marginalized people. Some of the social determinants of health cited included poverty, lack of affordable housing, lack of food, and social exclusion (section 5.3 and 4.1). Thus these CBOs play a role in facilitating health/well-being.

The social service CBO sector appears to be uniquely but precariously situated in communities. In the CBO documents reviewed, it was noted that community volunteers are usually the first to respond to human crises in communities and that government responses usually lag behind this community volunteer and CBO response (Canadian Red Cross Society 1990; Canadian Welfare Council 1938; Hall and Banting 2000; Sanche and Bates 1976). As well CBOs “deliver services on behalf of the state, some fill gaps left by the state and some respond to emerging social needs” (McFarlane and Roach 1999c, p.

---

I recognize that we are discussing perceived positive impacts of CBOs on marginalized people’s lives. Program impact assessments would be necessary to discern more clearly the actual effects of these CBOs’ services on people lives.
3). Government annual reports indicated some departments have “devolved responsibility and authority to provincial organizations that work with a range of community based institutions and agencies” (Saskatchewan 2000, p. 2), yet there were a myriad of funding and government-CBO relations issues also cited (section 5.3). Finally, there appears to be no more clarity today than in the past about who is responsible for what and who should pay for what between the government and CBOs in Saskatchewan (Canadian Welfare Council 1938; O'Sullivan and Sorensen 1988; Thériault, Gill, and Kly 2002). This lack of clarity regarding the role of social service CBOs is concerning because the health literature reviewed earlier explains the role of social determinants of health in contributing to population health.

5.4.5 Government-CBO relations over time

The findings revisited here stem from the four data collection sources. Central categories that help describe government-CBO relations over time include: changes in the type of funding arrangements with governments, government rules about advocacy, both positive and negative feelings as well as reactions to government resistance, and preferred relationships.

First, the government-CBO funding relationship is one of the most controversial (Brock and Banting 2001a). There has been an increase over the past 30 years in government fee-for-service contracts and a reduction in grants which has affected CBOs work (Banting 2000; Brooks 2001; Browne 1996; Pedscalny 2004). All four methods of data collection alluded to this shift and the influences of government funding on the relationship between governments and CBOs (sections 5.1.2, 5.1.3, 5.2 and 5.3). This
shift toward an increase in contracts appears to have coincided with a decrease in advocacy over those 30 years as noted by some of the 39 interviewed CBOs; some of them feared their funding would be cut if they spoke out (section 5.3). This shift toward contracts also coincided with greater competition among CBOs because they had to submit proposals to governments and governments then chose which CBOs would be funded. The literature cited in chapter 2 indicated that CBOs are less likely to criticize government policies if they are funded by that government (McFarlane and Roach 1999c; Vogel 1991). It is significant that “the state can hand over responsibility” to CBOs yet maintain “control through a funding mechanism” (O'Sullivan and Sorensen 1988, p. 88); “this is a relationship of power and control” (Manning 1994, p. 116).

Nonetheless, 53% of the CBOs interviewed indicated that more recently, over the past few years, there has been growing co-operation among CBOs and more working together for both service delivery and advocacy (see Table 5.5 and section 5.4.2). The advocacy piece in particular, includes a growth in CBO partnerships and coalitions, a readiness to respond because networks are already in place, cross pollination of issues and concerns, and finally less fear in speaking out (ibid.).

Second, CRA rules affect CBO behaviours. Due to of the lack of clarity in definition and description from CRA, some CBOs tend not to participate in public debates or discussions – that is, advocate for certain policies or principles - because of fear of sanctions by CRA; evidence of this was found during provincial elections in the fall of 2007 (section 5.2). This was labeled “advocacy chill” in the literature review (see also Bridge 2002; Harvie 2002). The macro-context described in section 5.2 showed a strong federal government role through the CRA in reminding CBOs about advocacy.
rules. This was confirmed through CBOs who stated the government has been more watchful recently, especially in enforcing the 10% rule (section 5.3).

Third, there were different feelings expressed through the CBO documents and the 39 CBOs interviewed. The CBO documents cited in section 5.1.3 relayed negative feelings about the state of government-CBO relations, including tension, antagonism, feeling de-valued, feeling powerless and feeling impatient about the lack of change. Some CBOs indicated they thought there was some resistance on the part of governments to their proposed policy solutions as well as their policy participation: “the policy writers didn’t appreciate our input” (CBO1-2) and “I’m stunned at how entrenched the levels of bureaucracy are against genuine participation from the residents” (CBO1-20). However, some of the 39 CBOs interviewed indicated they thought they were received positively by governments including being listened to, encouraged, seen as a resource, and asked for information.

Fourth, in terms of types of relationships, the CBO documents and the 39 CBOs reflected a desire to have “balanced relationships” and better “partnerships” with governments (sections 5.1.3 and 5.3). In general, there are problems with the contracting relationship and CBOs want greater co-operation, collaboration and partnerships. It is interesting the provincial government stated through its annual reports, it has “partnerships” with many CBOs (section 5.1.2) yet CBOs pleaded for partnerships in their documents dating back to 1938 and continued to do so from the 1970s into the 1990s (section 5.1.3). Thus, there appears to be a difference in perception between these two groups. We must remember there are different types of government-CBO relationships (Coston 1998) and different types of involvement in policy-making (Boyce
et al. 2001; Gauvin et al. 2006; Labonte and Edwards 1995) which reflect different degrees of power sharing (Arnstein 1969).

I had hypothesized that if the government created advisory committees with membership from CBOs and marginalized communities that this would reduce the need for policy advocacy (Analytic notes Sept. 2004), but something appears to have gone wrong with government advisory committees that were created in the 1970s and 1980s. CBO interview data offered a glimpse of one possible reason for the disappearance of government advisory committees: “typical advisory thing that you couldn’t really speak out” [CBO1-19]).

In closing, CBO advocacy exists within a dynamic context comprising numerous trends as shown in the data collected from these four sources. There are national CBOs distributing advocacy material regarding social policies and encouraging governments to increase CBO and citizen participation. There are multiple links, relations, and reactions among governments and CBOs; some of these exist with uneasiness for CBOs. Finally, there are four different levels of government – First Nations governments, local/municipal governments, provincial/territorial governments and the federal government. Within each of these are different divisions, organizational cultures, rules, functions and behaviours, and levels of financial resources. Thus, different relationships, types of participation, and types of advocacy ensue between these CBOs and governments, which in turn, affect the participation of marginalized populations over time. In the next chapter, I will move deeper into the collected data to expose more fully, CBO-facilitated social policy advocacy as a form of civic participation involving marginalized groups.
6. ADVOCACY PROCESSES AS CIVIC PARTICIPATION

Hancock et al. (2000) explain there are many different processes which affect the health of populations. My primary interest is the dimension of their process labelled “governance” because this is where policy advocacy occurs. Hancock et al. describe governance “as the sum of all the ways …. in which we participate in running our communities and our society” (p. 51) (see also Jenson 2001; Phillips 2001b). Hancock et al. explain that participation benefits communities as well as individuals and that citizen apathy does not exist in communities where there is a high level of citizen action, advocacy and public demonstrations. Governance indicators include voluntarism, human rights legislation, voter behaviour, perception of political leaders and citizen action/civicness. Volunteerism and citizen action are my primary interest because they are key for CBO-facilitated social policy advocacy. Citizen action and civicness is about “individuals actively engaged in social and political action such as lobbying and advocacy …” (ibid., p. 53). Citizen action is a component of civic participation.

The two research questions answered in this chapter are: question #2, how do social service CBOs in Saskatchewan understand and incorporate marginalized people into policy advocacy processes; and question #4, what were the experiences and perceptions of marginalized people, CBO staff and government regarding a local social policy advocacy coalition process? (see Table 6.1). The data necessary to answer these questions were collected from 39 CBOs, 17 individuals involved in a Coalition and the Coalition’s documents (e.g., meeting minutes, email communication, reports). I completed open and axial coding on the interview data (Strauss and Corbin 1998) and
content analysis including summarization and explication on the Coalition’s documents (Titscher et al. 2005). Sections 6.1 and 6.2 contain data findings while section 6.3 contains a discussion.

Table 6.1: Overview of chapter 6 data collection and analyses

<table>
<thead>
<tr>
<th>Research question for each phase</th>
<th>Methods of data collection</th>
<th>Methods of data analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question #1 – completed in chapter 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Question #2 (section 6.1)</strong></td>
<td>- Phone interviews</td>
<td>- Coding, categorizing &amp; theme development</td>
</tr>
<tr>
<td>How do social service CBOs in Saskatchewan understand and incorporate marginalized people into policy advocacy processes?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Phase 2 – case study</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Question #4 (section 6.2)</strong></td>
<td>- Documents (meeting minutes, email messages, reports)</td>
<td>- Content analysis</td>
</tr>
<tr>
<td>What were the experiences and perceptions of marginalized people, CBO staff and government regarding a local social policy advocacy coalition process?</td>
<td>- Personal interviews</td>
<td>- Coding, categorizing &amp; theme development</td>
</tr>
</tbody>
</table>

6.1 Advocacy processes based on the 39 CBOs

6.1.1 Advocacy work around the province

Research question #2 asked, how do social service CBOs in Saskatchewan understand and incorporate marginalized people into policy advocacy processes? This section provides a list of the advocacy issues raised by the 39 CBOs, a description of advocacy types and a description of advocacy strategies involving marginalized groups. My goal was to create a general description of a diverse sample of CBOs and their advocacy work. Most of the data for these three areas were extracted from the interview question which read, “in general, please describe social policy advocacy undertaken by your organization with marginalized groups of people, and if relevant in partnership with other voluntary organizations.” However, given the nature of this qualitative interview, answers to this question were found throughout the interviews.
Let us begin with the advocacy issues described by CBOs. As I already explained in chapter 5, some CBOs focused on social policies while others talked about program and funding advocacy as well as research advocacy, which for them was connected to policy advocacy; policy advocacy is not a discrete phenomenon and is directly connected to CBO social service delivery work. Table 6.2 offers an overview of the types of policies, programs and research in which CBOs were advocates. Since the participation of marginalized peoples is a central component of this research, the table is divided into two columns reflecting this. One column lists the initiatives for which CBOs explicitly noted the involvement of marginalized people in their advocacy work at that time while the second column lists initiatives that did not involve marginalized people.

Caution is drawn here about marginalized people not being directly involved for two reasons. First, 13 of the CBOs disclosed they had staff who had – or they themselves had had - experiences with marginalization, thus their perspective may be brought to bear on policy discussions (see for example CBO1-7 and CBO1-28). Second, given the dynamic nature of advocacy processes, CBOs may not have had active participation of marginalized people at that point in time, but that could have changed during the process (CBO1-15). It is noteworthy that all 39 CBOs indicated they brought marginalized peoples’ concerns and issues to policy advocacy processes in some way given their service delivery role (section 5.3).

Table 6.2 shows CBOs described a total of 42 policy initiatives, 26 program initiatives and 8 research initiatives. Forty-three of these initiatives involved marginalized people directly while 33 initiatives did not. Some of the CBOs that talked about the 33 initiatives not involving marginalized people explained reasons for this non-involvement.
These included: not wanting to re-victimize women (CBO1-5); as a provincial association, there are no clients (CBO1-21); clients were not involved but that could change depending on our direction (CBO1-12); there was no time to involve program participants (CBO1-1); and they cannot speak for themselves (e.g., parents who speak on behalf of their children who have disabilities [CBO1-34]) (see also section 6.1.2 regarding barriers to participation).
Table 6.2: Examples of policy, program and research advocacy initiatives

<table>
<thead>
<tr>
<th>Focus</th>
<th>Marginalized people directly involved</th>
<th>Marginalized people not directly involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies (total=42)</td>
<td>Landlord Tenant Act, low cost transit pass in a large city, property base tax in a medium size city, self managed care, individualized funding, bridges training program and women’s problems, city anti-violence by-law, working against medical model of mental illness, child welfare geographical boundaries, city by-laws regarding nonprofit housing, integrated schooling for intellectually impaired, public transit issue in a large city, extra-judicial sanctions for youth, First Nations spirituality in correctional institutions, advanced language training for professionals, respite for people with disabilities, homecare excludes people with psychiatric disabilities, income security issues for people with disabilities, Transitional Employment Assistance policies with groups around province, women in poverty and shelters, UN covenants and Canada/Saskatchewan policies, basic allownees through provincial government, shelter subsidies through provincial government, advocate for special housing needs for those with mental health issues, transitional employment assistance and utility problems for renters, domestic violence act, concern where those with cognitive disabilities will live when they’re adults, public transportation issues in a medium size city (total = 28)</td>
<td>Special court for domestic violence in a medium size city, food security, bus pass issue in medium size city, disabled people’s anti-abuse policy, licensing landlords/rental properties, tenant rights and affordability, Transitional Employment Assistance, income supports for disabled people, provincial call centre problems for clients, Transitional Employment Assistance and Saskatchewan Assistance Program poverty policies, Saskatchewan Assistance Program problems for people with disabilities in a small community, province-wide residential services association for mental health, restorative justice, combining work and family for lower waged employees (total = 14)</td>
</tr>
<tr>
<td>Programs/ funding (total=26)</td>
<td>Mothers group fought for funding, literacy project with people with intellectual disabilities, women offenders peer support group, justification for homeless shelter, fight against library closure, family services regarding First Nations, government dictator issues in a small community, North 54 Violence Free, parent mentoring program of Saskatchewan, paratransit services (total =10)</td>
<td>Push for podiatry services for cognitively impaired, advocate for change bus routes, call centre needed special technology for people with disabilities, subsidized housing units fund, push for another 24-hr care home, lobby for community kitchens, develop meaningful activities for cognitively impaired people, adult alternative measures program, social economic development initiative, interagency approach needed for people with mental health issues seeking employment, abuse helpline in phone book, unresolved issues for people with mental health issues in a medium size community, Child Action Plan issues, advocate for more community resources for people with mental health issues, early psychosis initiative, youth hunger/homeless initiative (total =16)</td>
</tr>
<tr>
<td>Research (total=8)</td>
<td>ongoing research with tenants who have mental health issues, extra-judicial sanctions research project, alternative provincial budget, research needs of shelter users, justice issues for First Nations and Metis peoples (total =5)</td>
<td>Research on housing needs of 50-60 yr. olds, study on homelessness, mental health workforce follow-up (total = 3)</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>TOTAL</td>
<td>43 initiatives (57%)</td>
<td>33 initiatives (43%)</td>
</tr>
</tbody>
</table>

Notes: The names of these initiatives have been modified to protect the identity of the CBOs. Some initiatives may appear to be duplicates, but they are not. Different CBOs in different communities have worked on similar issues. There were more initiatives than these in the transcripts but they are not included here because advocacy volunteers’ roles were not clear. This is not an exhaustive list of all advocacy initiatives undertaken by these CBOs; they were asked to highlight a couple of examples which best explained their advocacy work.

The second main finding that emerged from the 39 transcripts was a collection of advocacy types. Policy advocacy “types” emerged from the analysis of telephone interview data using open and axial coding (Strauss and Corbin 1998). Figure 6.1 offers a conceptualization, a typology, of the interview data. I followed two basic rules for creating typologies (Lofland and Lofland 1995). First, the categories must be mutually exclusive and second, all or almost all, cases should be classified exhaustively (ibid., p. 126). This is how I analyzed and presented these policy advocacy data.
CBOs do front-line service delivery daily; this work informs CBOs of issues and leads to choices regarding advocacy.

Advocacy remained 1-on-1 (never became policy advocacy)

CBO policy advocacy moved forward without marginalized people (N = 14)

CBO policy advocacy moved forward with marginalized people (N = 28)

Single CBO

CBO Coalition/network

CBOs work with government

Self Help CBO

Single CBO

CBO Coalition/network

CBOs work with government

Note: The numbers cited refer to the policy initiatives from Table 6.2.

**Figure 6.1: Typology of social policy advocacy described by 39 CBOs**

Figure 6.1 shows that CBO service delivery work informs their advocacy work (see left side of Figure 6.1). According to CBO1-14, “that’s the opportunity that will always be there as long as we’re involved in direct service delivery … we’ll always have our finger on the pulse” (CBO1-14). The CBOs in this sample delivered social, mental health, development/housing, and law/advocacy services (refer to ICNPO classification in section 1.3). It was from their service delivery work that these CBOs came to see problems as experienced by their program participants, which they thought required
action (see for example CBO1-10). Some CBOs noted their advocacy work began with a crisis (e.g., CBO1-23 described a murder in his neighbourhood, CBO1-20 described a drug house raid by police which brought immediate attention to his community) while others indicated it was the cumulative, repetitive day-to-day issues which led to policy advocacy (CBO1-10, CBO1-12, and CBO1-24).

CBOs stated their social service delivery work led them to decision-making points about their advocacy work. If CBOs saw that the same issue appeared to be occurring with others, then a decision about further action was discussed among the CBO staff and sometimes between CBOs and sometimes in consultation with program participants (as explained in chapter 5). This led to one of three possible actions as shown in the three middle boxes in Figure 6.1: no collective policy action ensued, advocacy moved forward without marginalized people’s participation, or advocacy moved forward with marginalized people’s participation. Marginalized people’s place in advocacy processes was a central feature in this diagram given my critical inquiry orientation.

The series of boxes on the right side of Figure 6.1 show the main types of advocacy work that were pursued as indicated by the collected data. First, some policy advocacy initiatives were pursued without marginalized individuals and included the following types: a) a single CBO picked up an initiative and advocated for change; b) groups of CBOs came together and formed a coalition or network without government participation and were either locally-based or province-wide; and c) a coalition of CBOs began working together at the same table with government representatives on concerns that were either time limited or ongoing. Second, some policy advocacy was pursued with marginalized people involved and included the same types with one key addition –
the addition of self help CBOs which in these data refer to CBOs operated by marginalized individuals with/for marginalized people.

This coding process also led me to develop a series of two-way arrows as shown on the right side of Figure 6.1. Figure 6.1 is a point in time, a snapshot, of what these 39 CBOs were working on; today if we were to undertake the same interviews the data and consequently the figure may not be identical (Strauss and Corbin 1998). These arrows represent the fluidity of advocacy work undertaken by CBOs and show that in reality advocacy is not a static snapshot but rather a series of snapshots, a movie (ibid.). These arrows illustrate how these categories relate to each other and that CBOs choose and alter advocacy types over time – although some CBOs indicated they chose one advocacy type and stuck to it over the duration of their initiative. Strauss and Corbin (1998, p. 128) explain “there are interactions, which are strategic or routine responses [are] made by individuals or groups to issues … that arise under” certain conditions. These influence advocacy work.

In general, CBOs described a number of conditions that affected their decisions to alter their advocacy course. Some examples included: the level of receptivity of government representatives to the issue (CBO1-38); the evolution and degree of acceptance of the issue in the local community (CBO1-37); the processing of the issue within the CBO through staff and volunteers (CBO1-11); and crises (e.g., a murder in a neighbourhood [CBO1-33]) (refer to section 6.3. for conditions that affect advocacy types, strategies and advocacy volunteers’ participation). Policy advocacy appears to run in cycles but seldom are cycles identical (CBO1-16, CBO1-20 and CBO1-30).
Third and finally, CBOs described a variety of advocacy strategies that incorporate marginalized people’s participation into policy advocacy processes. A number of strategies were adopted and none of them appear to be mutually exclusive. At various points in an advocacy process, CBOs will adopt a strategy or collection of strategies and move them forward, but these choices change over time depending on a number of factors or conditions (e.g., crises, degree of acceptance by government) (refer to section 6.3). Across the 39 CBOs, seven strategies were used including: raising awareness, contacting governments (i.e., creating opportunities for interaction between marginalized groups and governments, talking regularly with government representatives, and bringing marginalized groups to city council meetings), conducting research, talking with already-organized marginalized groups and then moving forward, cross fertilizing issues and networking across groups, monitoring governments and making decisions to work on multiple governments simultaneously or one-at-a-time, and finally, pursuing legal or policy enforcement routes. Table 6.3 contains these data along with examples of marginalized people’s involvement. The categories which appeared across the greatest number of CBOs, extensiveness (Strauss 1987), are presented first in the table. These strategies may be done by a single CBO or in collaboration with other CBOs and sometimes government representatives are integrally involved as per Figure 6.1.
Table 6.3: CBO advocacy strategies and involvement of marginalized groups

<table>
<thead>
<tr>
<th>Advocacy Strategies</th>
<th>Examples of marginalized people’s involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a) Generated public awareness (stated by 28 CBOs)</strong></td>
<td>“We developed three videos and they were stories about supported employment … So people with developmental disabilities would talk about what they did…” (CBO1-35)</td>
</tr>
<tr>
<td>Included speaking out on a small scale (e.g., at high schools) or large scale through the media (e.g., newspapers and radio for anti-stigma campaigns) as well as public demonstrations (e.g., marches).</td>
<td></td>
</tr>
<tr>
<td><strong>b) Contact with governments</strong></td>
<td>“Have the meeting with government here, once people come and see who it is that we’re asking for things for, it personalizes it … we actually took the first fellow around and had him meet the people … You get inundated at our place … We have four or five participants that will just immediately be there wanting to have a conversation with you” (CBO1-13).</td>
</tr>
<tr>
<td>Created opportunities for interactions between CBOs, marginalized groups and governments (stated by 24 CBOs)</td>
<td>“He [the mental health consumer] was the one, a meeting would be called and he’d be the one to phone everyone to verify there was a meeting” with government (CBO1-10).</td>
</tr>
<tr>
<td>Included holding large public gatherings like conferences/workshops, CBO annual general meetings, and social events that were meant to be entertaining but carry a message (e.g., multi-cultural festivals). It also included creating space and time for government staff/politicians to “visit” with marginalized groups of people – for example, this was commonly used to give cognitively impaired adults the chance to talk to government as they walked through their workshops or group homes.</td>
<td>“The co-chair of our committee is not associated with any agency, she’s a parent and has had family involvement with sexual assault and victimization … so she and I are both doing that presentation” (CBO1-4).</td>
</tr>
<tr>
<td><strong>CBOs talked regularly with provincial Ministers, city councillors, and senior government staff (stated by 22 CBOs)</strong></td>
<td></td>
</tr>
<tr>
<td>This occurred informally in groceries stores or on the street in small communities, formally through CBO-office-to-government-office, created CBO/government partnerships, and had conversations with opposition parties.</td>
<td></td>
</tr>
<tr>
<td><strong>CBOs brought marginalized people to participate in government meetings (stated by 8 CBOs)</strong></td>
<td></td>
</tr>
<tr>
<td>This included taking marginalized groups of people to city council and the legislature (e.g., Cabinet Days) to tell their stories.</td>
<td></td>
</tr>
<tr>
<td><strong>c) Conducted or participated in research and wrote papers (stated by 22 CBOs)</strong></td>
<td>“They [low income people] helped with the development of the survey for the feasibility study” (CBO1-38).</td>
</tr>
<tr>
<td>Included research conducted by CBOs like action research, researched and wrote anthologies, and did feasibility studies. It also included collecting names on petitions and seeking out best practice models locally, provincially and nationally. CBOs said research got people talking and networking.</td>
<td></td>
</tr>
<tr>
<td><strong>d) Talked with already-organized marginalized groups then moved forward (stated by 16 CBOs)</strong></td>
<td>“We started the anti-poverty parleys. We brought low income people … They talked about their issues … a list of issues … Then we brought every one back together and asked them how we</td>
</tr>
</tbody>
</table>
service system dynamics. should address these things” (CBO1-24)

e) Networked with groups and cross fertilized issues (stated by 10 CBOs)

Cross fertilized issues, for example, this occurred when a CBO took a shelter subsidy problem that was already being pursued in one group to another group that was working on a training allowance problem.

“We all kind of sit on each other’s boards. Of course, I’m on other boards as well and if there’s a big issue … it’s talked about, like at all these different tables, the critical mass” (CBO1-16).

f) Monitored governments and decided multiple or single government approach (stated by 7 CBOs)

As CBOs monitored governments, they then strategized about working on multiple-government departments simultaneously – this required careful consideration of government staff versus elected officials – versus working on a single government or department first and then dealing with another in sequence. It included meeting with Regional Inter-sectoral Committees.

“We actually have a meeting right now with … the assistant deputy ministers at Justice, Learning, Community Resources and I’m missing one, Health. The four ministries, we’ve had initial meetings on coordinating and providing equal access to services for --- throughout the province” (CBO1-25).

g) Chose a legal/policy enforcement route (stated by 3 CBOs)

Chose legal routes – some CBOs took collective problems to the Ombudsman’s Office while others learned about by-laws, and regulations and applied them.

“What we did was we, and that includes residents, understood and used government policies and procedures … regulations under different legislative bodies from health, fire, and city” (CBO1-20).

6.1.2 Perceived participation barriers noted by 39 CBOs

Asking CBOs about barriers to marginalized people’s participation offers us a glimpse into their perceptions of marginalized people and their environment. Based on open and axial coding (Strauss and Corbin 1998), CBOs talked about seven main barriers including psychological barriers, practical supports, survival issues, disabilities, language and culture, lack of awareness and skills, and structural barriers. Table 6.4 shows a summary of these barriers. The categories which appeared across the greatest number of CBOs are presented first in the table (i.e., extensiveness across CBOs not within all CBOs). Six of the seven barriers focus on what defines marginalized populations. Only a few of the CBOs talked about structural barriers that are created by governments and CBOs that reduce the opportunity for people’s participation.
Table 6.4: Perceived participation barriers noted by 39 CBOs

<table>
<thead>
<tr>
<th>a) Psychological barriers (stated by 28 CBOs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>These appeared to be directly related to people’s experiences of constantly being put down (e.g., “poor bashing”, “crazy person”). There were five main types of psychological barriers described by the CBOs:</td>
</tr>
<tr>
<td>- “fear” about participating in advocacy because of threats from government staff and employers including fear of losing their welfare cheque, losing their children, or losing their jobs</td>
</tr>
<tr>
<td>- sense of hopelessness and powerlessness to change anything; nothing ever changes</td>
</tr>
<tr>
<td>- feelings of inadequacy, lack confidence, lack self esteem, lack comfort level</td>
</tr>
<tr>
<td>- sense of isolation psychologically in meetings and physically in neighbourhoods</td>
</tr>
<tr>
<td>- feeling stigma and discrimination; people labelled negatively by society and do not want to be exposed publicly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>b) Practical support barriers (stated by 24 CBOs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Including lack of transportation, lack of money, lack of child care, lack of decent clothing to wear to meetings and lack of access to technology like a computer to stay connected to email messages.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>c) Survival barriers and lack of time (stated by 19 CBOs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>These include marginalized people’s struggle to survive on a daily basis including finding food and shelter, crowded living arrangements, too many crises and repeated trauma (e.g., suicides in communities), which means there is little energy left to do advocacy. It was also noted that policy advocacy takes a long time and there is a risk of burn-out; some people cannot commit to long periods of time.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>d) Disability barriers (stated by 14 CBOs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three main barriers were described – physically inaccessible buildings where meetings take place, cognitive disabilities which lead to people’s inability to comprehend issues, and psychiatric disabilities which includes episodic illnesses that take an advocacy volunteer away from an initiative for a few months.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>e) Language and culture barriers (stated by 12 CBOs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occur when there are no sign language interpreters at meetings for people who are deaf, when there are no translators for people whose first language is not English, or when a First Nation person’s issue is mislabelled and mishandled because of cultural misunderstanding.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>f) Awareness, knowledge and skills barriers (stated by 7 CBOs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>These barriers included people’s lack of awareness about what is going on, as well as a lack of knowledge and understanding about how to tackle issues</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>g) Structural barriers (stated by 7 CBOs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structural barriers are those imposed by governments and/or CBOs including not inviting people to meetings, meetings are too formal/professional resulting in people feeling awkward and/or intimidated, governments perceive CBO voices are a substitute for marginalized voices, and governments have their own inter-departmental problems. In a few cases, CBOs said their funding contract with governments prohibited them from doing advocacy.</td>
</tr>
</tbody>
</table>

6.1.3 Opportunities to enhance participation noted by 39 CBOs

CBOs were also asked about the opportunities they pursued in an effort to reduce these barriers and enhance people’s participation. The 39 CBOs offered a collection of
responses that were coded into four main categories. These categories included offering reassurance and encouragement to speak out, offering practical supports and teaching about advocacy, offering guidance and coaching people in the process, and doing outreach to connect with others. Table 6.5 presents a summary of these data. The categories which appeared in the greatest number of CBOs are presented first. Taken together two of the most commonly cited categories, reassurance and encouragement as well as offering guidance and coaching, appear to focus on one of the most challenging barriers listed above – psychological barriers.

Table 6.5: Opportunities pursued to enhance participation noted by 39 CBOs

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of CBOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Reassured/encouraged marginalized people to talk together and speak out (stated by 22 CBOs)</td>
<td></td>
</tr>
<tr>
<td>CBOs talked about the need to explain the benefits of getting involved in advocacy work, the need to reassure and comfort people, encouraged marginalized people to voice concerns in their small groups of peers and then go public, for example by talking with the media. It was explicitly noted by some CBOs that public meetings and discussions are well suited for First Nations people’s to share stories because of their oral traditions.</td>
<td></td>
</tr>
<tr>
<td>b) Offered practical supports and taught about policy advocacy (stated by 20 CBOs)</td>
<td></td>
</tr>
<tr>
<td>Included money or bus passes for transportation, gave people rides to meetings, provided child care, organized meet-and-eat meetings, arranged to have interpreters at meetings and ensured meetings were held in different communities. It also included honoraria for participation and access to technology for people who were deaf/hearing impaired. Learning opportunities were also cited and included helping people to become more aware. Some CBOs explained they provided a comfortable meeting place.</td>
<td></td>
</tr>
<tr>
<td>c) Offered guidance and coaching (stated by 17 CBOs)</td>
<td></td>
</tr>
<tr>
<td>Coached people that they can do it, started small, developed teamwork and networking approaches, when many people talked together it became part of a healing journey (e.g., First Nations women), pointed out ‘strength in numbers’ because there is less chance of government targeting a group.</td>
<td></td>
</tr>
<tr>
<td>d) Did outreach to connect with others (stated by 5 CBOs)</td>
<td></td>
</tr>
<tr>
<td>Outreach to residents and others with similar issues was cited. Communication within neighbourhoods, and through the media and newsletters were noted.</td>
<td></td>
</tr>
</tbody>
</table>

Once again, we are reminded about the dynamic and inter-connected nature of some of these processes. For example, the following quote draws attention to a CBO
getting people together, having people talk about their experiences, which open other people up to talk, which can then lead to action.

“Well I mean what happens is, once people start talking about their own experience then it encourages other people to open up and talk … the frustration with the schools and how their hands were tied, we had another lady who had dealt with a domestic violence case, she talked about her frustration in dealing with the police and feeling that the police were ill equipped to deal with her domestic violence situation and that led to … more disclosures and more discussions so what ends up happening, what the opportunity is people get to tell their story. From their story … we as a community need to respond” (CBO1-4).

6.2 Advocacy process based on the Coalition case study

6.2.1 Coalition advocacy process

Research question #4 asks, what were the experiences and perceptions of marginalized people, CBO staff and government regarding a local social policy advocacy coalition process? The data presented here answer this question. The Coalition case study chosen is an example of a local social policy advocacy process – an “issue advocacy campaign” (McCarthy and Castelli 2001) - that began with CBOs, government and marginalized people as shown in the bottom, right side box in Figure 6.1. Over time however, government staff left the process and ceased to be active members. It was through the inputs-processes-outputs-outcomes/impacts frame that I interviewed people about their experiences and perceptions of this advocacy process. This approach aided interviewees’ memory to re-create their story. I only briefly cover inputs and outputs here because they are not salient components of my research. My main focus was on processes and outcomes (as per Figure 3.1 in section 3.3 in the methodology chapter); the outcomes/impacts component is presented in chapter 7.
I began by analyzing the data collected from the Coalition’s files and then examined interview data. The Coalition’s files were generated over the history of its work to advocate for a new policy with a municipal government and inspire the creation of a new funding relationship between the municipal government and the provincial government. I adopted Lofland and Lofland’s (1995, p. 134) “tracing back” technique to create a summary; this technique helped me to re-create the sequence of events and processes that taken together, is the Coalition’s story. Yin (2003) refers to this approach as a type of chronological “time-series analysis” (p. 125). The contents of Coalition files were put in chronological order in order to re-create the story (Methodological Notes April 25, 2007); content analysis was used to summarize and explicate the material (Titscher et al. 2005). Coalition members’ interview data were also coded and categorized and used to aid in the re-creation of the Coalition’s advocacy story. Figure 6.2 tells this story.

In a multi-method project of this nature with many voices, I was concerned about ensuring the most marginalized voices would be heard given my critical inquiry approach. It was during this phase of my research that I re-labelled the marginalized Coalition members; they became advocacy volunteers because this label denoted a more active and engaged group of people than “marginalized” (Analytic Notes February 27, 2007). I decided to elevate the advocacy volunteers’ and CBOs’ voices above the governments’ because often their voices are suppressed (Kirby and McKenna 1989). Thus the Coalition’s story is told from the perspective of the advocacy volunteers and CBOs.
**Figure 6.2: Coalition’s advocacy story**

**Dynamic Context**
Provincial Government Community Development Division downsized over time, resistant government staff left job, governments’ budgets and economic issues dominate, city had advisory committee on this policy, other coalitions active in community, CBOs do not speak out because fear funding cuts, different levels of government have different mandates and pay for different programs, CBOs not sure if advocacy is allowed/not allowed, government elections and change in players.
I begin with inputs to the Coalition’s advocacy work process. The process began in 1999 with a few people involved including a provincial government staff person and some CBO staff. By 2001 there were approximately 25 active members including advocacy volunteers, CBOs, faith communities and governments. Advocacy volunteers who were interviewed said there were five main inputs that seemed to help the Coalition get started and move ahead in 2000-2001. These were a) a CBO staff person and a provincial government staff person got the Coalition started; b) research was done in classes at University of Regina; c) Coalition members had energy, commitment, skills, sense of community, and knowledge; d) some government representatives were supportive of the Coalition’s goals (e.g., a city councillor explained what was achievable, a provincial government staff ensured meeting minutes were done) and e) there was always a no-cost place for the Coalition to meet (e.g., food bank or a downtown Church). These inputs were also found in the CBO transcripts. Similar inputs were found in the government transcripts, although there was not as much detail.

As shown in the middle of Figure 6.2, the Coalition implemented nine advocacy strategies between 1999 and 2005. These were processes which Coalition members generated and participated in, in order to convince the city and the province to say yes to their policy request. The data indicate advocacy volunteers participated in all of these strategies. These strategies were mentioned by more than one Coalition member; this list reflects what was stated first by advocacy volunteers, then CBO staff and finally by government representatives. In instances where a Coalition member stated something had occurred, but I could not verify it through other transcripts or the Coalition’s files, it was not included. These nine strategies were similar to the collection of strategies explained
by the 39 CBOs in section 6.1.1. The nine categories of strategies\textsuperscript{78} included: conducted research (e.g., a survey of people to be impacted by the policy change was done, LICO was studied); generated public awareness (e.g., handed out flyers on buses, hung posters in public places, participated in radio talk shows); held regular Coalition meetings/emails/phone conversations which helped a diverse group of Coalition members stay connected to each other and stay on top of issues requiring attention; formed an all-volunteers’ group to re-mobilize efforts when the process stalled; held public gatherings with open meetings for residents to attend; talked with people who would be impacted by the policy change and gathered testimonials; interacted with governments (i.e., government representatives were invited to Coalition meetings to hear their perspective, Coalition members attended government meetings like city council, and Coalition members regularly visited government representatives to explain their perspective); the Coalition monitored municipal and provincial governments simultaneously; and finally, networked and linked across CBOs and groups and cross-fertilized issues (e.g., Coalition members took their policy issue to other community meetings to spread the word, talked about the issue at social gatherings).\textsuperscript{79} Coalition participants explained they did not create a rigid plan of action but rather, met regularly to make strategic decisions depending on conditions in their environment (Vol-42, Vol-45).

It is important to pause for a moment and draw attention to the formation and existence of the advocacy volunteers group that worked to re-mobilize efforts when the

\textsuperscript{78} Legal work as described in 6.1.1 was not part of the Coalition’s advocacy work.

\textsuperscript{79} This appeared to be an easy task for advocacy volunteers in particular because all six of them were involved in more than one advocacy coalition (Analytic Notes June 1, 2007). This group crossed a number of boundaries and did not seem constrained in the way that CBOs and governments were in their silos (Analytic Notes Aug. 6, 2007).
process stalled. This group comprised people on low incomes and/or people with disabilities. This would be considered a residual case (Lofland and Lofland 1995) because it was only mentioned by two advocacy volunteers and one CBO (Vol-40, Vol-45, CBO2-54). However, its formation and existence for five months is significant for two reasons. First this group was formed because advocacy volunteers believed the advocacy process had stalled and they were anxious to re-energize and re-mobilize the policy change process (ibid.). Second, it shows that advocacy volunteers’ had a sense of power and motivation to push the policy issue (ibid.).

These were the Coalition’s advocacy strategies. However, there were also data which indicated the governments had their own strategies. These data are presented as “behind-the-scenes” activities going on in the cloud-like shape in Figure 6.2 because this was the way advocacy volunteers and CBOs described government strategies. Thus the Coalition’s strategies were drawn at the front while governments’ work is behind-the-scenes. While the Coalition was busy doing its work, governments were doing their work including negotiating with each other especially regarding a new funding relationship (GOV-48), using cross-government personal friendship links (GOV-49), building inside-government support for the policy (GOV-47), and doing research on what policy option was financially viable (GOV-51).

An issue emerged from the CBO and advocacy volunteers transcripts regarding this behind-the-scenes government activity. Some interviewees stated there had been some kind of government take-over of their process (Vol-40, Gov-47, CBO2-53). One CBO referred to it as a “hijacking”:
“At one point in the process, it really felt hijacked somewhere along the way. Somewhere the two governments had a conversation … about this and decisions were made outside the context of the Coalition. They never came to us and said, you guys have been pushing this for a long time and I think we’re willing to work together with all of you to sort this out. This was instead the sort of conversation that would have happened at the Mayor’s office … … That wasn’t done through the format of the Coalition the way we had been operating up to that point … … and not once has the work of the Coalition been credited.” (CBO2-52)

This confirms there was a sense of ownership of the advocacy process by both advocacy volunteers and CBOs. It was the Coalition’s process and the government appeared to have taken it away from them.

A number of outputs were noted in the 17 transcripts and the Coalition’s files. These included more than 500 flyers distributed on buses and other public places as well as at least 1400 flyers in food hampers, more than 100 testimonials sent to city council, eight presentations at city committees and council, a phone campaign that had at least 100 calls made to city hall, letters sent to the Mayor and provincial Minister, two radio talk shows, and 20 newspaper articles and letters to the editor. The final policy adopted included people on provincial social assistance, but excluded people on federal social assistance, many working poor and people with disabilities.

Finally, the context upon which the Coalition’s work unfolded shifted between 1999 and 2005 as described in the interview transcripts and the Coalition’s files. Within the provincial government, the Community Development Division was downsized over that period. Within the municipal government, resistant staff left and budgets and economics dominated agendas. Also municipal government had an advisory committee on the same policy area for which the Coalition was active. Different levels of governments argued about who was responsible for what and who should be paying for
what. There were a number of other coalitions that were active in the local community. Some CBOs were worried about funding cuts if they spoke out and they also were not sure about whether they were permitted to speak out publicly. Finally, there were municipal elections which resulted in a change of elected officials and support base.

6.2.2 Perceived participation barriers noted by Coalition participants

An interview question posed to the advocacy volunteers was “what things prevented or discouraged you from participating in the work of the Coalition … or said another way, what barriers did you have to deal with?” A similar question was posed to the CBOs and government staff, but the focus was on their perceptions of advocacy volunteers; “what barriers surfaced to prevent low income or disabled people’s participation”? Once again I completed open and axial coding on the 17 transcripts. I coded the advocacy volunteers’ transcripts first and used those categories as the foundation by placing them in the left hand column of Table 6.6; the most frequently cited categories across volunteers were listed at the top. Then I coded the other transcripts and placed them across from the advocacy volunteers’ items. This process of collecting data from different groups of people about the same phenomenon in order to better understand it is known as triangulation (Marshall and Rossman 2006; Yin 2003).

Table 6.6 presents a summary of the data findings and in general, included barriers within the Coalition (e.g., personal issues, interpersonal dynamics, differences of opinion, different skills levels), government representatives and other structural barriers, psychological barriers (e.g., beaten down, fear), composition of the Coalition, survival issues (e.g., life is complicated for some people), lack of practical supports, and the
process took too long, thus some people left the process. All three groups identified three similar categories: within the Coalition and individual barriers; structural and government barriers; and psychological barriers. As well, the CBO list shows remarkable similarities with the advocacy volunteers, thus reinforcing the finding that CBOs are knowledgeable about advocacy volunteers.

It is essential to remember another context. It is the context within which some of the advocacy volunteers live. The following offers the essence of an advocacy volunteer’s context - someone who lives on social assistance.

“You see it’s hard to define it. You get used to being … no matter how well you take care of yourself on welfare, many people can’t do it all. All the people I know who live on welfare hate it because they just don’t have a life. They just know they got some money and they go out and spend it and live in a ditch the rest of the time … psychologically” (Vol-44).
### Table 6.6: Participation barriers noted by Coalition participants

<table>
<thead>
<tr>
<th>Advocacy volunteers stated barriers</th>
<th>CBO staff stated barriers</th>
<th>Government representatives stated barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Within the Coalition</strong> - personal issues like health problems; interpersonal dynamic issues including aggression and bickering; and differences of opinion, primarily between CBOs and advocacy volunteers. Skills barriers like running meetings were also noted.</td>
<td>Individual members - some members were uncomfortable with other members’ advocacy approaches, individual personalities, emotional states, lack of motivation and skill levels which inhibited their participation.</td>
<td>Individual members – extreme emotional reactions set up walls in meetings and lack of skills. <strong>Coalition inflexibility</strong> - could not adjust to the governments’ solution because result was people with disabilities excluded from policy decision</td>
</tr>
<tr>
<td><strong>Government representatives</strong> - the two main issues included: the poor manner in which government representatives treated Coalition members; and governments’ attempts to control people’s behaviour (e.g., a city councillor yelled at Vol-45 for joining another coalition)</td>
<td>Structural barriers - Election cycles and changes in government can mean losses in advocacy gains; culture of meetings can be intimidating; CBOs perceptions (e.g., involving marginalized “makes it harder to do things” [CBO2-55]).</td>
<td>Structural barriers - existing government policies and procedures are barriers, government meetings can be intimidating (e.g., City Council meetings) Coalition lacked awareness and understanding about government bureaucracy and not enough consciousness raising</td>
</tr>
<tr>
<td><strong>Psychological barriers</strong> due to welfare system – sense of hopelessness, fear/danger (e.g., “I should be careful …somebody might be listening” [Vol-43 and Vol-44], lack of confidence (Vol-45), have no life and live in a psychological ditch (Vol-44)</td>
<td>Psychological - including fear of repercussions for people living on low incomes and low self esteem.</td>
<td>Psychological - lack of will, fear speaking out, feeling beaten down, “suffering” (Gov-47)</td>
</tr>
<tr>
<td><strong>Composition of coalition</strong> – some thought it was too diverse while others thought there was not enough diversity in membership and that it needed more First Nations involvement</td>
<td>Perceptions of the Coalition - including it was not open enough to poor people and people could not see a role for themselves</td>
<td><strong>Perception of coalition</strong> - lack of openness to poor people.</td>
</tr>
<tr>
<td><strong>Survival issues</strong> – for example, “a lot on my plate” (Vol-42) and not enough time</td>
<td>Survival issues and complicated lives were stated as barriers for people with low incomes or disabilities (e.g., volunteering is too taxing for poor people).*</td>
<td><strong>Survival issues</strong> and complicated lives were barriers for people with low incomes or disabilities (e.g., volunteering is too taxing for poor people).*</td>
</tr>
<tr>
<td><strong>Practical supports</strong> – transportation, especially paratransit was an issue</td>
<td>Practical supports – for example “its easier being a middle class advocate than a low income advocate”, lack of transportation.</td>
<td>Practical supports – for example “its easier being a middle class advocate than a low income advocate”, lack of transportation.</td>
</tr>
<tr>
<td>Advocacy process took a long time – some people left, at times there was nothing happening.</td>
<td>Advocacy takes a long time – length of time was huge, lots of back and forth with government</td>
<td><strong>Took a long time</strong> to get governments to agree to policy, some people dropped out of the process (i.e., it took years)</td>
</tr>
</tbody>
</table>

Note: * He went on to say, “I’m not as romantic about it as I once was because I know the realities of people’s lives given the work we do out of our office, we recognize that for a lot of low income folks, it’s a pretty heavy expectation … to expect people to become their own advocate and join movements because there are other significant issues going on in their lives” (CBO2-54).
6.2.3 Opportunities to enhance participation noted by Coalition members

Another interview question posed to the advocacy volunteers was “What things seemed to make it easier for you to participate and get more involved in the Coalition?” A similar question was posed to the CBOs and government staff, but the focus was on their perceptions of the advocacy volunteers; “what opportunities did you pursue in an effort to increase marginalized people’s participation in the work of the Coalition?” Once again I completed open and axial coding on the 17 transcripts. I coded the advocacy volunteers transcripts first and used those categories as the foundation placing them in the left hand column of Table 6.7 (Yin 2003). Then I coded the other transcripts and placed them across from the related items. This process of collecting data from different groups of people about the same phenomenon in order to better understand it is known as triangulation (Marshall and Rossman 2006). Table 6.7 presents a summary of these findings and in general, includes practical assistance, encouragement, beliefs, diversity of choices regarding the work to be done, took initiative to re-energize, attracted to others’ conviction, supportive governments, and family/friends.

The list of items generated by the advocacy volunteers was longer than those generated by CBOs or the governments. Advocacy volunteers offered more detail about their perceptions than did CBOs or governments because they were speaking from personal experiences. For example, a CBO or government representative would not necessarily have known that an advocacy volunteer had received psychological support through a family member who regularly phoned and encouraged her/him to stay involved.
Table 6.7: Opportunities pursued to enhance participation noted by the Coalition

<table>
<thead>
<tr>
<th>Advocacy volunteers stated opportunities</th>
<th>CBO staff stated opportunities</th>
<th>Government staff stated opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Practical assistance</strong> like giving people rides to meetings and having food at meetings</td>
<td><strong>Practical supports</strong> - accessible &amp; comfortable meeting space at the food bank, people were offered rides to meetings</td>
<td><strong>Practical supports</strong> included an accessible city hall and Coalition members could get around on paratransit</td>
</tr>
<tr>
<td><strong>People were encouraged</strong> to join and talk at meetings, get involved, brought other disabled people’s issues to meetings, important to talk about issues</td>
<td><strong>People were encouraged</strong> - created a sense of hope which attracted people to Coalition &amp; marginalized members were encouraged to speak at meetings, as well, everyone’s contributions were respected and valued</td>
<td><strong>Beliefs</strong> - saw Coalition very strong in their beliefs</td>
</tr>
<tr>
<td><strong>Beliefs</strong> including: a belief things will change and a sense of optimism; a belief their knowledge was important for creating better policy; belief in helping others by doing this advocacy work</td>
<td><strong>Beliefs</strong> - saw Coalition very strong in their beliefs</td>
<td><strong>Coalition had skills</strong>, strengths and strong people</td>
</tr>
<tr>
<td><strong>Diversity of choices</strong> regarding the work and tasks to be done, matched tasks with people’s skills/capabilities</td>
<td><strong>Diversity of choices</strong> regarding the work and tasks to be done, matched tasks with people’s skills/capabilities</td>
<td><strong>Diversity of choices</strong> regarding the work and tasks to be done, matched tasks with people’s skills/capabilities</td>
</tr>
<tr>
<td><strong>Took initiative to re-energize</strong> the Coalition when there were lulls (formed a new group comprising just those people affected by the policy)</td>
<td><strong>Took initiative to re-energize</strong> the Coalition when there were lulls (formed a new group comprising just those people affected by the policy)</td>
<td><strong>Took initiative to re-energize</strong> the Coalition when there were lulls (formed a new group comprising just those people affected by the policy)</td>
</tr>
<tr>
<td><strong>Attracted to others in the Coalition</strong> because of their energy and conviction</td>
<td><strong>Attracted to others in the Coalition</strong> because of their energy and conviction</td>
<td><strong>Attracted to others in the Coalition</strong> because of their energy and conviction</td>
</tr>
<tr>
<td><strong>Government representatives</strong> - provided practical and psychological support at various points during the process.*</td>
<td><strong>Government representatives</strong> - provided practical and psychological support at various points during the process.*</td>
<td><strong>Government representatives</strong> - provided practical and psychological support at various points during the process.*</td>
</tr>
<tr>
<td><strong>Family/friends</strong> – provided psychological support, listened</td>
<td><strong>Family/friends</strong> – provided psychological support, listened</td>
<td><strong>Family/friends</strong> – provided psychological support, listened</td>
</tr>
</tbody>
</table>

Note: * Government representatives were seen to be both helpful and unhelpful to the Coalition. It depended on who the Coalition member was talking about (e.g., some elected municipal officials were not at all helpful while some provincially elected officials were very supportive), where they were in the advocacy process, and what tasks/work they were doing. Thus, results presented here do not contradict the results presented in Table 6.6.
6.3 Conditions that appear to affect advocacy

Social policy advocacy initiatives have life cycles within which strategies and people’s participation are multiple and fluid over time; they are not static entities (sections 6.1 and 6.2). This section presents a brief description of the multiple and fluid conditions which appear to affect advocacy types, advocacy strategies and advocacy volunteers’ participation. The list of conditions presented in Table 6.8 is based on the data and codes from the CBO phone interviews and the Coalition interviews. I found these conditions by stepping back from my analysis and doing a scan of all the codes and categories and re-reading corresponding segments of transcripts in search of patterns (Alvesson and Sköldberg 2000; Yin 2003). The key finding was there are diverse combinations and interactions of conditions which affect advocacy processes.

These conditions affect advocacy generally and volunteer participation specifically, but not always in the same way or direction. For example, in one community a women’s shelter CBO encouraged women’s participation in advocacy processes (CBO1-4) while in another similar size community, a women’s shelter did not engage women (CBO1-5). Table 6.8 presents a summary of these conditions by sphere including individuals, communities, CBOs, and governments (Labonte et al. 2002).
Table 6.8: Some conditions affecting advocacy types, strategies and volunteers

<table>
<thead>
<tr>
<th>Spheres</th>
<th>Description of conditions which appear to affect advocacy types, strategies and advocacy volunteer participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Psychological and personal survival issues, for example, sense of hopelessness and fear (Vol-44), or strong belief in making change (Vol-42), and too many crisis in one's life (CBO1-16)</td>
</tr>
<tr>
<td></td>
<td>The existence of practical supports, for example, free bus tickets or transportation to meetings for people on low incomes (Vol-41)</td>
</tr>
<tr>
<td></td>
<td>The diversity of choices about tasks to be done and whether advocacy volunteers believe they have the capabilities (Vol-40).</td>
</tr>
<tr>
<td>Community</td>
<td>The size of the community and visibility of the issue, for example, in a small town, people watch out for the people with disabilities (CBO1-17)</td>
</tr>
<tr>
<td></td>
<td>Community values/ideology, for example, who is deserving and undeserving of social services like people on social assistance they may not speak out because they are then exposed (CBO1-38).</td>
</tr>
<tr>
<td></td>
<td>Location of the community (north/south), for example, northern communities have long distances to travel for advocacy meetings and to confront government (CBO1-3)</td>
</tr>
<tr>
<td></td>
<td>A crisis in a community, for example, a murder in a neighbourhood may occur which results in a CBO taking a visible and public stand to advocate for three levels of government intervention to create a safer neighbourhood (CBO1-33)</td>
</tr>
<tr>
<td>CBOs</td>
<td>The number and types of CBOs in a community or region affect advocacy coalition building, for example, some CBOs are the only ones in their community (CBO1-5)</td>
</tr>
<tr>
<td></td>
<td>The size of the CBO in terms of its financial resources, number of staff and staff skills (CBO1-36)</td>
</tr>
<tr>
<td></td>
<td>The CBO’s history in the community regarding credibility, for example, a women’s shelter with a public history of excellent service to women who have experienced intimate partner violence and who advocate publicly for a specialized domestic violence court will be perceived positively (CBO1-37)</td>
</tr>
<tr>
<td></td>
<td>The CBO’s philosophy regarding marginalized people’s engagement and client empowerment – for example, one women’s shelter stated they would not re-victimize women by engaging them in public advocacy work (CBO1-5) while another women’s shelter in another community said women are engaged in policy advocacy (CBO1-4)</td>
</tr>
<tr>
<td>Government</td>
<td>The government staff and government department involved and their level of receptivity to the issue (Vol-45)</td>
</tr>
<tr>
<td></td>
<td>Government funding, for example, at least one CBO signed an agreement with a government agency to not engage in advocacy as a condition of funding (CBO1-18) and “I think about the ---, they had their funding cut because they were too noisy, yet they made valuable contributions to city discussions and … public policy” (Gov-48).</td>
</tr>
<tr>
<td></td>
<td>Political party in power, for example, people have been waiting patiently for 15 yrs for the provincial NDP to do the right thing, thus they have not advocated through large scale demonstrations (CBO1-21 and CBO1-24)</td>
</tr>
<tr>
<td></td>
<td>Advocacy is allowed/not allowed, for example, &quot;governments really are in place to listen to people and their issues - this kind of activity should be part of our everyday lives“ (Gov-48), we are a system that allows advocacy to happen - not that it’s easy though (Gov-50), but do not forget about the 10% rule imposed by the government (CBO1-28)</td>
</tr>
</tbody>
</table>
6.4 Discussion

This chapter focused on advocacy processes. In this section, I summarize the data results using method triangulation and integrate relevant literature. I offer observations about these results from a critical inquiry perspective. The following five areas are presented in this section: advocacy work in general; participation and exclusion; conditions are multiple and fluid; experiences of advocacy processes; and power-over and power-with concepts.

6.4.1 Advocacy types, strategies and volunteers

This section focuses on advocacy types, advocacy strategies and the participation of advocacy volunteers. First, the literature presented in section 2.3.4, showed that CBO advocacy could focus on government policies, programs, research and individual clients (Boland, Bartron, and McNutt 2002; Jansson 1999; McCarthy and Castelli 2001; Neufeldt 2003; Sheldrick 2004). These forms of advocacy were found in the 39 CBOs’ interview data as shown in Table 6.2.

Second, the advocacy strategies presented in section 2.3.6 included direct contact with governments, media advocacy, confrontation strategies, research, monitoring, and legal approaches (Brooks 2001; Cohen, de la Vega, and Watson 2001; D'Aubin 2003; Dobson 2003; Fox 2001; Hick and McNutt 2002b; McCarthy and Castelli 2001; McNutt 1999; Peters 2003). Across the 39 CBOs, similar strategies were noted and included the following seven: raised community awareness, created opportunities for contact with governments (e.g., talked daily with government staff), conducted research, talked with already-organized marginalized groups and then moved forward, cross fertilized issues
and networked across groups, monitored government activities, and pursued legal/policy enforcement strategies.

Third, the 39 CBOs used strategies that may or may not have involved marginalized people. Of the 76 policy, program and research advocacy initiatives, 42 (57%) focused on policies. If we examine just the 42 policy advocacy initiatives, 28 (67%) of them involved marginalized people.

As a result of this finding, I further analyzed the data about advocacy types and created a typology of policy advocacy, Figure 6.1, using this marginalized group of people as a key variable because I was most interested in their participation given critical inquiry. I discovered there were a number of types of advocacy; some CBOs embark on advocacy by themselves, some create or join coalitions/networks of CBOs and individuals while others create groups involving CBOs and governments that work together. In each of these instances marginalized individuals may or may not be active participants. At the outset of my data collection I had hypothesized that most policy initiatives would involve marginalized groups (Analytic Notes May 27, 2004). The analyzed data showed that approximately one third of the policy initiatives did not include marginalized communities at that point in time. To understand this further, let us now turn to a deeper examination of participation and exclusion.

6.4.2 Participation and exclusion

I began my research with the following definition: policy advocacy consists of those purposive efforts of CBOs to change specific existing or proposed government policies in collaboration with groups of marginalized people (Ezell 2001). Twenty-three
of the 39 CBOs stated marginalized people were involved in their policy advocacy work. Thus, 59% of the CBOs interviewed involved marginalized people while the remaining 16 CBOs (41%) said they did not in the advocacy examples they cited.\textsuperscript{80} This key finding led me to think about participation and lack thereof in advocacy work. Participation is a dimension of social justice (Fraser 2003; Hofrichter 2003a; Mullaly 1997), of social policy advocacy (Harvie 2002; Rektor 2002), of governance (Hancock, Labonte, and Edwards 2000; Jenson 2001; Phillips 2001b) and may have positive impacts on people’s health/well-being (Abelson et al. 2003; Labonte and Edwards 1995).

Based on the collected data, it is apparent that some CBOs ‘speak for’ marginalized people and do not engage them in policy advocacy work (CBO1-1 and GOV-47). From a critical inquiry perspective, when CBOs do this, they reinforce the exclusion and silence of marginalized groups – CBOs can actually act as a substitute for marginalized people. This is further reinforced when governments prefer to deal with CBOs directly and not marginalized groups (CBO1-21 and Gov-49) or governments treat volunteers badly (CBO1-24). Thus, depending on how advocacy is operationalized by a CBO, it can create exclusion and non-participation – an antithesis of social justice, good governance and health/well-being.

In the Coalition case study though, advocacy volunteers were integrally involved in all the strategies undertaken (section 6.2.1). However, even more compelling was the finding that a group of advocacy volunteers formed another group which attempted to re-energize and mobilize the advocacy effort when it stalled. Thus, this group of volunteers

\textsuperscript{80} I have already noted we cannot say definitely that marginalized people were not included because some of the interviewees may not have disclosed to me their marginalized life history.
took the initiative to encourage participation and control the direction of the advocacy effort.

In closing, taken as a whole, the 39 CBOs and 17 Coalition participants provided evidence they were actively advocating and changing policies. They talked about their advocacy stories and their successes but they also talked about risks to marginalized individuals and CBOs. The data show that a majority of CBOs encouraged marginalized people’s participation while others did not. These CBOs’ choices appear to depend on a number of conditions. It is these conditions to which we now turn.

6.4.3 Conditions are multiple and fluid

Social policy advocacy initiatives have life cycles within which strategies are multiple and fluid over time; they are not static entities (section 6.1). Thus labelling an advocacy initiative one thing and not another is problematic. At any moment in time, an initiative may be driven by a CBO coalition but then transformed into a round-table with government involvement. We are reminded of Kincheloe and McLaren’s (2005) point – advocacy processes can be viewed like a flowing river “in which the exact contents of the water are never the same” (p. 319).

There are many conditions which affect types and strategies, CBOs’ decision-making and volunteers’ participation. “Conditions … shift and change over time, affect one another, and combine in various ways … and there may be new ones added along the way” (Strauss and Corbin 1998, p. 131). Some of these conditions may reinforce exclusion and silence, while the same conditions for another group of CBOs in another community may result in the opposite. The key finding is there are diverse combinations
and interactions of conditions which affect advocacy processes; there are “multiple and diverse patterns of connectivity” but it is not “possible to discern all the possible connections among conditions” (Strauss and Corbin, p. 188).

In closing, advocacy processes can encourage talk or silence among marginalized people depending on how CBOs perceive and work with these conditions as well as government and community receptivity. It is clear that some people living in poverty will volunteer but not others, some people with disabilities will volunteer but not others and some sexual assault victims will volunteer, but not others. Given the exploratory nature of this study, it is not possible to discern clear patterns. However, based on the data analyzed in this chapter regarding barriers, opportunities and other conditions, some predictors of marginalized people’s participation may include: individuals’ sense they have a contribution to make and that things can be changed; they have not been put down by ‘the system’ and thus are not fearful of governments; they are not buried in survival struggles; there are practical supports for participation (e.g., accessible meeting rooms); they can choose tasks to do for which they know they are capable; and they are encouraged and coached along the way. This is the multiplicity inherent in fluid advocacy processes.

6.4.4 Experiences of an advocacy process

Before leaving this chapter, let us briefly examine a summary of what happens inside advocacy processes using the Coalition case study data from section 6.2. This stepping back, re-visiting and further exploring of the Coalition’s data from a different angle can give us further insight into the complexity of advocacy volunteers’ experiences.
and perceptions (Analytic Notes Aug. 13, 2007) (Kirby, Greaves, and Reid 2006, p. 235-237). Figure 6.3 shows the original model that was presented in chapter 2, with the addition of the data from the advocacy volunteers, labelled “the up side”, opportunities, (from table 6.7) and “the down side”, barriers (from table 6.6) of participating in advocacy work. I chose a list of verbs which best represented these advocacy volunteers’ data in order to make the advocacy process come alive. For example, in Table 6.7 regarding opportunities, practical assistance was listed. This included food at meetings and rides to meetings. I simply re-framed food as “eating” and rides as “getting rides” in Figure 6.3.

Figure 6.3: Outcomes/impacts model with a focus on the process component
6.4.5. Power-over and power-with-others

I began this study with an understanding of and a pre-occupation with government-CBO relations, and in particular, the power and control which governments exert over CBOs (section 2.2.3). Critical inquiry is based on theory that “keeps the spotlight on power relationships within society so as to expose the forces of hegemony and injustice” (Crotty 2003, p. 157). Indeed, as already shown in the literature review and data in chapter 5, there are data from the CBOs from across the province presented in this chapter which show CBOs’ advocacy behaviour is affected by governments. Governments control CBOs financial resources and expect certain behaviour from these CBOs, thus essentially, controlling CBOs (Grabb 2007). This is known as “power-over” and is often exerted by governments (Nozick 1992).

There are examples in these data collected from the 39 CBOs and Coalition participants that indicate “power-over” occurs between other groups too, namely between governments and advocacy volunteers. It appears governments exert power-over people who receive social assistance when they threaten them with taking away their welfare cheques or having their children apprehended if they engage in advocacy work (section 6.1.2).

Critical inquiry helped me to see yet another area of “power-over”, which I had not expected at the outset of my research. CBOs may exert power-over marginalized groups (Analytic Notes, May 27, 2004). When CBOs make decisions about who participates in advocacy work and who does not based on their perceptions about marginalized people, they are exercising a form of social control (Shragge and Fontan
If people are not given the opportunity to choose to participate because they may not be aware of their options, for example, this is a form of injustice and requires action.

Finally, the Coalition case study gave me the opportunity to look inside an advocacy process to see how participation and power are manifested. I chose this Coalition because it was an example of power-with-others and it had been discussed as an example of a policy win in community meetings I attended (Analytic Notes Sept. 29, 2004). However, after I finished the analysis, it was clear the Coalition’s policy win was only part of the story. In the beginning, the Coalition had power-with-others, but in the end, it appears the government exerted ultimate power-over the Coalition (Nozick 1992). The government controlled the resources for the new policy, the people involved and the application of knowledge (i.e., completed financial feasibility research that pointed to a certain policy choice) (Grabb 2007). The government created divisions within the Coalition when it made policy choices because these choices included dropping the low income cut-off (LICO) thus excluding some working poor people, excluding people who were involved in federal income assistance programs and excluding people with disabilities (see section 6.2.1). This government decision had the effect of reducing the power-with-others which the Coalition had in the beginning. I will examine power further in the next chapter.

81 All 17 Coalition participants stated the Coalition was victorious regarding convincing the city and the province to go ahead with the new policy – even though it was not the policy package the Coalition had originally sought.
7. OUTCOMES/IMPACTS OF ADVOCACY PROCESSES

The main focus of this chapter is on the outcomes/impacts of advocacy processes on individuals involved with the Coalition. Research question #5 was the focus; using a population health lens, what were interviewees’ perceptions of the outcomes/impacts of this local coalition? The data to answer question #5 were extracted from the personal interviews with 17 case study Coalition members and the observations of the Coalition over a one year period. I coded the interview data using categories from the literature because these categories were used as prompts during the interview (refer back to section 3.5.2 regarding phone interview analysis), however, I was also open to new categories that emerged from the data. I applied content analysis including summarization and explication to the observational data (Titscher et al. 2005).

I also briefly examined the 39 CBO transcripts because I had asked those interviewees about perceived outcomes/impacts too; their data were intended to aid in further description of the case study data. This is research question #3, using a population health lens, what did CBOs perceive were outcomes/impacts of these advocacy processes on marginalized people and communities?

I had not originally intended to analyze focus group data here, but upon examination of the data, outcome/impacts were a large part of the focus groups, so this analysis is included here too. I completed open coding on the focus group data (Strauss 82 These categories were deemed necessary because during the interview pre-test, respondents seemed to struggle with the question. As well, I had been concerned about keeping respondents focused on a broad definition of health, not a narrow definition.

82 Eighty-two
and Corbin 1998) and then reported on categories using intensity and extensiveness criteria for focus groups (Krueger 1994).

Sections 7.1, 7.2, 7.3 and 7.4 contain data results. The last section, section 7.5, presents a discussion. Table 7.1 provides an overview of the focus of this chapter.

**Table 7.1: Overview of chapter 7 data collection and analyses**

<table>
<thead>
<tr>
<th>Research question</th>
<th>Methods of data collection</th>
<th>Methods of data analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 2 – case study</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question #5 (sections 7.1, 7.2) Using a population health lens, what were interviewees’ perceptions of the outcomes/impacts of this local coalition?</td>
<td>- Personal interviews</td>
<td>- Coding and categorizing</td>
</tr>
<tr>
<td></td>
<td>- Observations of Coalition</td>
<td>- Content analysis</td>
</tr>
<tr>
<td><strong>Phase 3 – context and case study</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question #6 (section 7.3) Based on the answers to the above five questions, how can the links between CBO policy advocacy processes and population health be conceptualized?*</td>
<td>- Focus groups</td>
<td>- Coding and categorizing (extensiveness and intensity criteria)</td>
</tr>
<tr>
<td><strong>Phase 1 – context revisited</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question #3 revisited (section 7.4) Using a population health lens, what did CBOs perceive were outcomes/impacts of these advocacy processes on marginalized people and communities?</td>
<td>- Phone interviews</td>
<td>- Coding and categorizing</td>
</tr>
</tbody>
</table>

*Note: Only focus group data pertaining to outcomes/impacts were included here.

In general, the outcome/impact analysis model described in section 2.5 (i.e., inputs, processes, outputs, outcomes/impacts) provided the overarching structure for the case study (Flynn and Hodgkinson 2001a; Hatry et al. 1996; Legowski and Albert 1999). The population health concepts from section 2.4 were the specific content explored (e.g., social connectedness, power and control) within that model. This chapter focuses on interviewees’ perceptions of outcomes/impacts of advocacy processes on themselves and others. It also focuses on their perspectives of how, if at all, advocacy processes were
connected to their health/well-being as well as to their larger community.

Outcomes/impacts “are the benefits or changes derived from the program" or activity for individuals or populations and "may relate to behaviour, skills, knowledge, attitudes, values, condition, status or other attributes" (Hatry et al. 1996, p. 2).83 Thus, it was their reality that I sought to reconstruct based on their perceptions (Lincoln and Guba 1985).

### 7.1 Outcomes/impacts using a population health lens

Recall that in using the population health lens, I adopted a broad definition of health/well-being, “a state of complete physical, social and mental well-being and not merely the absence of disease or infirmity …” (cited in World Health Organization 1998, p. 11). Taken together the outcomes/impacts model and the population health lens adopted for this study pointed to the following elements: values and attitudes change, felt/emotional reactions, learning, social networks and relationships, inclusion/exclusion and discrimination, power and control, perception of place in social hierarchy, behaviour change, status/condition change. The population health lens reminds us there are a number of spheres within which we can search for outcomes/impacts: individual, CBO, government and community (Labonte et al. 2002). Data reported in this section fall into these different spheres.

I was interested in both cognitive and emotional data (Lofland and Lofland 1995, p. 113-18). Cognitive refers to the meanings, understandings, interpretations and beliefs which people attach to concepts (ibid.). Some of these may go unarticulated by

---

83 Recall from chapter 2 that outcomes and impacts are conceptually different (Flynn and Hodgkinson 2001) however there is no agreement in the literature (Amenta and Young 1999; Greenway 2001) and my pre-test results indicated confusion for interviewees, thus I use these terms synonymously here.
interviewees so I had to probe further in some of the interviews and then when I was analysing the data I had to think carefully because meanings are fragile, often owned by those in privileged positions, and constantly changing (ibid.) (see also Grabb 2007; Kincheloe and McLaren 2005). Emotional data refer to people’s feeling responses to their world. Emotions are inner experiences which are publicly observable (Robinson and McIntyre 2007). A number of studies have indicated that emotions impact health/well-being (Gallo and Matthews 2003; McIntyre, Officer, and Robinson 2003; Robinson and McIntyre 2007).

The question posed in the interviews with Coalition advocacy volunteers was

How did this advocacy process impact or change you? These can be negative or positive outcomes. Please reflect on the following: your status or daily living conditions, your learning including new knowledge and skills, your behaviour, your physical health, your mental health, your spiritual health or faith, your social connectedness and being included (or not), your well-being including overall satisfaction and happiness with your life, your sense of power and ability to take control and change something that you thought was unfair, and your values and attitudes (about the people involved in the Coalition, about governments, about your place in the community) and about making a contribution.

A follow-up question was also posed to Coalition advocacy volunteers:

How did this advocacy process appear to impact or change other people involved? Once again these can be negative or positive. You can refer back to the previous question if necessary. So were there any perceived changes in the other volunteers or CBO staff that were involved with the Coalition? Were there any perceived community-level impacts that you saw? Were there any perceived changes to the government staff or elected officials that were involved?

The same questions were asked of the CBOs and the government representatives who were involved with the Coalition. Thus, advocacy volunteers, CBO staff and government
representatives were each asked about the impacts on themselves and on the other two main groups as well as perceived impacts on the community.

In this section, I begin with advocacy volunteers’ data because from a critical inquiry perspective, their voices were primary. What follows are qualitative data findings from six advocacy volunteers, five CBO staff and six government representatives (both staff and elected officials).

### 7.1.1 Outcomes/impacts on advocacy volunteers

This section presents data about perceived outcomes/impacts on advocacy volunteers. In each paragraph, data from the advocacy volunteers are presented first, followed by CBO data and then government data.

**Status and daily living conditions**

Some advocacy volunteers said their status and daily living conditions were changed by the process. The three main categories of change identified were: they were invited by governments to speak further about issues which created an ongoing link with governments (e.g., at other government meetings, or their opinions were sought by city staff through follow-up phone calls); they believed governments got to “know” them (e.g., “the Mayor knows me by name now” [Vol-41]), and some advocacy volunteers stated it “was good for my physical health to be involved … I was doing a lot of walking” to meetings (Vol-40), and a second person stated “… after meetings, I’d come home with a big plate of food … good food … there’s always been benefits like that on the edges”

---

84 This may also reflect perception of one’s place in a social hierarchy; that a prominent politician knows someone by name infers he/she spends time together and that this person is important too.
CBOs identified three main categories including: advocacy volunteers seemed to get respect from city council after they did their presentations; over the years though, the Coalition did not appear to get credit for its hard work but instead the Mayor and other politicians “took credit” (CBO2-53 and CBO2-55); and that within the Coalition advocacy volunteers’ opinions were valued by others. Some government representatives stated the process was more credible because people who were affected by the policy were speaking about their experiences and they were accepted for that.

**Learning new knowledge and skills**

Some advocacy volunteers said they learned new things while others said they knew a lot already (e.g., “I still don’t trust politicians” [Vol-41], already knew about city hall processes) and brought their knowledge and skills to the process. Coalition members said they learned about: rules (e.g., got into trouble hanging flyers at the library without permission); poverty (e.g., “it brought poverty into reality for me” [Vol-45]); government priorities and processes (e.g., realized city hall was heavily focused on economics); internal group processes (e.g., taking turns to speak at meetings); how to do advocacy (e.g., learned to lobby, learned that you need baby steps); the community (e.g., “developed my knowledge about who lives here” [Vol-40]); and oneself (e.g., “I learned the older I get the bolder I get” [Vol-40]). The CBOs stated there appeared to be new knowledge and new skills gained from the process for volunteers including: consciousness-raising that one can do something about issues; about group dynamics and conflict; and about rotating who chairs meetings and the ensuing skills that are required to do that kind of work. CBOs also noted there appeared to be reciprocal learning take place among the diversity of advocacy volunteers, CBOs and governments. Government
representatives said there seemed to be mutual learning around the Coalition table (e.g., advocacy volunteers learned about city budgets, CBOs learned about disability issues).

**Behaviour changes**

Some advocacy volunteers said their behaviour changed while others said there were no changes in their behaviour; no one said the process had a negative impact on their behaviour. For those who said there were no changes, it was because they were already very involved in their community or that the process “confirmed that action is productive” (Vol-41). For those who said there were positive changes in their behaviour, an example was going on to join another coalition and feeling more comfortable talking with the community at public meetings. CBOs said they saw the following behavioural changes in advocacy volunteers: during certain times activism increased (e.g., during the fall when city council was about to vote); they were already active advocates but there was growth in their activism compared to where they were before they came to the Coalition; their activity level and their leadership roles increased over time (e.g., chairing meetings); and the Coalition continues to exist today because volunteers are leading it. Some government representatives stated they saw a shift in behaviour once Coalition members realized they needed to make strategic choices and act on a variety of avenues. As well, governments noted even though there are fewer faces involved in the Coalition today, it is still functioning today which is the result of advocacy volunteers’ behaviour.

**Emotional reactions**

There were four main categories of data emerging from the advocacy volunteers interviews. First, some members linked their current feelings to their past (e.g., “I think my sense of well-being is more positive now but this may be because of my sense of
groundedness or peacefulness with myself … building on something I’ve already got” [Vol-42], and “I had rage coming out of every part of my body … about 15 years ago … but not today” [Vol-44]). Second, there were some negative feelings about the process (e.g., “it didn’t feel good being left alone to present” at city council [Vol-43], when the policy change did not include people with disabilities “she was furious” (Vol-40). Third, a collection of answers focused on feelings about getting out and being involved (e.g., “you know being at home can get depressing … if you can’t get out to meetings ….”) [Vol-43]). Fourth, a collection of answers related to feeling good about the policy “win”. CBOs stated they saw a variety of emotional reactions resulting from the process too. CBOs stated they perceived that both positive and negative emotions seemed to exist for the advocacy volunteers including: desperation, fear and anxiety when it appeared the city was not going to run the pilot project; frustration when dealing with government representatives and the amount of time it took to get government approval; feeling happy about the policy win; feeling excited about their sense of power; and feeling sad and disappointed when people with disabilities were excluded from the final decision as well as when the Coalition was not recognized for its work toward the new policy (i.e., politicians took credit for the new policy). Government representatives stated they saw disappointment when it was learned that not all low income people would be eligible, euphoria when the policy change was made permanent, Coalition members’ tears at a city hall committee meeting felt like a “love in” (Gov-49), good feelings about working together, and frustration with the long process.
Motivation

Advocacy volunteers talked about the process being very energizing. One person said that despite her medical condition she kept going to meetings. Yet another person talked about determination regardless of the amount of pain (e.g., “I'm tenacious you know” [Vol-45]). CBOs said they perceived motivation too which included being driven by a sense that the situation had to change, that some had passion and “fire inside” (i.e., inner strength) (CBO2-56) regarding the need for change and this spread to others in the Coalition, and that something good was going to come out of all their work. The process seemed very motivating for certain members, however, at various points in the process, the work was also challenging and unrewarding which meant some people lost their motivation to keep going and quit. Government representatives said they had the sense the Coalition got behind a cause, there was hope and energy, and a sense that “yes we can do this” (Gov-47).

Power and control

Advocacy volunteers were asked if they thought they had a sense of power and ability to take control and change things (Hancock, Labonte, and Edwards 2000). The interviews revealed three main categories. First, volunteers talked about a sense of optimism and hope regarding change (e.g., “felt we had power in speaking out” [Vol-43], built a new network and this affects people’s ability to go forward again). Second, the lack of power and control is a sense of hopelessness (Hancock, Labonte, and Edwards 2000) and this existed for one volunteer, for example, “when you’re a long term advocate, you don’t get to see a lot of successes. You sometimes don’t see a lot of hope for the future, personally …” [Vol-44]). Third, some volunteers indicated “sometimes
you win and sometimes you lose” (Vol-44). CBOs indicated they observed: when advocacy volunteers chaired meetings they seemed empowered; they had a voice and sense of hope; the striving for change was empowering; they had a sense of control over the situation but not sure how this impacted their lives overall; and “I definitely think they had a sense of contribution … that they contributed to changing a situation for the better” (CBO2-55). Some of the government representatives said there appeared to be a change from hopelessness at the beginning to a realization one can make change and they persisted to make change. There also seemed to be a sense they were able to take control and change something and “that was fantastic” (Gov-49).

**Mental health**

During the interviews, advocacy volunteers talked about two areas which appeared to be related to mental health. In general, members talked about how good it was for their mental health to be involved (e.g., “it does so much good to oneself to get involved in these things” [Vol-40]). Second, they talked about being able to make a contribution to the process and they talked about feeling productive (e.g., “that I was now an active and productive part of the world really made a difference” [Vol-44]). The CBOs also discussed some mental health related outcomes/impacts, some were positive and some were negative. The positive elements they saw in advocacy volunteers included feeling comfortable and not stressed about the process and a sense of being respected during the process. The negative impacts they saw in advocacy volunteers seemed to be about stress, strain and anxiety regarding not achieving the policy change which in turn negatively impacted their quality of life. The CBOs indicated the level of stress increased
when the pilot project seemed threatened. Government representatives did not appear to talk about any mental health related issues.

**Sense of success, accomplishment and celebration**

The sense of success, sense of accomplishment and cause for celebration was a category discussed by all advocacy volunteers. They were a diverse group yet they all clearly had a sense of success and cause for celebration, but their emphases differed. The following examples illustrate these differences: “one of the biggest things was … welfare is not there to breed hope … It’s not there to breed success … so these little successes in my life have a huge impact” (Vol-44), “when we finally got it, I made up this thing that said ‘good news, we did it - we did it all together!’ … it was so wonderful that the poor and the well off, such a diverse group … accomplished it” (Vol-40). Only some CBOs spoke about sense of success for volunteers; one CBO stated “I think being part of something that was ultimately successful helped to make people feel good about themselves” (CBO2-54). Some of the government representatives stated the policy change was “a huge win” (Gov-50) and this win seemed to legitimize the Coalition’s struggle.

**Social connectedness**

Advocacy volunteers were asked if their involvement in the Coalition’s work changed their social connectedness, sense of feeling included, their social support networks, and their sense of belonging to the local community. First, some members began by talking about friendships. For example, one person said she/he did not make any new friends during the process while others said they did - “I have such a network of friends because of these campaigns” (Vol-40). A second category was people’s sense of
belonging to their local community; some interviewees felt no change had taken place
because they have always felt connected to their community while others felt more
connected as a result of their involvement (e.g., “I think I’m more connected and engaged
with Aboriginal communities than I was before” [Vol-42]). Third, a sense of
interconnectedness was another area (e.g., “you keep bumping into the same people at
different meetings” [Vol-41], and “you’ve built a new network” [Vol-40]. Some CBOs
reported there seemed to be a sense of community regarding the policy issue and their
involvement in the Coalition reduced their isolation within their community. Some CBOs
also stated they saw camaraderie and mutual bonds among Coalition participants. Some
of the government representatives observed that Coalition members seemed to feel good
about working together.

**Values and attitudes**

All the advocacy volunteers stated they believed that everyone had some
contribution to make to these processes. “There’s a general value of people and that
everybody has an ability to contribute, even though they may be in different positions …
I have a basic sense that there is value in them being involved” (Vol-42). A second area
for advocacy volunteers was a general belief that governments took credit for the policy
change and the Coalition received little if any recognition for their efforts; this seemed
unjust to advocacy volunteers (Vol-40 and Vol-44). Some CBOs stated they saw
everyone contribute to the process and that everyone’s ideas seemed to count. Some
government representatives said they thought the Coalition moved from a defiant attitude
against governments to one of co-operation over the course of their advocacy work.
7.1.2 Outcomes/impacts on CBOs

In this section there were few data to report on from the advocacy volunteers regarding their perceptions of CBOs. I present these first and then follow with the CBO and government data.

What outcomes/impacts on CBOs did advocacy volunteers perceive took place? Some advocacy volunteers said they did not see any changes in the CBO staff involved. Others said it was hard to say for sure because “we’re so in touch with each other so often that I don’t usually take the time to step back and observe them” (Vol-42). One person thought CBOs became better informed about the policy issue from the perspective of those who are most affected by the policy.

The remaining sections contain only CBO and government data because there were no additional data from volunteers.

*Behaviour changes*

Some of the CBOs thought the process added to their collective CBO capacity to work on other issues together. Some members felt burnt out after the very long advocacy process so they left the Coalition after the policy change was made permanent. There were no data about behaviour change from the government interviewees.

*Learning new knowledge and skills*

The CBOs stated they thought they acquired new knowledge and new skills from the process including: governments will listen and respond to communities; communities can make change; different advocacy strategies may be used (e.g., cooperative, adversarial, coalition building); political processes including city hall advisory committees and timing are important strategic elements in advocacy work; poverty and
disability issues; the importance of empowerment but also saw the negative internal dynamics within the Coalition; and learned the policy win was only a tiny change in the lives of marginalized people. Some government representatives stated they thought they saw CBOs learn from listening to the advocacy volunteers’ experiences.

**Emotional reactions**

CBOs cited both positive and negative emotional reactions. The positive emotions included feeling satisfied, happy and victorious about influencing change and making life better for people, and feeling proud because they were “doing the right thing” (CBO2-53). The negative feelings included feeling frustrated about the amount of time it took to get the governments to make decisions as well as to get agreement within the Coalition to move in certain directions, and feeling embarrassed about one’s own less-than-positive view of the world when compared to someone living on welfare who was so positive. Government representatives stated they saw different emotional reactions including frustration and excitement at various points in the process.

**Mental health**

CBOs stated they thought their opinions were more valued by others in the Coalition than they had thought they would be, some members said they were burnt out (i.e., exhausted) by the time the policy was made permanent, while others said they did not find it stressful but that might have been because they were not as actively involved as the others. There were no data about mental health from government interviewees.

**Motivation**

CBOs stated they thought the process was motivating, they were optimistic about change, and they thought the advocacy volunteers’ passion further motivated some of the
CBO members. “I admired people like --- because despite their financial situation they were in they still had smiles on their faces, they were still positive … kept me going” (CBO2-56). Some of the government representatives said they saw a sense of determination or drive to carry on within the Coalition.

**Power and control**

Some CBOs talked about having a sense of hope and optimism during the process and that they could control and change certain things. However, two CBOs explained they did not have much power and that it was powerful people like governments who actually changed the policy. For example,

“… well I think in the beginning people were very excited about their sense of power … their sense that they were working to change something and that something good was going to come out of all their work. I think people had a sense of control over this situation. However, I think the more we talked the more concerns were raised. For example, I remember a conversation we had about what if the government changes?” (CBO2-55)

There were no data about power and control from the government representatives.

**Values and attitudes**

Two types of CBO responses were found. First, some CBOs believed they were just doing the right thing and that direct engagement works. Another response was about having faith they would succeed and that there is a higher power in life;

“I know there were a few of us that have a belief in a higher power … I know when there’s a cause people come, you don’t know who’s going to come … and those people who come are the best ones suited for that job or task. And I always tell myself, it’s always the right people who show up and I don’t worry about it” (CBO2-56).

There did not appear to be data about attitudes and values from government interviewees.
Networking

Some CBOs stated there was a lot more connecting and communication within the CBO community as a result of the advocacy process. The government representatives said they thought existing collaborative relationships among CBOs were reinforced.

7.1.3 Outcomes/impacts on governments

In each of the following paragraphs, data from the governments are presented first, followed by CBO data. There were only a few data to report from the advocacy volunteers, thus I included them in the following paragraph.

Some advocacy volunteers said it was hard to say whether there were outcomes/impacts on governments because “we had city staff sitting on both sides of the fence at the same time” (Vol-42). As well, there seemed to be some confusion: “I could never place her … I was so impressed with her when I first met her but I could never put my thumb on her” (Vol-45). Second, some advocacy volunteers thought they saw some positive attitudinal changes in the government representatives who had to deal with the Coalition (e.g., “some government staff & politicians … are more aware and more sensitive now” [Vol-40]). However, some advocacy volunteers described governments’ behaviour negatively in the way they treated Coalition members at city hall meetings (e.g., “I went to present and he [city councilor] had his eyes closed the entire time I presented … he didn’t even want to acknowledge my existence” [Vol-44], “because I’m not a rubber stamper … he shut me out of the city committee” [Vol-45]).
Behaviour changes

Government representatives said they began to listen more carefully to community residents’ perspectives. Some noted how over time elected representatives slowly began to understand the issues and the budget ramifications and in the end, City Council voted unanimously in favour of the new policy. Some CBOs described how they changed the governments’ minds so that “in the end, all the city councilors voted in favour of it” (CBO2-53). There was also an explanation about how they changed provincial Ministers’ minds and they too supported the concept of the new policy.

Learning

Government representatives stated they gained new knowledge and skills from the process. In general, they said they learned: about poverty and disability issues and how essential the new policy was for certain groups of people to enable them to become engaged in their community; there are many passionate people who care about fairness and access; that community groups can encourage public policy change, but currently there are deficiencies in the policy making process regarding how to find and engage people most affected by certain public policies; and new skills (e.g., how to handle certain situations, how to reach out to those who are hard to find). CBOs offered the following observations about possible learning for government people affected by the Coalition: by the end they saw the "human side of it" (CBO2-52); initially there was no city or provincial government support but now it is “like an apple pie issue” (CBO2-54); government “consciousness raising” took place (CBO2-53); they developed a sense of ownership and it became important to them too; and governments “sat at our table in order to come to a common understanding” (CBO2-56).
Emotional reactions

Government representatives expressed many different emotions about the various phases of the process, including: happiness when the province agreed to get involved; joy and fun working with the Coalition; fear when there was an impending city strike because there was a deeper understanding about how the strike would affect people on low incomes and people with disabilities; satisfaction but had wished for more; and excitement and happiness when the policy was made permanent. CBOs said they saw both positive and negative emotions on the part of governments throughout the process: a provincial government staff person seemed very happy with the process; the government just kept saying ‘what a wonderful thing we’ve done’ (CBO2-54); a city staff person was “was just sick of us (CBO2-55); and the City “hated dealing with us” (CBO2-52).

Mental health

During the interviews, government representatives talked about having “a few headaches” (Gov-51), feeling beaten and quieted within his/her bureaucracy (Gov-47), that one had to work hard with certain individuals in the Coalition because they were “difficult” (Gov-46), and that over time, they began to feel respected by Coalition members. There were no data from the CBOs about mental health.

Status and daily living conditions

There were no government data on this topic. The CBOs data referred primarily to their perceptions of political status and included: a city councillor stated that Coalition members vote too (inferring that he should support their cause if he wanted to get their votes), and the Mayor “took credit for the bus pass … listing the bus pass as one of his
accomplishments over the past 10 years as Mayor … he wasn’t out knocking on doors to make this happen!” (CBO2-55).

Outcomes/impacts on government as an institution

Some data pointed beyond government as individuals toward government as an institution. Government representatives offered a few thoughts about the outcomes/impacts the Coalition had on them as an institution. These included: the Coalition built political will within their system; it was good to have another group appear before City Council instead of only hearing from business groups; the Coalition reduced the dry, stoic nature of city hall meetings; and concerns were expressed about community development within governments (e.g., presently “community development inside government is an oxymoron” [Gov-47]). CBOs said they saw enhanced communication and new relationships – especially a new funding relationship - between the municipal and provincial governments. Enhanced links between governments and the community also ensued.

7.1.4 Outcomes/impacts on communities

When asked about the changes to the larger community that may have resulted from the advocacy process, some advocacy volunteers perceived the community had become more aware of this policy issue. There was also a sense that advocacy volunteers were able to get many people out to public meetings at city hall and around neighbourhoods. Some volunteers talked about how the policy win had spread to other communities, a ripple effect, in the province. CBOs offered the following observations about the possible outcomes/impacts of the process on the wider community: there was
greater community organizing capacity after the policy win (e.g., when the public library decided to close branches, a major advocacy effort was launched which included a 26,000-signature petition); links were created among individuals and groups; and enhanced communication ensued between the governments and the community. Government representatives offered the following observations about community outcomes/impacts: people in the community appear to have watched the Coalition, saw its success and endeavoured to copy their strategies for other issues; and with Coalition encouragement, community residents seemed to see it was important to make their voices heard. The media was cited as a key player on having an impact on the community.

7.1.5 Summary, missing elements, emergent pieces

In summary, a variety of outcomes/impacts were found in the interviews with the 17 people involved with the Coalition. Table 7.2 presents a summary of these impact data for each of the three groups studied as well as the community. This table shows where there are similar areas of impacts observed by each of the three respondent groups. In summary, there are multiple types of impacts for different groups of people as well as for whole communities. Vol-40 offered this thought “Campaigns are still beneficial - especially socially - and you still learn a lot … like new knowledge and new skills … and you’ve built a new network and learned about the system. And this affects people’s sense of ability to go forward again” (Vol-40).

There were two missing elements in these data. First, despite my explicitness about a broad definition of health/well-being with the 56 interviewees, I only had two interviewees refer to spiritual/faith and neither of these was related to outcomes/impacts.
(Vol-40, CBO2-56). Second, I was interested in people’s perception about their place in the social hierarchy which was part of the health/well-being literature I reviewed. I did not find this element explicitly in the data, but perhaps given its complex nature, I may find it with a deeper analysis.

Finally, there were three emergent elements that I found in the data. Given the extensiveness of motivation across interviewees, I coded it as a separate element. Similarly, sense of success/accomplishment and celebration was also coded as a new element. Finally, Coalition interviewees talked about government as individuals as well as government as an institution; thus I divided these data findings and reported them separately.
Table 7.2: Summary of outcomes/impacts of Coalition’s work in four spheres

<table>
<thead>
<tr>
<th>Spheres</th>
<th>Advocacy volunteers reported impacts on …</th>
<th>CBOs reported impacts on …</th>
<th>Governments reported impacts on …</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy volunteers</td>
<td>Status, daily conditions</td>
<td>Status, daily conditions</td>
<td>Status, daily conditions</td>
</tr>
<tr>
<td></td>
<td>Learning</td>
<td>Learning</td>
<td>Learning</td>
</tr>
<tr>
<td></td>
<td>Behaviour</td>
<td>Behaviour</td>
<td>Behaviour</td>
</tr>
<tr>
<td></td>
<td>Emotional reactions</td>
<td>Emotional reactions</td>
<td>Emotional reactions</td>
</tr>
<tr>
<td></td>
<td>Motivation</td>
<td>Motivation</td>
<td>Motivation</td>
</tr>
<tr>
<td></td>
<td>Power and control</td>
<td>Power and control</td>
<td>Power and control</td>
</tr>
<tr>
<td></td>
<td>Mental health</td>
<td>Mental health</td>
<td>Sense of success</td>
</tr>
<tr>
<td></td>
<td>Sense of success</td>
<td>Social connectedness</td>
<td>Social connectedness</td>
</tr>
<tr>
<td></td>
<td>Social connectedness</td>
<td>Values &amp; attitude</td>
<td>Values &amp; attitude</td>
</tr>
<tr>
<td></td>
<td>Values and attitude</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBOs</td>
<td>No changes observed or not sure because work too closely together.</td>
<td>Behaviour</td>
<td>Learning</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Learning</td>
<td>Emotional reactions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emotional reactions</td>
<td>Motivation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental health</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Motivation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Power and control</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Values and attitudes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Networks</td>
<td></td>
</tr>
<tr>
<td>Governments</td>
<td>Not sure – governments on both sides of fence.</td>
<td>Behaviour</td>
<td>Behaviour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Learning</td>
<td>Learning</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emotional reactions</td>
<td>Emotional reactions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental health</td>
<td>Mental health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Motivation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Power and control</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Status</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Institutional links &amp;</td>
<td>Institutional &amp; political will</td>
</tr>
<tr>
<td></td>
<td></td>
<td>communication enhanced.</td>
<td>created.</td>
</tr>
<tr>
<td>For communities</td>
<td>Many people got out to meetings.</td>
<td>Increased community</td>
<td>Residents went to government</td>
</tr>
<tr>
<td></td>
<td></td>
<td>organizing capacity,</td>
<td>meetings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>links among groups,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>communication between</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>government &amp; community</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Other groups copied</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Coalition’s strategies</td>
</tr>
</tbody>
</table>
7.2 Observations of the Coalition over one year

Observations of the Coalition occurred during one year. The unit of analysis was the group of people who comprised the Coalition. This Coalition would be considered a “group” as defined by Lofland and Lofland (1995); “a dozen or so people who interact with some regularity over an extended period of time and who conceive of themselves as a social entity” (p. 107). I was invited to participate in Coalition meetings and took observational notes; the first entry was October 2006 and the last was September 2007.

In general, I was interested in people’s experiences and interactions in an advocacy process. There were five main areas of data collection: a) the settings within which advocacy meetings took place; b) the people who attended; c) what happened at these advocacy meetings (e.g., accepted rules of order, behaviour during meetings, interactions, the content/nature of the conversations); d) what was happening outside the meetings which might have affected Coalition meetings; and e) the physical artifacts used during the meeting as well as those created by the participants after the meetings (e.g., meeting minutes, research reports). I recorded this information as well as my reflections and impressions about what I saw using critical inquiry (Lofland and Lofland, 1995). The two content analysis procedures that I adopted were a) the summary which preserves the essential content but reduces its size and b) an explication which explains and clarifies the material (Titscher et al. 2005). I had 30 pages of observational notes. A summary of these notes is presented in Appendix J.

I attended six meetings over the one year period. First, all the meetings took place in a meeting room in a church in the downtown area. This church is a well known gathering place for a diversity of activities including faith and worship, leisure and
recreation programs, concerts, and meeting spaces for groups. The Coalition began meeting at this church in 2003 when it was decided the food bank was too hard to get to; the Coalition continues to meet at this church today.

Second, who attended these meetings? The majority of the people who attended and participated in these meetings were advocacy volunteers. Of the six meetings I attended, only one meeting had a CBO staff person participate. At two of the meetings, municipal staff were invited to present city policies and by-laws because the Coalition wanted to become better informed before deciding on a course of action. These municipal staff presented their material, answered questions and then left the meeting.

Third, what took place at these meetings? Every meeting began with a question about who would chair the meeting and who would take minutes; each time, volunteers stepped forward. The members agreed on the agenda and worked their way through them at each meeting. Each meeting agenda contained at least 4 items and in one instance there were 6 items. In general, members took turns speaking with few interruptions, unless the topic brought out some strong emotions. Even during these more chaotic moments, the group got back on track with the agenda. Identifying, defining and developing proposed actions happened at each meeting. The Coalition embarked on a qualitative survey of people with disabilities and collected data from 35 people about their concerns with a particular municipal government policy and program. Decisions about courses of action appeared to be arrived at by consensus, even though they may have been preceded by an argument. There was no voting.

Fourth, what was taking place outside the Coalition’s meetings which may have impacted the proceedings inside Coalition meetings? The Coalition paid close attention to
what was happening at different levels of government. Certain Coalition members knew when various advisory committees were meeting and what issues were going to city council. As well, certain Coalition members explained their connections to other coalitions and the need to share information across groups.⁸⁵

Fifth, what artifacts were created during and between meetings? Over the six meetings I attended, three different volunteers chaired meetings. Minutes were always taken and circulated after each meeting except in one instance in which the chairperson lost the minutes; she apologized for this occurrence. Research reports, city policies and city by-laws that were on the agenda as items for discussion were circulated before or at the meetings. After four of the meetings, email messages were sent around to members advising them of new developments or clarifying actions items.

Sixth, what were some of my reflections and impressions of those meetings? I made a number of observations of the meetings I attended.

- In general, there did not appear to be a hierarchy within the Coalition. Each month at the beginning of each meeting, a brief discussion ensued about who would chair the meeting. Coalition members took turns chairing the meetings each month. As well, meetings were run co-operatively with members speaking with few interruptions even though some topics generated arguments among the members but these seemed to be resolved at each meeting and decisions were reached by consensus (Observational Notes of Coalition, Oct. and Nov. 2006). Most of the work was shared; analysing the qualitative survey data was done through a study circle meeting (Observational Notes of Coalition, Aug. 2007).

- Five of the six meetings I attended comprised advocacy volunteers solely. At one meeting I attended there was a CBO representative. This has both positive and negative implications. It is positive this group of volunteers has assumed a sense of power, control and leadership on this policy issue but negative in that they have

---

⁸⁵ At one meeting I attended, it was noted that another Coalition had an anonymous membership list as the CBOs were concerned about reprisals from government regarding their advocacy work.
few supports to help implement their agreed-upon actions (Observational Notes of Coalition, Apr. 2007).

- The Coalition regularly worked with short time-lines. In a few instances, as they prepared for presentations to governments they met twice each week. It appeared they were rushed and some of them became frustrated and impatient with each other (Observational Notes of Coalition, Aug. 2007).

- The Coalition appeared to have energy, conviction, and sense of purpose as indicated by the monthly agendas, agreed-upon follow-up actions, and implementation.

- They appeared to enjoy their meetings together given there was humour and laughter at the meetings, despite the periodic arguments during meetings (Observational Notes of Coalition, Jun. 2007).

- After meetings ended, some Coalition members talked with each other informally about other issues. One volunteer explained her application to a city advisory committee had been rejected and two of the others encouraged her to persist and re-apply (Observational Notes of Coalition, Nov. 2006). Another volunteer at another meeting explained that he was told if he kept complaining about a city service that he would be cut off the program and all the members joined that conversation that revolved around unfair treatment, staying positive and action strategies (Observational Notes of Coalition, Jun. 2007).

- I saw a range of emotions at the meetings, from sense of hopelessness when the group realized their survey would never reach 750 like the City’s survey, to disbelief when municipal staff indicated deficiencies in their own by-laws, to frustration and embarrassment when members were belittled at a meeting at city hall, to happiness when one of them was quoted in the news, to impatience with each other when time was running short to complete a task, to affection when two members hugged each other before they left the meeting.

In closing, this group of advocacy volunteers continues to meet and follow their commitment to further change government policy two years after their partial policy win in 2005. The following email message offers a glimpse of the emotions, tasks and concerns with which some advocacy volunteers struggle as they press forward to change government policy. This email message was sent to me after a failed Coalition presentation at a city advisory committee meeting.
“… The entire presentation was spent by [the City Councillor who chaired the meeting] smirking at me and the committee raising comments about ‘who are we, they've never heard of us’ (that's a lie), ‘we don't represent anyone’ and ‘35 surveys is pathetic, we are wasting their time’. The presentation was received and filed by the clerk’s office. I received a letter today stating that it will not go any further. I was very depressed after but then I realized that the Coalition represents people who aren't being listened to; exactly the situation that we were subjected to. I commented that we didn't have adequate resources to complete a survey …

Thursday morning, I felt that the group needed to discuss the event so I phoned the city clerk's office about what we could do to press the issue. She suggested that we write a letter …

When I went to the study circle meeting, --- said he never wanted to be in that type of the situation again! He stated we needed more members and he wasn't going to make any more efforts for the Coalition. I told him that I had dug my heels in even further now. We had to keep pushing the issue.

He stated that he had to lick his wounds now and started blaming me for the situation … I got depressed again … I’m afraid of what will happen to people who are disadvantaged if we stop now…” (Email message from Vol-45, Sept. 7, 2007).

7.3 Focus group findings

The central feature of focus groups “is their explicit use of group interaction to produce data and insights” (Morgan 1997, p. 2). In my research, focus groups provided a feedback loop for respondents to verify the contents of the data summary (Lincoln and Guba 1985), an opportunity to spur memories and opinions based on what others discuss (Lofland and Lofland 1995), the opportunity to further reflect on their experiences because there would have been a “heightened awareness” of issues given the earlier interviews (Morgan 1997, p. 69) and the opportunity to conceptualize the links between CBO advocacy processes and population health.

The advocacy volunteer and CBO focus groups were each given the same five questions. I was interested in understanding each group’s responses, but I was also
interested in comparing the answers between the two groups (Morgan 1997). I was particularly interested in a) whether each individual participant mentioned certain codes (i.e., Krueger’s extensiveness) and how similar the words were, b) how much energy and enthusiasm the code/topic generated (i.e., Krueger’s intensity), and c) how similar or different were the two groups’ discussions of central advocacy categories/issues and their thoughts about the effects on the health/well-being of individuals and communities. The data presented here are based on data from five advocacy volunteers involved in a focus group and data from three CBOs involved in a focus group. The main topics presented are outcomes/impacts, Coalition membership diversity, healthy communities, not being part of the system, trends, and “band aids”. For each of these, I begin with those categories of data which generated much enthusiasm during the focus group (i.e., Krueger’s intensity) and for which most or all the focus groups participants joined in (i.e., Krueger’s extensiveness)

Several outcomes/impacts were discussed in both focus groups. First, advocacy processes through coalitions lead to larger social and friendship networks (advocacy volunteers focus group transcript) and greater interconnections among groups (CBO focus group); all five advocacy volunteers joined the conversation that coalitions can begin with a group of strangers and over time become a cohesive group. Second, emotional reactions were discussed. All five advocacy volunteers and all CBO representatives joined the discussion about type of coalition members – about one member in particular – who was passionate, but impatient and aggressive which subsequently impacted others in the Coalition. This member’s actions and emotional reactions affected other Coalition members who became frustrated and angry and had to
spend much time doing “what I would call, damage control” both within the Coalition and with governments (CBO focus group). Nonetheless, some advocacy volunteers noted “he softened everybody up for us … they were more willing to talk to us after they talked to him … he was fierce” (Advocacy volunteers focus group). Third, all the advocacy volunteers talked about their sense of victory and accomplishment but not getting any recognition for all their efforts; they talked about politicians taking all the credit for the policy change. Interestingly, one volunteer stated if they “give credit to community groups that make change that gives them power and they don’t want to empower …” (Advocacy volunteers focus group). Two CBOs talked about a sense of success and that the policy victory meant the advocacy work was worth it. Fourth, three advocacy volunteers said they felt valued while all three CBO representatives stated they thought advocacy work gave volunteers a purpose and that it was “need-satisfying” because it gave them a sense of power and connectedness. Fifth, none of the volunteers talked about any behavioural changes but all three of the CBO representatives said they saw some of the volunteers move into leadership positions in this Coalition and elsewhere in the community over the years since the policy change was made in 2005. The complexity of impact experiences was summarized by an advocacy volunteer,

“… I don't know if it was stressed enough but when we are marginalized, we feel very alone so getting together with others in the same circumstance and for a common cause is very important to our emotional well being. It's akin to seeing the light at the end of the tunnel rather than sinking into hopelessness and despair. There's a feeling of fear that can be really powerful if we let it. Councillor -- tried to instill it when we made the presentation to the [--committee] and [Vol-44] did succumb to it so I was dealing with the residuals today.

Marginalized people aren't given an opportunity to advance in our society because of all the roadblocks put in place "to keep them down". I didn't realize this till I
became one of them, "disabled". I consider my -- diagnosis to be a blessing in many ways because it allowed me the freedom to see life from a new perspective but because I had a little bit of money, I had more freedom than someone who is disabled and on social assistance. This is why I try to help others … (Email message from Vol-45, Sept. 28, 2007 after focus group meeting, quotations are from the original copy).

Another topic of discussion involving all focus group participants from both groups was the diversity of people involved in coalitions and the diversity of perspectives that are brought to bear on issues. Elements of the discussion in the two groups included: different people are involved for different reasons and sometimes have different goals; people are treated differently by governments; some people appreciate militant coalition members while others do not; some thought the policy fight was won while others thought it was lost; and the membership seemed to shift over time.

An area of discussion for the advocacy volunteers, but not for the CBOs, was about healthy communities. The essence of the conversation is captured in the following quote: “a really healthy community is constantly changing, always dynamic, the people are always pushing … living … independent strong people are essential” (Advocacy volunteers focus group). There appeared to be general agreement that coalitions helped to create healthy communities because they are always pushing for change to enhance quality of life for people.

Related to this notion of pushing for change was recognition by all five advocacy volunteers, but none of the CBOs, that “coalitions are not part of the system” (Advocacy volunteers focus group). This topic generated intense discussion as the advocacy volunteers discussed that “to some extent we’re pushed out of the system … because we’re a Coalition … there’s an unwillingness to have us as part of the organized
framework” (Advocacy volunteers focus group). They went on to discuss how none of them were involved in any of the municipal advisory committees but appreciated being part of the Coalition because they were freer to speak; municipal committees were viewed as unable to be comprehensive, they maintain the status quo, and they comprise “rubber stampers” (Advocacy volunteers focus group transcript).

In closing, some advocacy trends were noted. In general, the CBO representatives thought: earlier generations were able to make government change, but not so much today; today there is more cynicism and fewer people working together; and during social democratic government eras, activism is not as high. Finally, in both focus groups there was recognition the Coalition’s policy win did not result in structural change for marginalized people. The change was seen as “another band aid” (Volunteer focus group transcript) and it only solved part of the problem (CBO focus group transcript).

7.4 A glimpse of 39 CBOs perceptions of outcomes/impacts

After I coded the 17 Coalition transcripts for outcomes/impacts I went back and examined the 39 CBO transcripts to discern impacts they perceived had occurred for advocacy volunteers and communities due to advocacy processes. Research question #3 was the focus; using a population health lens, what did CBOs perceive were outcomes/impacts of these advocacy processes on marginalized people and communities? The data presented here aid in further describing advocacy process outcomes/impacts. First I present CBOs’ perceptions of impacts on volunteers; then I present CBOs’ perceptions of impacts on communities. Table 7.3 presents examples of these data. The categories which appeared in the greatest number of CBOs, extensiveness, are presented
first in the table (Strauss 1987). The outcomes/impact categories included: behaviour, learning, sense of power and control, social connectedness, mental health, attitude and feeling valued, and emotional reactions.

Table 7.3: Perceived outcomes/impacts on volunteers noted by 39 CBOs

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of CBOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Behavioural changes (stated by 21 CBOs)</td>
<td></td>
</tr>
<tr>
<td>CBOs said they actually saw advocacy volunteers go on to join other committees and participate in other initiatives. “We’ve seen people … who end up involved in political campaigns working in committee rooms for politicians. People running for office … who see that there’s something important that has to happen there. Who get involved in advisory groups with the city and yeah, there’s a lot of those kind of spin off things” (CBO1-23). However, some CBOs also explained some volunteers felt bullied and threatened – especially by governments – thus their behaviour was affected (i.e., tendency to quit their advocacy work instead of risk losing their welfare cheque).</td>
<td></td>
</tr>
<tr>
<td>b) Learning (stated by 19 CBOs)</td>
<td></td>
</tr>
<tr>
<td>CBOs explained they observed learning occurred for advocacy volunteers including learning about the policy making process and systems, that change takes time, how to work together, to be persistent, and how greater knowledge can support more speaking out.</td>
<td></td>
</tr>
<tr>
<td>c) Sense of power, control and voice (stated by 19 CBOs)</td>
<td></td>
</tr>
<tr>
<td>There appeared to be two main categories of responses here. First CBOs observed that advocacy volunteers appeared to believe they could accomplish something, “I can’t, became I can” (CBO1-28) and they actually can make change. Second, the notion of voice seemed important including volunteers were able to speak about their perspectives and concerns and they valued networking and talking. For example, “it gave them a voice and … there’s different times people feel voiceless, they feel like nobody cared so it gave them a voice … well that’s part of the process that was very positive” (CBO1-6).</td>
<td></td>
</tr>
<tr>
<td>d) Social connectedness (stated by 18 CBOs)</td>
<td></td>
</tr>
<tr>
<td>CBOs stated they observed social impacts for advocacy volunteers; they described a growth in social networks, connecting and sharing about common issues, mutual support, talking together and healing. A second cluster of answers focused on enhanced sense of belonging and sense of community including feeling “more connected to their community” (CBO1-4), feeling like they were part of the community and the process helped create “a sense of community” (CBO1-18).</td>
<td></td>
</tr>
<tr>
<td>e) Mental health (stated by 12 CBOs)</td>
<td></td>
</tr>
<tr>
<td>CBOs stated they perceived some changes to volunteers’ mental health including enhanced self esteem, assertiveness, had a cause to believe in, and felt more confident with each success.</td>
<td></td>
</tr>
<tr>
<td>f) Attitudes and feeling valued (stated by 11 CBOs)</td>
<td></td>
</tr>
<tr>
<td>CBOs said they observed changes in attitude when advocacy volunteers did not passively accept a policy decision, when volunteers insisted their opinions were important, and their attitudes became more positive over time. CBOs also observed that volunteers seemed to grow in their sense of feeling valued, for example, “I think individuals with disabilities suddenly realized that someone is actually listening and caring about what the hell they’re saying” (CBO1-23).</td>
<td></td>
</tr>
<tr>
<td>g) Emotional reactions (stated by 9 CBOs)</td>
<td></td>
</tr>
<tr>
<td>CBOs indicated they saw volunteers feeling frustrated about not being heard, feeling happy about being connected and excited about participating.</td>
<td></td>
</tr>
</tbody>
</table>
CBOs also talked about community level outcomes/impacts that result from advocacy processes. Some CBOs thought there was greater awareness throughout the community of the marginalized people and their policy issues as a result of their advocacy processes. Some CBOs said they thought successes within advocacy processes lead to other successes as advocates continued advocacy work in the community; “when they succeed, whether it be in a small group or a larger group, when they succeed they tend to succeed in more than one area of their lives” (CBO1-12). As well, the behavioural changes noted in Table 7.3 indicate that some volunteers go on to be active in other areas of the community, thus a ripple effect occurs. As well, because advocacy participants cross-fertilize issues there are more links between groups. Some CBOs indicated it was hard to say what impacts there might have been on the community.

7.5 Discussion

Since the Coalition case study is the core of my study I concentrated my analysis on research question #5 data including interviews, observations and focus groups, but supplemented the analysis with data gathered from the 39 CBOs. I worked across methods, integrated pertinent literature, and offered observations about these results from a critical inquiry perspective. By working across methods, I knew that “multiple sources of evidence essentially provide multiple measures of the same phenomenon”, also known as triangulation (Yin 2003, p. 99).

I refer back to the literature in chapter 2 on outcomes/impacts and use the different levels of outcomes as a general aid to organize this section. The main levels adopted here include initial outcomes like learning new knowledge and intermediate
outcomes like changes in behaviour that result from new knowledge (Greenway 2001; Hatry et al. 1996; Legowski and Albert 1999); within these I highlight the population health elements chosen for my study (section 2.4). The following five areas are presented in this section because data for each were found across at least three of the methods: learning new knowledge and skills, emotional reactions, sense of power and control, changes in social connectedness, and behavioural changes.

### 7.5.1 Learning outcomes/impacts

Data about impacts on learning were found in personal interviews, observations of the Coalition during meetings and phone interviews with 39 CBOs. In the personal interviews with those involved with the Coalition, all interviewees stated they learned about the policy issue, about the groups most affected, how to work in groups, and how government operates. Learning occurred as part of the advocacy process as well as after meetings finished. During observations of Coalition meetings, I actually saw learning take place when two of the volunteers began talking about personal concerns and the group informally problem solved with them about what they should do. Experiential knowledge sharing is essential for the development of healthy public policy (Dobson 2003). The new knowledge and skills development learning that took place is “capacity building” (CBO1-8) which is one of the tenets of social justice theory (Gindin 2002) and “self-capacity is a fundamental health prerequisite” (Labonte and Edwards 1995, p. 11).

The data from the personal and phone interviews indicated learning not only took place within the individual sphere, but also within the community sphere. Community awareness raising was an advocacy strategy adopted by many CBOs (section 6.1.1) and
was a strategy implemented by the Coalition (section 6.2.1). Specifically, interviewees explained there was greater public awareness of marginalized populations and policy issues because of media coverage (sections 7.1.4). Unfortunately I could not measure this directly. Community awareness is an important precursor to gathering community support for a new policy in advocacy work (Cohen, de la Vega, and Watson 2001 and section 6.1.1).

7.5.2 Emotional reactions

Data about impacts of advocacy processes on people’s emotional lives which resulted from advocacy processes were found in personal interviews, observations of the Coalition during meetings, phone interviews with 39 CBOs and the focus groups. For example, the Coalition data showed that as people worked together, they felt a range of reactions. They felt doubtful about being able to convince the government, they felt angry and frustrated about government inaction, and most of them felt joyful about their victory (sections 6.4.4, 7.1.1 and 7.2). Thus, people were emotionally impacted by the Coalitions advocacy process – some of these impacted people positively while others, negatively. It is noteworthy that “felt experiences”, emotions, influence health/well-being (Gallo and Matthews 2003; McIntyre, Officer, and Robinson 2003; Robinson, McIntyre, and Officer 2005).

7.5.3 Advocacy volunteers’ sense of power and control

Data about impacts on advocacy volunteers’ sense of power and control which resulted from advocacy processes were found across the four methods - personal interviews, observations of the Coalition during meetings, phone interviews with 39
CBOs and the focus groups. Power and control is a central concept in critical inquiry (Carroll 2004; Kincheloe and McLaren 2005), in some health/well-being literature (Hancock, Labonte, and Edwards 2000; McCubbin 2001) and in government-CBO relations (Brock and Banting 2001b; Rice and Prince 2003). In the phone interviews and personal interviews, advocacy volunteers, CBOs and government interviewees perceived advocacy volunteers had some power and control to use their voices and participate within advocacy efforts. My observations of advocacy volunteers over the one year indicated they had the power to control their own monthly agendas, to choose and implement actions intended to influence municipal government decisions, and to keep the Coalition moving forward. However, in the volunteers focus group, one of the most intense discussions which involved all the volunteers, revolved around the recognition that “coalitions are not part of the system”, that they were pushed out and that none of them were involved in any government advisory committees (Advocacy volunteers focus group transcript). I recall Browne’s (1996, p. 82) point, that “if the voluntary sector and social movements produce social capital on the margins of a world ruled by market forces…” then concerns persist regarding social justice and population health.

7.5.4 Social connectedness outcomes/impacts

Data about impacts on people’s social connectedness which resulted from advocacy processes were found in personal interviews, observations of the Coalition during meetings, phone interviews with 39 CBOs and the focus groups. Social connectedness may be examined at both individual and community levels. Expanded friendship networks, mutual support, getting to know people in the community expanding
networks among CBOs and between CBOs and governments, and enhanced communication across groups were examples cited. These social connections among people can reduce stress in other areas of people’s lives (Hayes and Glouberman 1999; Levine 2007) and reduce isolation (section 7.1.1). Advocacy work brings together people who share the same interest in a particular problem (Hancock, Labonte, and Edwards 2000; Levine 2007) and it creates larger social networks because as noted in earlier data, cross-fertilization among community groups occurred (sections 6.1.1 and 6.2.1). All the advocacy volunteers described how a group of strangers came together and became known to each other over the course of their advocacy work (interview data in section 7.1.1 and advocacy focus group data in section 7.3). Based on my observations they worked co-operatively and were non-hierarchical which may reflect social equality among group members (Grabb 2007). However, other data show there are both negative and positive impacts as conflict ensues between people and some people quit processes while others supported each other further on different issues (ibid., section 7.2 and Observation Notes of Coalition Nov. 2006 and Jun. 2007). Thus advocacy impacts people’s social connectedness.

7.5.5 Behaviour outcomes/impacts

Data about impacts on people’s behaviour as a result of advocacy processes were found in personal interviews, observations of the Coalition during meetings, focus groups, and phone interviews with 39 CBOs. There is one example which clearly illuminated links between interviewees’ perceptions and what I actually observed, thus showing behavioural change occurred for some people. An advocacy volunteer stated
during her interview that she had not chaired Coalition meetings between 2001-2005 because she did not have the skills (Vol-45). However, I observed her chairing meetings in 2006-2007 (Observational Notes for Coalition 2007) and in the CBO focus group one of the CBOs described how she saw this same person “blossom” over time (CBO focus group transcript). The fact the Coalition is still meeting today is also testimony to advocacy volunteers’ behaviour – they are actively engaged. Data from the other sources included similar descriptions about advocacy volunteers who went on to volunteer in other CBOs and other initiatives. Thus advocacy impacts people’s behaviour.

Behaviour outcomes/impacts were also implicated at the community level. Some interviewees stated these were difficult to observe (section 7.4). The data across methods indicated that people participated in public meetings, that there was increased community organizing capacity, that advocacy groups copy each other’s advocacy behaviour and that there is a certain community readiness for other issues that occurred after advocacy processes had run their courses. These results are linked to the proposition that active communities make healthier communities (Hancock, Labonte, and Edwards 2000). In the focus group the advocacy volunteers generally agreed that healthy communities are “constantly changing, always dynamic, people are always pushing …” for change (Advocacy volunteers focus group).

7.5.6 Closing thoughts

In closing, the goal of social policy advocacy is to change government policy. However, in the process, change occurs in different spheres – for example, individuals and communities. The impacts do not occur linearly, they are not totally predictable and
they affect different people in different ways. As well, these impacts are not discrete, bounded elements but rather they are interconnected (e.g., learning leads to behaviour changes which can then affect social relationships). These outcome/impact results remind us of a key characteristic of qualitative research using critical inquiry – any concept viewed through different people’s eyes yields multiple meanings and is not fixed over time (Crotty 2003).
8. CONCLUSIONS

This study is about social service CBOs working in collaboration with marginalized populations to advocate for and assist in the movement toward healthier communities through public policy participation based on a social justice orientation. In this final chapter, I begin with an answer to my last research question, question #6, “based on the answers to the five main questions, how can the links between CBO policy advocacy processes and population health be conceptualized?” Second, I present seven major conclusions based on my research questions and the collected data; I discuss conclusions that stem from the findings, highlight contributions to the literature, discuss implications, and offer suggestions for action. I did not structure this chapter using my original research questions because I was interested in documenting explicitly, the major conclusions that emerged from the data and across-methods. Third, I offer a description of some limitations of my research and, since this study is exploratory and descriptive, I offer some thoughts and suggestions about future research. Finally, I close with some lingering questions.

8.1 Conceptualization of CBO advocacy and population health

Research question #6 is based on the analysis of data collected through the first five research questions, and is about conceptualizing the links between social policy advocacy processes and population health. After re-thinking my analysis within the context of the literature, I determined the most fitting way to present the links between these two central concepts is through a discussion about ‘shared terrain’. Figure 8.1 offers
a visual depiction of CBO policy advocacy and population health; the two large ovals represent each concept and their overlap is considered the shared terrain.86 This overlap is shown in the middle of Figure 8.1. Four main dimensions of CBO facilitated policy advocacy processes and population health are made evident through this study: social justice orientation, social conditions/social determinants, governance processes, and outcomes/impacts in different spheres. Let us now examine each of these four dimensions.

Figure 8.1: Conceptualization of CBO policy advocacy and population health

86 There are also a number of elements of CBO facilitated advocacy and population health that are in opposition to each other too. Advocacy is about community development while population health is about epidemiology (Corin 1994), and advocacy is a politically charged term whereas population health feels politically neutral (Hayes and Dunn 1998).
First, a social justice orientation can be illuminated in both social policy advocacy and population health. Social justice is about reducing marginalization and inequities through the redistribution of material and nonmaterial resources (Fraser 2003; Hofrichter 2003a; Mullaly 1997), recognition and respect for all people (Cohen, de la Vega, and Watson 2001), participation in community life (Fraser and Honneth 2003; Hofrichter 2003a), and human capacity and human development (Gindin 2002). Advocacy and population health both share the goal of making change, especially regarding inequities that exist across populations (Hancock, Labonte, and Edwards 2000; Hofrichter 2003b). As well, advocacy and population health both promote societal, not individualist, responsibility for creating healthy populations (Levy and Sidel 2006b).

Second, CBO advocacy is concerned with changing negative social conditions while population health is concerned with changing the social determinants of health in order to create healthier populations using a broad definition of health. For example, poverty is considered to be a social condition and a determinant of health. I was interested in the following five conditions, which are simultaneously social conditions and social determinants of health: socio-economic status, social connectedness, exclusion and discrimination, perception of one’s place in a social hierarchy, and sense of power and control (Hancock, Labonte, and Edwards 2000; Raphael 2003; Reid 2004b). Population health encourages us to examine these determinants/conditions in different spheres, from the micro to the macro (i.e., individual to community).

Third, governance is “the sum of all the ways …. in which we participate in running our communities and our society” (Hancock, Labonte, and Edwards 2000, p. 51) (see also Jenson 2001), but there is a need to reform and democratize governments in
order to facilitate this participation (Panitch 1993; Phillips and Orsini 2002). Civic action/participation and voluntarism are two elements which fall into this governance dimension (Hancock, Labonte, and Edwards 2000). Advocacy too, is a form of civic participation which includes roles for volunteers. Advocacy initiatives are dynamic processes that, over time, are influenced by a variety of conditions (e.g., advocacy volunteers’ perception of their vulnerability, government receptivity). Data collected from Coalition participants showed there were positive aspects to advocacy including motivation and energy, a belief things will change, contribution to a collective effort and feeling supported by others. There were also negative aspects including arguing, burning out, feeling angry and frustrated, and feeling controlled by governments.

Fourth, population health and advocacy both have implications for health/well-being within different spheres. Population health focuses on tracing pathways through processes from health determinants to health status (i.e., positive health, negative health, and health disparities) (Hancock, Labonte, and Edwards 2000). Advocacy processes can change people and unjust situations; these changes have implications for health/well-being (e.g., enhanced social connectedness, increased sense of control) in different spheres (e.g., individuals, CBOs, governments and communities). For example, my collected data from 39 CBOs and 17 Coalition participants indicated a perception that communities had changed as a result of advocacy processes. One perceived change was that communities became more aware of unjust situations, marginalized groups and policy options. Another perceived change was that communities became more organized and ready to engage in further action for change. Thus, by paying attention to different spheres and different population health elements, we can better trace the impacts of
participatory advocacy processes (Flynn and Hodgkinson 2001b; Greenway 2001; Guthrie et al. 2005; Hatry et al. 1996; Mayne 1999).

8.2 Main themes, implications and suggestions for action

The seven sections that follow present seven major conclusions based on the collected data. These sections were formulated using my study questions, the rationale in chapter 1, and data found cross-methods. I should emphasize at this point that I struggled to find balance in this chapter between the theoretical and the applied. Since critical inquiry encourages us to think about action for change, I chose the applied approach and formulated suggested actions for change.

8.2.1 Advocacy volunteers and advocacy work

This study shows the existence of advocacy volunteers and CBO-facilitated social policy advocacy through interview data and CBO documents but not through government annual reports (research question #1). The data collected from the 39 CBOs indicate volunteers work to change policies that affect themselves, a group of other marginalized people, or both. These volunteers play a variety of roles within advocacy processes. The data collected from 17 Coalition participants indicated advocacy volunteers are not powerless, voiceless and inactive people. A critical inquiry approach was beneficial in this research because it encouraged me to see both repressive and emancipatory elements (Crotty 2003; Denzin 2005). The fact the Coalition still exists today and continues to put pressure on municipal council for certain policy changes is wholly the result of advocacy volunteers who organize monthly meetings – or more often – as well as plan and implement actions. CBOs are not currently playing a leadership role in the Coalition the
way they did between 1999 and 2005. Examining a phenomenon such as advocacy using a strengths-based approach, which does not view people as helpless victims, aids in creating a balance between the challenges people face and the possibilities before them (McIntyre, Officer, and Robinson 2003).

How is advocacy work conceived (research question #2)? Social policy advocacy unfolds within a dynamic context comprising communities, governments, and local, provincial and national level CBOs, all of whom interact with each other in various ways depending on the advocacy issue on hand. The telephone interview results showed that all 39 CBOs rely on their service delivery experiences to inform their advocacy work. They believe their front-line service delivery work informs their advocacy work, which may remain as one-on-one advocacy with an individual or become a collective policy advocacy initiative. In general, these CBOs saw policy advocacy, program advocacy, funding advocacy and research advocacy as being interconnected. These advocacy types may or may not include marginalized people directly, may include other CBOs and may include government representatives. Across the 39 CBOs, seven general advocacy strategies were described.

There were many conditions which affected CBOs’ decisions to involve certain people and to choose certain strategies, which made these processes fluid in nature. The interview results indicated CBOs gather people together, encourage people to talk about their experiences, which then opens other people up to talk, which can then lead to action. In order to conduct further research on the advocacy function of CBOs, some actions are required.
Action 1: That Statistics Canada, in collaboration with the Canada Revenue Agency, provincial/territorial governments and national CBOs, re-configure and operationalize annual CBO forms (e.g., Form T3010) as well as engage in further survey research about advocacy (see Legowski and Albert 1999). These data would contribute substantially to an enhanced picture of CBO-based advocacy and advocacy volunteers in conjunction with studies like the Canada Survey of Giving, Volunteering and Participating (Hall et al. 2006).

Action 2: That in order for CBOs to feel safe about providing advocacy data – that is, for “advocacy chill” to be reduced - the Canada Revenue Agency should revise and update its definitions and add clarity regarding permitted CBO advocacy activities based on the research and recommendations already published by numerous scholars (Bridge 2002; Harvie 2002; Phillips, Chapman, and Stevens 2001; Rektor 2002). Advocacy appears acceptable to the public, given an opinion poll indicated 95% of community residents agreed that CBOs should speak out on issues relating to the environment, health care and poverty (Muttart Foundation 2004).

8.2.2 Social service CBOs play roles in creating health/well-being

CBOs believe they help to create health/well-being through their advocacy work and their service delivery role (research question #3). Thirty-four (87%) of the 39 CBOs said they believe that advocacy is a necessary function for CBOs in this current era in order to enhance the health/well-being of individuals and communities. The data also showed that 35 CBOs (90%) believed that they contribute to health/well-being by providing services directed at ameliorating negative social conditions. They provide essential services like food, shelter and clothing, as well as places for marginalized people to go, and encourage social interactions (e.g., drop-in centres for people with mental health issues). 87 One study in particular presented data which showed mental health CBOs in Saskatchewan “play a role in providing essential services for mental

87 What is not known from these data, is to what degree these CBOs are into “social integration”, which may also be a form of social control (Shragge and Fontan 2000). CBOs may provide essential services but also act to control marginalized people. As well, without program evaluation data we do not know about actual programs impacts.
health clients” (Kly and Thériault 2001, p. 9) (see also Hall et al. 2004; Salamon and Anheier 1997).

The analysis of the Saskatchewan CBO reports indicated community members and CBOs are usually the first to respond to human crises in communities and that government responses usually lag behind this community volunteer and CBO response (Canadian Red Cross Society 1990; Canadian Welfare Council 1938; Sanche and Bates 1976). As well, CBOs “deliver services on behalf of the state, some fill gaps left by the state and some respond to emerging social needs” (Brock and Banting 2001a; McFarlane and Roach 1999c, p. 3). Yet, there appears to be no more clarity today than there was in the past about who is responsible for what and who should pay for what between the government and CBOs in Saskatchewan (Canadian Welfare Council 1938; O'Sullivan and Sorensen 1988; Thériault, Gill, and Kly 2002). This lack of clarity is concerning because the voluntary social service sector contributes to enhancing population health through its work on the social determinants of health (e.g., socio-economic status, social exclusion) and its engagement of marginalized people in social policy making. The experiential knowledge of people with certain lived experiences, as well as that of the CBOs who serve them, is critical to the creation of responsive social polices; “even though it would be more time consuming and involve more money on the part of governments, if they’re really wanting to develop policies that are meaningful to the people they’re wanting to help” then they should involve those people (CBO1-2). The shifts in democratic governance as well as more deliberative, participatory policy making approaches and interest in local knowledge may offer a refreshing environment for CBO advocacy (Fischer 2003; Hajer and Wagenaar 2003). Social service CBOs are engaged in
social innovation (Goldenberg 2004) and have an important role to play in the future regarding place-based policies and possible emerging new roles for the federal government in creating stronger, healthier neighbourhoods (Bradford 2005).

Action 3: That social service CBOs that work closely with marginalized communities and these communities themselves become integrally involved in health research and planning because they work closely with the social determinants of health due to their social service delivery function.

Action 4: Much knowledge translation (KT) refers to a researcher-policy maker dyad but this research points to the utility of a triad in KT: community (including marginalized people and CBOs), researchers, and policymakers. From a social justice and a critical inquiry perspective, marginalized people and CBOs must become involved in knowledge creation and knowledge transfer for healthier public policies – despite the barriers to participation. This focus would assist in moving policy makers beyond making health/well-being policy decisions based on political feasibility and preoccupation with the health care system (Evans and Stoddart 2003).

8.2.3 Advocacy processes: power to include or exclude

CBO advocacy may or may not include advocacy volunteers

Thirty-nine CBOs from around the province were interviewed by telephone about their social policy advocacy work (research question #2). I found that 23 of the 39 CBOs stated marginalized people were directly involved in the policy advocacy initiatives they cited as examples; of the 42 policy advocacy initiatives cited, 28 (67%) involved marginalized people.88 I was surprised there were so many examples of marginalized people’s non-participation in CBO advocacy work. This fact may indicate that, at least in some instances, the CBO sector can be an agent of the state using quiet coercion to

88 Given the nature of this interview protocol, I cannot say definitively that only 28 initiatives included marginalized individuals because of the fluidity of these processes. Some CBO interviewees, however, disclosed they were part of a marginalized community and brought their experiences and voices as well as other marginalized voices to advocacy tables.
influence behaviour (Cruikshank 1999) and work toward social integration and social control (Shragge and Fontan 2000) as opposed to creating resistance and advocating for healthy change.

A number of barriers to participation were cited by the 17 Coalition participants and the 39 CBOs, although based on the extensiveness criterion, the order of barriers was different for each sample (research questions #4 and #2 respectively). First, Coalition participants discussed (from most extensive to least cited) “within-Coalition issues” (e.g., aggression, bickering, differences of opinion, lack of skills to run meetings), government mal-treatment and other structural barriers, psychological barriers (e.g., fear of speaking out), survival issues, lack of practical supports, and lengthiness of the process. Second, the most extensive barriers cited by the 39 CBOs (from most to least) included psychological barriers (e.g., fear, hopelessness, lack of confidence), lack of practical supports, survival issues, disabilities, language and culture barriers, lack of awareness and skills, and structural barriers imposed by governments or CBOs (see Labonte and Edwards 1995 for additional information). Some CBOs indicated they used their understanding of some of these barriers as well as other conditions to decide whether or not to include marginalized people in their advocacy work. Participation is a dimension of social justice (Fraser 2003; Hofrichter 2003a; Mullaly 1997), of social policy advocacy (Harvie 2002; Rektor 2002) and of governance (Hancock, Labonte, and Edwards 2000; Jenson 2001; Phillips 2001b), and may have positive impacts on people’s health/well-being (Abelson et al. 2003; Labonte and Edwards 1995). Thus, CBOs should be careful not to be disempowering, controlling and exclusionary (Cruikshank 1999; Shragge and Fontan 2000) by making assumptions about marginalized people and their participation.
All advocacy volunteers in this study were involved in at least four other initiatives.\(^{89}\)

Communities are made up of a diversity of people from which advocacy volunteers could be sought for participation. Recent research shows citizens want to be engaged in policy issues (Sheedy 2008) and that shifts toward more deliberative and participatory policy making approaches (Fischer 2003; Hajer and Wagenaar 2003) with an acceptance of diverse groups’ creative problem solving capacity and dialogue (Laforest and Orsini 2005) may make engagement more effective.

**Action 5:** That CBOs strive to include marginalized people directly in their advocacy processes regardless what they have come to understand as barriers to participation. Our communities comprise diverse peoples and this study has shown that marginalized people can and do participate in advocacy work. Marginalized people should be encouraged to participate as well as name their needs and engage in ongoing processes of claimsmaking (Drover and Kerans 1993), which is maximized when the CBO sector plays its citizenship-building and social change roles (Shragge, Graefe, and Fontan 2001).

**Action 6:** That social policy makers ensure marginalized citizens who are the focus of a new or modified policy are at the centre of the policy making process from beginning to end – including the evaluation phase. These are the people that I have labelled ‘advocacy volunteers’ who have lived experiences that can enhance policy content.\(^{90}\) On the next concentric circle out from the centre should be CBOs. On the periphery should be government staff whose task would be to draft policy based on this input.

**Action 7:** That social policy curricula in Canada adopt a community-centred policy making process approach wherein people who are the focus of a proposed new or modified social policy are more valued than what is politically feasible. Curry-Stevens (2006) points out that public policy schools teach very little about advocacy and social movements as influential public policy vehicles. As already stated, current social policies are based on neo-liberal values of individualism, self reliance and targeted programs (Bakker and Scott 1997; Brooks 2001; Browne 1996; Teeple 2000). As well, social policy making processes do not require public participation (Gil 1992, p. 24; Graham, Swift, and Delaney 2003; Langille 2004).

---

\(^{89}\) Two of the advocacy volunteers were involved as volunteers in four other initiatives, while the others were involved in five or more; one volunteer had 10 volunteer commitments.

\(^{90}\) Some theorists would argue this is exactly how economic and fiscal policies are formulated in Canada – and at the centre of these policy making processes is the business community (Langille 2004).
Wharf and McKenzie 1998) yet from a social justice perspective, marginalized people should be full participants (Fraser 2003; Hofrichter 2003a; Mullaly 1997). This requirement is similar to what is already required through environmental protection acts wherein public notification and discussion are required before new policies or projects are approved.

In advocacy processes, I found both positive and negative features. These have implications for health/well-being. In the advocacy Coalition case study some of the positive features of the process included: having choices regarding the tasks to be done; believing one’s knowledge is important and that things will change; thinking beyond one self; supporting others and feeling supported; contributing; committing and persisting; and feeling excited and happy. Some of the negative features included: struggling and arguing with each other and with governments; burning out and dropping out; being controlled and silenced by governments; not being able to get to meetings; doubting; feeling frustrated; and needing to be careful because “somebody might be listening”. Some of these have implications for positive health/well-being while others would be negative.

**Coalition included everyone and used its power to make change**

Advocacy work through coalitions comprising marginalized people and CBOs is a form of civic participation and voluntarism as defined by Hancock (2000) (research question #4). The data indicated power-within existed for some advocacy volunteers and CBO representatives (Nozick 1992). Both the group of volunteers and the group of CBOs had mixed reactions about power and control. Some said they had optimism about making change and they had a sense of power to change things, while others said this was not the case for them.
The data also indicated power-with-others existed in the work of the Coalition as people worked together on a variety of strategies to encourage governments to make the policy change. Some of these strategies included: deciding on presentations to city council, raising awareness, and conducting literature searches. The formation of an all-volunteers group was significant because it showed they were concerned about the need to re-mobilize efforts, they had a sense of power-with-others, and they had motivation to push the policy issue. This finding is linked to critical inquiry, which is concerned with both the oppressive aspects of power but also “focuses on the productive aspects of power – its ability to … engage marginalized people” in rethinking their role (Kincheloe and McLaren 2005, p. 309).

The analysis also showed the government exerted power-over the Coalition when it “hijacked” the process (CBO2-52) and made decisions about the new policy which subsequently had the effect of dividing Coalition members. Some members left the process, others argued among themselves, and others continued to focus on the change agenda. The governments appeared to have controlled the financial resources, people, and ideas (Grabb 2007). In the end, based on these data, it was the government representatives who had the power to choose policy content. Thus, even though this was a Coalition process, the government still had ultimate power to control it and in the end ensured no structural change took place. The Coalition had to settle for incremental change at the lowest level (Amenta and Young 1999).

**Advocacy volunteers included in Coalitions but excluded from government committees**

The Coalition data showed advocacy volunteers spoke out at various public government meetings and/or voiced their concerns about certain government services
over time (research question #4). It appears that one consequence of this behaviour, however, is that they are no longer permitted to join government advisory committees. As well, some have been threatened with loss of access to public services. At the time of data collection, none of these volunteers were members of municipal government committees. In fact, at one Coalition meeting, they discussed how they submitted their applications to city hall but were turned down. Thus, they were included in advocacy coalitions and worked on policy from outside government but were excluded from government policy committees.

There are positive and negative implications of this situation. Some advocacy volunteers indicated they believed they were freer to speak in and through coalitions. Other advocacy volunteers seemed to feel a loss about not being able to participate in government committees though. Labonte (2004) explains an inclusion/exclusion tension and encourages us to think critically about “socially excluding structures and practices” rather than socially excluded groups (p. 253). In the case of the Coalition members, they were excluded from the government-accepted system of policy making discussions but they still managed to gain a partial policy victory based on their work from the outside.91

91 What is curious here is that the government had an advisory committee set up to make decisions about a policy similar to that which the Coalition was advocating. In general, government advisory committees are typically viewed as governments’ links to communities. However, recently there has been a wave of government mandated changes that affect CBOs independence. For example, Saskatchewan boards of education forced parent-teacher associations, a type of CBO, to cease operating as independent nonprofits and become advisory groups to school boards (http://www.learning.gov.sk.ca/Default.aspx?DN=c2f581ae-05a0-4de8-8cd6-99274e05b111, accessed May 10, 2008). In essence though, as advisory committees, they became arms of government. Similarly, in Ontario, passage of Bill 36 now gives the Minister of Health the power to merge CBOs (http://www.health.gov.on.ca/transformation/lhin/011706/lhin_bul_19_011706.html, accessed May 10, 2008). Do these two examples reflect a trend toward more government control of what were ‘independent voices’? Or might these government advisory committees show that people will have a better “in” with governments than they had before? Data from advocacy volunteers in my study indicate yes to the first question and no to the second.
In conclusion, social policy advocacy as a form of civic participation can increase social inclusion and lead to healthier public policy for marginalized people, but it can also increase social exclusion from government systems. Power-within and power-with-others through the Coalition moved the policy issue on to the public agenda, while the government’s power-over created the shape of the policy. From a social justice perspective, participation in one’s community is essential and should be encouraged. Healthy communities are not made up of apathetic citizens, but rather active citizens (Aronson et al. 2006; Hancock, Labonte, and Edwards 2000).

8.2.4 Advocacy changes individuals and communities: health/well-being links

Advocacy by definition for my study consisted of those purposive efforts of CBOs to change specific existing or proposed government policies in collaboration with groups of marginalized people (Ezell 2001). During the process of doing advocacy work, people and communities can change. I was interested in perceived changes that may be linked to health-well-being in individuals, CBOs, governments and communities (research questions #3 and #5).

Given my interest in perceived outcomes/impacts, I had created a list of categories related to population health for Coalition interviewees (e.g., learning, social connectedness, sense of power). Using a multi-method approach in order to triangulate data (Marshall and Rossman 2006; Yin 2003), I found similar responses in a number of categories across the three groups constituting the Coalition case study. The data revealed both positive and negative perceived impacts. I offer a general summary here of three groups’ perceived impacts on advocacy volunteers which resulted from the Coalition’s
process: enhanced status because people like the Mayor knew them by name; learned new knowledge and skills about policy making and working in groups; behavioural changes included going on to become the chairperson of another coalition; emotional reactions included both positive (e.g., feeling excited) and negative responses (e.g., being furious when the government dropped LICO, feeling excluded from government committees); an increase in motivation to keep moving forward; a sense of power and control to change a situation; mental responses included both positive (e.g., feeling productive) and negative (e.g., stress) elements; a sense of success due to the partial policy victory; an increase in social connectedness including an expanded network of friends; and an attitude of valuing everyone’s contributions.92

There were also perceived impacts on CBOs. Some of these impacts on CBO representatives included: behavioural changes which saw CBOs work more collaboratively; learned about governments; felt satisfied and victorious after the partial policy win; felt mentally exhausted near the end; felt motivated and optimistic about making change; had a sense of control to change things; had an attitude of knowing they were doing the right thing; and expanded networks among CBOs.

There were also perceived impacts on governments. Some of these impacts on governments included: enhanced political status when they made the policy change and took credit for the policy idea; behavioural change which resulted in listening more carefully to groups; learned about poverty and disability issues; emotional reactions included joy when the province agreed to partner with the city, but resentment about

92 In general, similar results were found about impacts on volunteers in the data gathered from the 39 CBOs.
having to deal with the Coalition; and mental responses that included “headaches” from
the process. Interviewees also talked about changes that occurred institutionally and
included, for example, enhanced links and communication between government
departments and between different levels of government as well as between governments
and CBOs.

Finally, perceived impacts on communities were cited. Some of the perceived
impacts on communities included: increased community organizing capacity because
people came to know each other through working together; groups copied other groups’
advocacy behaviour; increased communication between governments and the
community; sense of success in one initiative encouraged more advocacy and more
activity in other areas in the community; increased awareness throughout the community
about marginalized groups and their policy issues; and sometimes policy wins spread to
other communities. In the focus group, the advocacy volunteers had a discussion about
healthy communities. There appeared to be general agreement that healthy communities
are “constantly changing, always dynamic, people are always pushing …” for change.

The 39 CBOs showed notable similarities compared with the Coalition data
regarding perceived impacts on communities. In general, these 39 CBOs stated they also
perceived changes in the community sphere. These changes included: a sense of success,
which encouraged more advocacy; increased links among groups due to the cross
fertilization of issues; that advocates went on to be active in other areas of the
community; and the community became more aware of the social policy issue as a result
of media coverage.
In conclusion, the data collected from the 56 interviewees showed advocacy processes were perceived to have changed individuals and communities. The data reflect both positive and negative changes on some variables related to population health in a variety of spheres. First, individual wellness has been shown to result from three dimensions, all of which were found in varying degrees in the interview data: the attainment of material and psychological resources; participation and ability to make choices; and competency (Prilleltensky, Nelson, and Peirson 2001). Second, at the community level, most of the interviewees perceived that advocacy processes can create more active and engaged communities (Nunn 2002); these kinds of communities tend to be healthier communities due to an increase in social capital (Aronson et al. 2006; Hancock, Labonte, and Edwards 2000; Kawachi and Berkman 2000) and participatory policy making may be a “health promoting activity” (Reid 2004b, p. 238). These data results offer evidence to the dearth of literature about CBO-facilitated advocacy which was cited in chapter 1 (Brock and Banting 2001b; Harvie 2002; Legowski and Albert 1999).

Action 8: That CBOs and governments realize that social policy advocacy work is not simply about fighting for policy change, but that advocacy is itself a form of civic participation which can change individuals and communities. Data collected for this current study indicate that these processes give marginalized people a place to go, participate, belong (Jenson 1998), and contribute to democracy beyond simply voting during elections (Panitch 1993). In our current era where talk about social exclusion is common, collaborative social policy advocacy should not be overlooked.

8.2.5 Multiplicity, fluidity and some unpredictability

Advocacy processes across communities and time are seldom identical (research questions #2, #3, #4, and #5). “Process-sensitive scholars watch the world flow by like a
river in which the exact contents of the water are never the same” (Kincheloe and McLaren 2005, p. 319). There are different advocacy volunteers, different CBOs, different governments, different communities (e.g., rural, urban), different social problems, and different political histories, all of which influence advocacy processes. These multiple “conditions … shift and change over time, affect one another, and combine in various ways … and there may be new ones added along the way” (Strauss and Corbin 1998, p. 131) but it is not “possible to discern all the possible connections among conditions” (ibid., p. 188). Thus, there can be multiple experiences of the same advocacy process, which may explain why some research on participation does not show clear positive health/well-being impacts (Keleher 2007b). For example, some people may burn out and quit while others become more motivated and energized to win the policy battle. Some people learned about city council while others learned how to work better within coalitions. Some people became angry and yelled while others withdrew and became pensive during meetings. Some women’s shelter CBOs encouraged women to speak out while other women’s CBOs spoke for them. Some government representatives said they were happy that a non-business group came to city hall to plead their case while another wished the Coalition did not exist. The critical concluding points are that processes are multidimensional, fluid and sometimes unpredictable, but at the end of an advocacy process, seldom do individuals or communities remain unchanged.

Action 9: That when we undertake to do research and social policy development, we are prepared for multiplicity, fluidity and some unpredictability. From a critical inquiry perspective, “the spotlight is on power relationships” (Crotty 2003, p. 157) and we should begin with those who are marginalized and ensure their experiences remain central throughout. We must work to change processes that
currently do not incorporate the plurality of identities, experiences, and histories that constitute current society (Jenson 2001) (see also Action #7).

One additional note is warranted before leaving this section. The data collected for this study showed that a multiplicity of government-CBO relations exists. This discussion about multiplicity of relations began with the literature review (Boudreau 2006; Brock 2002b; Brock and Banting 2001b; Coston 1998; Shragge and Fontan 2000). The analyzed data from government annual reports, CBO reports, observations of the macro-context and interviews with the 39 CBOs showed similar evidence including the impacts of shifts in the type of funding arrangements with governments (e.g., shift toward fee-for-service contracts), lack of clarity about government rules about advocacy led some CBOs to withdraw from advocacy work, CBOs stated both positive (e.g., felt encouraged) and negative feelings (e.g., antagonism, felt de-valued) about their relationship with governments, some CBOs said they preferred to have a “partnership” with governments while governments said they already have many “partnerships” with CBOs, and finally, some CBOs interact with different levels of governments, each with their own organizational cultures and different financial resources. These government-CBO relations are shaped by historical events, the amount and type of government funding to CBOs (Banting 2000; Brock and Banting 2001b; Brooks 2001; Browne 1996; Hall et al. 2005; Rice and Prince 2003; Vaillancourt and Tremblay 2002) and government rules and expectations (Bridge 2002; Harvie 2002). I will now explain further, government rules and funding.
8.2.6 Rules, money, fear and silence … but not always

The influence of government funding and/or government rules on advocacy (i.e., those from Canada Revenue Agency based on the *Income Tax Act*) was made obvious through this study (research question #1, #2, and #3). In general, money and rules are sources of power that are used by governments (Grabb 2007) to produce fear in people, which in turn silences them. But this may not always be the sequence of events. Let us explore this further.

Literature cited showed that government funding arrangements can affect the degree to which CBOs speak out (McFarlane and Roach 1999c; Vogel 1991). As well “advocacy chill”, a term used in chapter 2, describes the dampening effect put on CBO advocacy specifically because of government rules (Bridge 2002; Harvie 2002). Interview data from the 39 CBOs indicated that many CBOs are aware of CRA rules, nine of the 39 explicitly noted that CRA rules limit CBO advocacy work and that some CBOs have signed funding contracts with governments in which they agreed they would not do advocacy (e.g., CBO1-18). The observational data indicated that during provincial elections in the fall of 2007, the CRA circulated e-bulletins to CBOs reminding them about the rules, definitions and criteria which limit advocacy. This led some CBOs to decide not to get involved in the election. Interestingly, the CBOs involved in my study

---

93 It is not just advocacy behaviour that may be affected. When money is granted to CBOs, governments have been known to tell CBOs how to behave. For example, in a phone conversation in early 2008, CBO1-21 indicated that she had been interviewed by the press about government funding that she and other similar CBOs had recently received. The day after the story ran in the newspaper, a senior government staff person called her and suggested that she should not have talked so much about community needs, but rather, she should have focused on where the money will be spent and how wonderful it was that that government gave that group of CBOs this funding. She went on to say that she would not be attending an upcoming government-CBO meeting; she thought “it was best not to go”.

265
do advocacy work, thus fear did not seem to immobilize them. It may be concluded then that
government rules and money create fear and silence for some CBOs at times, but not always.94

Further, data collected from the 39 CBOs and the 17 Coalition participants indicate that “advocacy chill” appears to extend to advocacy volunteers too. Data from some of the 39 interviewees indicated marginalized people chose not to get involved in advocacy initiatives because they were threatened by governments with loss of their welfare cheque and/or with having their children taken from them. Within the dataset created from the 17 Coalition participant interviews, some of the advocacy volunteers talked about a sense of fear and danger, and CBOs also perceived advocacy volunteers feared repercussions from governments. Thus, government money and rules can have serious impacts on volunteers’ psychology and behaviour.

As I worked through these data, I was struck by a question. Does keeping advocacy volunteers and coalitions silent serve neo-liberal, free-market, capitalist purposes? If no one is allowed to speak out about social and health inequities, then the promotion of neo-liberalist policies can dominate public discourse. Healthy public policy built on marginalized people’s experiences would be weakened. But, from a social justice perspective, this silencing process should not be permitted. Application of human rights, a social justice tool, can be used to counter the apparent power and control that some governments exert over marginalized people and social service CBOs to discourage participation. Human rights can be used as a framework for analysis and advocacy to

94 Given the qualitative nature of my study, I could not discern the magnitude of this silencing effect.
expose human rights violations which have negative health consequences (Gruskin and Braveman 2006). Human rights language was not common in the interview data: it was raised by only four out of the 39 CBOs, three out of the 17 Coalition participants and in the advocacy volunteers’ focus group. The Canadian Charter of Rights and Freedoms and the Universal Declaration of Human Rights include clauses about freedom of thought and opinion (article 2.b as well as 18 & 19 respectively), freedom of peaceful assembly (article 2.c and 20, respectively) and the right to take part in government (article 21 of the Universal Declaration).95 The Charter can “legitimize social action … social discourse … protest” (Savarese and Morton 2007, p. 289). Advocating for social policy is civic participation within the context of governance. Thus, when governments threaten people, they are contravening human rights laws.

Action 10: That advocacy volunteers and CBOs learn more about human rights laws and use them as a regular point of reference to educate and, if necessary, confront governments regarding violations in human rights.

8.2.7 Structural and political determinants of health/well-being

I began my research with an interest in the social determinants of health in particular. However, when I reached the end of my analysis and re-thought connections between the data and some of the literature in chapter 2, structural and political determinants of health surfaced. According to some scholars, structural and political determinants of health are the ultimate causes of health and illness (Hofrichter 2003a; Labonte 2004; Reid 2004b). Mullaly (1997) offers a way to explore three main

---

dimensions of a structural framework: the foundation of society which is composed of the 
dominant ideology which in our current era is neo-liberalism; “social institutions that 
carry out society’s functions” including political institutions (ibid., p. 135); and social 
relations among people including superordinate-subordinate relations. I have results 
which fall into each of these main dimensions. These will be presented next.

First, let us consider the dominant ideology of our current era. Neo-liberal 
ideology and its proponents reflecting capitalist interests have done well over the past 30 
years in organizing an anti-welfare state campaign and de-legitimizing the needs, rights 
and demands of marginalized groups (e.g., visible minorities, single mothers) (Block et 
al. 1987; Teeple 2000). The results of my research indicated that by the late 1980s, public 
attitudes toward welfare recipients had hardened (Wardhaugh 2007), and that between 
the 1970s and 2000s there was more government financial support for CBOs working 
with “deserving groups” (e.g., those with physical disabilities but not single mothers on 
social assistance). As well, some of the 39 CBOs talked about volunteers’ psychological 
barriers including a feeling of constantly being put down by society (e.g., “poor bashing”, 
“crazy person”, feeling inadequate, feeling hopeless). Finally, some of the advocacy 
volunteers talked about having no life and living in a psychological ditch. CBOs should 
challenge the neo-liberalist’s campaign with a more progressive ideology given 
government ideology shapes policies (Wharf and McKenzie 1998).

Action 11: That national scale CBOs (e.g., Voluntary Sector Forum, Canadian 
Centre for Policy Alternatives) collaborate to create advocacy efforts similar to 
the neo-liberal campaign to positively influence social policy in Canada. When 
the business community wants to influence fiscal policy in Canada, it creates both 
informal and formal collaborations and lobbies for change (Langille 2004).
Action 12: That CBOs continue to play a major role in public education campaigns to encourage civic participation and re-value all people. CBOs should demand that healthy public policy be based on research evidence rather than on what is politically feasible. The data collected during this study indicate that the majority of CBOs play a role in raising community awareness of issues. Mass media and alternative media should be used as tools to encourage participation toward healthy public policy development (Wallack 2003).

Action 13: That CBOs work to educate individuals who support neo-liberalism. The CBO sector is a social force; it comprises a diversity of organizations providing a diversity of services and engaging large numbers of volunteers in practically every pocket of our communities (Hall et al. 2004). Many CBO volunteers have jobs in the private sector (e.g., local small businesses, multinational corporations). It is critical to help them understand the negative impacts of the current dominant ideology and subsequent policies on marginalized communities.

Action 14: That municipalities endorse the Toronto Charter on social determinants of health as some other municipalities have done. It is a tool to promote health and social justice (Raphael and Curry-Stevens 2004, p. 358). Enhancing public health requires a re-commitment to its roots in social justice (Beauchamp 2003).

Second, institutions – in particular political institutions – can be labelled a determinant of health because over the past few decades in Canada, governments have made choices about social policies that have not significantly benefitted marginalized people (Raphael 2003; Vaillancourt et al. 2003). “Public policy has been moulded to the needs of business” (Langille 2004, p. 283). However, a recent collection of critical policy studies offers optimism regarding more deliberative and participatory approaches beyond the business sector (Fischer 2003; Hajer and Wagenaar 2003). There are three main institutional elements to highlight here. I have already discussed government rules, but it cannot be emphasized enough that rules that silence people and/or restrict their sharing of
knowledge for the creation of healthier public policy is unjust. Another element of political institutions that advocacy volunteers and CBOs indicated worked against long term healthy public policy were election cycles in which governments change every few years. With these changes come shifts in ideology and political agendas as well as losses in advocacy gains that were made before the election. Finally, in the interviews with the 39 CBOs and the Coalition participants, one of the strategies noted was the cross-fertilization of issues by taking different issues to different groups’ meeting as well as pushing for the integration of issues across different levels of government and across government departments. Basically, these CBOs ignored government department walls - institutional silos. Thus, CBOs are able to force re-consideration of what might be artificial boundaries because in the community, people’s health/well-being is multi-dimensional and not constrained within silos. This appears to be another critical role for CBOs in that they are able to work on problems that governments cannot or will not because of the way they are structured. Raphael (2003) notes there are institutional, ideological, and attitudinal barriers to restructuring. Nonetheless, there is recognition of the need to work cross-departmentally (Institute of Medicine of the National Academies

---

96 Some of these rules are not legislative in nature like the CRA rules and the Income Tax Act, but rather they are subtle ways of operating wherein for example, marginalized groups are not even invited to meetings to discuss policy. Or, if they are invited, the atmosphere of the meeting is too professional and intimidating to people outside government, thus they may attend the meeting but do not speak (sections 6.1.2 and 6.2.2).

97 The Coalition began with a goal of having a new social policy adopted using the LICO. Adopting a policy based on LICO would have meant that three levels of government would have become involved and diverse populations would have become eligible (e.g., people with disabilities, some post-secondary students, working poor). However, LICO was not accepted by the governments involved, thus the Coalition had only a minor gain in cross-silo work.

98 I recognize that Regional Inter-Sectoral Committees exist in Saskatchewan and that quality of life reporting systems (e.g., Canadian Federation of Municipalities) are attempts to reduce silo effects.
2003) and that putting resources into places other than the health department may have a
larger impact on people’s health (Evans and Stoddart 1994).

Action 15: That when any level of government wants to implement a policy –
especially a tax policy – that, from an economic perspective, will have a
deleterious impact on the poorest neighbourhoods/areas in our cities, that health
department staff, neighbourhood clinics and other health groups work with social
service CBOs to advocate against those policies. Social policy advocacy should
be expanded to include governments confronting each other using social justice
principles to cross different levels of government and different government
departments.

Before leaving this section, we must not forget about the collected data which
indicated the CBO sector – or parts of the sector – may be part of the problem. It appears
CBOs have the capacity to engage in power-over marginalized people in a manner
similar to governments and that some of the participation barriers described include those
created by CBOs as well as governments (e.g., not inviting people to participate in policy
meetings). This may be the result of CBOs accepting a government-imposed social
control function (Cruikshank 1999; Shragge and Fontan 2000).

Third, social relations in the form of oppressive patterns “such as patriarchy,
racism and ageism” exist but should change (Mullaly 1997, p. 187). Data collected from
the six advocacy volunteers and the five CBOs involved with the Coalition indicated that
some marginalized people fear negative repercussions from speaking out and that they
feel constantly put down because “the welfare system is not there to breed hope” (Vol-
44). Data from the same two groups also indicated that in some instances governments
treated marginalized people badly at meetings as well as after meetings by contacting
them and voicing – sometimes by yelling - their disapproval of advocacy work. That
some government representatives act this way indicates their need to control and have
power over some marginalized people. Finally, some CBOs’ treatment of marginalized groups might also indicate a sense of control over them (e.g., not inviting them to participate in meetings).

In closing, neoliberal ideology has “shaped our social determinants of health” (Langille 2004, p. 283) and helped to create degrees of inequality (Coburn 2003). “Many socio-economic and environmental influences on health/well-being lie largely outside individual control” (Olivier 2003, p. 26) (see also Hancock, Labonte, and Edwards 2000). In the end, not only do structural and political determinants affect health/well-being and social policy content, but according to my research, they can also negatively affect civic participation and volunteering.

8.3 Limitations and further research

I want to highlight six main limitations to this current study and areas for further research. First, this study was based on people’s self perceptions as well as their observations and perceptions of others. “Language does not permit speakers or writers to ever have full access to the meaning they are attempting to convey” (Denzin 2004, p. 236). I tried to minimize this effect by probing during the interviews. As well, I reduced uncertainty by using multiple forms of evidence and engaging a variety of people. I think in future research I would build into the process an opportunity for study participants to keep a diary. This would be an observational log where they could write about and reflect on their advocacy experiences as they unfolded (Lofland and Lofland 1995). This would contribute deeper insight into these individuals’ perceptions.
Second, the Coalition interview data indicated that some people dropped out of the process. It would have been illustrative to interview them, to ask them the same set of questions, and then compare the answers with those who remained involved. 99 What are the similarities and differences between people who persist in advocacy processes and those who leave? Who is more socially isolated, less hopeful about making change, or less trusting? A better understanding of the differences between those who participate in advocacy processes and those who do not may help to explain some social determinants of health (e.g., sense of power, social connectedness) and health status.

Third, in the CBOs sampled from around the province, I intentionally left out fundraising CBOs like United Ways and community foundations. However, given their strong ties with corporations and governments, do they do social policy advocacy and if so what does it look like? What role if any do marginalized populations play in their processes? What influence might they be able to wield within the corporate and political worlds to change unhealthy health and social policies? These types of CBOs could shed further light on policy change and power issues in particular. If our goal is to create healthier populations and we know there are structural and political barriers, perhaps fundraising CBOs have a role to play in overcoming these.

Fourth, and also connected to structural and political determinants of health, further research should go beyond marginalized people’s perspectives – which was the emphasis in my current study. As Labonte (2004, p. 253) asks, why focus on “socially excluded groups rather than socially excluding structures and practices?” What are policy

99 Similar questions persist about CBOs around the province of Saskatchewan who refused to participate in my study.
makers’ values, bureaucratic structures, political frameworks and perceptions of marginalized communities which lead to various types of policy making processes and choices about who participates? What are the possibilities for altering these structural and political determinants in order to create healthier communities? A critical analysis of government legislation, regulations and underlying assumptions as well as interviews with government staff and elected officials would offer some answers.

Fifth, my current study collected data after an advocacy event had occurred. The limitation of this approach is that I had to rely on people’s memories and perceptions of what happened and how they had felt five years earlier. Another research method that would better track outcomes/impacts on people would be to select an advocacy initiative as it begins to unfold and administer before-, mid- and after-measures to track changes in people. The use of validated survey instruments to measure change over time in self-reported health status and subjective well-being (e.g., life satisfaction, stress/anxiety, sense of control, happiness), would be important.

Finally, in a province like Saskatchewan, with growing Aboriginal populations (Stokes 2003), does this volunteer advocacy paradigm fit? What might we learn from studying treaty rights advocacy work? It would be essential to explore this within a four-government system; that is, Aboriginal governments, federal government, provincial/territorial governments, and municipal governments.

8.4 Lingering questions

During my years working with CBOs, I noticed that some areas of public policy making encouraged people’s participation while other areas excluded people. For
example, why did the local health department invite low income people to discuss the formulation of new nutrition policies but the social services department did not invite low income people to develop poverty reduction policies? Why is the Canadian Council of Chief Executives participating in national economic policy development which serves their needs (e.g., Security and Prosperity Partnership Pact) but poor people cannot participate in policy development that serves their needs? Why does the Saskatchewan Environmental Assessment Act (Sections 10 and 13) require a media notice and suggest public meeting(s) before a policy or land use decision is made, yet no such activity is required regarding anti-poverty policy making in the Social Services Act? In Canada is there a hierarchy of deservedness which allows certain groups into policy making processes and not others? These questions remain unanswered, but I hypothesize there is a hierarchy of deservedness in policy making. People who are deserving (i.e., business people) participate in public policy development while those who are undeserving (i.e., people with mental health issues) do not. Similarly, within the social service sector specifically, I hypothesize that people with physical disabilities are engaged in public policy making more so than are single mothers who are on social assistance.

8.5. Concluding comment

Through their policy advocacy function, social service CBOs work with marginalized groups to advocate for and assist in the movement toward healthier individuals and communities. Social justice and critical inquiry helped us to explore advocacy as a change process within the context of civic participation from the field of population health. Social justice and critical inquiry also assisted us to see that many
social determinants of health arise from societal structures, rather than individual failing. How we define social problems, which are also social determinants of health, and where we attribute cause leads us directly to certain policy processes and policy content.

“Health is a product of many social, political and economic forces and institutions outside of health … The achievement of equity in health status is not about improving the management of disease or simply increasing resources. Realizing health requires cooperation and coalitions among disparate organizations and communities in a coordinated campaign against social and economic inequality, including the institutions that sustain it. Health inequities are not primarily the result of accidents of nature or individual pathology but result from long-standing conditions and injustice …” (Hofrichter 2003a, p. 33) (emphasis added is mine).

Finally, in the end, I believe two of the defining characteristics of the social service CBO sector – nonprofit and strong role for volunteers – will persist to maintain the sector as unique in a capitalist society. This knowledge alone offers optimism for significant social policy advocacy work among disparate organizations and a shift toward healthier communities in the years ahead.
REFERENCES


Centre for Community Studies. 1959. *A summary of meetings held in five co-operating communities to explore the relationships of community councils, government field staff*, 279
and the center. Saskatoon, SK: University of Saskatchewan, Centre for Community Studies.


Crocus Co-operative, Saskatoon Mental Health Association, and Saskatoon Housing Coalition. 1987. *Community support research project*. Saskatoon, SK: no publisher.


Haire, Christopher. 1975. In want of a policy: A survey of the needs of nonprofit housing companies and co-operative housing societies. Ottawa, ON: Canadian Council on Social Development.


Hancock, Trevor, Ronald Labonte, and Rick Edwards. 2000. Indicators that count! - measuring population health at the community level. Toronto, ON: Centre for Health Promotion at University of Toronto and ParticipACTION.


Keleher, Helen, Colin MacDougall, and Berni Murphy, eds. 2007. Understanding health promotion. Victoria, AU: Oxford University Press.


Lewis, David and Frank Scott. 1943. Make this your Canada: A review of CCF history and policy. Winnipeg, MB: Central Canada Publishing Co.


Luther, Rashmi and Edward Osei Kwadwo Prempeh. 2003. Advocacy matters: Reviving and sustaining community advocacy networks to support multiculturalism and anti-racism in
the Ottawa region. Ottawa, ON: Community Advocacy Action Committee on Access and Equity, funded by Heritage Canada.


McCubbin, Michael and Odd Steffen Dalgard. 2002. Power as determinant of population health. Quebec, QC: Lavel University. Presentation to SPHERU at the Universities of Regina and Saskatchewan based on a presentation to the Faculty of Nursing Sciences Seminar Series.


Saskatchewan, Department of Social Services. n.d-b. *Annual report, Saskatchewan social services, 1984-85.* No location: no publisher.


________. n.d-d. *Annual report, Saskatchewan social services, 1994-95.* No location: no publisher.


Saskatchewan, Department of Welfare. n.d-h. *1964-65 annual report, Province of Saskatchewan, Department of Welfare.* No location: no publisher.


________. 1989. *Supplement - conclusions and recommendations to: A study of the unmet needs of off-reserve Indian and Metis elderly in Saskatchewan.* Regina: SK.


Vogel, Donna. 1991. NGOs, development assistance and the state: A critical analysis. MA Thesis, Department of Sociology, University of Saskatchewan, Saskatoon, Saskatchewan.


Woolcock, Michael. 2000. The place of social capital in understanding social and economic outcomes. Quebec City, QC: Human Resources Development Canada and the OECD. Paper prepared for an international symposium on "The contribution of human and social capital to sustained economic growth and well-being".


Appendix A - Social policy advocacy and social movements

A brief comparison of advocacy and social movements is necessary because they share common features, but they also have differences. I understand advocacy is different from social movements, yet it is noteworthy that some researchers use the terms together; for example, (Luther and Prempeh 2003) undertook research in the Ottawa area on multicultural and anti-racist “advocacy movements”.

To begin, what are social movements? della Porta and Diani (1999) offer a detailed definition of social movements following from their historical and theoretical review of some literature. Social movements are described as “informal networks, based on shared beliefs and solidarity, which mobilize about conflict issues through the frequent use of various forms of protest” (della Porta and Diani, 1999, p. 16). They assert this definition will help readers distinguish social movements from other forms of collective action especially political parties, religious sects, and single protest events. Social movements are “fluid phenomena” (ibid., p. 17). Tilly (1999) defines a social movement as consisting “of a sustained challenge to power holders in the name of a population living under the jurisdiction of those power holders by means of repeated public displays of that population's worthiness, unity, numbers and commitment” (p. 257; see also Giugni 1999; Tarrow 1998). All movements operate with at least three distinct populations - power holders, participants who are often from CBOs and those who are the focus of the challenge (Tilly 1999).

There are similarities and differences between social movements and collective social policy advocacy. I thought one way to conceive their relationship was to place them on a continuum. On a continuum, they would be placed beside each other. Figure 2.A provides this continuum as an aid to highlight differences and similarities using a few dimensions (i.e.,
goal/target, who and how many are involved, how is change being sought, length of time to accomplish goals, where the work takes places).

The similarities between policy advocacy and social movements often make them indistinguishable. For example, both are about participation and relationship-building, both involve three groups of people (those who are negatively affected by a situation/policy, organizers/advocates, power holders/governments), both have change as goals, both focus on marginalized issues and people, both create a sense of belonging to a collective endeavour, both have similar life cycles using similar strategies although their speed and intensity may differ, and both share the difficulty of measuring causation.

Social policy advocacy and social movements also differ. These differences include: social movements tend to have a long temporal span (e.g., decades) and geographic span (e.g., across provinces and countries) while social policy advocacy is more contained in time and space; social movements tend to have a larger number of people involved than do advocacy initiatives; and social movements comprise complex sets of strategies that may not be known to all in the movement while advocacy processes tend to have agreed upon strategies resulting from meetings or e-communication.

I agree with (Burstein 1999). I too would treat social policy advocacy as a subset of social movements. On most of the dimensions specified on the continuum, social movements seem larger, more complex and enduring.
<table>
<thead>
<tr>
<th>DIMENSION</th>
<th>Individual/self/parent advocacy</th>
<th>Collective social policy advocacy</th>
<th>Social movements</th>
</tr>
</thead>
<tbody>
<tr>
<td>OVERALL PURPOSE</td>
<td>To reduce injustice/inequity for an individual or family</td>
<td>To reduce injustice/inequity for a group of people (e.g., people who live in poverty)</td>
<td>To reduce injustice/inequity for a group of people (e.g., people who live in poverty) and create community</td>
</tr>
<tr>
<td>GOALS</td>
<td>Make support services available and accessible to vulnerable populations, focus is on personal gain</td>
<td>Change government policies and/or supporting people’s rights, usually the focus is on securing collective benefits for a group(s) &amp; not solely personal gain</td>
<td>Change government policies and mainstream ideology, usually the focus is on securing collective benefits for a group(s) &amp; not solely personal gain</td>
</tr>
<tr>
<td>WHO &amp; SIZE</td>
<td>Involves small # of individuals and usually only one CBO</td>
<td>A network/coalition of individuals and organizations formally engaged in setting goals and agendas, usually contains &lt; 100 “members”*, solidarity &amp; sense of belonging to the group.</td>
<td>Involves a large variety of individuals and organizations in tight clusters or loose networks, often contains 1000s of “participants”**, solidarity &amp; sense of belonging to the group.</td>
</tr>
<tr>
<td>HOW</td>
<td>An agency, the individual requiring a service &amp;/or family request meetings with government staff to argue their case. Periodically, they contact the media</td>
<td>An advocacy network/coalition meets regularly to explicitly set goals, choose timelines, formulate change strategies, and implement specific tactics aimed at various government departments. There is usually agreement among members on goals, timelines &amp; strategies. Difficult to measure causation.</td>
<td>&quot;Social movements are complex sets of … actions that may have different goals as well as different strategies for reaching their aims&quot; (Giugni, p. xx). Participants do not necessarily agree on strategies and in fact, may not even meet regularly.</td>
</tr>
<tr>
<td>LENGTH OF TIME</td>
<td>- short term (i.e., usually less than 1 or 2 years)</td>
<td>- variable, depends on the issue on hand, usually &lt; 5 years, unless the advocacy issue is systemic in which case the group could be working together for 10 years +.</td>
<td>- sustained action over the long term, usually over decades</td>
</tr>
<tr>
<td>WHERE</td>
<td>- a household</td>
<td>- a community, region, or province (e.g., advocacy for increasing minimum wage)</td>
<td>- a community, region, province, country or group of countries (e.g., anti-violence women’s movement)</td>
</tr>
</tbody>
</table>

Notes: I developed this continuum. The individual and collective advocacy columns are based on the literature presented in section 2.3. The social movement column is based on: (Amenta and Young 1999; Angus 2001; Burstein 1999; della Porta and Diani 1999; Giugni 1999; Klandermans and Staggenborg 2002; McHale 2004; Tarrow 1998, second ed.; Tilly 1984). * della Porta and Diani (1999) draw a distinction between members and participants.
Appendix B – Research Ethics Board approval for phases 1 and 2
Appendix C – Research Ethics Board approval for phase 3
Appendix D – Introductory letter for Phase 1 Telephone Interviews

December 1, 2005

Dear

The public policy advocacy work of voluntary organizations – also known as community based organizations (CBOs) or nonprofit organizations – has not been studied much in Canada. This lack is particularly striking because these organizations have existed in various forms since the early settlement days of Canada. The studies that do exist on policy advocacy deal primarily with legal issues. In Saskatchewan, I have found no studies on the policy advocacy role of CBOs.

As a full-time PhD student in the Interdisciplinary Studies Program at the University of Regina I am very interested in studying policy advocacy. I have recently returned to school after 17 years working in the nonprofit sector. My focus is public policy advocacy processes and their links to health and well-being. Public policy advocacy can be defined as the efforts of voluntary sector agencies to change existing or proposed government policies in collaboration with a group of marginalized people. Health and well-being are broadly defined; they are not just about the absence of disease, but rather, about feeling well, having energy, having a sense of purpose in life, having good social relationships, feeling connected to one’s community, and having a sense of control over one’s life and living conditions.

My proposed research focuses on voluntary sector social service organizations and the marginalized populations (e.g., people living in poverty) with whom they work. My main research questions are: “What is the nature of public policy advocacy work of voluntary social service organizations in Saskatchewan; and what are the effects of these processes on marginalized people, voluntary organizations, communities, and governments?”

My research will be in three phases. Phase 1 is a province-wide environmental scan. It will include a search for unpublished reports written by voluntary organizations as part of their public policy change efforts, an analysis of provincial government annual reports, and telephone interviews to collect data from CBOs. Phases 2 and 3 will include an in-depth case study of a specific policy advocacy initiative.

Your organization has been selected as one of 40 agencies to participate in the phase 1 telephone interviews. This selection was based on a purposive sample of CBOs in Saskatchewan that I created using the Canada Revenue Agency registered charities dataset and the Saskatchewan Corporations Branch dataset of registered nonprofit organizations. I am very interested in interviewing a staff person in your organization who has the following characteristics: she or he has been very involved in policy advocacy work through your CBO in collaboration with marginalized people; she or he has at least 5 years experience doing advocacy work of this kind, in your organization or through other CBOs.

I would like to contact this staff person by telephone at a date and time that suits him/her to set up a telephone interview, which will last no more than 1.5 hours. This interview will take place after the staff person has spent about an hour reading, thinking, and generally preparing for the interview. The interview will be qualitative in nature, with open-ended questions. It will be audio-taped, and notes will be taken. The audiotape is simply an aid for me; I want to be sure not to miss vital information. Participants will be given an opportunity to verify their answers, by way of a written draft of the interview transcript that I will send to them. This verification work should not take more than an hour. Thus, the total time requirement for your staff person will be approximately 3.5 hours. I will then do
thematic analyses of the interview data that have been collected from the 40 agencies, write a summary, and send your agency a copy.

Complete anonymity for research participants is not possible because my co-supervisors and I will know that you have participated, though no one else will know. However, I can guarantee confidentiality of participant responses because only my co-supervisors and I will know whose data belongs to whom. Note, in addition, that the data from the interviews will be locked in a filing cabinet and the electronic copies will be password protected. As well, your name will not appear in any public documents with any of your answers. Should I wish to use any of your statements (with your permission), I will omit from the quotations any information that may identify you. I would be pleased to talk with you further about this issue if you so wish; simply call me.

Your participation in this study will help to advance knowledge in some key areas. It will enable: a) a description of the diverse advocacy work of CBOs in Saskatchewan; b) descriptions of the processes and impacts of policy advocacy efforts pursued by CBOs in collaboration with marginalized people in Saskatchewan; c) analyses of experiential data from people who are marginalized and who have participated in a public policy advocacy process; d) an exploration of the connections between advocacy processes and health/well-being, and e) suggestions for governments to facilitate voiceless people’s participation in policy-making. As well, this research has direct relevance to larger public debates on citizen engagement and healthy democratic reforms. The results of this study will be disseminated to you, to other CBOs, and to government policy makers.

I look forward to talking with you about your staff designate’s participation in this research. I kindly ask that you forward this letter to the most appropriate person in your organization and ask her/him to call me at 306-569-8605 before January 20th. Once this person and your organization have agreed to participate, I will send him/her a consent form, a participant profile form, and a list of telephone interview questions. Please note that your organization may withdraw from this study at any time simply by telling me so through email, telephone, or in a brief letter. No explanation is required. Questions from participants and your agency are welcome at any time during the study.

This project has been approved by the Research Ethics Board, University of Regina. If you have any questions or concerns about your rights or treatment as a study participant, feel free to contact the Chair of the Research Ethics Board by telephone (306-585-4775) or by email: research.ethics@uregina.ca.

Thank you very much for taking time to consider this request. If you wish to speak to one of my co-supervisors about my research, please do not hesitate to call, Dr. Bonnie Jeffery (University of Regina, Prince Albert Campus, 306-953-5311) or Dr. James Mulvale (University of Regina, 306-585-4237).

Sincerely,

Gloria DeSantis
306-569-8605 (home)
Ph.D. Candidate
Canadian Plains Research Centre
Suite 340, 10 Research Drive
The Terrace Building
University of Regina
Regina, SK., S4S 0A2

Dr. James Mulvale
306-585-4237 (office)
Head, Department of Justice Studies
University of Regina
3737 Wascana Parkway
Regina, SK. S4S 0A2
Appendix E - Consent form and information package: phase 1 phone interviews

Public Policy Advocacy Work of the Voluntary Sector
(from Gloria DeSantis, University of Regina, 2006)

Contents and Instructions

Please read this package of material as soon as possible. We kindly ask that you complete the first two items within one week of receiving them.

1. a consent form – please complete it and mail it back to Gloria within one week in the postage-paid envelope included in this package. An extra copy is included in this package for you to keep.

2. a participant/agency profile form – please complete it and mail it back to Gloria, along with the consent form in the same envelope, within one week.

3. one page of definitions (blue page) – please keep this page and refer to it regularly throughout the study. If you have any questions, please phone Gloria (306-569-8605).

4. a list of questions for the telephone interview (yellow pages) – this does not need to be done within one week. In preparation for the interview, please

   ✓ read through the entire list of questions, but do not write anything
   ✓ then go back to the beginning and write down all the things that you think are important and relevant for each question
   ✓ then meet and discuss the questions and your answers with other staff/volunteers in your agency

5. I will be calling you soon to set up a phone interview time that fits best with your schedule. Please remember to set aside 1.5 hours. We probably won’t need all of this time though.
Consent Form for Phase 1 Telephone Interviews

Please sign page 2 and mail this back to the researcher within one week. (There is an extra copy of the same form which you should keep for your file in case you need to refer to it later.)

Date: January, 2006

Project title: An examination of the public policy advocacy work and impacts of the Saskatchewan voluntary sector using a population health lens

Principal Researcher (there are no research assistants involved in this study):
Gloria DeSantis, Ph.D. Candidate
Canadian Plains Research Centre, Suite 340, 10 Research Drive
University of Regina, Regina, Saskatchewan, Canada, S4S 0A2
306-569-8605 (home)
gdesantis@sasktel.net

Co-supervisors: Dr. James Mulvale (Regina campus, 585-4237), and Dr. Bonnie Jeffery (Prince Albert campus, 953-5311).

Overview:
There is very little data on the public policy advocacy function of the voluntary sector, also known as community-based organizations (CBOs), in Canada. The proposed study focuses on voluntary sector social service organizations and the marginalized populations (e.g., people living in poverty) with whom they work. The main goal of the research is, first, to explore the evolving nature of public policy advocacy work by voluntary sector organizations in Saskatchewan and, second, to examine the health and well-being outcomes/impacts of these processes on marginalized groups of people and communities.

Method and Time Commitment: A telephone interview will be conducted at a time that is convenient for you. Please sign this consent form, complete the profile form and mail them back in the postage paid envelope. Then think about and discuss the interview questions (see attached copy) with agency staff/volunteers before I conduct the interview with you; this may require about an hour of your time. The telephone interview will take no more than 1.5 hours. I will audiotape the interview so as not to miss anything you say. After I have completed a full written transcript of the interview, I will send it to you for verification before beginning any analysis. It should take you less than an hour to complete this and return the transcript to me. Thus, your total time commitment will be approximately 3.5 hours.

Risks and Benefits: None of the interview questions will cause physical or emotional stress or harm to you or your organization. You and your organization will receive a summary of the study results within a year of your interview. By participating in this interview, you will be helping to build a knowledge base about policy advocacy in general and Saskatchewan CBOs in particular.

Anonymity and Confidentiality: Complete anonymity is not possible because my co-supervisors and I will know that you participated in this study. However, your name will not appear with any of your individual responses in any public reports, since they will be presented in aggregate form along with the information from other participants. Some of your statements might be very useful to illustrate a point, in which case you will simply be labeled “a CBO staff.”
Other information that might identify you will be altered in the quotations (e.g., a government department). I can guarantee confidentiality of participant responses because only my co-supervisors and I, who will be analyzing the data together, will know whose data belongs to whom. The raw data from the questionnaires will be locked in a filing cabinet and the e-copies will be password protected.

All materials pertaining to these interviews (e.g., audio cassette tapes, paper copies of interview transcripts, and electronic transcript copies) will be stored in a locked filing cabinet at the researcher’s home office; all electronic copies will be password protected. All data collected through the phone surveys will be destroyed no later than five years after the end of this project.

**Voluntary Participation:** Please note that you do not have to answer any questions you are not comfortable with, and that you may change your answers. You may withdraw from this study at any time by telling me so through email, telephone, or in a brief letter. If you withdraw, you do not need to give me an explanation.

**Ethics Approval:** This project was approved by the Research Ethics Board, University of Regina. If you have any questions or concerns about your rights or treatment as a study participant, you may contact the Chair of the Research Ethics Board at 306-585-4775 or by email: research.ethics@uregina.ca.

If you have any concerns or questions about the procedures outlined above, please contact me or one of my co-supervisors at one of the phone numbers listed above.

**Consent:**
I have read and understand the contents of this consent form and my organization and I agree to participate in this interview and this study.

I have received a copy of the consent form for my files.

I agree to have my interview audio-taped.

I wish to have material related to this study and my interview transcript sent to me so that I may review it for omissions and errors.

I give the researcher permission to use direct quotes from my interview if these quotes are seen as helpful to illustrate a particular finding and as long as these quotes do not reveal my identity.

_____ yes _____ no

I understand that my address will only be used to return study materials to me:

**Email** (not required, however if used, data transcripts will be password protected) –

**Agency** -

**Address** -

**Phone** -

Please mail this consent form and the participant profile form back to the researcher in the postage-paid envelope provided within one week. Thank you very much!
Participant Profile Form for Phase 1 Telephone Interviews (Jan. 2006)
(Please complete and mail back to the researcher along with the consent form within one week)

This profile form is to be completed only after the consent form has been completed and signed, but before the telephone interview takes place. This information will be stored separately from the telephone interview data. This form is simply a way for the researcher to collect and track some key characteristics of study participants and then to examine possible patterns across the interview data. Please read to the page of “Key Definitions” before you complete this form. If you have any questions, please do not hesitate to call Gloria DeSantis at 306-569-8605.

1. Name of agency
____________________________________________________________________________________

2. Name of staff person to be interviewed
____________________________________________________________________________________

3. In general, what types of services does your agency provide and to whom? Please attach a brochure or additional information if necessary.
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

4. Can you please estimate the breakdown of funding sources for your agency in 2004?
_____ % government funds  
_____ % fundraising  
_____ % fee for service  
_____ % donations  
_____ % other
____________________________________________________________________________________

5. More specifically, who are some of the groups of marginalized people with whom your organization has engaged in public policy advocacy work over the past 10-20 years? Please attach an extra page if you need more space.
____________________________________________________________________________________
____________________________________________________________________________________

6. How long has your agency been doing public policy advocacy work? ____ years

7. How long have you been doing public policy advocacy work through this particular agency? ____ years

8. How long have you been involved in public policy advocacy work through the voluntary sector in general? (This can include advocacy work as a paid staff person as well as a volunteer.) ________ years

9. Other than the voluntary sector, where else have you been involved in policy advocacy work during your life?
____________________________________________________________________________________

Please mail this form along with the signed consent form back to the researcher within one week in the postage-paid envelope provided. Thank you very much!
Key Definitions for the Study:
“Public Policy Advocacy Work of the Voluntary Sector”

(Gloria DeSantis, University of Regina, Jan. 2006)

Please take some time to carefully read this page and refer to it periodically as you work your way through the interview questions in advance of the phone interview. Gloria DeSantis (306-569-8605) would be happy to discuss any of your questions relating to any of these definitions at any time; please note though, it would be best to discuss these before the interview takes place. If there is a word not included in the following list that you would like to discuss before the interview, once again, please do not hesitate to call.

Health/well-being are broadly defined; they are not just about the absence of disease, but rather, about feeling well, having energy, having a sense of purpose in life, having good social relationships, feeling connected to one’s community, and having a sense of control over one’s life and living conditions.

Marginalized people/groups/communities refer to people who live on low incomes, First Nations peoples, people who have disabilities (e.g., psychiatric, physical, cognitive, etc.), people who have recently immigrated to Canada and may be a member of a visible minority group, to name but a few. There are many different groups of people in Canada who are marginalized. A similar term that is often used is “oppressed groups”. Oppression and marginalization are group-based, not accidental, and have a systematic application.

Outcomes and impacts refer to the benefits or changes for marginalized people derived from the policy advocacy work undertaken. (These are different from outputs which are simply the number of meetings held, the number of letters written to governments, the number or types of conferences held, etc.)

Policy advocacy can be defined as the efforts of voluntary sector agencies to change existing or proposed government policies in collaboration with a group of marginalized people. Thus, this research focuses on collective policy advocacy – collective refers to voluntary agency staff/volunteers working in collaboration with marginalized people; other voluntary agencies might also be involved. Please note this study is not about one-on-one advocacy with clients to access specific services; it is also not about the advocacy work agencies do to access funding for new services to be delivered through their agency.

Public policy refers to the policies developed by governments; we are not referring to voluntary agency policies, which are internal to the agency. We intentionally selected social service agencies like yours to participate in this study, but we recognize the public policy advocacy work you do can focus on economic policies, social policies, health policies, housing policies, immigration policies and recreation policies. Please do not restrict your responses to only those that you think are “social” policies.

Also, please note that we are using the term “policy” in a broad way as well. We are interested in your advocacy work directed at changing federal or provincial legislation, changing the criteria or guidelines for a government program, changing government regulations, and changing municipal by-laws or regulations.

Voluntary agencies/organizations refer to “organizations that exist to serve a public benefit, are self governing, do not distribute profits to members, and depend to a meaningful degree on volunteers. Membership or involvement in these organizations is not compulsory, and they are independent of, and institutionally distinct from the formal structures of government and the private sector. Although many voluntary sector organizations rely on paid staff to carry out their work, all depend on volunteers, at least on their boards of directors” (Government of Canada, 2002, p. 13). The voluntary sector is also known as the nonprofit sector, community-based organizations (CBOs), charities, and the third sector. Although there are legal differences among these, for this study, they are all considered to be the same.
Telephone interview questions for phase 1

Public Policy Advocacy Work of the Voluntary Sector

(Please read, discuss with your agency staff/volunteers, & make notes on these pages before the phone interview.)

This study is about public policy advocacy processes and their links to health and well-being. The following questions are the telephone interview questions. They are being sent to you in advance so that you can take the time to think about your answers and discuss them with your agency staff and/or volunteers, including board members, and make notes on these pages. If you need more writing space, please use additional pages as necessary. It is noteworthy that we are focusing on what your agency thinks and does regarding policy advocacy, not solely what you think or do. As you work through the questions, you may notice some overlaps in your answers, this is expected in light of the nature of policy advocacy work. Please refer to the page of definitions to ensure you are thinking about the interview questions in the same way we intended them. If you have any questions while you are working on these questions, please do not hesitate to call Gloria DeSantis at 306-569-8605, or send an email to gdesantis@sasktel.net

Section A: Overview

1. In general, and based on the definition of health and well-being provided on the definitions page, do you think your agency contributes to marginalized people’s health and well-being?

   {  
   ___ Yes  
   ___ No  
   }

   If yes or no, please describe why you think so.

2. In general, please describe public policy advocacy undertaken by your organization in collaboration with marginalized groups of people, and if relevant, in partnership with other voluntary agencies. Please be prepared to discuss, one or two examples/case studies which best illustrate the key characteristics of your agency’s policy advocacy work; please make note of these key characteristics.

Section B: Inputs and Resources required for Policy Advocacy Processes

3. What kinds of inputs/resources did your agency use to do this policy advocacy work in collaboration with marginalized groups of people? Are these similar to other policy advocacy work that your organization has undertaken?

Section C: Strategies and Activities to Involve Marginalized Groups of People

4. What are the specific strategies and activities in which your agency actually involved marginalized groups of people in the policy advocacy work you cited in #2? In what ways do you think these processes were healthy and/or unhealthy for marginalized groups of people?
5. Why did/does your agency use these strategies and activities, and in your experience, have these changed over the past 10 years?

6. What barriers surfaced to prevent marginalized people’s participation and what opportunities did you pursue in an effort to enhance their participation in the example(s) you cited in #2? Please limit your list to 3 barriers and 3 opportunities. Have you encountered these barriers and opportunities in other policy advocacy work that your organization has undertaken?

**Section D: Perceived Outcomes and Impacts**

7. Would you say this advocacy work you described above was successful and why do you think so? We recognize there are many different ways to describe “success”.

8. What have been some policy outcomes or benefits for your participants, which resulted from your agency’s policy advocacy initiatives described above? And how do you think this policy advocacy work, impacted or changed the people involved? Please consider both the healthy and the not-so-healthy for the following:

   a) perceived changes/impacts on people who are marginalized including:
      - their values and attitudes
      - their well-being
      - their social connectedness, social supports, sense of belonging to their local community, etc.
      - their learning (e.g., knowledge and/or skills)
      - their behaviour (e.g., encouraged subsequent participation in another issue, etc.)
      - their status/condition (e.g., did people living on low incomes increase their incomes as a result of policy advocacy work, etc.)
   b) perceived changes/impacts on your agency or the other agencies involved
   c) perceived community-level changes/impacts
   d) perceived changes/impacts on the governments involved

**Section E: Conclusion**

9. Are there other trends you have noticed in your organization’s policy advocacy work over the past 10 years that we haven’t yet discussed? Trends can relate to what your policy advocacy work looks like (e.g., numbers and types of people participating in advocacy meetings, women versus men, more or fewer multi-agency coalitions, long term versus short term service users involvement, etc.) or trends can relate to larger systems issues (e.g., role of technology, shifts in ideology, impacts of globalization, competition for funding, your agency’s service delivery function versus your agency’s policy advocacy function, etc.)?

10. Finally, do you think that in this current era, public policy advocacy work is a necessary function for voluntary agencies in order to enhance both the well-being of individuals as well as communities? Why?

Please keep this copy for the telephone interview.
All study participants will receive a copy of their individual interview transcript as well as a summary report containing information from all the agency interviews completed.
Thank you so much for taking the time to share your insights with us.
Appendix F – Introductory letter for phase 2 personal interviews

November 2006

Dear

The public policy advocacy work of voluntary organizations – also known as community based organizations (CBOs) or nonprofit organizations – has not been studied much in Canada. This lack is particularly striking because these organizations have existed in various forms since the early days of Canada. The studies that do exist on policy advocacy deal primarily with legal issues. In Saskatchewan, I have found no studies about the policy advocacy role of CBOs. Thus, I am interested in CBO advocacy work in Saskatchewan. In particular, I am interested in studying the affordable transit pass process undertaken by the Regina Citizens Public Transit Coalition (RCPTC) which began in early 2001.

I am a full-time PhD student in the Interdisciplinary Studies Program at the University of Regina. I have recently returned to school after 17 years working in the nonprofit sector. My focus is public policy advocacy processes and their links to health and well-being. For my research, public policy advocacy can be defined as the efforts of voluntary sector agencies to change existing or proposed government policies in collaboration with a group of people who live on low incomes. Health and well-being are broadly defined; they are not just about the absence of disease, but rather, about feeling well, having energy, having a sense of purpose in life, feeling satisfied with life, having good social relationships, feeling connected to one's community, and having a sense of control over one’s life and living conditions.

More specifically, I’m interested in studying people’s experiences and perceptions of the Transit Coalition process as well as the outcomes and impacts. There are three groups of people who were involved in getting the affordable transit pass adopted by the City that I would like to interview - people who live on low incomes, government staff and elected officials, and voluntary sector social service organizations (CBOs) such as the Regina Anti-Poverty Ministry and the Food Bank. My main research questions are: 1) what are people’s experiences and perceptions of the processes as well as the outcomes/impacts of the Regina Citizens Public Transit Coalition? and 2) What may be the links between policy advocacy processes and health/well-being, especially for people who live on low incomes?

Your name was given to me by Mr. Peter Gilmer from the Regina Anti-Poverty Ministry. I understand that you were very involved with the Regina Citizens Public Transit Coalition in getting the affordable transit pass approved. The work of this coalition is an excellent example of the kind of advocacy work that I’m studying.

You are being invited to participate in Phases 2 and 3 of this study. This will involve an in-depth look at the work of the Regina Citizens Public Transit Coalition (RCPTC) while it was working on the affordable transit pass. (Phase 1 was a telephone survey of voluntary organizations across the province of Saskatchewan who were involved in different types of advocacy work.)

In phase 2, I am asking you to take part in one face-to-face interview with me that will last no more than 2 hours. The interview will include a number of open-ended questions. I will use a tape recorder and take notes during the interview. The tape recorder is simply an aid for me; I want to be sure not to miss anything that you say. You will be given an opportunity to check your answers when I send you a written draft of the interview by mail. Reading through the written interview draft should not take more than an hour. In total, then, for phase 2, I am asking for 3 hours of your time.

Phase 3 will involve a small discussion group. Only citizens who were involved in RCPTC will be invited to this group discussion. A separate group will be organized for government staff and voluntary agency staff. We will discuss issues that arise from the personal interviews. The focus group will last no longer than two hours, and refreshments will be provided. About an hour of your time will be required, however, prior to the meeting so that you can read some information related to what we talked about during the interview. Then, after the focus group, I will send you a draft of written information that we discussed.
would ask that you read this to make sure I have not missed anything from our discussion group. This should take approximately 1 hour of your time. The entire phase 3 process will take about 4 hours of your time. Phase 3 will take place a few months after phase 2.

I realize this is a great deal of time for you to commit, but your input is essential for me to do a proper job on this case study. Given the amount of time I am asking of you, I would like to offer you a small honorarium of $30 to express my gratitude for your participation. I will be giving everyone his/her honorarium after the interview in phase 2. I will also pay for your transportation to attend the interview and the focus group.

I will analyze your responses together with the responses of others involved in the Transit Coalition, but will never share information from participants like you with other participants. Complete anonymity is not possible because my co-supervisors and I will know that you participated in this study. There is also a slight chance that you, other low income citizens, and/or government staff may know who is participating in the study due to the nature of ongoing meetings and discussions in the community about transit issues. However, I can guarantee confidentiality of your responses because only my co-supervisors and I will know whose interview data belongs to whom. I can assure you that the raw data from the interviews will be locked in a filing cabinet and that the computer copies will be password protected. As well, your name will not appear in any public documents with any of your answers. Should I wish to use any of your statements (with your permission), I will omit from the quotations any information that may identify you.

Your participation in this study will support further understanding and knowledge development in some key areas. For example, it will enable a description of the processes and impacts of the Transit Coalition as undertaken by citizens like you volunteering with agencies. It will also make suggestions for governments and voluntary agencies to better involve citizens in policy-making. This research initiative has direct relevance to discussions about citizen involvement for a healthier democracy. The results of this study will be distributed to people like you who participated in the project, other voluntary organizations, and to government policy makers.

I look forward to talking with you about your possible participation in this research project. **Please reply to me at 306-569-8605 before November 24th.** Once you have agreed to take part, I will mail you a consent form. I will also send a participant profile form and a list of interview questions. The interview will be arranged for a place and time that works best for you. Please note that you may withdraw from this study at any time simply by telling me so through email, telephone, or in a brief letter. No explanation is required. Please also note there will be no negative consequences or withdrawal of services should you choose not to participate, or should you decide to participate and have negative answers to some of my interview questions.

Finally, this project has been approved by the Research Ethics Board, University of Regina. If you have any questions or concerns about your rights or treatment as a study participant, feel free to contact the Chair of the Research Ethics Board by telephone (306-585-4775) or by email: research.ethics@uregina.ca.

Thank you very much for taking the time to consider this request. If you prefer to talk with one of my co-supervisors, please contact Dr. Bonnie Jeffery (University of Regina Prince Albert Campus, 306-953-5311) or Dr. James Mulvale (University of Regina Campus, 585-4237).

Sincerely,

Gloria DeSantis  
306-569-8605  
Ph.D. Candidate  
Canadian Plains Research Centre (Interdisciplinary)  
University of Regina, Suite 340, 10 Research Drive  
Regina, SK., S4S 0A2

Dr. James Mulvale  
306-585-4237  
Head, Department of Justice Studies  
University of Regina  
3737 Wascana Parkway  
Regina, SK. S4S 0A2
Appendix G - Consent form and information package: phase 2 interviews

Public Policy Advocacy Work of the Voluntary Sector:
Case Study of the Regina Citizens Public Transit Coalition

(from Gloria DeSantis, University of Regina, 2006)

Contents and Instructions

Please read this package of material as soon as possible. If you have any questions, please phone Gloria (306-569-8605) or email her at gdesantis@sasktel.net

1. a consent form – please complete it before the interview. Gloria will pick it up on the day of the interview. An extra copy is included in this package for you to keep.

2. a participant profile form – please complete it before the interview. Gloria will pick it up the day she meets with you.

3. one page of definitions (blue page) – please keep this page and refer to it as you read through the interview questions and think about your answers.

4. a list of questions for the interview (yellow pages) – In preparation for the interview, please

   ✓ read through the entire list of questions, but do not write anything
   ✓ then go back to the beginning and write down all the things that you think are important and relevant for each question
   ✓ call/email Gloria if you do not understand a question

5. Please remember to set aside 2 hours maximum for the interview.
Consent form for phase 2 personal interviews

December 2006

Project title: An examination of the policy advocacy work and impacts of the Saskatchewan voluntary sector using a health and well-being lens

Principal Researcher (there are no research assistants involved in this study):
Gloria DeSantis, Ph.D. Candidate
Canadian Plains Research Centre, Suite 340, 10 Research Drive
University of Regina, Regina, Saskatchewan, Canada, S4S 0A2
306-569-8605
gdesantis@sasktel.net

Co-supervisors: Dr. James Mulvale (Regina campus, 585-4237), and Dr. Bonnie Jeffery (Prince Albert campus, 953-5311).

Overview:
There appears to be very little data on the public policy advocacy function of the voluntary sector in Canada. This proposed research focuses on voluntary sector social service organizations and the marginalized people (e.g., people living in poverty) with whom they work. The main goal of the research is to explore the evolving nature of public policy advocacy work undertaken by voluntary sector organizations in Saskatchewan and to examine the health and well-being outcomes/impacts of these processes on marginalized groups of people and communities.

Method and Time Commitment: This research project involves three phases. Phase 1 was a phone survey of voluntary agencies in Saskatchewan. Phase 2 involves personal interviews with people involved with the Regina Citizens Public Transportation Coalition (RCPTC). Phase 3 involves focus groups with those people who were interviewed in phase 2. This consent form is for phase 2, personal interviews with Regina residents.

In general, I’m inviting you to participate in one face-to-face interview with me. The interview itself will take no more than 2 hours. I’d like you to read and think about some questions before the interview (see attached list of questions). I will audiotape the interview so that I do not miss anything that you say. After I have completed a full written transcript of your interview, I will send it back to you for you to check to make sure I haven’t missed anything, or misinterpreted anything you said, before I begin any analysis. If you do not wish to read and comment on the transcript from our interview, please indicate so on the next page.

After we have finished the interview I will explain the focus groups (phase 3), which I’m organizing a few months from now. I welcome your participation in both the interview and the focus group; however, we will discuss this in more detail after your interview. Please remember, this consent form is solely for the interview (phase 2). You will be requested to sign a different consent/non-disclosure form before participating in a focus group (phase 3, in a few months).

Risks and Benefits: None of the interview questions will cause physical or emotional stress or harm to you. Please also note there will be no negative consequences or withdrawal of services if you choose not to participate in this study or if you decide to participate in this study and you have negative answers to some of my interview questions. You will receive a summary of the entire study results within a year of your interview. In general, you will be helping to build understanding about advocacy in general and Saskatchewan in particular. As a token of my appreciation, I will be giving citizen participants a $30 honorarium after the interview.

Anonymity and Confidentiality: Complete anonymity is not possible because my co-supervisors and I will know that you participated in this study; there is also a slight chance that you, low income citizens,
community-based organizations and/or government staff may know who is participating in the study because of the nature of ongoing meetings and discussions in the community about the low cost bus pass.

However, I can guarantee confidentiality of participant responses because only my co-supervisors and I will know whose interview data belongs to whom. All materials pertaining to these interviews (e.g., audio cassette tapes, paper copies of interview transcripts, and electronic transcript copies) will be stored in a locked filing cabinet at the researcher’s home office; all electronic copies created by the researcher and shared with her co-supervisors will be password protected. All materials will be destroyed no later than five years after the end of this project.

As well, your name will not appear with any of your answers in any reports; however, some of your quotes might be very useful to illustrate a point and in this case, you will simply be labeled “a community resident” and other information that might identify you will be altered in the quotes. Most of your individual responses will be presented in aggregate form along with the information from other participants.

**Voluntary Participation:** Please note that you do not have to answer any questions you are not comfortable with and that you may change your answers. You may withdraw from this study at any time by telling me so through email, telephone or a brief letter. If you withdraw, you do not need to give me an explanation.

**Ethics Approval:** This project was approved by the Research Ethics Board, University of Regina. If you have any questions or concerns about your rights or treatment as a study participant, you may contact the Chair of the Research Ethics Board at 306-585-4775 or by email: research.ethics@uregina.ca.

**If you have any concerns or questions about the procedures outlined above, please contact me or one of my co-supervisors at one of the phone numbers listed above.**

**Consent:**

I have read and understand the contents of this consent form and I agree to participate in this interview and this study.  

_____ yes  _____ no

I have received a copy of the consent form for my files.  

_____ yes  _____ no

I agree to have my interview audio-taped.  

_____ yes  _____ no

I wish to have material related to this study and my interview transcript sent to me so that I may review it for omissions and errors.  

_____ yes  _____ no

I give the researcher permission to use direct quotes from my interview if these quotes are seen as helpful to illustrate a particular finding and as long as these quotes do not reveal my identity.  

_____ yes  _____ no

**Participant name (please print)****************************

Participant signature

Researcher signature

Date

I understand that my address will only be used to return study materials to me:

**Email** (not required, however if used, data transcripts will be password protected) —

**Address** —

**Phone** —
Personal Interview Participant Profile Form (Phase 2 Citizens)

This profile form is to be completed only after the consent form has been completed and signed, but before the interview takes place. This information will be stored separately from your interview data. This form is simply a way for the researcher to collect and track some key characteristics of study participants, and then to examine possible patterns across the interview data. Please note that you do not have to answer any questions you are not comfortable with. If you have any questions, please do not hesitate to call Gloria DeSantis at 306-569-8605.

1. Name of person to be interviewed ____________________________________________

2. Your sex: 
   _____ female
   _____ male

3. What age category do you fall into:
   _____ less than 20 years
   _____ 20-29 years
   _____ 30-39 years
   _____ 40-49 years
   _____ 50-59 years
   _____ 60-70 years
   _____ 71 years of age or older

4. Please name the ethnic group to which you feel most connected __________________

5. What is the highest level of education you have completed?
   _____ less than grade 11
   _____ completed grade 12
   _____ completed some technical institute
   _____ completed technical institute certificate/diploma
   _____ completed some university
   _____ completed undergraduate university degree
   _____ completed Master's university degree
   _____ completed PhD
   _____ other; please specify ______________________

6. If you attended college or university, please describe your educational program (e.g., social work with a focus on children with disabilities)?
   __________________________________________________________________________

7. Please check all of the following roles that apply to you:
   _____ employee ___ full time
   _____ employee ___ part time
   _____ partner/spouse
   _____ caregiver (for elderly parents/friend, for disabled family member/friend)
   _____ parent
   _____ volunteer
   _____ student
   _____ other, please specify __________________________________________________________________________

8. Do you have any disabilities?  
   _____ no
   _____ yes, please summarize briefly ______________________
   __________________________________________________________________________
9. Would you identify yourself as a person who lives on a low income (e.g., live in poverty)?
   ____ yes
   ____ no

10. In general, would you say your health is …
    (please check one)
    ____ excellent
    ____ very good
    ____ good
    ____ fair
    ____ poor

11. a) Compared to five years ago, how would you say your health, in general, is now? Is it …
    (please check one)
    ____ much better now than 5 years ago
    ____ somewhat better now than 5 years ago
    ____ somewhat worse now than 5 years ago
    ____ much worse now than 5 years ago?

11. b) Please list the things that you think had the biggest impact on changing your health over the past 5 years. Perhaps list the top 3 things.
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

12. How many years have you lived in Regina (check one)?
    ____ less than 2 years
    ____ between 3 and 5 years
    ____ 6 to 10 years
    ____ 11 years or more

13. What form of transportation do you most frequently use to get around the city, do your shopping, visit friends, and get to appointments?
_________________________________________________________________________

Please complete this form and give it to Gloria when she arrives for the interview.
Thank you very much!
DEFINITIONS

“Public Policy Advocacy Work of the Voluntary Sector: Case Study of the Regina Citizens Public Transit Coalition”
(Gloria DeSantis, University of Regina, revised Nov. 2006)

Please read this page carefully and refer to it as you read through the interview questions in advance of the interview. Gloria DeSantis (306-569-8605) would be happy to answer any questions you might have before the interview.

**Advocacy** – please see “public policy advocacy” below

**CBOs or voluntary agencies** refer to “organizations that exist to serve a public benefit, are self governing, do not distribute profits to members, and depend to a meaningful degree on volunteers. Membership or involvement in these organizations is not compulsory, and they are independent of, and institutionally distinct from the formal structures of government and the private sector. Although many voluntary sector organizations rely on paid staff to carry out their work, all depend on volunteers, at least on their boards of directors” (Government of Canada, 2002, p. 13). CBOs, community based organizations, are also known as the nonprofit sector, charities, and the third sector. Although there are important legal differences among these, for this study, they are all considered to be the same for this research.

**Health and well-being** are broadly defined; they are not just about the absence of disease, but rather, about feeling well, having energy, having a sense of purpose in life, feeling satisfied with life, having good social relationships, feeling connected to one’s community, and having a sense of control over one’s life and living conditions.

**Inputs** to the Coalition’s process includes things like money, CBO staff people with certain expertise, free meeting rooms used by the Coalition, etc. to get their advocacy process started and move forward.

**Low income** – please see “marginalized people” below

**Marginalized people** refer to people who have disabilities (e.g., psychiatric, physical, cognitive), many First Nations peoples, people who live in poverty because they have to rely on government financial assistance or work at minimum wage jobs, refugees who have recently come to Canada … to name but a few.

**Outcomes and impacts** are different from outputs. They refer to the benefits or changes for people that result from the policy advocacy work undertaken. These changes can relate to people’s values and attitudes, their sense of ability to take control of something, their well-being including life satisfaction and happiness, their social connectedness, their learning about new things, and their behaviour.

**Outputs** are simply a list of the Coalitions’ accomplishments/products including the number of meetings held, the number of letters written to governments, the number or types of rallies held, the number of names collected on a petition, etc.

**Processes and strategies** refers to the variety of activities which Coalition people participated in, in order to convince the city and the province to say “yes” to a new transit policy (e.g., having meetings with government staff or elected officials, collecting research from other cities, circulating a petition, etc.).

**Public policy advocacy** is also known as government policy advocacy. It can be defined as the efforts of CBOs to change existing or proposed government policies in collaboration with a group of people who are marginalized because they live on low incomes, have a disability, etc. Thus, this research focuses on collective policy advocacy; “collective” typically refers to a group of people including CBO staff/volunteers, and community residents. For our purpose here, the focus is on low cost bus pass policies involving the City of Regina and the provincial government.
This study is about public policy advocacy processes and their links to people’s health and well-being. The following questions are the interview questions. They have been sent to you in advance so that you can take time to think about your answers and if you like, make notes on these pages; please use additional pages as necessary. PLEASE DON’T WORRY IF YOU CAN’T SEEM TO FIND ANYTHING TO WRITE DOWN ON THESE PAGES BEFORE THE INTERVIEW; IT IS GLORIA’S JOB TO WORK WITH YOU ON THE QUESTIONS DURING THE INTERVIEW.

As you work through the questions, you may notice some overlaps in your answers, this is to be expected. Please refer to the blue page of definitions to ensure you are thinking about the interview questions in the same way we intended them. If you have any questions while you are reading through these pages, please do not hesitate to call Gloria DeSantis at 306-569-8605, or send an email to gdesantis@sasktel.net

Gloria would like to spend the first part of the interview – about 30 minutes - having you tell her about your life experiences with advocacy. The second part of the interview – about 90 minutes - will focus specifically on the Regina Citizens Public Transit Coalition.

A) BRIEF LIFE HISTORY AS IT RELATES TO PUBLIC/GOVERNMENT POLICY ADVOCACY

1. Please take a moment and think about your life, as far back as childhood, your teenage years and young adulthood. Please tell me about any memories you have about your parents, other family members, and friends who tried to change a situation that was not good (advocacy). For example, a neighbourhood problem, a problem at work, a farming issue, a problem at school, etc. Do not restrict yourself to policy advocacy. These memories may be things that you heard about, or, you may have got involved.

2. Over the course of your life, have you been directly involved with friends, neighbours, family and/or CBOs in trying to get a government to change a policy or rules (advocacy)? If, yes, what kinds of advocacy activities did you find yourself most frequently involved in?

3. Were there certain organizations and groups of people with whom you did advocacy work more often than others (e.g., people who had disabilities, people living on low incomes, food banks, First Nations agencies, neighbourhood groups, unions, etc.)?

B) THE REGINA CITIZENS PUBLIC TRANSIT COALITION STORY

Now I’d like you to discuss in more detail the advocacy work of the Regina Citizens Public Transit Coalition. I’m very interested in your experiences with the low cost bus pass advocacy work of the Coalition. Please note there are no right or wrong answers. Your perspective is just as important as the perspectives of anyone else involved with the Coalition.
In general, I would like to ask you about four things:

**Inputs** to the Coalition’s process including things like money, CBO staff with certain expertise, free meeting rooms used by the Coalition, etc. to get their advocacy process started and moving forward.

**Processes and strategies** refers to the variety of activities which Coalition people participated in, in order to convince the city and the province to say “yes” to the Coalition’s goal of a new transit policy (e.g., having meetings with government staff or elected officials, collecting research from other cities, circulating a petition, etc.). We are also interested in barriers to and opportunities for people’s participation.

**Outputs** are simply a list of the Coalitions’ accomplishments/products including the number of meetings held, the number of letters written to governments, the number or types of rallies held, the number of names collected on a petition, etc.

**Outcomes and impacts** refer to the changes or benefits for people that result from the policy advocacy work undertaken. These changes can be about people’s values and attitudes, their sense of ability to take control of something, their well-being including life satisfaction and happiness, their social connectedness, their learning about new things, and their behaviour. These are different from outputs.

These 4 things can be put into a picture; this picture may help us talk about the work of the Coalition. Your story will probably not look like the neat picture below; we’ll just move around the picture as you think appropriate. Do you have any questions before we go to question #4 below?

<table>
<thead>
<tr>
<th>INPUTS</th>
<th>PROCESSES/STRATEGIES</th>
<th>OUTPUTS</th>
<th>OUTCOMES/IMPACTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Things used by the Coalition to get started and move forward.</td>
<td>What the Coalition actually did to achieve its goal. What strategies &amp; activities were used? What barriers &amp; opportunities existed?</td>
<td>Simply a list of the Coalition’s accomplishments like meetings, rallies, petitions, etc..</td>
<td>Changes/benefits for participants during &amp; after the Coalition’s activities.</td>
</tr>
</tbody>
</table>

**Inputs & resources used by the Coalition to get started**

4. Let’s start at the beginning. What appears to have helped the Coalition get started and move forward on a low cost bus pass? When and how did the Regina Citizens Public Transit Coalition begin and when and how did you become involved?

**Processes, Strategies and Activities**

5. As the Coalition moved forward, please tell me about the concrete ways that you were involved in the Coalition and whether you tried involving others – especially people living on low incomes or people with disabilities. Why did you choose these ways of being involved?
6. What were the other strategies and activities which the Coalition used in its work over the years and why do you think these were chosen? (Gloria realizes that you may not have been involved in some of these because other Coalition members were responsible for carrying them out.)

7. a) What things prevented or discouraged you from participating in the work of the Coalition? Or said another way, what barriers did you have to deal with? Perhaps you can think of at least three barriers.

7. b) What things seemed to make it easier for you to participate and get more involved in the Coalition? Perhaps you can think of at least three opportunities here.

Outputs/Accomplishments of the Coalition’s processes

8. Can you please list the accomplishments made by the Coalition over those few years (e.g., the number of meetings held, the number of letters written to governments, the number or types of rallies held, the number of names collected on a petition, etc.)?

Outcomes and Impacts

9. How did this low cost bus pass advocacy process impact or change you? These can be negative or positive outcomes. Please reflect on the following:

- your status or daily living conditions
- your learning including new knowledge and skills, for example, about how government works, about government policies, about running a meeting …
- your behaviour, for example, did you go on to tackle another community problem as a result of what you learned?
- your physical health
- your mental health
- your spiritual health or faith
- your social connectedness, being included or not, social support networks, sense of belonging to the local community, level of trust in your social relationships
- your well-being including overall satisfaction with your life, overall happiness with your life …
- your sense of power and ability to take control and change something that you thought was unfair
- your values and attitudes …. about the people involved in the Coalition, about governments, about your place in the community, that you can/cannot make a contribution …

10. How did this advocacy process appear to impact or change other people involved? Once again these can be negative or positive. You can refer back to the list in #9 if necessary.
   a) any perceived changes in the CBO staff or volunteers that were involved with the Coalition?
   b) any perceived community-level impacts that you saw?
   c) any perceived changes to the government staff or elected officials that were involved?
General Comments

11. What if the Coalition had failed in its advocacy work and not been able to get a low cost bus pass accepted by the governments involved … how do you think your answers in #9 and #10 might have changed?

12. Is there anything else that we haven’t yet discussed that you would like to add that might help me better understand the advocacy work of the Coalition and the changes it made?

13. Finally, do you think that today, public policy advocacy work – like that of the Transit Coalition - is a necessary function for CBOs in order to increase the well-being of individuals as well as communities.

Thank you so much for taking the time to think about these questions in advance of our interview!
## Appendix H - List of Saskatchewan CBO policy advocacy documents

<table>
<thead>
<tr>
<th>YR.</th>
<th>Author (yr)</th>
<th>Central topic</th>
<th>Population group(s)</th>
<th>Focal issue(s)/ policies to be changed</th>
<th>Advocacy strategy noted? Barriers/oppors</th>
<th>Gov-CBO relations noted?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1938</td>
<td>(Canadian Welfare Council 1938)</td>
<td>Who should deliver what social and health services?</td>
<td>All populations in need in Saskatoon</td>
<td>Calculate family and individual needs more effectively, help people stay off relief, which services should be delivered by governments &amp; which by CBOs, possible participation in a “community chest”</td>
<td>40 CBOs implicated, effectiveness of community welfare program depends on relationships and working toward common objectives among CBOs and between governments &amp; CBOs</td>
<td>- governments &amp; CBOs should participate equally “to build a well balanced program” (p. 69), there should be cooperation (ibid)</td>
</tr>
<tr>
<td>1959</td>
<td>(Centre for Community Studies 1959)</td>
<td>Government and CBOs working together</td>
<td>All voluntary groups in small towns</td>
<td>Community self development, partnerships among governments and CBOs</td>
<td>With mutual understanding “the community &amp; the public servant can build a more fruitful relationship” (p. 10)</td>
<td>We perceive “governments often hinder rather than help” (p. 10)</td>
</tr>
<tr>
<td>1961</td>
<td>(Laskin 1961)</td>
<td>Descriptive survey of voluntary groups</td>
<td>All voluntary groups in Biggar, SK</td>
<td>Unmet needs in the community especially for the elderly population, under-representation in associations (e.g. youth), the gap between town &amp; country participation. There does not appear to be evidence to support that Biggar is “over-organized” (i.e., has too many organizations).</td>
<td>Lack of participation in local government is noted. “Voluntary Associations could be an important means through which citizens develop an understanding of public problems… discussions are however, rare … Petitions and delegations … and other attempts to influence the public or government are even more uncommon” (p. 32)</td>
<td>Town council at that time was considered a voluntary agency because it comprised volunteers. There is no discussion about these organizations/groups links to the provincial government, yet they were asked about problems with finances and relations with their</td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Description</td>
<td>Focus</td>
<td>Key Themes</td>
<td>Recommendations</td>
<td>Notes</td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>-------------</td>
<td>-------</td>
<td>------------</td>
<td>----------------</td>
<td>-------</td>
</tr>
<tr>
<td>1975</td>
<td>(Haire 1975)</td>
<td>Nonprofit housing in Canada</td>
<td>Low income (primarily seniors) in Saskatchewan</td>
<td>Housing policies and programs need to be changed to better serve those in need. This was a national study and the section on Saskatchewan is dominated by seniors housing material.</td>
<td>A list of recommendations is directed at governments and housing CBOs in order to fill gaps.</td>
<td>The entire report is about government-CBO housing responsibilities.</td>
</tr>
<tr>
<td>1976</td>
<td>(Sanche and Bates 1976)</td>
<td>Comprehensive community-based services for “the mentally retarded”</td>
<td>“Full range of residential, recreational, educational, health and vocational services for the retarded, based in the local community or region, are considered more desirable than institutional placement” (p. 1). It is acceptable practice that groups “actively promote” new services “to the community and to government” (p. 1). Explained community-based services policy has been adopted by government, but the old policy, bureaucracy, traditions and communication are major barriers to progress.</td>
<td>Recommendations are directed at government but two focus on the government-CBO relationship. There is a sense of urgency in the recommendations including the need to remove the barriers to progress.</td>
<td>Provided a critique of the policy, regulations and legislative change barriers. It is a blunt statement about barriers to services with few kind words re government. The CBO wants local consumer and advocacy groups involved in regional planning.</td>
<td></td>
</tr>
<tr>
<td>1976</td>
<td>(Riches 1976)</td>
<td>Elder care including facilities</td>
<td>Elderly</td>
<td>The importance of universality, questions about means testing, the appropriate use of tax revenue, standards and levels of care, and possible role for CBOs in facilities and caring for the elderly.</td>
<td>We are asked to make a choice. Should we let the private market deal with dependent groups like the elderly or should we be implementing universal care approaches? He believes this choice should not about funding, but should be based on societal values.</td>
<td>Different political parties through time up until 1976 have all implemented the residual welfare model regarding care for the elderly (i.e., care is received from private market or the family). Is this similar to my conclusion re no change across political parties re use of CBOs?!</td>
</tr>
<tr>
<td>1977</td>
<td>(Saskatchewan Co-ordinating Council on Social Planning 1977)</td>
<td>Housing for people with special needs (which includes Aged, infirm, &amp; “those with any type of disabiling”</td>
<td>A key theme is the need to integrate shelter issues with care issues for people with disabilities. Philosophy or principles are: choices, range of services available, integration of services and</td>
<td>List of recommendations stated including the need for the provincial government to develop a</td>
<td>Recognize housing-care options for people with disabilities can include private sector alone, gov</td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Services Provided</td>
<td>Variety:</td>
<td>Trends and Analysis</td>
<td>Government Spending</td>
<td>None explicit, but …</td>
</tr>
<tr>
<td>----------</td>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1979</td>
<td>(Riches and Kramer 1979)</td>
<td>Personal social services</td>
<td>Variety: elderly, mentally retarded, physically handicapped, children and people with mental health issues</td>
<td>The research examined trends in personal social services development, government policy, government funding, and the roles of government and CBOs in service provision between 1966-76. During the time period under study, higher spending occurred for the elderly, mentally retarded and physically handicapped than on children and people with mental health issues; this trend appears to reflect NDP policy. An increasing proportion of government expenditures went toward the funding of private agencies and CBOs. Saskatchewan government expenditures on personal social services rose by 12.6% between 1966/67 and 1976/77.</td>
<td>Government spending is indeed choosing and there is much to be said about conflicting priorities. The authors believe the government made some inappropriate choices, which led to support for the residual welfare model.</td>
<td>“What this growing financial support of non-government … means is difficult to say, though one rationale might be that it allows government to control the number of public servants and at the same time permits an expansion of basic services” (p. 72).</td>
</tr>
<tr>
<td>1983</td>
<td>(Riches and Maslany 1983)</td>
<td>Personal social services</td>
<td>Variety</td>
<td>Between 1971 and 1981, share of government spending under its own auspices dropped by nearly a half, while government spending through CBOs increased. In 1977, 130 of 169 agencies (77%) providing PSS in Saskatoon were nongovernmental bodies. Strong growth in</td>
<td>Difficult to suggest a strategy against government downloading on to CBOs because how does one argue against “community control over</td>
<td>Described quasi-NGOs (QUANGOS) which are CBOs that rely heavily on government funding and/or there is involvement of senior</td>
</tr>
<tr>
<td>Year</td>
<td>Source</td>
<td>Topic</td>
<td>Description</td>
<td>Recommendation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>---------------------------------------------</td>
<td>-------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1983</td>
<td>(Saskatchewan Coordinating Council on Social Planning and Taylor 1983)</td>
<td>Income security &amp; employment</td>
<td>The authors state it is time that people with disabilities have access to appropriate employment and an adequate level of income assistance. They state “... all legislation should be examined ... and laws should be passed which assure co-ordination of government and nongovernment rehabilitation, prevention, employment and income security measures” (p. 15). And they conclude that “the services offered by the Canada Employment and Immigration Commission were inadequate and/or inappropriate” (p. 24).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>People with disabilities</td>
<td>No strategy stated but goals, a series of principles and recommendations were listed for a comprehensive rehabilitation system. An agency or authority should be entrusted to develop this system and “achieve co-operation &amp; coordination between public &amp; private bodies” (p. 16)</td>
<td>Some discussion about who should be responsible for what components of such a system, although in most items, no one was listed. The authors state a principle of “government leadership” to develop legislation as well as policies as an employer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1987</td>
<td>(Crocus Cooperative, Saskatoon Mental Health Association, and Saskatoon Housing Coalition 1987)</td>
<td>Housing and community mental health</td>
<td>There are gaps in certain service areas, need for both government and CBO components, deinstitutionalization funding that was agreed upon by governments, has not yet landed in community programs.</td>
<td>Recognize costs of community programs are reasonable, community programs are effective in reducing hospital episodes, but recommend a new service delivery model which includes both governments and CBOs. CBOs have demonstrated they are an effective solution yet government funding has not followed their own deinstitutionalization policies (which was probably the main reason these CBOs undertook this study!)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>People with mental health disabilities and their housing issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1988</td>
<td>(Saskatchewan Senior Citizens Provincial Council)</td>
<td>Unmet needs including income, Off-Reserve Indian and Métis elderly</td>
<td>The results of the research involving Indian and Métis elderly revealed the following: lack of formal education and issues surrounding use of their services” (p. 49).</td>
<td>For the many unmet needs, “a collaborative effort is needed to ensure “The continued sensitization of the provincial system of long-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Reference</td>
<td>Description</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
<td>-------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1988</td>
<td>Dickinson 1989</td>
<td>Preferred language, there was a history of lack of employment especially for women, source of income was predominantly government assistance, difference between those who live in the south versus the north in home ownership rates, living in extended family situations was more common in the north, 72% of those from the south had moved during the past 5 years, and “6 of every 10 native elderly perceive their health to be only fair or poor” (p. viii). In terms of need for assistance and care, 50% of those from the south and 73% of those from the north indicated they needed assistance with at least one item of personal care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1989</td>
<td>Dickinson 1989</td>
<td>Psychiatric services in institutions and the community - He describes the transition from “asylum”/institution to community-based psychiatry and mental health clinics as well as the shift from medicalization to de-medicalization of psychiatric illnesses. - 1950 Canadian Mental Health Association 1st branch in Canada opened and identified with “consumer rather than the provider” (p. 139) yet CMHA board officers were also government employees and often criticized government policies. CMHA encouraged shift to community-based care. - 1967 Frazier Report commissioned re state of Psych Branch of government indicated not enough money in hospital system; government became more supportive of CMHA operating White Cross centres/drop-in centers for ex-mental patients because cheaper than hospitals. By early 1970s with government deinstitutionalization policy, CMHA was heavily funded by government and term care to include the special concerns of the native elderly is also a need which is very much in evidence” (p. 161).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fairly innocuous.

An enduring tension between politicians, government staff and a CBO – the Canadian Mental Health Assoc.

It describes multi-person advocacy – the push and pull of psychiatry over time in Saskatchewan
<table>
<thead>
<tr>
<th>Year</th>
<th>Source/Study</th>
<th>Focus/Method</th>
<th>Findings/Outcomes</th>
<th>Implications/Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>(Pennell 1989)</td>
<td>Battered women’s CBOs and their organizational decision-making</td>
<td>Saskatchewan women’s CBOs were selected for this study because of the influence of the agrarian co-operative movement. When women from these CBOs communicate and advocate with governments they make themselves look hierarchical in order to appear mainstream, but within their organization, they operate as collectives.</td>
<td>Not the focus of the research.</td>
</tr>
<tr>
<td>1989</td>
<td>(Community Needs Partnership 1989)</td>
<td>Analysis of human services and community needs</td>
<td>The following issues were noted: “shift from government to nongovernment responsibility for planning, development and delivery of human services” (p. 20), changes in agency focus from prevention to crisis intervention, increasing instability of core and donor funding, increasing reliance on volunteers, and changing service demands, fragmented services, and sense of powerlessness to change things and fear of reprisal (e.g., fundings cuts) if one contradicts funders.</td>
<td>They conclude with 10 recommendations and a call to action to reconstruct social policies and the mechanisms to operationalize these policies (e.g. staffing, volunteering, and management within human service organisations – both government and nongovernment). Coordinated lobbying and advocacy may be necessary to make policy makers aware of necessary changes.</td>
</tr>
<tr>
<td>1990</td>
<td>(Canadian Red Cross Society 1990)</td>
<td>Assessment of socio-health needs</td>
<td>Comprehensive community needs assessment was completed. The findings echo trends impacting the sector found in other studies including: decline in volunteering, “voluntary organisations are being required to provide more services with fewer resources” (p. 20).</td>
<td>No recommendations and no advocacy strategies listed. However, set within a mood of pessimism based on 67% of the respondents. Described the Conservative government’s multi-million dollar cuts to programs and the difficulties of providing services.</td>
</tr>
</tbody>
</table>
the concept of “community” is changing and is no longer heavily based on geographical proximity, and concern about economic issues including privatization and farm crises. A number of specific issues and needs were noted: lack of community-based health and social services, bad feelings/racism, alcohol/substance abuse, family dysfunction, the needs of an aging population, and the needs of youth.

respondent who thought “these issues would get worse in the next 5 years”, almost half of them said that solving these issues should be a collective effort between governments, CBOs and private agencies. On the reserves, most thought the Bands should be providing the needed services.

“conducting needs assessment in a politically, economically and socially sensitive area” (p. 23). The government might hold the money, but CBOs can make things happen.

<table>
<thead>
<tr>
<th>Year</th>
<th>Source</th>
<th>Participants</th>
<th>Issues</th>
<th>CBOs</th>
<th>Government</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>(Ad Hoc Committee to Realistically Change Welfare Rates 1990)</td>
<td>People struggling to survive on welfare</td>
<td>Recent social policy changes have resulted in a reduction in the amount of money one can earn and keep while on welfare, monthly transportation allowances were reduced, food allowances were increased slightly, and there were stricter eligibility criteria to receive government assistance.</td>
<td>CBOs are noted as an advocacy vehicle for people on welfare to use to confront provincial government workers. Advocacy is defined on the first page including: “achieving positive changes in government programs and policies through media, coalitions, networking and lobbying”.</td>
<td>It is clearly about “welfare recipients” being looked down on by society and treated badly by “the government” as reflected in government policies, programs, and criteria.</td>
</tr>
<tr>
<td>1993</td>
<td>(Council on Social Development Regina Inc. 1993)</td>
<td>A critique of the social service CBO system of services</td>
<td>Issues requiring attention included: NGOs and governments overwhelmed with people in crisis, government funding methods contribute to fragmented services, funding should be driven by community needs not government criteria, funding should not encourage competition among NGOs, NGOs need to be able to participate in government funding allocation decisions, service users’ opinions are critical in service planning.</td>
<td>The need to develop strategies to engage CBOs and communities in social service planning and the need “to end government off-loading” (p. xvii).</td>
<td>This report summarizes peoples’ thoughts about what is working well and not so well, suggestions for improvements and what partnerships with governments can look like. In particular, government funding should not encourage competition among</td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Description</td>
<td>Recommendations</td>
<td>NGO Observations</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>1994</td>
<td>(Manning 1994)</td>
<td>The evolving relationship between the provincial government and CBOs and its impact on social services.</td>
<td>Saskatchewan social services could be better coordinated and more responsive to the expressed needs of marginalized populations. Government should stop “off-loading” onto CBOs, the government should be prepared to pay more for service delivery in northern and remote communities, economic and social development are inseparable, and “grassroots participation” should be sought in developing, implementing and funding a social vision for Saskatchewan.</td>
<td>&quot;A government’s relationship to the CBO community is typical of that which exists between someone who has money and someone who needs it. This is a relationship of power and control&quot; (p. 116).</td>
<td></td>
</tr>
<tr>
<td>1995</td>
<td>(Saskatoon Social Planning Council 1995)</td>
<td>Presents well-being trends re children and is intended to act as a stimulant for long range planning discussions and policy change.</td>
<td>Well-being of children 0-14 yrs. in Saskatoon. Trends that were identified based on quantitative data and focus group discussions included: poverty is a major problem which contributes to many other problems, services are inadequate to meet people’s crisis need, gambling is increasing, children experiencing many pressures (e.g., drugs), structural racism exists, expectations of schools, society is becoming less compassionate (e.g., blame the victim, user fees), increase in violence and fear, no confidence in the future (e.g., lack employment, government supports disappearing).</td>
<td>No recommendations or advocacy strategies listed. The authors state that to make change, there is a need “to assemble the appropriate information, in a form that is accessible and understandable to all” (p. 1). Seems a bit weak.</td>
<td></td>
</tr>
<tr>
<td>1999</td>
<td>(McFarlane and Roach 1999b) (McFarlane and Roach 1999a), (McFarlane and</td>
<td>Survey of 72 CBOs in western Canada &amp; Ontario</td>
<td>They point out the need to recognize the role of volunteers in CBOs, the characteristics that make CBOs a good choice for social service delivery, and the positive and negative aspects of CBO-government relations. Governments and the CBOs</td>
<td>Work toward a more balanced relationship between governments and CBOs including ongoing two-way relations. Complex relationships exist because some CBOs “deliver services on behalf of the state, some fill gaps left by the state.”</td>
<td></td>
</tr>
<tr>
<td>Year</td>
<td>Author(s)</td>
<td>Context</td>
<td>Key Points</td>
<td>Recommendations</td>
<td>Notes</td>
</tr>
<tr>
<td>-------</td>
<td>------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>2000</td>
<td>Roach 1999c</td>
<td>Relationship between governments and CBOs</td>
<td>McFarlane and Roach 1999c explore this relationship between governments and CBOs in more depth - CBOs receive funding from governments through contract renewals, a direct offer to fund a new service, or through tendering processes and “the overall government-nonprofit working relationship is determined by the tone set during contract negotiations, the length of time the contract has been in place, and the degree and nature of the personal interaction among government personnel and nonprofit staff” (ibid., p. 12)</td>
<td>List of recommendations directed at CBOs and governments including: communication, recognize/respect important differences, etc.</td>
<td>and some respond to emerging social needs” (McFarlane and Roach 1999c, p. 3)</td>
</tr>
<tr>
<td>2000</td>
<td>(Roach 2000)</td>
<td>Variety</td>
<td>He cites qualitative data from CBOs that suggest there is a need to improve the relationship between governments and CBOs, that CBOs’ comparative advantages should make them attractive resources, and that autonomous CBOs are important to democracy. Currently CBOs are underutilized.</td>
<td>List of recommendations directed at CBOs and governments including: communication, recognize/respect important differences, etc.</td>
<td>The entire report is about government-CBO relations &amp; tensions</td>
</tr>
<tr>
<td>2000</td>
<td>(Vaillancourt et al. 2000)</td>
<td>Comparison of Saskatchewan &amp; Quebec re emerging welfare models and the role of the CBO sector</td>
<td>Concerned that CBOs in Saskatchewan dominate areas “on the margins abandoned by government such as home help services” (p. 79). Saskatchewan CBOs do not appear to have become institutionalized to the same degree as they did in Quebec over the past 30 years.</td>
<td>No advocacy noted because this was a descriptive article about health/welfare models including the role of CBOs in provinces in Canada.</td>
<td>Governments are constantly needing to be “vigilant” of social movements and their advocacy work directed at governments</td>
</tr>
<tr>
<td>2001</td>
<td>(Beaudry 2001)</td>
<td>Assessment of 8 social service CBOs in Regina</td>
<td>The main theme is one of paradoxes for CBOs. For example, federal legislation impedes advocacy CBO work yet advocacy is badly needed, funding cutbacks affect CBOs’ programs yet at the same time CBOs are faced with greater demands, and</td>
<td>No advocacy strategies suggested, but recommendations directed at the key issues.</td>
<td>The thesis is about government-CBO relations, conflicts &amp; tensions. For example, CBOs scramble to</td>
</tr>
<tr>
<td>Year</td>
<td>Authors</td>
<td>Topic</td>
<td>Summary</td>
<td>Recommendations</td>
<td>Findings</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-------</td>
<td>---------</td>
<td>-----------------</td>
<td>----------</td>
</tr>
<tr>
<td>2001</td>
<td>Fairbairn</td>
<td>Community economic development (CED)</td>
<td>People who may be left behind in a new economy of information technology</td>
<td>Historically, Saskatchewan has been relatively successful because of its mixture of private, public, and CBOs in the economy. However, now there is a need for people to develop ventures in their own communities.</td>
<td>Search for a balanced mix of economic development generators (e.g., private industry, government programs and CBO enterprises).</td>
</tr>
<tr>
<td>2001</td>
<td>Thériault and Salhani</td>
<td>Homecare (non-medical)</td>
<td>Homecare for the elderly in Regina &amp; Saskatoon</td>
<td>Two Senior Citizens Centres are providing non-medical services to seniors living in their own homes; some say these services are being provided to low income seniors who cannot afford services through the private sector. The homemakers from these two agencies “become, in some ways, an integral part of the seniors’ support networks” (p. 234) and are able to provide continuity of service. The agencies are under funded and lack recognition from governments for the work they do.</td>
<td>These two CBOs have funding and referral relationships with governments and advocacy networks with other CBOs. Managers who were interviewed did not think their CBOs work was adequately valued by governments.</td>
</tr>
<tr>
<td>2001</td>
<td>Kly and Thériault</td>
<td>Human rights and community mental health services</td>
<td>People with mental health issues</td>
<td>Interviews with 17 CBOs showed a) CBOs provide essential services to people with mental health issues including support, “supervision”, encouraging independence and integration into the community, b) inappropriate funding constraints make agency staff feel obligated to close or cut back on programs deemed beneficial to clients, c) lack of funding in general, d) lack of culturally appropriate services especially for First Nations.</td>
<td>The authors state governments are obligated to ensure human rights – even mental health – are met, however the data suggest human rights are being violated and this is not acceptable.</td>
</tr>
</tbody>
</table>
peoples, and e) the impacts of competition for funding on agencies and their subsequent inability to cooperate with others for better services.

<table>
<thead>
<tr>
<th>Year</th>
<th>Source</th>
<th>Research Population</th>
<th>Goal</th>
<th>Recommendations</th>
<th>Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>(Saskatchewan 2002)</td>
<td>All CBOs in Saskatchewan and their working relationships with the provincial government</td>
<td>Goal to have CBOs &amp; government work more effectively &amp; efficiently together, recognize independence of CBOs from government, attempt to draw lines re who is responsible for public policy development. Recognize the following principles: accountability, advocacy, primacy of community, consensus, cooperation, interdependency, &amp; shared leadership. The values and principles are laudable, but in reality they create incredible tension between CBOs and governments.</td>
<td>Recommendations focus on the following government-CBO sector relations: sustained dialogue, create an ongoing working relationship, create working tables to address specific issues, ensure sound communication and transparent reporting.</td>
<td>The entire report is about government-CBO relations &amp; tensions.</td>
</tr>
<tr>
<td>2002</td>
<td>(Gill and Thériault 2002)</td>
<td>Executive director’s perceptions of government recognition of women’s shelter work</td>
<td>There is a need to develop a “more flexible decentralized model” in dealing with community needs (p. 94). There is also a need to fix funding issues including the amount of work required to complete applications that inevitably causes work stress, the security of funding and the scope of required responsibilities. Government funding relationship “creates resistance” (p. 101). No specific advocacy strategy noted however, suggestions included: develop a 3-5 year funding plan, government should recognize and respect practices developed by shelter workers, research recruitment and retention of shelter staff, and measure government perceptions of shelters.</td>
<td>The dialectic process between these shelter CBOs and governments has resulted in mutual learning, however, the funding relationship causes strain in their relations.</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>(Clark 2002)</td>
<td>Co-location study for multiple CBOs in Saskatoon</td>
<td>Issues facing CBOs in Saskatoon: a) increasing proportion of Aboriginal individuals and families living in the city and on low incomes thus there is need for CBOs to assess their mission, values and practices to work more effectively with the families and Aboriginal CBOs, b) Increase in assaults against women and violent crimes, c) family counselling agencies report serving more people. No specific strategies noted however, there are many anticipated benefits of a community service village including; joint programming and planning among CBOs, as well as more public “policy. During the post-war era, CBOs were supported by “sympathetic provincial governments” (p. 14) and a “legacy of government emphasis on human service delivery in 1960s and 1970s” (p. 15).</td>
<td>The entire report is about government-CBO relations &amp; tensions.</td>
<td></td>
</tr>
</tbody>
</table>

The entire report is about government-CBO relations & tensions.
<table>
<thead>
<tr>
<th>Year</th>
<th>Author(s)</th>
<th>Topic</th>
<th>Description</th>
<th>Government Actions</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>Thériault, Gill, and Kly 2002</td>
<td>CBO involvement in the health and welfare fields</td>
<td>Focus on six types of CBOs: community health clinics, homecare, nonmedical/preventive home support, foodbanks, women’s shelters, and mental health services. Government influenced the creation &amp; growth of these agencies through funding &amp; participation on their boards of directors. There is “… movement back and forth …” over time (p. 141) between CBOs and governments delivering various services, however, there is no clear division of labour between them. CBOs provide complementary services to government programs. Under funding of CBO services and lack of service flexibility due to funding restrictions are problems.</td>
<td>No strategies specifically noted but elements include: long tradition of progressive social action, mutual aid and cooperation from which to draw upon … “profound conviction that the state must play a fundamental role in the funding and delivery of services in the fields of health and welfare” (p. 158). A two-way dialogue is needed “if the relationship between the state and the third sector is to evolve into a true partnership” (p.158).</td>
<td>Government shifting of services to CBO sector, private sector and informal sector (i.e., family &amp; friends). “Is it acceptable that social workers in the Department of Social Services regularly refer their clients to food banks to circumvent the inadequacies of their services?” (p. 146)</td>
</tr>
<tr>
<td>2002</td>
<td>Hayward and Kennedy 2002</td>
<td>Affordable housing</td>
<td>Community residents who lived in sub-standard housing were interviewed about their housing issues. Key issues requiring change include: increase social assistance allowances &amp; minimum wage, government investments in affordable housing, increase in government funding to CBOs to work on housing-related issues, expansion of the home ownership program, &amp; amend Residential Tenancies Act.</td>
<td>List of recommendations directed at both the provincial government and CBOs re the focal issues just noted in the column to the left.</td>
<td>It is clear that the authors and those interviewed believe the provincial government can be modifying existing policies and ensuring adequate funding for housing.</td>
</tr>
</tbody>
</table>
Appendix I - Macro-context observations list

A) SOURCES FOR MATERIAL RECEIVED THROUGH E-LISTS
Between September 4, 2003 and January 29, 2008, I received material (e.g., press releases, updates, summaries, announcements) through e-communication from the following organizations:

National CBOs
Vol. Sector Forum - Voluntary Sector Forum
Can. Vol. Initiative - Canadian Voluntary Initiative
Imagine Canada
CPRN - Canadian Policy Research Networks
KAIROS - Canadian Ecumenical Justice Initiatives
NAPO – National Anti-Poverty Organization
IMPACS - Institute for Media, Policy and Civil Society (IMPACS), ceased operations 2007
CCSD - Canadian Council on Social Development
CCPA - Canadian Centre for Policy Alternatives
Toronto SPC - Toronto Social Planning Council, this is not a national CBO but it is a large CBO that does a lot of local, provincial and national policy advocacy work

Federal government
Canada Revenue Agency
Human Resources and Social Development Canada
Standing Committee on Finance
Finance Department and Treasury Board

Collaborative CBO-Governments groups
Voluntary Sector Initiative (Government of Canada)
Premier’s Voluntary Sector Initiative for Saskatchewan

B) CONNECTIONS I SUBSEQUENTLY SOUGHT OUT FOR REACTIONS
In some instances, after receiving an e-communication, I went searching for clarification on websites and/or talked to people:

National Anti-Poverty Organization – regarding its loss of charitable status through CRA

Local Regina networks/coalitions and CBOs – Regina Anti-Poverty Network, Provincial Inter-Agency Network on Disability

Ontario Social Planning Network
C) DESCRIPTION OF THE ARROWS IN FIGURE 5.1

i) Flows from national CBOs to local CBOs

- alternative federal budget
- a “new social architecture”
- how to do social change
- series of workshops to educate CBOs about advocacy and encourage dialogue regarding charities law
- issues and relationships important to Saskatchewan CBOs
- income and wealth inequality are fundamental determinants of health
- citizen engagement research
- employment trends and policies
- electoral reform
- advocacy and governance issues

ii) Flows from local CBOs to Saskatchewan Government

- recommendations to make significant changes to the Transitional Employment Assistance program,
- recommendation to close down the Call Centre for income assistance recipients
- modify policies regarding utilities for people on income assistance programs
- alter disability framework
- partnership requested to rewrite social policies

iii) Flows from national CBOs to the federal government

- make changes to poverty level income assistance programs
- adopt a social justice perspective in government policy
- change Aboriginal social policies
- adopt pre-budget submission to the Standing Committee on Finance
- the need for the government to adopt a “new social architecture”
- citizen engagement requirements for a healthier democracy

iv) Flows from the federal government to national and local CBOs

- reminders about CRA rules regarding advocacy, political activities, sanctions, qualified donors, etc.
- $1 billion cut to social programs- especially those who do advocacy work
## Appendix J - Summary observations of Coalition’s meetings

<table>
<thead>
<tr>
<th>Coalition meeting date</th>
<th>People who attended &amp; participated</th>
<th>What happened at meetings: rituals, interactions, atmosphere, the content/nature of the advocacy conversations, self-reported outcomes/impacts</th>
<th>What was happening outside the meetings which might have affected the Coalition inside their meetings</th>
<th>The physical artifacts used during the meeting as well as those created by the participants after the meetings</th>
<th>My reflections, impressions, feelings</th>
</tr>
</thead>
</table>
| October 10, 2006       | 6 advocacy volunteers, 1 aide and 1 university placement student (no one else) – 3 had physical disabilities, 4 were low income | - meeting began with round the table introductions.  
- interesting Vol-43 sat on a chair at the door, not at the meeting table. He was invited to join the group but insisted on staying were he was.  
- discussion about who should chair the meeting; Vol-45 chaired the meeting while her aide took notes  
- everyone asked if agenda is adopted as circulated; people nodded and said yes. The agenda contained 5 main items  
- in general people took turns speaking without interrupting each other  
- raised voices occurred when roadblocks to policy change identified  
- content of meeting included discussion to send out information in a CBO’s newsletter, and to prepare a presentation to the City’s Parks and Community Services Committee outlining the issues and offering recommendations,  
- discussed need for volunteers to revise presentation and present it to Parks and Community Services Committee | - a city advisory committee was considering people with disabilities in an action plan that was related to the Coalition’s work  
- agenda and minutes from previous month  
- One key issue arising from last meeting was out of 500 complaints regarding a city service, only 9 were from people with disabilities. Talked about people with disabilities not wanting to complain because they are afraid to loose services and may not know they have the right to complain  
- a 2-page mobility plan including recommendations to city’s Parks and Community Services Committee drafted by a Coalition member was circulated. | - there were no CBOs at meeting  
- Vol-43 did not say anything during meeting  
- ‘fear about complaining about city services’ was noted in last month’s minutes  
- raised voices at the meeting reflected people’s frustration with municipal government’s perspective  
- interestingly I went back and checked Vol-45’s transcript and found that she said that she had never chaired Coalition meetings because that’s not a job that she was capable of doing back in 2002-2004. And now she’s chairing these meetings.  
- Vol-45 has a disability and cannot move but she works with her aide to accomplish so many things (i.e., gets meeting minutes done and circulated, connects with city clerk department regarding being put on an agenda for | Setting - All meetings took place at an 100-year old church in the downtown area of the city. Meetings were held in a rectangular shaped room (seating estimate 15 people) on the second floor accessible by a stairway and elevator. At one end of the room was a podium, cross and table cloth draped small table. Piano stood in the back corner. Five floor to ceiling windows (about 18 inches wide) stretched the entire length of one wall with broken blinds on some of the windows. The walls and carpet were all brown/beige. We sat at 2 rectangular wooden tables placed together. We sat on wooden or metal stackable chairs. |
Community Services; 2 members readily agreed to work together
- one member agreed to raise these issues at another coalition meeting that she will be attending next week; she indicated she thought this other coalition should be made aware and speak out too.
- no voting took place, general agreements reached

- no voting took place, general agreements reached
- one-day conference brochure was circulated for “Making Peace with the Earth”
- had current numerical data from city department and police regarding their policy issue

Nov. 15, 2006
- all volunteers (2 people with disabilities, 2 low income residents, 1 resident who was not low income or disabled), No CBOs, no governments.
- meeting began with round the table introductions.
- discussion about who should chair the meeting; Vol-45 chaired the meeting while her aide took notes
- everyone asked if agenda is adopted as circulated; people agreed. Then looked at minutes from previous meeting. Adopted without voting – general agreement.
- in general people took turns speaking without interrupting each other
- discussion focussed on a pedestrian corridor at the food bank and success with urban design changes, a city task force on access, a presentation to be made to an advisory board of city council, transportation for people with disabilities, urban design issues in the east end of Regina
- concern raised about “rubber stamping” committees at city hall
- Vol-45 pointed out task force terms of reference included some of her work
- no voting but rather conversation toward concensus

- an Advisory Committee on Access has been operational for a number of months now and provides advice to the Mayor
- a CBO has agreed to help the Coalition promote a number of issues through its newsletter and bulletin boards at their office
- one member noted that Yorkton is about to be included in the policy change (perhaps in December) the Coalition won back in 2005 for Regina; thus the policy change is still being expanded to other communities.

- agenda and minutes from previous month
- draft terms of reference to re-constitute the advisory committee into a Mayor’s Task Force on Access was circulated at meeting
- a public consultation report on winter maintenance policies from city hall was circulated.

- Vol-45 is also involved in two other Coalitions – one of which has an anonymous membership list. She said people fear reprisals from governments so the coalition’s email distribution list is not public.
- Nov. 29, 2006 Observational Notes: Coalition seem to have a double focus – on one hand they can appear to be self-serving, yet on the other hand, they are attempting to secure benefits for a much larger group than themselves.
- very focused conversation on the agenda
- detailed critique of proposed task force terms of reference
- Vol-45 seemed happy her issues were in the draft terms of reference but upset/disappointed that she could not be involved in the implementation because her application to be on the task force was rejected by the city. “I’m not a rubber stamper … so they don’t want me” she said (ibid.)
- humour was injected into the meeting a variety of times; sense of camaraderie and shared laughter
<table>
<thead>
<tr>
<th>Date</th>
<th>Details</th>
<th>Press release by provincial government regarding implementation of policy in Yorkton.</th>
<th>Coalition volunteer interviewed for evening news regarding another potential new policy through municipal government.</th>
<th>--</th>
<th>--</th>
</tr>
</thead>
<tbody>
<tr>
<td>No meeting in Dec. 2006</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>I missed Feb. and Mar. 2007 meetings</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Apr. 4, 2007</td>
<td>8 advocacy volunteers (3 had disabilities, 3 lived on low incomes, 1 university student, 2 residents who came to hear government staff). Two municipal staff attended. One CBO present.</td>
<td>- meeting began with round the table introductions.</td>
<td>- the Mayor is lobbying the federal government for more funding to support the policy change made back in 2005.</td>
<td>- agenda and minutes from previous month - copies of the city by-law were circulated at the meeting by municipal staff</td>
<td>- coalition members were polite but firm with municipal staff; when inappropriate or contradictory elements of the by-law were presented, coalition members were quick to point those out. Municipal staff acknowledged the Coalition was correct in its numerous observations - coalition members made numerous suggestions to make the by-law better based on their experiences; there seemed to be little if any inhibition to speak out - strange that municipal staff did not take many notes during the hour they were there. - in general, the Coalition seems to have energy and conviction given all the work they commit to doing</td>
</tr>
<tr>
<td>June 26, 2007</td>
<td>5 advocacy volunteers present (2 with disabilities, 2 living on low income, 1 with - meeting began with a request for a volunteer chairperson; Vol-44 agreed to chair the meeting - most of the meeting spent discussing the qualitative survey including where to administer surveys, etc. as well as follow-up on business arising from previous meetings</td>
<td>- noted another coalition doing similar work, thus should connect with them.</td>
<td>- Vol-45 emailed an apology to everyone for losing the March minutes (for which there is now no public record, but which some critical issues were</td>
<td>- there seemed to be lots of confusion about who was circulating the surveys and where; there were also concerns about how the data would be compiled - Vol-43 told the group near the end of meeting that the city sent him a letter</td>
<td>- there seemed to be lots of confusion about who was circulating the surveys and where; there were also concerns about how the data would be compiled - Vol-43 told the group near the end of meeting that the city sent him a letter</td>
</tr>
<tr>
<td>Date</td>
<td>Participants</td>
<td>Notes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
<td>--------------</td>
<td>-------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aug. 8, 2007</td>
<td>4 advocacy volunteers present</td>
<td>- meeting began with a request for a volunteer chairperson; Vol-45 agreed to chair the meeting - entire meeting spent on qualitative data results - want to present survey data to city hall committee - finally agreed on key messages to deliver on Sept. 5 to city hall committee. Vol-44 agreed to oversee the drafting of the presentation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>discussed but now no record) - agenda and minutes circulated from previous month</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>advising him “that he would be kicked off the system if he complains again”. This led to a heated discussion among members about respectful and disrespectful approaches to concerns we might have as we use public services. - They seem to be struggling with no resources. After much discussion they finally came out and asked me to do the data entry in preparation for their study circle meeting scheduled for July 19th. This study circle idea is very interesting; they sit down and work on the data together. - Vol-44 seemed really upset about having to set aside 4 hrs to do the study circle work in July. “I can’t commit to that – I’m very busy”, but he said he’d try to get to the meeting.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>felt like a real scramble to try and get everything discussed and written up with only a few days to do the work; they were rushing for city hall deadlines and the city’s advisory committee - members got impatient and were pretty blunt with each other, but still drew closure to the meeting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sept. 25, 2007</td>
<td>6 advocacy volunteers and 1 aide as well as 2 municipal government staff</td>
<td>- meeting began with round table introductions and request for chairperson and recording secretary; Vol-44 agreed to chair the meeting - began with municipal staff providing an overview and answering questions from - municipal by-law being reviewed along with public consultations by municipal government</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- agenda and minutes circulated from previous month</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- City’s -- Service Customer Survey was</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>municipal staff did not take any notes as questions and comments were posed by Coalition members during the meeting. Do they not care about these issues? Do they think this Coalition is</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Coalition members
- after government staff left, they discussed issues that should be followed-up and sent to these two municipal staff
- then they discussed the qualitative survey and how the Sept. 5 presentation went at city hall. Apparently it did not go well; the city councillor who chaired the meeting and a few committee members said they had never heard of the coalition before, who does the Coalition represent, and 35 surveys is pathetic. Coalition meeting became quite heated at that point as individuals described how badly they were treated, why the city committee felt they had the right to behave like that, and what Coalition members should have done differently.

- City’s by-law circulated
- Sept. 13, 2007 email sent from Vol-45 to Coalition members before the Sept. 25 meeting:
  “…Good morning team members,
Now that the impact of what [City Councillor] & Company managed to accomplish last week, has subsided sufficiently in my memory, we must continue to reach our goals. This is exactly what the city did to us prior to the implementation of the [2005 policy change]. I remember the feeling well. Obviously, as Vol-40 stated ‘they do recognize that we have some issues’ but they refuse to act on them …”

- Vol-41 said ‘they’ won’t consider her application to join the -- Advisory Committee’. The group encouraged her to keep trying; send application in again- ‘if you believe/vision yourself there, you will get there’.
- Vol-44 noted how successful he thought this group has been; for example, got the bus pass, got snow removal by-law altered, etc.
- “we’re helping the city to do its work” by monitoring --- and calling the city when we see problems … issues appear to be dealt with better these days at city hall” (Vol-44).

- the discussion about the Sept 5 meeting at city hall created some very angry and embarrassed people. Vol-44 said “we just weren’t ready … and I don’t ever want to be in that kind of situation again” (insinuating he was embarrassed). Vol-45 said she did not want to hear any negativity.
- At the end of the meeting Vol-44 talked with Vol-45 and they hugged each other before they left.
- Vol-41 said ‘they’ were wasting their time? Not sure what this is about.
- circulating