BMJ Open

Perspectives of structurally marginalised patients attending contextually tailored and integrated care practices in Canada: a focused ethnography study

Christine Loignon [ID] ,[1] Sophie Dupéré,[2] Lynda Benhadj,[1] Diane Carru,[1] Simone Dahrouge[3]

[1]Family Medicine and Emergency, Université de Sherbrooke, Sherbrooke, Quebec, Canada
[2]Nursing Faculty, Université Laval, Quebec, Quebec, Canada
[3]Community Health, Université de Sherbrooke, Sherbrooke, Quebec, Canada

Correspondence to
Dr Christine Loignon;
christine.loignon@usherbrooke.ca

ABSTRACT

Objectives To better understand the experience of patients attending community-based primary healthcare practices (CBPHCPs) aimed at improving equity and access to primary care for underserved patients, which have been implemented locally in several countries, including Canada. There are currently little data on how, or to what extent, they mitigate patients' experience of social inequalities in care and improve their access to health. This study explored the impacts of the sociospatial characteristics of these practices on patients' care experience.

Design and methods Qualitative, multisite, focused ethnographic study based on in-situ observations and interviews, incorporating inductive and deductive analysis, and using the concept of sense of place.

Setting Three CBPHCPs located in deprived urban areas in two provinces of Canada.

Participants 28 structurally marginalised persons (17 women) attending the clinics, ranging in age from 18 to 79 years, and 16 managers, clinicians and practitioners working in these clinics.

Results Data underscored the importance of clinic proximity and accessibility in facilitating patients' navigation of the health system. Patients appreciated the clinics' positive sociospatial characteristics. Non-judgmental environments and informal spaces fostered patients' empowerment and social interaction among themselves and with peer navigators and healthcare professionals. The experience of supportive continuity of care had a positive impact on patients' sense of well-being and, for many, a positive ripple effect and long-term impact on their social integration.

Conclusion These results have important implications for policy given the current context, in which governments are challenged to support primary healthcare that addresses the social determinants of health to achieve greater equity. We conclude that scaling up contextually tailored care and deploying humanistic innovative organisational practices into mainstream care will help narrow the equity gap and reduce current prevalent social inequalities in the health system.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ This qualitative study highlights how the equity-oriented features of community-based primary healthcare practices (CBPHCPs), such as access to a social network of resources and to peer navigators, contribute to the empowerment and social integration of marginalised patients.

⇒ Using a focused ethnography approach, and especially with the trust and involvement of clinic gatekeepers, we were able to capture in depth the hidden dimensions shaping structurally marginalised patients' experience of care in CBPHCPs.

⇒ While transferability of the results is limited, credibility was ensured through the use of multiple methods, the involvement of multiple researchers in data analysis, and a process of continuous reflexion throughout the study.

INTRODUCTION

According to the WHO, primary healthcare (PHC) 'is rooted in a commitment to social justice and equity and in the recognition of the fundamental right to the highest attainable standard of health'.[1] PHC is strongly associated with healthcare performance[2] and health outcomes.[3–5] Yet, Canada's health system reforms have failed to address social inequities and do not benefit structurally marginalised persons (eg, living with poverty, social exclusion, racial discrimination).[6–8] These reforms, such as services reorganisation, practices standardisation and reduced professional time allocated to interventions, are changing caregiver–patient relationships.[9] Of particular concern are those who are socially stigmatised or living under deleterious conditions and who face persistent social and structural barriers in the health system.[10 11]

Sociocultural barriers deprive these patients of timely access to care.[12 13] Access may depend on clinics' location and people's 'ability to reach,' influenced by access to

transportation.[14] Despite having complex healthcare needs, these patients are more likely to have no family physician and to have negative care experiences.[15 16] Recent studies have shown they face significant barriers, including lack of transportation to clinics, and sometimes feel judged by physicians, which discourages preventive care-seeking.[16 17]

To address these gaps and strengthen equity, various countries or regions with universal healthcare are implementing PHC innovations aligned with 'equity-oriented healthcare'.[6] Innovations involving patient participation, a strong interdisciplinary team and care vision, partnership between community resources and healthcare organisations and support services such as community health workers, health services brokers, or peer navigators, hold promise for improving access and quality of PHC for structurally marginalised populations.[18 19]

This study focused on community-based PHC practices (CBPHCPs), which: (1) offer contextually tailored and integrated care and services (medical, psychosocial, community) in a single location or organisation; (2) adopt a holistic approach centred on patients' active involvement; and (3) use preventive and health promotion approaches that take into account social determinants.[20] While there are a variety of CBPHCPs in Canada, the USA and other wealthy countries, little scientific knowledge is available about their impact on the care experience and health of the marginalised people they serve, whose subjective views remain largely understudied.[18] It is therefore relevant to document users' perceptions of these clinics' practices, so as to inspire decision-makers and clinicians to implement solutions based on patients' perspectives.

In this study, we used the notion of sense of place, a multidimensional and dynamic concept from cultural geography comprising three core aspects: (1) geographic location; (2) physicality; and (3) meaning and affects.[21–23] Here, 'place' refers to two dimensions: subjective reaction (eg, feeling welcomed) and environmental characteristics (eg, furnishings, amenities, secure surroundings). The literature on sense of place as applied to care settings suggests both dimensions interact and affect well-being.[21] More importantly, 'place' is a space where individuals develop social relationships and undergo a process of identification with the place; it is, as Kearns and Moon suggest, 'an operational and living construct which 'matters' as opposed to being a passive 'container".[22] There is also growing interest in understanding how physical and social dimensions of place are subjectively experienced.[24]

METHODS
Setting and design
This study was conducted in three CBPHCPs located in deprived urban areas of two Canadian provinces: Quebec and Ontario (ie, within census tracts with a high percentage of low-income population, ranging from 30% to 40%).[25] These do not represent the current PHC model in Canada, but rather three alternative or advanced models of integrated medical and social care for vulnerable or marginalised populations. These models integrate prevention, collaboration with community organisations and comprehensive approaches promoting care quality and appropriateness. Our choice of clinics was also based on criteria of scientific legitimacy (credibility, transferability) and pragmatism (pre-existing collaborative links between the researchers and those organisations).

Our collaborative approach involved developing a relationship of trust with the managers, or 'gatekeepers'.[26] CL, LB, SDupere and SDahrouge had pre-existing relationships with these clinical settings, which fostered positive rapport with these gatekeepers. With them, we planned patient recruitment via the CBPHCP infrastructure. Our methodological approach used multisite focused ethnography, combining observations and semistructured individual interviews in several community-outreach clinics.[27 28] The strength of focused ethnography is that it targets specific contextual attributes and quickly generates contextualised data.[29] This was a pragmatic choice, as we had received funding for 1 year and had limited financial resources. Moreover, as with all ethnographic projects, this design allows for multiple perspectives, in terms not only of data sources but also of methods, which enhances triangulation and thereby strengthens internal validity.[30] This qualitative methodological approach is shown to be judicious when a phenomenon is little known, but especially when investigating certain populations such as persons encountering social and cultural barriers in the health system, whose previous experiences with research may have been negative, or even traumatic. CL and SDupéré have been involved in different projects with persons living in poverty and organisations that fight poverty, which may have enriched the study process. As the research assistant had a mixed ethnic background, this also may have aided recruitment in two of the three clinics with a multiethnic patient mix.

Patient and public involvement
This study was part of a larger research programme developed with the involvement of persons living in poverty and facing barriers to healthcare. The numbers and types of persons and their level of involvement varied over the course of the programme. We recruited eight persons living in poverty in Montreal who lacked PHC services and invited them to describe how they navigated the healthcare system. For this study, we also worked closely with three groups of 6–10 persons living in poverty, recruited through community organisations in Montreal and Quebec, which helped us in preparing data collection strategies (recruitment, interviews, etc) and analysing the PHC challenges and needs of marginalised people.

Data collection
Data were collected through on-site observations and both formal and informal interviews with patients,

managers, healthcare professionals and other personnel. We conducted the fieldwork in 2016–2017 in each clinic successively to produce a thick description. For consistency, all observations and interviews were conducted by the same research assistant, a bilingual female PhD student with a mixed ethnic background, trained in qualitative research.[31][32] She recruited patients in person, with the gatekeepers' assistance, applying four selection criteria: (1) materially or socially disadvantaged, that is, living in poverty, having a low literacy level and/or experiencing social exclusion; (2) receiving services at that clinic for at least 1 month for chronic conditions; (3) French speaking or English speaking; and (4) aged 18 years and over. We used a flexible collaborative recruitment strategy aligned with gatekeepers' preferences, daily workflows, ways of working, and schedules. We presented and explained our research objectives and inclusion criteria in staff meetings at each clinic. We used different recruitment strategies in each clinic, but for all of them we worked in tandem with the gatekeepers on site to identify potential participants corresponding to our inclusion criteria. Before conducting semistructured interviews, the interviewer verified in person with each participant whether they met those criteria.

The observation guide was developed by the research team, led by three experienced qualitative health researchers who hold PhDs (CL, SDupere and SDahrouge), in collaboration with clinic partners. It was validated and produced in French and English. Using patient shadowing techniques,[33] we observed daily activities, including patients' reception, encounters with professionals and managers, interventions by navigators and health professionals, referrals to community services, and on-site activities (mother–child workshops, cooking workshops). The guide described the setting, clientele, activities, patient–professional interactions and the clinic's medical and organisational practices. It was adjusted during data collection to better reflect each clinic's particular features. On-site observations were used to describe professionals' day-to-day practices and patients' healthcare routines in the community clinics. While we adapted the timing of observations to each setting and its activities, we spent at least the equivalent of five half-days in each clinic.

Semistructured individual interviews were conducted only with patients. An interview guide based on the literature was prepared by the researchers and validated by members of the clinical teams. It included questions about participants' experiences in the healthcare system, their perceptions of the benefits for patients using the clinic and ideas for improvements at the clinic, such as: How do the services and care offered by this clinic help you feel well and healthy? How do your visits to this clinic improve your living conditions (housing, employment, education, social relationships, etc)? What do you think about the approach health professionals use and how they interact with you?

Interviews lasted 45–60 min and took place in locations conducive to confidentiality, either at the clinic or

Table 1 Sociodemographic characteristics of participants (N=28)

Characteristics	n
Gender	
Women	17
Men	11
Age	
18–30	6
31–40	9
41–50	3
51–60	5
61–70	1
71–80	1
Unknown	3
Marital status	
Single	11
Married/partnered	12
Unknown	5
Children	
Yes	13
No	12
Unknown	3
Highest educational level	
Primary/middle school	3
High school/some college	12
University or postgraduate degree	10
Unknown	3
Employment/income source	
Unemployed/Welfare	18
Student	2
Employed	1
No income source	2
Retired/pension plan	2
Unknown	3

in participants' homes, at their choice. The interviewer introduced the study, explained the consent form and had the participant read and sign it before proceeding. Interviews were recorded and professionally transcribed. Recruitment ended when information from new interviews was redundant.[34] We interviewed 28 patients (17 women) aged 18–79 years. Half (n=14) were immigrants, of whom one-half were from African countries and the other half from Western Europe, Asia and Central/South America. A majority were living on social welfare or a government disability programme (see table 1). The numbers of patient interviews were nearly equal across the three clinics. We conducted informal unstructured interviews with 16 clinic managers or coordinators more than once, and with secretaries, physicians, nurses and peer navigators at least once. Informal interviews were

generally audio-recorded with the respondent's consent, and the content noted in the observation journal and subsequently analysed. Informal interviews were conducted during those observation half-days. These were unplanned, generally lasted just a few minutes, and were used to better understand the contextual factors influencing the patient experience at the clinic.

Data analysis

The research team (LB, DC, CL, SDupéré) conducted the thematic analysis iteratively to improve rigour and credibility.[35] In debriefing sessions held after a few days of clinic observations and after every two to four interviews, one researcher and one research assistant together reflected on the data collection, summarised findings, identified emerging hypotheses and prepared subsequent interviews. Through independent analyses of transcripts, we developed codes for themes and subthemes, which were then consolidated in team discussions. Each transcript was analysed by at least two team members, summarised, and coded manually. Once all transcripts were coded and analysed, CL, LB and SDupere met to compare coded data from each interview, create broad categories across the interviews and observations notes, and identify dominant themes.[35] We integrated our observation notes for the three clinics, producing a synthesis of similarities and differences. Based on numerous team debriefing sessions and extensive write-ups of patients' care experience, we identified major patterns and similarities across the clinics and patients' experiences. We then prepared a table with the main emergent themes, supported by quotations from all the interviews.[32] We shared our interpretations with our coresearchers and with professionals from the three clinics, and we maintained a logbook for the duration of the study. Key results were related to place, and our interpretation of findings was guided by the concept of sense of place. Data were analysed directly in French or English, according to the language in which they were produced. French quotations were translated into English for this paper. To promote reflexivity, during the course of the study we used peer debriefing following the interviews and observations and kept a logbook (including reflexive notes). After each semistructured interview, the research assistant completed an interview report to record the challenges encountered, the emotions experienced, her impressions and reflexive notes. The principal investigators (CL and SDupéré) regularly discussed the reflexive dimensions (ethical issues, intrusive nature of the ethnographic approach, recruitment choices and issues, etc) with the research assistant.

RESULTS
Description of the clinics

The clinics studied offer prevention and health promotion services as well as routine medical and psychosocial services to which certain populations generally have little access (disadvantaged and disenfranchised persons with mental health problems, pregnant women in precarious circumstances, people who inject drugs). Services are offered either on the clinic premises or through community partners.

Clinic 1 is a non-profit organisation founded in 2014 whose mission is to improve the health of structurally marginalised persons with limited access to healthcare. Its services are available in five community organisations across the city to patients coping with medical, psychological and social challenges.

Clinic 2 is a social perinatal care centre founded in 2007, operating in four neighbourhoods of Montreal. It offers medical and psychosocial services to vulnerable pregnant women and their families, most of whom are recent immigrants or refugees. It is a hybrid structure: a non-profit charitable organisation and a family medicine group within an integrated university health and social services centre (Centre intégré universitaire de santé et des services sociaux). The four service points are actual houses and function as such: patients are encouraged to walk in, use the space and make themselves at home, with or without an appointment.

Clinic 3 is one branch of a community health centre (CHC) that provides PHC and social services at different locations in Ottawa. Like clinic 2, it is a hybrid structure (non-profit community organisation/Ontario healthcare system). Building on the CHC model, it goes beyond healthcare services, offering a wide range of health promotion and community development services focused on social determinants of health for patients living with various types of social vulnerability.

Patients' experience of sense of place

Social and relational dimensions were central to the patients' experience of sense of place. Patients appreciated the relaxed care interactions and social interactions in these premises. They saw themselves reflected in the flexible care approach (the welcome and assistance received even without an appointment, the harm reduction approach taken with persons who used drugs, etc) and in the non-condescending regard of others. They could come to socialise without needing healthcare and find a 'friendly' and 'warm' place. This young man attending clinic 1 described it as a social space:

> I think there are so many people because some enjoy socializing afterwards and leaving after that. They're good people and they're doing their best to help people.

Through spending time in the clinics, many patients had developed significant social bonds with other patients, community or peer navigators, and/or professionals, all of whom welcomed them without judging when or how they showed up for medical attention or social services. Patients saw the care space (clinic) as a social space, a physically constructed and ritualised place where they could socialise, develop meaningful social bonds, and

strengthen their social and/or cultural integration, while obtaining care for their health problem in the short term.

Geographic proximity

All participants appreciated that the clinic's location in their neighbourhood removed transportation-related barriers (cost, time, etc). Our clinic observations and discussions with staff revealed how access to programmes and services revolved around the target populations' location and needs. For example, clinic 2 had opened three houses where their target clientele was more likely to be found, in deprived and multiethnic urban areas.

> I came, because also the clinic is closest to my home,… I'm a regular client, you could say, so they know me very well.

> This meets three-quarters of the demand in the local population. Someone passing by, he sees the clinic, he knows what it is, he comes in.

All participants, to varying degrees, noted that patients were familiar with these places and felt comfortable there. Clinic 1 is anchored in several community organisations that are local landmarks for deprived/marginalised persons. Their trust in the clinic stemmed from their trust in these community organisations and peer navigators, and from 'word of mouth' in the community.

Patients valued finding, under one roof, a 'home' or 'place like home', or, depending on their personal situation or health condition, a familiar place near home. Geographic proximity thus engenders a sense of social proximity. Patients reported feeling welcome; some even got involved as volunteers or peer navigators as a way of giving back to the community. The clinics developed organisational responsiveness and flexibility, adapting services quickly and progressively to meet expressed needs, thereby reinforcing the sense of social proximity.

Spatial informality

The clinics' spatial disposition appeared to strongly influence patients' experience. Their lively, colourful, warm and 'cosy' environments contrast sharply with the impersonal environments of medical clinics. In these inviting spaces, patients reported feeling welcome to enter, ask questions and socialise with the staff, including the community navigator, or other patients. There were familiar faces, people could come and go, and it was always possible to see a healthcare professional, even without an appointment.

For instance, clinic 2 functions like an actual house, with few spatial barriers. Patients are welcome almost everywhere, free to use the space as they wish. This is in sharp contrast to 'regular' clinics, where spaces (reception, waiting area, consultation rooms, etc) are clearly defined and patients must not wander without authorisation. In the clinics studied, services were more relaxed. Patients appreciated the informal spaces (kitchen, shower, playroom, etc) available and said this made the environments warm and reassuring.

> I feel I can stop by whenever I feel like it. [The clinic] is always open, with a kitchen where you can have a coffee, tea, and sometimes cook with others [during activities].

These places offer services that bring comfort and reassurance, such as spaces for playing with children and meeting other mothers (clinic 2), rooms where patients can eat together, or even bathrooms where they can shower (clinic 3). The clinics' physical characteristics and their attendance by people from the same social groups in the neighbourhood produced a sense of security and inclusion. Most patients made negative comparisons when referring to other clinics, to explain why they identified with this more welcoming place.

> You know, I see that I fit better in these surroundings than if I go to a clinic somewhere else and sit in a waiting room.

> Here, it's very cozy, it's like a little family.

Belonging to the place: respect, dignity, non-judgment

The staff knew everyone's names, greeted them warmly and treated them with respect. Patients said they did not feel reduced to their problem or illness but welcomed as a person with their identity and experience. We observed particular attention paid to literacy levels (time taken to listen, explanations in simple language, avoiding jargon), which the interviews confirmed. In these clinics, the experience is tailored to the patient, in contrast to the traditional healthcare system, where everyone is processed in the same way. Our observations and patients' comments suggest that the more relaxed attitude towards time is a dimension of the sense of belonging to place. One woman with a disability (stuttering) affecting her ability to express herself in medical encounters said the clinic was the only place where people took the time to listen and adapt to her disability, which helped restore her confidence in health professionals and improved her well-being. Persons who are stigmatised by the healthcare system do not 'fit in' easily, which creates tension with staff in other care organisations. Some patients reported having felt oppressed, judged or discriminated against elsewhere.

> People aren't laughed at here… There have been times when I've sent people to the ER because they needed to go there, and they were turned away and ridiculed.

> [At the local community service centre (CLSC)], I would lie about my substance use. But here, I laid it all out. I said, 'look, I used this much; I took this, and that, I used…'. If I'd gone to the CLSC, I wouldn't have said that.

Not only were they not judged, but also in some cases they were recognised and valued for their experiential knowledge. One mother at clinic 2 was invited to show an infant care technique to another. The social and

interdisciplinary aspects of medical practice were emphasised. Nurses reported being able to take more initiative, while doctors were less prominent. Structures were less hierarchical among professionals. The interdisciplinary teams discussed patients and decided together how to proceed.

Patients were reassured by the staff's positive and supportive attitudes. Staff made conscious efforts to create a feeling of inclusion for patients and avoid stigmatisation or judgement. The social context of care was taken into account by medical staff and shaped their practice.

> At the hospitals and other clinics I feel like a number, I feel like people are looking down on me.
>
> [Here] I feel like I'm on the same level as everyone else. I don't feel put down.
>
> I trust them…. They don't speak above me. They don't condescend to me. They don't use big medical terms.

Personalised care made the difference for these patients, who felt respected and treated with dignity. This lessened their resistance to medical personnel and fostered positive relationships. Peer navigators—people with whom they could relate—helped patients express their needs and questions to the health professionals.

> I think it's great there's a peer navigator, someone who's been through some hard stuff. He can warn you, 'Look, you're going to be refused [for a prescription], I know you're going to be angry soon', so, I'll prepare myself for that.

Things were simpler here than in the bureaucratic healthcare system. Staff were accommodating. Patients knew that if they showed up, they would see a professional, so they were more willing to return for follow-up.

> From the beginning, it was a clinic designed for people like me…. To me, it's complicated, family doctors, I find that CLSCs are complicated.
>
> It encourages you to follow up, which you wouldn't necessarily have done [before]…. [T]hose who were on the street… they don't like making appointments… taking elevators, and…. You know, when it's too complicated, people don't go.

Staff went the 'extra mile' to make sure patients feel supported. For instance, in one clinic a patient was still allowed to come in for care, despite having left the neighbourhood. Many patients refused to get treatment anywhere else. Even so, some complained about not having, or having very limited, access to specialised mental health services or free consultations on-site with psychologists or child specialists.

Long-term ripple effects: empowerment and social integration

Our analysis revealed unanticipated and long-term benefits of clinic attendance, far beyond appreciation of the professionals' humanism and the resolution of health problems. Indeed, most patients' reports attested to broader impacts on health and well-being, empowerment and social integration. For many, care from the PHC team and referrals to community-based services helped them gain self-confidence, take care of themselves and improve their overall health and well-being.

For many, the social relationships and trust developed through their clinic experiences inspired them to carry out a project or become more socially integrated. One woman who had attended clinic 2 subsequently became a peer navigator, helping women cope with the challenges of being mothers and women immigrants in vulnerable situations. Another woman, who had received financial support from clinic 3 to get back into shape, said this was a turning point in her life.

> [The] Woman's Live program they had, that program was so good. At first I didn't want to go at all, and now I'm completely sold on it. My gym life is what I live for…. And it's because of them, they sponsored me, they referred me, I got the subsidy, and that has been the… biggest new change that I've had in my life for years.

Several patients described how having access to the support and services network in the neighbourhood beyond the clinic's walls had helped their social integration. One mother, a recent immigrant, said the occupational guidance she received had lessened her anxiety.

> They give me a lot of information. So, with regard to my decision about what I might do here… in terms of an occupation, I told them my ideas, what I was aiming to do, and everything. They gave me advice, told me where I could go, all that. That's important for newcomers who don't yet have a source of income.

One patient described how the support and referrals to community-based resources had been a turning point for a woman at clinic 1 who was experiencing domestic violence.

> One woman, she had just been beaten by her partner, and she went to [agency X]. They helped her. They called a place so she could go to a battered women's shelter. She went there, and now she has a job, an apartment, and she has everything now.

DISCUSSION

The aim of this study was to deepen our understanding of the experience of structurally marginalised patients attending CBPHCPs offering contextually tailored care. The focused ethnography approach allowed us to capture in depth these patients' experience, an understudied phenomenon, particularly among the marginalised. This study makes a new contribution to understanding how, in the PHC experience, geographic and social proximity as well as infrastructure characteristics are of utmost importance for structurally marginalised patients.

Our study is noteworthy for its focus on the particular importance of clinic settings for people facing inequities in healthcare use. Few studies have explored, with nuanced sociocultural analysis, patients' experience in different types of contextually tailored care practices in urban areas in Canada. Our study showed that these clinics, strategically located to enable easy access for the socially vulnerable or marginalised, and presenting informal and inviting physical premises, promote a sense of inclusion among patients. The study also underscores the importance of humanistic, non-hierarchical clinical practices that strengthen relational proximity among people. Patients reported feeling emotionally secure and taking on social 'ownership' of these 'safe spaces', rather than just visiting them passively. For most, this had positive repercussions on their self-esteem, their trust in health professionals and their social relationships. For some, it also had an empowering and socially integrating effect.

Despite a vast body of evidence suggesting the importance of patient-centred care and of integrating social services and care, very few qualitative studies have considered the notion of sense of place in patients' experience of PHC practices. Indeed, there is abundant literature focused on personal factors related to marginalised patients in terms of healthcare access (non-compliance, low health literacy, etc). Our study focused more on system aspects, by exploring how a care setting's configuration and location, as well as the structure of the place, could affect patients. Our results corroborate other studies that have gone beyond patient characteristics to examine health system factors, such as distance to access a source of care or a PHC facility. When that distance is significant, it can lead to reduced service use and area-based inequities in health status.[36] The scientific literature is unanimous regarding the negative effect of distance. A study based on patient interviews found that geographic inaccessibility was a 'system-level' factor that inhibited access to quality care.[37]

It has been shown, for example, that structurally marginalised people, pregnant immigrant women, and people living on the street, for instance, are very sensitive to the quality of relational care, and that having access to responsive care when the person's social network is weak or absent has a positive impact on health.[38] Also, as mentioned by Browne *et al* in their work on equity-oriented care, PHC practices should address the dimensions of structural and interpersonal racism in their organisational strategies.[39] The present study adds the finding that accessibility is not the only vector of social integration; equally important is the care experience in an organisation that takes a humanistic approach centred on people's needs, including a social network of resources and peer navigators.

It is important to note that our patient respondents referred repeatedly to painful and stigmatising experiences of care in 'cold and hostile' environments elsewhere in the health network or prior to attending the clinic. These experiences leave scars that are difficult to repair and lead many to consult only in crisis.[15] The presence of navigators—people from the community who have experienced the same social situations or who were past patients of the clinic—appears to have a soothing effect on people's fears and enacted stigma. This type of intervention (peer navigation) has long been used in the mental health field, but not so much in PHC. Studies have found that these 'community connectors' support patients in navigating the system and help them improve their health.[40 41] The literature reports that interventions involving a support service such as community health workers, health service brokers, or navigators, hold promise for improving PHC access and quality for disadvantaged people.[19 42] However, qualitative research on the experience of patients and professionals involved in this type of innovation remains sparse.

While this study contributes significantly to the current state of knowledge on the importance of place in the care experiences of structurally marginalised people in contextually tailored care practices, it is important to note certain limitations. Even if our findings are relevant for other similar contexts, the focused ethnography approach was confined to three clinics, and the numbers of interviews and observations were limited by time and budget constraints, such that results reflect the experiences of only the individuals involved at the time of the study. Further observations and additional interviews could have enriched the data. Also, we did not conduct observations in the community, which might have provided more insight into the contributions of peer navigators in particular. Despite these limitations, we consider that this study makes an important contribution to understanding the effect of place on marginalised patients that should be taken into account in healthcare policy. There is growing evidence that neoliberal policies concerning healthcare services have undermined providers' ability to adapt to individuals' needs and diversity.[43] The policy environment in Canada favours a focus on clinical services and lifestyle interventions in PHC to the detriment of health promotion informed by a social determinants focus.[44] Future research is needed to identify how healthcare policy in Canada can better support equity-oriented services adapted to the needs of marginalised patients. We believe there is a continuing need to explore how solutions implemented at different health system levels, and especially in primary care, such as contextually tailored and integrated care practices, can enhance marginalised patients' access to health.

ORCID iD
Christine Loignon http://orcid.org/0000-0002-9828-3090

REFERENCES

1 WHO. Primary health care. fact sheet. World Health organization, Geneva, 2019. Available: https://www.who.int/news-room/fact-sheets/detail/primary-health-care [Accessed 14 Feb 2020].
2 Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q* 2005;83:457–502.
3 Macinko J, Starfield B, Shi L. The contribution of primary care systems to health outcomes within organization for economic cooperation and development (OECD) countries, 1970-1998. *Health Serv Res* 2003;38:831–65.
4 Shi L, Macinko J, Starfield B, *et al*. Primary care, social inequalities, and all-cause, heart disease, and cancer mortality in US counties, 1990. *Am J Public Health* 2005;95:674–80.
5 Shi L, Macinko J, Starfield B, *et al*. Primary care, income inequality, and stroke mortality in the United States: a longitudinal analysis, 1985-1995. *Stroke* 2003;34:1958–64.
6 Browne AJ, Varcoe C, Ford-Gilboe M, *et al*. Disruption as opportunity: impacts of an organizational health equity intervention in primary care clinics. *Int J Equity Health* 2018;17:154.
7 Tang SY, Browne AJ, Mussell B, *et al*. 'Underclassism' and access to healthcare in urban centres. *Sociol Health Illn* 2015;37:698–714.
8 Giesbrecht M, Stajduhar KI, Mollison A, *et al*. Hospitals, clinics, and palliative care units: Place-based experiences of formal healthcare settings by people experiencing structural vulnerability at the end-of-life. *Health Place* 2018;53:43–51.
9 Malone RE. Distal nursing. *Soc Sci Med* 2003;56:2317–26.
10 O'Donnell P, Tierney E, O'Carroll A, *et al*. Exploring levers and barriers to accessing primary care for marginalised groups and identifying their priorities for primary care provision: a participatory learning and action research study. *Int J Equity Health* 2016;15:197.
11 Wilkinson R. *The impact of inequality: how to make sick societies healthier*. The New York: New Press, 2005.
12 Reid C. *The wounds of exclusion: poverty, women's health and social justice*. Routledge, New York, 2004.
13 Malat J. Expanding research on the racial disparity in medical treatment with ideas from sociology. *Health* 2006;10:303–21.
14 Levesque J-F, Harris MF, Russell G. Patient-Centred access to health care: conceptualising access at the interface of health systems and populations. *Int J Equity Health* 2013;12:18.
15 Dixon-Woods M, Cavers D, Agarwal S, *et al*. Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups. *BMC Med Res Methodol* 2006;6:35.
16 Loignon C, Hudon C, Goulet Émilie, *et al*. Perceived barriers to healthcare for persons living in poverty in Quebec, Canada: the EQUIhealThY project. *Int J Equity Health* 2015;14:4.
17 Loignon C, Dupéré S, Fortin M, *et al*. Health literacy - engaging the community in the co-creation of meaningful health navigation services: a study protocol. *BMC Health Serv Res* 2018;18:505.
18 Samb O, Loignon C, Contandriopoulos D. Innovations visant améliorer l'accès aux soins des personnes vulnérables dans les pays de l'OCDE. *Santé Publique* 2019;4:497–505.
19 Henderson S, Kendall E. 'Community navigators': making a difference by promoting health in culturally and linguistically diverse (CALD) communities in Logan, Queensland. *Aust J Prim Health* 2011;17:347–54.
20 Browne AJ, Varcoe CM, Wong ST, *et al*. Closing the health equity gap: evidence-based strategies for primary health care organizations. *Int J Equity Health* 2012;11:59.
21 Hubbard P. Space/place. In: Sibley D, Jackson P, Atkinson D, *et al*, eds. *Cultural geography: a critical dictionary of key concepts*. I.B. Tauris, New York, 2005: 41–8.
22 Kearns R, Moon G. From medical to health geography: novelty, place and theory after a decade of change. *Prog Hum Geogr* 2002;26:605–25.
23 Moore A, Carter B, Hunt A, *et al*. 'I am closer to this place'--space, place and notions of home in lived experiences of hospice day care. *Health Place* 2013;19:151–8.
24 Schwanen T, Atkinson S. Geographies of wellbeing: an introduction. *Geogr J* 2015;181:98–101.
25 Statistics Canada. Census profile. 2016 census. statistics Canada catalogue No. 98-316-X2016001. Ottawa, 2017. Available: https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E [Accessed 11 Apr 2022].
26 McFadyen J, Rankin J. The role of gatekeepers in research: learning from reflexivity and reflection. *GSTF J Nurs Health Care* 2016;4:82–8.
27 Higginbottom GMA, Pillay JJ, Boadu NY. Guidance on performing focused ethnographies with an emphasis on healthcare research. *Qual Rep* 2013;18:1–6.
28 Gagnon AJ, Carnevale F, Mehta P, *et al*. Developing population interventions with migrant women for maternal-child health: a focused ethnography. *BMC Public Health* 2013;13:471.
29 Hammersley M, Atkinson P. *Ethnography: principles in practice*. 2nd ed. London: Routledge, 1995.
30 Lincoln YS, Guba EG, Pilotta JJ. *Naturalistic inquiry*. . Sage, Newbury Park, CA, 1985: 9. 438–9.
31 Spradley JP. *The ethnographic interview*. Wadsworth, Belmont, CA, 1979.
32 Wolf ZR. Ethnography: the method. In: Munhall PL, ed. *Nursing research: a qualitative perspective*. Jones & Bartlett Learning, Mississauga, ON, 2012: 285–338.
33 Fetterman DM. *Ethnography: step-by-step*. 2nd ed. Sage, Thousand Oaks, CA, 1998.
34 Malterud K, Siersma VD, Guassora AD. Sample size in qualitative interview studies. *Qual Health Res* 2016;26:1753–60.
35 Miles MB, Huberman MA, Saldaña J. *Qualitative Data Analysis: A Methods Sourcebook*. 3rd ed. Sage, Thousand Oaks, CA, 2014.
36 Bissonnette L, Wilson K, Bell S, *et al*. Neighbourhoods and potential access to health care: the role of spatial and aspatial factors. *Health Place* 2012;18:841–53.
37 Wellstood K, Wilson K, Eyles J. 'Reasonable access' to primary care: assessing the role of individual and system characteristics. *Health Place* 2006;12:121–30.
38 Battaglini A, Gravel S, Boucheron L, *et al*. Quand migration et maternité se croisent : perspectives des intervenantes et des mères immigrantes. *Serv Soc Que* 2002;49:35–69.
39 Browne AJ, Varcoe C, Ford-Gilboe M, *et al*. Disruption as opportunity: impacts of an organizational health equity intervention in primary care clinics. *Int J Equity Health* 2018;17:154.
40 Najafizada SAM, Bourgeault IL, Labonte R, *et al*. Community health workers in Canada and other high-income countries: a scoping review and research gaps. *Can J Public Health* 2015;106:e157–64.
41 Wallace C, Farmer J, McCosker A. Boundary spanning practices of community connectors for engaging 'hardly reached' people in health services. *Soc Sci Med* 2019;232:366–73.
42 DeHaven M, Kitzman-Ulrich H, Gimpel N, *et al*. The effects of a community-based partnership, project access Dallas (pad), on emergency department utilization and costs among the uninsured. *J Public Health* 2012;34:577–83.
43 Baum F, Freeman T, Sanders D, *et al*. Comprehensive primary health care under neo-liberalism in Australia. *Soc Sci Med* 2016;168:43–52.
44 Rootman I, Pederson A, Frolich KL. *Health promotion in Canada: new perspectives on theory, practice, policy, and research*. 4th ed. Toronto: Canadian Scholars' Press, 2017.