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EMPOWERMENT THROUGH COMMUNITY PARTICIPATION:
A CASE STUDY OF THE RAISING SEXUALLY HEALTHY CHILDREN
CHINESE PEER PARENT LEADER PROJECT

by

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A thesis submitted in conformity with the requirements
for the degree of Master of Science
Graduate Department of Nursing Science
University of Toronto

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Empowerment through community participation:
A case study of the Raising Sexually Healthy Children Chinese Peer Parent Leader Project

Master of Science in Nursing 2001
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ABSTRACT
This study explored the relationship between community participation and empowerment at the individual and community levels. Guided by the concepts of health promotion and empowerment, a descriptive single-case study was used to explore the phenomenon of empowerment in the Raising Sexually Healthy Children Chinese Peer Parent Leader Project in Toronto. Data collection included project documents, focus groups and individual interviews with 10 peer parent leaders, 4 service providers and 2 training participants.

Major findings of this study suggest that systemic racism and sexism create structural, social and economic barriers that prevent racialized immigrants from integrating successfully into Canadian society. Community participation is an important venue for social integration, especially among racialized immigrants. Parenting programs tend to be the entry points for immigrant women to connect with their communities. Health promotion programs that use multiple strategies such as community participation, mutual support, empowerment education, community partnership and intersectoral collaboration contribute to empowerment at the individual and community levels.
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Acronyms

CSSP  Critical Social Science Perspective
RSHC  Raising Sexually Health Children
TCHEC Toronto Chinese Health Education Committee
TPH   Toronto Public Health
Chronology of the Raising Sexually Healthy Children Chinese Peer Parent Leader Project

September 1998  Toronto Public Health (TPH) met with organizations from the Chinese, Portuguese, Spanish, Tamil, Vietnamese and Tagalog communities to explore family sex education programs for parents.

October 1998  Toronto Chinese Health Education Committee (TCHEC) approved the proposed RSHC Chinese Peer Parent Leader Project funded by Toronto Public Health. A Sexual Health Subcommittee was set up to oversee this project.

November 1998  Program planning and resource development for the RSHC project began.

November to December 1998  Recruitment of RSHC project participants through the Chinese media and community network took place. This project targeted Cantonese-speaking parents.

February 1999  The RSHC Training program began. A total of 10 training sessions and a number of follow-up training sessions were conducted.

May/June 1999  The RSHC Chinese Peer Parent Leaders began their practice in doing community workshops and outreach activities.

June 1999  Graduation of the first group of RSHC Chinese Peer Parent Leaders.

September 1999 and ongoing  The RSHC Chinese Peer Parent Leaders regrouped and continued to do community workshops and outreach activities.

November 1999 to February 2000  TCHEC established the second RSHC Peer Parent Leader Project. The second group targeted Mandarin-speaking parents. One of the peer parent leaders from the first RSHC project co-facilitated some of the training sessions with the service providers.

October 2000  TCHEC met with coalitions from the Portuguese, Spanish, Tamil and Vietnamese communities to explore partnership and collaboration in securing funding to continue parent-to-parent sexual health work in the community.

November 2000 to February 2001  TCHEC established the third RSHC Peer Parent Leader Project. This third group targeted Cantonese-speaking parents. Four of the peer parent leaders from the first RSHC project took part in the planning and revision of the training program. They also co-facilitated the training sessions.
INTRODUCTION

Each chapter of this thesis begins with an excerpt of a story, which I have adapted from a childhood story my mother told me. The original folk tale was about a young boy, whose family was too poor to burn an oil lamp at night; however, he aspired to become a scholar so every night he went outside to catch fireflies and put them in a little cloth pouch to use it as a lamp. I have decided to rewrite the story from a woman’s perspective and adapt it to complement my respect for the ecological interconnectedness of all beings and my belief in individual and collective freedom based on social justice and equity.

In the Midst of Darkness

A long, long time ago, in China, a little firefly called Ying-Ying lived by the Kwai-Fah River at the foot of the Seven-Star Hills. Nearby, a little village sprawled along patches of rice fields that had been carved along the hillsides, reaching up to the sky like a staircase of jade. A little girl called Siu-Mui lived in this village.

Siu-Mui’s family was very poor. Every morning, Ying-Ying watched as Siu-Mui followed her parents to work in the fields; but she knew that Siu-Mui’s heart was with the piles of books in her Grandpa’s room. Ying-Ying had listened to Siu-Mui reading aloud in the evening. There was a world of wonder in Grandpa’s books. She had also heard Grandpa telling Siu-Mui that that becoming a scholar was the only way out of poverty.

Unfortunately, Siu-Mui’s family was too poor to keep the oil-lamp burning at night. Every evening, soon after dinner, MaMa would turn off the oil-lamp. If Siu-Mui was lucky, or if Grandma was slow with the dishes, she might be able to read one page of her books before the house became totally dark...

My passion for doing a case study on the Raising Sexually Healthy Children (RSHC) Chinese Peer Parent Leader Project came from my experiencing a surge of energy while working with the project, at a time when Toronto Public Health (TPH) was undergoing a period of uncertainty, organizational upheaval and turmoil.

In 1997, the Ontario government passed a number of bills in the Legislature that put the City of Toronto and other Ontario municipalities into a state of chaos. Under Bill 103 - the City of Toronto Act, the former seven municipal governments of Metropolitan Toronto were merged on January 1st 1998 into one mega-city with a population of 2.4 million (City of Toronto, 2000).
provincial government’s stated rationale of amalgamation was “to reduce cost through eliminating duplication, streamlining operation and improve efficiency” (City of Toronto, 1999). To further complicate the amalgamation process, Bill 152 – the Service Improvement Act was also passed in 1997. This act brought a budget implication of $61 million through downloading of provincial programs onto the new City of Toronto (City of Toronto, 1999).

Over the subsequent 3 years, every single municipal department went into flurries of restructuring, budget reduction and strategic planning activities. Toronto Public Health (TPH) was no exception. By May 1999, every TPH staff was involved in some form of restructuring and planning, with “budget reduction” and “efficiency” hanging like dark clouds across the division. The politics of merging six former health units, which had different visions, values, cultures, policies, leadership styles, resources and levels of services, into one big health unit was overwhelming. Since the process of restructuring took place over a relatively short period of time, changes in TPH programs and services were perceived as a top-down approach by many staff. Health promotion projects that were not directly covered under the Mandatory Health Program and Services Guidelines (Ministry of Health and Long Term Care, 2000) were at risk of being eliminated due to budget constraints. I observed a sense of confusion, frustration and disempowerment among many of my colleagues.

The RSHC Chinese Peer Parent Leader Project was one of the few sexual health pilot projects that were developed in partnership with various ethnospecific communities after many years of internal advocacy at TPH. It was implemented in February 1999 with seed funding of $4,500 and resource support from TPH. During this transition period, TPH staff were told to conduct business as usual. However, by the summer of 1999, as different teams began the process of strategic planning, conflicts related to regional ideological differences surfaced. Programs that were perceived to have originated in different former health units were not automatically embraced by all program staff in the new structure. Although the RSHC Chinese Peer Parent Leader Project was a citywide community partnership project, its future was uncertain. I was assigned to this project at its initial stage because of my experience in cross-cultural sexual health promotion and my role in advocating for programs/services for the underserved communities. However, as TPH restructured and moved towards a new direction of program/service delivery, staff roles and responsibilities were being redefined. I was “encouraged” to reduce my involvement with these community development projects and health communication campaigns.

During restructuring, my team at the Planning and Policy Section had lost the budget for special sexual health projects. While we were told to conduct “business as usual” during the first year
of transition, we were also reminded continuously that TPH might not have the budget or resources to continue with these pilot projects. Working in the midst of uncertainty, contradictions and regional value conflicts was challenging. When I worked with the TPH administrators on program budget and resource allocation, I realized that the continuation of these pilot community projects was dependent on our team’s ability to document the outcome of these projects. I began to embrace my new “assigned” role in program evaluation, research and policy development.

Because I was the only Chinese speaking sexual health staff at TPH at the time, I was allowed to continue my involvement with the project until the fall of 1999. Working with the RSHC Chinese Peer Parent Leader Project had provided me with encouragement and a sense of hope that sustained me through the amalgamation process. As one of the workshop trainers and group facilitators, I observed behaviors, interactions and a development of relationship among the peer leaders that were empowering. The transformation and collective energy of the group had become a source of light for those of us who were struggling in the realm of darkness and chaos.

Summary

In this introduction, I have presented the background and challenges against which the RSHC Chinese Peer Parent Leader Project was initiated. In Chapter 1, I will describe the RSHC Chinese Peer Parent Project and the literature review on community participation and empowerment.
CHAPTER 1: COMMUNITY PARTICIPATION AND EMPOWERMENT

A Wish to be Realized

Each night, Ying-Ying watched as Siu-Mui stared into the vast darkness and whispered to thousands of twinkling stars that were smiling above, "Oh, how I wish to have a magic lamp that will burn all night!" Ying-Ying listened and wished she could help...

Community Participation as a Health Promotion Strategy

In recent years, the concept of health has been expanded beyond merely being the “absence of disease”. The Ottawa Charter (1986, p.1) defines health as “a resource for everyday life” and “a positive concept emphasizing social and personal resources, as well as physical capacities”. It also defines health promotion as “the process of enabling people to increase control over, and to improve their health”. It identifies five priority action areas: build healthy public policy; create supportive environment for health; strengthen community action for health; develop personal skills; and re-orient health services. The vision of health promotion is confirmed by the Jakarta Declaration on Leading Health Promotion into the 21st Century (WHO, 1997), which recognizes the importance of the above strategies and further identifies five priorities: promote social responsibilities; increase partnership for health development; expand partnerships for health promotion; increase community capacity and empower the individual; and secure an infrastructure for health promotion. Guided by the Ottawa Charter and the Jakarta Declaration, health promoters are increasingly aware of the importance of using multiple strategies such as community participation, partnership, empowerment and capacity building to promote health (Raeburn & Rootman, 1998).

Until recently, health promotion programs have tended to use single-track strategies such as stand alone health education programs that focus on individual lifestyle changes and information giving. These programs have limited impact on individual behavioral change and on public health as a whole (Travis, 1997). The new vision of health promotion is concerned not only with providing health information but also with developing skills and confidence in individuals and communities to take action in improving health (Nutbeam, 1998).

Adolescent sexual health promotion is a good example for illustrating the importance of using multiple strategies. Despite the efforts of a variety of school and community-based programs, unintended pregnancy and sexually transmitted diseases (STDs) rates continue to be high among adolescents. In the United States, a million teenage girls get pregnant each year (Kirby, 1997). In Canada, the teen pregnancy rate during 1994 was 48.8 per 1000 and in big cities such as Toronto, the
pregnancy rate was 60.2 per 1000 (City of Toronto, 1996). According to Health Canada’s Communicable Diseases Report (2000), Canadian adolescents continue to have the highest rate of genital chlamydia and gonococcal infections for all age groups.

The challenge in reducing adolescent unintended pregnancy and STD infections lies in the complexity of adolescent sexual behaviors. These behaviors are influenced by individual internal factors such as physiological maturity, cognitive and psychosocial development, and external social environmental factors such as family support, peer influences, socio-economic status and socio-political structures (Haffner, 1998; Kirby, 1997). Unfortunately, many sexual health promotion programs are restricted to using a single-track strategy because of the strict guidelines imposed by the funding organizations. At the same time, the dichotomy of the two kinds of public health, medical and social, is still pervasive in the health sector and continues to create tension. The medical tradition tends to focus on risk factors, epidemiological evidence and quantitative experiments while the social tradition tends to focus on social factors, macro theories and multiple research methods (McQueen, 1998). Although these two traditions are not necessarily in conflict, recent reduction in public health funding tends to push public health programs to focus on lifestyle risks, individual behavioral change and epidemiological evidence. Hawe, King, Noort, Gifford and Lloyd (1998) suggest that many health programs may have used multiple strategies but documented only selected activities in the evaluation. Strategies such as community development and capacity building are often hidden from program funders and administrators because the official purposes of the programs are to reduce risks in the identified health priority areas. Activities or strategies that do not work directly towards risk reduction may be perceived by the funding organizations as illegitimate or ineffective. Program effectiveness is often being measured only quantitatively, that is, in terms of the number of health education workshops that have been delivered or the number of participants attending each workshop. Ironically, these other activities and strategies may be highly cost-efficient and may have contributed to the effectiveness of the official strategies. Therefore, evaluation of the multiple dimensions of health promotion programs is essential to the development and advancement of health promotion practice.

Raeburn and Rootman (1998, p.15) advocate for a people-centred approach to health promotion which is concerned “first and foremost with real, living people, not abstract policies or statistics”. They suggest the use of multiple strategies that emphasize participation, skill development, strength building and empowerment. In the case of promoting adolescent sexual health, a comprehensive approach is necessary since young people do not live in an isolated vacuum. Health promotion efforts need to be directed not only at adolescents but also to the mediating structures in
young people's lives; for example, their parents and families, teachers and schools, the media, youth service organizations, and faith communities, etc.

This case study is based on a community parenting project. The explicit goal/purpose of the project is to encourage family sex education and parent-child communication on sexual health matters. However, implicit to the project are the multiple dimensions and outcomes of community participation such as individual empowerment, collective actions and community capacity building.

**Raising Sexually Health Children - Chinese Peer Parent Leader Project**

In the spring of 1996, Toronto Public Health collaborated with community organizations in the Chinese, Portuguese, Spanish and Vietnamese communities to develop a series of social marketing and health communication campaigns to promote family sex education in each of the four communities. Family sex education is defined as open discussions on human sexuality between parents and children at home. It includes providing children with age-appropriate and accurate information about how the body works, where babies come from, puberty changes, relationships, sexual decision-making and other sexual health issues. It also includes sharing one's own personal, family and cultural values on sexuality with one's own children and/or family members.

Family sex education and effective parent-child communication were identified by community members and public health staff as important contributing factors to adolescents' sexual health. Many studies have documented that parent-adolescent discussions on sexuality are associated with adolescents' development of self-esteem, sexual attitudes/values, and adoption of gender roles (Brage, Meredith & Woodward, 1993; Werner-Wilson, 1998; Witt, 1997). Family discussions on sexual behaviours and condom use are found to be associated with adolescents' delayed initiation of sexual activities and increased condom use at first and subsequent sexual intercourse (Whitaker, Miller, May & Martin, 1999; Miller, Levin, Whitaker & Xu, 1998). Family functioning, in general, also influences adolescents' ability to perform at school and delinquent behaviours (Masselam, Marcus & Stunkard, 1990). Therefore media campaigns that promote family sex education and parent-child communication are useful in promoting adolescent sexual health.

The effectiveness of the media campaign was reflected in post-campaign focus groups, community surveys, and increased calls received by the Ontario AIDS-Sexual Health InfoLine (Toronto Public Health, 1997). During a post-campaign evaluation focus group, stakeholders including community agency staff, community parents, public health nurses and project partners, identified community education workshops and discussion groups as an important support for family sex education. A number of workshops were organized and delivered by Toronto Public Health staff.
or contracted educators in the four communities. However, the demand for culturally and linguistically specific workshops continued to exceed the existing available resources. In addition, while the immediate feedback on these individual workshops was positive, it was difficult to assess what kind of lasting impact these workshops had on the participants and each specific community.

In May 1998, members of the Toronto Talks Sex Ethnocultural Outreach Subcommittees, from the Chinese, Portuguese, Spanish and Vietnamese communities, held a joint meeting to share ideas, successful strategies and challenges/barriers and further explore the community needs. At this meeting, the idea of training peer parent leaders within each of the four communities to lead discussion groups on family sex education and parent-child communication was generated. Most of the subcommittee members, who were Toronto Public Health staff and community agency service providers, identified peer-to-peer support as an important and effective strategy. Some members recalled their experience in other peer-to-peer projects that had provided opportunities for community development and community empowerment through mutual support, networking and community ownership. At the end of the meeting, each subcommittee agreed to explore the possibilities and venues in establishing a peer-to-peer project targeting parents in each specific community.

In the fall of 1998, Toronto Public Health collaborated with the Toronto Chinese Health Education Committee (TCHEC) to develop a pilot *Raising Sexually Healthy Children – Chinese Peer Parent Leader Project*. TCHEC is a community coalition with 17 member agencies that provide diverse social and health services to the Toronto Chinese community. The goal of this pilot project was to promote family sex education and parent-child communication through community discussion groups and workshops led by trained peer parent leaders within the Chinese community.

The project was implemented in February 1999. Fifteen Cantonese speaking immigrant parents were recruited through media promotion and community advertising to participate in this project. Each successful candidate signed a contract with TCHEC and agreed to commit at least 20 hours of peer outreach activities upon the completion of the training program. Participants were also informed during the first training session that the project would be formally evaluated jointly by Toronto Public Health and TCHEC and all the participants agreed to take part in the evaluation.

I participated in the project as one of the four workshop trainers/facilitators and a partnership representative from Toronto Public Health. My background as a Chinese immigrant, my fluency in Cantonese, my professional experience in sexual health education and my previous collaboration with TCHEC and other community agencies contributed to a positive working relationship with this project.

The initial phase of this pilot project was completed in June 1999. Fifteen parents completed a 10-session training program on children’s sexuality and family sex education. Ten of the trained
parents remained with the project and participated in community outreach and education activities during May and June 1999. The group did not meet formally over the summer but members regrouped in September 1999 to continue with their outreach activities in the Chinese community. In October 1999, the group established its own structure so that its members could interact with each other and other community organizations more efficiently. The peer leaders have continued to meet as a group and engage in community outreach activities beyond their 20-hour commitment. They have become an active subgroup of TCHEC and continue the outreach activities with support from member agencies and Toronto Public Health.

As one of the workshop trainers and group facilitators of the project, I observed behaviours, interactions and the development of relationships among the group members that were empowering. Silka and Tip (1994) note that most of the literature on Southeast Asian communities tend to focus on problems and “helping” strategies of the professional with very little documentation on strengths and competence of the community. Raeburn and Rootman (1998) note that the empowerment literature is often written as an abstraction or in terms of political power structure; there is very little documentation on people’s experience of being empowered. Kar, Pascual and Chickering (1999) report a great difficulty in finding well-written descriptions of case studies for their meta-analysis on community empowerment. It is unclear whether there are indeed a lack of community empowerment cases or a lack of case documentation. As discussed earlier, the community capacity building and empowerment dimensions of many health promotion programs may be hidden (Hawe et al., 1998). Others (Freudenberg et al., 1995; Gómez, Hernández & Faigeles, 1999) suggest that many creative, intensive and innovative community-based programs have never been evaluated and are therefore left unable to share their success or failure with others. Convinced that an evaluation case study on the Chinese Peer Parent Project would contribute to the understanding of empowerment practice in the Chinese and other immigrant communities, I decided to pursue this case study as my master thesis.

**Research Questions**

The purpose of this case study was to explore the relationship between community participation and empowerment at the individual and community levels. More specifically, the following questions were posed:

1. What were the peer parent leaders’ individual and collective experiences of participating in the RSHC project?

2. To what extent did the peer parent leaders feel more competent and able to take control of their lives at home and in the community?
3. What were the empowering characteristics of this project? What were the characteristics of this project that created barriers to individual and community empowerment?

4. What were the identifiable outcomes of individual and community empowerment in this project?

Review of Literature

As discussed previously, very little has been written on the topic of health promotion and empowerment in the East Asian and other immigrant communities. Therefore, a literature review on three related phenomena: 1. health promotion and the concept of empowerment, 2. determinants of health in the immigrant population, and 3. a critical social science perspective (CSSP) in health promotion research, was conducted to provide a theoretical framework and guide this case study.

Health promotion and the concept of empowerment

“Empowerment” is a popular concept used in different disciplines including psychology, social work, education, public health and nursing (Ellis-Stoll & Popkess-Vawter, 1998; Perkins 1995). In recent years, policy makers, politicians, corporate administrators and others have appropriated the use of the term to such an extent that “empowerment” has become a buzz word with ambiguous meanings (Perkins, 1995; Rappaport, 1995; Wallerstein & Berstein, 1994).

Despite the ambiguity, empowerment has become a central concept to health promotion. The concept of empowerment can best be understood by first looking at the concept of “powerlessness”. Social activist and empowerment educator, Freire (1981), sees powerlessness as the passive acceptance of oppression and a lack of awareness of the causes of being oppressed. When individuals are submersed in a system of social relations that does not allow them to participate equally over an extended period of time, they begin to lose the sense of control over these social relations. Yet, powerlessness is more than a subjective intrapsychic phenomenon; it is an objective phenomenon embedded in the social and political context of people’s lives. The entrapment of individuals in these oppressive social structures produces a cycle of victimization and self-blame, leading to general distrust, social isolation, economic alienation and political marginalization (Kieffer, 1984). It also reinforces the power structures and status quo.

In a literature review on powerlessness and empowerment, Wallerstein (1992) identifies the different ways powerlessness manifests itself in people’s lives. These include poverty, unsanitary living conditions, poor working environments, malnutrition, unhealthy lifestyles, lack of social support, unemployment, poor education opportunities, discrimination and marginalization. There is increasing evidence that “powerlessness” is a broad risk factor associated with poor health. Seeman and Lewis (1995) propose that powerlessness, manifested in a sense of low control, generates stress, which leads to physiological deterioration and unfavorable behavior patterns. Their analysis on the
US National Longitudinal Survey on older men and mature women shows that powerlessness is associated with greater activity limits, more psychosocial symptoms and mortality in a subgroup of older men. A similar analysis on the British Household Survey of adults by Chandola (2000) also shows a significant association of socio-economic status to mortality.

The understanding of the impact of powerlessness on health has contributed to the development of empowerment in health promotion. In 1948, the World Health Organization (WHO, 2000) defined health in its Constitution as “a state of complete physical, mental and social well being, and not merely the absence of disease and infirmity”. In the 1970s, there was a paradigm shift in the ideology of health care nationally and internationally. The term “health promotion” was used by Marc Lalonde, the Canadian Minister of National Health, in his working document — *A New Perspective on the Health of Canadians* (1974). Lalonde argued that the causes of illnesses and death are related to the environment and the individuals’ behaviors and lifestyles. The shift of emphasis from medical care to primary prevention was further advanced by the World Health Organization in the 1980s. The Ottawa Charter for Health Promotion (WHO, 1986) redefines health as not merely an “absence of disease” but “a resource for every day life”, and health promotion as “the process of enabling people to increase control over, and improve, their health… At the heart of this process is the empowerment of communities, their ownership and control of their own endeavors and destinies” (p. 3). This new health promotion framework embodies the principles of empowerment in that it recognizes the fundamental prerequisites for health and actions at the individual, organizational and community levels necessary to achieve health.

While there is little documentation on how empowerment contributes to better health, many studies have shown that people who feel powerless or disempowered experience worse health (El-Askari et al., 1998; Flick, Reese, Roger, Flectcher & Sonn, 1994; Rissel, 1994). If powerlessness is a determinant of health, empowerment is an important health promotion strategy because it “seeks to effect community wide changes in health related behaviors by organizing communities to define their health problems, to identify the determinants of those problems, and to engage in effective individual and collective actions to change those determinants” (Beeker, Guenther-Grey & Raj, 1998. P. 833).

What then is empowerment? Empowerment is a concept intertwined with the concept of powerlessness. It is about human liberation from oppression. According to Freire (1981), liberation occurs when the oppressed engage in dialogues, use critical thinking to understand their reality and participate in collective action and reflection. Labonté (1994) points out that the word “empower” is both a transitive and intransitive verb. Used transitively, it means granting power on others, enabling or sharing power; used intransitively, it describes the act of assuming power. He cautions against the
traditional paternalistic view of health professionals "giving" power to clients. He suggests that empowerment is important only when it is assumed by people.

Wallerstein (1992) defines empowerment as "a social-action process that promotes participation of people, organizations, and communities towards the goal of increased individual and community control, political efficacy, improved quality of community life, and social justice" (p. 198). Within this concept of empowerment, there are three levels of analysis – individual, organizational, and community.

**Psychological Empowerment (PE)**

Psychological empowerment (PE) is a term used in empowerment literature to describe individual empowerment. However, PE differs from individual empowerment in that it recognizes the reciprocal influences of individuals and the social structural forces on each other (Robertson & Minkler, 1994). Zimmerman (1995) identifies three components in PE – intrapersonal, interactional, and behavioral. The intrapersonal component of PE is influenced by individuals' experiences of being effective; it is reflected in individual self-efficacy, their sense of motivation and competence. An individual's sense of community leads to greater participation in the community whereas social isolation is associated with powerlessness (Saegert & Winkel, 1996). The interactional component involves individuals' critical understanding of the forces that shaped their environment and the knowledge of how to access resources in order to gain control of their environment. Freire (1981) suggests that critical thinking comes from dialogue and communication. In this sense, PE occurs when individuals get together to listen, talk, identify problems and work together to find solutions (Bernstein, Wallerstein, Braithwaite, Gutierrez & Zimmerman, 1994). The behavioral component of PE involves taking action to influence outcomes or meet one's specific needs. A combination of all three components—the intrapersonal, interactional, and behavioral—are therefore necessary to provide a complete picture of PE.

**Organizational Empowerment**

The focus of organizational empowerment is on the achievement of increased social power and resources of community-based organizations. Speer and Hughey (1995) identify a cycle of influence between organizations and individuals. In this cycle, individuals' dialogues, reflections, and actions lead to relationship development; organizations are built on the strength of relationships; and empowerment is achieved only through organizations. Organizations such as places of worship, schools, neighborhood associations, etc., act as mediating structures through which the redistribution of power is negotiated (Robertson & Minkler, 1994).

An empowering organization facilitates individual empowerment by encouraging autonomy, innovation, commitment, and increased sense of control (Maton and Salem, 1995). It also provides a
context for participating individuals to achieve a specific goal. At the same time, an organization becomes empowered when it gains increased control and social power through community mobilization and coalition building (Israel, Checkoway, Schulz & Zimmerman, 1994; Speer & Hughey, 1995).

Studies on empowerment identify a number of organizational characteristics that reflect an empowering praxis. Empowering organizations are often task-focused with a strength-based system that inspires growth, encourages collectivity, commitment and shared leadership; they provide opportunities for members to participate in decision making and function in different roles (Fawcett, Paine-Andrews, Francisco & Schultz, 1995; McMillan, Florin, Stevenson, Kerman & Mitchell, 1995). Community Empowerment

To understand community empowerment, one needs to define “community”. A community can be defined by many characteristics including shared identity, sense of belonging, common language and rituals, shared values and norms, mutual influences, shared needs and commitment to meet needs, and shared emotional connection through common history or experiences (Israel et al., 1994). A community can also be defined by its geographic location or neighbourhood, its culture or ethnicity, or its social stratification. There is a common misconception that a community is homogenous, but in reality, each community is diverse with people who base their identity on one or more factors such as class, race, religion, gender, sexual orientation, profession or special interests, etc. (Naidoo & Wills, 1994). The diversity and power relations within a community can generate conflicts and dissensus. Robertson and Minkler (1994) suggest that sometimes the notion of community participation may lead to unintended consequences of community solution that reflect racism, sexism, ageism or other oppressive or problematic approaches. Therefore community empowerment must be negotiated within the context of equity and social justice.

Community empowerment is concerned with building capacity and achieving equity. Eisen (1994, p. 240) refers community empowerment to the Cornell Empowerment Project definition -- “empowerment is the intentional ongoing process, centered in the local community, involving mutual respect, critical reflection, caring and group participation through which people lacking a proportional share of the resources gain greater access to and control over those resources”. Within the concept of empowerment, the community level of analysis is of utmost importance. Empowerment strategies that focus beyond the individual or personal dimension are able to use interpersonal or social power to build capacity, achieve political power and influence resource allocation (Berstein et al., 1994). In community empowerment, although the intervening power is not directed at the individual level, by influencing the social and political structures, individuals are also affected in the long run (Speer & Hughey, 1994).
Empowerment as Process and Outcome

Empowerment is both a process and an outcome (Eisen, 1994; Israel et al., 1994; Zimmerman, 1995). It is a mechanism by which individuals, organizations and community gain control over their lives (Rappaport, 1984). In a study on a small grassroots citizen organization, Kieffer (1984) outlines four distinct stages in the process of empowerment: 1. the “Era of Entry” – an initial stage in which individuals with a sense of shared common identity, motivated by a perceived tangible threat to the sense of integrity, react together as a group to deal with the problem. These initial reactions are not “conscious-raising” or educational; instead they are exploratory. However, through interacting in a group, individuals come to understand the structure of power and reorient themselves in relations to this power structure; 2. the “Era of Advancement” – the three major aspects of empowerment during this stage include a mentoring relationship, an enabling collective relationship of peer support and the cultivation of critical understanding of social and political relations. As individuals get more involved in the collective organization, they gain more critical understanding which in turn, motivate them to become more proactive and to participate further. The consciousness-raising activities and critical analysis work as fuel to sustain continuous political actions; 3. the “Era of Incorporation” – in this phase, the group has reached maturity; members become increasingly aware of their individual and collective capacity in influencing the socio-political world. This maturity is reflected in their organizing skills, leadership skills and survival skills; and 4. The “Era of Commitment” – in this final phase, empowered members integrate their knowledge and skills into mastering their every day life. They are committed to apply their new abilities collectively and proactively in community mobilization such that empowerment is not a commodity to be acquired but a transforming process of collective actions.

Drawing on the concept of community development, Fawcett et al. (1995) develop a model of community empowerment that focuses on community partnership. They suggest that empowerment can be achieved through strategies that enhance individual experiences and competence, group structure and capacity, environmental support and resources. They identify five interrelated components in community partnership. These include collaborative planning, community action, community change, community capacity/outcome, adaptation, renewal and institutionalization. The framework reflects the interconnected relationship of the process and outcome of community empowerment. Through community partnership, organizations join forces to develop plans and take actions to achieve changes. These changes lead to outcomes such as new resources, new policies or new programs that contribute to the community’s capacity to take control. As the community changes, community partners adapt themselves to address new issues; new leadership and new resources are established through a renewal process.
To the extent that empowerment is a process, it is also an outcome. Empowerment outcomes can be expressed in terms of individual and community capacity, changes in social and political structures, and redistribution of power and resources. However, measurement of these outcomes remains a challenge in the field of empowerment practice or research. Some of the difficulties are related to the nature of empowerment as a dynamic variable (Zimmerman, 1995). This means that empowerment manifests itself in different forms in different populations, different contexts and at different times. For example, an individual who feels empowered at his/her religious organization may feel disempowered at work. In addition, empowerment is a multi-level construct such that outcome evaluations are concerned with different variables at individual, organizational and community levels. Therefore, it is neither possible nor appropriate to develop a universal, global measure for empowerment because it is theoretically incongruent with the empowerment construct (Bernstein et al., 1994).

Evaluation of empowerment in health promotion

Labonté and Robertson (1996) identify many challenges in doing health promotion evaluation research. These challenges are related to: 1) the tension between research and practice, with research often being seen as not real; 2) the two different types of interventions within practice - one based on disease prevention and the other based on broader social determinants of health, and the problematic dichotomy of “either-or” with these two types of interventions; and 3) the differences in the ontological, epistemological and methodological underpinnings in the various disciplines involved in health promotion. Despite these challenges, evaluation research on health promotion and community empowerment is essential in generating knowledge that contributes to the development of theories and evidence-based practice.

Because empowerment is a multi-level construct, evaluation needs to be undertaken at individual, organizational and community levels. Wallerstein (1992) emphasizes the “synergistic” interactions between the various levels of analysis and cautions against evaluating individual outcomes in isolation from the social setting or contexts. Thus, the individual level of analysis may include intrapersonal components such as self-efficacy, self-esteem, perceived control, interactional components such as individual political efficacy, critical understanding of one’s reality, sense of group affiliation, community bond, and the behavioral components of citizen participation, and collective actions (Israel et al., 1994; Ovrebo, Ryan, Jackson & Hutchinson, 1994).

With organizations being a context for empowerment, evaluation at the organizational level includes its “empowering” and “empowered” components. Empowering components may include organizational values, operational styles, decision-making process, networking with other organizations, leadership and acquisition of resources. Empowered outcome components may
include an organization’s capacity to mobilize members, acquire resources, and influence social policies or shape community thinking (Speer & Hughey, 1995).

The evaluation of community empowerment is complex with multiple dimensions. It must first define “community” as a unit of analysis rather than the aggregate of individual dimensions (Wallerstein, 1992). Since community empowerment is a long-term process, outcome evaluation requires longitudinal observation and study. It may include analysis of the historical and contemporary settings, numbers of empowered organizations, interorganizational and intersectoral collaboration and leadership opportunities (Perkins & Zimmerman, 1995; Speer & Hughey, 1995). Empowerment can also be evaluated by assessing community capacity which includes access to and effective use of resources, level of civil engagement, citizen participation and the production of social capital (Beeker et al., 1998). Fawcett et al. (1995) suggest that in some marginalized communities, the broader social environmental factors such as persistent patterns of discrimination or chronic lack of resources can diminish the individual and group competence and limit the effect of community empowerment. Thus, empowerment evaluation must be done in consideration of both the historical and current contexts.

**Empowering practice in health promotion**

The concept of empowerment is guided by a set of values and assumptions. Zimmerman (as cited in Berstein et al., 1994) emphasizes that empowerment is not a panacea. It is one way of transforming the current social and political structures to achieve human liberation, social justice and equity (Freire, 1980; Rappaport, 1987) and it requires long term commitment. Labonté et al. (1996) point out that although health promotion and empowerment are interconnected to all the broad human, social and environmental issues, it does not mean that any one sector or discipline needs to presume or assume the responsibilities-for-all.

Empowerment, as defined in education and health promotion, does not lead to a zero-sum gain, with one group taking away power and leaving none for others. Power is seen as an expanding resource as individuals act to gain control over their personal and community life. It is about the redistribution of resources to create equitable social power relations (Israel et al., 1994; Wallerstein, 1992; Wallerstein & Berstein, 1994). It implies that competencies exist in individuals and communities; when given the right opportunities, people can use these competencies and learn new ones to take greater control of their lives.

Empowerment emphasizes relationships, interdependencies, and collectivism (Simon-Morton & Crump, 1996) and is achieved through participation and collective actions. Riger (1993) and Braithwaite (as cited in Bernstein et al., 1994) caution against empowerment that is based on individual opportunistic behaviors and hidden agendas. Individuals who gain personal power do not
necessarily lead to empowerment; they may become oppressors themselves (Freire, 1981). Instead, empowerment is about the collective actions of individuals. When people work together to transform the social and political structures so that their groups or community gain equitable access to resources and power, each individual benefits in the end. Thus, an empowerment practice must be guided by common goals and collective commitment.

Zimmerman (as cited in Bernstein et al., 1994) also comments on the paradoxical nature of empowerment. While our democratic society values participation and pluralism, our capitalistic foundation embraces individualism, thus creating “tension and opportunities, action and withdrawal, empowerment and disempowerment and everything else in between” (p. 291). Many of these contradictions become barriers to empowerment. Other barriers to empowerment include hopelessness related to the prolonged experience of powerlessness, pervasive resistance to change the status quo, conflicting values and the need of long term commitment (Israel et al., 1994; Kar et al., 1999; Rissel, 1994). Therefore, working with disempowered communities requires long term commitment and extra efforts in community and resource development.

To what extent can health promotion practice become empowering? As discussed previously, many “traditional” health education programs have continued to emphasize individual behavioural change and lifestyle modification as ways to improve health. This type of education program takes on what Freire (1981) calls the “banking” concept of education in which students are empty vessels and the teacher fills them with knowledge. It does not recognize the possible health determinants that are beyond the students’ control and it denies the students as potential change agents in transforming the social and environmental structures that affect their health (Travis, 1997). In addition, some of the current funding systems in health promotion also hinder the development of empowerment because the “deliverables” are often pre-determined by the funders, making it difficult for the community to take control or make decisions for themselves (Plough & Olafson, 1994; El-Askari et al., 1998).

An empowering health promotion practice must take on a reflexive praxis. It requires changes in how we, as health professionals, define our roles and relationships with individuals and their communities. First of all, we need to recognize the inherent power and privileges that comes with our social position. At the same time, we also need to acknowledge the relative powerlessness we may experience within our institutions so that we do not project it onto our less powerful clients (Bernstein et al., 1994; Labonté, 1994).

Secondly, we need to redefine our roles from the traditional helper/teacher/expert to that of a facilitator/partner/collaborator. By engaging in an egalitarian relationship of mutual learning, dialogues and reflection, we can facilitate social actions that aim at changing individual, social, and
physical environments, communities and policies, and linking participants’ concerns about health to broader concerns (Chalmers et al., 1996; Freudenberg et al., 1995; Rissel, 1994). Zimmerman (as cited in Bernstein et al., 1994) suggests that professionals take on the role of catalysts and be willing to step aside to allow community partners to take control of their own health. However, it is important to recognize that an egalitarian relationship is different from an “anti-professionalism” relationship. Labonté (1999) cautions against the polarization of health professionals vs. the community. He emphasizes that many health professionals are also community activists and have been recognized by community groups as valuable members in collective actions.

Thirdly, we need to embrace individuals and their communities as resources (Airhihenbuwa, 1994). This is especially important when working with specific cultural communities. Many health promotion programs fail because the interventions are not relevant to the target population; to be effective, health promotion programs, materials and messages must be congruent with the cultural dynamics of each specific community to be effective. Participant involvement in the production of learning materials is one way to ensure material relevancy; it also facilitates an empowering process in which participants identity their own health problems and solutions (Rudd & Comings, 1994; Wang & Burris, 1994).

Fourthly, we must be constantly mindful of and critically assess how our own practice is immersed in a system of oppression that is related to race, gender, class, sexual orientation, abilities, etc. Since some politicians and administrators have used community empowerment and community capacity as strategies to reduce health program funding, it is important for us to differentiate between “self-reliance” and “self-sufficiency”. Labonté (1999) emphasizes that self-reliance is the ability of a community group to negotiate effective interdependencies with external professionals, organizations and institutions. In other words, community development promotes equitable relationships and not local autonomy or withdrawal of support by the powerful institutions. In addition, we need to critically examine our own individual values and worldviews to reflect on how they affect our practice and relationships with others. Airhihenbuwa (1994) advocates for “border pedagogy” which constantly challenges everyone involved in the education program to cross their political, educational, and situational boundaries to understand the “otherness”.

Fifthly, as discussed previously, because health promotion is defined in broad social terms, it is important for us to develop a practice that is accountable and evaluation research that can withstand scrutiny. Labonté and Robertson (1996) suggest the use of a constructive paradigm which embraces both quantitative and qualitative methods and biological and social theories in reflexive ways.

In conclusion, empowerment, community participation and health are three important concepts in the new health promotion discourse. These three concepts are overlapping in complex
ways, both in theory and in practice. Since the new health promotion movement is a relatively new
development, health promotion professionals and researchers must continue to generate knowledge
that is useful and usable by other practitioners and citizens (Labonté & Robertson, 1996).

**Determinants of health in the immigrant communities**

The Canadian society has become increasingly pluralistic as its patterns of immigration and
refugee settlement evolves. According to 1996 census data (Statistics Canada, 1996), approximately
48% of the residents in Toronto are immigrants; and Toronto is home to 42% of the total non-white
population in Canada. The changing population calls for changes in the ways we traditionally
promote health. Meleis (1996) suggests that the increase in societal diversity has led to increasing
awareness of the need to provide culturally competent health care. However, since the health of
immigrants is greatly influenced by the complex historical, cultural, social, political and
environmental factors in the society of settlement, larger structural issues must be addressed to
enhance the health of immigrants.

**Integration and acculturation**

Literature on immigration and settlement has extensively focused on the concepts of
“acculturation” and “adaptation”. Successful acculturation or adaptation is associated with positive
health among immigrants. In principle, acculturation is a neutral term; acculturation occurs when
groups of individuals come in continuous first-hand contact with each other, resulting in changes in
the cultural patterns of either or both groups, but in practice, changes tend to be less in the dominant
culture (Berry, 1997). A more commonly recognized definition of acculturation is “the degree to
which an individual from one culture has given up the traits of that culture and adopted the traits of
the dominant culture in which he/she now resides” (Huff & Kline, 1999, p. 9). In his framework of
acculturation, Berry (1997) identifies four acculturation strategies: assimilation,
separation/segregation, marginalization and integration. The use of these strategies is dependent on
many complex individual, group and structural factors. At the individual level, push/pull factors in
acculturation include migration motivation and expectation, cultural distance between the society of
origin and the society of settlement (e.g. language, religion, values and beliefs), and individual
variables such as age, gender, education, coping skills and experiences in the society of settlement.
At the group level, acculturation factors include physical, environmental and social changes such as
climate, spatial organization, dietary intake, exposure to new diseases, employment opportunities, and
new family or social networks. At the structural level, historical and existing social orientations
towards immigration and pluralism play an important role in the process of acculturation. Societies
that embrace cultural pluralism are less likely to enforce cultural assimilation and exclusion, and more
likely to provide supportive resources that encourage integration.
Adaptation is an outcome of acculturation. How well individuals or groups adapt in the society of settlement is dependent on the type of acculturation strategies they use. Berry (1997) suggests that integration is associated with the most successful adaptation; marginalization is associated with the least, with assimilation/separation being in the middle. He emphasizes that the acculturation strategies used by individuals and their communities are highly dependent on the structural moderating factors. Positive moderating factors such as equitable opportunities and supportive resources in both the society of settlement and one’s own cultural community encourage integration which is associated with lower stress, increased coping and successful adaptation. Negative moderating factors such as racism, discrimination and prejudice in the society of settlement are associated with separation/segregation and marginalization that contribute to serious health problems. While Berry’s framework was developed mainly to be used as a guide for research, and it is by no means complete in addressing all the complex dimensions of migration and settlement, the concepts of individual, group and structural moderating factors in acculturation are useful in guiding the understanding of health determinants in immigrant communities.

Central to the discussion of health among immigrants are the concepts of stress and coping. Immigrants may experience a sense of chaos from the time they plan to leave their countries of origin until they become integrated or adjusted in the society of settlement (Foss, 1996). As individuals go through the transition of settlement, they are often faced with increased levels of stress related to the loss of family/social network, loss of employment and socio-economic status, intergenerational conflict and difficulties in social integration related to cultural and language barriers (Aroian, Norris, Patsdaughter & Tran, 1998; Foss, 1996; Lazarus, 1997; Nesdale & Rooney, 1997).

The ability for individuals to adjust to all of these settlement challenges is dependent on many complex personal and social factors. At the individual level, factors such as age, gender, education, language abilities, coping strategies, migratory motivation or premigratory negative life events may contribute to one’s ability to adjust (Berry, 1997; Nesdale et al., 1997). However, since acculturation does not occur in a vacuum, social and structural factors play a significant role in immigrant settlement and adjustment.

Despite Berry’s (1997) suggestion that multicultural societies promote integration and facilitate successful acculturation, barriers such as systemic racism, sexism, dominance and unequal power relations continue to exist in all societies. In Canada, all immigrants do not fare the same. Immigrants of color experience more economic, social and cultural barriers in settlement compared to white immigrants of a British background. Using the 1991 census Public Use Microdata, Pendakur and Pendakur (1996) analyze the earning disparities between white and visible minorities. They find that immigrants of colour earn less than white immigrants, even if they have been educated in
Canada. In addition, the analysis shows that Canadian-born visible minority also suffer large earning gaps; thus, cultural differences, language skills and education quality cannot be used as the explanation for the earning differentials.

"Racialization" of immigrants and their offspring is a major barrier to successful settlement and acculturation (Creese, Dyck and McLaren, 1999). Lee (1999) defines racialization as the social construction of "race" resulting from historical and cultural processes in which people are classified as different, based on the use of different phenotypical, cultural and behavioral markers as signifiers, and then treated as subordinate. In countries such as Canada, United States, Australia and New Zealand, where the dominant culture is English and white, immigrants of color report various types of discrimination while white immigrants from Britain or Western European countries report enhanced status (Pernice & Brook, 1996). Although discrimination may be manifested more explicitly in day-to-day individual interactions, it is the systemic discrimination embedded in our society that impacts significantly on the health of immigrants.

Most immigrants relocate to a new country in hope of a better life and improved life opportunities; but in reality, many of them experience economic and social barriers. Their opportunities to gain employment are compromised by the "non-equivalence" or "non-recognition" of their qualifications, education, specialized training and previous work experience (Pendakur et al., 1996; Schaafsma & Sweetman, 1999). Many immigrants find themselves being exploited by employers, underemployed or jobless. Aroian et al. (1998) suggest that, in addition to financial stability, adequate employment provides immigrants with a sense of purpose, accomplishment and social integration that is essential to their mental health. At the same time, immigrants from countries of very different cultural and religious values tend to experience more cultural shock and social isolation. For economic and social survival, many immigrants band together to develop a social and economic base that uses their skills and provides them with a social support network (Foss, 1996). These close ties strengthen their ethnic identity, contribute to their positive self-esteem and act as an important coping resource for immigrants (Herz & Gullone, 1999; Nesdale et al., 1997; Schnur, Koffler, Wimpenny, Giller & Rafield, 1995).

However, ethnic identity is a double-edged phenomenon in immigrant settlement. Immigrants prefer integration as their acculturation strategy but the culturally dominant ideologies of the "host" country often demand assimilation. This difference creates a vicious cycle in which immigrants who experience cultural, linguistic, social and economic barriers to integration seek to have stronger ties with their own ethnic community for survival. As their ethnic identity is strengthened, they also experience increased stereotyping, prejudice and discrimination from the
dominant group in the new country, resulting in further segregation and marginalization that potentially decrease the overall self-esteem of the whole community (Nesdale et al., 1997).

Creese et al. (1999) suggest that current Canadian immigration policy, procedures and discourses unsettle family relations in ways that put a lot of stress on immigrant women. Men are frequently categorized as independent applicants in immigration and women as their dependents. This practice reinforces the myth that immigrant women are without skills and unemployable when in fact they have high rates of employment in their countries of origin. The stereotypes of dependence marginalize immigrant women and make it difficult for them to find decent employment. In addition, when immigrant women arrive in Canada as spouses or dependents, their skills are not tested or matched for the Canadian labour market; their human capital is further compromised when their pre-migratory qualifications are not recognized. As a result, they tend to compete for low-wage or seasonal employment (Shamsuddin, 1999). The ability for immigrant women to obtain and sustain low-wage employment often creates family conflicts, especially if the men within the households are underemployed or unemployed and if the families come from countries where gender roles are rigidly defined (Drachman, Kwon-Ahn & Paulino, 1996). The "perceived" improved social status of immigrant women may create conflicts in their marital relationships or in the community as a whole.

**Immigrant Parents**

Immigrant parents who have not been able to integrate successfully into the society of settlement often have a fragile sense of the future and experience prolonged stress. Many of them invest all their hopes in the future of their children. They view education as the only way to succeed in the new society. This puts tremendous stress on the children and the mothers who are often given the responsibility to ensure that their children succeed (Creese et al., 1999; Foss, 1996; Gorman, 1998; Shek & Chan, 1999). Some immigrant mothers experience a sense of incompetence as they struggle to learn a new system of education and socialization. They may not know how to apply previously acquired parenting skills within a social context that is unfamiliar to them (Florsheim, 1997). For women who come from societies that have different spatial and social organization, mothering has become extremely challenging since it is located both within and outside the home. The proximity to school, community resources and social support network, accessibility and affordability of transportation and language fluency impact on the dependence and independence of immigrant mothers and their children. Immigrant mothers in suburban areas may find less time for themselves when traveling between home and school and other activities which all take up more time. Many of them may become isolated if transportation is not easily accessible or affordable in terms of financial cost and time. Women who do not speak English tend to rely on their children or spouses to get out or they are restricted to interact within their own ethnic communities. All of these factors put
limitations on the extent to which immigrant women can participate fully in society or take control of their own lives. With the additional spatial and time demand, immigrant mothers tend to sacrifice their own needs in order to fulfill the needs of their children, spouses or other family members, leading to increased isolation and depression. At the same time, older children in the family may experience additional stress and resent their parents' dependency on their language skills (Creese et al., 1999; Man, 1996).

Other tensions arise as immigrant children adjust to the new society faster than their parents. Immigrant families from cultures that value collectivity, kinship, interdependence and interrelatedness are faced with many acculturation dilemmas during their settlement in Western countries that value independence, individualism and self-determination (Drachman et al., 1996). On one hand, parents want their children to integrate fully into the new society; on the other, they also want their children to maintain their heritage and culture. As the children adopt Western values, intergenerational and intercultural conflicts surface in the family, leading to parental stress and depression (Creese et al., 1999; Shih, 1998; Ying, 1999). Parenting practice of collective societies which stress family harmony, protection and obedience is perceived by the acculturated youth as being over-protective, controlling, unaffectionate and old-fashion (Herz & Gullone, 1999, Rosenthal & Feldman, 1989). Immigrant children often feel torn and find themselves not fitting into either of the two cultures.

In conclusion, the health of immigrants is affected by many complex personal and social factors. Many immigrants experience anxiety, stress and depression as they go through the acculturation process. Social support has been identified as a buffer to stress and provides individuals with a sense of stability, predictability and control (Foss, 1996; Man, 1996). Despite the challenges and difficulties, some immigrants are resilient in building strength in their communities. Those who have lost the support networks of extended family with relocation may attempt to replicate these networks by adopting friends as relatives; others have worked together to establish community organizations that help new members to settle and integrate (Creese et al., 1999). In light of the above discussion, strategies such as advocacy, community development, networking and capacity building are essential in promoting health among the immigrant populations.

**Critical Social Science Perspective and Health Promotion Evaluation Research**

A critical social science perspective (CSSP) is a framework of critical scholarship derived from postmodern critical, cultural and feminist theories (Eakin, Robertson, Poland, Coburn & Edwards, 1996; Poland, 1996). The postmodern critical social theories challenge the positivist and structuralist notions of rationalism, ultimate truth, monolithic or grand narratives, objectivity and autonomous individualism (Falk & Adeline, 1997). They embrace multiple realities, value local and
specific truth and recognize that knowledge development is mediated by power relations embedded in historical, social, cultural and political contexts (Boutain, 1999, Fulton, 1997); there is not one voice but a multitude of voices that sometimes speak together (Glass & Davis, 1998). Critical social science recognizes the existing structures of inequity and domination; its goal is emancipation through raising awareness of how oppression operates and finding ways to change the oppressive structures (Boychuk, 1999; Lenzo, 1995).

A CSSP is a new paradigm of inquiry in health promotion research; it advocates for "reflexivity, power analysis and the value of dialectic between the researcher and the phenomenon being studied" (Wallerstein, 1999). Eakin et al. (1996) describe reflexivity as the "capacity to locate one's research activity in the same social world as the phenomena being studied". A reflexive researcher recognizes that all research processes are based on certain assumptions and ideologies that are socially constructed. Ideologies are cultivated to become commonsense knowledge and the purpose is to conceal, deny or maintain relations of domination (McKeever, 1995). Since these ideologies and political positions are often hidden within the argument of research methodology and technical concepts (Poland, 1996), researchers must ensure that all of the assumptions are made explicit and available for contesting.

Reflexivity also calls for a critical understanding of the historical, cultural, social and political context of the research phenomena. This critical understanding is reflected in the researchers’ ability to interpret situations using a body of knowledge, their awareness of the structural influences on the participants’ responses (Im, Meleis & Park, 1999), and how their own social location, background, values and ideologies affect every component of their research (Allison & Rootman, 1996).

A CSSP challenges the traditional power relations between researchers and the research participants. In contrast to the positivist assumption that the subjective knowledge of the research participants is less valid than the objective knowledge of the researcher (Eakin et al., 1996), a CSSP advocates for a more egalitarian relationship in which participants are free to talk about and interpret their experiences, but at the same time, engage in reciprocal dialogues that raise their critical consciousness about the oppressions in their life (Falk & Adeline, 1997; Henderson, 1995). Wallerstein (1999) suggests that when research participants and their community gain a fair share of power in the research relationship, their capacity to take action towards social transformation also increases. However, Im et al. (1999) emphasize that, despite the attempts of creating more equitable power relations in research, a researcher and the participants can never possess equal power because of "their differentiation by knowledge, boundaries, power and the purpose of the encounter".

Concerted effort is necessary to establish horizontal relationships and shared authority and ownership of the research data.
Unlike traditional research that values order, consistency and consensus, a CSSP embraces paradoxes and contradictions. While it is important for research to be theoretically grounded, Lather (1991) cautions against theory imposition in which data are poured into pre-determined “containers” to fit our chosen theory; instead, she suggests that researchers critically look for inadequacy and potential counter-interpretation of a theory. Contradictions are critical in emancipatory inquiry because they provide an entry point for both the researcher and the participants to see how cultural and social ideologies serve their interests. Eakin et al. (1996) suggest that contradictions and dissensus can generate insights that become forces behind social change. They recommend a dialectical approach that bridges the understanding of how the macro structural forces shape the everyday life of individuals and groups, and how individual/group actions also influence the same macro structural forces.

In conclusion, a CSSP advocates for research as praxis, that is, reflection with action (Fulton, 1999). Lather (1991, p.64) identifies a central challenge for researchers, that is, “how to maximize self as mediator between people’s self-understandings and the need for ideology critique and transformative social action without becoming impositional”. She cautions against the practice of dismissing resistance to critical reflection as “false consciousness” as she quotes the definition of resistance written by one of her graduate students, Kathy Kea (p.76):

A word for the fear, dislike, hesitance most people have about turning their entire lives upside down and watching everything they have ever learned disintegrate into lies. “Empowerment” may be liberating, but it is also a lot of hard work and new responsibilities to sort through one’s life and rebuild according to one’s own values and choices.

Therefore, researchers in critical inquiries must constantly reflect on the research processes to ensure that the ideals originally intended for emancipation and empowerment do not become oppressive (Falk & Adeline, 1997).

Summary

In this chapter, I have described community participation as an important health promotion strategy and outlined the development of the RSHC Chinese Peer Parent Leader Project. I have also described the literature review on the major components of empowerment, determinants of health among immigrants and the application of a Critical Social Science Perspective on health promotion research. In the next chapter, I will present the methodology of the case study.
CHAPTER 2: METHODOLOGY

In Search of an Answer

Ying-Ying really wished to help Siu-Mui. "What can I do?" she kept asking herself. "I am only a little bug." One afternoon, she flew into the woods and talked to Grandfather Cicada, who smiled and said, "Little Ying-Ying, look deeply into your heart and you will find the answer."

Conceptual Orientation

This research study was guided by the concepts of health promotion and empowerment. As discussed previously, the Ottawa Charter (WHO, 1986) emphasizes health promotion as "the process of enabling people to increase control over, and to improve, their health". Parallel to the concept of empowerment, health promotion actions include: "build public policy; create supportive environment, strengthen community action; develop personal skills; and reorient health services".

When applied to health promotion, an empowerment strategy "seeks to effect community-wide change in health-related behaviors by organizing communities to define their health problems, to identify the determinants of those problems, and to engage in effective individual and collective action to change those determinants" (Beeker et al., 1998). Based on these two concepts, this study aimed to evaluate the process and outcome of community participation at the individual, organizational and community levels. In addition, as mentioned in Chapter 1, a Critical Social Science Perspective (CSSP), which is consistent with the concepts of health promotion and empowerment, was used to guide this study.

Design and Method

A descriptive single-case study was used to explore the phenomenon of empowerment in the RSHC Chinese Peer Parent Leader Project. Merriam (1998, p.27) defines a case study as a process of investigation on a bounded system with the end product being "an intensive, holistic description and analysis of a single entity, phenomenon, or social unit". Yin (1994) suggests that a case study can be used to investigate a contemporary phenomenon within its real-life context, especially when the inquiry uses multiple sources of evidence in a triangulating fashion. A case study allows the researcher to focus on the particulars and gain in-depth insight into the meanings of the participants' personal experiences (Dale, 1995).

Yin (1994) further explains that when a case is considered to be a pilot case or is critical, unique, revelatory, using a single-case design is appropriate. A critical case consists of component
that can be used to confirm, challenge or extend the theory under investigation; a unique case presents a situation that is rare; and a revelatory case provides an opportunity to study a phenomenon in ways that not previously accessible to researchers. Since the RSHC Chinese Peer Parent Leader Project was a bounded system and a pilot project, and consisted of components that are relevant to evaluating the concept of empowerment, the use of a single-case study design was appropriate.

**Research Participants and their Relationship with the Researcher**

Based on a case study design, the research participants of this study consisted of the 9 female and 1 male peer parent leaders in the project, 4 female community service providers from TCHEC and the 2 project participants who dropped out of the project after they completed the training.

In qualitative research, the investigator is the primary instrument of data collection. Thus, they need to have the ability to work with ambiguity and to be intuitive or sensitive to the data, the context and all emerging themes within the study. (Patton, 1990; Merriam, 1998)

In addition to skills and ability, the researcher must be sensitive to the biases inherent in qualitative research since there is not a single objective reality in qualitative inquiry; rather there are many interpretations of reality. Since all observations and analyses are filtered through the researcher’s worldviews, values and perspectives, the *reality* or final product of the study is indeed the researcher’s interpretation of the participants’ constructions or interpretations of the phenomenon being studied (Merriam, 1998). Temple (1997) suggests that the socioeconomic and political locations of the researchers provide them with a set of experiences that influence how they know what they know, in other words, their epistemological stances. Therefore, it is important for the researcher to make explicit his/her assumptions, his/her position in relation to the phenomenon being studied and the theoretical perspectives that influence the study.

I am a part-time graduate student at the University of Toronto Faculty of Nursing and I work full-time as a Health Education Consultant at Toronto Public Health. Since the Peer Parent Leader Project was a pilot partnership project of TCHEC and TPH, I participated on behalf of Toronto Public Health and was a member of the trainer/facilitator team during the planning stage (October 1998 to January 1999) and the implementation stage (February to October 1999) of the RSHC project. My role was to work with the Family Sex Education Subcommittee of TCHEC to develop, implement and evaluate the project. I co-facilitated the training program with staff from 3 other community agencies.

In October 1999, the RSHC Chinese Peer Parent Leader Project established its own structure and functioned as a community outreach project of TCHEC. TPH continued to support the project by
providing print resources and consultation. As described in Chapter 1, my role had evolved from that of a trainer/facilitator to that of a consultant. I was no longer involved with the project’s day-to-day operational activities; I provided the group with information, advice and suggestions upon their requests. Recognizing the importance of outcome documentation, I decided to take on this case study as my Master thesis.

My involvement as one of the initial project facilitators/trainers might have put me under scrutiny in terms of my objectivity and potential conflict of interest because of my role as an advocate on providing sexual health programs and services to the underserved communities and my gain as a student. From the onset of the project, I made explicit to TCHEC and the peer parent leaders my interest in doing an evaluation study on this project as a graduate student. When TPH emphasized its new direction in evidence-based practice and program evaluation, my administrators were supportive of my plan to conduct this case study and I received approval to do this study from both organizations (Appendices A and B). To clearly maintain my role as a graduate student researcher in this case study, I did not receive any time or resources from TPH to conduct this study.

During the research period, I had withdrawn my direct professional involvement with the group and provided support to the project indirectly through another staff and the sexual health team when needed. Occasionally, the group had invited me back to do workshops with them on women’s reproductive health and other sexuality topics. While they acknowledged my new role as a consultant to the project and a student researcher, they continued to embrace me as one of the members of the group.

My interest in the evaluation of the Chinese Peer Parent Leader Project was in accordance with my professional practice. Program planning, implementation, evaluation and program revisions are essential components in evidence-based health promotion practice. In reality, very few programs have the resources to contract external evaluators to do program evaluation. In addition, as TPH underwent restructuring and budget realignment, health promotion projects for the underserved communities were once again at risk of being eliminated. I believed it was within my professional responsibilities to study the outcomes of community development projects such as the RSHC Peer Parent Leader Project. The findings of this case study would contribute not only to public health practice, but it might also provide evidence to support and advocate for community empowerment education in the underserved communities.

At a personal level, I was deeply touched by the interactions and energy that was generated in the RSHC Chinese Peer Parent Leader Project. It brought back a similar sense of encouragement and fulfillment that I had experienced in previous community development projects. I realized that, after
ten years of working at TPH, I had never spent time nor had the resources to capture the abstract and fluid outcomes of these community development projects. Our team had not gone beyond the quantitative documentation of the numbers of workshops and clients reached. The enthusiasm of the peer leaders and the threat of program cuts at TPH worked side by side to instill in me a passion to study this project.

**Placing my “Self” in the Research**

Traditional and positivist researchers emphasize the notions of rationalism, ultimate truth and objectivity. Based on a critical social science perspective (CSSP), I argue that there are multiple realities and a multitude of voices that sometimes speak together (Glass, 1998). Because of my intensive and extensive involvement with the project during its first year, my role as a researcher had somehow taken on some aspects of an ethnographer. Unlike researchers who are “new” or ‘strangers’ to the group, I was an ‘insider’ with access to participant observation.

Tedlock (2000) identifies the contradiction of traditional participant observation which “implies simultaneous emotional involvement and objective detachment” (p. 465). She highlights the changing trends in ethnography where native scholars work towards narrowing the gap between self and other by acknowledging both parties as vulnerable experiencing subjects who work together to produce knowledge. This type of reflexive and engaging ethnography (autoethnography) is especially relevant when the researcher has grown up, lived or achieved some degree of inside status. Fine, Weis, Weseen and Wong (2000) also caution against the practice in which the researchers often hide behind the so-called neutrality, asking for revelation from the informants and making them carry the burden of representation, without ever revealing much of themselves.

Since RSHC Chinese Peer Parent Project was an empowerment education program, the orthodox ideology of the professionals being objectively separated from the clients/participants was irrelevant. As a member of the program development team and a co-trainer, I was an active participant in this project, just like the other service providers. Therefore, I argue that my individual and collective experiences needed to be included as data of this study. I acknowledge the challenges that my dual roles have created for me in analyzing the data and weaving my voice into the text. Following the CSSP as a framework, I shall make explicit my social location and my “self” in the context of this project and my day-to-day experiences to allow the readers to critically examine my work. Data of my “self” as the subject of inquiry will be written in *italic* to separate them from those of the other research participants.
Like all the peer leaders, I am an immigrant from Hong Kong; my native dialect is Cantonese. Unlike most of them, I came to Canada in my teenage years. I received most of my education in Toronto and that contributed to my "relatively" successful integration into the Canadian Society. Although I do not experience the stress and challenges of settlement that many of the peer leaders do, my understanding of their struggles came from witnessing the hardship that my parents had gone through as non-English speaking racialized immigrants. I consider myself a Chinese Canadian. The Chinese cultural identity is significant to me not totally by choice; rather it is subtly imposed upon me when I am constantly being perceived as an "immigrant" despite my Canadian citizenship. As a visible minority woman working in a "mainstream" government organization, I witness racism, inequity and injustice. I constantly have to advocate for and justify the need for programs and services for the underserved and marginalized groups. At times, I feel powerless within my organization. However, out in the community, my visible identity as a racialized woman tends to enhance my working relationship with other racialized immigrants or minority groups. Paradoxically, my advocacy work with the gay/lesbian/bisexual communities has also put me under scrutiny by the fundamentalist Christians in the Toronto Chinese community. My passion in doing education training for parents is not only related to my roles as a health promoter, but also to the hundreds of personal stories I have heard from young people from different communities regarding the intergeneration and intercultural conflicts they have experienced at home and in the society.

Data Collection

One of the strengths of a case study research design rests with the multiple sources of data it can use. As suggested by Patton (1990, p. 244) "no single source can be trusted to provide a comprehensive perspective on the program... using a combination of data types can increase validity..." Therefore, in this study, I have used data from five sources:

1. Interviews: one audio-taped focus group interview with the peer parent leaders, one audio-taped focus group interview with 4 community workers/TCHEC members; 1 short follow-up telephone interview with all of the research participants and an audio-taped telephone interview with 2 participants who dropped out from the program.

2. Social demographic forms: filled out by the peer parent leaders (Appendices C & D).

3. Documents:
   - project training manuals
   - program training evaluation forms
   - participant attendance and outreach activity records
- peer leader reflective journals
- community workshop evaluation forms
- meeting minutes
- Newspaper clippings and media interviews.

4. Observation:
- project progress notes on training sessions, outreach activities and community workshops taken by project trainers/facilitators and peer leaders
- notes taken during focus group interviews

5. Artifacts: education materials developed by peer leaders of the project.

Since empowerment is a participatory process, I chose to use semi-structured focus group interviews to elicit the participants' perspectives and to minimize any preconceived influence from the interviewer. Interviews of the peer leaders and service providers were conducted during September and October 2000, when the project had been established for less than 2 years. Interview guides (Appendices E, F & G) were used to assist me in exploring, probing and asking questions without straying from the topic of inquiry (Patton, 1990). Study information sheets and consent forms (Appendices H, I, J, K, L & M) were sent to the potential participants one week prior to the interviews so that they had time to reflect and consider the agreement without pressure. The consent forms were written in Chinese and English and they were reviewed by a bilingual Cantonese/English speaking service provider to ensure that they were easy to understand and that the translation was accurate.

The focus group interview with the peer leaders was conducted in a training facility that they were familiar with while the group interview with the service providers was conducted at a local community agency. Three of the peer leaders and one service provider could not attend the group interviews because of work and other commitments; however, they all agreed to participate in individual interviews and were interviewed later at a time convenient to them. Participants were called one week after the initial interviews to ensure that each of them had an opportunity to tell his/her perspectives away from the group environment. It also allowed me to clarify and obtain more information on certain aspects of the interviews. All interviews were conducted in Cantonese by myself. A Cantonese-speaking community colleague, who had signed an agreement to confidentiality, was asked to assist me in taking notes and recording the group interactions during the peer parent leaders focus group interviews.

To understand the barriers to participation, I attempted to contact the five participants who dropped out of the project after they completed the training. A request for participation in a telephone
interview and consent forms (Appendices N, O, P & Q) were sent to these participants by mail, followed up with a telephone call. Two out of the five women responded and consented to a telephone interview which was audio-taped.

Since the project was implemented with staff support from four agencies, field notes were kept and shared among the trainers/facilitators to enhance communication and effective operation of the project. Patton (1990) recommends overt observations in which program staff and participants are fully aware that observations are being made and who the observer is. The peer leaders and my community colleagues were made aware that, with their permission, field notes would be used for the purpose of evaluation. Other project documents, including project training manuals, program training evaluation forms, participant attendance, outreach activity records, peer leader reflective journals, community workshop participant evaluation forms and meeting minutes, were also used upon the consent of the peer parent leaders and permission from TCHEC and Toronto Public Health.

Additional data used in this study included community newspaper articles and media interviews about the project.

**Issues of translation**

One of the challenges identified by researchers in doing cross-cultural qualitative research is the lack of equivalence of meanings across different cultures (Neubret, 1997, p.10). This challenge exists because languages and cultures are intertwined. Since words are the linguistic realization of images and perspectives that are recurrently shaped by culture (Gommlich, 1997) and certain experiences are unique to people of a specific culture, the lack of language equivalence is understandable.

Translation is more than taking the words of one language and replacing them with those used in another language. Translators are required to perform two complex tasks – translation and interpretation. They have to make explicit the meanings embedded in the source data and reproduce them in another language in ways that the receptor audience can understand. Thus, the translators must possess not only language competence but also knowledge of the two cultures in the specific context of the research topic (Neubert, 1997).

In addition, translation/interpretation cannot be separated from the theoretical framework of the research because both assume a position that has been constructed using a different language (Temple, 1997). When translation is used in cross-cultural research, three levels of meaning construction take place. The participants construct their experiences in their own terms and from their own perspectives; the translator reconstructs the participants’ experiences through his/her own
perspective using the researcher's culture-language; and the researchers do the same except through the accounts of the translators. The final accounts may differ because each individual’s perspectives are based on her/his own benchmarks gained through her/his experiences within her/his own social, cultural, economic and political contexts (Sparks, 1997). To ensure “rigor” in qualitative research, issues related to the process and interpretation of translation must be made explicit for open discussion.

In this case study, I conducted the interviews in Chinese (Cantonese) which is the first language of the participants and the researcher (myself). The interviews were translated and transcribed into English simultaneously by me. The similarity in age, language and cultural background between the participants and myself enhanced the translation/interpretation process. At the same time, my acculturation, education and participation in the Canadian society had provided me with the skills and ability to present the research data within the Canadian cultural context. To ensure that my translation was accurate, I asked one of my bilingual Chinese/English colleagues to randomly choose an interview tape with matching transcripts for review and she found the translation to be valid.

**Data Analysis**

Data analysis is a challenging process in qualitative research because of the massive volume of data and information that can be generated in the inquiry. Yin (1994) emphasizes the need to start with a general strategy which sets the priorities for what should be analyzed and why. It is preferable that this general strategy is based on the theoretical propositions and the purpose of the case study. A utilization-focused approach of data analysis helps to keep the research findings from being too abstract and theoretical (Patton, 1990). Since the purpose of this study is two-fold: 1) for me to develop competence in research as a graduate student, and 2) to explore the relationship between community participation and empowerment in the individuals and their community, data analysis of this study was guided by the theoretical concepts of health promotion, community participation, empowerment and program evaluation.

Merriam (1998) identifies three levels of analysis: descriptive account, category construction and theory construction. Descriptive account compresses and links the data in a narrative so that the readers can draw their own conclusion. Category construction is the next level of analysis. It is a process guided by the research purpose and the researcher’s orientation and knowledge. A category or subcategory, as a unit of analysis, should reveal information relevant to the research and can be interpreted in the absence of additional information except the context in which the research is
conducted. The emergence of these categories and patterns is considered inductive if they come about without prior impositions. There are two kinds of categories: *indigenous concepts,* which are developed and articulated by the research participants and *sensitizing concepts,* which are based on social science theories and brought into the analysis by the researcher.

To derive relevant themes and categories, I began by reading the interview transcripts and project documents to develop a broad understanding of the data. Once I was familiar with the data, I began to identify indigenous and sensitizing concepts/themes by moving back and forth between parts of the data and the whole. To enhance the organization of my data from different sources, I used the NVivo computer program to code the different categories and sub-categories (see Appendix R & S). I first developed broad categories such as individual empowerment, organizational empowerment, community empowerment, barriers to empowerment, immigrant parents and training. Then I developed sensitizing subcategories as identified in the scientific literature, and indigenous subcategories as the data revealed emerging themes.

After a system of categories was developed, I tested it for completeness based on the following criteria suggested by Patton (1990) and Merriam (1998):

1. the system of categories are integratable: the categories are internally consistent, but when viewed externally, they offer the whole picture;
2. the categories are exhaustive: all important and relevant data are placed into categories and there is no unassigned data;
3. the categories reflect the purpose of the study;
4. the categories are congruent such that same level categories have the same level of abstractions;
5. the categories should consist of *internal homogeneity* -- the extent to which the data within each category hold together in a meaningful way, and *external heterogeneity* -- the extent to which differences among categories are clear and mutually exclusive.
6. the categories are sensitive to a system audit in which a second observer is able to verify the fit of the categories.

In analyzing the data, I continually shifted back and forth between inductive and deductive thinking. For theory confirmation, I used the inductive process in which the categories, properties and hypotheses were constantly compared, integrated and refined to generate enough evidence to establish suggestions. At the same time, I used the deductive process to test the tentative categories against the data to ensure that they were supported by sufficient evidence before they were retained. Unlike a phenomenological study, my proposed case study utilized narrative and discourse analyses.
While the study embraced naturalistic inquiry and the emergence of indigenous categories from the participants, the data were also analyzed using a Critical Social Science Perspective.

**Methodology Rigor**

This case study was guided by a CCSP, which calls for reflexivity. In doing this research, I constantly reminded myself how my own social location, background, values and ideologies affected the way I asked questions, listened and interpreted the data. At the same time, I paid attention to the historical, social and structural influences on the participants’ responses. As suggested by Merriam (1998, p. 202), “reality is holistic, multidimensional, and ever-changing; it is not a single, fixed, objective phenomenon waiting to be discovered, observed and measured as in quantitative research”. I kept an open mind as I went through the research processes without imposing my own preconceived assumptions on them.

The scientific rigor and face validity of this study was established through the use of triangulation (Patton, 1990). By using different sources of data, I was able to compare the data from interviews, observation notes and project documents to check for consistency in what participants said about the same thing over time and to compare the points of view expressed by different stakeholders.

To increase the credibility of this study, I performed “face validity” by inviting the research participants to review the preliminary findings in terms of accuracy, fairness and validity. In addition, I looked for alternative patterns of findings and tested rival explanations by examining the negative cases through the interviews of participants who dropped out from the project.

The reliability of this study was strengthened through the establishment of what Yin (1994) calls a chain of evidence or what others call an audit trail. I divided all of the data into categories and kept them in a chronological order with details of how, when and where the data had been collected, and systematically organized the data in paper and computer files for easy retrieval.

**Ethical considerations**

Researchers are faced with a certain degree of ethical dilemma in doing qualitative inquiries. Merriam (1998) suggests that all interviews carry with them both risks and benefits to the participants. I was aware that questions that are seemingly benign and routine may illicit emotional stress or painful memories from the participants and was therefore prepared to make referral or provide resources for assistance. Ethical issues pertaining to informed consent, risks of harm and benefits, confidentiality and voluntary participation were all incorporated into the study.
As presented earlier, the participants, TCHEC, my manager and my director at Toronto Public Health, were all informed of the evaluation of the Peer Chinese Parent Leader Project as a case study. My vested interest in this study was both personal and professional. Having worked with many immigrant families, and being aware of the challenges and difficulties they face in relation to the lack of resources and system barriers, I believed the findings of this study would help to improve my own health promotion practice and that of my colleagues. Before any data were collected, I obtained ethical approval from Office of Research Service at University of Toronto (Appendix S).

Throughout the research process, confidentiality of the participants had been strictly kept. Every participant was assigned a code and a pseudonym in the transcripts to protect his/her anonymity. Audio-taped interviews were listened only by myself and a translation evaluator who validated the accuracy of my translation and transcription. The transcripts and written data were reviewed only by my thesis committee and the translation evaluator who had signed an agreement of confidentiality (Appendix T). The written notes and transcripts will be destroyed five years after the completion of this study. All audio-tapes, transcripts, field notes, data files and computer disks are stored in a locked cabinet accessible only to myself.

Since this study used focus group interviews as a data collection method, I had made it explicit to the group that confidentiality was guaranteed only when everyone in the group respected it and kept it. I reminded participants that anything they did not wish to share in a group should be kept unsaid but each person would have the opportunity to provide more information in the individual follow-up telephone interview if he/she wished.

**Limitations of the Study**

There were a number of limitations to this case study. Since the RSHC Chinese Peer Parent Leader Project had been established for only 2 years at the end of my data collection, it was difficult for this research to identify the intermediate and long-term outcomes of the project. In addition, being a single-case study, the applicability of the research findings to other settings and other communities might be limited. However, this limitation could be overcome by the particularized knowledge generated in this study and be recognized for use in other contexts.

**Summary**

In this chapter, I have presented the theoretical framework and the methodology that guided this case study. I have also described the data collection and analysis processes. Most importantly, I have made explicit my position as a researcher and my relationship to the research participants so that
the readers can critically examine the credibility and reliability of this study. In the following chapters, I will present the findings and the analysis of this study based on the theoretical framework and methodology outlined in Chapter 1 and this chapter.
CHAPTER 3: COMING TOGETHER

Thinking, Asking and Listening

Ying-Ying kept thinking about what Grandfather Cicada said. She was thinking so hard that she bumped into Mother Dragon Fly who was resting on a lily pad. “Look deeply. I must look deeply and I shall find the answer.” Ying-Ying whispered to herself. Mother Dragon Fly petted her on the head and laughed, “Ying-Ying, may be you are looking too hard. Have you talked to your sisters, brothers and friends? Remember, the answer is within you.”

The purpose of this study is to explore the relationship between community participation and empowerment at the individual and community levels through examining the individual and collective experiences of the Chinese Peer Leaders and the service providers. These experiences, however, cannot really be understood or realized except within the historical, cultural, socioeconomic and political contexts in which they live.

Who were the RSHC Chinese Peer Parent Leaders?

Of the 10 Chinese Peer Parent Leaders who stayed with the RSHC Project after the completion of training, 9 of them were women. The only male in the group was the spouse of one of the female peer leaders. All of the peer leaders were immigrants from Hong Kong (see Table 1). Their length of time in Canada ranged from 5 to 25 years, with half of them having been in Canada for less than 10 years. All but one were Canadian citizens. Their ages ranged from 37 to 46 with most being over 40. More than half of them had college/university education; the male peer leader had a post-graduate degree. Their children’s ages ranged from 8 to 19 with over half of them being under age 15. While this profile provides a general picture of the demographics of these peer leaders, it is indeed their own accounts and voices that allow us to have a glimpse of who they really were and provide us with the contexts in which they participated in the RSHC Peer Parent Leader project.
Table 1. Profile of RSHC Chinese Peer Parent Leaders

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Amy</th>
<th>Tina(1)</th>
<th>Doris</th>
<th>Wai-Ling(2)</th>
<th>Marianne</th>
<th>Emily</th>
<th>Shui-Yin</th>
<th>Betty(3)</th>
<th>George(3)</th>
<th>Bul-Chi</th>
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<td>15</td>
<td>5</td>
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<td>2</td>
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sp = spouse  ch = child(ren)  pa = parents  HS = high school  C = college  
U = university  PG = post-graduate  P/T= part-time  F/T = full-time

(1) Tina: While Tina considered her living arrangement as being with her spouse and children, her spouse actually spent most of his time residing in Hong Kong for economic reasons.

(2) Wai-Ling: At the beginning of the project, Wai-Ling’s spouse also spent most of his time residing in Hong Kong for economic reasons. Wai-Ling was employed as a heritage language teacher part-time in Canada.

(3) Betty and George came into the program as a married couple.
Life after Immigration

Emily came to Canada with her husband 15 years ago. Her 9-year old son and 8-year old daughter were born in Canada. Years before her immigration, she received her university education in Toronto and returned to Hong Kong where she worked in a management position. During one of the training sessions, she shared with her peers, "Sometimes when I look at my friends in Hong Kong, most of them had climbed up the ladder to some important positions and here I am, being nobody."

During the focus group interview, Emily talked about her life after immigration.

After moving to Canada, I stayed home to take care of the children, I felt quite useless and a lack of knowledge, goals and determination; I wanted to restructure my life, build an umbrella before it rains (be prepared) and learn more about different things to improve myself.

Emily’s sense of loss and lack of direction was echoed by Shui-Yin, who came to Canada 5 years ago with her husband and daughter. She worked as a secretary in Hong Kong and at the time of interview, she was employed as a part-time sales assistant in Toronto.

Yes, ai, if I did not immigrate, I would have worn the square hat (graduated from university)... In Hong Kong, I knew my own past, I knew what kind of courses I needed to take, I knew where to find that information and what to do. But here (hesitated), I have considered taking courses on administrative assistance, but people were telling me, even if you have taken the courses, it would not be useful because to get these positions, you must have connections... So I am hesitant; it is not like I do not want to attend school, but after I go to school and there are no results, then I do not want to waste the time. Here (in Canada), it is hard to have any aims or goals. What should I do? What should I learn? If I take the courses and there is no future, then it would be a waste of my energy, because [paused] if I spend my energy on this, I may neglect something else...

Aside from the issues of career development and sense of direction, other peer leaders spoke of the challenges of immigration and settlement. Wai-Ling, age 46, immigrated to Canada 6 years ago with her two sons. She was a teacher in Hong Kong. She considered herself more fortunate than others because she was able to find a part-time job teaching the Chinese Heritage Program in the Greater Toronto Area. When she first joined the project, her spouse spent most of his time living and...
working in Hong Kong in order to support the family, just like other men in the “astronaut families”\(^1\). The ways of life in the two countries were drastically different. She recalled during a discussion on the challenges she experienced after moving to Canada.

It is not so easy bringing up children, especially when you are here on your own.

You all know that my husband is working in Hong Kong. When I first came here and had to take care of the house, the kids, all by myself, it was really hard. I never had to do any household repair before, but here, you have to do everything. I did not even know how to change a light bulb. But now you get used to it, you learn and you can do much more.

In addition to the challenges of learning new day-to-day household maintenance, women in astronaut families also have to face other challenges such as sole parenting and maintaining familial harmony. Tina, who lived with her son and daughter, shared her frustration regarding her relationship with her astronaut spouse.

My husband is in Hong Kong. Just as you were saying, it is very hard for us to communicate since we are so far apart. Also, he would not respond to any of my concerns, I can ask, but he does not express himself, he does not mention anything, he does not write back. At the beginning, I tried, but I cannot do it on my own when he does not respond. He is a typical Chinese big man (patriarchal), I have given up and let it be. But I do not want my son to be the same.

While the peer leaders spoke of the challenges in settlement, many of them also identified the positive aspects of living in Canada. Wai-Ling spoke of her family’s decision to move to Canada, “I think our decision to immigrate is really good for him (the youngest son). His health was not very good in Hong Kong; after he came, the Canadian living environment has been much better for him.”

Doris, who was 46 and divorced, had been living with her 15-year-old son in Canada for 5 years. She spoke favorably of the move.

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\(^1\) In 1984, China and Britain signed a declaration to return the British colony of Hong Kong to Chinese sovereignty in 1997. The political uncertainty of Hong Kong had sparked an exodus of Hong Kong Chinese to countries nearby and to the West. During the same period, Canada had changed its immigration policies to recruit entrepreneurs, investors, and the self-employed as immigrants of the “Independent Class”. Upon arrival in Canada, the economic reality, such as lack of employment and financial opportunities, forced many of the adults in these families to return to Hong Kong. In most cases, the husbands were the ones who returned to Hong Kong while the wives stayed in Canada to take care of the children because Canada was perceived as a land of hope and bright future for their children. Many women sacrificed their careers to become in charge of the astronaut households. Detailed readings on the ‘astronaut family’ phenomena can be found in Man, G. C. (1996). The experiences of women in middle-class Hong Kong Chinese immigrant families in Canada: An investigation in institutional and organization processes. (Doctoral dissertation, University of Toronto, 1996). Dissertation Abstract International, 58 (06), 2403.
It is not really special for me. When I was in Hong Kong, I was a full-time housewife, so when I got here, I felt even happier; there is more room [laughs] and also, I got to know a group of good friends. With the larger space, I can do gardening, so I feel happier than being in Hong Kong, in fact, being in Hong Kong was the same, I cooked and took care of the home...

Others leaders also commented on the slower pace of life in Canada because they were not employed. Amy, who was 43, married, with one daughter, talked about having the opportunities to participate in more leisure activities since moving to Canada.

But here, after immigration, life is more relaxed, whether you see it as good or bad, it is because there is nothing to do. When there is time, you attend a course, do some flower arrangement, play with clay; you have this kind of leisure activities. But in Hong Kong, you have to make a living, so you wouldn’t (join leisure activities). The priority was to earn money; but here the philosophy of life is different. Since I do not work, I put all my energy into my family and my daughter...

Although Amy expressed interests in seeking employment every now and then, she did not work outside her home because of health reasons. When I met with the peer leaders to discuss the preliminary results of this case study in February 2001, Amy shared with the group her struggles with stage IV cancer.

**The Reality of Integration**

The ability of immigrants to integrate into their society of settlement is one of the most significant predictors of their health and well-being. Some of the peer leaders spoke proudly of the multicultural concept in the Canadian society. Amy shared, “I teach my daughter, just because we are Chinese does not mean we do not accept people of other ethnic backgrounds. Canada is a multicultural society, every group has its strength and positive parts…”

Most of the peer leaders also expressed the desire to integrate. Betty and George had been in Canada for 11 years; they have two teenage sons. George worked as an engineer for a big firm in Hong Kong but had not been able to find similar employment in Canada. His exploration on self-employment and business opportunities had been met with many challenges. However, they both expressed firm desires and positive attitude towards integrating into the Canadian society.

Like if your neighbors invite you to some activities and you decide to go; when you get there, whatever their cultural or religious practice may be, that’s okay; if you don’t understand it, just ask and learn about it. It is just that simple… Canada is a
multicultural society, so if we just stay within the Chinese community, then we are limiting ourselves, really limiting.

However, regardless of their length of time being in Canada, many peer leaders shared similar barriers to integration and the sense of being “excluded”. Doris had a strong desire to integrate but found it difficult to achieve.

Actually, I have always paid attention to the community. Now that I have moved to Canada, I believe that I should not just stay within my own box, like, just staying within the Chinese circle. In fact, I want to participate outside (the Chinese community), but because my English is not very good, it is very difficult for me to communicate with them (non-Chinese). I also do not know through what kinds of venues I can participate, so I am still within my own box; I cannot go beyond it.

In addition to the lack of venues to integrate into the “mainstream” society, other peer leaders identified cultural differences and racism as barriers to integration. Many of them commented on the cultural differences between the East and the West. Marianne had been in Canada for over 25 years. She lived with her husband, her 4 Canadian-born children and her elderly parents. Although her mother was pretty healthy, her father had health problems that required constant care. She commented on her cultural beliefs and those of the West.

It’s not because we cannot understand English, I think we may have conflicting philosophy and thinking. Our value system is quite traditional in general, like in the Chinese family; in regards to the Chinese seniors, we still adhere to our traditional social norms or rules. If you want us to think or treat the elders as if they do not exist, that just doesn’t do. Unless it is really beyond the children’s control, they would not do such things like excluding the elders. We cannot say that they (non-Chinese and Westerners) are wrong. Our value systems are just different.”

Other peer leaders spoke about the misconceptions and stereotypes that Canadians of the dominant culture had on the Chinese people. For Emily, the hope for integration was not within the reach of the first generation immigrants. Like many other racialized immigrant parents, she put her hopes in her children.

I feel that I get to know about the mainstream community through my children and their peer, because I feel that it is not because we are not strong enough to have any direct encounter. They have lots of misconceptions about us... they have a certain set of views about Chinese. I think we should, if we have a chance, to listen to their views about us... then we would have a chance to tell them what we think. For
example, we can tell them “what you are talking about is history of more than 20 years ago; don’t still say that we eat snakes, and this and that...” I feel that this is very humiliating. As Chinese, I have a big struggle; I try to interact with you (Westerners) and I cannot, when I interact with the Chinese, you (Westerners) criticize us. I think this is something our generation has to deal with...

In their attempts to integrate into the “mainstream” society, some of the peer leaders volunteered at their children’s schools; they wanted to role model for their children the importance of integrating with others. However, some of their experiences were quite negative, as Shui-Yin recalled:

It was really explicit, there were many other parents (on the trip) and coincidentally, I sat on the bus with another parent who was also a person of color and we could chat a bit; but when the whole group got together, when every body was there, those other (white) parents would not talk with me.”

Marianne also identified similar experiences, “There were times I had seen people sitting there, with facial expressions like they looked down on you; you sat next to them and they refused to greet you or interact with you.” Despite these experiences, many of the leaders were looking to their children’s generation for a better future and more successful integration. Marianne and her husband’s strategy was to encourage their children to participate fully in all activities that they enjoyed.

We decided to let our children experience outside (the Chinese community) as much as possible; for example, painting and skiing, my husband and I do not know how to do that, but we let them go; the same with baseball, this is such a (Canadian) tradition. We let them go because we did not want them to be disconnected... it is our responsibilities to ensure that they survive because there are many generations ahead of them, may be they would be disconnected in the future, we don’t know that, I can only do my best.

Despite their intention and efforts, successful integration of their children into the Canadian society could not be guaranteed. Doris shared her conversation with her son on the topic of intercultural dating.

I said the most important thing is that the person has a good heart and are compatible with you, the cultural background does not matter, but my son said, I think I would still like Chinese. My son often says that there is racism here. But right now at school, he makes friends with everyone, if you speak to him in English, he speaks English; if you speak with him in Chinese, he would speak to you in Chinese. He has
Japanese friends and he would even speak some non-standard Mandarin. But then he feels that in the future he will choose a Chinese partner.

Some of the peer leaders stated that they had non-Chinese acquaintances, with whom they socialized at different festive occasions. However, their good friends and confidants were all Chinese because of their shared values, mutual understanding and the ability to communicate² effectively on equal terms.

**Being Mothers and Wives**

Since 9 out of the 10 peer leaders were females, gender issues became a dominant theme in the group’s interactions and sharing. Although all the peer leaders were born in Hong Kong and shared certain commonality, they also differed in the ways that they were raised. Doris was brought up in a traditional Chinese family. She had never worked outside her home. “Ever since I finished school, I have not worked outside. I have only helped my father in his business, so I have never had any contact with others in a work setting.” Upon her divorce, she experienced the challenges of being a sole parent.

Since my husband is not around and I am a female, I felt that I really needed to learn some of these things. I was hoping that I would learn something about puberty so I could teach my son. Living here in Canada, there are so much conflicts between the Eastern and Western cultures, I really think it is important to learn more about all these issues (sexuality) so that if my child has questions, I would know how to answer.”

Most of the other peer leaders had all worked outside the home in Hong Kong. After moving to Canada, most of them stayed home with the children. At the beginning of the RSHC project, only 2 of the female leaders were employed in a part-time basis. The role of being a mother became a prominent feature in their lives. When asked about the amount of time they spent on parenting and caring for their families as compared to self-care, many of them identified spending much more time on their children and family then on themselves (see Table 1).

Bui-Chi, 43, came to Canada with her husband 10 years ago. She worked as a Human Resources manager in Hong Kong. Since the arrival of her son, she had stayed home to take care of him. She often shared with her peers about the challenges and stress of being a mother. She wanted

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² Since language and cultures are intertwined, having the knowledge of English does not automatically equate to effective communication in English. As pointed out by the peer leaders, one of the biggest challenges experienced by immigrants of the non-dominant culture in communicating with the dominant group is the inability to understand the cultural context in which the English language is being used. Non-native English speakers often experience exclusion when the dominant group communicate in their own “inside” languages, using words and phrases that are not comprehensible unless their contexts are made explicit.
to provide the best for her child, but at the same time, she experienced high level of frustration. Her biggest concern was the lack of time in her life. By the time she completed all her daily household chores and parenting responsibilities, she had very little time left for herself. She could rarely find time to keep in touch with her friends; she sounded sad as she told me in the interview,

I knew I had to be patient, I had to use different skills, but when my son worked so slowly and there was no time left, then I felt that I would lose control, and became cranky... Everyone is so busy; for example, the other day, I wanted to give Emily a call, but then it was already late and you knew that just before bedtime, she would be busy with the children. So, I did not call, but it did not mean that I did not care about them any more. It's like friends, I don't call very often, not unless there is something really specific, but then every so often, I would think about them and wonder how they are.

Like Bui-Chi and other peer leaders, Marianne also experienced the stress of living a very busy and hectic life. Having four children and 2 elderly parents to care for, Marianne worked as a part-time real estate agent because of the flexible work hours. The cost of day care for her children and elderly parents would probably exceed the financial gain from a full-time job. Managing the children, family and work was extremely challenging, but Marianne had found time to join the RSHC project because of her desire to be a good mother.

To a great extent, the motivation for the peer leaders to join the RSHC project was mostly based on their desires to become more effective parents. However, many of them also joined because of their needs and desires to connect with the world outside of their homes. Emily spoke of the isolation of being a full-time mother and homemaker.

When we are home taking care of kids, we live in an overly sheltered environment...
I think these (workshops) are opportunities for us because housewives can be so isolated; I felt that joining the project has sharpened my mind in how I see things and how I accept others.

Tina echoed Emily's thoughts on full-time motherhood. Joining the RSHC project had helped her to focus beyond her children, expand her social network and explore her own potentials.

When I first joined the program, I thought I was going there to learn how to teach my children, but when I look back, I found that it has done much more for me than for my children. I have learned to look at things in wider perspectives... I can start to explore new interests for my own personal growth so that when the children grow up, I would not feel empty or that everything is gone."
Although many of the female leaders had the full support from their spouses to participate in the RSHC project, some of them felt uncomfortable in taking time away from the family. Social activities that were planned in addition to their project and outreach activities would usually include their spouses and children. Emily’s response to the peer-leader-only social function was:

Yes, I am actually going to call Marianne in a couple of days; the three of us like to organize a social gathering but the biggest concern is time... It seems better if only the women get together because we can be more engaging with each other. Maybe we need to ask our family for half a day off, so that we can come out on our own. But then I am not sure if that would make us look like we have been drawn into the evil fire (being too extreme and irrational), or that we have become “female chauvinists” when we say we have to go to our own gatherings. What do you think? [laughs]

However, soon after the focus group interview, they managed to organize a peer leader only pot-luck dinner every month or two to chat and support each other.

**Being Fathers and Husbands**

In the very first training session, there was one male participant. However, he did not return to the second session because of his work schedule. When George and his wife, Betty, joined the project at the third session, he became the only male in the project. He found out about the project through his cousin, Marianne. When George first came, he admitted to be a traditional man and a very strict father. He attended the training because he wanted to improve the relationship between himself and his sons. When asked whether he had experienced any challenges or discomfort being the only male in the project, he laughed and said, “No, not at all. I feel that they were all very comfortable with me; none of them felt that they have to avoid sharing things because I was there. Yeah, they call me their sister.”

The acceptance of George by the other female leaders was probably related to his participation with his wife as a couple. In the evaluation of the first training session, which was attended by one male participant, some of the female participants expressed some discomfort and embarrassment in talking about sexuality in the presence of a male stranger. However, none of them expressed a similar discomfort with George. I asked him for his opinions on why very few males participated in parenting workshops, George’s answer was:

I think others (males) have to work. They might not have flexible hours like myself.

Also for some men, when you ask them to come out to workshops, they would say,
oh no, not for me, and they would say to their wives, you go. They would send their wives to represent them in everything (in parenting).

Betty, on the other hand, felt that it did not have anything to do with time, “I guess for some men, they may not be used to this type of thinking. They have never been taught by the previous generation, and when there are other women around, they may feel embarrassed.”

Betty’s view was echoed by other peer leaders. Tina shared that when she talked with her son and daughter about sexuality, her daughter would asked questions but her son would not say a word nor show any reaction. She attributed some of that to her husband’s non-expressiveness. Emily described the men that she had been outreaching to at her church.

When our friends found out that I am one of the parent leaders, they wanted to know more. My husband and I facilitated some discussion groups as a couple. The women in our group were all very open, but the men were much more reserved and shy. But you could tell that they really wanted to know, so my husband and I used the question box technique; we gave them paper and they can write out their questions to put in a box...

Other peer leaders found it frustrating when their husbands would not talk about their feelings and needs. Wai-Ling wanted it to be different for her sons.

Like my husband, no matter how much pressure he had at work, he would not say anything. As a wife, I felt that when he did not talk about it, it was very hard to communicate and share any feelings. So I have started to encourage my sons to be more expressive, I told them that if they talked about it, they would feel much better and I could help them to find different venues to handle their stress.

Despite the warm acceptance by all the female peer leaders, George seldom discussed his feelings and emotions openly. Sometimes he would speak of the conflicts he had with his sons but he seldom named his feeling beyond “I was so mad”. The only one time that George expressed his feelings was in a reflective journal exercise in which the leaders were asked to describe how they would feel if they woke up in the morning and all their problems had disappeared. He wrote: “For a moment, I would feel relaxed and happy but then in a split second, I will feel a bit empty, without purpose.” In describing his world without problems, he first wrote “free and colorful” but then these words were crossed out and replaced by “Someone without a purpose, lack a sense of security, and with nothing to do.”
Our Children: Growing up Chinese or Canadian

Some of the peer leaders recognized the challenges in bringing up their children in Canada because of the intercultural and intergenerational differences. Marianne identified the difficulties faced by her children.

When our children were born my husband and I felt that it would not be easy for them to grow up here because they are in between 2 generations. They have to satisfy their grandparents but they also have to fit into their own generation.

Wai-Ling agreed with Marianne. Since her children were the oldest within the group, she often shared her parenting experiences and insights with her peers.

Nowadays, the kids are very different; we cannot use the old way or our parents’ ways to relate to them anymore. Here in Canada, the schools teach them a whole new set of thinking and values, so we have to learn and find out what they think and how they see things.

Finding a new way to bring up their children was not easy for many peer leaders because they were unfamiliar with their children’s peer culture. What seemed to be common in the “mainstream” Canadian culture was sometimes inconceivable to the peer leaders. The first time Marianne’s oldest son told her that he wanted to attend a school dance, she did not know what to do. She was concerned that being 14 was too young to go to a dance alone at night; but most of all, she was fearful because she did not know what a school dance was like. At the same time she did not want to be unreasonable to her son.

Marianne’s concerns and challenges were not unique; most of the peer leaders were faced with similar situations and issues. Tina wrote in her reflective journal an incident with her son that was quite common among other Chinese immigrant parents.

After school we were talking about the movie Poke’mon which was released last night. My son told me that some of his classmates went to see it and did not get home till after 11 p.m. At first, they were going to invite my son, but they knew that I would say no, so they did not ask him. So, I asked my son if his classmates thought that I was “mean”. He said “yes”. He said that his classmates could do everything because their mothers said yes to everything...I feel that it is very difficult to be mothers. Sometimes, it is like I have to bribe them and please them. I have reflected on it. Am I really so mean? Yes, he has to ask me about everything. But I am afraid that if I relax the rules too much, it will be hard to tighten them again later. I also...
know that the greater the pressure, the greater his resistance will be. This is so
difficult.”

Like Tina, some of the peer leaders often wondered if the ways they were disciplining their children were appropriate or not. Coming to Canada as adults, they could not use their own adolescent experiences as reference to their children’s needs or behaviors. They also found it difficult to understand the way their children expressed themselves. Amy was tearful as she talked about how recently her daughter had stopped hugging her. She found her daughter’s new behaviors hard to accept. The other peer leaders comforted her and explained to her that these changes were natural among adolescents. They went on and told Amy about Betty’s incident with her son.

You did not hear the story because you were not here. Betty was so upset. She was at Fairview Mall, going up an escalator, when she saw her son, holding the hand of a girl. They were going in the opposite directions, passing each other, but the son did not say hi or anything to her. Just passed by. May be the son thought, oh, no there is mom; may be he was too surprised or scared to say hi to her. It was a big deal when he got home that night... She felt that ‘I am your mother and you did not respect me.’ But may be the son just did not know what to do... Of course, there are other cases; some kids when they grew big and when their mother picked them up from school, they would not greet their mother, and asked the mother not to come any more.”

The sharing among the peer leaders reflected the many day-to-day challenge that immigrant parents are faced with in raising children in Canada and these parents’ ongoing need of mutual support.

Beyond Information Giving: Empowerment Education

The RSHC Chinese Peer Parent Leader Project was a pilot project developed based on the principles of adult learning and empowerment. It came as a result of identified needs in the community. It differed from other health education programs because in addition to addressing the three core components of knowledge, skill development and attitude/values, it included a component of practice (see Appendix V).

Community Needs

As discussed earlier, the needs of community education program on family sex education and children’s sexuality were reflected in the number of workshop requests at the AIDS-Sexual Health InfoLine and in the discussions during the community consultation meetings. Eva, one of the facilitators reiterated these needs in the interview.
One of the community organizations stated that a lot of their clients were asking about family sex education, so I agreed to do a workshop on how to talk with children about sexuality. It turned out that more than 100 people showed up. Then we realize that there was a great need.

Felicia, another facilitator also observed the needs in the community. She noticed that her colleagues at different community organizations and peers at church were all interested to learn more about sexuality.

Co-incidentally, in the movie, Titanic, the scene of a nude woman led to the attention of many parents at church. This movie was very popular, and they did not know how to respond to the children’s questions about this scene. It was like one hundred flowers were suddenly blooming and they had to respond; there were many requests on sexuality education... On the other hand, in TCHEC, you and Eva had done quite a bit of mass media work, so some people would tell us, now that even the TV and radios are talking about this, maybe we can also talk more openly about this...

people are feeling less embarrassed and this becomes a common need.

Kristy, who co-ordinated and administered the project, pointed out that the community needs were partly related to the cultural differences in the Canadian society. When the parents were faced with the unfamiliar, they wanted to know more. She suggested that the overwhelming response of community parents to the peer leaders’ outreach activities further reflected the needs in the community.

**Motivation to Join the RSHC Project**

A review of the original application forms of the RSHC project showed that all the peer leaders joined the project because they wanted to increase their knowledge on family sex education in order to better educate and nurture their children. The few leaders who mentioned about “helping myself and others” were addressing the “self” in the context of “parents”. Bui-Chi identified the lack of resources on sexual health as one of her reasons for joining the project.

It so happened that I heard about the program on the radio, and I felt quite interested because I lacked information in this area. Previously, I had been to the library and tried to learn more about sexual health but I could not find a lot of resources and after I read the information, I still felt it was not enough; my understanding was not sufficient. I felt that I should be the one who teaches my own child about sexuality. If I were to teach my own child, then I felt I did not have enough information, so this
was a good opportunity for me. I can be a volunteer, and at the same time I can learn something to teach my own child.

In an interview with a local Chinese newspaper\(^3\), Winnie, who completed the training program but did not stay with the project to do outreach activities, spoke of the sexual problems she experienced during the first seven years of her marriage. She ascribed her problems to her lack of accurate information and the lack of positive family sex education when she was growing up.

The first time I had my period, my mom told me to ask my tutor or the lady next door. When I went to the doctor, she warned the doctor not to do anything ‘wrong’ because I was still a virgin. When I started dating, she told my boyfriend in a very serious way, ‘I am giving you a fresh flower so you better be very careful with it.’

She also threatened that I better not get pregnant or she would kick me out.

Winnie joined the project because she wanted to bring up her child differently. In the same newspaper interview, another leader, Marianne, explained to the reporter that she and her family did not experience any sexual problems, however, with her four children growing up in Canada and the oldest boy being 14, she felt that she should not wait any longer to teach them about sexuality. She was worried that if she did not talk with them, they might learn it outside their home and that information might be harmful.

**Motivation to Stay with the RSHC Project**

As discussed in the above section, the major reason for the peer leaders to join the RSHC project was to learn more about sexuality so that they could talk to their children. At the beginning of the training program, the peer leaders were asked to sign an commitment contract, which stated that each one of them would contribute at least 20 hours of their time to outreach to other parents in the Chinese community. Since the contract was only symbolic, they were not legally obliged to stay or contribute their time to the community at all.

However, at the end of the training program, 10 out of the 15 project participants stayed with the project beyond their 20 hours of commitment. Of the 5 participants who did not stay, one of them was Sara, a community worker. Sara explained why she could not stay with the project,

When I joined, I had to take time off work and come at my own time, so, it was actually quite a big commitment. So, for the other activities, I could not participate because I work full time and when I get home, I have children to look after. In terms of knowledge, the training had fulfilled what I wanted to learn; because I have

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\(^3\) The newspaper is not referenced to protect the anonymity of the peer parent leaders.
opportunities to practice in my daily life, I feel I could continue on my own instead of joining the other leaders in their activities. I think it is about setting my priority. She stated that she would apply her learning at her own agency and in her church community whenever she could. Winnie and Elaine, who left the project at the end of the training program, also cited their new employment as the main reason for leaving the project. I was unable to get in touch with the other two participants who left the project to explore their reasons and issues.

For the remaining 10 peer leaders, their motivation to stay was developed during their participation in the project. Bui-chi identified the positive atmosphere as a motivating factor, When we were in the training, the experience was really wonderful. If it were not a happy experience, I would not have attended from the beginning to the end. I had never missed any session. I was really motivated and I made sure that I kept the training dates open so I could attend... it did not waste any of my time... the atmosphere was very attractive to me; from the facilitators to my peers, we all got along and I was able to fully participate. It gave me a feeling that I did not just drop my son off school and then I went home to work.”

For some peer leaders, the process of learning about family sex education made them realize the needs of other parents in the community. They wanted to share their learning with other parents, as George put it,

“Well, we came to the training because we did not know or understand how to talk with our children, but now that we understand, we realize that most people in the community also do not know or understand. Some of them know really very little, some know a little bit... so we felt that within the Chinese community, there are so many needs, so we decided to continue.

Other peer leaders found that it was during their outreach practices and sharing with other parents that they continued to learn. Emily found the outreach experience very rewarding.

When we led the workshop discussions, it felt very rewarding because the parents (participants) responded and asked questions. Some of the questions were very insightful; they helped me to continue with my own reflections. So the outreach was not about teaching others but learning during the interactions.

Some leaders also identified continuous learning as a motivation to stay with the project. As they talked with other parents in the community, they became aware of their new learning needs and requested more training from the project facilitators/trainers, as Shui-Yin suggested, “It is not like
when the children grow up, we finish being a mother. We will always be mothers and there will be new things to learn.”

Eva and Felicia, two of the project facilitators reported similar kinds of observations. They felt that it was through their practice that the peer leaders really integrated their learning in their life and therefore motivated them to stay. Eva recalled,

Although they have gotten more knowledge in their heads after the 10 training sessions, they did not feel they were able to apply the information very well. But some how, each time after they have gone to do a workshop, they came back with some reflections… That was important because they realized that there were areas that they still needed to improve. May be this is the adult learning process, when they identified the areas that they did not do very well, they were motivated to work on those areas.

As one of the facilitators, I observed that another strong motivating factor for the peer leaders to stay with the project was the development of a supportive relationship, as Bui-Chi explained in the interview:

Yes, at the beginning, we did not talk or share very much. We worked together on different cases, nothing special, but then as we worked together some more, we all began to really care about each other, we developed a friendship and our relationship was good. We were able to give each other feedback instead of just saying polite words.

Bui-Chi’s appreciation of the new friendship was echoed by others. In the final training evaluation, different leaders wrote:

I am so happy that I have joined this program, not only because it has enriched me for the rest of my life, but also because I have come to know a group of friends. I am also very happy to get to know the facilitators and our classmates. Based on time available, I hope that our classmates will continue to share, learn and practice together, have mutual understanding, encourage each other, and grow with our children.

Since every one of us was eager to learn, most of us were very open so that the atmosphere was very harmonious. The facilitators were very vivid in explaining the information and they understood our situations. They did not despise our ignorance and stupidity. That gave us more security and confidence to face our future.
Actually, the training was more like a group therapy; unknowingly, we have learned more and more, especially in the area of mutual respect within this small social unit.”

The supportive environment, opportunities for continuous learning and the development of supportive relationships motivated the peer leaders to stay with the project.

**Group Process: Conflicts and Resolution**

Despite the many positive aspects identified by the peer leaders, the group development was not without conflicts and challenges. The individual training session evaluation documents showed that at the very beginning of the project, the leaders found it difficult to embrace each other’s differences. While some members valued the opportunities to share freely, some were annoyed that a couple of them had steered the discussion off the main topic. One member wrote, “What I liked the least in today’s session was when a participant changed the topic and talked about something totally unrelated so that we did not have enough time.” Some also expressed discomfort when a member shared her personal experiences of sexual difficulties.

At this initial stage, the peer leaders expected the trainers/facilitators to correct the “problem”. They did not feel comfortable to confront each other. Some of them wrote, “When people have been off topic for over 10 minutes, the facilitator can tell them to stop” and “usually, the same few people are always talking, may be the facilitator can assign each one of us to speak or make us take turn; those who really have nothing to say, they can tell us frankly”.

However, as the peer leaders developed a relationship and matured as a group, they no longer look to the facilitators to correct the “problems” for them. They viewed the potential conflicts differently. In the follow-up telephone interviews, the peer leaders were asked if they had experienced any frustration or conflicts. Most of them felt that the group had been cohesive and wonderful to work with. Emily described the way they dealt with conflicts.

For example, I have not worked for a long time and people in our group also have not worked for a long time, so when we worked together in a project, I could see the differences in the ways we handled things; our personalities... It reminded me to be sensitive... like learning about human interactions. Sometimes when there were conflicts in the group, we all tried to help and we were careful in how we said things. Then you realized that the communication skills are not limited for use with our kids, we have to use it here, too.”

As pointed out by Emily, despite their common vision and shared identity as peer leaders, some of the leaders might not understand each member’s unique experiences and how these experiences impacted on his/her confidence and ways of doing things. At the end of the training...
program, all the peer leaders partnered with one another to prepare for their mock presentations. At that time, Amy had partnered with Susan, someone who did not return to the project after the last workshop. Susan was an extremely shy person with great fear of public speaking. When it was their turn to present, Susan could not do anything at all. Her face turned red and she was feeling dizzy. Amy, who had the reputation of being a “perfectionist”, was very disappointed and upset. She later told me in tears that she felt it was unfair that Susan did not prepare for the mock presentation. More importantly, Amy was upset that Susan gave the other leaders the wrong impression that Amy had taken over the whole presentation and did not want Susan to do anything. When other peer leaders and I called Susan afterwards, she said that she could not come to the meetings because she had relatives visiting from Hong Kong and was very busy. Since Susan did not return to the group, the conflict was never resolved.

A year and a half later, Eva met Susan in the community and told her that we were about to start the third RSHC Chinese Peer Parent Leader Project. Susan expressed some interests to rejoin the new group. When Eva informed the peer leaders at a meeting, Amy was very upset and stated that if Susan ever returned, she would leave the project. The resurfacing of this unresolved conflict led to a big discussion. According to Eva, over lunch, the peer leaders were able to help Amy see things differently and accepted the potential return of Susan. The incident allowed me to explore the issues of conflicts in the follow-up interviews with the peer leaders. While we could not hear Susan’s side of the story, Doris spoke of her own experience of dealing with peer pressure within the project.

So, actually, at the time of the incident, I could really understand how Susan felt because the two of us were very similar. Both of us had never really worked outside the home... Every time we had to do outreach, I felt scared but excited at the same time. I wanted to go but I was also scared... They might think that I was not doing a whole lot, but I have done my best. [laughs] I remember one time, they were also after me and said I must go and do the workshop, but fortunately, Wai-Ling and Bui-Chi said, just try your best, give it a try. I think that these two leaders are more understanding.”

When I spoke with Amy in the follow-up interview, she said that after having the opportunity to share with the other peer leaders her side of the story, she felt much better and she had let go of her negative feelings towards the conflicts. She said that if Susan returned, she would have reservation about working with her but she would not leave the project. The peer leaders manage to help each other in sorting out the occasional conflicts in the group.
Discussion

The voices and accounts of the peer leaders had provided a context for us to explore the impact of community participation among immigrants. While language and cultural barriers had commonly been identified as the major challenges to successful integration of immigrants, it is also critical for us to examine the systemic and structural barriers such as racism, sexism and social inequities. In the case of the Chinese Peer Parent Leaders, over half of them had college/university education and most of them could converse in English, yet most of them had experienced difficulties integrating into the Canadian society and the dominant culture.

Since 9 of the 10 peer leaders in the RSHC project were female, themes related to gender, class, culture and race emerged from their narratives. Although Canada offered political stability, hopes of a brighter future for their children, a better living environment\(^4\) and a more relaxed pace of life, many of these women also experienced losses that impacted on their sense of self, family and social relations. As pointed out by Creese et al. (1999) and Lee (1999), the current Canadian immigration and settlement policies discriminate against immigrant women in that their skills are not matched for the Canadian labour market and the job retraining programs in settlement services are mostly designed for immigrant men. In addition to the language, cultural and systemic barriers, the recent decline in the global and Canadian economy made it difficult for immigrant women to find similar employment in Toronto. While some immigrant women settle for underemployment in the hopes of getting better positions in the future (Man, 1996), others become full-time homemakers and mothers because of the lack of affordable child-care and their sense of insecurity about their children’s future. By taking on the roles of cultivating their own children, they have a better sense of control regarding what will become of their children. Caring for the children and the family becomes the major purpose and anchorage in their lives, which may otherwise be chaotic and unsettled. In either case, immigrant women are put into the situation of increased financial dependency on their male partners or spouses. If their male partners or spouses also experience unemployment or underemployment, the family may end up being split, as in the case of the “astronaut” families. The astronaut wives become sole parents and have to manage the entire household, taking on new tasks and roles that they have never done before.

\(^4\) In general, immigrants from Hong Kong find that Canada provides a better living environment because of the comparatively more affordable housing, bigger living space, cleaner environment and a better social welfare system for all citizens including universal health care and education. However, many also have a hard time adjusting to the less desirable environmental factors such as the cold weather and different spatial organization. The fear to drive on highway and/or the fear to drive in downtown Toronto was one of the many barriers to full participation by some of the peer leaders.
I argue that within the context of Hong Kong and Canada, changing from a professional and financially independent status to that of a full-time homemaker and mother can be difficult and challenging, especially when the women do not perceive the change as a choice. This is partly because the sense of self-worth and social identity in both societies are closely related to achievement and success, which are usually measured in terms of accomplishment, income, social status and wealth accumulation. With domestic work being unpaid labour that is seldom measured or valued in the same way as paid employment, the sense of achievement in full-time immigrant mothers and homemakers is either lost or can only be measured in terms of the subjective evaluation by their family members, spouses and children and/or the level of success in their male partners or children. For some immigrant women, their perceived lack of financial contribution to the family creates a sense of guilt and a feeling of "being useless". This may further lead to their unrealistically high expectations on themselves, their children and spouses and compromise their mental health.

In their own words, the peer leaders had identified the difficulties they have encountered in their attempts of integrating into the Canadian society and the dominant culture. Without successful integration, mothering is extremely difficult for immigrant women because they are unfamiliar with the new cultural, social and political structures that impose a set of complex influences in their lives. As a result, the concepts of parenting that they were familiar with prior to their immigration can no longer be used as references to guide their mothering decisions. When their children acculturate and integrate faster and more successfully than they have, immigrant mothers begin to experience intercultural and intergeneration conflicts that further increase their self-doubt and diminish their sense of competency.

In addition, full-time mothering can lead to social isolation. "Being very busy" and "having little time" for themselves were common themes that came out of the female peer leaders' narratives. When women spend most of their time meeting the needs of their children and family, they lose their sense of self and neglect their own needs. Although their daily mothering activities put them in contact with many people, like teachers, other parents, shopkeepers, or scout leaders, etc., they are isolated in the sense that there is very little social support for themselves. These daily activities do not build relationships or support networks unless they are deliberately organized to do so.

Paradoxically community programs that attract participation by immigrant women are usually related to parenting or caregiving issues. In the case of Chinese women from Hong Kong, this is understandable because of the traditional cultural imposition that men's domain is in the outside world while women's domain is at home (Chen, 1999). When Chinese immigrant parents experience barriers to successful integration and downward social mobility, they invest all their hopes in the
future of their children, thus putting even greater demands and pressure on the mothers to train and cultivate their children to success. Lee (1999) cautions that many community programs are designed to support women but at the same time, they reinforce women's domestic and maternal roles in the family.

It is in the context of their post-immigration experiences and their new racialized identity of immigrant women that we can make sense of the impact of community participation on the health and well-being of the female leaders. Since being the “best” parent is desirable and in many cases an expectation, most immigrant women, will continue to choose to participate in community programs that focus on parenting or caregiving over those that focus on themselves. It is therefore important for health promoters and service providers to recognize parenting programs as an entry point to community participation by immigrant women. Instead of providing parenting or health information in isolation and reinforcing the children's needs over the women's own needs, we must develop empowerment education programs that facilitate the development of peer support, encourage self-care and build individual and community capacity.

Because George was the only male peer leader, it was hard for this case study to capture the issues experienced by immigrant fathers. However, his inability to obtain comparable and suitable employment despite his previous work experiences and education reflected a common experience among racialized immigrant men. His words in the reflective exercise: “I will feel a bit empty... Someone without a purpose, lack a sense of security, and with nothing to do...” expressed a deep pain that is seldom brought to the open by immigrant men. It was as if George was saying that the daily problems and struggles had become his purpose in life.

Aroian et al. (1998) suggest that employment provides immigrants with a sense of purpose, accomplishment and social integration. I argue that unemployment and/or underemployment among immigrant men in Canada are complex issues that go beyond a sense of purpose, accomplishment and social integration. George has to renegotiate his identity of being a male, a husband and a father in a new context of race, gender, class and culture. While the limited data of this study cannot contribute to any conclusion on the self-identify and family relations of Chinese immigrant men in Canada, it does raise many questions that require future research. A limited number of scientific studies have suggested that social and economic losses of Asian immigrant men in North American have contributed to the challenges of traditional patriarchal authority resulting in stress to both the Asian immigrant men and their female partners (Drachman et al., 1996). However, little is known about how Chinese immigrant men negotiate their new masculinity in the new societies where their manhood is being challenged not only in relations to “gender” but also against racist, colonial and
capitalistic images of being unworthy, inferior and incomplete (Chen, 1999). In addition, since most of the literature on social isolation among immigrants focus on domestic violence and women, little is known about how social isolation is manifested in the lives of immigrant men within their own cultural communities and in the larger society. Knowledge in this area is important because their sense of identity and self-acceptance impacts on their familial and social relations. Without better understanding of these two areas, it was difficult for this study to establish whether community participation had similar impact on George as it had on the female peer leaders.

Summary

The individual voices and accounts of the peer parent leaders provided the social, cultural, political and historical contexts in which the importance of community participation and empowerment education in the immigrant communities is accentuated. While Canada is a land of hope and offers political stability, most racialized immigrants and refugees experience losses and hardship in their process of settlement and integration. Since social isolation and stress impact negatively on our health, community empowerment education, that emphasizes skill development, collective actions, social support and community capacity building, is an the important strategy in improving the health and well-being of immigrants. In the next two chapters, I will document the process and outcomes of empowerment among the Chinese peer leaders and the community service providers.
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CHAPTER 4: FROM INDIVIDUAL TO COLLECTIVE EMPOWERMENT

Becoming the Magic Lamp

One night, Ying-Ying was flying over the pond and when she looked at her own reflection in the water, she suddenly understood the wise words of Grandfather Cicada and Mother Dragon Fly. A brilliant idea came to her mind. She whistled and gathered all her sisters, brothers and friends. One by one, they crawled through the cracks into Siu-Mui's room and danced together like a fireball. Each night they danced until the gong sounded once; then they returned to the garden. They had become Siu-Mui's magic lamp.

Because the RSHC Chinese Peer Parent Project was a "pilot" community empowerment education project, everyone involved in the project was apprehensive at the beginning. Most of the leaders joined the project with one major expectation, which was to obtain information and resources on children's sexuality. They did not have any other expectations because they had never been involved in a community development project before. While TCHEC endorsed the project based on the needs of the community and its previous successful working relationship with TPH, two of my community colleagues, who were directly involved with the project, were skeptical of the potential success or effectiveness of the project (as they revealed later). They were concerned about the extra demands on their already overwhelming workload. However, they took a leap of faith and put in their best effort because they believed the project was important to the community.

At TPH, I was leading my team in developing similar pilot peer-to-peer projects in a number of ethnospesific communities. The amount of preparation work was insurmountable. While I mentored my colleagues on cross-cultural community development strategies, I was working with a small group to develop all the training manuals. At the same time, I had to negotiate with the TPH administrators for the "seed" grants to implement these projects. Paradoxically, my deepest frustration regarding the lack of culturally appropriate sexual health programming within my team had become my greatest source of strength and energy in developing the RSHC pilot projects.

In this chapter, I will describe the experiences of individual empowerment among the peer leaders and the trainer/facilitators and their process of transformation into a group with common vision and collective actions.
Unleashing the Power Within: Individual Empowerment

In empowerment education, participants are not empty vessels to be filled with knowledge by the teachers or trainers (Freire, 1981). The peer parent leaders joined the project with many skills and abilities that were waiting to be re-discovered and/or reaffirmed. Their individual experiences of empowerment were captured in three areas: 1. increased knowledge and skills on family sex education, 2. changes in attitude and behaviors, and 3. increased confidence and self-efficacy.

Increased Knowledge and Skills on Family Sex Education

Some of the goals of the RSHC Peer Parent Leader project were to increase the peer leaders’ knowledge and skills on family sex education and to support them in developing effective communication and facilitation skills. Their increased knowledge and skills were captured in their reflections of how they applied them at home, among friends and in the community.

Before the peer leaders joined the RSHC project, they had a limited perspective on human sexuality and family sex education. Most of them thought that sexuality education only focused on sexual behaviors. During the first training session, they participated in an activity in which they expressed their opinions on when family sex education should begin at home. Over half of the leaders chose age 10 and older. However, at the end of the training program when I repeated the same exercise with them, they all chose “family sex education begins at birth”. Doris, who chose the category of age “15 and over” during the first training session made the following comment at the end of the training program:

I don’t know if I am right or wrong, but I believe that sexuality was there the moment we were born. But at different ages and stages, we need different information and knowledge. We need to learn children’s sexuality, but adult sex education is also important. It is like cooking, you learn as you grow, every day there are new events; there are different cases, and different ways to handle situations. That’s why I hope the community would offer more sexual health workshops.

Like Doris, most of the peer leaders reported having a broader and more holistic perspective on family sex education. In the group interview, Emily shared her thoughts,

I feel that I really get it now. Before when I talked to my children about sex education, I would focus on it as if it was a separate entity from our lives. Now I realize that it is part of daily living, and I am looking at it with a much more holistic perspective. It is about communication, parent-child relationship, moral and values.
Other leaders identified increased knowledge and skills in specific sexuality topics. In her interview with a Toronto Chinese newspaper, Tina recalled the changes in her understanding of affection and parent-child relationship.

Our 10-year-old daughter often wants to hug Mommy and Daddy. I used to tell my husband, maybe you should not hug her any more since she is growing up. And my son, who is 12, already feels that he does not want to be hugged or kissed. But I realize that sometimes our son thinks that we love our daughter more because of our physical affection towards her. I learned in the training that loving and caring touches are ways to maintain good parent-child relationships. Fortunately, it is not too late for us to work on this, otherwise our relationships with our children will become less close and we may develop communication gaps.

In the same newspaper article, Marianne spoke about how she had learned to communicate more effectively with her children. She acknowledged that children at puberty might become moody because of their hormonal changes; she advised the readers to be patient with their children. She also cited the time when she was able to use her learning to help a friend.

My friend’s 18 year old ran away from home; the ‘astronaut’ mom did not know what to do, so she just cried and cried. Later on, after we talked, the mom realized that it was not just the son’s fault, she also had problems. I persuaded both of them to go for counselling and it was a good ending. After the sex education training, I know where I can go for help. When I was talking to the mother, I knew how to use effective communication skills. When she was wrong, I did not point it out right away or blame her; that would have made her feel bad and it would not have helped at all. I did my best to be empathetic and supportive, and that made her change her attitude. At the end, when the son came home, she apologized to him.

In their final training evaluation, the peer leaders were asked how the program had influenced them in their knowledge or understanding of children’s sexuality and family sex education; all of them reported better understanding, more positive attitude and increased confidence in talking to their children proactively. One of them wrote:

I understand that healthy sexuality begins at home, and parents play an important role in terms of role modeling and teaching. I also realize that accurate sexual health information is not hard to talk about, we can talk openly to our children. Also, it is important for us to teach them the correct names of their sexual parts. I used to think that sex education for our children was a really difficult thing to manage, but now after the training, I find that it is a lot easier to deal with.
In addition to a more holistic understanding of children’s sexuality and family sex education, the peer leaders also identified the training on effective communication as beneficial and influential in their lives. Most of them reported improved relationships with their children, spouses and family. They found that by being active listeners and being patient, they were able to achieve better understanding among each other within the family. Some of them wrote:

I now use feelings to express myself, and I am more appreciative of their behaviors. In my day-to-day living, I proactively share my values and what I think on different topics so everyone in the family has increased awareness. Now we know that every matter can be discussed and during an argument, we can learn to compromise.

Our relationship is better than before because I have changed my attitude towards them. Also, I told them that they could try to do the same; we could mutually change what we did not do right in the past. I used to yell at my children and I also spoke directly and harshly to my husband, now I tend to talk to them patiently and reason with them.

The increased knowledge and skills of the peer leaders were also captured in their community outreach activities. Kristy recalled the increased knowledge and skills she could observe in the peer leaders during an outreach promotion activity, “The second time I had contact with them... it was almost half a year later... I felt their skills had improved and they were very natural in bringing the message to the big audience.”

To ensure public accountability and facilitate continuous growth, the community workshops and discussion groups led by the peer leaders were evaluated by the community workshops participants (tables 2, 3, 4 & 5), the peer leader presenters themselves, their peers and the facilitators (table 6).

The community workshop participants were asked to evaluate three categories: the presenters’ knowledge, the usefulness of the presentation and the presentation style, with a six point scale in which 6 = agree and 1 = disagree. Out of a total of 210 responses collected from 17 workshops, 77% of the participants gave a score of 5 or 6 on the peer leaders’ knowledge about the topic. Each workshop was also evaluated by a project trainer and a peer based on 5 categories: preparation, presentation, provision of correct and appropriate information, ability to engage participants and team work, with a six point scale in which 6 = excellent and 1 = poor. The peer leaders developed their workshops based on a workshop manual provided by the project, but they applied their knowledge using examples from their day-to-day experiences. The peer leaders scored 4-6 in most categories, with teamwork having the highest score of 5-6. The consistently
The high scores on the workshop evaluations reflected the peer leaders' increased skills and knowledge on family sex education, communication/facilitation skills and teamwork.

### Table 2: Community Workshop Evaluation by Participants

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<th></th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
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<tbody>
<tr>
<td>The presenters were knowledgeable about the topic</td>
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<td>6.00</td>
<td>5.1286</td>
</tr>
<tr>
<td>Presentation is useful</td>
<td>2.00</td>
<td>6.00</td>
<td>5.1381</td>
</tr>
<tr>
<td>Presentation style is helpful</td>
<td>3.00</td>
<td>6.00</td>
<td>5.2429</td>
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</tbody>
</table>

* Six point scale – 6 = agree; 1 = disagree

### Table 3: Community Workshop Evaluation by Participants – Were the presenters knowledgeable about the topics?

<table>
<thead>
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<th>The presenters were knowledgeable about the topic</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.00</td>
<td>5</td>
<td>2.4</td>
<td>2.4</td>
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<tr>
<td>4.00</td>
<td>44</td>
<td>21.0</td>
<td>23.3</td>
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<td>5.00</td>
<td>80</td>
<td>38.1</td>
<td>61.4</td>
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<td>81</td>
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<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>210</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

* Six point scale – 6 = agree; 1 = disagree

### Table 4: Community Workshop Evaluation by Participants: Usefulness of the Presentation Content

<table>
<thead>
<tr>
<th>The content of the presentation was useful to me</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
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<td>1.4</td>
<td>1.4</td>
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<tr>
<td>3.00</td>
<td>8</td>
<td>3.8</td>
<td>5.2</td>
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<tr>
<td>4.00</td>
<td>34</td>
<td>16.2</td>
<td>21.4</td>
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<td>5.00</td>
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<td>36.7</td>
<td>58.1</td>
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<td>6.00</td>
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</tr>
<tr>
<td>Total</td>
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<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

* Six point scale – 6 = agree; 1 = disagree
Table 5: Community Workshop Evaluation by Participants: Presentation Style

<table>
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<th>The presentation style is helpful to my learning</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative Percent</th>
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</thead>
<tbody>
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<td>2.9</td>
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<tr>
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</tr>
<tr>
<td>Total</td>
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<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

* Six point scale – 6 = agree; 1 = disagree

Table 6: Community Workshop Evaluation by Facilitators/Peers

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<tr>
<th>Statistics</th>
<th>Preparation</th>
<th>Presentation</th>
<th>Provision of Correct &amp; appropriate information</th>
<th>Ability to engage participants</th>
<th>Team work</th>
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<td>5.2308</td>
<td>5.4615</td>
<td>5.00</td>
<td>5.7692</td>
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<td>Maximum</td>
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<td>6.00</td>
</tr>
</tbody>
</table>

* Six point scale – 6 = excellent; 1 = poor
Changes in Attitude and Values

Although this case study was not designed to study the relationship of attitude and behavioral change, it did capture the changes in attitude and behaviors of the peer leaders. Since sexuality is a complex and value laden health topic, changes in attitude and behaviors are important components in individual and community empowerment.

One of the sexuality topics of debate in many communities is self-pleasure or masturbation. At the beginning of the training, all the peer leaders acknowledged that infants naturally touch their genitals when they have the opportunities. However, many of them were uncomfortable with the idea of children or adolescents touching their genitals. They had many questions about masturbation. Some of them shared the myths and worries they had, “What if the child’s fingers were dirty, then they might get an infection.” Some of them felt that it was harmful, sinful and wrong. But, after they attended the training sessions on the sexual growth and development of children, many of them reported a change in their attitude and beliefs. In their training feedback forms, some of them wrote:

I have better understanding about family sex education. Now I know that masturbation is harmless and I know how to deal with this issue in the future. I also hope to share with other parents what I have learned today. Now I clearly understand that self-pleasure or masturbation is not a sin. I will tell my children because in the past I had indirectly stopped them.

In a newspaper interview, Bui-Chi recalled her attitude towards children’s sexuality prior to the training. The article said:

Mrs. X, whose son was 7, often asked her why some women’s breasts were big and some were small or why he had erections. She even noticed that sometimes he was touching his sexual parts. Before the training, she thought that society was turning immoral; she could not believe that even a 7-year-old would ask this type of questions. “After the training, I realized that children ask these questions out of curiosity. They do not see sex the same way as adults. When they touch their own body, it is not different than touching their toes and fingers; they do so out of being curious of their own body, so when parents see it, they should not punish the children.”

While accepting self-pleasure as natural and harmless seemed to be a personal issue for the peer leaders, their attitude was significant in the context of their community outreach activities because many community parents also have lots of misconceptions about self-pleasure and masturbation. In one of their post-community workshop self-reflection forms, one of the peer
leaders wrote, “In today’s workshop, one of the parent participants asked: If I discover that my son masturbates, I would hit him; is that the right way to handle it?” Since the peer leaders had worked through their own misconceptions and worries, they were able to answer participant’s questions and role modeled a positive attitude towards children’s sexuality.

Another eye-opener for the peer leaders was having the opportunity to experience first hand the diversity within the Chinese community in Toronto. Prior to immigrating to Canada, most of the peer leaders belonged to the middle class. The immigration process, systemic racism and the sociopolitical structure of Canada had put the peer leaders into a much more complex social identity; they had become the “second class citizens within the Canadian middle class”. However, within the Chinese immigrant community, they still clearly had a middle class status. They lived in the suburban communities with little contact with the Chinese in downtown Toronto where the Chinese working class immigrants from Hong Kong and China settle. With TCHEC being a coalition of organizations that services the entire Toronto region and surrounding cities, the peer leaders received requests to lead community workshops in various geographical locations, including downtown Toronto.

A few weeks after the peer leaders completed their training, they were invited to lead two workshops at one of the community center in the east end of Toronto. This request had brought forth a number of issues. While all the peer leaders were eager to lead this workshop, many of them did not take on the task because they did not have the confidence to drive to downtown Toronto. As a result, Betty, George, Wai-Ling and Marianne, who were comfortable with driving to different neighborhoods, took on the task. I was assigned to observe and evaluate these two workshops and I thought the workshops went quite well. However, the peer leader presenter felt very stressed, especially during the first session. I wrote in the field notes:

*Our peer leaders all live uptown and they are more middle class than the workshop participants are. They experienced cultural shock in doing the workshop in the downtown working class neighborhood. These parents listened but they also chatted among themselves; they spoke out loud whether they agreed or disagreed with the information. They did not do it out of disrespect but more because they were used to free-style and informal discussions, especially when they were sitting with good friends. Our peer leaders were totally caught off guard because they had never experienced similar situations. When the uptown participants agreed or disagreed, they often took turns in expressing their opinions to the whole group...*

Yet, this experience was a positive one for the group. During the next meeting, Betty, George Wai-Ling and Marianne shared their experiences with the other peer leaders. They
discussed the challenges of doing outreach to the diverse groups within the Chinese community. One of them commented, “It was a cultural shock for me, but I think it is good for us to learn. This means we have to take on even more challenges, not just to know the information, but to figure out how to share the information with the different audiences.” During the second workshop, the peer leaders were much more at ease with these parents’ style of participation.

At another post-workshop debriefing discussion, the peer leaders reflected on their outreach experiences. Some of them cautioned each other to be more reflective of their own attitude and assumptions. One of them said, “Now we all think that family sex education is important, but sometimes we might become too ‘protective’ of what we have learned such that we could easily become defensive or dismissive of others’ differing opinions. We need to be careful.” This reflexivity showed that the peer leaders had entered a stage of maturity.

Perhaps one of the most significant changes of attitude among the peer leaders was in regards to sexual orientation and homosexuality. During the fifth training session, when sexual orientation was discussed in the context of human sexuality, I noted that the peer leaders’ reactions were negative or confused. Some of them commented that homosexuality was abnormal, wrong, or against their religion. Others wanted to know “What made children gay?” and expressed worries about their children becoming gay. One of them wrote in the feedback form, “The facilitator seemed to emphasize that homosexuality is natural; I am not saying that we should group together and attack these gay people, but such tendency is still abnormal.”

Based on my previous sexual health promotion experiences, I was aware that this type of reactions from the peer leaders was to be expected. However, I felt strongly that the topic of sexual orientation needed further exploration during the training. I wrote in the project progress notes:

I have heard this type of reactions many times before in every community I worked with, but it was still upsetting for me. It reminded me of the homophobic messages I heard in the Chinese media and the struggle gays and lesbians have to deal with daily. This topic must be addressed because it is an important component of family sex education. Based on their reactions, I have a feeling that no matter what we say, they may not hear because homophobia is so deep-rooted in society. It is not going to be easy, but this could be an opportunity to work towards reducing homophobia in the Chinese community.

After strategizing with the other trainers/facilitators and consulting with members of GenerAsian Together, a support group for Asian gays/lesbians/bisexuals and their families, I was able to organize a special presentation during the eighth training session. We invited Albert, a
Chinese young gay man and Rose, the mother of a young Chinese lesbian to come and share their ‘coming out’ experiences with the peer leaders. The sharing from the two guests was empowering.

Initially when Albert spoke about his experience of coming out to his family, the peer leaders asked him some ‘typical’ and challenging questions such as: “Were there troubles at home when you first thought you were gay? Were your parents still married? Did you have any problems with your parents? How did you know for sure that you were gay?” However, when Rose began to share her experience as a mother, most of the peer leaders became empathetic.

_During her sharing, Rose could not help being tearful; over half of the participants were so touched by her story that they started crying too. They were somehow connected. They did not ask her tough questions like they did with Albert. Some of the peer leaders were so touched that they individually went up to Rose afterwards to thank her._

The feedback from the peer leaders was mostly positive with one exception, which will be addressed in the next chapter. It was an emotional session, but I was deeply touched by what the peer leaders wrote in their feedback forms.

I need to correct my values towards homosexuality, to look at every issue from different angles, to look deeply into my own hearts and to explore issues that I used to think as non-issues.

The open and honest sharing of the two guests had widened my views, and made me more understanding of gays and lesbians.

The two guests gave me better understanding of homosexuality; I felt their sincerity. This is an important experience and I wish to have more opportunity to hear more about it.

The open sharing of the guests allowed me to have deeper understanding about gays and lesbians. It also made me wonder whether we need to reform our traditional views on sexuality and re-establish a new moral standard in regards to sexual orientation.

The peer leaders’ changes in attitude towards sexual orientation and homosexuality did not diminish over time. In the focus group interview a year and a half later, Wai-Ling shared her thoughts on one of the most significant learning for herself.

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5 ‘Coming out’ is a commonly used term to describe the process an individual goes through in becoming open about his/her sexuality, sexual orientation and/or sexual identity to himself/herself and others in their lives. In this case, coming out also applies to the process parents go through in acknowledging and becoming open about their children’s sexuality, sexual orientation and/or sexual identity.
I feel that my understanding towards sex and sexuality is much more holistic now.
I see that sex education consists of so many components, including issues about gender and sexual orientation. I have learned to look at things from others’ perspectives. I learned to be embracing. Before, I thought that homosexuality was wrong and bad, now my views are different. Those negative views are gone. Wai-ling’s new insights were echoed by others. Tina agreed that the experience of meeting and listening to the guests really changed her views and misconceptions. Marianne went on and spoke about how her attitude change on sexual orientation impacted on how she taught her children.
Before, I did not know much about homosexuality. I think even if I did have contact with gay people, I might not have been aware or did not pay attention. But after listening to the speakers, I felt that they are not different than us. I realized that I have to give my children the right message, to let them know that they must not have prejudice on others.
As a facilitator, I felt most empowered when I witnessed how the peer leaders’ changes in attitude had led to their behavioral changes. Soon after the completion of the training program, they met as a group to design and develop the display board for a community health fair. In the process of designing a poster to explain what family sex education was about, one peer leader wrote down “healthy male-female (heterosexual) relationships”; right away a few peer leaders pointed it out and said, “No, take out the male-female part; let’s just make it healthy relationships for everybody.” In addition, half a year later, at a community workshop, I observed that Doris and her teammates had chosen to include “sexual orientation” as one of the case examples for group discussion so that the participants had the opportunity to explore this issue.

Changes in Behaviors

Throughout the training program and community outreach practice, the peer leaders shared with each other their changes of behaviors at home, especially in the area of parent-child interactions and family relationships. In addition to their increased knowledge and understanding of children’s psychosocial development, many of the leaders identified ‘communication skills’ as one of the most significant and practical learning in the program. During one of the sharing session, Tina told the other peer leaders her experience of practicing effective communication at home.

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6 One of the core components of the training program was “effective communication”. In addition to the common communication skills such as active and empathetic listening, verbal and non-verbal communication, asking open questions, etc., the peer leaders also learned to communicate using the “I feel... when you... because...” technique, which emphasizes the expression of feelings without judging or blaming.
Since I attended the course, I have been calmer and more reflective. The other day, I bumped into my son coming out of the bathroom, he growled and said something rude. Before, I would have yelled at him and made him admit he was wrong. This time, I did not. I was still upset, but I did not say anything then. That evening, at the dinner table, I mentioned to him that I was sad. He looked at me and said that he knew. We did not talk about it over dinner, but later on, he came and apologized and we had a good chat. I noticed the change in my children's attitude when I changed.

It was the combination of having the knowledge on adolescent psychosocial development and the skills to apply this knowledge in their day-to-day interactions with their children that transformed the peer leaders' behaviors. George shared in one of the training sessions that, after joining the project, he realized that he might have been overly strict with his sons; he had not been able to sleep for many days because he worried about the potential negative impact his past parenting style might have on his sons. He wanted to improve his relationship with his younger son and had been looking at different ways. “I hate fast food myself, but the other day, I took my son to a fast food restaurant. I just sat there and watched him eat, to see that he was happy.”

Shiu-Yin also admitted that she had been very strict with her daughter. In the past, she felt that being strict would keep her daughter on the right path, but now she realized that her previous way of disciplining her daughter might affect their relationship negatively, as she explained:

Before I joined the program, I was very strict with my daughter. When I said yes, I meant yes and there was no further discussion. That's why my daughter used to be very scared of me. After I joined the program, I found that I have become more reasonable; it is easier for my daughter to negotiate with me. I feel that as I learn more skills, everything becomes natural. Now when I spend time talking with my daughter, she does not feel that I am setting a trap for her, or that I have a special intention to pry things out of her. Now she feels more natural and trusting about our chats.

In addition to their own reflection, the behavioral changes among the peer leaders were also noticed by the facilitators. Eva commented, “I observed that they have been much more patient with their children... Now they are also more willing to listen to their peers’ advice or feedback, they really listen and try it out at home.”

More significantly, the peer leaders felt really encouraged when their family members noticed their changes. Marianne’s experience was documented in her newspaper interview with the Weekend Magazine of a Chinese newspaper.
Mrs. X felt that the biggest benefit of attending the training was learning how to handle one’s emotions and moods... “I have 4 children at home, and 2 elders. My father could not walk very well. In addition, I have to work, so I have lots of pressure. Before, when things were not going right, I would be very tense, and I lost my temper easily... After the training, I asked my daughter if she had noticed anything different about me lately. She said that Mommy had been calmer, nicer; for example, when she spilled her pop, I did not yell at her right away. I have learned to control my temper, being aware that she did not do it on purpose, so I was not angry.”

During a winter holiday social gathering of all the peer leaders, facilitators and their families, Marianne’s husband echoed her description of change in the newspaper article. “I have really noticed that my wife is a lot more patient and reasonable with the children. Before, she got cranky easily; nowadays, she is patient and she does not have as many conflicts with the children. Everyone is happier.”

Wai-Ling recalled similar response from her husband, William. A year after Wai-Ling joined the project, William had decided to give up the ‘astronaut family’ arrangement and returned to live with the family in Canada. At the beginning, Wai-Ling wondered about how well they would readjust to each other, especially in terms of parenting since Wai-Ling had been sole parenting for a few years. However, she found that everything seemed to have worked out.

You were asking whether this program has any influence on our partners, I think unknowingly, we do affect them in many ways. Even if they do not praise you or say out loud ‘I really support you in what you are doing’, but in the day-to-day living, in many small ways, like when they do not challenge our ways of doing things, then they are already agreeing with us... Once we were at a gathering, my husband said, ‘My wife is right, children should be...” Aside from teaching my children, my relationship with my husband is also better, there is less argument and everything is easier to resolve. When there is a problem, we already have an approach. We don’t bother to argue over little things because there is no time [laughs]. It is like both of us have a natural agreement.

The peer parents leaders acknowledged that they and their family members could mutually influence each other’s attitude and behavioral change. Amy shared in the focus group interview the struggles and changes she had gone through with her husband and child.

You all know that in February this year, I have officially looked for a lawyer to process our divorce. Our relationship at the time was really very bad. If we did not
separate, we would be fighting all the time and it was not good for our daughter...
Now we are back together, I feel that he has changed a lot...he is willing to bring things out in the open and discuss them, and I really encourage him to do that. I think that mostly, both of us have changed a lot, may be I am much more moderate and accepting of things... I feel I am less stubborn, too... For example, when my daughter is cranky, I let her be. Before, when she was cranky, the louder she was, the even louder I became; but now, I would say, you don’t have to be cranky and she would calm down.

Confidence and Self-efficacy

One common way of measuring individual empowerment is through the documentation of the extent of increased confidence or self-efficacy in individuals. Since this is a descriptive case study, I did not use any self-efficacy tools as other researchers might have. Instead I continued to rely on the voices of the peer leaders and the trainers/facilitators and other observations.

The increased confidence and self-efficacy of the peer leaders could be explored in three areas: in their parent-child or family relationships, in their interactions with other parents in the community, and in the development of their “self”. Since the peer leaders’ initial motivation in joining the project was to increase their knowledge and skills in dealing with their children’s sexuality issues, all of them commented on this topic in the individual training session evaluation and the final evaluation of the training program.

Nowadays my views on sexuality have been broadened. I am much more focused and I am clear about my goals and expectations with my children. Before, I sometimes experienced insomnia because of my children. Nowadays, I don’t have the problem because I have learned to deal with things as they come and not being over worried about them.

I felt very proud to become a peer leader; the things I learned were all new to me. My views have been expanded, my thinking has matured, and I have found strategies to deal with different issues. Now I manage my emotions very well; my relationship with my family has become more intimate.

During the research interview, Betty and George talked about how they used to have difficulties talking with their sons, especially when they have grown older. However, George pointed out that after the training, it had been easier.

I have become aware that I can talk to my children. I can be more open and address the issues frankly, unlike before, we kind of hinted about things and did not
really discuss the issues; and when they did not ask questions, we did not know what to do. But now, we all raise the issues openly.

In addition to their increased confidence in communicating with their children and dealing with their children’s sexuality issues, most of the peer leaders also achieved varying degrees of increased confidence in their interaction with other parents in the community. Their comments in the final evaluation of the training program could be used as a base line or reference in showing how their confidence and self-efficacy had changed over time as they participated in the community outreach activities.

Because I did not have any employment experience, I only had to face my family and friends. My social circle is small, so suddenly when I have to speak in front of people, I feel very nervous. I don’t have much confidence. Because I have knowledge about sexual health, I feel very natural in discussing sexuality issues; therefore my confidence has increase tremendously. The most important thing is for me to express everything from my heart. Since there are no absolutely right or wrong answers, if I could bring out mutual understanding, then the joy is indescribable.

The community workshops and other outreach activities had provided the peer leaders with many opportunities to build up their confidence. However, for many peer leaders, increased confidence was not something that they could articulate with ease. During the group interview, Doris said, “Yes, it was true, before I joined the project, I felt very timid and shy, you all know that [laughs]. Now, there is some improvement, I felt much more courageous and bolder.”

As facilitators, Eva and I had observed that Doris was much more confident at the end of the training program. During the peer leaders’ mock presentations in May 1999, I wrote in the project progress notes:

George and Doris were very organized. They used an excellent diagram to help explain their topic... Doris was a bit nervous; her face was red and her voice was shaky. However, she was always insightful in using embracing terms such as ‘appropriate’ rather than ‘normal’...

In December 1999, Doris worked with three other peer leaders to facilitate 2 workshops in the community. Although she was still a bit nervous, she had developed an effective strategy in providing information to the participants.

Doris was very much at ease in leading small group discussions. She used cue cards to help herself in presenting the information to the large group. Although she was still a bit nervous, I noticed that she was smiling and having good eye
contact with the participants. She was very natural when she used her interactions with her son as examples in explaining adolescent issues.

It is important to keep in mind that confidence and self-efficacy are reflected in ways other than public speaking, which is a common source of stress for the majority of the general public (Orman, 1996). While Doris continued to feel anxious during public speaking, her confidence and self-efficacy was captured in many other ways such as having the courage to include controversial topics in her presentation segments. Her calm, soft-spoken and embracing manner role-modeled for other parents her unique strength and reaffirmed the value of diversity.

Other peer leaders had also become increasingly confident in their interactions with the community. Emily, who felt lost and “useless” at the beginning of the program, had rediscovered her competency and ability within. She admitted during the follow-up telephone interview, “Before, I felt too embarrassed to tell others that I was a parent leader, but now I am so used to it that I don’t even think about it.” Her increased confidence was reflected in her achievement in organizing discussion groups with five other couples from her church. She had expanded her role as a peer leader in her own social circle.

Perhaps the increase in confidence and self-efficacy among some of the peer leaders could best be illustrated by their participation in the Third Chinese Family Sex Education Peer Parent Project. Soon after my interviews with the peer leaders, Amy, Emily, Marianne and Doris had joined the TCHEC community service providers to revise, develop and facilitate the peer leader training program for the third group of RSHC Chinese peer parent leaders in Toronto.

Another important component of individual empowerment that was captured in this case study was “self-development”. Teresa, one of the facilitators commented on her observation on the peer leaders.

I can see that, at the beginning, the individual leaders came with some relationship issues. These were not necessarily about sexuality; it might have to do with their marriage or their own personal growth. When they joined the project, their intention was for their children, but somehow they were able to work through some of their own unfinished business, so there was definitely a positive impact on their dimension of “self”.

Although all the peer leaders’ initial intention in joining the project was to “perfect” their parenting skills, many of them had also taken on a path of self-development. During the group interview, Emily recited a famous Confucius saying:
"Sau Son Chai Gah Ji Gwog Ping Tin Ha", which can be translated as “To bring harmony to the world, govern the nation, manage the home, one must first cultivate the self”. She spoke of how her life had been transformed from focusing only on her children to finding a new meaning of existence.

My greatest learning during the puberty workshops was to pay attention to issues around “emotions and moods” — both my children’s and mine. Based on our mutual influences and interactions, I have done a lot to develop myself; for example, to self-exam, self-declare, self-enhance, and self-initiate. I joined community workshops and sat in parent support groups. Suddenly, I felt a sense of “rebirth”, and an improved sense of worthiness to society.

Bui-Chi, who shared similar struggles as Emily, also recognized her needs to develop or nurture herself. She wrote in her reflective journal:

After quitting my job and becoming a full-time mother, slowly and naturally my “self” has disappeared. Increasingly, I do not have any time for myself. Nothing goes according to my wishes. Silently I am bearing this hardship. The responsibility of bringing up a child and teaching him well is enormous. I feel really tired. When I think about my own progress and development, I wonder where the time has gone. After attending the training, the facilitators, my peers and friends all advised me to live and have some time and space for myself. I thought about it and realized that they were right. My son will slowly grow up, his needs for space and independence will be the same as mine. I should not only focus on love and devotion, making it a burden for each other. Now, I am working hard to change this, trying my best to take time to care for myself.

At the time of the focus group interview, Bui-Chi had just started a full-time job at an office. For the peer leaders who had full-time employment prior to their immigration, re-entering the work force could be an important part of their empowerment. Soon after the focus group interview in October 2000, Wai-Ling also found a full-time job, working as a settlement worker in a Chinese community agency. At a gathering in February 2001, she came up to me and said,

I really want to thank you and the others. I am very happy with my job. I am doing what we were trained to do. I am organizing community education programs, just like what we have been doing. But before, I did not even realize that I already have all these skills in me.
During the same period of time, three other peer leaders had found work. Shui-Yin got a job at a large soft drink company; Betty got a temporary contract position doing women's health workshops and Tina was working as a school assistant during lunch hours in a local public school.

**Shared Hearts, Shared Vision: Collective Empowerment**

As a trainer/facilitator, I observed that individual empowerment of the peer leaders was like blossoms on a flowering bush, being nurtured by a source of energy based on their shared identity, common vision, mutual respect and genuine friendship. The peer leaders attributed their friendship to having:

同聲同氣
“Tong Sang Tong Hey”

which can be translated as “same voice same breath”, and it means “mutual understanding due to shared language and shared culture”.

**Becoming Friends who Understand**

In March 1999, one month after the program started, Eva and I began to notice that the peer leaders had developed a friendship beyond that of “classmates” in a training program.

*Many of them brought in food to share with each other and they exchanged recipes.*

*When they arrived early, they would start chatting and sharing their personal issues with each other. Sometimes they were so excited to see each other and had so much to share that we have to start the training session with a 5-10 minutes relaxation exercise to bring them back to focus. Through this sharing of food and thoughts, they seemed to have developed a tolerance for each other’s differences.*

*It was a joy to see them establishing such a friendship.*

Although George was the only male in the group and Betty was the one who brought the food, all the other leaders embraced him as a friend. George felt very comfortable sharing his feelings with the group.

*When I see this group of people, I feel very happy. Even though we have known each other only for a short time, I feel like we have know each other for a lifetime, as if we grew up together. When we were together, we talked a lot, and sometimes we felt as if we could understand each other’s growing-up experiences.*

Bui-Chi, who did not know any of the other peer leaders prior to the training, experienced similar friendship and support. She expressed her appreciation of the positive and warm relationship that the group had developed.
I never expected that we all got along so well because I did not know anyone of them before the training. At the beginning, we did not talk or share very much; we worked together on different cases, nothing special, but then as we worked together some more, we all began to really care about each other. We developed a friendship and a really good relationship. We were able to give each other feedback instead of just saying polite words...

Some of the peer leaders identified their common struggles as immigrant parents to be as a contributing factor to this friendship development. Wai-Ling shared in the group interview, “I think I was most touched by how genuine we have been towards each other. We shared our own parenting experiences and we spoke from our hearts.” Emily suggested that having the opportunities to share and learn from each other was empowering.

I feel that our friendship is most precious, and I treasure the joy we have together.

For me, it has been a process of growth. I have learned how to face the day-to-day challenges, and learned a lot on interpersonal skills, not only for use outside but also at home. Being able to talk to each other as parents is rewarding.

The peer leaders’ friendship was also reflected in their informal social gatherings, when they brought their families and children together to socialize. They put effort into maintaining a friendship beyond their community outreach activities because they really enjoy seeing each other.

**Giving Each Other Support**

As the peer leaders’ friendship deepened over time, they established an informal mutual support network among themselves. This mutual support was evident in their interactions with each other during the training, as Eva remembered:

One of the mothers was getting so frustrated with her son that she almost lost control, and the group supported her and provided her with different suggestions; actually I think the ventilation was already a big help. Later on, this mom reported back to the group that their advice seemed to work. Somehow the group had become a source of support; they brought issues to the group and they brought strategies home. I felt they had really built a relationship.

The peer leaders supported each other through frequent phone calls and discussions of their problems and needs. Marianne described their support for each other, “We often call up each other over the phone, ask each other for advice; we are not just acquaintances, we are good friends and we can talk with each other openly.”

In addition, the peer leaders also shared their newly acquired resources among themselves. In the summer of 1999, when Wai-Ling visited Hong Kong; she obtained a set of sexual health fact
sheet in Chinese from a local family planning organization. When she returned, she shared all these pamphlets with her peers. When Doris attended a workshop on parent-teen relationship, she also brought the print resources back to share with the group. They have formed a network such that if one of them noticed that a potentially useful workshop was being offered in the community, he/she would call to notify the other group members.

Perhaps the genuine care and concerns the peer leaders had for each other was reflected in their support for Amy, who went through many personal difficulties throughout the last two years. When Amy lost her mother to cancer, some of the peer leaders attended the funeral to give her support. In February 2000 when Amy was experiencing marital problems, the peer leaders were very supportive of her, offering to help her to find housing and make plans for her immediate needs. In the progress notes, I wrote: “Amy was tearful and everyone listened to her empathetically. When Amy spoke of a divorce, I was touched by the non-judgmental and embracing attitude of the peer leaders.”

Some of the peer leaders acknowledged that each member’s personal difficulties were not only problems of the individual; they recognized that they were vulnerable to similar struggles because of their shared history, values and common experiences. Some of them were mindful of how in helping each other to deal with their problems, they also gained valuable insights. In the follow-up interview, Emily talked about how Amy’s sharing had given them the opportunity to learn and grow.

When Amy first talked about her problem with her marriage and that she wanted a divorce, we did not dare to ask her more or intrude. We were human; it took us a while to warm-up to such difficult situations. But later on, we all had the courage to talk about it. Amy was very open in her sharing with us. I felt that we have learned a lot from the situation, especially in terms of interpersonal relationships.

With the support from her peers, Amy was able to sort out some of the difficulties in her personal life. She had become more relaxed and less overwhelmed with the high expectations that she had imposed on herself and her family. Although she never openly admitted to her peers, she told me in the follow-up interview, “I liked the whole program, from training to practice, I was quite happy with it. I felt for sure that I have benefited. I have learned to relax, and shared with others, and at least there were opportunities for me to talk about the unhappy things in my life.”

In January this year, Amy who survived cancer a few years ago discovered many lumps along her neck. A few weeks later, she was diagnosed with Stage IV cancer, which had spread to many parts of her body. The peer leaders continued to provide Amy with support by calling her up
and exploring her needs. In my recent conversation with Amy, she laughed and said, “My husband said that now I have so many friends, he is not worried about me getting help…”

**Sharing a Common Vision**

The individual and collective empowerment of the peer leaders were intertwined, with one influencing the other. As the peer leaders expanded their knowledge and understanding on children’s sexuality, they began to see the importance of family sex education and parent-child communication. They developed a common vision of sharing their insights and learning with other parents in the Chinese community. As a facilitator, Felicia also observed how the peer leaders had evolved from being concerned with only their own children to being aware of the bigger needs in the community. She commented:

They have shown commitment in their hearts. They believe in the project and I think this is very important. They are willing to join and help facilitate the next training program because they see the importance and we are able to encourage them to go on.

Felicia’s observations were echoed by Wai-Ling who saw the community outreach activities as a natural outcome of the training program.

In terms of the community outreach and promotion, we all share the same goals and vision; we hope to do more so that more people will know about family sex education. Besides, every one of us has put so much efforts into it and we have taken on so many challenges, so our knowledge and skills should not be wasted. It is like using what we have learned to continue with the promotion.

All the peer leaders identified effective teamwork as an important component in their continuation with the community outreach activities. Emily commented, “I think the teamwork made a big difference. We all took on certain responsibilities and each one of us was committed to one part. When something came up unexpectedly, we just had to be flexible and helped each other out.”

Aside from the initial conflicts between Amy and Susan, the peer leaders worked very well together. They were able to identified each other’s abilities and skills and worked together to achieve their common goals. Days before the Chinese Family Health Fair took place in May 1999, the peer leaders worked together to develop a display. They all contributed in different ways: some had their children draw pictures, some worked on developing the content of the display and those with excellent calligraphy did the writing.

A similar kind of teamwork could also be observed in the way they delivered community workshops, as one of the facilitator commented in the peer leaders’ workshop evaluation forms:
"Excellent teamwork, 6 peer leaders presented different sections of the workshops. All the peer leaders were present to help facilitate small group discussions, put up posters, and give out materials.” The peer leaders themselves also identified having peer support during community outreach activities as important. Some of the peer leaders wrote in their post community workshop reflection forms:

Having peer support is so important. Like when some of you showed up, and when everyone was too shy to talk, you could act like plums and bring out the discussion. I could see that many parents wanted to ask questions but they were too shy.

Most of the peer leaders attended each other’s community workshops. In addition to providing support to their peer presenter, the peer leaders also considered these workshops as continuous learning opportunities for themselves. They did not see themselves as experts providing information for other community parents, but as parents who had the opportunities to acquire new knowledge and therefore wanting to share their learning with other parents. By attending the community workshops even when they were not presenting, they had the opportunities to learn from each other and the community parents, as one of them wrote in their reflective journals:

We learned from the last presentation and we worked on improving our lesson plan and supplementing it with more information. Teamwork is important. I like getting the support from all the peer leaders. They were like backups and they joined the discussion if necessary. Listening to another team’s presentation was like a rehearsal. We learn from each other…

During the training, the peer leader had learned the skills in providing constructive feedback to each other. When they began to do community workshops, a couple of peer leaders who were not presenting would join the facilitators/trainers in completing a peer evaluation on the workshop presentation. After the workshops, we got together as a group, sometimes over lunch or at the next meeting, to debrief their experiences and to identify community issues and their own learning needs. One of the leaders wrote in their reflective journal, “Practice makes perfect, next time it will be better. The practice was very valuable; I benefited out of it and I enjoyed the whole process, including our team discussion before and after the workshops.”

Over time, the peer leaders matured as a team and they established their own method of “self-evaluation” as a team. In addition to their peer evaluation, they taped all their workshops so

7 ‘Acting like plum’ is a Cantonese saying, which means to plant someone in the audience to achieve the desirable effect without the audience’s awareness. In this case, the extra leaders sat with the workshop participants to encourage open discussions. The workshop participants knew that they were peer leaders because they all wore name tags.
that the peer leaders who were not there could listen to the tapes. More importantly, they got together as a group to listen to their own workshops so that they could identify areas for improvement and brainstormed on finding new examples for future workshops.

Marianne suggested that their team spirit came from their shared identity, culture and values. "I think, this program is our motivation. If our group had not been trained in Chinese or if the project was not organized in the Chinese community, we might not have done as good a job in our outreach activities. We would not have been as engaged because of our cultural and language differences." Marianne's comment suggested that successful integration into the larger or "mainstream" society is a necessary step before the peer leaders can participate in similar kinds of projects in the "mainstream" community.

**Providing Mutual Influences**

As discussed earlier, empowerment was an interactive process that involved every member of the RSHC project. Most of the peer leaders identified the community outreach activities as their opportunities to develop their confidence and continue with learning. Kristy, a community worker, who had invited the peer leaders to provide 2 workshops at her agency commented on the importance for the leaders to practice what they had learned.

In terms of how to facilitate them to become peer leaders, I think there are mutual influences. I think the workers themselves have to provide more opportunities for growth, for example, you have to find the peer leaders the opportunities to practice, and then they would mature. If they never have the opportunities to use what they have learned, they would never know where they are at. I think this is important.

Bui-Chi echoed Kristy's comments; she identified having the opportunity to apply what she had learned as an important motivating factor in her outreach to her friends and other parents. She saw it as an opportunity of mutual influences and gain.

It was not as simple as just fulfilling a promise, I felt that I have learned something and I liked to share with others; also if I did not practice what I have learned, it would not be beneficial to me either. I found that when I used it at home and with friends, it was beneficial to my friends and other parents... this helped to motivate me.

For many of the peer leaders, the feedback from the community parents was a source of energy and encouragement. At the February 2001 gathering, many of them talked excitedly about running into some of the community workshops participants. Bui-Chi said, "The other day, I ran into a parent who attended our workshops. She remembered me and said that she had listened to
our radio programs. She said we were good.” The recognition and appreciation from the community parents reaffirmed and validated the value of their outreach effort.

In addition, some of the leaders suggested that the group was motivated to commit to the community outreach activities because they recognized the commitment of the facilitators. Bui-Chi told me during the follow-up telephone interview, “We see you and the other facilitators poured your hearts into teaching us, so we poured our hearts into learning”.

At the same time, the facilitators were also influenced and motivated by the peer leaders’ eagerness to learn, their growth, their energy and their dedication. During the focus group interview, both Eva and Felicia shared their initial lack of confidence in the project. Eva recalled her doubts regarding the project:

When we were doing recruitment, I was a bit worried because the training was quite long, and I was not sure if people here have the time... Actually, I was a bit skeptical whether this model would work, but then I thought, it would not matter, let’s try it out... in working with them, I noticed how they were all changing, and that also changed my views. I used to think... how would we ever get long-term volunteers here in Canada... But then, this group of peer leaders made me understand. When they moved here, they had lost so many positive aspects of their life such as good jobs, good connections, etc. that this program has provided them a new way of evaluating themselves. It also increased my job satisfaction by a lot.

Felicia also shared Eva’s initial skepticism about the project. Based on her experiences in working with volunteers in Hong Kong and in Toronto, she was not sure if the peer parent project would succeed.

To be frank, I used to question about peer training programs, not just about this project... We all know that when we use volunteers, not that many people actually commit themselves. So for me, the peer education model was a big question mark. In addition, we were working on a more sensitive topic like sex education, so the question mark was even bigger. But throughout this whole training, I saw that it was a very good capacity building model... their hearts were committed to community contribution; this is really positive because it really fulfills our program goals.

As one of the project facilitators, I also echoed Eva and Felicia’s observations and experiences. The peer leaders’ dedication and energy, the support and mutual encouragement from
my community colleagues, and the positive reinforcement from TCHEC partner agencies, all contributed to my increased energy and impetus. As I shared the progress of the RSHC Chinese Peer Parent Project with my colleagues at TPH, some of them were also energized to work with their RSHC projects in the other ethnospecific communities.

**Discussion**

The scientific literature defines psychological (individual) empowerment as a process in which individuals participate to listen, discuss, identify their needs and work together to achieve specific outcomes. These outcomes lead to increased individual and community control, improved quality of life and social justice (Eisen, 1994; Israel, et al., 1994; Wallerstein, 1992). It is important to keep in mind that empowerment is contextual and can best be understood in light of powerlessness. Zimmermann (1995) suggests that individuals may experience empowerment in one context but feel powerless at another. This paradoxical nature of empowerment is significant because it helps us to recognize that marginalized groups are not completely powerless. Given the right opportunities, they will be able to use their existing capabilities to actualize their goals.

In the case of the RSHC project, the immigration and settlement process had brought many challenges and difficulties to the lives of the peer leaders. Their experiences of social isolation, downward social status, loss of adequate employment and barriers to integration had contributed to a sense of powerlessness among some of them. Their participation in a community project within the Chinese community had therefore provided them with an opportunity to break through this social isolation and to begin taking better control of their lives. As discussed in Chapter 3, mothering is a role with magnified significance among the female peer leaders. While it is important for us to recognize that parenting programs may potentially reinforce the ‘domestic’ and ‘caregiver’ roles of immigrant women, we must also keep in mind that for many women, these programs may be the first or the only point of entry to social and community support.

Current scientific literature tends to emphasize empowerment in abstract and ambitious terms of political power or sociopolitical efficacy. Although structural and policy changes are important, empowerment among marginalized groups must first take place at the individual level. Most of the peer leaders joined the project because they felt inadequate or they wanted to increase their parenting skills in family sex education. However, as they acquired knowledge and developed skills, they also begin to rediscover their individual and collective capabilities.

Unlike the one- or two-session stand-alone community education programs, the RSHC training program was implemented over a period of 5 weeks with two half-day training sessions per week (see Appendix V). It was followed by at least two months of community outreach practice
with follow-up training and discussion sessions. The intensity and length of the program helped to establish the necessary conditions for the process of empowerment to take place. I argue that the individual and collective empowerment of the peer leaders had resulted from a combination of interactive factors, including the acquisition of knowledge and skills by the peer leaders, the development of an embracing environment and the establishment of a social support network.

According to Social Cognitive Theory, an individual's behavioral capability is dependent on his or her knowledge and skills for the specific behavior (Baranowski, Perry & Parcel, 1997). We also know that adults learn best when the education information is relevant and offers immediacy (Vella, 1994). The in-depth nature of the RSHC training program provided the peer leaders with the opportunity to acquire knowledge and skills that met their identified needs of effective parenting, family sex education and communication. As the peer leaders acquired new knowledge and skills, they were encouraged to integrate their learning into their day-to-day interactions with their children, family and friends. They were also encouraged to share and discuss their application experiences as a group. It was this praxis that moved the peer leaders beyond the focus of individual parenting skills to that of relationship building and collective visioning. It is important to recognize that the peer leaders' increased knowledge and skills did not come solely from the program or facilitators; but also from their sharing of lived experiences and open discussions within the group and with other parents.

Empowerment is a dynamic cyclical process in which individuals, groups and situational factors interact with one another to achieve the desired outcome. As the peer leaders acquired new knowledge and skills, their sense of confidence and competence increased to the extent that they were able to change their behaviors and the ways they interacted with others. These changes created a new social environment of reciprocal determinism (Baranowski et al., 1997) in which their children, spouses, family members and friends also behaved differently as a response to the peer leaders' behavioral changes.

This reciprocal determinism had been expanded to the community setting where the growth, enthusiasm and commitment of the peer leaders had become a source of encouragement for the project facilitators and other service providers. At the same time, recognition by the service providers and feedback from the workshop participants became a source of motivation for the peer leaders to continue with the project. This cyclical process of positive feedback and reinforcement contributed to the individual and collective empowerment among all the members of the project.

As a facilitator of the RSHC project, I was deeply touched and empowered by the peer leaders' attitude change towards sexual orientation and homosexuality. Perhaps it was their
reflexivity on other social oppressions such as sexism, racism and classism that helped them to transcend differences and embrace diversity.

In addition to increased knowledge, skills and self-efficacy, the RSHC project has also demonstrated that relationship development is an essential component of empowerment education. As the peer leaders learned and worked cohesively on the community outreach activities, they gradually developed a friendship that was built on shared values, mutual understanding and common vision. This friendship also turned into a support network among them. Heaney and Israel (1997) suggest that social support is the functional component of relationship that is intended to be helpful; it acts as a buffer to stress by influencing the frequency and duration of exposure to stressors and supporting health behavior choices. When the peer leaders shared their lived experiences, challenges and problems, they were also producing knowledge and strategies as a group to deal with their problems. As a result they were better able to recognize the contributing factors of their stress and develop effective mechanism to cope with their problems.

Another important outcome of the RSHC project was the development of a common vision and collective actions among the peer leaders. As the peer leaders became more confident with their parenting skills and experienced the positive outcome of their behavioral changes in family sex education and communication, they began to look beyond their own individual needs to those of the community. Their new and positive attitude towards family sex education motivated them to share their knowledge and experiences with other parents. For many of them, being in the role of a peer parent leader had become second nature in their day-to-day living. Their eagerness to reach out to other parents and contribute to the community was congruent with one of the traditional Chinese cultural values:

老吾老以及人之老　幼吾幼以及人之幼
"Lo Mm Lo Yi Kup Yan Ji Lo, Yau Mm Yau Yi Kup Yan Ji Yau".
which can be translated as “To truly honor the elders in my family, I must also honor the elders in the community; to truly care for my children, I must also care about the children of other families.”

Last but not least, empowerment education facilitates egalitarian relationships in which the trainers and learners dialogue, reflect and mutually influence each other (Chalmers & Baramadat, 1996; Freudenberg et al., 1995; Rissel, 1994). The RSHC project had demonstrated that empowerment is not a one-way process in which the service providers give the participants power. Instead it is a dynamic process in which the facilitators and the participants share a common vision, influence each other and work collectively to achieve their common goals. In the case of the RSHC project, the individual and collective empowerment of the peer leaders had contributed to the
empowerment of the facilitators who also experience systemic oppressions in their work place and in their day-to-day living.

Summary

In this chapter, I have described the process of how the peer leaders had moved beyond individual empowerment towards a group identity, common vision and collective actions. The peer leaders' experiences demonstrated the significance of human caring and relationship building in health promotion. They also confirmed that competencies exist in individuals and communities, such that when given the right opportunities, people can build on their competencies to gain control over their lives. In this sense, empowerment is truly not a zero-sum gain. While the peer leaders and the facilitators expand their power and resources, they were not taking power away from another group and leaving none for others.

In the next chapter, I will document the relationship between community participation and community empowerment, identifying the contributing factors and barriers as experienced by the peer leaders, the trainer/facilitators and the organizations involved in the RSHC project.
CHAPTER 5: MULTIPLE STRATEGIES TO COMMUNITY EMPOWERMENT

Echoes in the Hillsides

Siu-Mui was grateful and happy. As she waded through the rice fields, she recited all the poems and verses she learned the night before. Soon, Siu-Mui and her friends were all sharing the wonder and wisdom from her books. Even Grandma and Grandpa came out to the fields to listen to their chattering. Ying-Ying could hear their laughter echoing through the Seven-Star Hills, and their songs were so full of joy that they were reaching heaven...

Since community empowerment is a multi-level construct, to understand the relationship between participation and community empowerment, we must explore all the contributing factors and barriers to empowerment beyond the individual or small group level to the organizational and community levels. In this chapter, I will explore TCHEC as an ‘empowering’ and ‘empowered’ organization.

Because community empowerment is a long-term process, and the RSHC project has been underway for less than two years at the time of my data collection, it is difficult for this case study to document the long-term impact of the project. However, using a variety of data sources and through the voices and accounts of the peer leaders, trainers/facilitators, community service providers and community workshop participants, I will describe some of the outcomes of the RSHC project.

TCHEC: An Empowering and Empowered Coalition

The empowerment literature often describes organizations as the vehicle through which individuals and groups work together to achieve empowerment; at the same time organizations are built on the strength of membership and relationships (Speer & Hughey, 1995). Although TCHEC is a coalition of non-profit community organizations or publicly funded agencies, it took on the role of an ‘organization’ in managing and administering the RSHC project.

TCHEC was established in the mid-1980s by a number of non-profit community organizations in response to the emerging health issues that impacted on the health of the Toronto Chinese community but were not adequately addressed by the ‘mainstream’ health care services. Because TCHEC is a coalition, it does not have any core funding or operation budget. Its strength and resources are memberships, which include local community health centers, settlement agencies, community organizations and public health units. When a health issue of concern to the Chinese community arises, members of TCHEC establish ad hoc subcommittees to pull resources together to address the issue.

The RSHC project was administered under the TCHEC Sexual Health Subcommittee, which consisted of four membership agencies, including TPH. While the subcommittee was accountable to the
coalition and reported its project activities regularly to the coalition at each meeting, it had the autonomy to make the day-to-day project operation decisions.

**Characteristics of an Empowering Project**

As described in Chapter 2, the scientific literature suggests that empowering organizations are task-focused, encourage collectivity, inspire growth, foster leadership, and provide opportunities for members to function in different roles and make decisions. In that sense, the RSHC project was empowering.

One of the strengths of the RSHC project was its ability to network with other community agencies to organize community workshops and outreach activities for the peer leaders to apply their skills immediately after the training was completed. Eva, who was the co-chair of TCHEC at the time, explained:

The advantage of being part of an umbrella group is that we have good working relationships. When there were many issues that we have to address, we all divide up the tasks and support each other. Everyone supports one or two programs and contributes whatever resources or skills he/she has. So, after we completed the training, different agencies at TCHEC identified their clients’ needs in family sex education. They organized the workshops and we sent the peer leaders to do them; for example, at one of the east end community health center, they said, “We have a women's group, please come and do a workshop with us.” We were able to rely on each other in promoting the project through this support network.

Because of its relatively long history of being a health promotion and advocacy coalition in the Chinese community, TCHEC was able to connect with other Chinese community agencies to promote the peer leader outreach activities. Kristy, a community worker of a TCHEC membership agency, suggested that having the opportunities to apply their learning in concrete activities such as community workshops was important to the individual and collective growth of the peer leaders.

I think the reason why after a period of time, different community agencies continued to invite the peer leaders back as speakers was partly related to their maturity and confidence... I think that as service providers, we have to provide the peer leaders with opportunities to grow. If they never have the opportunities to use what they have learned... they would never know where they are at in terms of knowledge and skills.

The peer leaders themselves also identified the benefits of being part of the TCHEC coalition. As volunteer peer parent leaders, their time, resources and community connections were limited. Thus, their community promotional activities had to rely on the community networks established by TCHEC.
When we are connected to the different community agencies, every so often they organize workshops and they can invite us. That helps us a lot because we can concentrate on the workshop preparation rather than having to spend time on registration and follow-up. Just like the two centers we have been to... every 3 months or so, they start some new programs. They can invite us to do some workshops. This is a better way of using our limited resources.

Another empowering characteristic of the RSHC project was reflected in the ways the project promoted autonomy and innovation. Throughout the training, the peer leaders were encouraged to be creative and self-directed. Instead of providing pre-set learning materials all the time, the peer leaders were asked to develop some of their learning materials as a group. For example, in training session 2 when the peer leaders were learning about "Where children get their messages about sex and sexuality", they were encouraged to develop their own Treasure Chest as their homework for the week as outlined in the manual:

During the next few days, keep a list of any messages about sex that you and your children come across, for example, on TV, radio, news, on the bus or subway, newspaper, on the street, in the shopping mall... Collect these materials if possible and make your own "Treasure Chest". When we return next time, we will all share our experience.8

Working in teams, the peer leaders collected newspaper articles, magazine pictures and some toys for their Treasure Chests, which they used later on as a workshop tool in the community. Their creativity was also captured in the Community Health Fair Display Board and a promotional bookmark that the peer leaders designed collectively (Figure 1).

In addition to innovation and creativity, the RSHC project also fostered leadership development and shared decision making. Upon the completion of the initial training, the project received a number of requests for the peer leaders to lead community workshops. Instead of assigning the leaders to specific workshops, the facilitators brought the information to the peer leaders and encouraged them to form their own small teams and discuss among themselves on how to divide the outreach activities among themselves. At the early stage of their community outreach practice, the facilitators worked closely with the peer leaders to facilitate their growth and confidence development. However, as the peer leaders matured, they were encouraged to take on leadership roles.

In September 1999, when the peer leaders returned to the project after summer vacation, they established their own structure to take on some of the program administrative tasks. In addition to all the regular project meetings or follow-up training sessions, they began to meet once a month on their own to

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8 Instruction on 'This Week's Homework' in Toronto Public Health (2000). Raising Sexually Healthy Children Peer Parent Leader Training Manual (For Educators/Community Workers). City of Toronto: Public Health. (p. 23)
Front of bookmark says: Promoting Family Sex Education begins with parents...
Back of bookmark says: Family Sex Education is about: understanding our rights and responsibilities towards our body, developing self-concept and building confidence, healthy psychological and biological development, having accurate sexual health knowledge, healthy relationships, mutual caring and respect, excellent parent-child relationship, increased effective communication. To learn more on how to talk with your children about sexuality, or to obtain more information on sexual health information, please call the AIDS-Sexual Health InfoLine at 1-800-668-2437 or (416) 392-2437. Chinese Language Services: Friday 5 – 11 p.m.
(See Appendix W for copyright information)
identify their own learning needs and work on project related issues. Wai-Ling was elected Chairperson to oversee community workshop requests and coordinate the peer outreach efforts with support from the facilitators and TCHEC. When asked of her experience being in this leadership role, she laughed and said, “Being a chair is really easy because everyone puts in the best efforts. Every time I receive a request, I call Marianne and she calls everyone and we all shared the tasks.”

Marianne took on the role of the secretary and became responsible for minutes taking and calling up all the peer leaders for meetings or other activities. She agreed with Wai-Ling that taking on these additional roles were not difficult, “Yes, we all have self-awareness and we know when to take action. We don’t ever have to wait around for things to get done.”

Since the project was started with a small seed grant of $4500, its financial resources were limited. There was a small budget for workshop expense and transportation reimbursement for the leaders. However, the peer leaders did not take the reimbursement individually. Instead they pooled the money together so that they could use it to develop promotional resources like the bookmarks for community parents. Occasionally, the group was given an honorarium of $25 by a community agency for doing a workshop; the peer leaders would add this money to their small budget so that they could use it for resource development. Amy, who was organized and detailed, was given the role as the finance officer. Last but not least, Shui-Yin volunteered to be the social activity coordinator with the responsibilities of organizing potluck dinners and other social gatherings for the peer leaders and their families.

In addition to leadership opportunities within TCHEC as a coalition, the RSHC project also encouraged the peer leaders to expand their roles. In November 1999, Wai-Ling, who could speak both Cantonese and Mandarin, joined Eva and Felicia to co-facilitate the training program of the Second RSHC Chinese Peer Parent Leader Project which targeted Mandarin-speaking parents. Wai-Ling’s presence as a co-facilitator strengthened the training program for the RSHC project, as Eva explained:

We were so lucky to have Wai-Ling join us. Aside from her Mandarin language skills, she was able to share with the participants her experiences going through the training and being a peer parent leader in the community. Some of the new leaders felt nervous about speaking in front of other parents; but with Wai-Ling being there with us, they could see her as a role model and said, “Ah, maybe I can do it, too.”

As the other peer leaders matured and gained confidence through their community outreach activities, they also began to see the RSHC project in a broader perspective. They were concerned with the sustainability of the project, especially when some of them started to work part-time or full time. In the follow-up interview, Amy spoke of her hopes for the future of the project:
Like we had talked about it before, if there is a new group of parents who come out to do outreach with us, then we would have time to do some core work, like organizing other activities or connecting with the community. This way, we are not relying on the same group of people. Despite our willingness, we just may not have the energy to do it all. So I really hope a new group of parents will be trained to come help in the community.

In November 2000 Amy, Doris, Marianne and Emily also joined Eva and Felicia in co-facilitating the Third RSHC Chinese Peer Parent Leader Project, which targeted the Cantonese speaking parents. When Amy could not participate due to her health problems, Wai-Ling took time from her busy schedule to replace Amy.

TCHEC as a coalition and organizer of the RSHC project continued to encourage the peer leaders to share the decision-making process. With the third RSHC project, the peer leaders attended meetings with the community workers to modify the training program based on their outreach experiences. Sometimes, they all met at Amy’s place so that Amy could still participate within her health capacity. Eva recalled the dynamics in the planning process:

I just met with them recently, we discussed the upcoming training program project and they gave me very mature advice. When I suggested certain things, they said, this might not work, and we might need to do this… Oh, yes, for example, I said, “let’s not decide on the training time yet.” And Marianne said, “No, we have to recruit people who can really come out to participate like us; all of us can participate Monday to Friday, in the mornings, not in the afternoon because we have to take care of our kids. So our time is set for participation and it is very stable. We need people who can come to the training and also be able to contribute as volunteers in the community after the training.

The peer leaders’ first hand experiences in balancing community participation and managing their family responsibilities helped in planning and improving the day-to-day operation of the new training project. In addition, their presence as role models had become a source of encouragement for the new project participants.

**TCHEC as an Empowered Coalition**

It was difficult to identify the extent of empowerment of TCHEC as a coalition through the RSHC project. However, there was evidence of increased community resources as a result of this project. Although City of Toronto is a city with diverse populations, the public library system has very few non-English books or other resources on sexuality and sexual health. The lack of language and cultural specific sexual health resource becomes a barrier for many Chinese parents who want to talk with their children about sexuality.
Felicia, one of the facilitators, saw the community workshops led by the peer leaders as one step closer in narrowing the gaps of inaccessible information. "When parents in the community want to learn more about how to talk with their children about sexuality, there are very few resources available. These workshops have provided a venue for them to get more information..." She also commented on the importance of having the project manuals and fact sheets as resources for herself and other community workers.

When I came to Canada, I read a lot of books on sexual health, but I had to go through a thinking process to integrate our cultural values into these materials with. At the same time, when we do community workshops, we have to face the challenge of applying the information appropriately. I really appreciate having the manuals because at least now we have a culturally sensitive and appropriate model. Sometimes we find some resources out there in Chinese, but those materials are imported from Taiwan and Hong Kong and they are not appropriate for our local community. But our project manuals were developed locally, so I really appreciate them. I also know that they have been culturally translated into other languages, and I think this is wonderful, so I should mention it.

In addition to providing more community workshops and acquiring more resources for the community parents, the RSHC had also expanded the knowledge and skills of the community workers in the areas of sexuality training and empowerment education. As Eva identified in the group interview, there were very few Chinese community service providers working in the sexual health field. While Eva worked with women’s sexual and reproductive health, it was the first time she was involved in an empowerment education project in Canada. She recalled the challenges at the beginning of the project.

You had shouldered most of the work and some of the stuff I was not following very well... I was being mentored... When I became more involved, I realized that I did not have all the skills. They asked me to talk about different issues; I sat there and said to myself, oh no, I don't seem to have any knowledge or materials in these areas, and so I need to improve myself.

Yet, as the RSHC project continued, Eva had acquired extensive knowledge and skills in family sex education and empowerment education. She went on to work with Felicia and other TCHEC members to develop the second and third RSHC projects while I took on the roles of providing support and consultation as my job was redefined at TPH.

Community Empowerment: Multiple Strategies and Outcomes

Unlike other community initiatives, the RSHC project used different strategies such as empowerment education, social marketing, intersectoral collaboration and community development to
promote family sex education and parent-child communication in the Chinese community. Teresa, who co-ordinated the RSHC project administration, suggested that the use of multiple strategies was important in achieving successful outcomes.

In regards to sexual health, the peer leaders have gone on the radio besides doing other outreach activities. I think this is about how to combine different ways to achieve what we want. When we do health education and promotion, we need to co-ordinate the time and different strategies. For example, if you do training this year and do radio promotion or other things next year, it would not be as effective. But if you use the different strategies to promote the same message, people will feel more impact. They will feel it is okay to talk about sexuality and ask questions.

The outcomes of the RSHC projects showed that the use of multiple strategies had led to cumulative and interactive effects that exceeded the sum of each individual strategy being used on its own.

**Empowerment Beyond the Individual Peer Leaders**

While peer-to-peer education has been popular since the 1960s especially in school and youth services, its efficacy has not been confirmed due to a lack of formal evaluation (Shiner, 1999). One of the frequently asked questions on peer-to-peer projects is their impact on the wider community beyond the peer educators or leaders themselves. The program development, implementation and evaluation of the RSHC project were partly guided by this critical question. The impact of the project on the Chinese community had been captured in the quantities and qualities of the community outreach activities delivered by the peer leaders.

Between April 1999 and December 2000, the peer leaders had delivered 13 community workshops, 4 parents discussion groups and 5 community health fair displays, reaching over 800 community parents in person (see Table 7). They also co-facilitated in the second and third RSHC training programs. In addition, they have participated in a number of newspaper and radio interviews, and delivered sixteen 10-minute family sex education in collaboration with a local Chinese radio station (see Table 8), reaching over 50,000 parents in the Chinese community.
Table 7. Community Outreach Activities delivered by RSHC peer leaders  
(April 1999 to Dec 2000)

<table>
<thead>
<tr>
<th>Types of Outreach Activities</th>
<th># of Sessions</th>
<th>Total # of Participants</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Workshops</td>
<td>13</td>
<td>181</td>
<td>Workshops took place at a variety of settings including settlement service organizations, Girl Guide parent groups and neighbourhood community centers.</td>
</tr>
<tr>
<td>Parent Discussion Groups</td>
<td>4</td>
<td>61</td>
<td>Discussion groups took place in various public school</td>
</tr>
<tr>
<td>Community Health Fairs Displays</td>
<td>5</td>
<td>Approx. 600</td>
<td>Two of the Health Displays took place in downtown Toronto and drew over 1500 participants during each event.</td>
</tr>
<tr>
<td>Second RSHC Peer Parent Leader Training Program</td>
<td>3</td>
<td>15</td>
<td>Second RSHC project targeted the Mandarin speaking parents</td>
</tr>
<tr>
<td>Second RSHC Peer Parent Leader Training Program</td>
<td>5</td>
<td>26</td>
<td>Third RSHC project targeted the Cantonese-speaking parents.</td>
</tr>
</tbody>
</table>
Table 8. Community Media Activities delivered by RSHC peer leaders (April 1999 to October 2000)

<table>
<thead>
<tr>
<th>Media Events/Activities</th>
<th>Date</th>
<th># of episodes</th>
<th>Average Daily Reach as per ACNielsen DJC Research</th>
<th># of audiences reached (estimated)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newspaper interview with Sing Tao Daily News</td>
<td>April 99</td>
<td>1</td>
<td>Sing Tao Daily News 54,000 (19%)</td>
<td>19,000</td>
<td>This was the first outreach activity by the peer leaders. The interview promoted the importance of parent-child communication.</td>
</tr>
<tr>
<td>Interview with Ming Pao Saturday Magazine</td>
<td>April 99</td>
<td>1</td>
<td>Ming Pao Daily News 77,000 (27%)</td>
<td>27,000</td>
<td>A special feature article on the RSHC Project and family sex education</td>
</tr>
<tr>
<td>Sharing and Talking at Canadian Chinese Broadcast Corp.</td>
<td>Oct 99</td>
<td>2</td>
<td>Canadian Chinese Broadcast Corp. Data not available</td>
<td>Not available</td>
<td>A collaborative program with a local community agency on parenting issues. The peer leader did 2 out of the total 10 programs.</td>
</tr>
<tr>
<td>Interview with Sing Tao Daily News</td>
<td>Nov 99</td>
<td>1</td>
<td>Sing Tao Daily News 54,000 (19%)</td>
<td>19,000</td>
<td>The purpose was to help recruit participants for the second RSHC Peer Parent Leader Project.</td>
</tr>
<tr>
<td>&quot;Afternoon at the City&quot; Fairchild Radio pre-record programs</td>
<td>Feb 00 to April 00</td>
<td>16</td>
<td>Fairchild Radio 69,000 (24%)</td>
<td>28,000 over 8 weeks²</td>
<td>Sixteen 10-minutes pre-recorded programs that covered the major topics in family sex education and aired over 8 weeks.</td>
</tr>
<tr>
<td>&quot;Afternoon at the City&quot; Fairchild Radio interview</td>
<td>Oct 00</td>
<td>1</td>
<td>Fairchild Radio 69,000 (24%)</td>
<td>10,000</td>
<td>An interview to promote the third RSHC Peer Parent Leader Project.</td>
</tr>
</tbody>
</table>

Based on 284,000 Chinese adults 18+ in Toronto CMA who speak Chinese at home.


2 Estimated calculation based on personal communication (January 10, 2001) with Dr. D. Patychuk, Social Epidemiologist at Planning & Policy Section, Toronto Public Health. According to Dr. Patychuk, there are 100,000 parents of Chinese ancestry in Toronto. The newspaper estimates are calculated based on the readership rate reported by ACNielsen DJC Research. For the radio audience reach, Dr. Patychuk suggested that in Toronto, up to 2/3 of the 100,000 Chinese parents work during the day while approximately 40,000 are at home. Using the 25% audience-reach rate, approximately 10,000 Chinese parents are reached by the radio programs on an average afternoon. Since audience reach usually increases over more days, the entire program of 16 episodes aired over 8 weeks would likely have reached 65% or 70% of the parents at home or approximately 28,000 of them.
Using Media to Promote Participation

Since the RSHC project had a small budget of only $4500, using paid media outreach was impossible. Thus, the project relied on previous working relationships with the Chinese media sector to promote its messages through interviews and community news. Being the first peer-to-peer project that targeted Chinese parents and focused on family sex education, the RSHC project was seen as newsworthy and therefore able to attract the Chinese Media's attention.

Newspaper interviews at the developmental stage of the initial RSHC projects were useful in soliciting response from the community parents. With the very first project, we received a total of 25 applications even though only 15 were able to join the training. Most of the applicants identified the media as the source of referral to the training program. At the end of the training, we were able to connect with the media sector again to organize more newspaper interviews to promote the community outreach activities of the peer leaders.

The media influence on community attitude was significant. Many service providers at TCHEC acknowledged that sexuality was not a topic for open discussions in the Chinese community. Teresa suggested that media promotion helped to facilitate attitude change in the community.

Living in a new society, many parents feel the pressure to be positive and learn more about family sex education. In addition, over the last few years, public health had done public service announcements in the newspaper and the media; these provided the parents with some positive reinforcement. Now parents in the community feel that talking about it is okay, it is not so embarrassing...

This change in attitude led to increased parent participation in community workshops, which in turn influenced the participants’ behavior at home as discussed earlier in this chapter.

In addition to increased workshop participation, the combined strategies of media promotion and community workshops had also motivated many community parents to join the RSHC project to become peer leaders. In October 1999, TCHEC implemented a second RSHC project that targeted Mandarin-speaking parents. Fifteen recent immigrant parents from Taiwan and China joined the project. They stated that they learned of the project through the newspaper articles. When TCHEC started the third RSHC project targeting Cantonese parents in October 2000, 26 parents enrolled. All of these 26 parents reported that they learned of the training.

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9 During 1996 and 1997, Toronto Public Health launched a number of Toronto Talks Sex Health Communication Campaigns in the English-speaking and four other ethnospecific communities. During these campaigns, I have established some close working relationships with the Chinese media sector through paid public service announcement contracts and collaborative partnership activities such as free sexual health education segments on radio.
through direct and indirect contacts with the peer leaders. Eva explained at a meeting, “For this new group, all of them have heard about the project either from the radio and newspaper interviews, or some of them have actually attended the last two community workshops delivered by the peer leaders.”

**Using Media to Promote Sexual Health**

As the profile of the RSHC project increased in the community, the peer leaders were invited to join one of the local community agencies in October 1999 to develop and deliver 2 out of 10 episodes of radio programs that addressed parenting issues. The peer leaders appeared as guests and joined the community worker in discussing family sex education on air.

In February 2000 the project was able to formalize a collaborative program with another local Chinese radio station to develop and delivered sixteen 10-minute pre-recorded episodes of Family Sex Education radio programs, which aired for 8 weeks during February to April 2000. The radio program provided the audience with culturally appropriate information. At the same time, it promoted the use of the AIDS-Sexual Health InfoLine as a resource to the parents in the Chinese community.

The media outreach activities carried out by the peer leaders had generated many positive responses from parents in the Chinese community. One of the counsellors on the Ontario AIDS-Sexual Health InfoLine reported having increased calls from the Chinese community. Most of the Chinese callers identified the Chinese Family Sex Education radio programs or the newspaper articles as their sources of referral in calling the InfoLine. The callers were interested in learning more about children’s sexuality or requested information on community workshops on family sex education.

Many Chinese-speaking community workers and public health staff had also received feedback from community members. Eva, who had worked closely with Chinese female factory workers over the last 10 years, suggested that local Chinese radio stations could be used effectively as venues in providing health information to factory workers, homemakers or other women in the community. She shared with us at various meetings what she had learned from these factory workers.

I ran into a few women in Chinatown. They work in the garment factories where I used to go and do workshops at lunchtime. They told us that they heard our radio programs. Some of them laughed and said, “We listened to the programs in stereo because every radio in our factory was tuned to the same station when the sex education programs were on.”
Another community worker also shared with us that she had heard from a few Chinese women who worked as housekeepers in a downtown hotel. These women workers arranged to have their afternoon breaks at a specific time so that they could listen to the sex education radio programs. During the focus group interview, many of the peer leaders reported positive feedback about the radio programs from their friends. Shui-Yin shared her friends reactions:

Some of my friends heard our programs and asked me questions afterwards. Their feedback was generally quite good. When they missed the program during the airtime, they would go to the website afterwards and listened to the ones they missed. This could be better than workshops since we are able to reach many more people at one time.

The intersectoral collaboration between TCHEC and the Chinese media sector had reinforced a non-traditional venue for promoting health and contributed to increased sexual health information and resources in the community. It also provided the opportunity for the private sector to contribute in community capacity building.

Community Workshops and Outreach Activities

As discussed in Chapter 5, using a scale of 1-6 with 6 = agree and 1 = disagree, 79% of the workshop participants had given a score of 5 or 6 to the ‘usefulness of the presentation content’ (see Table 4). One of the common criticisms regarding immediate feedback or evaluation from workshop participants is that without further follow-up, it is be difficult to assess whether these community workshops have any lasting effect on the participants. To address this problem, we brainstormed with the peer leaders to develop a solution. During each community workshop or discussion group, the peer leaders requested permission from the participants to do a follow-up telephone survey 3-6 months after the workshops. The peer leaders passed a sign-up sheet which stated:

To improve our workshops and further identify community needs, we would like to call you in 3-6 months to find out whether our workshops have been useful in supporting you in family sex education. If you agree to participate in our telephone survey, please write down your phone number and the best time for us to contact you.

Many of the participants agreed to be contacted by phone to provide feedback on the workshops. In the fall of 1999, Toronto Public Health conducted a Phase I program evaluation on the RSHC project. Phase I of the project refers to the planning, implementation, and the early application stages of the project, covering the time period of October 1998 to June 1999 when the
peer leaders had completed their agreed hours of community participation. I worked closely with an external Cantonese/English speaking evaluator to perform a process evaluation on the project.

During April and June 1999, the peer leaders had delivered 8 community workshops and discussion groups, reaching 80 community parents. Fifty-one of the 80 parents (64%) had agreed to a follow-up telephone survey. Working within her limited time and resources, the external evaluator randomly chose half of the 51 community workshop participants for a telephone survey and was able to reach 23 of them. She stated in the report:

> When the community participants were interviewed six months later, 70% of contacted participants have tried to apply what they learnt at home, and all of them felt the workshop was useful in their practice.

When I did a secondary analysis on the original telephone survey data, I was able to identify more detailed information. Of the six parents who had not talked with their children about sexuality, half of them stated ‘my children are still young’ while the other half stated ‘my children did not ask’ or ‘I feel too embarrassed’ or ‘I do not know how’ as their reasons. The 16 parents, who had proactively talked with their children, identified three main areas that the workshops had helped them in providing family sex education: 1. increased understanding of family sex education and children sexuality, 2. increased confidence in talking with their children about sexuality, and 3. increased awareness of sexual health resources. All of the survey participants stated that they would participate in future workshops if time permitted and many of them would like to learn more about adolescent sexuality.

In addition to reaching parents, some of the peer leaders’ outreach activities also reached the grandparents, especially grandmothers in the community. During the annual Chinese Family Health Fair, which was organized by TCHEC and held in downtown Chinatown, the peer leaders were able to outreach to approximately 150 participants through Questions and Answers games and other activities. I wrote in my field notes:

> It was interesting to note that many of the elderly participants at the health fair also stopped to talk with the peer leaders. Some of them shared that they took care of the grandchildren during the week when their sons or daughters were working. Some took bookmarks, pamphlets and pens with them, and said, “I will take these to my children and let them talk to their children.”

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10 At the beginning of the RSHC Peer Parent Leader training, all participants had signed an agreement with TCHEC stating that upon the completion of the training, each participant would contribute at least 20 hours of community outreach effort within the Chinese community. While this agreement was not legally binding, it was a symbol of collective commitment and many of the peer leaders took this commitment with pride.
By using multiple strategies and multiple venues, the RSHC project was able to expand its reach beyond its primary target population to include grandparents who may play a significant role in raising children in many Chinese families.

**Barriers to Empowerment**

While the RSHC project had encountered many empowering experiences, it had also encountered many barriers to empowerment such as conflicting values and systemic inequity in power and resource distribution.

**Conflicting Values**

Because sexuality is a value-laden topic, conflicting values are to be expected in any sexual health promotion work. Some of these conflicts become barriers to empowerment while others lead to disempowerment and marginalization within the community. Eva talked about her own growth as a sexual health educator and the challenges of finding community colleagues who had positive attitude towards sexuality.

Even for myself, it took quite a bit of time for me to change my own beliefs, which I brought from Hong Kong. For example, when I was in Hong Kong, we believed that homosexuality was a fixation with same sex relationships and that gay people just could not go beyond that fixation. That was what we were taught, and we believed that it was a weakness or an emotional handicap instead of seeing it as something natural. Since we were trained to think that way, we also said those things in workshops. Now when we are here, some workers would wonder why it is different here. We need to sort through all these misconceptions ourselves because if we are not able to sort it out, we cannot come out and talk to others. I cannot talk about something I don't believe in. So this is an issue. There is a lack of community workers who can come out and talk about sexuality in a positive way.

Eva's reflection and concerns regarding a shortage of Chinese service providers with positive attitude towards sexuality was also reflected in the journal of one of the peer leaders. Wai-Ling wrote about her interaction with a neighbor.

Recently, I talked with a neighbor about sex education. She told me that she once joined a workshop on sex education, and the presenter was a social worker. She thought that she would be able to learn some methods on how to educate her children, but the presenter did not answer the participants' questions. At the same time, that worker said that it was abnormal for children to look at pictures
of naked people. She disagreed with this social worker’s views and she felt it was a waste of time, but there was no other way to get this information. I took this opportunity to talk to her about our workshops. I also used what I learned and my own experiences to answer her questions.

As discussed in Chapter 5, homophobia is a significant value conflict that leads to disempowerment and marginalization. While most of the peer leaders changed their attitude to become much more embracing towards gays and lesbians after they heard the sharing from Albert and Rose, this change of attitude did not come without challenges. Sara, who did not stay with the project after she completed the training, was very upset during this particular session. It was an emotionally volatile situation, as I recorded in my field notes:

However, during the Question & Answer discussion time, one of the participants reacted in a very emotional way. She suggested that there was another side to homosexuality that we did not see. Then she shared with us her experience in learning about homosexuality from her pastor; she learned that homosexuality was abnormal and wrong. She said that her pastor had taken them on field trips to gay bars and gay clubs, where they saw the “sickening” behaviors of men having promiscuous sex with men. She was very emotional, her voice was shaky, and she felt that our presentation was one-sided.

Her sharing led to a lot of confusion and argument. Everyone was speaking at the same time, and the voices were getting louder. As the facilitator, I asked the group for permission to leave my role as a facilitator temporarily so that I could join the discussion on equal ground, just as a participant, so that nobody would feel that he/she was being told what was right and what was wrong. I asked Sara if her pastor had also taken them to the heterosexual bars and strip clubs to see what kinds of sex go on there. She said, ‘no’. I suggested that this pastor’s way of teaching was unfair and contributed to homophobic stereotyping. Some of the other participants agreed while some were confused. Some members calmed down and moved on to asked the mother more questions and I returned to the facilitator’s role.

The training program did not change Sara’s attitude towards homosexuality. When I interviewed her a year and a half later, she spoke positively about the training. She stated that she had learned a lot from the other parents and she really appreciated the resources. However, when I asked her how the program could be improved, she said:
Of course my biggest reaction was the time you brought the gay student and the parent. To me, that was for sure one-sided because you brought one person to shared his own personal experience... I also wanted to hear from someone who had the struggles and how they had walked out of it and become not gay any more... I just wanted a more balanced view, maybe because I had my own values and my religious background... Maybe my bottom line is that homosexuality contradicts what is natural...

However, it was important to note that although Sara could not agree with homosexuality, she felt that family sex education was important and she urged TCHEC to continue to provide more workshops and resources for parents, especially those experiencing language and cultural barriers.

While sexual orientation was one specific topic that roused value conflicts, the RSHC project and the peer leaders had also encountered other value-based barriers. Emily shared in the focus group interview the obstacles she had to go through before she was able to establish the parent discussion groups at her church.

At the beginning when I approached my own church, they rejected my suggestions because they felt that our program did not have any standard or values, and I was quite disappointed because they were segregating the two – us and them... I thought to myself, whether you use the Bible or not, you still have to teach your children about sexuality. But later, they started to learn more about what we do; then slowly six families got together and we started the discussions and they really liked it.

Shui-Yin reported similar reactions from her church, “I approached my church too, but you know what they said, we have such programs already, and our children are much older. They said it in such a cautious way, but when I looked around at church, I saw that there were lots of young children, too.” It appeared that some of the Chinese churches considered the RSHC program incompatible to their religious values. However, the religious value conflicts were not fixed or impossible to change. Although her church initially declined Emily’s offer to do family sex education workshops with the church members, later on Emily was able to initiate some discussion groups, first with her friends who attended the same church.

It was a slow process. When we told our friends that I needed to attend training, they started to ask questions and learned more about what we were doing. Slowly six families of friends got together and we started a discussion group... Then one person told another and another and so on... Others have heard about
it and they asked how come we did not invite them... The group that I am working with now is really good. They acknowledged that our program was not religious based, so they said, let us modify the program to suit our group. Now the 5 couples asked me to provide them with information so that they could make their own materials and put in their own values.

In addition to homophobia and religious value conflicts, the peer leaders also experienced the tension related to society’s values towards professional verses lay knowledge. While all the service providers saw the peer-to-peer approach and the lay knowledge as invaluable, the peer leaders felt differently because of some negative experiences. Kristy, who had invited the peer leaders to her parent groups, expressed a similar opinion about the importance of peer-to-peer interactions and lay knowledge.

Of course, some people may feel that a professional speaker has more knowledge and information, but his/her daily experiences may not be as relevant. The participants need strategies that they can really use. So, when the peer leaders share their own experiences, the participants may say, “Oh, my children used to do that too; may be I can try this method.” The participants may be able to identify more with the information given by the peer leader.

Although the peer leaders had also identified peer-to-peer sharing as beneficial and important, they were sometimes discouraged by some of the negative community responses towards their lay knowledge or status. Shui-Yin recalled her unsuccessful attempts in establishing partnership with some of the Chinese tutoring services where a lot of parents come through around. She shared in the interview, “Last year, I tried to contact them, I gave them the flyers and information, and they were interested, but at the end, they invited someone else because we do not have the same credentials. We are only volunteers.”

This tension of credentials and professional knowledge sometimes affected the peer leaders’ confidence in their community outreach activities, as one of them wrote in the post-workshop reflection form: “Would information such as statistics provide a sense of authority or professionalism? If we can provide this type of information, would the speakers be more confident and would our talk be more convincing to the speakers and the audiences?” During the focus group interview, Shui-Yin suggested, “If the workshops or programs are organized by Public Health, then people will think that it is more legitimate, especially when we approach the principles, who are from the mainstream community. If you tell them TCHEC, they may not know what it is.” Most of the peer leaders agreed and one of them said, “If we advertise Public Health as the organizer, it sounds more holistic and healthy.”
Systemic barriers

Other barriers to empowerment encountered by the RSHC project were more subtle and systemic. The TCHEC service providers and the peer leaders all identified the lack of culturally and linguistically appropriate sexual health resources as a concern. Dr. Patychuk (personal communication, January 10, 2001) estimated that there are 100,000 Chinese-speaking parents living in Toronto. Although the RSHC project had contributed to an expansion of resources, project members felt that the needs for sexual health information in the Chinese community had not yet been met. The TCHEC service providers suggested that the ongoing requests for community workshops reflected the immense needs in the community. Sara, who worked in a central location, identified the growing needs among the newer Chinese immigrant families in the downtown area of the new amalgamated city.

For example, would your group be doing workshops in the eastern part or downtown of the city? I am concerned about the lack of resources, and I would put the emphasis on those regions where nobody is doing any work at all... to make sure that someone is doing some ongoing work or at least once a year.

On the other hand, Teresa who worked in Scarborough also identified the needs of the growing number of Chinese parents in the suburban regions.

With the first project, we focused on Cantonese speaking. When we provided the workshops in downtown, people came from uptown, but there might be lots of needs among people at other areas, like Scarborough, North York, and even York Region. Because we do not have the resources or support from other agencies, and we have limited human resources, we could not go to such a big area. You know that the Chinese community in Toronto is actually spread in different areas, so this is a challenge.

In addition to the increased needs of workshops in the Chinese community, Teresa felt that other educational materials and resources were also lacking.

Right now, we have fact sheets and some basic information on the sexual growth and development of children between age 0-12, but is having fact sheets enough? As I have said before... we also need books and audiovisual materials. Not everyone will come out to a workshop, but if these are available in the library, then parent can access the information...”

Eva and Felicia were more concerned with the lack of human resources and the politics in partnership projects. While the RSHC project had been managed successfully by TCHEC and the four agencies involved in the project had been working effectively together, this working
relationship was not guaranteed. Eva talked about the challenges of doing partnership projects, "Actually at the time, Felicia had to work extra hard because this project was additional to her regular work. It was the same for Teresa whose work was not in the sexual health area; she had to take this work on as an extra project."

Felicia suggested that the flexibility of how each partnership agency contributed to the project made it possible for her to join the project.

I really appreciated how each agency could contribute its time and resources differently. If you demand all agencies agency to contribute equally, I don't think it would work. Each agency will allow different amount of staff time for different projects. When we started this project, we all had the same vision, and we were all willing to contribute in whatever way we could. But I think this could change. It is not guaranteed because the agency could change its commitment... I think funding is also an issue, it affects how much staff time an agency is prepared to commit; if the agency comes in only as a committee member, then the amount of staff time it commits would be very limited. Also, when there are staffing changes in the agency, we have to wait and see how much support there will be for the project; these are the practical issues."

Eva and Felicia's concerns were based on good reasons. At the beginning of the RSHC project, Felicia experienced a difficult time negotiating with her manager for time to participate in the project. Her organization did not see family sex education as part of its programming mandate. Also, since none of the partner agencies received funding for the work involved in this project, the worker had to justify their participation or involvement, just as I had to justify the need of the RSHC projects at TPH.

By the time I conducted the focus group interview, Teresa had left to work at another agency. Since her new workplace was not a member of TCHEC and the nature of her work had changed, she could no longer participate in the RSHC project. At the same time, the partnership organization that Teresa used to work at went through restructuring and strategic planning. The new staff who replaced Teresa could no longer be involved with the project in the same way as Teresa did. In January 2001, Felicia had also found a new job in the community. We were told that the new staff, who replaced Felicia, would not be involved in the RSHC project. A reason had not be disclosed or identified. Fortunately, Felicia could continue to represent her new organization at TCHEC even though the nature of her new job was different. Her new role was to oversee and co-ordinate the development of health resources for the marginalized communities and her involvement with TCHEC was supported by her administrator.
Looking into the Future

Despite the barriers and challenges, the future of the RSHC project is bright and positive. As some of the original partnership agencies changed their priorities and their degrees of involvement with the project, other TCHEC member agencies had joined the RSCH project to take on new responsibilities, as Eva commented,

And when we talk about staff changes, this is actually something that is happening at TCHEC... people have actually left their organizations so that new people are coming in. Members of TCHEC had been together for more than 10 years but suddenly almost everyone is gone. So this is pretty hard. Of course, old members are gone, but our values remain the same so I think it would be okay. We just have to take time to mentor new people.

At the same time, the budget constraint at TPH had brought both challenges and new opportunities. In the fall of 2000, I was able to negotiate only half of the seed funding to continue with the different ethnosepecific RSHC projects. The seed funding for each project had been reduced to $2500 from the original $4500. I worked with my TPH colleagues and community partners from the Chinese, Portuguese, Spanish, Tamil and Vietnamese communities to identify solutions and explore new sustainable resources to continue the much needed work in these communities. The various RSHC projects participated in a brainstorming session in October 2000. During this session, community workers and peer parent leaders from each project shared their successes and challenges. Despite their cultural differences, all five projects shared a similar vision. At the end of the meeting, all the five RSHC projects agreed to join each other to form a multicultural project and to work together towards obtaining sustainable funding to continue their work. Each project had also agreed to contribute $500 out of the $2500 seed grant towards hiring an external consultant to explore funding sources and to complete grant applications on behalf of the group.

In the area of resource development, the first group of Cantonese RSHC peer leaders had expressed interests in developing audio-tapes as resources for the community parents. The idea came from their participation in the radio programs. They identified audio-tapes as an important resource for parents who are constantly working and have little time to sit down and read. They also felt that tapes are useful for parents with low literacy skills. The Mandarin peer leaders from the second RSHC project also shared the enthusiasm of developing audio-tapes as resources for the communities parents. As a result, the 3 projects had pooled their resources and began the process of turning their ideas into a goal. In January 2001, Eva and I met with the executive director and staff of a TCHEC member agency to discuss the possibility of sponsorship for this
project. We had a verbal commitment from the executive director, who would bring this proposed project to his board of directors for approval.

In terms of outreach and community education, the RSHC peer leaders had continued to participate in community events. In our February meeting, the peer leaders, who had returned to the work force, reported that they had continued to talk with other parents in their own social circle. Some of them said, "It is like a second nature to us now. We cannot do anything but talk about this." Despite the value conflicts related to culture and religious beliefs, Emily had started a momentum at her own church. She worked with other families at her church to integrate their religious values into sexuality education and conducted workshops for parents at her church. Because of the shared values and common beliefs, she was able to gain the trust of these parents and started a process of exchange, which hopefully would lead to greater understanding of the different controversial issues on human sexuality.

The presentation on the "Coming Out Experience" by Albert and Rose was so successful that the second and third RSHC projects also used the same strategies to address homophobia in their training. They invited other guest speakers from GenerAsian Together to talk to the peer leaders. Through this process, TCHEC had established a positive relationship with GenerAsian Together and hoped to partner in doing anti-homophobia work in the future.

In the coming months, I will be working with Kristy to develop a similar empowerment education model for East and Southeast Asian women to address mental health issues. I have also met with a group of Chinese parents, whose children are developmentally challenged, to explore how TPH and TCHEC could support them in developing a parent-to-parent family sex education project.

Discussion

Although the RSHC project had been established for only 2 years when I completed the data collection for this case study, it has demonstrated some unique characteristics of the process and outcome of community empowerment. The literature suggests that an empowering organization inspires growth, encourages collectivity and provide opportunities for leadership and expanded roles (Bernstein et al., 1994; Fawcett et al., 1995; Keiffer, 1984; Speer & Hughey, 1995). Based on these effects, TCHEC was an empowering coalition. The RSHC project was effective and successful because of the shared vision and values among the TCHEC members. In managing the RSHC project, TCHEC granted the project members autonomy without compromising public accountability by establishing a set of evaluation mechanisms for the outreach activities. At the same time, it fostered an egalitarian relationship in which all members of the project participated in the planning and evaluation of the outreach activities. The RSHC
project also provided the peer leaders with opportunities to develop leadership, take part in decision making and expand their roles beyond community outreach activities to becoming co-facilitator of the other RSHC projects.

The RSHC project had achieved some degree of empowerment, which was reflected in an increase in intersectoral and interagency collaborations, human and educational resources, access to sexual health information and community participation of parents in the Chinese community. More importantly, this case study demonstrated the importance of using multiple strategies in health promotion (Nutbeam, 1998). By collaborating with the media sector, the RSHC project was able to reach a large population in the Chinese community to raise awareness and to increase the community’s comfort level in addressing children’s sexuality issues. The media outreach and education activities had also provided sexual health information to a large number of parents in the Chinese community. These activities were of particular importance in reaching community members who would otherwise had little or no access to the sexual health information due to social isolation and language/cultural barriers.

Airhihenbuwa (1994) suggests that many health promotion programs fail because the interventions are not relevant to the target communities. In a controlled study of women in prenatal care, Glazier et al. (1997) have found that health information provided in English is not beneficial to women who do not speak English at home despite their proficiency in English as a second language. Thus, health promotion materials, programs and information must be congruent with the cultural and linguistic dynamics of the specific community to be effective. When the peer leaders participated in producing the radio programs and the health promotion materials, they helped to ensure the program and material relevancy; at the same time, they also become empowered in the process of participating in these innovative and creative activities (Rudd & Comings, 1994; Wang & Burris, 1994).

In additional to intersectoral collaboration with the Chinese media, TCHEC also worked closely with other community organizations to promote family sex education through community workshops and outreach activities. Kegler, Steckler, McLeroy and Malek (1998) suggest that high quality action plans are associated to a coalition’s ability to mobilize resources and carry out activities. In the case of the RSHC project, TCHEC had developed a concrete action plan which involved networking and collaborating with relevant community agencies throughout its recruitment, training and community outreach/education phases. This concrete action plan was essential, not only in developing skills among the peer leaders and the facilitators, but it also enhanced efficient use of community resources and increased the community’s capacity to meet the needs of its members. The inter-organizational collaboration contributed to an increased
sense of community ownership among all the collaborating agencies. Instead of exhausting the limited resources of the RSHC project, the community partner agencies took on their roles in workshop promotion, participant recruitment and other administrative functions, resulting in effective and efficient use of existing community resources.

As the peer leaders matured, they have become invaluable sexual health promotion resources in the Chinese community. However, these newly gained resources must be handled with caution. One of the major concerns expressed by the service providers and the peer leaders in the RSHC project was the lack of culturally and linguistically appropriate sexual health information and resources in the Chinese community. This lack of resources reflected the inequitable distribution of power and resources in our health service sector. While the increase in sexual health resources resulting from the RSHC project was a significant step towards ‘self-reliance’ in the Chinese community, this self-reliance must not be confused with ‘self-sufficiency’ which is often used by those in power to justify the inequitable distribution of resources. As Labonté (1999) points out, self-reliance is the ability of a community group to negotiate effective interdependencies with external professionals, organizations and institutions. Thus, TCHEC and the RSHC project must continue to negotiate for equitable distribution and effective use of resources.

The process of community empowerment in the RSHC project was not without challenges and barriers. It is important for us to recognize that each community is diverse with members whose identities are derived from a combination of factors such as class, religion, gender, ethnicity, sexual orientation, professional or special interests, etc. (Naidoo & Wills, 1994). The diversity and power relations within the community can generate conflicts and dissensus. Therefore community empowerment must be negotiated in the context of equity and social justice to ensure that community actions and solutions do not reflect racism, sexism, homophobia, or any other oppressions (Robertson & Minkler, 1994). During the RSHC training program, sexual orientation emerged as a topic that generated intense value conflicts. When the trainers brought in a gay person and the mother of a lesbian as guest speakers on the coming out process, Sara, one of the training participants accused the trainers of being biased and demanded equal opportunities for guests speakers who could tell the “other” side of the story. I argue that the RSHC project was correct in only inviting guest speakers from GenerAsian Together because of the pervasive homophobic attitude in the Chinese community and the larger Canadian society. Equality based on oppressions does not constitute social justice and equity. Sara’s strong reactions and her description of how some religious leaders promoted homophobia in their congregation affirmed the need for TCHEC to do more anti-homophobia work in the community.
Another value conflict experienced by the peer leaders was in the area of professional expertise versus lay knowledge. While the peer leaders reported many positive community outreach experiences and recognized the values of peer-to-peer sharing, some of them also experienced self-doubt and expressed concerns regarding how the community parents perceived their lay knowledge. These concerns were understandable. The superiority of "professional expertise" is deeply rooted in the positivism of modern science (Eakin, et al., 1996). Despite the increasing awareness of the potential contribution of lay knowledge towards our understanding of health behaviors, public health science is still dominated by medical epidemiology that focuses on the probability of clinical diseases and lay knowledge is still considered inferior to that of the experts (Popay & Williams, 1996). Because the production of knowledge is connected to power relations and power acquisition, the marginalization of lay knowledge perpetuates the inequitable distribution of power and resources in society (Lather, 1991). It denies citizen participation in the development of health policies that impact on their health and the services that they receive.

To facilitate empowerment, service providers need to develop an egalitarian practice which recognizes the existing competencies in individuals/communities and promotes participation that enable individuals/communities to take better control over their health (Simons-Morton & Crump, 1996; Israel et al.1994; Wallerstein, 1992). At the same time, we also need to dismantle the depolarization of the professional versus lay members and recognize the specific roles of the service providers as advocates and facilitators of empowerment. In reality, service providers are more connected to and have better access to the source of power and resources. As in the case of the RSHC project, my position as a TPH staff made it possible for me to negotiate for the seed grants at work and access printing resources for the project. The RSHC project was effective because all the project members took on specific roles and worked together in ways that influenced, supported and empowered each other.

Perhaps the greatest tension experienced by the RSHC project facilitators including myself was the power relations within our own organizations and our social location within the larger society. All of us agreed that the success of the RSHC project was significantly related to the positive and effective working relationship of all TCHEC members. However, to understand the complexity of community development and empowerment, it is necessary to examine TCHEC membership at two levels – the representatives who were the working members of TCHEC and the organizations they represented. Almost all the working members of TCHEC were of Chinese ancestry and bilingual in Chinese and English. Our common historical, social and ethnocultural backgrounds and our similar interest in human services contributed to the development of a common vision and shared values. However, these values and vision did not
necessarily reflect those of the organizations we worked for. Some of the TCHEC members
worked in the Chinese-only service agencies while others worked in “mainstream” organizations
that provided some ethnospecific services. I argue that both groups experienced systemic
inequities but in different ways.

Despite their desires to contribute to the community, TCHEC working members from the
Chinese-only agencies often found it difficult to take on additional workload related to the
various coalition initiatives due to the lack of resources at their own agencies. Lee (1999)
suggests that most front-lined workers in the immigration and multicultural sector are racialized women who work for low wages with few benefits. The agencies they work for are often under-funded and operate with minimal core funding. Job security is minimal because the agencies have to rely on project grants from difference sources to sustain its service provision. Within the RSHC project, Eva’s work situation resembled this category.

Many cultural specific front-line workers in “mainstream” community organizations, which provide some multicultural services, are also racialized women who are seldom included in the organizations’ decision-making process. Their jobs are also dependent on project grants because these ethnospecific services were not the original mandate of the organizations. As the populations of their service area became diverse, these organizations looked for additional funding to provide services to meet the emerging needs of the communities, but many of them did so without ever changing the original internal power structure or service delivery framework. As a result, these ethnospecific workers became marginalized within the organizations and most of them had very little autonomy in defining their work in relation to the community needs. Felicia and Kristy were working within these types of constraints when they participated in the RSHC project. They had to justify and seek continuous approvals from their managers before they could participate in the RSHC project.

As a working member of TCHEC and a representative of TPH, I experience similar challenges as Felicia and Kristy. However, because TPH is part of the municipal government, I have comparatively more access to resources than my community colleagues did. Felicia was absolutely right when she said that partnership in the RSHC project was possible because it

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11 Lee (1999, p. 103) defines racialization as a socially constructed concept of “race” which has resulted from historical and cultural processes. Racialized people are classified as different, “using different phenotypical, cultural and behavioral markers as signifiers, and then treated as subordinate.” As I conducted this case study, I became increasingly aware of the inadequacy of using the word “immigrants” to describe immigrants of color because of the different sets of struggles and oppressions they are faced with when compared to their white counterparts. For examples, regardless of their citizenship status, racialized immigrants and their children will always be perceived and treated as “immigrants” and “new comers” whereas white immigrants from US are often perceived as Canadians even if they choose to retain their US citizenship.
allowed the four agency representatives to contribute differently according to their own capacities. In many occasions, we all did some of the project work with our own time because we were caught between the tension of insufficient work time allowed and our strong desires to contribute to our marginalized community.

Zimmerman (1995) suggests that empowerment is a dynamic variable which must be contextualized. In the case of the RSHC project, all the facilitators including myself, experienced empowerment during the process of developing, implementing and evaluating the project. However, within our own organizations, we were faced with many systemic challenges and barriers because of the existing inequitable distribution of resources and power. Most of our organizations have not yet adopted a practice framework that embraces diversity, access and equity. As a racialized woman and a public health staff, I had to put in extra effort to advocate for services for the marginalized communities and in many occasions, I experienced disempowerment during the process of negotiation.

Despite these barriers and challenges, the RSHC project was empowering and to a limited extent, TCHEC had facilitated community empowerment. I argue that empowerment is achievable because power is an expanding resource. As the RSHC project matured, we were able to share our learning and resources with other communities and support the development of other RSHC projects. When faced with the reduction and potential loss of funding from TPH, TCHEC had expanded its collective actions to work with other ethnospecific communities to explore other funding sources and acquire other resources. I believe this expansion of collective action among the five communities will strengthen TCHEC as a coalition and enhance its capacity in community networking and mobilization.

**Summary**

In this chapter, I have described the characteristics of TCHEC as an empowering coalition and how community empowerment was achieved through multiple strategies such as community education, intersectoral collaboration and community partnership. I have also described the challenges and barriers to empowerment, including value conflicts and systemic inequities. In the final chapter, I will describe the lessons learned from this case study and identify strategies that facilitate empowerment in health promotion and nursing practices.
CHAPTER 6: CONCLUSION AND IMPLICATIONS FOR PRACTICE

A Village Glowing with Light

Years later, Siu-Mui and her family had moved away from the village at the foot of the Seven-Star Hills. Some said that she had become the first female advisor to the Great Judge at the Imperial Court. The children in the village did not seem to remember Ying-Ying or the Magic Lamp. They only talked about the Great Lady who sent them books and barrels of lamp oil at each New Moon when the sky was velvety black with shimmering stars. From afar, one could see the light of oil lamps flickering through the windows of all the houses in the village, and by the Kwai-Fah River, thousands of fireflies were dancing to the echoes of children's songs...

Overview of the Major Findings

Through the voices and accounts of the peer leaders and service providers, this case study has described the struggles and challenges that racialized immigrants are faced with during their immigration and settlement processes. Systemic racism and sexism have created structural, social and economic barriers that prevent them from integrating successfully into Canadian society (Creese, et al., 1999; Pendarkur & Pandarkur, 1996). Studies have shown that social isolation, economic alienation, underemployment or unemployment, discrimination and marginalization contribute to the experience of powerlessness among marginalized groups. This powerlessness generates a sense of low control and prolonged stress, which lead to physiological deterioration (Seeman & Lewis, 1995; Chandola, 2000). It was against this backdrop of challenges and barriers that the RSHC project has demonstrated the significant impact of community participation on individual and community empowerment.

Unlike other case studies on empowerment, this study focused on immigrant parents in the Toronto Chinese community. The peer leaders’ experiences in the immigration, settlement and integration processes have brought forth a different set of dimensions to the concept of empowerment. While the empowerment literature often speaks of “raising consciousness” and “achieving political power”, I suggest that for many racialized immigrants and new Canadians, these goals are not within their reach until they have achieved a certain level of integration in the Canadian society. Thus, empowerment must first be achieved through skill development, increased self-efficacy and strengthen social support, which eventually lead to better social integration (Berry, 1997).

In the case of the RSHC project, community participation had contributed to improved health among the peer leaders. Many of them reported better management of anger, feeling more relaxed
and experiencing less insomnia. Their increased skills in parenting, communication and problem solving led to an improved sense of self-worth, increased self-efficacy, better family relations and greater control of their lives. The decreased social isolation and increased mutual support contributed to their improved mental health status. In addition, through their interactions and participation in community activities, the peer leaders had opportunities to rediscover their abilities and capabilities. As a result, some of them were successful in finding employment which would contribute to further social integration.

Although the RSHC project did not raise consciousness that led to conventional 'political' actions, it had helped the peer leaders to better understand the impact of systemic discriminations such as racism, sexism, classism and homophobia on the health of individuals and the community. Many studies have documented that parent-child discussions on sexuality are associated with the children's development of self-esteem, sexual attitudes/values and adoption of gender roles (Brage, Meredith & Woodward, 1993; Werner-Wilson, 1998; Witt, 1997). Therefore, I argue that the peer leaders' reflexivity would impact directly on the sexual health of their own children and indirectly on other children, through their outreach activities to other parents in the community.

In addition, this case study has found that individual and community empowerment are intertwined. As identified in other empowerment literature, when the peer leaders participated in the RSHC project, they slowly developed a relationship of mutual support and collective vision (Israel et al., 1994; Ovrebo et al., 1994). However, empowerment cannot be achieved without the support of an empowering organization (Speer & Hughey, 1994). By encouraging autonomy, interdependence and collective actions, providing leadership opportunities and sharing decision-making, TCHEC was able to facilitate organizational empowerment through the RSHC project and expand its resources and capacity to meet the needs of the community.

In recent years, health promoters are increasingly aware of the importance of using multiple strategies such as community participation, partnership, empowerment and capacity building to promote health (Raeburn & Rootman, 1998). This case study has confirmed the positive effects of using multiple strategies to promote health. Despite its limited resources, the RSHC project was able to encourage community parent participation and shape community thinking through community outreach activities, empowerment education, community partnership and intersectoral collaboration. The successful use of the Chinese media by the RSHC project to promote family sex education and parent-child communication was a significant finding. Collaboration with the media sector in ethnospecific communities may be an important health promotion strategy, especially when these communities are often faced with a lack of culturally and linguistically appropriate health information and materials.
Most importantly, by using multiple strategies, the RSHC project has demonstrated an effective and efficient ways of resource utilization. With a seed grant of $4500, the project was able to combine both a community education approach and a population health approach (see Tables 7 & 8). Through community workshops, discussion groups and health displays, the peer leaders were able to reach over 800 community parents in person, and over 50,000 parents through their media activities. In addition, through partnership and collaboration, the project was able to produce culturally and linguistically specific resources such as training manuals, fact sheets, health displays and other promotional items, which were desperately needed in the target community.

Last but not least, this study has identified a number of barriers to empowerment. These barriers were associated with the value conflicts and competing interests within the Toronto Chinese community and the society at large. Like other communities, the Toronto Chinese community is not homogeneous. It is diverse with its own structure of power relations. The RSHC project experienced resistance and tension that were associated with social and religious value conflicts. At the same time, it also experienced structural barriers that were embedded in systemic discriminations and social inequities.

**Implications for Health Promotion and Nursing Practice**

This study has shown that empowerment education programs are useful in promoting health among racialized and marginalized immigrants who experience structural barriers to acculturation and integration. In addition to skills building and knowledge acquisition, these programs facilitate citizen participation, relationship development, mutual support and collective actions.

In developing empowerment education programs, public health nurses and service providers may consider the following:

1. **Providing cultural and language specific programs**: Based on the experiences of the RSHC peer leaders, initial empowerment education programs need to be culturally and linguistically specific. The shared culture and common experiences facilitate a sense of belonging and group identity. In addition, cultural and language specific programs provide a safer environment for participants to listen, talk, identify problems and find solutions. This is especially important among immigrants who experience language barriers since language ability is a means by which individuals and groups negotiate power relations (Lee, 1999). As individuals achieve empowerment and develop collective identity and action, they may then move on to participate in other multicultural programs.

2. **Facilitating self-care and self-development**: As discussed previously, parenting programs tend to attract the participation of immigrant women. To avoid the perpetuation of women being
confined to their domestic and maternal roles, we need to be proactive in integrating self-care and self-development into empowerment education programs regardless of the health topics that are to be addressed. However, it is essential for us to be aware that facilitating self-care and self-development does not mean placing more value on individualism and self-determination which are Western social concepts. We need to respect and support women from cultures that value collectivity, kinship, interconnectedness and interdependence (Drachman et al., 1996). We need to go beyond the dualistic or polarized thinking of individualism versus collectivity. As demonstrated by some of the peer leaders in this case study, self-care and self-development can be achieved without compromising their cultural values on kinship and interrelatedness. In fact, one of them came to realize that “self-cultivation” is a concept that has been deeply rooted in the Confucius tradition and the Chinese culture. Therefore, as service providers, we must support women to define self-care, without imposing our own definitions or values on them. Instead, we can follow the health promotion principles as stated in the Ottawa Charter (1986), that is, to create and advocate for increased participation by women to gain control of and improve their health.

3. **Using Peer-to-peer outreach strategy:** One of the strengths of the RSHC project was its use of a peer parent leader model. However, we need to recognize that an effective peer-to-peer model must have clear goals and objectives, sufficient training and ongoing support for the peer leaders, clearly defined roles and boundaries, expertise in managing outreach activities and multiple-agency support (Walkers & Avis, 1999). We must also keep in mind that “peerness” is a complex concept that is negotiated based on many factors such as social class, ethnicity, religious beliefs, sexuality and gender, etc. (Shiner, 1999). At the same time, we need to recognize that the purpose of peer-to-peer programs is not to replace professional services; instead they complement each other in meeting the diverse needs of the community.

4. **Promoting and practicing reflexivity:** To carry out an empowering health promotion practice, we need to establish egalitarian client-nurse relationships in which we engage in mutual learning, dialogue and reflections. We need to acknowledge the inherent power and privileges that come with our social positions. At the same time we must recognize the relative powerlessness we may experience within our own organizations without projecting it onto their our less powerful clients or community colleagues (Bernstein, et al., 1994, Labonté, 1994).

5. **Recognizing social justice and equity as determinants of health:** When working with marginalized communities, we need to recognize how the existing power relations and structural inequities in Canadian society impact on the health of these communities and their members. At the same time, we also need to be aware that each community is not homogenous. Instead, it is diverse
with members whose identities are defined by one or more factors such as class, gender, sexual orientation, socioeconomic status and other special interests (Naidoo & Wills, 1994). The diverse values, beliefs and power relations within each community often generate conflicts and dissensus. Therefore, community empowerment must be negotiated in the context of social justice and equity (Robertson & Minkler, 1994).

**Implications for Health Promotion and Nursing Research**

This study has confirmed some of the findings documented in the literature on empowerment and immigration/settlement issues. Being a single-case study, the rich data and major findings have provided some directions for future health promotion and nursing research.

1. This case study has focused mostly on the experiences of participation by the peer parent leaders, the facilitators and community parents in the RSHC project and related activities. The major findings of the study confirm that although empowerment is a concept developed in the West, some of the characteristics and components of empowerment can be applied to the Chinese community. However, as discussed earlier, components such as ‘civil engagement’ and ‘political actions’ may not be applicable to marginalized and racialized communities. Future exploration on the concept of empowerment within the context and reality of the marginalized communities will contribute to the development of specific knowledge to guide us in providing relevant and appropriate public health programs/services. In addition, more research studies are needed to identify the necessary conditions and ways that marginalized groups may participate in civil engagement or political actions.

2. Social marketing and health communication have been identified as effective health promotion strategies in the “mainstream” communities (Langlieb, Cooper & Gielen, 1999; Rotheram-Borus, et al., 2001). This case study has shown that the Chinese media was an effective venue to disseminate health information and outreach to community parents. However, there are very few research studies on the use of social marketing and media to promote health in ethnospecific communities. Future studies in this area will be useful, especially when ethnospecific communities are often faced with a lack of culturally or linguistically appropriate health information or materials.

3. Within the limited scientific literature on immigrants, most studies focus on mental health, employment and settlement issues (Creese et al., 1999; Naidoo, 1992, Pendakur & Pendakur, 1996; Schaafsma & Sweetman, 1999). There are comparatively more studies on immigrant women than immigrant men. These studies on immigrant women tend to focus on gender conflicts within immigrant families, social isolation of immigrant women and domestic violence.
(Bui & Morash, 1999; Kim & Grant, 1997; Wong, 1999; Um, 1998). While these studies are extremely important and essential in guiding our practice, the lack of research studies on the experiences of immigrant men can be problematic because women do not live in isolation of men. The health and well being of women, particularly racialized immigrant women, are interdependent on the health and well being of men and others in their families and communities. This case study has identified the need to explore racialized immigrant men's experiences of social isolation and the challenges in negotiating new identities in the contexts of gender, race, class and colonial legacies.

**Conclusion**

This case study has provided a rich description of the challenges and barriers of integration faced by racialized immigrants in Toronto. While the peer leaders might not really know the term “community empowerment” as it is defined in the literature, they have demonstrated that when given the opportunities to participate and acquire skills, they could work together to transform and strengthen their community.

Over time all of us, who were involved in the RSHC project, developed a strong relationship that was based on mutual respect and support. Together we traveled on a journey of self-discovery and self-cultivation, in which we recognized our existing competencies, capabilities and collective strength. As we all acquired new skills and became more anchored, we were able to go beyond our individual sense of “self” and developed a common vision and a commitment towards of sharing our “wealth” of knowledge and experiences with others in the community. Our collective wisdom was embedded in Emily’s quotation of Confucius:

“Sau Son Chai Gah Ji Gwog Ping Tin Ha”

“To bring harmony to the world, govern the nation, manage the home,

修身齊家治國平天下

one must first cultivate the self.”

When we look deeply into our “self”, we may recognize the interconnectedness of all things and all beings; we may realize that the true “self” cannot be separated from the social, political and physical environments. Thus, as we achieve individual empowerment, it is natural that we will continue to go beyond our own immediate environment to participate and contribute at the community, nationally and global levels.
EPILOGUE

In doing this case study, I also went through a journey of empowerment. My interactions with the peer leaders and community colleagues have helped me to look deeper into the meaning of being a public health nurse in the City of Toronto, where social inequities such as poverty, discrimination and marginalization exist. This journey reaffirmed my passion in advocating for accessible and equitable health and social services for marginalized and underserved groups in our city. It made me realize that empowerment within TPH is a necessary condition for us to provide empowering programs and services. In October 2000, I had decided to take on the challenge and accepted a secondment to develop Access and Equity Policies at TPH.

Ironically, as I am finishing this chapter, the dark clouds over TPH has not been lifted. In her State of the City’s Health 2001 Report, Dr. Sheela Basrur, Toronto’s Medical Officer of Health, spoke of the growing poverty and homelessness in the city and the negative impact of social and economic disparities have on the health of individuals and their communities (Toronto Public Health, 2001). While TPH is undergoing program redesign with the goal to harmonize services across the whole city, the division is once again faced with budget reduction. The City of Toronto has to deal with a budget pressure of $305 million on a gross operating budget of $5.9 billion, resulting from “increased cost of delivering services because of salary and benefit increases, higher utility costs and other inflationary costs, as well as downloading in such areas as social housing, child care and the transfer of the Provincial Offences Act” (City of Toronto, 2001).

However, I am hopeful that as each TPH program goes through redesign, the crosscutting programs such as Access and Equity and Quality Assurance will be integrated into program development, implementation and evaluation. TPH has a long history of leadership in health promotion and community development. I believe the current turmoil and aftermath of amalgamation are only temporary. It is through crises that an organization may experience renewal and rebirth, and that is my hope for TPH.
REFERENCES


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Appendix A: Letter of approval from the Toronto Chinese Health Education Committee

多倫多華人健康教育委員會

Toronto Chinese Health Education Committee
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Ms Josephine Wong
MSc Student, Faculty of Nursing
University of Toronto
Health Education Consultant – AIDS Prevention
Planning and Policy Section
Toronto Public Health
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May 1, 2000

Re: Research Proposal

Dear Ms Wong,

As Co-Chairs of the Toronto Chinese Health Education Committee, we have reviewed your research proposal and presented it to Committee members at our recent meeting. Committee members took great interest in the proposal and in-depth discussion ensured. They feel that the study would make major contribution to cross-cultural health promotion and education, as well as community development through the narratives and lived experience of the informants. However, in view of the qualitative nature of the study, concerns were expressed regarding the generalizability and applicability of the findings to the larger Canadian Chinese community and members of other multicultural communities. We trust that you and your thesis committee would address these methodological issues and limitations of the study.

The Committee voted unanimously to support the study. We agree to give you approval to interview the 10 peer leaders, 4 participants that did not complete the program and the members of the Toronto Chinese Health Education Committee’s Sexual Health Ambassador Subcommittee that oversees the Peer Leader Project. We also give you permission to utilize documents such as project evaluation forms, participants’ attendance records, project-training manuals, meeting minutes and community workshop evaluation forms for the purpose of the study. However, the willingness to participate in the study would be strictly the decision of individuals, and this Committee would play no role in influencing their decision.

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We believe this is a groundbreaking study addressing a series of questions that are important for the health promotion endeavors to the increasing multicultural Canadian mosaic. We look forward to our collaboration. Should you require further assistance please do not hesitate to contact either one of us.

Yours sincerely,

Ruth Lee, Co-Chair

Phyllis Lam, Co-Chair

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Appendix B: Letter of approval from Toronto Public Health

August 15, 2000

Ms Josephine Wong
Health Education Consultant
175 Memorial Park Ave
Toronto ON

Dear Ms Wong,

You recently submitted a request Toronto Public Health for permission to conduct your graduate research *Empowerment through Community Participation* with our co-operation. I received the ethics approval from the University of Toronto and co-ordinated our review process in which anonymous reviewers further assessed your proposal for relevance and feasibility and for scientific and ethical integrity. I am pleased to inform you that Toronto Public Health is willing to co-operate in this matter.

I want you to know that reviewers recognized great strengths both of your proposal and of the proposed project.

- **This is a most worthwhile project. A descriptive case study is certainly an appropriate design. I am confident that the quality of the research will be enhanced by the prior involvement of the researcher in the demonstration project.**
- **The proposal was well conceived with clearly stated research question.**
- **This is an exemplary proposal that draws on the researcher’s personal heritage, her professional practice and her academic pursuits. I look forward to reading what I am sure will be insightful findings.**

And so to reiterate, Toronto Public Health will be pleased to co-operate with you over the next sixteen months as you complete your research. This consent, of course, is granted on the condition that you proceed with your work as set out in the proposal submitted for review. Should you find it necessary or advisable to deviate from the project as approved you should immediately notify me in writing of any proposed change as a further review may be required. Should you need co-operation from TPH beyond December 2001, please forward a request for any needed extension in writing to me as soon as that situation becomes apparent to you. I wish you success in this intriguing and worthwhile research endeavour and look forward to reading your thesis once you have completed it. If you have any questions do not hesitate to contact me at 338-2295.

Sincerely,

[Signature]

Rouleen Wignall, PhD.
Manager (Acting)
Education and Research
590 Jarvis Street
Toronto ON
Appendix C  
Peer Parent Leader Demographic Form

1. Gender/Sex:  
   F ( )  
   M ( )  
   Other ( )

2. Age: __________

3. Marital Status:  
   Single ( )  
   Married ( )

4. Common-law ( )  
   Separated ( )

5. Divorced ( )  
   Other ( )

6. What is your citizenship/immigration status?  
   Canadian citizen ( )  
   Landed immigrant ( )  
   Other ( )

7. How long have you been in Canada? ________________

8. How many children do you have? ________________

9. What are the age(s) of your children: __________________________

10. Who do you live with at present? __________________________

11. What is your highest level of formal education? __________________________

12. What other informal education/training or skills have you acquired? __________________________

13. Were you employed before immigrating to Canada?  
   No ( )  
   Yes ( )

14. If yes, what was your occupation? __________________________

15. Are you currently employed?  
   No ( )  
   Yes ( )

16. If yes, you are working  
   Full-time ( )  
   Part-time ( )

17. What is your occupation? __________________________

18. How many hours of paid employment do you work each week? _______

19. Are you seeking employment?  
   No ( )  
   Yes ( )

20. How many hours per day do you spend on parenting activities? _______

21. How many hours per day do you spend on taking care of the family? _______

22. How many hours per day do you spend on self-care? _______

23. Prior to joining the Peer Parent Leader Project, many hours per week in average do you spend in community participation? _______

24. Since you joined the Peer Parent Leader Project, how many hours per week in average do you spend on community participation? _______
Appendix D - Demographic Form: Peer Parent Leader (Chinese)

家長大使個人資料

1. 性別: 男( ) 女( ) 其他( )
2. 年齡: _______
3. 婚姻狀況: 單身( ) 已婚( )
   同居( ) 分居( )
   離婚( ) 其他( )
4. 你的公民/移民身份是: 加拿大公民( ) 移民( ) 其他( )
5. 你來了加拿大多久? ________________
6. 你有多少個孩子? ________________
7. 你的孩子年齡分別是: ________________
8. 你跟誰人一起住? ________________
9. 你的最高學歷是: ________________
10. 你有甚麼其他非正規教育/培訓或其他技巧? ________________

11. 在移居加拿大前你是否受僱? 是( ) 不是( )
12. 若曾受僱，當時的職業是甚麼? ________________
13. 你現在是否受僱? 是( ) 不是( )
14. 若你現在受僱，你的工作時間是: 全職( ) 兼職( )
15. 你現在的職業是: ________________
16. 你每星期的受薪工作有多少時? ________________
17. 你是否正在找工作? 是( ) 不是( )
18. 你每天用幾個小時培育子女? ________________
19. 你每天用幾個小時照顧家庭? ________________
20. 你每天用幾個小時照顧自己? ________________
21. 在未參與家長大使計劃之前，你平均每星期會花幾個小時參加社區活動? ________________
22. 在你參加了家長大使計劃之後，你平均每星期會花幾個小時參加社區活動? ________________
Appendix E
Interview Guide: Peer Parent Leaders

Introduction:
- Review the purpose of the study and information on the consent (Appendix C).
- Review the guiding principles of confidentiality; encourage participant to share freely whatever they wish, but also remind them that there are opportunities for them to share information that they do not feel comfortable to share in a group.
- Explain demographic form and have participants complete the form.

Topics and Questions:
1. Experiences of participating in the project
   (a) What are some of your main reasons for joining the project?
   (b) What were your experiences, thoughts and feelings during the training phase of the project (February to May, 1999)?
      - Positive or satisfying experiences
      - Negative or dissatisfying experiences
      - Individual and group experiences

2. Perception of competence
   (a) In what ways have you been able to use the information, learning or resources from the project in your own personal life (self, family, friends)? And in the community?
   (a) What was it like for you when you started to do community outreach activities (during September to December 1999)? What is it like for you now?
   (b) The project has been going on for over a year now, what are the things that keep you interested in continuing with the project?

3. Perception of the project
   (a) What do you think are the strengths of this project?
   (b) How can the project be improved?
   (c) Would you recommend this project to other parents? Why?

4. Additional comments

Telephone follow-up interview
- What was it like for you to participate in this study?
- For the female parent leaders: Having a male peer parent leader in the group, how does it affect your participation?
- For the male parent leader: How does being the only male parent in the group affect your participation?
- Any additional comments?
Appendix F
Interview Guide: Service Providers

Introduction:
• Review the purpose of the study and information on the consent (Appendix E)
• Review the guiding principles of confidentiality; encourage participant to share freely whatever they wish, but also remind them that there are opportunities for them to share information that they do not feel comfortable to share in a group.

Topics and Questions:

1. Perceived needs of the Chinese community
   (a) How long have you been involved with TCHEC?
   (b) Why did you/your agency participate in the Chinese Peer Parent Leader Project?
   (c) What do think are the needs of the Chinese community in the area of family sex education?

2. Experience of working with the project
   (a) What are your experiences in working with this project?
      - Positive and satisfying
      - Negative and dissatisfying/frustrating

3. Effectiveness of the project
   (a) Based on your observations and experiences working with the project:
      - What are the impacts of this project on the individual peer leaders?
      - What are the impacts of this project on the Chinese community?
   (b) To what extent do you think the peer parent project has met the needs of family sex education and sexual health promotion in the Chinese community?

4. Strengths and barriers
   (a) What are the strengths of this project?
   (b) How can this project be improved?
   (c) Would you, your agency or TCHEC use a similar model to address other health issue? And why?

5. Other comments
Appendix G
Telephone Interview Guide: Non-graduates

1. Background information:

Gender: F ( ) M ( )

Marital Status: Single ( ) Married ( )
Common-law ( ) Separated ( )
Divorced ( ) Other ( )

Did you immigrate to Canada? No ( ) Yes ( )

If yes, How long have you been in Canada? ________________

How many children do you have? ______

What are the age(s) of your children: ____________________________

2. Involvement with the project:

(a) How did you find out about the project?

(b) What are some of your main reasons for joining the project?

(c) What were your experience, thoughts and feelings during the training phase of the project
   (February-May, 1999)?

(d) What are some of the things that you found satisfying/positive in the project?

(e) What are some of the things that you found dissatisfying/negative in the project?

(f) In what ways have you been able to use the information or learning from the project in your own
    personal life (self, children, family, friends)?

(g) What are some of your main reasons for leaving the project?

(h) How can the project be improved?

(i) Would you recommend this project to other parents? Why?

(j) Any additional comments?
Appendix H
Information for Research Participants: Peer Parent Leaders

**Research Title:**
Empowerment through Community Participation – A case study of a Chinese Peer Parent Leader Project in Toronto

**Investigators:**
**Primary Investigator**
Josephine Wong, RN, BA, BScN (Master of Science Candidate), Faculty of Nursing, University of Toronto, (416) 696-5179 or (416) 338-0903

**Thesis Supervisor**
Denise Gastaldo, RN, PhD, Assistant Professor, Faculty of Nursing, University of Toronto, (416) 978-4953

**Thesis Advisors:**
Dr. Geraldine Macdonald, Faculty of Nursing, University of Toronto
Dr. Irving Rootman, Department of Public Health Science, Faculty of Medicine, University of Toronto

**Purpose of the Research:**
I am doing this study to gain a better understanding of your experience in taking part in the Chinese Peer Parent Leader Project and the relationship between community participation and empowerment in the individual and community levels. I am doing this study as part of my degree fulfillment in the Masters of Science Program in the Faculty of Nursing at the University of Toronto. I believe that the findings of this study will help nurses, educators and community workers to plan effective health promotion programs in different communities.

**Description of the Research:**
The research consists of 2 focus group interviews – one with peer parent leaders and one with community workers at Toronto Chinese Health Education Committee. You will be asked to take part in a focus group interview together with all the other peer parent leaders of this project. Before the interview, I will ask you to fill out a consent form for taking part in this study. If you agree to participate, I will ask you to fill out a form that gives me some information about yourself such as age, education and employment, etc. Whether you take part in the study or not, you and your family will continue to receive the same support/services from Toronto Chinese Health Education Committee and its community partners including Toronto Public Health.

**Interviews and Observation:**
The group interview will take about 3 hours. I will ask you some questions about your experience related to joining the project. You are encouraged to talk about your experiences, feelings and thoughts on the project. The interview will be taped so that I do not have to write down everything or forget some of the things you say. The group interview will be followed up by one short individual telephone calls of approximately 5-10 minutes at a time that is most convenient for you. A community colleague who has signed an agreement to confidentiality will assist me in taking notes during the interview.
Use of Project Data:
I will be using project documents, such as training evaluation forms, field notes, reflective journals, meeting minutes, newspaper clips, media interviews/programs, community workshop evaluation forms as part of the research data. Before I utilize these data for the research study, I will ask you to sign a consent form, giving me permission to use any documents that are identifiable with you.

Confidentiality:
Since the interview will be conducted in a group, absolute confidentiality cannot be guaranteed. However, it will be strongly suggested that all research participants will respect the confidentiality of each other. Any information that you disclose will strictly be used for the purpose of this research study and will be kept confidential, except in situations when I am required by law to release the information (for example, information on child abuse cases and/or professional misconduct). Pseudonyms will be used in the written notes and with any direct quote to further protect all research participants' anonymity. All cassette tapes of the interviews, written notes, and computer disks related to this study will be stored in a locked filing cabinet. Information files related to this research on my computer will be password protected. I will be the only person with access to all the information collected for this study. Audio-taped interviews will only be listened to by myself and several support members of my research team. Written notes related to this research will be read by myself, a bilingual Cantonese/English community service provider who will verify the accuracy of my translation, and my research committee (Dr. Gastaldo, Dr. Macdonald & Dr. Rootman) for the purpose of providing me advice, guidance and supervision. All audio tape recording related to this study the written notes will be destroyed after ten years.

Participation:
Participation in this study is voluntary. After you agree to take part in this study, you are still free to withdraw from the study at any time during the research process, and you do not have to answer any questions you do not wish to answer. Whether you take part in the study or not, you and your family will continue to receive the same support/services from Toronto Chinese Health Education Committee and its community partners, including Toronto Public Health.

Potential Harms (Injury, Discomforts, or Inconveniences):
There are no direct risks associated with this research study. It is possible that you may find it difficult or uncomfortable to talk about your feelings and experiences. It is also possible that comments from other members of the focus group interview may be of concern or upsetting to you. If you become uncomfortable, you may end the interview at any time. Sometimes, self-reflection and discussions can lead you to have unexpected changes in thoughts, feelings or actions. If this happen to you and you need to talk to someone for assistance, I refer you to the appropriate resources in the community.

Potential Benefits:
You may not benefit directly from this study. However, many people find the opportunity to share their experiences both enjoyable and rewarding. I also believe that this study will help health educators, nurses, community workers and other professionals better understand the impact of community participation on individual and community health such that they will be able to plan more effective programs in the future.
有關研究須知(供家長領袖)

1. 研究題目
由社區參與促進自強—多倫多華人家長大使計劃個案研究

2. 研究員
學院碩士研究生黃佩卿 (416) 696-5179 或 (416) 338-0903
論文導師: 多倫多大學護理學院助理教授 Denise Gastaldo 博士
(416) 978-4953
論文顧問: 多倫多大學護理學院 Geraldine MacDonald 博士
多倫多大學醫學院公共健康學系 Irving Rootman 博士

3. 研究目的
本人希望能藉著這項研究了解你在參與華人家長領袖計劃的經驗及
社區參與和個人/社區強化的關係。此項研究亦是本人在多倫多大學
護理學院碩士課程的部份要求。本人深信這項研究的發現能協助護
士、教育工作者及社區工作員在不同社區策劃更有效的健康推廣活
動。

4. 研究簡介
此項研究包括兩個討論小組，一個是訪問家長領袖，而另一個是訪
問多倫多華人健康教育委員會的社區工作員。你會被邀請與其他家
長大使一起參與一個討論小組訪問。訪問前本人會詢請你填妥參與
這項研究的同意書。若你同意參與，本人會請你填寫一些有關你的
資料，例如年齡、教育程度、就業狀況等。無論你是否參與是項研
究，你及你的家人仍可繼續享用由多倫多華人健康教育委員會及其
合作團體。，包括多倫多公共衛生署所提供的同等支援及服務。

5. 訪問及觀察
小組訪問需時三小時。本人會向你查詢有關你參與這項計劃的經驗
及鼓勵你表達你對這項計劃的體會及感想。為免遺漏你們在小組討
論時發表的意見，本人會把小組討論錄音。小組討論完成後，本人
將會在一個適合你的時間，進行一個5至10分鐘的跟進訪問。一位
已簽了保密協議的社區同事會協助我紀錄訪問的過程。

6. 計劃資料的用途
本人會用計劃內的文件，例如訓練評估表、計劃進度筆記、大使日
記、會議筆記、剪報、傳媒訪問/節目、社區討論小組及外展活動評
估表作為研究的部份資料。本人引用資料前會徵求你簽署同意書
，讓本人引用與你有關的資料。
Appendix I (continued)

7. 保密
由於是次訪問採用小組形式，難以絕對保密，但本人建議每位參與
研究的被訪者都尊重保密的原則。所有你提供的資料都會被保密、
只會用作研究，除非本人在下列情況（例如：有關兒童受虐或違反
專業操守），被法庭要求提供資料。為進一步保護研究的參加者，
所有訪問筆記及直接節錄都只會用縮名。所有研究的錄音帶、筆記
、電腦磁碟會存放在有鎖的柜內，在本人電腦儲存的研究資料亦會
用密碼保護，只有我本人才能涉取研究搜集的資料。訪問所得的錄
音帶只會由本人及論文委員會及一至二名已簽署保密協議的翻譯評
估員收聽。研究筆記會由本人、一位雙語（廣東話／英語）的社區
工作員閱讀，以證實翻譯的準確性，與及研究委員會（Gastaldo教
授、MacDonald教授、Rootman教授）
，以便提供建議及督導。所有與研究有關的錄音帶及筆記會在十年
後被毀滅。

8. 參與
是項研究的參與全屬自願性。就算你已同意參與此項研究，你仍可
在研究過程的任何一刻自由地選擇離開。無論你是否參與是項研究
，你及你的家人可繼續享用由多倫多華人健康教育委員會及其合作
團體，包括多倫多公共衛生署所提供的同等支援及服務。

9. 可能被引致的傷害（受傷、不適、不方便）
此項研究不會帶給你直接的危險，當你在表達自己的感受或經驗時
，你可能會感到困難或不適，亦有可能在聽到其他小組成員的評語
時，會引起你的關注或使你感到不快。若你感到不適，你可隨時停
止訪問。有時候自我反省及討論亦可能會引出你意想不到的思潮、
感受或行動改變。若發生在你身上而你需要向別人求助，我會轉介
你去適合的社區資源。

10. 可能被帶出的益處
你或許不會在此項研究直接獲益處。但是有很多人發現當有機會
與別人分享經驗時，是一種享受及獎勵。我相信此項研究能協助護
士、教育工作者、社區工作員及其他專業人士更了解社區參與對個
人及社區健康的影響，因而能計劃更有效的健康推廣活動。
Appendix J
Consent Form: Peer Parent Leader (English)

I acknowledge that the research information on the attached pages has been explained to me and any questions I have about the study have been answered to my satisfaction. I am aware of my right not to participate and my right to withdraw from the study at any time without compromising the support/service I receive from Toronto Chines Health Education Committee or Toronto Public Health. I understand that the names and identifying information of myself and my family will be kept confidential and none of this information will be released except in situations when the researcher is required by law to do so, for example, information on child abuse cases, or professional misconduct.

I understand that the interview will focus on my experiences of being a Chinese Peer Parent Leader. The purpose of the study is to explore the relationship of community participation and empowerment in the individual and community levels. I am aware that the research study involves one 3-hour group interview and one follow-up telephone calls of approximately 5-10 minutes. I understand that the group interview and telephone calls will be audio-tape recorded and the interviewer and her assistant will take notes during the interview and the telephone calls. I also know that documents such as training evaluation forms, field notes, reflective journals, community workshop evaluation forms and meeting minutes of the Chinese Peer Parent Leader Project will be used in this research study. When I consent to take part in this study, I also give the researcher permission to use any of these documents for the purpose of this research study.

I hereby consent to participate in this research study which will be conducted by Josephine Pui-hing Wong, a graduate student at the Faculty of Nursing, University of Toronto. I am aware that I can contact her regarding the research at (416) 696-5179 or (416) 338-0903. In the event that I am not satisfied with the information provided, I can also contact Dr. Gastaldo of University of Toronto, at (416) 978-4953.

________________________________________  ____________________________
Name of Participant  Signature

________________________________________  ____________________________
Name of Witness  Signature

________________________________________
Date
Appendix K – Consent Form: Peer Parent Leader (Chinese)

同意書（供家長大使）

本人確認研究員已將隨附頁的研究須知清楚地向本人說明，而本人對研究有關的
任何問題亦已獲得滿意的解釋。本人確認自己有權不參加及有權隨時退出研究，
而由多倫多華人健康教育委員會及其合作團體，包括多倫多公共衛生署向本人所
提供的支援及服務不會因此而受到副面影響。本人明白有關自己之姓名及能確認
本人及家人身份的資料不會被透露，除非研究員在下列情況（例如：有關兒童受
虐或違反專業操守），被法庭要求提供資料。

本人明白此次訪問會集中於本人作為一位華人家長大使的經驗。此項研究之目的
是在於探討社會參與及個人自強及社區強化的關係。本人知悉是次研究包括一個
三小時的小組訪問及一個大約5至10分的跟進電話。本人同意在小組及電話訪問
時接受錄音，而訪問員及其助理會在訪問中做記錄。本人同時明白「華人家庭性
教育家庭教育大使計劃」的文件，例如：計劃進度記錄，大使日記，社區講座評價表
及會議記錄等都會被此項研究採用。當本人同意參與此項研究時，本人亦同時授
權研究員引用任何有關文件以達成研究目的。

本人同意參與此項由多倫多大學護理學院研究生董佩卿所推行的研究。本人認知
可以因與研究有關各方面而致電 (416) 696-5179或(416) 338-0903
與董佩卿聯絡。在過程中若本人對任何提供的須知資料感到不滿，本人亦可致電
(416) 978-4953與多倫多大學的Gastaldo教授聯絡。

__________________________________________  簽名

參加者姓名

__________________________________________  簽名

見證人

__________________________________________  簽名

日期
Appendix L

Information for Research Participants: Service Providers

Research Title:
Empowerment through Community Participation – A case study of a Chinese Peer Parent Leader Project in Toronto

Investigators:
Primary Investigator
Josephine Wong, RN, BA, BScN (Master of Science Candidate), Faculty of Nursing, University of Toronto, (416) 696-5179
Thesis Supervisor
Denise Gastaldo, RN, PhD, Associate Professor, Faculty of Nursing, University of Toronto, (416) 978-4953
Thesis Advisors:
Dr. Geraldine Macdonald, Faculty of Nursing, University of Toronto
Dr. Irving Rootman, Department of Public Health Science, Faculty of Medicine, University of Toronto

Purpose of the Research:
The purpose of this study is to explore the relationship of community participation and empowerment at the individual and community level. Specifically, the study will seek to understanding of the experiences of the participants in the Chinese Peer Parent Leader Project and the experiences of the community partners in organizing and implementing this project. I am doing this study as part of my degree fulfillment in the Masters of Science Program in the Faculty of Nursing at the University of Toronto. I believe that the findings of this study will help nurse, educators and community workers to plan effective health promotion programs in different communities.

Description of the Research:
The research consists of 2 focus group interviews – one with peer parent leaders and one with community workers at Toronto Chinese Health Education Committee. As a community educator/service provider, you will be asked to take part in a focus group interview with other colleagues of TCHEC Sexual Health Ambassador Subcommittee. Before the interview, I will ask you to fill out a consent form for taking part in this study.

Interviews and Observation:
The group interview will take about 3 hours. I will ask you some questions about your experience being involved in this project. You are encouraged to talk about your experiences, feelings and thoughts on the project. The interview will be taped so that I do not have to write down everything or forget some of the things you say. The group interview will be followed up by one individual telephone calls of approximately 5-10 minutes. A community colleague who has signed an agreement to confidentiality will assist me in taking notes during the interview.

Use of Project Data:
I will be using documents, such as training evaluation forms, field notes, reflective journals, community workshop evaluation forms and meeting minutes of this project as part of the research data. Before I utilize these data for the research study, I will have obtained consent from the peer parent leaders.
Confidentiality:
Since the interview will be conducted in a group, absolute confidentiality cannot be guaranteed. However, it will be strongly suggested that all research participants will respect the confidentiality of each other. Any information that you disclose will strictly be used for the purpose of this research study and will be kept confidential, except in situations when I am required by law to release the information (for example, information on child abuse cases, or professional misconduct). Pseudonyms will be used in the written notes and with any direct quote to further protect all research participants’ anonymity. All cassette tapes of the interviews, written notes, and computer disks related to this study will be stored in a locked filing cabinet. Information files related to this research on my computer will be password protected. I will be the only person with access to all the information collected for this study. Audio-taped interviews will only be listened to by myself and supportive members of my research team. Written notes related to this research will be read by myself, a bilingual Cantonese/English community service provider who will verify the accuracy of my translation, and my research committee (Dr. Gastaldo, Dr. Macdonald & Dr. Rootman) for the purpose of providing me advice, guidance and supervision. All audio tape recording related to this study and the written notes will be destroyed after ten years.

Participation:
Participation in this study is voluntary. After you agree to take part in this study, you are still free to withdraw from the study at any time during the research process, and you do not have to answer any questions you do not wish to answer. Whether you take part in the study or not, it will not affect your working relationship with Toronto Chinese Health Education Committee and its community partners including, Toronto Public Health.

Potential Harms (Injury, Discomforts, or Inconveniences):
There are no direct risks associated with this research study. It is possible that you may find it difficult or uncomfortable to talk about your feelings and experiences. If you become uncomfortable, you may end the interview at any time. Sometimes, self-reflection and discussions can lead you to have unexpected changes in thoughts, feelings or actions. If this happen to you and you need to talk to someone for assistance, I will do my best to find you the appropriate resources in the community.

Potential Benefits:
You may not benefit directly from this study. However, I believe this study will help health educators, nurses, community workers and other professionals better understand the impact of community participation on individual and community health such that they will be able to plan more effective programs in the future.
Appendix M  
Consent Form (For Educators/Service Providers)  

I acknowledge that the research information on the attached pages has been explained to me and any questions I have about the study have been answered to my satisfaction. I am aware of my right not to participate and my right to withdraw from the study at any time without compromising my working relationship with Toronto Chinese Health Education Committee or Toronto Public Health. I understand that the names and identifying information of myself and my family will be kept confidential and none of this information will be released except in situations when the researcher is required by law to do so, for example, information on child abuse cases, or professional misconduct.

I understand that the study questions will focus on my experience of being involved in planning, implementing and supporting the Chinese Peer Parent Leader Project and the impact of community participation on the health of individuals and their community. I am aware that the research study involves one 3-hour group interview and one or two follow-up telephone calls of approximately 5-10 minutes. I understand that the group interview and telephone calls will be audio-taped and the interviewer and her assistant will take notes during the interview and the telephone calls. I also know that documents such as training evaluation forms, field notes, reflective journals, community workshop evaluation forms and meeting minutes of the Chinese Peer Parent Leader Project will be used in this research study. When I consent to take part in this study, I also give the researcher permission to use any of these documents that are identifiable of me for the purpose of this research study.

I hereby consent to participate in this research study which will be conducted by Josephine Pui-hing Wong, a graduate student at the Faculty of Nursing, University of Toronto. I am aware that I can contact her regarding the research at (416) 696-5179. In case I am not satisfied with the information provided, I can also contact Dr. Gastaldo of University of Toronto, at (416) 978-4953.

Name of Participant ___________________________ Signature ___________________________

Witness ___________________________ Signature ___________________________

Date ___________________________
Appendix N
Request for Telephone Interview: Non-graduate

Dear __________________:

I am doing an evaluation case study on the Raising Sexually Healthy Children Peer Parent Leader Project organized by the Toronto Chinese Health Education Committee and Toronto Public Health in February 1999. I am doing this study as part of my degree fulfillment in the Masters of Science Program in the Faculty of Nursing at the University of Toronto.

The purpose of the study is to gain better understanding of your experience in taking part in this project. Part of this study involves a telephone interview with the participants who did not complete the program. The interview will take approximately 15-30 minutes and can be arranged at a time of your convenience. To protect the identity of you and your family, pseudonyms will be used in the written notes. All information gathered will be kept strictly confidential and used only for the purpose of this research study, with the exception of information that I am required to release by law; for example, information on child abuse cases or professional misconduct.

Participation in this study is totally voluntary. After you agree to take part in this study, you are free to withdraw from the study any time during the research process. Whether you participate or not, you and your family will continue to receive the same support/service from Toronto Chinese Health Education Committee and its community partners including Toronto Public Health.

There is no direct risk associated with this study. You may find it difficult or uncomfortable in talking about your experience or feelings. Sometimes self-reflection and discussions may bring unexpected changes in thoughts, feelings or action. If this happen to you, I will refer you to appropriate resources in the community. You may not benefit directly from this study. However, the findings of this study will help nurses, educators and community workers in to develop future programs.

If you agree to participate in this study, please signed the attached consent form and return it in the enclosed envelope to me. Please indicate on the form the most convenient time for me to contact you for the interview. I am looking forward to talking with you.

If you require any further information, please do not hesitate to contact me at (416) 696-5179 or (416) 338-0903. If you are not satisfied with the information, you can contact my thesis supervisor, Dr. Denise Gastaldo of University of Toronto, at (416) 978-4953. Thank you.

Yours truly,

Josephine Wong

MScN Student, Faculty of Nursing
University of Toronto
Appendix O: Request for Telephone Interview: Non-graduate (Chinese)

電話訪問徵求書

致：

本人正進行一項於1999年二月由多倫多華人健康教育委員會及多倫多公共衛生
署合辦之「華人家庭性教育家長大使計劃」的評估研究。此項研究是本人在多倫
多大學護理學院碩士課程的要求。

此項研究之目的是希望能了解你參與以上計劃的經驗。研究包括向一些沒有完成
計劃的參加者進行訪問，訪問大概需時15至30分鐘，而訪問可以被安排在方便
你的時間。為了保護你及你家人的身份，在記錄上會用別名代稱。所有研究的錄
音帶、筆記、電腦磁碟會存放在有鎖的抽內，訪問所得的錄音帶只會由本人及論
文委員會及一至二名已簽署保密協議的翻譯評估員收聽。所有研究資料都會被保
密、只會用於研究，除非本人在下列情況（例如：有關兒童受虐或違反專業操守
），被法庭要求提供資料。

此項研究的參與全屬自願性。就算你已同意參與此項研究，仍可在研究過程的
任何一刻自由地選擇離開。無論你是否參與此項研究，你及你的家人可繼續享用
由多倫多華人健康教育委員會及其合作團體，包括多倫多公共衛生署所提供的同
等支持及服務。

此項研究不會帶給你直接的危險，當你在表達自己的感受或經驗時，你可能會感
到困難或不適。有時候自我反省及討論亦可能會引起你意想不到的思潮、感受或
行動改變。若發生在你身上而你需要向別人求助，我會轉介你去適合的社區資源。
你或許不會在本項研究直接獲益處，但此項研究能協助護士、教育工作者、
社區工作員及其他專業人士計劃更有效的心理健康活動。

假如你願意參加此項研究，請將簽妥的同意書放進隨附的信封寄回給我，同時請
在同意書上指定最適合與你電話聯絡的時間，本人盼望能與你談談。

假若你需要更多有關此項研究的資料，請致電(416)696-5179或
(416)338-0903與本人聯絡。若你對任何提供的須知資料感到不滿，
你亦可致電(416)978-4953與多倫多大學的Gastaldo教授聯絡。謝謝。

黃佩卿(Josephine Wong)譯啟
多倫多大學護理學院
碩士研究生
Appendix P
Consent Form: Non-Graduates

I understand that the study will focus on my experiences in participating in the Chinese Peer Parent Leader Project. The purpose of the study is to explore the relationship between community participation and empowerment at the individual and community levels. I am aware that the research study will involve one 15-30 minutes telephone interview. I understand that the names and identifying information of myself and my family will be kept confidential and none of this information will be released except in cases when the researcher is required by law to do so; for example, cases of child abuse or professional misconduct.

I have read and understood the information provided on the Request for Telephone Interview letter. I hereby consent to participate in this research study which will be conducted by Josephine Pui-Hing Wong, a graduate student at the Faculty of Nursing, University of Toronto. I am aware that I can contact Ms. Wong regarding the research at (416) 696-5179 or Dr. Gastaldo at (416) 978-4953.

The best time to contact me for a telephone interview is ______________________.

_________________________________________________  __________________________
Name of Participant                                      Signature

_________________________________________________
Date
電話訪問同意書

本人明白這個研究會集中於本人參與「華人家庭性教育家長大使計劃」的經驗。這項研究之目的在於探討社區參與及個人自強和社區強化的關係。本大知道此項研究包括一次15至30分鐘的電話訪問。本人亦明白我的姓名及可以辨認我與家人的資料會被保密。所有資料不會被透露，除非研究員在下列情冫(例如：有關兒童受虐或違反專業操守)，被法庭要求提供資料。

本人已閱讀及明白此「電話訪問徵求書」。我同意參與此項由多倫多大學護理學院研究生黃佩卿所推行的研究。本人認知可以因與研究有關之各方面致電與黃佩卿(416) 696-5179或與多倫多大學的Gastaldo教授(416) 978-4953聯絡。

最合適致電訪問我的時間是_________________________________________。

__________ 參加者 ___________ 簽名

__________ 日期 ___________
Appendix R
Coding Tree using N-Vivo Computer Program

- Individual empowerment
  - Self efficacy
    - Parent-child
    - Family
    - Friends
    - Community
    - Self confidence
  - Knowledge & skills
    - Family sex education
    - Communication skills
    - Community resources
  - Critical thinking
    - Self development
    - Increased understanding
    - Attitude change
    - Social responsibilities
  - Behavioural change
    - Parent-child
    - Family
    - Friends
    - Community
  - Collective identity
    - Mutual support
    - Mutual influence
    - Common vision
    - Relationship
    - Collective actions

- Organizational empowerment
  - Empowering characteristics
    - Leadership opportunities
    - Autonomy
    - Shared decisions
  - Empowerment
    - Acquired resources
    - Community network
    - Shape community attitude

- Community empowerment
  - Intersectoral collaboration
  - Community partnership
  - Citizens participation
  - Resource development
Appendix R (continued)

- **Barriers to empowerment**
  - Systemic
  - Value conflicts
    - family
    - community

- **Immigrant parents**
  - Post immigration
  - Isolation
  - Gender issues
  - Cultural issues
  - Integration

- **Training**
  - Community needs
  - Outreach methods
  - Peer parent leaders
    - Motivation to join
    - Motivation to stay
  - Service providers
    - Motivation to join
    - Satisfaction
  - Group process
    - Conflicts
    - Resolutions
  - Program strategies
  - Program outcome
1: Date of interview: Sept 22nd, 2000
2: Present: 7 out of 10 leaders, the other 3 were not available.
3: Setting: Scarbo Civic Centre Training room, a place the leaders are very familiar with.
4: Process: Interviewer reviewed study information sheet, consent form and demographic form with participants.
5: 
6: Interviewer
7: What are your main reasons for joining the Chinese Family Sex Education Peer Parent Leader Project?
8: 
9: PL001
10: The main goal for me, well, I was mostly curious and wanted to expand my knowledge.
11: 
12: §1 PL002
13: My children have started to grow up, I was reading the newspaper and read the article about this training, I thought this would be very useful for me to use with my children. Also, I am a new immigrant, I thought I should expand my understanding and knowledge, and at the same time get to know some new friends.
14: 
15: §2 PL003
16: For me, it is because I am a divorced woman and I have a son. Since my husband is not around and I am a female, I felt that I really needed to learn some of these things. I was hoping that I would learn something about puberty so I could teach my son. Living here in Canada, there are so much conflicts between the East and West cultures, I really think it is important to learn more about all these issues (sexuality) so that if my child has questions, I would know how to answer. I read about this project in the newspaper, and knew that there would be a certificate, and the training time suited me, so I decided to join.
17: 
18: §3 PL004
19: I am a teacher (heritage program), I am often in contact with children. I felt that sexual health education is really important. I also wanted to consolidate myself, learn more things and get to know the community more.
20: 
21: §4 PL005

< Training/ motivation to join (Indigenous)

< Training/motivation to join (Indigenous)

< Training/motivation to join (Indigenous)

< Immigrant/cultural issues (Sensitizing)

< Training/outreach method (Indigenous)

< Training/motivation to join (Indigenous)
Appendix S (continued)

22: I have four children, they are growing up, although they did not directly ask me questions about sexuality, I felt that I really need to know more about it. I read the newspaper article, it even had your picture on it (laughs), so I called the phone number on the paper to sign up. I also called my friend (PL006) and told her about it. We decided to join together. I have 2 daughters and 2 sons, I wanted to know how to address the different issues and know how to face them when the time comes.

23:

24: §5 PL006

25: After moving to Canada, I stayed home to take care of the children, I felt quite useless and a lack of knowledge, goals and determination. I wanted to restructure my life, built an umbrella before it rains (be prepared) and learn more about different things to improve myself. My friend (PL005) told me about this project and I was glad I could join. When I first joined, I did not expect it (the training) to be such an excellent program; it is beyond my expectations and my demands. In our culture, there is a saying, "Sau son chai gar ji gauk ping tin ha" (To bring harmony to the world, govern the state, manage the home, we must begin with the self-cultivation). I find that joining this project has been very meaningful; before there were so many things that I did not have the knowledge and understanding, now I feel very happy, because we are learning meaningful things.

26:

27: §6 PL007

28: Just like the others, I wanted to see what the program was all about and learn some new skills.

29:

30: §7 Interviewer

31: Please share with us your experiences, thoughts and feelings during the training phase of the project, that is February to May 1999.

32:

33: §8 PL005

34: At the beginning, everything was new and interesting; that is very motivating. I wanted to learn more and build up my skills; after we learned for a while, and started to participate in the community, there is a new sense of social responsibility; so I spent a lot of time talking to others about what we learned. I wanted to devote all my effort. I felt it was very worthwhile. Some of the things we learned, it was not like I did not have any of
before, but it was more like reinforcing the positive things. Now I think it is very natural, family sex education is very natural. After coming to the training, I also developed interests towards other parenting workshops or training offered in the community. I have gained new ideas to use with my children. Any time, I see community workshops being offered and if I have time, I would attend. I notice that my character has changed to be better, I am a lot more calm towards my children. I also feel much more focused. Before, I have many methods that were not effective, now in terms of relating to my 4 children, it; much better. I felt that I can deal with family matters according to my principles, everything is in much better control.

36: §9 PL003
37: Yes, it was true, before I joined the project, I felt very timid and shy, you all know that (laugh). Now, there is some improvement, I felt much more courageous and bolder. Just like PL005, when I looked back, my parents never taught us anything about sex. I thought about it and I did not really want to be like my parents, so I was determined to be different, I must learn more so I can communicate with my son.

38: §10 PL007
40: Before I joined the program, I was very strict with my daughter. When I said yes, I meant yes, and there was no further discussion. That's why my daughter used to be very scared of me. After I joined the program, I found that I have become more reasonable, it is easier (for my daughter) to negotiate with me. I feel that I am learning more skills, everything becomes natural. Now when I spend time talking with my daughter, she would not feel that I am setting a trap for her, that I have special intention to pry things out of her. Now she feels more natural and trusting about our chats. You don't know, the things that teens are talking these days, there are many things that they would share with each other, and I am much more alert than before, I can pick from their conversation what the issues are and be prepared to help my daughter think through them.

41: §11 PL005
43: Yes, before it was kind of scary, I did not know how to teach them (about sexuality). After becoming a parent leader, it is much
easier. I feel that I am much more tolerant and patient (with children).

44: %12 PL004
45: I feel that my understanding towards sex and sexuality is much more holistic now. I see that sex education consists of so many components, including issues about gender, homosexuality. I have learned to look at things from others' perspectives. I learned to be embracing. Before, I thought that homosexuality was wrong and bad, now my views are different. Those negative views are gone. However, after attending the classes, sometimes, I went home and tried to talk with my sons. They felt a bit embarrassed, so when I told their friends that I volunteered, I did not tell them directly that I am a volunteer parent leader doing sex education, I did not want to make my sons uneasy. I don't understand why they feel that way.

47: %13 PL006
48: I feel that I really get it now. Before when I wanted to talk to my children about sex education, I would concentrate on it as if it was a separate topic. Now I realize that it is part of daily living, and I am looking at it with a much more holistic perspective. It is about communication, parent-child relationship, moral and values. These days, I am so relaxed when I talk about it that they think I am an expert (laugh). When we led the workshop discussions, it felt very rewarding when the parents (participants) responded and asked questions. Some of the questions were very impressive; they helped me to continue with my own reflections so it was not going to teach others things but to learn during the interactions.

50: %14 PL001
52: One of the things though, is the amount of time we have to spend on preparing for workshops.

53: %15 PL005
55: At the beginning, I was not used to doing presentation. I worried that the participants would have no response, worried about not knowing how to answer the questions, but now with more experience, it is not so worrisome. I think the program is fun and it provides skills. It is enjoyable. [laughs] We have good relationship, we often call up each other over the phone, ask each other for advice, we are not just acquaintances, we are good friends and can talk with each other directly.
Appendix T: Letter of Ethics Approval from University of Toronto

University of Toronto
OFFICE OF RESEARCH SERVICES

PROTOCOL REFERENCE #6284

June 27, 2000

Dr. D. Gastaldo
Faculty of Nursing
50 St. George St.
University of Toronto

Ms. J. Wong
Faculty of Nursing
50 St. George St.
University of Toronto

Dear Dr. Gastaldo & Ms. Wong:

Re: Your research protocol entitled, “Empowerment through Community Participation: A case Study of a Chinese Peer Parent Leader Project in Toronto”

We are writing to advise you that the Health Sciences Review Committee (membership list attached) has granted approval to the above-named research study.

The approved consent forms are attached. Subjects should receive a copy of their consent form.

During the course of the research, any significant deviations from the approved protocol (that is, any deviation which would lead to an increase in risk or a decrease in benefit to human subjects) and/or any unanticipated developments within the research should be brought to the attention of the Office of Research Services.

Best wishes for the successful completion of your project.

Yours sincerely,

Susan Pilon
Ethics Review Officer

SP/mr
Enclosure

cc: Dr. A. Moore, Dr. G. Donner, Dean
Appendix U

Agreement to Confidentiality: Translation Evaluator

I, ________________________________, agree to assist Josephine Pui-Hing Wong at the focus group interviews of the research study -- Empowerment through Community Participation: A Case Study of a Chinese Peer Parent Leader Project in Toronto. I understand that all information revealed at the focus group interviews must be kept strictly confidential to protect the participants and to maintain the ethical integrity of this study.

I, hereby agree to keep all information and data related to the above study confidential. I will not discuss the information with anyone except the principal researcher, Josephine Wong and her thesis advisory. I agree to return all the materials related to this research to Josephine Wong upon the completion of the interviews.

__________________________________________________________  ____________________________
Name of Interview Recorder                       Signature

__________________________________________________________  ____________________________
Witness                                               Signature

__________________________________________________________
Date
Appendix V

Description of the RSHC Chinese Peer Parent Leader Training Program

The RSHC Chinese Peer Parent Leader Training Program was guided by Adult Learning Principles; it embraces flexibility and self-directed learning. It consists of three core components:
1. Knowledge about human sexuality and children’s sexual development
2. Exploration of sexual attitudes/values
3. Skills development in communication and facilitation

These 3 components are embedded in each training session. Each week, project participants are encouraged to practice what they have learned in training with their children, family members or friends in the community.

Session 1
Introduction & Warm-up
Guiding Principles
Overview of the Project
Energizer: When should sex education begin at home? (Interactive exercise during which participants express their opinions on when parents should start sex education at home.)
Survey - Great Expectations: participants’ self-identified learning priorities and learning style
Communication Skills: Active Listening
Wrap-up & closure

Session 2
Introduction/Check-in
Sharing of Homework or Experiences
Warm-up/Energizer
What I think... (Quiz on Children’s sexual growth and development)
What is Sexuality? (Exploration on the multiple dimension of human sexuality)
Peer Leadership & Support (Written self-reflection exercise to identify participants previous experiences in helping and supporting their friends to problem solve.)
Where do children get their messages about sex and sexuality?
Homework: Treasure Chest (Participants to collect materials or messages about sex from the media and their personal surroundings to make their own treasure chest.)
Wrap-up & Closure

Session 3
Introduction/Check-in
Sharing of Homework or Experiences
Communication Skills: Say it with “I”... (Participants learn the skills of saying I feel... when you did... because... It is a technique that focuses on personal opinion/feelings, specific behavior, not the person, and consequences or impact.)
Family of Origin: Where I came from! Where will I go? (Participants discuss in small groups how different sexual issues were being deal with in their families and how those experiences impact on their current sexual values and behaviors.)
Wrap-up & Closure
Appendix V (continued)

Session 4
Introduction/Check-in
Sharing of Homework or Experiences
My hopes and Expectations... (Participants work in small group to complete the sentence – “I want to talk to my children about sexuality because I want them to grow up... Each participant contributes one hope or expectation.)  
Sexual Growth and Development of Children (Participants are given information and materials to work in small group to develop answers to a set of questions on children’s sexuality. At the end of the discussion, each group presents their answers formally as an initial step in developing presentation and facilitation skills.)
Homework: Participants are encouraged to read the RSHC Parent Workshop Manuals to get familiar with the materials. Continue to practice communication skills at home and in the community.
Wrap-up & Closure

Session 5
Introduction/Check-in
Sharing of Homework or Experiences
Identifying Important Messages from Previous Sessions (Participants take the opportunity to self-assess where they are at with their own learning; it also allows the facilitators assess and revise the program according to the needs of the participants)
Parents’ Role in Raising Sexually Healthy Children (Facilitate the participants in identifying their existing knowledge and expertise in raising their children. Provide information on how parent can help their children grow up healthy)
Answering Children’s Questions on Sex (Participants learn the principles behind answering children’s question – Why answer, When to answer, What to say and How to answer...)
Homework: Talk to another parent about Answering Children’s Questions on Sex. (An initial step toward developing peer outreach skills)
Wrap-up & Closure

Session 6
Introduction/Check-in
Sharing of Homework or Experiences
Review of Children’s Sexual Growth and Development
Energizer: Getting in Touch with Myself (A fun and interactive exercise in which each participant draw a picture of an object that represents his/her personality or how he/she feels. The aim of this energizer is to help the participants to take time and experience how energizing and nurturing it can be when it he/she takes time to focus on himself/herself in a fun way.)
Facilitation Skills: Giving and Receiving feedback (Participants work in small groups to share their experiences in giving and receiving feedback and discuss the challenges and develop effective way to give and receive feedback. This pave the way for the participants to take part in peer-evaluation and self-evaluation when they begin their community outreach activities.)
Homework: Participants practice giving and receiving feedback to their children and family members
Wrap-up & Closure
Session 7 and Beyond

The remaining training sessions focus on skills and confidence building. For each session, the facilitators choose one appropriate activity from each core component to meet the learning needs of the group.

Core A: Facilitation Skills
1. Remaining Neutral
2. Encouraging Participation
3. Gate-keeping/Bring everyone back to focus

Core B: Practice
1. Answering Children’s Questions on Sex or Sexuality
2. Answering Other Parents’ Questions about Family Sex Education or Children’s Sexuality
3. Dealing with Challenging Situations

Core C: Attitude, Values and Other Issues
1. When Children’s Sexual Behaviors Raise Concerns
2. Guest Speaker: Coming Out Experiences – members from GenerAsian Together
3. Revisiting “I think… the Children’s Sexuality Quiz. Where do I stand now?”

Core D: Community Development
1. Networking – Group Identity
2. Peer Support and Peer Leadership
3. Planning for Community Workshops and Outreach Activities

Post Core Training

Sessions for Practice:
- Mock Presentation
- Resource Development
- Sharing and Discussion
- Consolidation of knowledge and skills
Permission to allow inclusion of published material in the thesis

To: Toronto Chinese Health Education Committee
From: Josephine Wong, MSc. Nursing Student, University of Toronto
Date: March 19, 2001
Subject: Permission to allow inclusion of TCHEC Family Sex Education Bookmark in thesis

I am completing a master's thesis at the University of Toronto entitled "Empowerment through community participation: A case study of the Raising Sexually Healthy Children Chinese Peer Parent Leader Project". I would permission to allow inclusion of the following material in the thesis and permission for the National Library to make use of the thesis (i.e. to reproduce, loan, distribute, or sell copies of the thesis by any means and in any form or format).

These rights will in no way restrict republication of the materials in any other form by you or others authorized by you.

The material to be reprinted is: "TCHEC - Family Sex Education Promotion Begins with Parents, 1999"

If these arrangement meet with your approval, please sign this memo where indicated below. Thank you for your assistance in this matter.

Yours truly,

Josephine Wong

Permission granted for the use requested above:

Signature
Printed Name
CO-CHAIR, TCHEC
Date